THIRD EDITION



Gerald R. Weeks and Stephen T. Fife

Couples in TREATMENT

Techniques and Approaches for Effective Practice

COUPLES IN TREATMENT

This third edition of *Couples in Treatment* helps readers conceptualize and treat couples from multiple perspectives and with a multitude of techniques. The authors do not advocate any single approach to couple therapy and instead present basic principles and techniques with wide-ranging applicability and the power to invite change, making this the most useful text on integrative, systemic couple therapy.

Throughout the book the authors consider the individual, couple, and intergenerational systems of any case. Gerald Weeks' Intersystem Model, a comprehensive, integrative, and contextual meta-framework, can be superimposed over existing therapy approaches. It emphasizes principles of therapy and can facilitate assessing, conceptualizing couples' problems, and providing helpful interventions. Couple therapists are encouraged to utilize the principles in this book to enhance their therapeutic process and fit their approach to the client, rather than force the client to fit their theory.

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Selected works by Gerald R. Weeks

Focused Genograms: Intergenerational Assessment of Individuals, Couples, and Families by Rita DeMaria, Gerald R. Weeks, and Larry Hof (Routledge, 1999).
New edition available June 2014.

Systemic Sex Therapy edited by Katherine M. Hertlein, Gerald R. Weeks, and Nancy Gambescia (Routledge, 2009).
New edition available February 2015.

A Clinician's Guide to Systemic Sex Therapy by Katherine M. Hertlein, Gerald R. Weeks, and Shelley K. Sendak (Routledge, 2009).
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Third Edition

Gerald R. Weeks and Stephen T. Fife

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To Nancy Love
— GW

To April Fife
— SF

We are grateful for their enduring love and support

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CONTENTS

List of Illustrations ix
About the Authors x
Preface xi
Acknowledgments xvi

PART I
Basic Principles and Processes of Couple Therapy **1**

1 Couple Therapy and the Intersystem Approach 3
2 Assessment, Case Formulation, and Avoiding Common Mistakes 13
3 Orienting Couples to Therapy 33
4 Systemic Conceptualization and Treatment 46
5 Keeping Therapy Balanced 55
6 Moving from Content to Process 68
7 Building and Managing Intensity 81
8 Systemic Therapy with Individual Clients 96
9 Common Factors of Change in Couple Therapy 105

PART II
Basic Approaches and Techniques **117**

10 Enhancing Intimacy in Relationships 119
11 Reframing 137

12 Communication Techniques 147
13 Conflict Resolution 160
14 Cognitive Techniques and Interventions 182
15 Techniques of Relationship Contracting 201
16 Working with Emotions 214
17 Homework: Extending Techniques from the Office to Home 228
18 Treating Infidelity 242
19 Working with Highly Reactive Couples 279
20 Solidifying Change and Maintaining Progress 291

References 297
Index 320

ILLUSTRATIONS

Tables

14.1	Individual Record of Automatic Thoughts	196
16.1	The "My World of Feelings" Exercise	219
16.2	Feeling Words	220

Figures

0.1	Gerald R. Weeks, Ph.D., ABPP	x
0.2	Stephen T. Fife, Ph.D.	x
1.1	The Intersystem Model	8
2.1	Intersystem Assessment Model	27
4.1	Circular Nature of Couple Interaction	47
9.1	Lambert's Common Factors of Change	107
9.2	Wampold's Common Factors	110
10.1	The Intimacy, Passion, and Commitment Triangle	121
13.1	Flow Chart for Conflict Resolution	171
14.1	A-B-C-D Model	184
14.2	The "Downward Arrow" Technique	195
14.3	Circular Pattern of Cognitive Distortions	197
19.1	Flow Chart of Two Wounded and Emotionally Reactive Partners	285

Boxes

10.1	Aspects of Intimacy	126
13.1	Essential Do's and Don'ts	168
13.2	Steps to Fair Fighting	169

ABOUT THE AUTHORS



Figure 0.1 Gerald R. Weeks, Ph.D., ABPP

Dr. Weeks is a Professor in a COAMFTE-Accredited program in Marriage and Family Therapy at the University of Nevada–Las Vegas and also in private practice. He is an Approved Supervisor, and Clinical Fellow of the American Association of Marriage and Family Therapy, and is Board-certified by the American Board of Professional Psychology and the American Board of Sexology. He has published 19 professional textbooks (8 in couple therapy) in the fields of psychotherapy, sex, couple/marital, and family therapy.

Dr. Weeks won the Outstanding Contribution to Marriage and Family Therapy in 2009 from the American Association of Marriage and Family Therapy, and was named the 2010 Family Psychologist of the Year. Among his most popular texts are: *Paradoxical Psychotherapy* (with Lou L'Abate), *Focused Genograms* (with DeMaria and Hof), *If Only I Had Known: Avoiding Common Mistakes in Couple Therapy* (with Odell and Methven), and *Systemic Sex Therapy* (with Hertlein and Gambescia). Several of his books are available in multiple translations. Dr. Weeks lectures nationally and internationally on the topics of sex and couple/marital therapy.

Dr. Fife is an Associate Professor in a COAMFTE-Accredited program in Marriage and Family Therapy at the University of Nevada–Las Vegas and also in private practice. He is a Clinical Fellow of the American Association of Marriage and Family Therapy, and member of the National Council on Family Relations. He has published and presented his research nationally and internationally on couple therapy, therapeutic change processes, and the foundations of effective clinical practice. His research has been published in several of the leading couple and family therapy journals. He also lectures extensively in the community on topics related to couple and family relationships. He is happily married and is the father of two sons.



Figure 0.2 Stephen T. Fife, Ph.D.

PREFACE

We are pleased to be able to publish the third revision of our text. It was originally written as a professional book, but is widely used in marriage and family therapy programs. The new edition presents the latest developments in the field of couple therapy, but maintains the same basic structure and goals of the previous volumes.

The purpose of this book is to present the concepts regarding the therapeutic process with couples and many of the techniques, methods, and strategies needed by the couple therapist. In several previous volumes, and Weeks (1989) and Weeks and Hof (1987, 1994, and 1995) presented a theoretical approach to couple therapy and provided an overview of the structure and process of treatment primarily through case studies. The current book presents the next step, which is that of providing the "how to" of couple therapy. In this book, we discuss the process of couple therapy, treatment approaches, treatment of some specific relationship problems, and how to properly implement the techniques with couples. Unlike other books on couple therapy which emphasize theory, our text is written by academic clinicians for the clinician who is seeking practical and effective applications, and for students taking a course in couple therapy

The book is divided into two sections. Part I provides the reader with an understanding of how to conceptualize cases from a systems perspective using a metatheoretical model developed by the senior author called the Intersystem Approach. This provides a framework for the clinician to systematically and theoretically integrate various approaches to dealing with couples. There are also several chapters devoted to the process of couple therapy. Most books on therapy will mention process, but none that we have seen offers so much on therapeutic process. A new and exciting addition to Part I is on the common factors in couple therapy. This chapter helps to balance the book between common factors in couple therapy. Part II of the book is a mix of how to treat several of the most common couple problems and how to apply different theories or approaches to couples, such as the application of cognitive therapy to couples. We also guide the reader through the effective implementation of interventions with couples. A clinician may know of a technique, but if the technique is not properly implemented it will be ineffective.

The authors selected scientific information from the field that had clear and effective clinical application and combined that with extensive clinical experience with couples. The senior author has conservatively provided over 30,000 hours of couple therapy and supervised hundreds of cases of couple therapy. The junior author has

also been practicing therapy and supervising graduate students for over 10 years, specializing in couple therapy. The skills and interventions described in this book are practical, straightforward, and foundational for couple work. Advanced skills, unorthodox techniques, and techniques with limited applicability have been purposely excluded. For this reason, the text is ideal for therapists who are beginning to work with couples and as a review volume for the seasoned couple therapist or for the therapist providing supervision. We believe this book has several unique features:

- It is grounded in the Intersystem Approach to therapy.
- It offers clear guidelines for assessment and conceptualization of couple problems.
- It offers practical suggestions for dealing with process issues.
- Approaches and techniques for resolving particular problems are discussed with an emphasis on implementation.
- New techniques are offered to deal with couple problems.
- It discusses common factors associated with positive outcomes in couple therapy, regardless of the specific model used by the therapist.
- The principles and interventions are applicable to diverse clients, recognizing that each couple is different and the therapy must be tailored to the client rather than forcing the client into a particular theoretical framework.

Another unique feature of this book is the emphasis on couples' growth and not just problem resolution. Many couple therapists assume that by eliminating problems they will enhance the intimacy of the couple. Our approach is to focus on both goals simultaneously—problem resolution with enhanced intimacy. To our knowledge, this volume is the only text that focuses on both. By adding the growth-oriented or intimacy enhancement dimension to couple therapy, the process is enriched for both the therapist and the couple.

Chapter Overview

Chapter 1, Couple Therapy and the Intersystem Approach, begins with an overview and history of couple therapy as a unique treatment modality. The primary focus of the chapter is to introduce readers to a comprehensive approach for the treatment of couples called the Intersystem Approach. The Intersystem Approach is meta-theory that is broadly applicable across different therapy approaches and provides an overarching framework to guide therapists in their work with couples. This framework emphasizes three interactive systems or subsystems that must be simultaneously considered when working with couples: the individual, the couple, and the intergenerational. The model provides guidance to therapists as they undertake assessment, conceptualization, and intervention with couples.

Chapter 2, Assessment, Case Formulation, and Avoiding Common Mistakes, describes the comprehensive assessment and case formulation of the couple using the Intersystem Approach. This assessment enables the clinician to formulate a multileveled treatment plan. The chapter also discusses some of the common mistakes made during the evaluation phase and provides suggestions for avoiding these pitfalls.

Chapter 3, Orienting Couples to Therapy, discusses principles that will enhance the ability of a couple to use the therapeutic process effectively. General topic areas include expectations and myths; boundary issues such as lateness, fees, and missed appointments; and instruction on how to help a couple take responsibility for their growth.

Chapter 4, Systemic Conceptualization and Treatment, emphasizes the importance of approaching the conceptualization and treatment of couples from a systemic perspective. The chapter contrasts linear thinking and interventions with a systemic perspective. The difficulties many beginning therapists have in learning to think systemically are elaborated through the descriptions of a number of systemic interventions.

Chapter 5, Keeping Therapy Balanced, covers the importance of balance in systemic therapies. Several techniques for a balanced approach with individual partners in dyadic therapy are discussed. The topics addressed include client understanding of balance, inclusive language, intensity and balance, and seating arrangement to promote balance. The chapter concludes with understanding psychopharmacology and balance, determining whether balance has been established, and loss of balance as an important area for personal insight.

Chapter 6, Moving from Content to Process, covers the challenges of learning to listen to the content of a client communication while understanding and being sensitive to the process. Content and process are defined and contrasted. Methods of understanding the process of a therapeutic session are enumerated.

Chapter 7, Building and Managing Intensity, orients the reader to skills of building appropriate intensity within a therapeutic session. The chapter presents various approaches to building intensity and emotional expression, as well as learning to manage them with couples. The use of images and analogies, a description of specific interventions to raise emotion, use of repetition, and the importance of focusing on primary themes and material are the main topic areas.

Chapter 8, Systemic Therapy with Individual Clients, discusses the use of systemic intervention when counseling an individual member of a marital dyad or committed relationship. Issues of balance, empathy, self-responsibility, and the development of personal power are emphasized.

Chapter 9, Common Factors of Change in Couple Therapy, addresses one of the most significant developments in couple therapy in the 21st century: the theory and research on common factors associated with change and positive therapy outcomes. Following a brief history of common factors debate and research, prominent common factors research and models are reviewed. The chapter concludes with a discussion of common factors unique to couple therapy and practical application of common factors in treatment.

Chapter 10, Enhancing Intimacy in Relationships, provides a growth-orientated model for the clinician based on a clinically useful theory of love. This chapter shows that many couple problems can be traced to the partners having underlying fears of intimacy. Techniques to enhance intimacy are suggested for the couple who want to move beyond a problem-focused therapy and the underlying fears of intimacy which generate many problems.

Chapter 11, Reframing, covers one of the most common of all therapeutic techniques used with couples. Reframing is a technique used to change the meaning

of symptomatic behavior from negative to positive and to change the couple from seeing their problem as individual to one of relationship. This technique appears simple but is very difficult to correctly implement. It is also necessary to reframe problems in a way that is congruent with the couple's belief system in order to lay the groundwork for the implementation of other approaches or techniques with couples.

Chapter 12, Communication Techniques, reviews common communication problems that couples bring to therapy and offers practical guidelines for working with couples to address these problems and learn to communicate more effectively. A general framework is used to teach couples different levels of communication, and specific techniques are reviewed. The authors also elucidate some of the implicit assumptions that facilitate couple communication.

Chapter 13, Conflict Resolution, addresses the issues of conflict as inevitable in all relationships and gives therapists guidance for constructively working with conflict in couple therapy sessions. This chapter examines anger and its underlying emotional components, and the meaning and function of anger in relationships. A model for conflict resolution is proposed that addresses conflict at the individual, couple, and intergenerational levels. The model helps therapists address the couple's feelings, attitudes, and motivations associated with anger before moving to the problem-solving stage of the conflict resolution model.

Chapter 14, Cognitive Techniques and Interventions, reviews an area of couple therapy that is often ignored by therapists: how and what partners think. The chapter reviews the application of cognitive models in couple therapy, with an emphasis on common cognitive distortions as they apply to couples. A systemic model for using cognitive therapy is described.

Chapter 15, Techniques of Relationship Contracting, focuses on several methods of contracting that couples may use to help collaborate to make behavioral changes in their relationship. General principles for creating, implementing, and maintaining contracts are discussed.

Chapter 16, Working with Emotions, follows the cognitive and behavioral chapters with a discussion of how to work with clients' feelings in couple therapy. The authors describe models and techniques to help the couple identify and express emotions. Guidelines are also given for therapists to effectively manage feelings in the session.

Chapter 17, Homework: Extending Techniques from the Office to Home, covers the subject of giving homework to couples in treatment. Many of the techniques in the book may be extended beyond the therapy hour to practice at home. This chapter discusses how to give homework, identifies the structural elements of a homework assignment, and offers suggestions to increase compliance with doing homework.

Chapter 18, Treating Infidelity, grew from students' and colleagues' requests for help in dealing with extramarital affairs. Affairs are among the most difficult and complex moral, ethical, and therapeutic challenges a therapist and couple will face. The primary focus of this chapter is to discuss assessment and treatment. We offer an integrative, structured framework and emphasize the latest research on forgiveness as one of the key components to recovering from an affair. However, forgiveness alone without the other components having been successfully completed is not likely to work.

Chapter 19, Working with Highly Reactive Couples, deals specifically with the therapeutic challenges related to highly reactive, narcissistically wounded couples. These couples are very difficult to work with and often fail to respond to traditional approaches to couple therapy. The dynamics of such couples are described and a step-by-step process is laid out for their treatment.

Chapter 20, Solidifying Change and Maintaining Progress, is directed toward helping couples sustain the changes they have made and prepare for the conclusion of therapy. Topics include encouraging clients to take responsibility for their progress and future success, tapering sessions, continuing relationship enrichment, preventing relapse, and addressing setbacks.

ACKNOWLEDGMENTS

In the early 1980s, Mr. Bernie Mazel, then President of Brunner/Mazel Publishers, asked if I (G.W.) would be interested in writing a book on couple therapy. He was familiar with the fact that I had been teaching one of only a few year-long courses in couple therapy, which was widely acclaimed.

Inspired by Mr. Mazel's suggestion, I and a colleague wrote the first edition of *Couples in Treatment: Techniques and Approaches for Effective Practice*. Writing this volume led us to appreciate how much our students have taught us about what is usable, and often used, by the beginning therapist. This third edition was written by myself and Stephen Fife, a new co-author who is an authority in the field of couple therapy. We not only teach and have our own practices, but also supervise students, and it is still the case that our students help us recognize what the beginning couple therapist needs to learn in the long trek to becoming an effective therapist.

After the publication of our first edition, Taylor & Francis bought Brunner/Mazel publishers. Marta Moldvai has been our constant supporter and Editor at Routledge. She and George Zimmar, Publisher, informed us that the book was selling well, was being used in training programs, and should be updated. We want to thank her for her excellent editorial work, patience, and help in moving this writing project along.

We want to thank several research assistants who tirelessly tracked down references for us and proofread the book from a student's perspective. Rebecca Nemecek, Justin Smith, Lauren McCoy, and Tamara Marsar did much of the heavy lifting in this regard. Additional assistance was provided by Austin Ellis, Tod Young, Lindsey Lee, Kathy Disney-Fairchild, Sarah Steelman, Heather Hoshiko, and Luisa Martinez-Cruz.

Part I

BASIC PRINCIPLES AND PROCESSES OF COUPLE THERAPY

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1

COUPLE THERAPY AND THE INTERSYSTEM APPROACH

Although marital and couple relationships received a modest degree of clinical focus during the first half of the 20th century, they emerged as a unique focus of treatment in the later part of the 20th century with the advancement of system theory and its application to psychotherapy. The development of systemic theories and therapies represented a major paradigmatic shift in psychotherapy. These therapeutic approaches represented a shift away from the individualistic and intrapsychic theories developed and employed by Freud and the psychoanalytic/dynamic therapists, as well as many cognitive–behavioral and humanistic models of psychotherapy. The systemic theories all share the concept of the individual-as-part-of-a-system, and they focus on interpersonal variables and relationship dynamics.

The past 40 years have been the "systems era" in the history of psychotherapy. In this short period of time, eight major schools have developed, which Kaslow (1981) grouped under the following headings: (a) psychodynamic–psychoanalytic; (b) Bowenian; (c) relational or contextual; (d) experiential; (e) structural; (f) communication–interaction; (g) strategic–systemic; and (h) behavioral. An additional school represents the most recent development in couple therapy and can be broadly classified as postmodern–constructivist, although not all systems thinkers agree that postmodern–constructivist approaches are systemic (Minuchin, 1998).

These schools of thought all share some basic assumptions about the systemic nature of dysfunction and treatment, but they are clearly different in content. In fact, these schools of therapy were originally presented as if each was to be used exclusively, without "cross-fertilization" from others (Gurman & Kniskern, 1981a). However, most practitioners of systemic therapy and others who are not systems oriented do not operate from such a purist basis. They recognize the implicit need to fit the theories to their clients rather than fitting the client to a single theoretical approach. Thus, integrative approaches have become more common among therapists addressing systemic issues.

This clinical need for integration has led to a new effort within the systems approaches. The latest development, one which spans approximately the last 30 years, is toward the integration of individually and interpersonally oriented theories and the integration of the various systemic approaches. A number of books and papers have been published advocating the synthesis or integration of various theories. Many of these texts have moved thinking within the field towards developing models demonstrating how different, sometimes apparently mutually exclusive, theories and

therapies can be combined. For example, Kaslow (1981) published one of the earliest papers advocating an integrative approach to family therapy, in which practitioners can draw "selectively and eclectically" from various theories.

Duhl and Duhl (1981) presented one of the first clinically integrated models that they called "integrative family therapy." They looked at all the levels of the system, for example, developmental level, individual processes, and transactional patterns. Their approach was focused primarily on how the therapist thinks and intervenes, and was less concerned with theoretical discussion regarding how theories could be integrated. Berman, Lief, and Williams (1981) also published a chapter in which they discussed how several theories could be integrated therapeutically. In this paper, they presented a coherent way of combining contract theory, object-relations theory, multigenerational theory, systems theory, and behavioral analysis all within a developmental and therapeutic model.

In addition, a number of other articles and books have appeared which address the issue of integration in systems therapy. These include: Hatcher (1978) on blending Gestalt and family therapy; Abroms (1981) on the interface between medical psychiatry and family therapy; Stanton (1981) on how to integrate the structural and strategic school; Green and Kolevzon (1982) on convergence and divergence in family therapy; Levant (1984) on a classification scheme for different theories; Lebow (1984) on the advantages of integrative approaches; a series of articles on the integration of structural–strategic therapy edited by Fraser (1984); Doherty, Colangelo, Green, and Hoffman (1985) on ways of reconceptualizing structure and distance in integration; Wachtel and Wachtel (1986) on designing intervention strategies based on family dynamics in individual therapy; Weeks and Hof (1987) and Hertlein, Weeks, and Gambesica (2008) on integrating sex therapy and marital therapy; and Weeks (1989a, 1989b) on integrating individual, couple, and intergenerational approaches. Additionally Case and Robinson (1990) and Snyder and Balderrama-Durbin (2012) both present excellent reviews of efforts at integration in couple and family therapy.

In revising our text, we were disappointed that more efforts toward integration in couple therapy have not taken place since our original publication of *Couples in Treatment* in 1992. With a majority of couple therapists utilizing integrative or eclectic methods (Lebow, 2003), it is surprising that there have not been more formalized attempts at developing integrative approaches to couple therapy. Nevertheless, some of the notable efforts include: Christensen, Jacobson, and Babcock (1995); Jacobson and Christensen (1996); Lawrence, Eldridge, Christensen, and Jacobson (1999); Clark-Stager (1999); Gurman (1992); Dattilio and Padesky (1990), and Dattilio (2010). The majority of the new efforts toward integration involve behavioral approaches and stress cognitive/behavioral-systems integration. The major work to come out of this effort, *Integrative Couple Therapy: Promoting Acceptance and Change* (Jacobson & Christensen, 1996), is an acceptable book on couple therapy, but does little to advance any systematic effort toward integration. They stress what we call an eclectic, rather than integrative, approach. Similar to many efforts at integration, Jacobson and Christensen's model lacks a coherent theory that ties foundational concepts and methods together; thus it is an approach based on technical eclecticism rather than being truly integrative.

In 2000, Johnson and Lebow published an article in which they considered whether couple therapy had "come of age" (Johnson & Lebow, 2000, p. 23; see also Gurman & Jacobson, 1995). Although marital therapy began formally in the 1950s and has received consistent, yet sparse, attention since that time, we question whether it has truly "come of age." There are relatively few texts on marital/couple therapy when compared to the number of books devoted to individual therapy and family therapy. Most training programs offer one course in marital/couple therapy even though they are called marriage/couple and family therapy programs. Clinicians and some faculty still believe anyone trained in family therapy can automatically do couple therapy. The fact is, these two approaches require different skill sets, although they share many of the same basic assumptions about the systemic nature of relationships. Our experience in training literally hundreds of therapists is that family therapists know relatively little about couple therapy.

Although the past decade has brought some improvements, the field of couple therapy has been overlooked and underfunded by governmental bodies such as NIMH. Couple therapy simply is not viewed as fundable research, which has meant university faculty struggle to investigate important questions about couple therapy. Thus, empirical studies historically have been scattered, and those that are conducted are often done with little or no funding or with small university grants, have small sample sizes, and are sometimes poorly designed.

Nevertheless, over the past two decades the field of marital/couple therapy endeavored to establish a foundation of empirical support for the effectiveness of treatment. These efforts resulted in an ever-growing body of research that has helped solidify several conclusions related to treatment effectiveness. First, couple therapy is effective. A meta-analytic review of effectiveness research revealed that those receiving couple therapy are better off than 84% of those not receiving treatment (Shadish & Baldwin, 2002). Second, the effectiveness of treatment is generally consistent, regardless of the treatment approach being used (Sprenkle & Blow, 2004a, 2004b). Part of the effort to improve the empirical support for couple therapy included efforts to determine which model(s) was most effective. However, results indicate there is not one couple therapy approach that is superior to the others. Because of these findings, some have postulated that there are certain curative factors related to successful treatment outcomes that are independent of theory or the treatment model being used (Asay & Lambert, 1999; Davis, Lebow, & Sprenkle, 2012). Chapter 9 discusses in more detail common factors of change in couple therapy.

Given the lack of funding for empirical research and a lack of scientific rigor in its early days, the field of couple therapy has attracted its share of self-proclaimed experts, many of whom are really expert self-promoters. Some of the more charismatic figures have managed to capture the attention of many of the newer, more naive members of our field. As an example, in the Johnson and Lebow (2000) article some of these figures are mentioned without due criticism of their work. The clinician who is unfamiliar with this field might assume a John Gottman and a John Gray are of equal significance and value to our field. In addition, both fields of marital therapy and family therapy are highly political. Certain groups are "in" and others are "out," depending on the source. In particular, the Johnson and Lebow article mentioned above, which purports to be a comprehensive review of the field, does not mention

the several volumes the current authors and others have produced, in spite of the fact that the senior author has published more professional texts on couple therapy than anyone in the U.S.

The therapist who is new to this field is urged to have a critical attitude and maintain a healthy degree of scientific skepticism, objectivity, and scholarship. Unfortunately these values are underemphasized in master's-level training programs, partly due to the fact that clinical practice tends to run ahead of empirical validation, and faculty do not stress the connection between research and practice. The clinician must learn to balance his or her clinical experience with sound theoretical arguments and empirically based research.

The Intersystem Model

There are a variety of formalized therapy approaches that therapists can choose from in their work with couples. These approaches generally align with one of the eight schools identified by Kaslow (1981). Nevertheless, the purpose of this book is not to review these models; this has been effectively done by others (for overviews of the various couple and family therapy models, see Goldenberg & Goldenberg, 2012; Gurman, 2008; Nichols, 2012; Sexton, Weeks, & Robbins, 2003). Rather, our intent is to present fundamental principles related to couple therapy in order to help the reader conceptualize and treat the couple from multiple perspectives and with a multitude of techniques. We do not advocate any single approach to couple therapy. The therapy should be crafted for the couple *and* their problem(s). Techniques can be sequenced and blended in order to tackle different problems and problems at different depths. The principles and techniques described in this volume are not advanced or complex. They are basic with wide-ranging applicability and power to invite change.

The model we present to guide therapists in their work with couples is known as the Intersystem Model. It is a comprehensive, integrative, and contextual model, originally conceived by Gerald Weeks and published in 1977 in a paper on dialectics in psychotherapy. This early article did not present the model in its current form but was the genesis of intersystemic thinking based on dialectics. The model was first presented in the 1989 edited book *Treating Couples: The Intersystem Model of the Marriage Council of Philadelphia* (Weeks, 1989a). The theory was further developed by Weeks in 1994 in *The Marital-Relationship Therapy Casebook: Theory and Application of the Intersystem Model* (Weeks & Hof, 1994; see also Weeks & Cross, 2004).

The Intersystem Model is not a specific approach to couple therapy. Rather it is a meta-model or meta-theory that provides an overarching framework to guide therapists in their work with couples. A meta-model, or meta-framework, can be superimposed over existing therapy approaches to help therapists know what to focus on and why (Fife, Whiting, Bradford, & Davis, 2013). The Intersystem Model, as a meta-framework, emphasizes principles of therapy, rather than specific theories or techniques. It is broadly applicable across different therapy approaches and helps facilitate the integration of different ideas, interventions, and theories. Its application can enrich the theoretical depth and therapeutic versatility of a clinician's work with couples.

According to the Intersystem Model, whenever a couple is being treated, three systems or subsystems must be simultaneously considered: the individual, the couple, and the intergenerational. Most other approaches to marital and family therapy focus only on one or two of these systems, whereas we have found a comprehensive approach requires focus on all three. The model increases the therapist's awareness of these different systems in terms of assessment, conceptualizing couples' problems, and providing helpful interventions. It also highlights the interactive nature of the three systems (see Figure 1.1). One system cannot be adequately understood without considering the influence of the others.

The need for this model stems from the limitations arising from two dominant forces in psychotherapy: individual philosophy and the natural sciences. An individualistic worldview makes up the philosophical foundation for most of the therapy models available to clinicians. Furthermore, the natural sciences promote a linear view of events (i.e., A causes B) and approach the natural world from a reductionist stance (trying to reduce complex phenomena to their smallest components). These two perspectives make it difficult to understand and treat relationship partners as an interlocking system. In contrast to traditional psychological theory, the Intersystem Model is grounded in a systemic perspective that accounts for the interconnected nature of couple relationships while simultaneously recognizing that couples are inherently made up of individuals and are also connected to other social systems (Weeks, 1994). As a meta-model, it can also provide a framework for therapists as they integrate various approaches in their work with clients.

The Individual System

Perhaps our most striking departure from other systems approaches is our recognition of the couple as a system consisting of two individuals. Other systems approaches have for the most part been anti-individual and anti-diagnostic in the traditional sense. Unfortunately, systems thinkers have been so intent on separating or differentiating themselves from individual psychotherapy that they have totally discarded the value of seeing the individual *as* an individual, as well as an important part of the couple system. In our approach to couple therapy, the individual's coping mechanisms, defense mechanisms, life cycles, ethnicity, intrapsychic dynamics, and individual psychopathology are assessed and treated within the context of the relationship, rather than denying that individuals exist in such contexts. We also recognize and draw upon the individual strengths and abilities that partners bring to therapy in order to facilitate progress toward the relationships goals they have for treatment.

The Couple System

Obviously, the couple's interactional system must also be assessed and treated, because a couple is more than the sum of its parts. Couples develop spoken and unspoken contracts, communication styles, patterns of dealing with or avoiding conflict, and so on, and the interactional system is usually the first experience a therapist has with a couple. As a system, a couple's interactions are circular, with each partner influencing and being influenced by the other. This system is always present and the easiest to

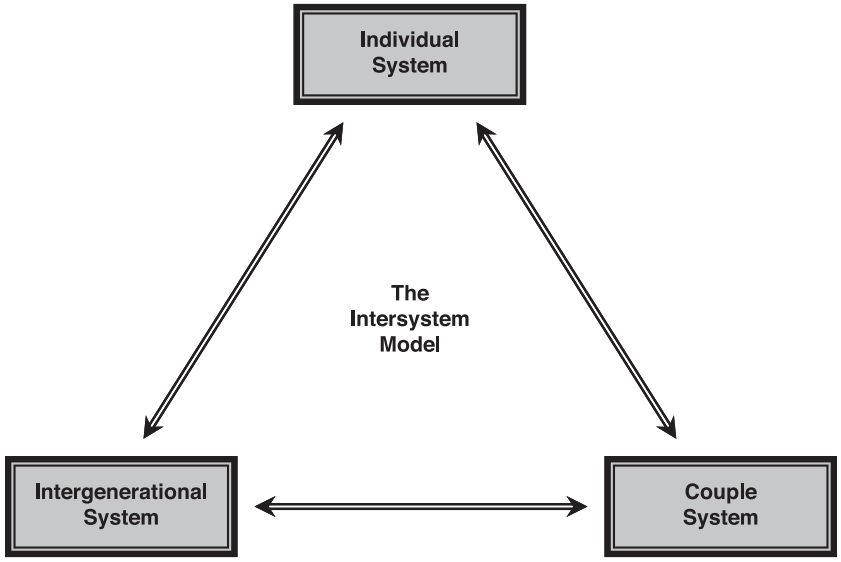


Figure 1.1 The Intersystem Model
Source: Adapted from Weeks (1994).

observe. Relationship dissatisfaction and dysfunction often are the couple's stated reasons for seeking treatment, so naturally couple therapy will focus on clients' problematic interpersonal processes. Although couples often present in therapy with a very problem-saturated view of their relationships, the couple therapist recognizes that each couple will have certain relationship strengths and resources (although perhaps dormant) that can be identified and incorporated into the treatment process.

The Intergenerational System

Many couple therapists focus their assessment and treatment of couples exclusively on the couple system, overlooking the importance of the intergenerational system. Each member of the couple has a unique history rooted in his or her family of origin. They draw upon experiences, expectations, roles, and behaviors from their parents to guide them in their own marriage or committed relationship. These experiences, historical and present, influence the current relationship. In many cases, couples recreate unresolved issues with their own parents or previous relationships using their partner or children as a substitute. Consequently, intergenerational influences are often hidden until an exploratory process uncovers them. Neglecting the intergenerational context of couples also means that therapists and couples may miss out on the family of origin influences that are positive, as well as resources and traditions from which clients can draw to improve their relationship.

Clinical Application and Therapeutic Principles

As a meta-framework, the Intersystem Model transcends specific couple therapy models. It is a model or meta-theory that views therapy as a theoretically integrative process. Thus, it does not offer specific prescriptions in terms of theories, techniques, or methods to use with clients. Non-integrative approaches each have their own set of defined techniques consistent with the theory. Our meta-theory recognizes that therapy is not a one-size-fits-all enterprise, and what works for one couple may not work for another. Therefore, therapists must be flexible in their methods and responsive to their clients. The principles of the overarching model help the therapist tailor therapy to the couple, rather than forcing clients to adapt to the therapist's model (Weeks & Cross, 2004).

The Intersystem Model helps clinicians think of multiple levels of clients/treatment concurrently: the individual, couple, and intergenerational systems. It provides a framework for clinicians as they make decisions related to assessment, case conceptualization, and treatment. For example, it guides therapists during assessment to focus on vital individual, relationship, and intergenerational issues that may be contributing to the couple's problems. Likewise, it helps facilitate treatment planning and interventions that focus on each of the three interrelated systems.

Weeks (1994; Weeks & Cross, 2004) argues that to be truly integrative, a model must (a) include both foundational and integrational constructs, and (b) retain the fundamental aspects of the combined theories while seeking to achieve an integrative balance that is clinically useful for therapists. As a truly integrative and contextual theory, the Intersystem Model contains the *foundational* and *integrational* constructs necessary to combine individual, interpersonal, and intergenerational theories of treatment. Foundational constructs are the underlying philosophical assumptions upon which a theory rests. The foundational construct for the model is dialectic meta-theory (Weeks, 1977, 1986), which is grounded in the thinking of Riegel (1976) and Basseches (1980). Integrational constructs include the concepts or principles that are used to integrate disparate phenomena. The integrational constructs of the Intersystem Model pertinent to this volume are based on Strong and Claiborn's (1982) model of social interaction. In particular, Strong and Claiborn's model includes six integrative principles: three interpersonal/interactional (congruence, interdependence, and attributions) and three intrapsychic (definition, interpretation, and prediction). Presenting the complex theoretical formulation of the model is beyond the scope of this book. Interested readers are referred to Weeks' earlier work (1977, 1986, 1994, Weeks & Cross, 2004), in which he thoroughly articulates the foundational and integrational aspects of the model. Nevertheless, there are some important principles of application within the model that the therapist should keep in mind in their work with couples.

Therapeutic Relationship

An important foundation for successful couple therapy is a strong therapeutic relationship between the therapist and the client(s). This begins with the process of joining. The clinician should be friendly, attentive, empathetic, respectful, supportive, and non-judgmental. Clients often fear that the therapist will be disapproving of

them. However, the therapist's overarching attitude is one of acceptance of each partner. Joining with clients also includes learning what their expectations are for therapy and developing an approach that is a good fit with them. The clinician works to remain balanced and join with both partners and to provide interventions that are congruent with the couple's expectations and needs.

As the therapist successfully joins with clients and presents a congruent and coherent plan for treatment, clients will come to trust the therapist and have confidence that by working together their needs will be met and their goals will be achieved. The therapeutic relationship must be attended to throughout the course of treatment. Therapy does not always proceed smoothly, and it is common for small ruptures in the therapeutic relationship to occur. Clinicians must be quick to recognize and seek to repair them, lest clients become disillusioned with therapy and/or the therapist.

Choice and Responsibility

An important part of the therapy process involves the therapist helping create a context in which change can occur. Therapists create this context by building a strong therapeutic relationship, helping clients feel they have choice in their decisions, and helping them accept responsibility for change. If therapists take over responsibility for change or get caught in clients' efforts to recruit them to one of their sides, then one or both partners may not perceive choice or responsibility and may reject the interventions the therapist offers.

Strong and Claiborn (1982) argue that change can either be forced or spontaneous. Weeks (1994) points out that when clients change because they are forced to (or feel that they are being forced), they often attribute change to someone or something outside themselves. "They experience themselves as *doing* something different, but not as *being* different" (p. 13, italics added). The effect may be that clients see change as being external to themselves, rather than something for which they are responsible, which may have a negative effect on whether the changes will last. Nevertheless, when a therapist creates an appropriate context for change, spontaneous compliance is more likely to occur, and clients are more likely to accept responsibility for change. For example, rather than using language such as "You should . . .," the couple therapist might engage clients in a collaborative process by saying, "Let's think together about what the two of you need to do . . ." Clients who accept responsibility for change will likely engage in the work necessary to reach their goals for therapy and sustain the progress they make in treatment. Furthermore, they are more apt to attribute successful outcomes to their own efforts rather than the therapist's efforts, outside forces, or luck.

A systemic approach also invites clients to accept responsibility, not only for their participation in relationship problems but also their role in resolving them. A systemic approach assumes circular, rather than linear, causality. Clients stuck in a linear view of problems blame their partner for the relationships problems, which leaves them believing that the other is the one that needs to change. In the end, such a perspective is disempowering, leaving the client with little choice and little motivation to change. However, as the therapist helps a couple see the circular nature of their struggles, individual partners can see that they are linked together in circular patterns (Weeks, 1994). For example, one partner may withdraw in response to the other's intense

efforts to engage him or her. The withdrawing leads to further efforts to connect, which may lead to more withdrawing. Each one's behavior invites the other in a circular, mutually perpetuating manner. Couples who learn the connection between their behaviors may come to accept more responsibility for change and ultimately the outcome of treatment.

Control

Closely related to choice and responsibility is the principle of control. Clients often view their problems as involuntary and uncontrollable. Part of the process of therapy is to help clients experience newfound control over what was seen as uncontrollable, volition over the involuntary, and mindfulness over mindless or automatic behavior (Weeks, 1994). Paradoxically, therapists help create a context for this kind of change by taking control of the process while not appearing to take control. As Weeks and Cross (2004) explain, "The process of therapy requires that the therapist be in control of the process. This is accomplished paradoxically by giving control back to the client in order to effect change. In this way, the client simultaneously learns self-control and self-reliance" (p. 60).

Therapists deliberately attribute change to the couple's efforts and help them embrace responsibility for and take ownership of change. As clients work through their struggles, they learn that their symptoms and behaviors—once thought to be beyond their control—are voluntary and controllable. When they experience change that arises from their own efforts, couples begin to attribute change and successful outcomes to themselves. As a couple's sense of control grows, so also will their confidence in their ability to maintain and build upon the changes they've made in therapy.

Context

Symptoms are best understood within the context in which they occur (Weeks, 1994). The individual, couple, and intergenerational systems are each part of the couples' relationship context, and each needs to be considered when assessing, conceptualizing, and treating couples. Clients bring complex problems to therapy, and the therapist must attend to the individual context, the interpersonal context, and the intergenerational context of the issues. The Intersystem Model provides a framework for understanding couples issues and then designing treatment that best meets their needs. Before applying interventions, therapists would be wise to thoroughly consider the multiple systems and contexts of their clients.

Integrating the Individual, Couple, and Intergenerational Systems

Marital/couple therapists constantly face the decision of which of the three systems they should focus on in treatment. Historically, couple therapists have seen these systems as discrete, and treatment has tended to focus on the individual/intrapsychic context of the couple (essentially individual therapy with each partner), on the here-and-now interactions of the couple (the interpersonal system/context), or on the

family histories of clients (intergenerational system/context) (Weeks, 1994). Therapists may feel overwhelmed by the thought of attending to all three systems simultaneously, and working on each one separately may seem less complicated. However, the Intersystem Model helps the therapist better fit treatment to the couple by providing a framework for integration that recognizes the complex nature and wholeness of individuals, couples, and families.

Each of the three systems relates to and interacts with the others in a dynamic way. A couple is made up of two separate individuals, each with his or her own internal processes (individual), who form a relationship system that transcends their individual selves (couple), and who bring with them family histories that influence both of the above (intergenerational). The three systems exert reciprocal influence on each other, and a systemic therapist recognizes that a change in one part of a system effects a change in the whole system. "Without considering all three systems and using them therapeutically, change would likely not be long-lasting" (Weeks & Cross, 2004, p. 64).

Integration is also facilitated by viewing clients through a systemic lens and helping couples come to understand the interpersonal nature and the variable contexts of their struggles. In fact, the first task of couple therapy is to view the couple as a system and to help the couple see themselves in this manner. Couples should come to see their behavior as reciprocal and interlocking.

Conclusion

Couple therapy is a highly dynamic and rewarding endeavor. There are multiple systems to which a therapist must attend, and the complex nature of couples' problems can be overwhelming. Doherty (2002) suggested that couple therapy is the most difficult form of therapy. He also suggested that most therapists are not very good at it. Yet there is a great need for well-trained, competent couple therapists. The purpose of this book is to illustrate fundamental principles of couple therapy. In this chapter we provided an overview and history of couple therapy and its distinction from individual psychotherapy. We also discussed the notion of integration and presented our integrative Intersystem Model. In the chapters that follow, we present more on the practice of couple therapy including assessment and basic principles, processes, and techniques of treatment. We conceptualize therapy in terms of process, rather than outcome, and couple therapists are encouraged to utilize these principles and techniques to enhance the therapeutic process and fit their approach to the clients, rather than forcing the clients to fit their theory.

2

ASSESSMENT, CASE FORMULATION, AND AVOIDING COMMON MISTAKES

In order to use the techniques presented in this book effectively, it is necessary to conduct an assessment of the couple and develop a formulation of the case. The assessment phase consists of the initial interview and may include up to four or five more sessions. This chapter will not focus on the details of how to conduct an initial session because this aspect of treatment has been adequately covered elsewhere (see Haley, 1976; Heller, 1987; Patterson, Williams, Edwards, Chamow, & Grauf-Grounds, 2009; Weber, McKeever, & McDaniel, 1985; Young & Long, 1998). Heller is a colleague of ours, and thus her article is especially representative of our approach. Instead, our focus will be on how to conduct a thorough assessment and case formulation. The chapter will also include ideas regarding common mistakes made by therapists. If these mistakes are made early on, especially during the assessment phase, therapy may be abruptly ended by the couple.

Our ideas for assessment and case formulation stem directly from the Intersystem Model, which was presented in Chapter 1. We advocate an assessment approach that is comprehensive, multidimensional, and multilayered, which will allow for comprehensive, multidimensional, and multilayered treatment. A case formulation is a method of summarizing the data provided by the clients into a theoretically consistent framework that includes the couple dynamics and a treatment plan based on those dynamics and the goals of therapy. Many case formulations in couple therapy are based on a single theory, which means the couple may be conceptualized and treated within narrow parameters. This fact exists because many practitioners tend to adhere to just one model of intervention. As we have indicated, the field is becoming more theoretically and technically integrated.

However, rather than being haphazard in combining ideas and interventions, we encourage clinicians to be knowledgeable and thoughtful in their integration of theories and techniques in their work with couples. Good therapists not only know *what* to do, they also can articulate *why* they decide to use certain interventions. In other words, good therapists have a sound theoretical rationale to support the interventions they use. The Intersystem Model is one framework that can facilitate thoughtful integration by couple therapists.

Before describing how to develop this type of case formulation, we would like to give the reader some guidelines on how to get started with the assessment phase of treatment. These guidelines are framed in terms of don'ts and do's, and are designed to help the clinician avoid some of the common mistakes which are made with couples.

Common Mistakes Made in the Assessment Phase

Assessment in couple therapy is a process that continues throughout the course of treatment. The therapist constantly monitors the couple for change and progress, as well as for newly emerging problems or setbacks. Because of this, assessment and treatment often overlap when doing couple work. Nevertheless, the initial assessment or evaluation phase is critical for the success of therapy and usually requires two to four meetings. During these meetings the therapist's task is to join with the couple, collect information needed to develop a case formulation, and avoid mistakes that would disrupt development of a therapeutic relationship. The first two of these tasks have been discussed widely in the literature. However, with the exception of Haley (1976) and Doherty (2002), little attention has been given to describing the typical mistakes a couple therapist might make that can abruptly end treatment. The purpose of this section is to list some of the don'ts and do's which are so important during this phase. Many of these ideas apply throughout treatment, but the importance of adhering to these guidelines is greater during the first few sessions than later sessions, as the joining process is still taking place and the therapeutic relationship is still forming. However, once the therapist has established a good therapeutic relationship with a couple, a mistake has less potential to result in premature termination, as couples are more likely to be forgiving and discuss mistakes openly with the therapist. Although we call this list don'ts and do's, the reader should view them as useful guidelines and not as dogma. The reader who is interested in an in-depth study of common mistakes made in couple therapy and how to avoid them may wish to read our book focused specifically on this topic (Weeks, Odell, & Methven, 2005).

Don'ts and Do's

1. *Don't take sides.* Therapists should remain balanced in their attention to each partner. It is easy to get seduced into taking one partner's side, especially when that partner's pathology or contribution to the problem is not as clearly evident. However, the therapist must keep a systemic perspective. Otherwise, one partner may feel sided against and decide not to return, and the accusing partner has his or her linear view of the situation reinforced. Systemic assessment requires therapists to recognize the interconnected aspects of couples and pay attention to the interpersonal dynamics of the clients. The therapist should shift back and forth trying to understand each partner's perspective. The way the therapist uses language during this phase is important. The therapist needs to utilize reflective listening and use phrases such as "It is your perception, belief, opinion, idea, thinking, feeling," and so on. For example, in response to a client complaining that his or her partner is controlling, the therapist might say, "It is your perception that your wife is controlling," rather than "Your wife controls much of your behavior." The latter statement implies that the therapist

agrees with the validity of the statement being made, while potentially disregarding the perspective of the other partner. Utilizing a systemic approach in assessment will set the stage for systemic intervention later on, which empowers couples to work together to bring about desired changes, rather than expecting change just in one's partner.

2. *Don't intervene too quickly.* Clients may come to the first session in crisis with an urgent desire or expectation to see changes right away in the relationship (or in their partner). One or both partners may see treatment as a last resort (i.e., "If this doesn't work then we are getting a divorce"), and they place a lot of weight on the first session or two. In response to the clients' anxiety and sense of urgency, the therapist may feel obligated to start changing the system before understanding it. Premature intervention may destabilize the couple in such a way that it is too threatening for them. It is best to go slowly and intervene in ways that appear safe or nonthreatening to the couple.

The primary task is to join and collect information early on in treatment. The couple can be told that change is a process and that the first few sessions will be to conduct the evaluation and then to develop a treatment plan with their collaboration. The assessment phase is also a good time to educate couples that change is going to require effort on their part, both during the sessions and in between sessions, and that therapy is designed to give them tools that, if applied, can help them manage their current and future problems.

3. *Don't answer questions from the couple until ready.* In some cases, a question from a partner is designed to show how the other person is wrong, at fault, sick, or crazy. Questions from each partner need to be viewed with caution and skepticism. For example, a client might ask, "How would you feel if your partner said that to you?" "Do you think it is a good idea for me to stay in this relationship?" "Do you think that is what a husband should say to his wife?" The therapist needs to quickly assess whether the question has a hidden purpose or is designed to get the therapist to take sides. Therapists may respond to problematic questions by saying they don't know the answer yet or by deflecting the question, asking the questioner what she or he thinks, and getting the partner to offer an opinion. Legitimate questions about the therapeutic process, such as how long a session lasts, should be answered openly and honestly.

4. *Don't assume you understand the real problem.* It can be enticing for a therapist to start interventions early on to show the couple that she or he can help, but without a thorough understanding of the problem useful solutions cannot be developed. Therapists should avoid the tendency to quickly assume an understanding of couples' problems, even if they have worked with clients who have had similar complaints or presenting problems. Prematurely foreclosing on assessment may leave the clinician with an incomplete understanding of the couple's problems and goals. Therapists must treat each couple as unique and conduct a thorough assessment and case formulation so they can tailor treatment accordingly. The real problem may not be highlighted or even mentioned during the initial session or for many sessions. The real problem may be too threatening to mention, such as partner violence or an

addiction, or the couple may too ashamed or embarrassed to mention it, such as in the case of a sexual problem. Clients may be testing the therapist and need to feel they have joined before revealing the nature of the real problem. When clients are avoiding the real problem they will present minor problems or vague problems such as "communication."

5. *Don't proceed until the problem(s) and goal(s) have been clarified.* Couples usually present with a number of different problems. In the initial session it is useful to get an overview and then come back to discuss the specific problems in greater depth. Part of the process is deciding which problems to work on first, whether the stated problem is the real problem, and whether the partners desire the same resolution of the problem. The couple needs to be clear on the goals for treatment. This includes identifying goals in terms of desired outcomes for their relationship. Couples often define goals in terms of what they do not want (e.g., "We don't want to fight any more," or "I don't want us to keep neglecting our relationship"). Therapists should help clients articulate their goals in terms of positive or desired outcomes (e.g., "We want to learn to communicate our feelings and solve problems in more constructive ways," or "I would like us to make nourishing our relationship a priority").

6. *Don't proceed until both partners have made a commitment to therapy.* Clients may come to the first session confused and uncertain about whether or not they want to stay in the relationship. It may be premature at the beginning of therapy to ask clients for a commitment to the relationship; however, before moving forward with treatment, therapists should confirm each partner's commitment to therapy. Doherty (2007) suggests this means that clients take divorce/separation off the table and agree to a course of treatment over a defined period of time where they both agree to put forth a united effort to build the relationship with the help of the therapist.

To obtain a commitment to therapy it may be helpful to discuss with clients how they would feel if they were able to work out the problems and what they would be willing to do to obtain the desired joy, peace, or happiness (whatever they want out of therapy). Once they have obtained a clear view of what they want, the therapist can discuss how long they are willing to work in therapy and try the solutions they discover in order to see if they can bring about the desired changes. At this point the therapist might want to reiterate that change is a process and that progress is best achieved through sustained effort over time.

7. *Don't assume that partners will perceive the problem in the same way.* Part of the reason the couple is coming to treatment is because they see things differently. The therapist should communicate this idea to the couple and not push for a similarity of perception or definition or even goals. At this stage, it is useful to normalize differences, stating that it will take time to work through these issues. When the therapist communicates this attitude, she/he is giving them permission to express their differences.

8. *Don't discuss problems abstractly and nonconcretely.* Couples will sometimes begin therapy stating their difficulties in abstract, nonspecific, nonbehavioral language (e.g., "We have communication problems"). This type of language does not lead to

any understanding of the problem, particularly the sequence of behaviors involved in their reciprocal interactions. The therapist can quickly move from the abstract to the concrete by asking who, what, when, and how questions. Therapists can also begin to emphasize the systemic nature of relationship problems by asking circular questions. For example, "When your wife is upset, how do you respond?" By focusing the couple to begin thinking in circular ways, they will usually see what the therapist needs and alter their description of the problems. In other words, while doing the assessment the therapist is beginning to teach them to view their problems as circular or interlocking patterns of behavior, which can be accomplished by asking the questions in certain ways and in a certain sequence. For example, after asking one partner about their behavior the therapist may quickly turn to the other partner to ask how they typically react and the reaction that is elicited in the partner.

9. *Don't discount problems, even small problems.* When partners come in together they are sometimes reluctant to discuss complaints openly, honestly, and with the intensity they actually feel about the problem. This tendency results in problems being understated or minimized. Some clients may do this to test whether or not therapy is safe for them or to see if their concerns will be validated. If the therapist allows small complaints to have validity it may help clients to open up about deeper issues. Although a problem may not seem significant to the therapist, she or he might ask the client how it is important to them. If clients feel the problem impacts them or their relationship, ignoring it has the potential to make them hesitant to open up and explore other possibly "bigger" concerns.

In some cases, the real problem is not brought up at all in the initial session because of the level of sensitivity, embarrassment, or shame associated with it. The therapist must read between the lines or listen with a "third ear" to what is being presented and go back to those problems at a later time, once the therapeutic relationship is established. Problems that are often understated include alcohol and drug abuse, emotional/verbal abuse, physical violence, financial issues, and sexual difficulties. Couple therapists should routinely ask about these issues as part of assessment to create space for these conversations. If the clinician brings these issues up as part of the assessment the clients may be willing to open up about it sooner rather than later. Nevertheless, the therapist should remain aware that partners may not be forthcoming at the beginning of treatment about these sensitive issues.

Additionally, the therapist could inadvertently fall into collusion with one partner by agreeing that the other partner's problem is not that distressing. For example, a wife may complain that her husband is not attentive enough. The husband may then discount her statement by giving numerous examples of being attentive. If the therapist summarily dismisses her complaint because of what the husband said, then she or he has colluded with him. In order to effectively join, the therapist must take each partner seriously.

10. *Don't allow differences to escalate.* Couples often come to treatment when they are unable to resolve their differences. In all probability they have struggled with these differences for some time and with some emotional intensity at home. During the assessment phase, the therapist does not want these differences to escalate. She or he wants to understand them and for each partner to feel heard and understood.

Additionally, therapists need to show clients that the therapy office is a safe place where differences and problems can be discussed openly without being attacked or mistreated. To do this a therapist should set boundaries and intervene quickly when interactions become too heated. The therapist can also normalize this type of situation, letting the clients know that all couples have differences and these do not necessarily mean the partners cannot get along or are incompatible. When the level of emotional intensity begins to escalate, the therapist can ask cognitively oriented questions (e.g., who, where, what, how) or shift to another topic, stating that it is clear the partners are very much at odds on the issue at hand and that it will be discussed later. Therapists who fail to appropriately manage the escalation of differences risk alienating clients and undermining their trust.

11. *Don't allow emotion to take charge of the session.* One or both partners may become emotionally distressed to the point of controlling the session. The therapist's task is to manage affect. In later sessions, the therapist may want to intensify and escalate affect. However, in order for the couple to feel safe and secure with the therapist early on, they must know the therapist is not frightened by their emotions and is able to keep emotional exchanges under control. In some relationships, one partner is controlled by the emotions of the other. If the therapist allows this process to be repeated, the controlled partner will not see how therapy can be helpful. Techniques to control affect are discussed later in Chapter 16, Working with Emotions.

12. *Don't unbalance the system.* This guideline has two meanings. The first was discussed above in terms of not intervening until the therapist understands the problem(s), goal(s), and consequences of change. The second meaning deals with siding with one partner or accepting one partner's definition of the problem over the other's. Although it may be useful to conduct separate interviews during the evaluation phase, one of the greatest risks is that of appearing to be or actually siding with one partner. Each partner may be very convincing about the pathology in the other. The therapist should reserve judgment, stay balanced, and keep a systemic perspective, especially at the beginning of treatment. Later in treatment it may be therapeutic to temporarily align with one or both partners to help the couple develop better balance and a stronger partnership.

13. *Don't make premature interpretations.* One of the fundamental techniques in psychotherapy is interpretation. In individual therapy, early and/or premature interpretations are often forgiven, overlooked, or constructively challenged. However, when an interpretation is made about one partner in the context of couple therapy, the therapist may be seen as blaming or siding with one partner against the other. It is best to contain an interpretation until enough information has been gathered to feel confident of its validity—and only after the joining process has been completed. The safest interpretations early in the treatment process are systemic (e.g., "The two of you appear to . . ." or "It seems when one of you does . . ., the other of you does . . .").

14. *Don't get hooked on the past.* When couples begin treatment, it is easy for them to begin rehashing the past all over again. The therapist may see the 50th

or 100th replay of an argument. The therapist's task is to help the couple change in the present. This includes enabling the couple to talk about the past and how the past is currently affecting them, while not to allowing the couple to regress or get stuck on past events. The therapist may need to intervene actively and directly when clients insist on recounting past grievances, which usually deteriorates to blame and accusations. Questions designed to unravel the interlocking or circular nature of an argument, get at individual meanings, and understand current feelings are helpful.

15. *Don't get hooked on the clients' theories or explanations.* Clients often have some kind of theory or explanation for their problems. It may be useful to ask, if the partners do not volunteer, how they each explain the problem. One way to keep their theories from getting put forth as the truth is to ask simply, "What is your theory about the problem?" The question communicates that whatever answer is provided is not going to be given the status of absolute truth. This way of phrasing the question is useful when the therapist reframes or redefines the problem because the therapist is not stuck with a definition of the problem that is viewed as the truth. A detailed description of reframing is presented in Chapter 11.

16. *Don't allow the couple to tell stories.* Some couples believe they have to tell stories in order to exemplify their problem. The stories may include elaborate detail and require a great deal of time to fully tell. Allowing couples to tell stories is not a productive use of time. Usually the stories amount to blaming the other partner for the problems, and the telling (and retelling) may have the result of further entrenching the person in this view of the problem. Some clients appear to be uncontrollably compelled to tell the therapist an in-depth story of their troubles, seemingly motivated by a belief that if the therapist knows all the details, she or he will surely agree with their view of the problem(s). When couples are allowed to engage in lengthy storytelling and blaming, therapists may find themselves feeling that they are being put in the position of being judge and jury on whose story is correct.

Of course, couples need to explain what is bringing them to therapy, but the therapist should attempt to get to the point that is being made by taking charge of the session. Otherwise, the therapist may be waiting 30 minutes while the full rendition of a story is given. The therapist can begin by asking focused questions in order to obtain information that is clinically useful. A useful technique is the "one question" question developed by Wright (1989) that asks, "If you could have just one question answered through our work together, what would that one question be?"

17. *Don't allow the couple to take charge of the session.* One of the most difficult tasks for the beginning couple therapist, and for any therapist at the beginning of treatment, is how to take charge of what happens in the session. Napier and Whitaker (1978) suggested that the therapist must win the battle for structure (while the client must win the battle for initiative). The therapist does not want to appear rigid or controlling, yet some partners/couples can be very controlling. In order to deal with situations when one or both partners attempt to control the interview, the therapist can stick to the evaluation procedures outlined below in a businesslike fashion and avoid the mistakes listed above. Of course, if the couple is in crisis, the evaluation

procedures are put on hold while the therapist takes charge of dealing with the crisis situation.

Case Formulation

Dattilio and Epstein (2003) stress that in order to understand the functioning of a couple, particular attention needs to be paid to the multiple layers in the system, which include individual characteristics, patterns that the couple has developed, and any interpersonal and physical environment factors affecting the relationship(s). The case formulation proposed here is comprehensive and is based on the Intersystem Model. It requires the therapist to have a general and broad understanding of systems theory, personality theory, psychotherapy, psychodiagnosis, and the major approaches to marital/couple and family therapy. This approach to case formulation has been used since 1984 in training student clinicians. Currently, students in our graduate program find this form of case formulation to be challenging and time consuming, but they report it is well worth the effort as it provides them with more insight than any other method they have used to conduct a comprehensive assessment. In order to develop a case formulation, we use the case formulation form (see below). The items on the form serve as a guide for clinicians during the initiation of treatment and assessment over the first few sessions. The case formulation form also guides the clinician in what information to collect and then how to use it in treatment planning. In our supervision, students are required to complete the form prior to receiving supervision on selected cases.

The first section of the form asks for general background information such as age, occupations, names of family members, and so on. It is also useful to know by whom and why the couple was referred. Permission should be obtained to talk with the referring therapist, often the therapist of one partner. The reason they were referred or referred themselves is very useful. Additionally, the form covers the presenting problem, history of the problem, and desired changes. There are also sections that focus on assessment and treatment planning, which are closely aligned with three aspects of the Intersystem Model. The remainder of this chapter will be devoted to reviewing this form item by item. Each section or question is numbered. These numbers will serve as reference points for the item-by-item description provided later in this chapter.

Case Formulation Form

Date of First Interview: _____

Partner's Name (First and Last): _____ Age: _____
Occupation: _____ Ethnicity: _____
Religious Affiliation: _____

Partner's Name (First and Last): _____ Age: _____
Occupation: _____ Ethnicity: _____
Religious Affiliation: _____

Years Married/In Relationship: _____

Children: Name: _____ Age: ___ Lives with you? __Yes __No
Name: _____ Age: ___ Lives with you? __Yes __No
Name: _____ Age: ___ Lives with you? __Yes __No
Name: _____ Age: ___ Lives with you? __Yes __No
Name: _____ Age: ___ Lives with you? __Yes __No
Name: _____ Age: ___ Lives with you? __Yes __No

Other Family in Home (Name, Age, and Relation):
Name: _____ Age: ___ Relation: _____
Name: _____ Age: ___ Relation: _____
Name: _____ Age: ___ Relation: _____
Name: _____ Age: ___ Relation: _____

Referred by: _____ Reason for Referral: _____
_____

1. Initial impressions and reactions:
_____
_____
_____
_____
_____

2. Precipitating event(s) that motivated them to seek treatment at this particular time:
_____
_____
_____
_____
_____

3. Presenting problem(s)—give a concrete description, including who, where, what, how. What is each member's view of the problem? How is the problem maintained in the system?
_____
_____
_____
_____
_____

4. History of the problem—abbreviated form of #3, above:

_____
_____
_____
_____
_____

5. Solutions attempted—including previous therapy:

_____
_____
_____
_____
_____

6. Changes sought by client(s):

_____
_____
_____
_____
_____

7. Recent significant changes—stressors and life-cycle changes (e.g., new job, move, death, divorce, child leaving home, etc.):

_____
_____
_____
_____
_____

Intersystem Assessment Questions

8. *Individual system (s)* (intrapsychic components, i.e., cognitive distortions and irrational thinking, defense mechanisms such as denial, projection; definitions, predictions, beliefs, expectations, and interpretations; past trauma; addictions; also include DSM diagnoses):

_____
_____
_____
_____
_____

9. *Couple system* (e.g., styles of communication; patterns of dyadic interaction; linear attribution strategies such as blaming, justification, vilification, rationalization, or debilitation; conflict resolution skills; emotional contracts; and so forth):

_____
_____
_____
_____
_____

10. *Intergenerational system* (e.g., scripts, boundaries, cutoffs, triangles, closeness-distance issues, anniversary reactions, attachment style, etc.):

_____
_____
_____
_____
_____

Treatment Plan Questions

11. Hypothesis regarding the client(s):

_____
_____
_____
_____
_____

12. Treatment plan & strategies (individuals, couple, intergenerational):

_____
_____
_____
_____
_____

INDIVIDUAL PROBLEMS	CHANGE STRATEGY OR TECHNIQUES
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

COUPLE PROBLEMS	CHANGE STRATEGY OR TECHNIQUES
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY-OF-ORIGIN PROBLEMS	CHANGE STRATEGY OR TECHNIQUES
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

13. Prognosis and expected length of therapy (provisional):

_____
_____
_____
_____
_____

14. What are your strengths and weakness in dealing with this client system?

_____
_____
_____
_____
_____

Item Descriptions

Item 1 deals with the therapist's initial impressions and reactions. It is the therapist's first, intuitive response to the couple. Clearly, this item is impressionistic and idiosyncratic. It consists of intuitions about the couple, strong emotional reactions observed and felt, and projections (countertransference) the therapist may experience. This item helps the clinician better understand the context in which the case is being formulated. For example, if the major initial reaction by the couple is one of extreme tension, fear, and suspicion, then all the data the therapist gathers about the couple are understood in light of this emotional context. If the therapist feels the couple is open and relaxed and both partners take some responsibility for the problem, the

therapist may believe what is being said is open, honest, and direct. The degree of probing and listening with a "third ear" would be needed less in this case.

Item 2 focuses on the specific event (or events) that have brought the couple to seek treatment. Of all the reasons couples might have for coming to treatment, most important is *what was the precipitating event that motivated them to seek treatment at this particular time*? Unless this question is asked, the therapist may not be told this critical event. Couples in treatment often report that, even though they had not been doing well for a number of months or years, they had become accustomed to the status quo—until a particular event occurred that prompted them to seek treatment. This event may serve as a catalyst for the couple to seek lasting changes in their relationship, or they might only be interested in resolving the precipitating event and then terminate treatment.

Item 3 has to do with obtaining a picture of the presenting problem(s). The therapist needs to get a clear and complete picture of all the problems partners want to address in therapy. Each partner is permitted to express his or her perception of the problem(s). After each one has a turn, they may be asked to comment on or ask questions about the other person's perception of the problem. An essential part of asking about the presenting problem(s) is to get a sense of each problem from an interactional or circular perspective. The therapist always maintains a systemic perspective and searches for the contributions that both partners make to the problem. By exploring the sequence of behaviors through a complete cycle, the therapist may begin to discover the role of each partner. What appears to be a problem in only one partner may be part of an interlocking system of behavior.

Item 4 asks about the history of the problem(s). Once the current problem(s) is/are understood, it is useful to find out whether the pattern has been the same or different in the past. In some cases, the therapist may see the same pattern with reversals in roles. The problem(s) may predate the current relationship, having been present in prior intimate relationships. If the problem has a beginning in time that can be identified, it is useful to know what precipitated it. Perhaps the problem began the day after marriage, after the discovery of an affair, or with a life cycle transition, such as the birth of a child.

Item 5 is aimed at getting some information about the solutions the couple has tried in order to solve the problem. In some cases the couple will have a history of therapy that was unsuccessful. The current therapist will want to know how or whether their previous therapy ended. Some couples jump from therapist to therapist prematurely with no therapist ever given a chance to help. Knowing what happened in the previous therapy lets the present therapist in on the problems discussed earlier and the efforts made to solve those problems. Because the previous therapy may have been unsuccessful or incomplete, the present therapist wants to avoid mistakes made earlier or interventions that did not fit with the couple. Asking about a couple's attempted solutions may also help the therapist learn what has worked for the couple and may give direction to the therapist in preparing a plan for treatment.

Item 6 gives the therapist the opportunity to find out the couple's goals. After the couple has described their problem(s) and it is clear to the therapist what the problem(s) is/are, the therapist should not make any assumptions about what kinds of changes are desired. Each partner should be asked what they want changed. The

therapist must seek to help the couple find some common ground regarding the changes they want and their goals for therapy, and collaboratively decide on the order in which the work will be done. Couple therapists often feel compelled to offer interventions quickly to clients, especially when couples are in crisis. However, doing so too soon can be detrimental if the couple and the therapist are not clear on the goals and desired outcomes.

Item 7 recognizes the importance of stressful events in precipitating and/or creating problems. The therapist may simply ask what changes and stresses have occurred during the last 2 years, especially the last 6 months. The therapist can also give some examples, such as a death in the family, health problems, job loss, moving, the birth of a child, divorce, problems their children are having, or issues with extended family. Many couples will not connect the level of change/stress in their lives to their relationship problems. Yet problems such as these have the potential to place a significant strain on a couple's relationship. The number of challenges in some couples' lives is truly remarkable, and the therapist can help them understand the consequences of these events for their relationship. Therapists may also ask about the ways in which their challenges have brought them closer together as a couple.

The first seven items of the case formulation are data-based. Subjective and objective information is gathered. The therapist sticks close to the data without drawing many inferences. Items 8, 9, and 10 are more inferential and focus on the three systems that make up the Intersystem Model. The data are now being organized according to different levels and theoretical systems. Figure 2.1 (Weeks & Cross, 2004) illustrates how this portion of assessment and case formulation can be organized around the three interrelated systems.

Item 8, which assesses the individual system, may strike the couple therapist as odd within the context of a systemic approach. Marital and family therapy started as a reaction against individual psychopathology and therapy (Nichols, 2010). For many years individual concepts have been viewed as antithetical to systems thinking. Yet, couples are composed of individuals, each with his or her own set of genetics, beliefs, expectations, behaviors, history, dynamics, and possible pathology. To deny this fact for the sake of taking a pure systems perspective would be unnecessarily dogmatic and also limiting. Consequently, we suggest an assessment of each individual's mental and emotional health. This includes, but is not limited to, the individual's emotional and cognitive well-being, use of defense mechanisms and cognitive distortions, past trauma, and addictions, as well as the concepts of definitions, predictions, beliefs, expectations, and interpretations mentioned earlier in the book. Including individual DSM diagnoses is appropriate in this section of the case formulation. Therapists also need to be aware of the physiological limitations of clients. Dattilio (2010) highlights that there are certain neurobiological processes that can limit change for individuals in therapy. Some of the struggles the client is experiencing may need to be dealt with by referral to and/or collaboration with another professional outside of therapy such as a family doctor, psychiatrist, or neuropsychologist (Dattilio, 2010). For example, trying to do couple therapy when one partner has a major depression or ADD may not work. The individual problem may need to be treated first.

The issue of individual psychopathology requires the therapist to consider the interlocking nature of psychopathology. In our companion text, Goldberg (1989)

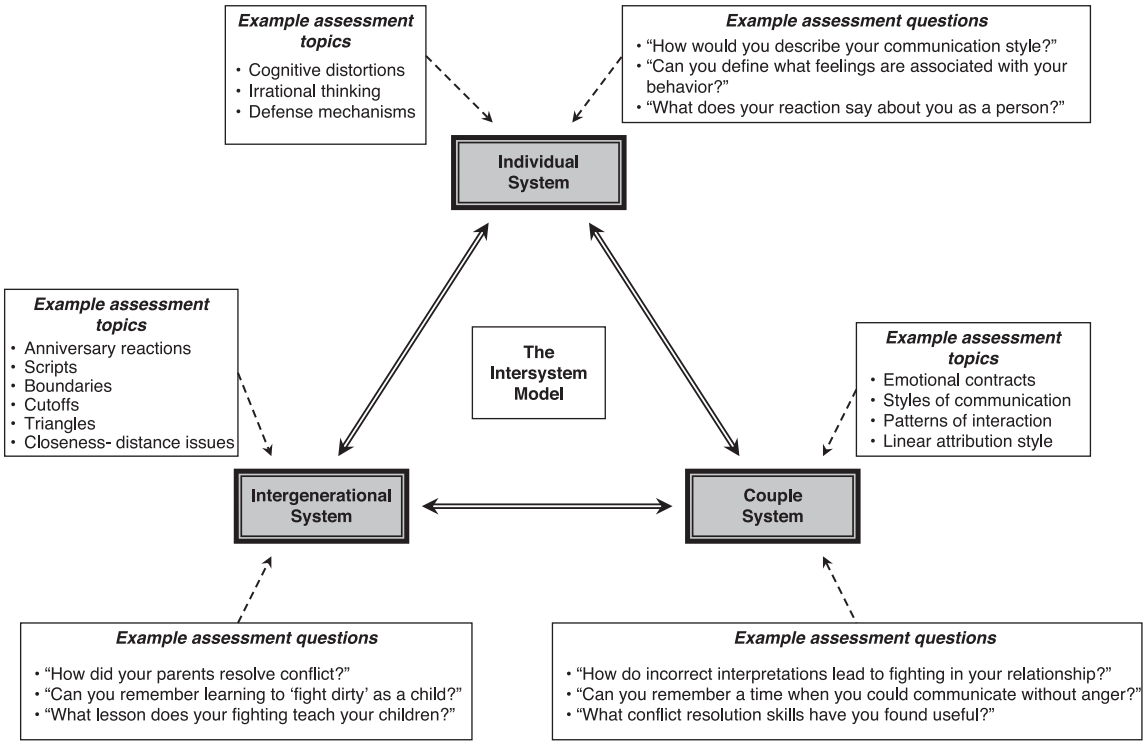


Figure 2.1 Intersystem Assessment Model

discussed how to view individual pathology from a systems perspective. Some systemic models assume that partners are equally healthy or unhealthy and that the severity of individual pathology is often quite similar. That notwithstanding, an area which has been neglected in diagnosis with couples is that of personality disorders and other individual pathology. We see numerous cases in which partners present with co-occurring personality disorders or traits of personality disorders. Some common combinations of personality disorders are the narcissistic/dependent or inadequate pair, obsessive-compulsive/histrionic-borderline pair, and the aggressive/dependent pair. Millon (1981) has written extensively about these personality types in his book entitled *Disorders of Personality* (see also Millon, 1999).

Individual diagnoses help the therapist understand and treat the interlocking part of the pathology. The couple may also need concurrent individual therapy which is co-ordinated with the couple therapist. Obviously, some individual pathologies require attention prior to the onset of couple therapy. Severe psychopathology is a clear contraindication for couple therapy. Cases involving psychosis, severe depression, suicide, and drugs/alcohol abuse all require individual attention first. In general, individual diagnoses should not be emphasized with couples, as they may be used by one partner to project more blame or criticism onto the other.

Item 9 is the part of the case formulation most directly concerned with the couple's functioning. This item involves assessing the interactional problems of the couple in accord with any number of marital/couple therapy models and concepts. Some of the common concepts in this category deal with deficits in communication and conflict resolution skills, interlocking cognitive distortions, dysfunctional patterns of interactions, emotional contracts, and inappropriate and blocked emotions. Special emphasis should be given to understanding how the couple uses attributional strategies, which are designed to externalize personal responsibility and blame the other partner for the marital problems. In couples, a spouse manifesting certain symptoms (e.g., depression) may simply blame the other partner for the dysfunctional mood. The linear attributional tactics seen in couples are, however, more varied than simple projection.

Four methods of destructive linear attribution have been identified by Strong and Claiborn (1982).

1 *Justification* is the practice of assigning the negative or harmful effects of one's behavior onto external causes (e.g., "I cannot help the way I act because of my partner's behavior").
2 *Rationalization* is the practice of denying that one's internally controlled behavior was intended to be harmful (e.g., "I just did it [*it* being overcontrolling] to help you").
3 *Debilitation* involves assigning hurtful behavior to causes inside of oneself but beyond one's control (e.g., "I cannot help it; when you do that, I go off. . . . You should know that and stop what you are doing").
4 *Vilification*, in which the other person is made a villain by attributing negative intent to him or her. Consequently, the partner's behavior is justified as a response to hurtful behavior (e.g., "You just have to put me down in front of your family so you can feel superior").

The therapist may note whether these tactics are being used and then work toward eliminating them.

Item 10 is concerned with how family-of-origin issues may play a role in the marital dynamics. Patterns learned in the family of origin tend to be repeated in later relationships. It is beyond the scope of this section to describe all of these patterns. Readers should be familiar with the major concepts of Bowen's theory (see Kerr, 1981) and the genogram assessments in *Focused Genograms: Intergenerational Assessment of Individuals, Couples, and Families* by DeMaria, Weeks, and Hof (1999) and *Genograms: Assessment and Intervention* by McGoldrick, Gerson and Petry (2008).

Creating a genogram with couples can be an effective way of collecting information about the partners' families of origin and finding out more about each individual and where some of their patterns of thought or behavior may have originated. A traditional genogram, which is a common assessment tool in couple therapy, is constructed as a chart that visually diagrams family relationships for individuals in the couple system. A genogram may include information about children, parents, siblings, and grandparents as many generations back as may be relevant. It can include a history of addiction, mental/emotional disorders, abuse, divorce, and so on. In addition to creating a visual depiction of the clients' families of origin, therapists may also gather more detailed information through focused genogram questioning (DeMaria et al., 1999). A focused genogram is a series of structured questions that help a therapist gather information about a specific area of a client's life. This can be valuable in identifying where patterns of interaction and beliefs may have begun. If a genogram is used during assessment the therapist, as well as the couple, may begin to get a better understanding of the couple's problems. This understanding can be used therapeutically when creating the treatment plan with the couple.

In addition to the concepts found in these books, there are questions about clients' family background that deserve mention.

1 What were the roles you observed in your parents' marriage/relationship?
2 What did your parents appear to expect from each other?
3 What did you learn about being a companion?
4 How much closeness/distance did you see in your parents' marriage/relationship?
5 How did your parents handle their anger and conflict?
6 Did your parents show their affection/intimacy openly?
7 How did your parents order their priorities among self, marriage, children, and work?
8 What emotions were encouraged, allowed, not allowed, denied, or said to be bad?
9 Were there any traumas in your parents' marriage such as affairs, abuse, incest, unresolved grief, or psychological or medical problems?
10 What did you learn about intimacy from your parents?

In cases where the couple is also presenting with a sexual problem, another series of questions is useful. Larry Hof and colleagues (DeMaria et al., 1999; Weeks & Hof,

1987) have found that some sexual problems are rooted in family history. Weeks and Hof published a set of questions to help obtain information pertinent in these cases (pp. 48–49). An outline of the *sexual genogram process*, along with these questions, is listed below.

The Sexual Genogram Process

1 *Introduction*: Explain and discuss the role of early learning and intergenerational processes in the development of individual, couple, and family systems. "Life Scripts," "Family Scripts," and "Family Loyalties."

2 *Creation and exploration of a genogram*: Graphic depictions of three or four generations of each partner's family (if couple-oriented) or of the individual's family, emphasizing facts, feelings, alliances, boundaries, coalitions, closeness, distance, emotional cutoffs, conflicts, connectedness, patterns, and so on.

3 *Creation and exploration of a sexual genogram*: Reconsideration of the multigenerational system with a specific focus on pointed questions relating to sexuality and intimacy.

   (a) What are the overt/covert messages in this family regarding sexuality/intimacy? Regarding masculinity/femininity?
   (b) Who said/did what? Who was conspicuously silent/absent in the area of sexuality/intimacy?
   (c) Who was the most open sexually? Intimately? In what ways?
   (d) How was sexuality/intimacy encouraged? Discouraged? Controlled? Within a generation? Between generations?
   (e) What questions have you had regarding sexuality/intimacy in your "family tree" that you have been reluctant to ask? Who might have the answers? How could you discover the answers?
   (f) What were the "secrets" in your family regarding sexuality/ intimacy (e.g., sexual abuse, incest, unwanted pregnancies, extramarital affairs, etc.)?
   (g) What do the other "players on the stage" have to say regarding the above questions? How did these issues, events, and experiences impact him/her? Within a generation? Between generations? With whom have you talked about this? With whom would you like to talk about this? How could you do it?
   (h) How does your partner perceive your family tree/genogram regarding the aforementioned issues? How do you perceive his/hers?
   (i) How would you change this genogram (including Who and What) to meet what you wish would have occurred regarding messages and experiences of sexuality/intimacy?

4 *Exploration and discussion of genogram material/issues with extended family members*: Review of the total process and integration within the treatment plan for sexual dysfunction.

Genogram assessment may be done early on or scattered throughout the assessment and treatment phase. The use of family-of-origin and intergenerational

questions depends on the extent to which the problem appears to have an historical versus current basis. More information on how to collect historical (genogram) information can be found in DeMaria et al. (1999).

To this point in the case formulation, the therapist has been reporting information shared by the couple during assessment interviews and organizing information according to the three aspects of the Intersystem Model. The remainder of the items helps the therapist focus on synthesizing the information, generating hypotheses regarding the couple, and developing a treatment plan and interventions in order to facilitate the changes that the couple desires.

Item 11 consists of the therapist's hypotheses based on all the data. Beginning treatment involves developing some basic hypotheses about the nature and causes of the problem. The primary hypotheses are listed in this section of the case formulation. Couple therapists should be deliberate in creating systemic hypotheses that focus on interpersonal aspects of the couple's problem(s). For example, the therapist might hypothesize that the basic problem is one of closeness and distance based on the husband's experience of a rejecting mother and the wife's experience of incest with her stepfather. Hypotheses are "tested" as treatment proceeds. If the hypotheses lead to treatment that facilitates desired outcomes for the couple, the hypotheses are probably valid. If not, the therapist may want to reconsider the hypotheses.

Item 12 is the treatment plan and change strategies. Couple therapists have generally not stressed this aspect of treatment enough in their work. For each category of assessment (individual, couple, intergenerational), a treatment goal and strategy may be formulated. For an individual with severe depression, referral to a psychiatrist would be an appropriate strategy. In the same case, the denial of depression by the other partner might require a reframe of the depression so that the "unaffected" partner sees his/her role in the depression in the system. There also might be an intergenerational pattern of depressed women in the family requiring some family-of-origin work, accompanied by sessions involving mother and grandmother. The treatment plan can involve any combination of techniques, approaches, or strategies. The plan needs to be developed with an awareness of which changes to make first, the couple's readiness for work in different problem areas, and how to build sequentially on successes. Therapists may share the plan with clients and collaborate with them in developing it so that it focuses on their need and priorities.

Item 13 is the therapist's prognosis and estimated length of treatment. Following the evaluation phase, it is useful for the therapist to be realistic about the outcome of therapy and to share with the couple the most probable outcome and requisite effort required in order to meet their goals. Couples often ask about the length of treatment. Being realistic means starting with a valid contract and commitment to therapy. If a couple will need at least 6 months and they are unwilling to go more than 6 weeks, there is little basis for a working relationship. When the therapist has followed the procedures outlined above, she or he can explain which problems will be treated, how, with what probable success, and for roughly how long. The couple will be better informed as to what to expect from treatment and then make an informed decision about continuing treatment.

Item 14 is designed to help the therapist recognize the strengths he or she brings to the case and potential limitations or countertransference issues. One therapist may

find he or she has significant experience in working with conflict in couples, while another is intimidated by anger because of personal history. The therapist who experiences a countertransference reaction from the outset should seek supervision and/or therapy to resolve this problem. If the therapist is unwilling to be responsible for the countertransference reaction, the case should be referred. Treating a case when there is a countertransference reaction is at best likely to be unsuccessful and at worst damaging to the couple.

The 14 items covered in this approach to case formulation are by no means exhaustive or unique. It is the combination of items that makes this approach stand out as more comprehensive than others. As the couple therapist becomes more knowledgeable and practiced in this approach, this series of questions will become second nature. To reach this point will require time and persistence.

Conclusion

The purpose of this chapter was to discuss two topics. First, guidelines for conducting the first few sessions were offered. These guidelines are designed to help the couple therapist avoid some of the more common difficulties and potential pitfalls that may occur at the beginning of treatment with couples. The guidelines are just that; they are not hard-and-fast rules that must be adhered to strictly. The therapist should use her or his own judgment in deciding when these guidelines do or do not fit. Following the assessment/evaluation phase of treatment, it is much less important to follow these guidelines. In fact, they may be contra-indicated in some circumstances. For example, the therapist may later want to unbalance the system by temporarily taking sides. This procedure would be done for therapeutic, not diagnostic, reasons.

The second issue covered in this chapter was assessment and case formulation. Assessment and treatment are usually blended in doing couple work. The difference is in the emphasis paid to one or the other. The assessment and case formulation approach described above reveals a procedure for collecting a tremendous amount of information in a systematic way. Some of the information may be collected much later in treatment as the need arises and as the need to further develop the treatment plan emerges. During the assessment phase, at least enough information should be collected to permit the development of the initial case formulation. The case formulation is the basic road map that enables the therapist to begin the course of treatment.

3

ORIENTING COUPLES TO THERAPY

Orienting couples to therapy from the beginning of treatment is imperative to the success of therapy, and it will set the tone for the entire therapeutic process. Most couples enter therapy with unrealistic expectations and preconceived notions about the therapist's role and the process of therapy. Therefore, one of the responsibilities of the therapist is to be aware of these expectations and correctly inform clients about the therapeutic process. Appropriate expectations and understanding of couple therapy can set a positive tone for the entire therapy and for the couple's relationship with the therapist.

Important tasks for the couple therapist are: (1) to inquire about clients' general expectations for couple therapy and to educate where necessary; (2) to teach couples about specific boundary issues pertaining to length of appointments, fees, lateness, missed appointments, communication via phone, text, and/or email, and so on; (3) to discuss general expectations of the therapeutic process, for example, instructing a couple on how to take responsibility for a session, discussing who speaks to whom and the importance of balance, and advising the couple not to quote or *triangulate* the therapist in a negative fashion during arguments or discussions at home. When these issues are clear, the clients can benefit more from the therapy hour. This chapter will cover each of these tasks.

Unrealistic Expectations

As part of the orientation process, the therapist needs to inquire about the reasons a couple has initiated therapy and what they expect from the therapist and then to educate them about any misconceptions. The following misconceptions are often held by clients at the beginning of therapy.

"We are going to therapy so that the therapist will tell us what to do."

In most cases, instructing clients how to behave or what to do next is not a therapist's role. Therapists who direct clients' every move in their relationship may create a situation where they become dependent upon therapy, and a systemically trained therapist is not seeking regressive behavior or dependency from a couple. Instead, couple therapists encourage active couple participation and insight into areas of difficulty, as well as facilitating behavioral change that is consistent with clients' desired outcomes. A

therapist could describe several images or roles depicting appropriate relationships between the couple and therapist. For example, the therapist may be *a guide* to help the couple reflect on key relationship dynamics and to discover what things work for them as a couple, *a teacher* with whom to explore interpersonal relationships, *a confronter* of possible cognitive distortions or dysfunctional behavior, *a coach* to facilitate teamwork between partners, *a mediator* to maintain some balance and fairness in the couple's communication, or *an empathetic person* to talk with during times of stress and depression. Many images and roles are applicable for a couple therapist.

There are also some roles that are generally not appropriate. In most cases a marital therapist should not be: a mother or father leading dependent children, an all-knowing person who does not respect the intelligence of the client, or the sole interpreter of truth and the meaning concerning a client's relationship. The therapist should not claim to possess a monopoly on what is right or wrong for a client, shame a client to take a specific ethical position, or be a friend who relates to or develops a dual relationship with couples outside of the therapeutic setting.

"I'm afraid we will be doing all of the talking and the marital therapist won't be saying anything at all."

Systemic therapists are most often *interactive and assertive*, not passive. Couple therapists need to demonstrate an active stance during the initial stages of therapy in order to interrupt destructive interactions and raise the hope that communication can be less dysfunctional and more nurturing and healing in the future. Lack of interaction between the therapist and clients is one of the primary reasons couples leave therapy. Often, a couple is searching for someone who will institute some control, structure, fairness, boundaries, and the confidence that their relationship can be different in the future. To accomplish these goals the therapist's primary tools are sharing insight, structuring behaviors, changing process, assigning homework, and creatively using his or her personality to facilitate change.

If clients come to therapy feeling angry about certain issues and an argument ensues, they are probably re-enacting a communication pattern repeated many times in private. Such a couple may be seeking therapy in the hope of breaking this repetitive communication cycle and overcoming feelings of discouragement or rejection. A passive approach will rarely help couples break their destructive interactional patterns. Passivity can and probably will lead to more couple conflict and feelings of despair.The therapist should generally stop negative and harmful communication so that clients feel confident that the therapy room will be a safe place to express their feelings and learn new ways of interacting with each other. This may require the therapist to be assertive and firmly interrupt destructive interactions in order to prevent further escalation.

"I did not think that a marital and family therapist would work with an individual. My partner will not attend therapy, so I cannot work on our relationship."

Systemic issues can be approached in the context of an entire family, a couple, or an individual coming to therapy. In the systemic framework, change in an individual's

behavior can affect the interaction of a couple or a family as directly as change in the couple or family can affect an individual (Becvar & Becvar, 1999).

One mistake many therapists make is to turn away an individual coming to work on his or her marriage when one partner refuses to participate. A partner who can understand how different patterns have developed within a relationship can begin to realize the part he or she might play in perpetuating or altering those patterns, and may be able to significantly affect the quality of his or her marriage through individual changes. In other words, the partner can begin to understand the circular nature of his or her relationship—that is, how the communications or behaviors of one partner elicit a response in the other partner and vice versa. On the other hand, if the partner who comes to therapy insists on spending the time projecting onto his or her absent partner all of the responsibility for the problems in the relationship, the therapy will probably not be very fruitful. These clients see the problems in linear terms and blame their partners for the conflict, in spite of the therapist pointing out how such a view is counterproductive. For example, a husband might say that his wife does not want him to drink and have a good time, so he leaves home whenever she returns home to find him "hanging out" with his friends. He blames her for having to leave because he can see she is angry. He is unable to see his part in her being angry.

Therapists must assist clients in assuming responsibility for their own actions. Many times couples come to therapy with the idea that their partner is to blame for the relationship problems. Ironically, such a view leaves the blaming partner with very little power to help fix the relationship problems. Thus, it is up to the therapist to encourage the couple to move away from the blaming tendencies and realize that both partners helped to create the present relationship and are therefore both responsible for the present state of the relationship (Becvar & Becvar, 1999). This notion can be very empowering, as it invites partners to take shared responsibility not only for problems but also for solutions and healing.

Another mistake a therapist can make is to alienate the presenting individual client who is seeking therapy for relationship problems by having him or her "beg" the absent partner to come into therapy. The more a reluctant or outright resistant partner is pressed, the more power the presenting individual may lose in the relationship. This is because the most power in a relationship is held by the person with the least investment in whatever is being pursued (Sprecher, Schmeecle, & Felmlee, 2006; Thibaut & Kelley, 1959). If the reluctant partner finally agrees to come in, his or her attitude is often expressed thus: "I don't need to be here. I'm just here because you insisted I come" or "You're the one who wants to come to therapy, so it is your problem. How can I help you change, because I don't have a problem?" Such placing of responsibility onto the partner and lack of desire to be in therapy will probably undermine the process.

"The success of the therapeutic process is based on the skill of the therapist."

The insight and skill of the therapist are certainly key components to the success of the therapy. However, a seasoned therapist will realize and accept his or her limitations, particularly when clients are highly resistant to working productively on the relationship. A client needs to be taught that responsibility for movement in therapy depends

on each participant. The inexperienced therapist who is overly anxious or insecure can assume too much responsibility for change. For example, he or she could lecture or be more invested in client growth than the couple. In so doing, the therapist can inadvertently teach the clients not to be self-responsible, and take more responsibility for client movement or growth than the clients. However, as Napier and Whitaker (1978) wisely observed, the clients need to win the battle for initiative in treatment. Getting both partners to accept responsibility for the problem is, therefore, a goal of the systemic therapist. Then, if change occurs, the clients can attribute the change to themselves and not to the therapist. The therapist who claims responsibility for client growth and movement disempowers the couple and diminishes the effectiveness of therapy.

"A male or female therapist will be more sensitive to my needs."

A competent therapist of either gender will be able to maintain balance and be fair and just with both partners. Maintaining balance involves confronting, sharing empathy, and talking to each partner in an equal and fair manner (see Chapter 5 for further discussion of this principle). The therapist who continually ends up siding with one sex or the other is likely in need of personal therapy before continuing to practice *conjoint* therapy. Continual siding suggests transference or countertransference issues that the therapist may not have worked through from his or her family-of-origin experiences.

When a therapist senses that one or both partners are fearful of being sided against, it may be helpful for the therapist to verbalize how every attempt will be made to keep a balanced perspective and to look at mutual responsibility. For instance, this conversation may begin by asking a client, "Do you think that because I am male/female I may be more likely to side with one of you?" Direct questioning and discussion of this issue with a couple might calm anxieties about issues of fairness in terms of gender and make the clients aware that the therapist recognizes and understands such concerns. The therapist may also ask the couple to voice their concerns during conjoint therapy if they believe the therapist is siding on the basis of gender.

If the client maintains the bias that a therapist of one sex or another will be more sensitive to specific issues and is resistant to the therapy, referral should be offered. It is probably better client care and more productive for the therapeutic process to help the client begin therapy with a minimal amount of bias or prejudice.

"Once the therapeutic process begins, it will never end."

Clients sometimes fear entering therapy without knowing how long it will last, how to know when treatment is finished, or how to end therapy. It is often helpful for the therapist to explain that this process is to help them, it was their initiation that determined when they began therapy, and *they* will determine how much each invests in the process and when they are ready to end treatment. Therapists can share with couples that the purpose of therapy is to help them achieve their goals and learn to be self-sufficient in their relationship, rather than depending on therapy to solve their problems. A therapist who needs a particular client for ego gratification or financial

security should not be doing therapy. Such needs can override sound therapeutic judgment.

Clients entering marital therapy can be taught that the duration of marital and family therapy can last anywhere from several sessions to several years, depending on what the couple wants and needs. If the couple feels they have the power to determine the length and frequency of therapy, they are more likely to invest in the process. A therapist might say to a client, "I'm not sure how long the therapeutic process should last. In general, therapy continues until your goals are achieved. Many variables can contribute to that decision. Let's first take some time to see if it is helpful, and if not, we can decide on other directions, or I can refer you to another therapist."

General Boundary Issues

Most couples come to therapy with some difficulty in establishing *effective interpersonal or structural boundaries.* Many couples are enmeshed or disengaged due in part to boundary problems in their respective families of origin (Boss & Greenberg, 2004; Minuchin, 1974; Nichols, 2012). If the therapy and the therapeutic relationship between client and therapist *do not* model healthy boundaries (i.e., flexible rather than rigid or chaotic), the client's dysfunctional boundary problems can be re-enacted in the therapist–client relationship and in the overall therapeutic process. The therapist needs to maintain appropriate boundaries in both the content and process of therapy. *The health and welfare of both therapist and client are at stake.* The following discussion will illustrate and explain five kinds of boundary issues.

Length of Sessions

Most therapists work on a 50-minute hour. Clients need to be told this limit directly and, if possible, to pay at the beginning or prior to the beginning of the session. For example, they should have their check written out before the session begins. The process of finding the checkbook, writing the check, figuring out the correct date, and recording the correct check number, while often talking to the therapist at the same time, is an awkward and cumbersome period of time. A client has the right to a full session and the therapist has the right to take a break before the next therapeutic hour begins. It is the therapist's responsibility to keep track of the time and set boundaries with clients.

The reasons a therapist might not appropriately set boundaries relative to the length of sessions are quite diverse and most often indicative of unresolved personal issues or insufficient structuring skills. Possibly, the therapist is taking too much responsibility for the movement or growth of the couple and believes that one more intervention will make the difference. Or therapists may be concerned clients won't be happy with them or the treatment if they indicate that they need to wrap up the therapy session when clients still have more they want to address in the session. One of the worst effects of not placing boundaries on the length of a session is that it may reinforce clients in putting off dealing with significant material until later in the session, often when there is not sufficient time to address the issue sufficiently. A client who knows that the therapist is going to start and stop on time is much more

likely to be prompt and invest in substantive material early in the session. Additionally, therapists may decide to schedule back-to-back sessions with some clients. Although there may be some situations in which this is warranted, it is a myth to think that because some movement and insight were achieved in one hour, twice as much can be accomplished in two.

Lateness

In general, if a couple is late for a session and the therapist accommodates this by exceeding the set ending time (usually ten minutes to the hour), they will be encouraged to not worry about being prompt. The therapist can unwittingly collude in a couple's resistance and manipulation by not setting limits. Lack of personal limit setting can result in a therapist feeling disrespected, frustrated, and abused. A therapist should explain to the couple that if they are late, the time cannot be made up; however, if the therapist is late, the full 50-minute session will take place.

In couple therapy, one protection against triangulation of the therapist is to not visit with the one partner of a couple who comes on time. A therapy session begins when both partners arrive. Waiting for both partners to be present before therapy begins is a rule that should be explained to the clients. The issue of always starting sessions together becomes less important when considerable trust and a balance of perspectives have been established between the couple and therapist.

Missed Appointments

In the first session, it is helpful to explain the ground rules concerning missed appointments. If the client misses an appointment, especially more than once, the therapist in most cases should charge the client and set up another time to meet. The therapist who communicates clearly to a couple that at least 24 hours notice is needed for a cancellation, or the clients will be charged for the therapy hour, demonstrates appropriate boundaries and self-respect. Therapists who do not set up these kinds of parameters will find themselves feeling abused by the whims of clients who are too tired to come to therapy or who found, due to resistance, something more "fun" to do. If the therapist makes a mistake and misses an appointment or schedules two clients at the same time—*hopefully* a rare occurrence—it is important that he or she makes up the session for the couple that is turned away and does not charge them for that session. The client has made the trip to therapy twice and has been seen only once.

Phones, Knocking, and General Disturbance

Many couples come to therapy because they have been unable to establish effective boundaries regarding their children, parents, work, or personal lives to allow for protecting and strengthening their marital relationship. The therapy must model appropriate boundaries, which are needed for a couple to develop definition, security, and stability. Therapists can inform clients that, in general, during a session they will not be disturbed. They should not answer the phone, go to the door, or do anything

that would detract from their focus on the clients in session. In turn, the therapist should convey his or her expectation that clients should not answer phone calls or text messages during session unless it is an emergency. Furthermore, clients should not knock on a closed door, but should wait in the appointed waiting area.

With some possible exceptions, a client should be taught to honor the boundaries of the therapist and not call him or her at home or at a private number. Clients with few boundaries can intrude upon the therapist's personal time and undermine the therapy by having private conversations which exclude one partner. An exception might be a therapist giving his or her telephone number, and permission to use it, as a demonstration of caring and concern, particularly in cases when a client might be at risk of self-harm or suicide. Sometimes it is easier for a therapist to request that a client call during certain hours to change appointments or express concerns that cannot wait until the next session, instead of playing telephone tag. In general, if the therapist feels confident that a client will honor the boundaries and respect the time of the therapist, he or she may be more willing to give out his or her telephone number. If the therapist misjudges and ends up getting interrupted unnecessarily, she or he needs to be able to effectively set boundaries with the client to stop unnecessary phone calls and further intrusion.

Payment

Therapists who are confident about the services they provide feel appropriately entitled to receive payment for their services at each session. Therapists who do not collect payment do the therapeutic process an injustice. Couples who do not pay may resist working, not take the work seriously, prolong the length of therapy (Bishop & Eppolito, 1992), or in a passive-aggressive manner set up the therapist to become frustrated and angry. Furthermore, a therapist who does not insist on payment can establish client indebtedness and a subsequent imbalance of power. When a client feels that he or she owes a therapist for sacrificing his/her time and energy, the dynamics of guilt and obligation can be manipulated. For instance, a couple may not terminate therapy when they feel it is appropriate because the therapist has been so generous with his or her personal time, or a therapist might manipulate a couple to stay in therapy by sharing feelings of self-sacrifice. Therapists must let clients know that payment is expected at each session. If a client does not pay for a session (e.g., if they forgot their checkbook), the therapist may decide not to schedule another appointment until payment is made. Otherwise, the client may develop a pattern of "forgetting" their money.

If the therapist charges on a sliding scale, the negotiation of a fee for service gives the therapist a great deal of information about the client, and the client gains insight into the therapist. The therapist can learn how resistant or lackadaisical a couple might be if comments made by the couple in the negotiation suggest that therapy might not be a priority. Early patterns of manipulation might appear at this time when a couple hedges on the actual amount of their income. Cries of poverty, combined with planned vacations on a later date or other discretionary expenses such as expensive electronic devices or satellite TV, can create feelings in the therapist of being misled and used.

Conversely, a couple who negotiates in good faith for a lower fee or agrees to the fee presented by the therapist communicates a respect for the therapy, personal motivation, and valuing the therapist's time. A client learns a great deal about the therapist who lowers every fee and doesn't insist on payment. Perhaps the therapist does not value his or her own time or have a high regard for his or her competence. The way a therapist negotiates fees, the degree of flexibility, the tone of voice, and the level of anxiety can raise hope and respect or, conversely, erode confidence in the therapist.

In general, negotiation of the fee is a good way for the therapist to learn about a client's investment, resistance, control needs, and assertiveness, while the client can learn about a therapist's professional identity and confidence. The dynamics surrounding the setting of fees and timely payment can either teach effective boundaries and self-respect or become a dysfunctional aspect of the client–therapist relationship. Thus, it is imperative that the therapist sets clear boundaries regarding fees and stays consistent in upholding those boundaries.

Confidentiality and Ethical Concerns in Couple Therapy

Couple therapy, when compared to individual therapy, presents therapists and couples with some unique and often challenging situations related to a variety of ethical concerns, including confidentiality. Therapists must be cognizant about not becoming secret-keepers between the couple, in particular if one partner reveals a secret when the other partner is not present. According to the AAMFT code of ethics (AAMFT, 2012), individual conversations are protected, and therapists may not reveal individual confidences to others in the client unit without the written consent of the individual (Wilcoxon et al, 2012). Thus, the therapist who chooses to meet with individual partners may put themselves in a situation in which they must keep track of what information is confidential and what information all clients know. This task can become draining and can make it difficult for the therapist to conduct therapy effectively. Additionally, therapists may struggle in this situation because they cannot breach confidentiality, but at the same time, withholding the secret may interfere with the success of the therapy (Kuo, 2009).

A way to avoid the above situation while adhering to the ethical principle of confidentiality is by having clients sign a consent form that states the therapist will not keep any secrets (Kuo, 2009). However, this policy may cause clients to be hesitant to open up to the therapist. Therefore, many therapists tend to find a happy medium between secrets and no secrets in regard to their confidentiality policy. In this policy, therapists reveal secrets if it is vital to therapy (Habrel & Oberle, 2012). When receiving the consent of clients for this type of confidentiality policy, it is important to list examples of what the therapist considers vital to therapy, such as extramarital affairs (Kuo, 2009). In this way, if a client tells the therapist one of these secrets, the therapist is able to reveal the secret without breaking confidentiality.

Therapists must determine their policy on meeting with individual partners and communicate this clearly to the couple in the first session. Some may use the strategy described above. Others may choose not to meet with individual partners at all in the context of couple therapy. Still others may agree to meet with individual

partners upon their request, but only with the full knowledge of the other partner. Furthermore it is important to offer equal time to both partners in order to keep therapy balanced.

General Expectations of the Therapeutic Process

Issues of Personal Responsibility

Many couples come to therapy expecting the therapist to somehow solve their problems. "Tell me what to do." Many couples make this statement directly, while others indirectly attempt to get the therapist to claim or to take responsibility for change. With some partners, it is as if they are saying, "Tell me what do (but don't ask me to do anything)." The therapist who takes responsibility for the content and emotional energy of a session might find himself or herself working very hard, often feeling exhausted at the end of the session. Furthermore, a client who does not accept enough responsibility can have the luxury of sitting back in a resistance mode, wondering why the therapist is not more effective. Beginning therapists may be especially susceptible to taking too much responsibility for client change.

In order to avoid this situation, therapists should discuss their expectations for clients during the initial session, letting them know that each member of the couple–therapist system has responsibilities and that the clients will need to take responsibility for the changes they desire to see. This requires that the clients be committed to therapy both by attending scheduled appointments *and* by implementing at home what is learned in a session by following through on homework assignments. If clients are resistant to taking responsibility and try and shift it onto their partner or the therapist, the therapist may need to address this explicitly and remind clients of their responsibility for change.

Enabling the Client to Begin the Session

In between sessions, the couple should be working on their relationship and planning to bring to therapy communication difficulties, results from homework assigned in the previous session, insights, and issues that stymie or confuse them. If clients know that their session will begin with a directive or structure chosen or imposed by the therapist, they will most likely be passive and defer responsibility to the therapist. A therapist who insists on controlling the content and direction of the session undermines the message of client responsibility for change and successful outcome. However, if the direction and content of the therapeutic hour is left to the initiation of the clients, the message of responsibility is reinforced, and they are more likely to have talked and processed material between sessions and will arrive at therapy with issues and concerns on which to focus.

A therapist who gives responsibility to clients will begin a session with silence or with an open-ended question. Open-ended questions do not guide the content of the answer or the direction of the session. In addition to addressing a couple's interactional patterns, therapeutic growth often requires clients to be self-reflective and to explore themselves from the inside out. When the clients begin the session, it forces them into

self-reflection and self-confrontation and may help reveal hidden resistances. Therapists who initiate the content of a session can thwart the sharing of clients' most important insights and fears.

Examples of open-ended questions are:

- Where would you like to begin?
- What should we talk about today?
- How would you like to use this time?

Therapists mistakenly believe they are giving responsibility to the clients when they ask closed-ended questions, but in fact, they are controlling the content and process almost entirely. Examples are:

- Did the two of you have any challenges or problems this week? (The couple ends up talking about what didn't go well, when they may have wanted to share their successes).
- Have you been feeling angry? (A client then talks about feeling angry instead of anything else.)
- Did you do your homework last week? (Then the client does not begin with the feeling or idea that he or she wanted or intended to share or discuss.)
- Would you like to begin with what you said last week? (Clearly the therapist is setting the agenda. This information can be requested at a later time in the session, but hopefully not at the expense of the couple's agenda.)

Another type of interaction that results in transferring responsibility from the clients to the therapist is when clients' passivity is demonstrated in the "question and answer game." An example of this kind of difficult and exhausting interaction is given below:

Therapist: How are you today?
Couple: Fine.
Therapist: What would you like to talk about?
Couple: We aren't sure.
Therapist: How about discussing the intimacy in the relationship?
Couple: What about . . .?

This type of question and answer sequence can be endless. In such a process, the client takes little responsibility for exploration into personal issues or difficulties, and the therapist continually tries to guess what would be meaningful content. Therapists will know that this dynamic is occurring when they are spending all of their mental energy in the session trying to figure out the next question. By worrying about how to frame the next question during an interactive process, the therapist will be distracted and will not be able to listen effectively to the clients. When couples take responsibility for the content and process of a therapeutic hour, therapists can monitor and guide instead of remaining responsible for the content of the interaction.

Another difficulty with a question and answer process, when used during initial sessions, is that of setting a standard and/or expectation for the couple about what

the therapy is going to be like. Once this mental and behavioral set has been established, it is difficult for couples to make the shift from the therapist asking questions to taking responsibility for the content of the session. An intake should not only include therapist inquiry, but also give to the couple a sense of their central role through their interaction and exploration. Couples should begin to learn that they have some responsibility from the very first session.

A therapist might encourage client responsibility and investment by saying something like, "I could ask you many questions that I may think are important, but I would rather focus on your ideas, perceptions, and questions and have you talk about them together. I won't be silent for long and will ask for clarification and insight into your understanding of the strengths and weaknesses of your relationship." The skill in this process *for the therapist* is to explore the relationship with the couple through the specific themes and emotions that may surface as the clients take responsibility for sharing the presenting problem(s).This approach is in contrast to asking unrelated or *discontinuous* questions about the couple relationship and family of origin as if the therapist were reading off a list. For example, if a couple state that they feel the relationship has grown very distant, the therapist can orient the discussion about the relationship and the family of origin around the idea of distance. The history, feelings, origins, and behaviors of the couple can all be explored using distance as a theme. If a wife states that she feels very abandoned and the husband retorts that he feels smothered, the feelings of abandonment and smothering can be focused on and explored as the therapist gets to know the couple through the concerns and feelings of the couple, and not an unrelated set of "standard" questions from the therapist. Using the themes and feelings presented by the clients places responsibility for the presentation of material with the clients and not on the questions of the therapist.

Facilitating Communication Between Partners as Central to the Process of Couple Therapy

Couple therapists should create the expectation that clients will come to therapy having talked at home and will be prepared to discuss significant issues both between themselves and with the therapist. To establish the expectation that clients will speak directly to each other, rather than always through the therapist, part of the initial session should include the couple spending time talking to each other while the therapist observes. In addition to establishing a pattern for the therapy sessions, this dialogue helps in the assessment of reciprocal patterns (Minuchin & Fishman, 1981), which then can begin to be processed in the session.

The most natural way to introduce the idea that the therapist would like the couple to talk to each other is to redirect the conversation away from the therapist to between the partners. Most often, each partner, *due to some fear of emotional intimacy or vulnerability with their partner*, will be intent on sharing directly with the therapist her or his specific version of the couple's difficulties. While it is important for the therapist to listen empathically and respond to each individual to facilitate joining, ultimately it will be positive communication between the couple that will create healing and reconciliation. Butler and colleagues (Butler & Gardner, 2003;

Davis & Butler, 2004) have developed a very effective approach to structuring *enactments*, or therapist-guided couple interactions, in order to facilitate direct communication between partners in session (see Chapter 12 for an expanded discussion of enactments). With repeated therapist insistence on partner communication, the couple will soon realize the therapist will not fill up therapeutic time with lectures and advice, but is far more interested in the couple's communication patterns in and out of therapy.

Confronting Blame and Judgment and Inspiring Self-responsibility

The most common presentation in therapy by each partner is to place blame and responsibility for the couple's difficulties on the other partner. When clients are asked to describe what brought them to therapy, often the response from each partner is essentially mutual finger-pointing. As both are sure the other is the primary cause of the difficulty, each attempts to align the therapist to his or her perception. As the therapist stays balanced and fair, she or he attempts to empower the clients by helping them come to see their specific contributions to their difficulties and begin the process of accepting responsibility. Central to all systemic thinking is the idea that a change in one part of the system can bring a change in the system as a whole, and clients have a great deal of power to change themselves and relatively little power to change their partners. Communication patterns that are characterized by blaming can be broken through the client's acceptance of individual responsibility and behavioral change.

Warning the Client Against Quoting the Therapist or Using the Therapist's Name at Home in a Destructive Manner

Therapists may want to suggest that clients not use the therapist's name or words. It is sometimes helpful to suggest that the therapist's name or words not be used in order to support one person's perception over the other in the couple's communication at home. "Dr. ___ said . . . "—especially when attached to a misquoted or badly communicated "fact"—can create anger and dissatisfaction with the therapy. Such statements often convey blame or are used to criticize the other partner, which will likely undermine the possibility of constructive dialogue. If the conversation gets heated enough, both partners might become angry with and attribute blame to the therapist. If clients do repeat information, feelings, or ideas about a session, they should communicate them as their own subjective experience. "I believe" instead of "the therapist said" will lead to a healthier discussion without putting the therapist in the middle of every conversation.

The use of the therapist's name or a recollection of things discussed in therapy can be useful in specific couple interactions if each individual has a positive regard for one's partner, feels that the therapist's suggestions will be helpful, and has a desire to share sensitively and reflectively with his or her partner. "Dr. ___ said that we should be talking amongst ourselves, how about tonight?" is an example of a couple using the name of the therapist positively in order to strengthen their resolve and initiate more intimate communication.

Conclusion

In summary, many couples come to therapy with apprehension, unrealistic expectations, and a lack of information about the roles and boundaries of clients, therapists, and the therapeutic process. Educating the client on some of the above-mentioned issues and making what might seem obvious to the therapist explicit to the couple can prevent a great deal of misunderstanding and help the therapy begin in a healthier, more productive manner.

4

SYSTEMIC CONCEPTUALIZATION AND TREATMENT

A systemic approach focuses the couple therapist's attention not only on the individual but also on the interpersonal context in which the individual partners relate. Systems theory delineates the interrelatedness of family members to each other, with an understanding that the behavior of each member of a family cannot be understood and treated in isolation (Bevcar & Bevcar, 1999; Bowen, 1972). An ability central to systemic thinking is to differentiate linear conceptualizations and interventions from systemic ones. Many couple therapists have never made the conceptual transition from a more linear and individual approach to one that is more circular and systemic. Because a great deal of Western culture and psychotherapy education is designed around almost exclusively linear and individualistic ways of thinking, it is virtually impossible for some therapists to reorient their conceptual perspectives to include assessing, questioning, and intervening with clients in a circular, *systemic* manner. In contrast to a linear epistemology, which views reality as one event causing another in a linear fashion, circular epistemology embraces a circular model of causality that is multicausal and multidetermined.

Linear thinking is grounded in individualistic and mechanistic worldviews which lead therapists to probe merely for cause and effect. Clinical questioning and conceptualization grounded in linear causality may neglect clients' interpersonal context and limit a therapist's understanding of clients' thoughts, feelings, and behaviors. *For example, in the interchange below, each of the therapist's questions asked without the other is quite linear. However, combinations of linear questions can develop a circular understanding of the nature of a couple's interaction* (see Figure 4.1).

For example:

Therapist to Wife:	Why do you get so angry?
Wife:	Because he always withdraws from me.
Therapist to Husband:	Why do you withdraw?
Husband:	Because she is always so angry.

In this case, withdrawal and anger contribute to and are exacerbated by a circular and reciprocal pattern. They fit together, as two pieces of a puzzle might, although in a destructive manner. Singular linear questions that do not probe the interrelatedness of behavior can result in a therapist or client attributing blame by focusing the responsibility for a problem or conflict upon a single person or event. Using the above

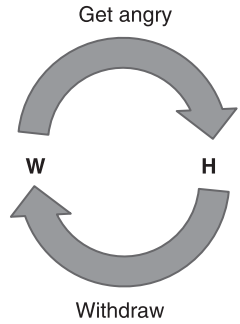


Figure 4.1 Circular Nature of Couple Interaction

example, the wife blames and justifies her anger on the basis of her husband's withdrawal. The linear-oriented therapist may think the same way and attempt to solve the problem by helping the husband not to withdraw, while not examining the effect of the wife's anger on the pattern of withdrawal.

Linear thinking could be diagrammed as A → B. If the notion that A causes B is true, then fix A, and B will be fine. However, it is equally valid that the wife's anger is contributing to the husband's withdrawal. Consideration of the interaction of anger and withdrawal brings the therapist from a more linear perspective to a more circular one. Linear thinking does not take into account the more complex, circular, and interrelated nature of human behavior and interrelationships, because it focuses responsibility in only one direction.

In comparison, systemic thinking includes causality, but extends the concept to include identification of circular and reciprocal patterns (Watzlawick, Beavin, & Jackson, 1967; Watzlawick, Weakland, & Fisch, 1988). The diagramming of such patterns would be A → B → A → B → A *ad infinitum* (Penn, 1982). In systemic thinking, discovering who is at fault or who began the problem is secondary to exploring how each partner, family member, influences of family of origin, societal values, and so on contribute to the reciprocal patterns. Of course, circular interpersonal patterns are not limited to problematic interactions. If the client says, "I am happy because my husband is so attentive," the therapist who thinks in a systemic way will likely discover that the husband is attentive, in part, because the wife is happy. The feelings of happiness and resulting intimacy experienced by both partners form a positive circular and reciprocal pattern.

Therapists who think linearly tend to stay focused on the individual, while systemic therapists will look at the relationships and processes between partners, families, and social contexts (Nichols, 2010). Systemic thinking reinforces the idea that even an illness such as depression, with its "cause" perhaps rooted in psychobiology, *still* has enormous interpersonal ramifications for spouses and family members. The role and function of the depression, and how the partners and family members respond to the depression or those with the depression, are always significant factors in relationship dynamics and the depth of the depression itself.

The relationship of any behavior, emotion, or thoughtful expression to the personality of the individual, marital relationship, family, or society is always key (Pierce, Nichols, & DuBrin, 1983). It is the function and purpose of behavior that can be elaborated more fully in systemic thinking. What was the behavior for? How does the behavior fit into the relational patterns? Where does the behavior come from? What things serve to maintain the behavior? How was it influenced by family of origin? This chapter will illustrate linear and circular or systemic principles, questions, and techniques for the couple therapist seeking to intervene in diverse ways.

Circular Questions Deepen the Meaning of Linear Questions

The information elicited by circular questions extends beyond the traditional linear inquiry of individually oriented psychotherapists. Circular questions deepen the meaning of linear questions and provide more in-depth understanding of clients and relationship contexts and patterns. For example, if the client says, "I feel depressed," linear questions might be:

1 What caused the depression?
2 What event started the depressed feelings?
3 When did you first notice the depression?

Questions that seek a more systemic understanding might be:

1 Is anyone else in your family depressed?
2 How does your spouse respond to your depression?
3 What role does depression play in your marital intimacy?

If the client says, "I am furious!" linear questions might be:

1 What causes you to be furious?
2 When did you get so furious?
3 Who causes you to be so angry?

Systemic questions might be:

1 What does your spouse do when you are furious?
2 What is the relationship between your anger and your ability to be intimate and vulnerable?
3 Were either of your parents angry in a similar manner?

Both types of questions are important. However, the systemic questions are going to enrich the therapist's understanding of how an individual issue is part of a couple or family pattern in ways that linear questions will not. Linear questions give the therapist a more narrow view of the etiology and understanding of an individual's or couple's behavior. Such a viewpoint is limiting for the therapist and the couple. If we

look at an individual within a couple as just an individual, then when considering the individual's problem, we have an individual who still has an individual problem (Collins & Tomm, 2009). However, recognizing relationship contexts and couple patterns can provide additional insights and possibilities for change. The individual's problem is embedded within the couple and may be an expression interlocking patterns of behavior. By focusing just on the individual, the nonsystemic therapist completely misses the etiology and/or function of the problem.

Although looking for cause and effect can be enlightening, looking at participation and responsibility as part of a more complicated set of circumstances and relationships will give the therapist more opportunity to intervene and change couple patterns. The question "Who caused you to be so angry?" will possibly lead to the identification of one person as the cause. Asking the question "Were either of your parents angry in a similar manner?" begins the process of a client looking at family-of-origin patterns and developing insight into how anger has affected his or her past and current relational patterns. Furthermore, asking circular questions such as "What does your partner do when you are angry?" shifts attention to the relational and reciprocal impact of the partners' behaviors.

Circular Questions and Balanced Intervention

One of the primary responsibilities of the couple therapist is to remain balanced and to demonstrate fairness by relating to both individuals of the dyad. "There are two sides to every coin" and "It takes two to tango" are colloquialisms that suggest the importance of looking for shared responsibility in any couple issue or problem. When the therapist thinks linearly, it is often quite difficult to remain balanced and fair because blame can more easily be attributed to one partner instead of viewing blame within its social context (Nichols, 2010). The therapist can be easily inducted into a couple's dysfunctional pattern by listening and agreeing with one partner's description of the other's faults. By thinking systemically and looking at the circular patterns of behavior, the actions of both partners are taken into consideration.

Circular questioning is a fundamental aspect of systemic hypothesizing (Tomm, 1984). It allows the therapist to visualize the problem in a systemic manner without placing blame on a single individual. Within systemic thinking, circular questioning also allows the therapist to look at family beliefs, behaviors, rules, and patterns. Additionally, by extending the understanding of systemic thinking beyond the couple, the therapist seeks to encourage both partners to look at patterns of relating in family-of-origin and other social contexts. The systemic assumption that nothing happens in a vacuum and that both partners should be held accountable makes balance and fairness easier to establish.

It is important the therapist encourages each partner to speak his or her mind when answering circular questions. In doing so, the couple begins to think systemically as they listen to the effect of individual actions on others individually within the system and how individual actions affect the entire family system (Tomm, 1984). A transition from linear to circular thinking frees both therapists and clients from the need to assign blame. They can then focus their attention on how each partner can be part of the solution.

Learning to Think in a Systemic Manner

How does a therapist learn to think in a systemic way? Part of the answer is to look for the meaning of any behavior outside of, as well as inside of, the person exhibiting the behavior. Consider the following examples.

1 *A woman client begins to cry during a conjoint therapy session.* Linear thinking may lead the therapist to ask who or what caused her to cry and probably limit the inquiry to that understanding. A more systemic thinker will attempt not only to understand why she is crying but also to ascertain the function and purpose of the crying for both the individual and the system in which she relates. For instance, the therapist will notice how the spouse or partner responds to the crying. If the partner becomes angry in response to the crying, perhaps it means more than a sharing of a sad feeling. Crying may be used to manipulate or to elicit guilt. The partner's anger may be a safer way of expressing feelings of fear or incompetence. In such a manner, the couple might create distance from each other. There are many possibilities for the meaning of crying and the response of anger within a dyad.

2 *A husband grows very hostile towards his wife.* Before the therapist responds or intervenes, it is crucial that she or he look over at the wife to understand her response. The nature of the response will provide the therapist with an increased understanding of the meaning and purpose of the hostility. If the woman withdraws, maybe the husband is trying to *create* or *provoke* rejection and withdrawal. If the wife yells back in a hostile way, perhaps this is the only way that the couple is able to stay out of depression or knows how to connect. The man's hostility may be grounded in feelings of powerlessness. Once expressed, it may serve some personal and systemic function. The therapist can examine each partner's reaction in order to better determine the meaning of the hostility from multiple perspectives.

3 *A man states, "I really feel sad."* On the surface this statement seems to be assertive and quite revealing. Because the therapist thinks in a systemic way, she or he searches for understanding by looking at the partner's response. To the therapist's surprise, the woman is disinterested. When asked about her disinterest, the woman states that whenever her husband wants sex later in the day, he starts to express his sadness and vulnerability early in the morning. He has a circuitous and passive way of asking for intimacy and care. The therapist discovers that the wife is angry about her husband's indirectness. The husband asks circuitously in part because he fears his wife's anger or rejection. The couple's sadness and anger then organize in a circular fashion. Systemic interpretations can aid in the therapist's understanding of the function of a specific individual's behavior. In the above example, "I really feel sad" was not a catharsis or an attempt to share an emotion to establish intimacy, but an indirect request for sex, which was then perceived as a manipulation by the partner. *The therapist, however, will not know this if he/she immediately intervenes with linear questions.*

4 *A husband states, "Every night when I come home from work I approach my wife and try to be very affectionate."* The therapist who concludes, without inquiry, that

this statement is sensitive and caring is not necessarily thinking in a systemic way. A systemic therapist may wonder, "When the husband is affectionate, what does the wife do in response?" Upon further inquiry, the therapist finds that every night just before the husband comes home, his wife becomes agitated and withdrawn. When the husband approaches, his wife wants to pull back. The affection now takes on a new meaning. The husband may be unconsciously distancing his wife because he knows that she will withdraw upon his approach. He can then criticize her unavailability and justify his own behavior. This example of one partner reaching out in a seemingly affectionate way for the purpose of distancing his partner is a common marital dynamic (Napier, 1978). The systemic therapist must be able to sit back and be enough of an observer of the couple's process to determine how a singular comment or behavior by one partner is related to the behavior(s) of the other.

5 *When a woman states, "I really understand how I have let you down. Please give me another chance," the man receiving this message remains unforgiving and rigid in his response.* The therapist can confront the man for not being more open by saying, "This was a clear, reasonable, and assertive request by your wife." But what the therapist may not understand is that the woman's statement is part of a dance that the couple does together (Lerner, 1989). After the woman asks for forgiveness several times, the man finally softens and becomes more giving. As soon as this occurs, the woman disappoints the man again, and he becomes enraged and rigid as the cycle repeats itself. Both spouses feel abused and rejected, which are old repetitive feelings perhaps derived from their families of origin.

Once the message sent and the partner's response are understood and their interrelationship is noted, the function of a behavior can be examined as it relates to the couple's relationship, their families of origin, partners' levels of differentiation, individual personality, and self-concept. Partners who recognize systemic patterns, their origins, and the effects on their behavior are better able to take some personal responsibility to change him- or herself, the couple patterns, and other relationships in which the patterns are manifested.

Systemic Thinking Leads to Wider Interpretation and Intervention

Systemic thinking leads to other types of questions and interventions that assist the therapist in his or her understanding of the intricacies of a couple's relationship and their extended family relationships. A therapist who thinks systemically assumes that behaviors of a couple are not random but intricately connected. What one partner receives from another is not by mistake, and often there are some, or many, covert or overt dynamics creating patterns and responses that, positively or negatively, are of service to each individual. By exploring with clients the interrelated nature of their interactions, couples may come to see and be able to break free from constraining patterns.

For example, in the frequently observed reciprocal patterns of anger in response to withdrawal and vice versa, one systemic intervention is to probe whether the person

who is angry is unknowingly asking his or her partner to withdraw (Napier, 1990). Is the person who withdraws for some reason inviting anger or mistreatment? Part of the answer to such questions may be found in the early introjected or internalized feelings from the husband's or wife's family background. Early introjects, if strongly negative and hurtful, can result in repetitive patterns later in life, which may be unconsciously repeated with a spouse (Scharff & Scharff, 1987, 1991). Unresolved childhood feelings often find expression in the intimacy and commitment of a marital relationship. *Other areas for insight exploration are the repetitions of negative entitlements, negative self-concepts, and unconscious contracts between couples.*

For example:

1 Bob is an adult child of an alcoholic mother. He experienced a great deal of verbal abuse and inconsistent parenting. Overall, he felt abandoned and rejected as a child. Feelings of abandonment and hurt were internalized and, once he was married, were *projected onto his* wife and transformed into issues of abandonment within the marriage. Bob picked a woman who was also hurt in her upbringing. By being emotionally unavailable to his wife, he elicited a great deal of criticism and rejection from her. By blaming her for being emotionally distant, he repeated an old pattern and lacked understanding about his own role in the repetitive relationship pattern. Bob did not understand the function of his critical behavior *as that of creating distance.* A systemic intervention, done with good timing and with sensitivity, is to inquire about how being abandoned is predictable and perhaps keeps him safe. After gaining some understanding, the patterns of eliciting rejection in a repetitive way can be directly confronted and worked through. This is discussed further in Chapter 10 on enhancing intimacy.

2 Joan married a man who was completely unaware of his feelings. She spent a long time in the marriage trying to elicit feelings from him in order to build emotional closeness between them. However, the more she pushed, the more he resisted. The couple came to therapy with the goal of decreasing the tension in their relationship. Joan also had the unspoken goal of trying to get her husband to express his feelings. Linear thinking might lead the therapist to attempt to elicit the husband's feelings. Such change may be one crucial aspect of altering the couple interaction. However, a systemic thinker will also ask what investment Joan has in being married to someone so quiet and unemotional and how she interacts with him in a way that maintains his silence and lack of intimacy.

3 A client comes to a therapist saying, "My wife left me for another man." A linear thinking or individualistic therapist may respond immediately with empathy and side with the husband's view of the distressed relationship. Systemically, however, the therapist needs to think at least in terms of what part the husband played in his wife's leaving or, at the very minimum, how he was distancing his spouse. Does his wife's leaving provide him with justification for his own neglect of the marriage? Does this recent abandonment fulfill some old loyalty or legacy in the husband's background? Thinking systemically stimulates different ways of conceptualizing the dynamics of the couple's interaction. This, in turn, opens up new possibilities for intervention and for change in the couple.

In systemic thinking, family-of-origin issues reconstituted in current relationships are a key focus. Couples commonly exhibit a homeostatic tendency to maintain the status quo and to organize these reconstituted patterns by keeping everything the same in the couple dyad and the family, as well as between generations. Within such repetitive patterns, another type of systemic intervention and a series of questions might invite insight and allow for movement. Everyone has some resistance to change. Thus, the recognition of reciprocal and systemic patterns can be very frightening for one or both partners. For instance, a wife might constantly complain that her husband is never around or is never emotionally available. If the systemic assumption that she has some investment in the distance is true, then the following interventions, either directly asked of the client or elicited through client insight, might be fruitful.

- Would you be scared if your husband turned to you and opened up emotionally?
- How do you contribute to the failed attempts by your husband to be affectionate?
- How might you be unknowingly undermining your husband's efforts to express emotion?
- Would you be able to feel or to see if your husband was being emotional? You seem very sure that he can't be.

A general systemic assumption is that one spouse may resist the movement of the other if the couple's established homeostatic patterns are challenged. Even though one partner is finally giving the other exactly what is being asked for, change can be frightening and unpredictable. Change of behavior might increase the possibility of vulnerability and intimacy. Systemic questions can point out the lack of reinforcement given to change, make clients aware of the different levels of resistance, and increase the likelihood of movement. For instance, consider the following questions: "Would you be anxious if you received what you asked for?" "If you felt loved by your spouse, how you would have to change the way you think about yourself?" When carefully considered, these questions denote individual and couple change, which can be frightening. It is part of the couple therapist's work to anticipate that what a husband and wife might want most could actually be what they most vehemently resist and fear at a deeper level. As small movements of change are not reinforced and given insight, significant couple growth is thwarted.

Systemic thinking, when modeled and taught to clients, begins the process of the couple gaining power to enhance the quality of their relationship. Replacing the linear processes of blame and judgment with personal understanding and insight into the interrelatedness of different behaviors gives partners the opportunity to take personal responsibility for changing the patterns in their relationship. For instance, if a husband or wife understands that withdrawal elicits anger from the other, he or she can work on the withdrawal to effect change. One definition of personal power is the ability to take responsibility for one's own functioning without projecting blame onto another. Insight into the function of behavior and the expression of thought or feeling gives an individual the tools to relate in a more powerful and effective manner.

Inviting Systemic Change Through Enactments

Although the couple gains some power over enhancing the quality of their relationship through eliminating linear thinking and replacing it with systemic reasoning, there are still opportunities for additional contextual insight which can be sustained through the use of enactments. Enactments are therapist-guided structured interactions designed to promote self-sufficient communication by couples (Butler & Gardner, 2003; Davis & Butler, 2004; Nichols & Fellenberg, 2000). Successful use of enactments is at the heart of couple therapy, regardless of the clients' presenting problem.

Enactments serve three very important therapeutic functions: (1) they invite reflection within the couple regarding the process of their communication, (2) they help couples learn more effective communication and problem-solving skills, and (3) enactments move the therapist out of the couple relationship and on to the sidelines, allowing the couple to gain strength and proficiency apart from the therapist. The ultimate goal of enactments is to coach the couple toward self-sustaining positive interaction (Davis & Butler, 2004). Specific details on how to structure an enactment are presented in Chapter 12.

Conclusion

It is important to understand the relationship of linear and systemic thinking and intervention. Linear thinking focuses on cause and effect, while systemic approaches seek to discover the meaning and function of symptoms in reciprocal and repetitive patterns of relationships. Basic to a systemic approach is the assumption that both partners of a couple are at least somewhat involved in every conflict and issue. Such an approach reduces blame and fault-finding and promotes acceptance of responsibility. If an individual can understand his or her contribution to a dysfunctional communication or reciprocal pattern, then she or he can be empowered towards change and growth. Within the systemic approach, circular questioning deepens understanding, helps to maintain a therapist's balance, and leads to wider interpretations and interventions than linear questions alone. When considering problematic patterns of the relationship, the therapist who uses systematic or circular questioning can help shift the focus more to constructive patterns the couple should enact. Enactments allow the therapist to assist the couple in creating positive emotional communication by stepping away from the midst of the couple and facilitating direct interaction between partners. By focusing on constructive enactments, the therapist can spend less time on the problematic patterns (Collins & Tomm, 2009). Through the co-ordination of circular questions, systemic thinking, and enactments, the therapist creates a setting which fosters positive communication and emotional connection.

5

KEEPING THERAPY BALANCED

The concept of balance is central to systemic thought and the process of couple therapy. A therapist who thinks systemically believes that both members of a couple dyad contribute to, and thus share responsibility for, the intimacies and difficulties they might be experiencing. The couple therapist who is balanced in approach asks both partners to be accountable, confronts both with relatively equal intensity, and finds ways to be supportive and nurturing to each person. In such an approach, the therapist does not align with one partner or form a coalition against the other, but consistently addresses the influence and contribution of both partners. Failure to maintain balance can have a negative impact on treatment outcome. For example, clients' perception that the therapeutic alliance is not balanced or fair is one of the reasons for premature termination (Westmacott, Hunsley, Best, Rumstein-Mckean, & Schindler, 2010). Furthermore, if the therapist loses balance, the therapy may be destructive to one or both partners. Judgment and accusations can take the place of personal responsibility and a climate of fairness and trust.

This chapter will discuss several techniques for a balanced approach to couple therapy. These techniques involve the therapist joining with clients in an impartial manner, educating couples about the importance of the therapist's balanced approach, and structuring therapy in a balanced way. Also discussed are considerations of the clients' understanding of balance, the use of inclusive language, intensity and balance, and seating arrangement to promote balance. Understanding psychopharmacology and not attributing blame when one partner needs medication, determining therapeutic balance, and examining the potential for a loss of balance as a vital area for personal insight and growth are topics that conclude the chapter.

Joining with Clients

Creating a balanced relationship with couples begins with the first session. It is important to establish balance during the process of introducing oneself and getting to know a couple in the initial session (Patterson et al., 2009). New clients will be especially sensitive to the balancing skills and objectivity of the therapist. Such sensitivity is dualistic. On one hand, clients will join with the clinician and commit to therapy on the basis of a therapist's ability to implement balance, and on the other hand, a client might be disappointed or angry that his or her attempt to seduce the therapist into agreeing with his or her way of thinking did not work. Despite the possible risk of

negativity, a couple therapist's mandate is to be systemic and equally committed to the well-being of both partners.

The following are some common-sense ideas for the therapist to use in order to join with the couple and establish a balanced approach.

1 Shake the hands of *both* partners.
2 If small talk prevails for the opening minutes, make sure you are equally invested in the conversation with both partners.
3 When asking for the presenting problem and the reasons for seeking therapy, try not to allow one partner to monopolize the conversation for too long. While the verbosity of one partner and the quiet of the other are "grist for the mill" in assessing couple dynamics, letting one person dominate in the opening session could create destructive coalitions. In order to be fair, the therapist might have to stop one partner in the middle of his or her discourse, or to look to the other partner and simply ask for his or her perspective or response.
4 A first session would include the therapist seeking to understand the perceptions of both partners to let each know that what he or she has to say is important.
5 Beginning attempts at assessment should be very balanced and fair in terms of responsibility; never confront only one partner. For example, "I can see that you both have a part in the struggles you described—how you elicit this from him and how you elicit this from her."

Educating Clients

Therapists often struggle to approach a dyad in a balanced way. Many clients will attempt to persuade the therapist that his or her particular view of the couple relationship is correct (usually that the other partner is at fault). In the initial stages of therapy, there is frequently a battle for the allegiance of the therapist. In addition, the couple often enters the therapeutic process having already sought out the advice and counsel of individually aligned friends and family members who support their view.

Educating clients about the importance of the therapist being balanced is crucial. When such education is done well, the therapist may save time that otherwise would have been spent by partners justifying their individual positions and perspectives. At the beginning or the end of the initial session, the marital therapist can emphasize balance and process issues with the couple by stating the following.

- I am going to work hard to understand both of your perspectives. Both of you are key to making effective change.
- I am going to try to be very balanced in my approach. What this means is that I assume that both of you have some responsibility for the problems and the solutions in your relationship, and that each of your contributions to the problems will be addressed.
- I am going to try not to take sides. I can feel each of you trying to convince me of the rightness of your perspective, but if I do my job well, I will remain fairly neutral.

- If you feel unfairly sided against or judged by me, please let me know. It is not my intent, and I want to talk about it right away when you feel it happening.
- In order for the relationship to become more nurturing, both of you must begin to think more systemically. We will talk about this more as our work progresses, but briefly it means that as a couple, your behaviors are interconnected, and the ways you are both treating each other are circular in nature. Your behavior does not happen in a vacuum; it influences and is influenced by the responses of the other. Each of you needs to take some responsibility for creating and continuing the negative circular interactions that are hurting you, your partner, and the relationship.

The above are examples of how to begin to educate clients about a systemic and balanced approach. When the education is explicit, trust can develop and the healing process will often proceed at a quicker pace.

Overall Structure of Therapy: Who Participates?

There are many views about who should participate in the therapeutic process. Many individual psychotherapists believe that in-depth work can be done only during the course of an individual session. Some couple and family therapists conceptualize therapy as needing to include every member of the family. Others believe couple work includes only partners. Whatever the perspective, several key considerations are important for the maintenance of a balanced approach if partners are seen individually.

1 If the therapist sees the one partner for an individual session in the beginning of therapy, the other partner should also be seen individually and given the same amount of time.

2 If individual sessions are deemed necessary to break up emotional blocks or enmeshment, the number of individual sessions should be approximately equal for both partners.

3 If one partner appears for a session when both partners were supposed to be present, it is a judgment call on whether the therapist should see the individual client. If the individual client is seen, the next session might be an individual one for the other partner in order to maintain balance.

4 Often individual therapy will evolve into conjoint therapy. If the individual has been in therapy for a long time, it may be problematic for the current therapist to do the conjoint work. In many cases this can be counterproductive because loyalties, real or perceived, have been established with one partner. If it is decided that the same therapist should do both the individual and the conjoint therapy, several techniques to balance loyalties and alignments are important. The longstanding individual client must be educated about what feelings he or she might anticipate when the partner is included in the therapy. The education might include the therapist saying the following:

> When your partner is included in the therapy, you might very well experience some feelings of loss or of being judged. I will attempt to be very balanced in my approach and will try to understand your partner's perspectives as well as yours. Because you have felt my commitment to you, you might experience this as a betrayal. If you do, let's process this together in the conjoint session.

In terms of structuring the session, an effective approach to establish a sense of balance might be to see the partner who is joining the therapy for several individual sessions. During this time, the therapist can listen to his or her perspectives and show some empathy for his or her thoughts and feelings. It may be helpful to clarify that the transition from individual therapy to couple therapy is provisional, and if it is not helpful, other alternatives will be sought. In order to address potential difficulties with the transition, it is crucial for the therapist to discuss directly with the partner entering therapy the following:

> I am concerned that you will feel that my approach with both of you is not fair. There is a danger in what we are about to do in that you might feel aligned or "ganged up" against. I am going to try to be very balanced. However, if you feel otherwise, please let me know immediately.

Issues related to confidentiality are also a concern when meeting with individual partners as part of couple therapy. We discuss in detail how to establish rules with clients related to confidentiality in Chapter 18 on treating infidelity.

Clients' Understanding of Balance

Individual partners in couple therapy are often afraid that the therapist will blame, focus upon, or confront one partner more intensely than the other during a conjoint session. In a balanced approach, the timing of challenging or confrontation is very important. When the couple therapist decides to confront one partner at a time, it is crucial that the one who is first being confronted or asked probing questions about his or her participation in a certain dynamic trusts that the other partner will also be confronted in a similar manner. To establish balance and build trust, before asking one partner a question, the therapist can make statements such as:

- I am going to ask you both the same question, one at a time.
- I will want you both to take a turn.
- (Turning to one partner) What do you think is your responsibility? And, in a minute (turning to the other), I'd like to know what you think is yours.
- I will ask you both to respond to what your understanding is.

The importance of timing is that the partner who is first confronted needs to understand prior to making a response that his or her partner will next be asked a question or comment of similar intensity. Consider the following interaction in which the promise of a balanced approach is not adequately established prior to the confrontation.

Therapist to Wife:	Can you see what you were doing in that last interaction?
Wife:	I was just trying to express myself.
Therapist:	You were expressing yourself in a very judgmental way.
Wife:	But he never listens to me and just walks away.
Therapist:	Perhaps your judgment pushes your husband away.

Note what each of the three parties present in the therapy session could be thinking while this particular dynamic is taking place. The wife might be feeling unfairly judged and confronted by the therapist. She cannot understand why the therapist does not confront her husband. Consequently, in response to the therapist's intervention, she spends most of the time being defensive and trying to convince the therapist of the husband's role. The therapist might be thinking in a systemic manner, but is not functioning in one. It may be in his or her mind to confront the husband next; however, he or she has not communicated this fact to the wife and ends up inviting her defensiveness. The husband, on the other hand, may be thinking that the therapist understands how his wife's critical nature is the crux of the problem and feels an alliance with the therapist as he or she confronts his wife. Perhaps the husband communicates this nonverbally with a nod, suggesting agreement with the therapist's assessment of the wife's "problems." He may begin to see himself more as a "co-therapist" than a participant in therapy and partner with his wife in working on their relationship.

Each partner of a dyad needs the *a priori* trust and understanding of the therapist's intent and ability to balance interventions, especially before being confronted or challenged in an individual way. Such trust is needed whether the therapist is nurturing and supportive or points out a cognitive distortion or dysfunctional behavior. With adequate preparation and education about a balanced and fair approach, the therapist can confront or challenge individual partners in couple therapy with a very positive result. For example:

Therapist to Couple:	I want to ask both of you a question.
Therapist to Wife:	Can you see what you were doing in that last interaction? (looks at the husband before an answer is given and says, "I will ask you the same question next.")
Wife:	I know I get very angry and critical.
Therapist to Husband:	And what do you contribute?
Husband:	I guess I do something to annoy her.

Because the wife understood that the therapist was going to ask the husband also, she was able to reflect more on her functioning and be less defensive. The husband was also more self-reflective with the balanced approach. The client's perception of balance is essential for allowing him or her to be vulnerable and reflect honestly and openly.

However, balance can be lost in an intervention such as the one illustrated above. While the therapist asked fair and just questions to both parties, the husband did not respond at the same level of insight and reflection as his wife. He did not share the same level of vulnerability or take personal responsibility for his part of the negative communication. The therapist needs to recognize that the vulnerability of the wife is

being exposed and not that of the husband. Direct and supportive confrontation of the husband is necessary to establish balance. After the husband answered, "I guess I do something to annoy her," the therapist could ask:

Therapist to Husband: Can you be more specific?
Husband: I tend to get quiet and withdraw. Perhaps I give the impression that I am not listening to what she's saying.

If and when the husband is reflective, the therapist might return to challenge the wife. As the therapist moves back and forth between clients, she or he constantly assesses the balance of intensity, the depth of responsibility being asked of and responded with by both partners, and the partners' perception of balance. An example of balanced intensity and personal responsibility would be:

Wife: I know I have been very angry and critical over the last few days. I feel very alone and am afraid of losing you. I get mad, and that pushes you away, which is not what I want.
Husband: I understand. I keep withdrawing and going into myself in part because I have felt so rejected and hurt. I just couldn't communicate my feelings directly.
Therapist to Husband: What effect does your withdrawing have on your wife?
Husband: I know this has a negative effect on her. When I pull away, she feels that I might leave her. I don't want to leave, though. I just feel hurt at the time.

Both partners are sharing their vulnerable feelings and insights into how their behavior has influenced their partner. When such balance is achieved, deeper meanings and feelings can be explored.

Inclusive Language

Balanced couple therapy should promote fairness and shared responsibility as well as facilitating direct interaction between clients. If the process of therapy consists mainly of the therapist talking to each partner with little couple interaction, the therapist is probably more oriented toward individual psychotherapy. Such an orientation might lead to a loss of balance, with the therapist speaking to only one partner at a time and failing to structure couple dialogue and conflict resolution. There is also the risk of imbalance if the therapist spends an inordinate amount of time challenging one partner or the other and striving for insight. The easiest technique for establishing balance is to confront or inquire of the *couple* rather than individual partners. When the therapist asks questions such as, "Can you both see what is happening?" or asks questions of both partners, a sense of fairness can be established. Inclusive language such as "both," "the two of you," "shared responsibility," and "similar," used to suggest mutual responsibility, will often decrease the competition for who is more "right" and contribute to a systemic understanding in the couple. This kind of inclusive language helps to set the tone of mutuality in the session.

Consider the following balanced interventions, which could be used by the couple therapist to heighten the awareness of the couple.

Therapist to Couple: Can you see how you both contribute to the problem? Can you understand that you both want to be closer to each other? However, the two of you are being very hurtful to each other. Do you understand that you are both really saying, "I miss you. I want to be close to you"? You are both very similar in the way you handle your frustration in the relationship. You are both competing to be heard. Let's examine this interaction. Can you see what each of you is eliciting from the other?

Such process interventions *addressed to the couple* attempt to make both partners accountable. They are not directed toward an individual but to both partners at the same time, thereby enhancing a balanced approach and perspective. Often such balanced interventions are used to stop negative and destructive interaction by insisting that each individual reflects on and takes responsibility for his or her own behavior.

Therapist interaction with one partner and not the other is fraught with opportunities for miscommunication. Clients begin to focus on issues of fairness, therapist objectivity, and individual responsibility when they believe that the therapist is aligning with one partner and not with both. For example, in a therapy session both members of a couple might feel frustrated and begin to argue about how each feels ignored. If the therapist loses balance and singles out the husband as not listening and being judgmental, he might become frustrated because he feels judged. He may then become more enraged, insist on drawing attention to his wife's part in their problems rather than his own, or possibly never return to a session. However, a therapist using a balanced approach might interrupt the destructive interaction by saying, "Please stop; you both are right. Neither of you is hearing the other person and you both are feeling ignored and judged." In doing so, the destructive interaction is much more likely to be slowed down or reframed into a more constructive conversation. The therapist who demonstrates a balanced and impartial approach to a couple calms down the fear that each partner holds of not being heard.

For the purpose of maintaining balance, whenever possible, it is helpful for the couple therapist to intervene in such a way that both partners of the dyad will simultaneously look at his or her own functioning, whether in a destructive and unhealthy interaction or a positive, nurturing one. However, there are also times in couple therapy when interventions addressed to one partner and not to the other can be important and effective. Some ideas about how to maintain balance when working with individual partners during conjoint sessions are discussed in the following section on intensity and balance.

Intensity and Balance

Applying balance in the questioning of clients and managing the timing of interventions are essential skills for a couple therapist to learn. Assessing balance in terms of the intensity and depth of questions and confrontations is a more difficult, higher-level skill to develop. The following interaction is unbalanced in the beginning

because the intensity of intervention with the wife is at a very different level from the one with the husband.

Husband:	I'm trying as hard as I can!
Wife:	But it just is not good enough. You aren't thinking through anything you are doing prior to doing it.
Husband:	Well if you would help me once in a while, I wouldn't get into these predicaments.
Wife:	But I don't want to help you. You just want to get me to do things for you. I want you to take the initiative.
Therapist to Wife:	Do you see that you are communicating in a very unfair way?
Therapist to Husband:	Try and communicate what you need without blaming.

The therapist has the concept of balance in mind but is challenging the couple in quite an unbalanced way. The word "unfair" said to the wife differs significantly in power and intensity from "Try . . . without blaming" when said to the husband. Understandably, the wife could feel blamed by the therapist, while her husband might feel the therapist to be quite reasonable. A possible subsequent intervention to the husband to balance the somewhat harsh and direct response to the wife might be one of the following questions:

Therapist to Husband:	Do you see how you are also communicating unfairly?
or:	Do you understand how you could be perceived as unfair to your wife?

The intensity of an intervention needs to be balanced in terms of the power of the confrontation and the request for vulnerability and insight. It is important that when asking for significant revelation from one partner, the therapist also asks the other partner. Even when the therapist feels balanced in approach, she or he never truly knows the entire impact of an individual intervention. In fact, the partners themselves might not perceive the power of an intervention until much later. Therefore, the therapist must constantly assess clients' verbal and nonverbal responses and reactions. If defensiveness occurs in one partner, it might be evidence of a perception that the therapist is unfair or unjust.

In addition to the intensity of interventions, the immediacy of balanced intervention is also very important. In the above dialogue, if the therapist stated that she or he would like to deal with the husband's issues in the present session and the wife's difficulties in the session the following week, a number of problems could occur. The husband's vulnerabilities and responsibility for the dysfunctional relationship patterns would be exposed for an entire week before the wife might have to deal with her complementary role in the couple dynamic. In that time, the husband could feel sided against, and the wife could feel justified. Coalitions might be formed with friends or family that would need to be processed and which might further entrench the couple in their dysfunctional patterns. The wife's responsibility in the couple's circular patterns might never be examined as the sessions become more imbalanced toward confrontation of the husband and addressing other issues precipitated by the imbalance.

Balanced techniques should be demonstrated within each therapy session, not week to week. In heated confrontation, balancing might be required every several minutes. This means that the therapist orients the conversation back and forth between two partners while trying to keep the length of discussion and the depth of intervention and intensity balanced and fair.

Using Room Setting to Promote a Balanced Session

One of the simplest balancing concepts to understand, and one of the most neglected, pertains to the room setting and clients' seating positions. Assessment of alignments and coalitions among any group of people can be readily ascertained by watching nonverbal cues such as who faces whom and physical proximity (Minuchin & Fishman, 1981; Minuchin, Lee, & Simon, 1996).

Therapist balance and clients' perception of fairness and therapeutic process can be affected by the positioning of the chairs and the posture of the therapist. For example, suppose the therapy room is set up with the two clients directly facing the therapist, as if in a classroom, and not at all towards each other. This structure suggests that the therapist will be the leader or instructor. Implicit is the idea that the therapist's insight and direction are the most important dynamic in the couple's therapy. By making it difficult for the couple to face or to speak to each other, the therapist reinforces clients' dependency on the therapist and inhibits the use of couple interaction to explore issues. This is a reason why the use of couches often makes it difficult to promote direct interaction between partners.

In seeming contradiction, this might be the exact structure a therapist uses if the clients are hostile and blaming or functioning in a highly enmeshed manner. By making the therapist central to the therapeutic process, there is a better chance of stopping the emotional reactivity and destructive interactions of the couple than if the couple were to continue to look directly at each other. Of course, the eventual goal is to move the therapist out of the center and to increase the effectiveness of the couple interaction. This can be facilitated by encouraging the couple to turn more towards each other and by coaching them in effective communication, a topic that is addressed in detail in Chapter 12.

On the other hand, a structure in which the couple directly faces one another could, in a negative way, increase the likelihood that the clients will be enmeshed and conflictual. However, in a positive way, it can facilitate an intimate communication between partners, with the therapist as an observer. Clients with high conflict might independently move their chairs to face the therapist and away from each other to create more safety and less couple intimacy or emotional vulnerability. The couple who has been working hard at their intimate communication might not need the buffer or the safety that the therapist provides and might move their chairs towards each other on their own. In cases in which couple intimacy is desired, the therapist might take him- or herself out of the middle of the couple interaction and encourage the partners to speak directly to each other. This can be facilitated through the use of an enactment, a technique which helps the couple interact with each other (see Chapter 12). A balanced, active therapist should certainly be able to intervene no matter what the seating arrangement.

In an initial session it is suggested that each chair be positioned equally to face the two other chairs, somewhat like the three points of a triangle. With equal ease of conversation among clients and therapist, there is the greatest likelihood for balancing the input of the therapist with enactments and couple interaction. From this position the therapist and clients can turn their heads to make the therapist more or less central to the couple conversation.

Understanding the relationship of body language and concepts of fairness and balance is crucial for every couple therapist. When the therapist positions herself or himself towards the couple and not towards an individual, a sense of balance and fairness is created. By facing one partner and not the other, feelings can emerge in the clients of being picked on or sided against or, conversely, being aligned with and being the favorite. The general body position of the therapist when not engaging a client in a specific interaction should be towards the middle of the space between the clients or equally towards both partners. Relative height between client and therapist is also important to consider. If the therapist sits in a professional chair and the clients on a soft couch, the height difference could be one or two feet. Looking down at someone can definitely affect the process of couple therapy.

In addition to body posture, other nonverbal behaviors help or hinder clients' sense of balance and fairness. For example, balance of eye contact is important. By looking straight at one partner the therapist will probably engage that partner. If continually done in an unbalanced way, the therapist is communicating a number of possible things. Perhaps she or he is aligned with or against that person or is reacting in some way to the personality of the client. Whatever the reason, the most negative effect of maintaining eye contact with one partner and not the other is that the individual being stared at will find it hard to look away and could be pulled out of an interaction with his or her partner.

Eye contact should be balanced in intensity and duration with each client as much as possible. When an enactment is being structured by the therapist, the therapist might look down. By the therapist avoiding any eye contact with either partner, the couple will find it more difficult to resist intimate communication with each other by engaging the attention and eyes of the therapist. Unconsciously, a therapist who fears intimate emotional conversation can disrupt the depth of couple conversation and connection by looking only at one partner.

Touch, if perceived to be appropriate by the therapist, should be of the same quality and nature with both partners. For instance, if the therapist shakes the hand of the husband, she or he should do the same with the wife. A hug offered to one partner and not to the other can create issues of injustice and feelings of alienation. Touch, in general, should emerge out of the feelings of the session and the needs of the client. When done as a habit, touch can communicate a superficial intimacy. For example, a hug after a difficult session has a very different meaning than a hug after every session.

Psychopharmacology and Balance

Perhaps one of the most difficult couple interventions to be made in a balanced way is the suggestion of medication for one partner and not for the other. Medication is often prescribed for the purpose of alleviating anxiety or depression, which affects

both the individual and the health of the couple relationship. When a therapist suggests that a client seek consultation with a psychiatrist about medication, there is a risk that the client needing medication may be seen (by him- or herself or the partner) as the "sick one," or the partner not needing medication may feel absolved from personal responsibility. Every couple therapist should be versed in the effective use of medication to enhance the health of an individual, which may also have a positive effect on the couple relationship and alter negative circular patterns of couple interaction. For accurate psychopharmacology, a psychiatric referral is needed. Framing such an intervention for the couple, in a balanced way, takes considerable thought. Possible ways to frame a suggestion for medication are as follows.

1 "You both are contributing to the problems in ways we have discovered over the last number of sessions. (To one partner) Some of the difficulties you are having with depression and your consequent negative feelings, I believe, could be helped with the use of medication. (To the other partner) On the other hand, your difficulties won't respond to medication and have more to do with learning and family of origin. You will have to work hard to positively influence these tendencies and personality traits. With the use of medication for you, and with both of you working on issues of family of origin, the quality of the relationship could be enhanced."
2 "I believe that medication can help you to function better and to feel less down on yourself. If that is the case, and one of you begins medication, you both will have to look at the relationship differently. (To the partner in need of medication) When not depressed, you might look at the actions of your partner very differently, with less hurt or rejection. As this changes, you (looking at the partner not in need of medication) may have to examine some of the fears you might feel when intimacy is more of a possibility."
3 "The issues you both describe are certainly workable. I believe that about 10 to 20 percent of the difficulty has to do with the anxiety that seems to have control of you. I would like you to see a doctor about medication to determine whether it can alleviate some of the symptoms. I can refer you to a psychiatrist, whom I know and respect, who can assess for the possible use of medication. I will continue to see both of you in therapy. The three of us will focus on the other 80 or 90 percent of the difficulty that the medication will not affect."

By balancing the responsibility for progress *in the therapy* and not making it impinge on the effectiveness of the medication, the individual member of a couple will be more likely to accept the referral for a psychiatric assessment. In the last example, if the importance of medicine is put in perspective, the referred partner is less likely to feel singled out in a negative way.

Techniques to Determine Balance

There are three effective ways for therapists to assess balance and level of bias. These include monitoring time, counting interchanges and who speaks to whom, and making inquiries to the couple.

Monitoring Time

While there are almost always exceptions to any rule, a therapist unknowingly spending considerably more time with one partner versus another is often a reliable indication of transference or countertransference issues or alignment and coalitions between therapist and one or both partners. A good exercise is for a couple therapist to assess how much time is spent with each partner. If 40 minutes is spent in discussion with one partner and 10 minutes with another, this might be a warning sign to the therapist that the therapy is losing its systemic foundation and becoming unbalanced.

Length of time spent can also be measured for the *amount of time the therapist talks*, the amount of conversation between the two partners, and the length of silences. If the couple therapist is doing the majority of the talking, there is probably little *in-depth* therapy taking place. Instead, the therapist is giving *a lecture* or, at best, offering some psychoeducational process. The verbose therapist, one who does not let the clients speak, probably has little sense of the process of couple therapy. The therapist spending time both talking to the individual partners and helping both partners engage in conversation with each other is probably facilitating a more effective relationship process.The therapist who facilitates communication will deepen the level of conversation and help the couple find more energy for the treatment. A therapist who talks too much is literally draining the energy from the couple therapy.

If, especially in later sessions, nearly all conversation is channeled through the therapist, she or he is probably either anxious and fears losing control or has been inducted into the resistance of the couple. Client interaction in enactments, structured by the couple and the therapist, is central to couple therapy. The presence of some silence in a session can be a positive indication that the therapist is asking probing questions for thought and insight or perhaps is allowing for a more profound level of feeling. Sessions filled with a constant flow of words are probably indicative of high levels of anxiety.

Counting Interchanges

Another helpful tool for determining balance is the counting of interchanges between the various participants. An excellent exercise to determine the nature of the process of a session is to listen to an audio or video recording and count how many times each person speaks to every other person. If all dialogue is between therapist and one individual of a couple, the therapist might actually be doing individual therapy in a conjoint setting. At certain times, such as when exploring family-of-origin issues or eliciting affect, such individual therapy with both partners present might be preferable.

However, in most cases when the dialogue is predominantly between an individual and therapist, the therapist does not have a clear enough understanding of systemic therapy and the use or *the importance* of enactments in couple therapy. The couple therapist who is central to all conversation might have a need for control or have an overresponsible attitude for the movement and content of the session. He or she may also be taking too much responsibility for client change. Most often a constructive and dynamic process of couple therapy will include significant couple dialogue, therapist's comments and interventions to each individual, and process comments and interventions directed towards the couple.

Making Inquiries

Perhaps the most obvious technique for adequately assessing the balance of the therapist's approach is to ask the couple, "How have I been balanced or unbalanced in my approach with both of you?" or "What is your perception of the responsibility you both are being asked to take in the relationship difficulties?" Clients will often feel safer with a therapist who can ask such questions because they know the therapist is thinking about issues of fairness, and can recognize that she or he is fallible in terms of offering a balanced approach and welcomes constructive feedback. If balance is lost and these questions are asked, there is a greater likelihood that the clients will verbalize their feelings before trust and confidence in the effectiveness of the therapy are undermined. When therapists are open to feedback and are willing to admit and strive to repair mistakes, it can lead to an improved therapeutic alliance with clients (Whiting, Nebeker, & Fife, 2005).

The Meaning of Loss of Balance

When a client feels unfairly confronted or challenged, when siding occurs and coalitions are created that alienate one of the partners, or when the couple therapist diagnoses a couple in linear cause-and-effect rather than systemic terms, there are a number of possibilities for the therapist to consider.

1 The therapist might lack the training, skill, and ability to think systemically.
2 The therapist might have unresolved issues from family of origin that are being tapped by the clients' content or process.
3 The therapist might be experiencing countertransference as a reaction to projections from the client or experiencing transference, in which the therapist is projecting his or her own material onto the client.
4 The couple is not willing to accept responsibility and might be working to get the therapist to be unbalanced so that they can exit therapy or fail to change a homeostatic pattern.

Whatever the reasons, violations of fairness, justice, and balance should prompt a therapist to discuss them with his or her supervisor or personal therapist. Self-reflection is necessary in order to understand the etiology of the imbalanced approach and then do what needs to be done to correct the imbalance.

Conclusion

In conclusion, balance is a central systemic concept. It is necessary for the couple therapist to develop skills to maintain a balanced and fair approach so that both individuals of a couple can examine their responsibility in the couple difficulty. For additional information about balance in therapy, the reader may also want to consult Weeks et al. (2005).

6

MOVING FROM CONTENT TO PROCESS

Clinicians trained in systemic models of therapy are likely familiar with the refrain: "focus on process, not content." *Content* consists of what is being said—the data and information. *Process* is the manner and intent by which the content is shared. In short, content is the *what*; process is the *how*. In therapy sessions, couples tend to emphasize the content of their communication with each other. A therapist who is not careful can get bogged down in the content of clients' problems and lose sight of the process of their interactions, which might limit the therapist's ability to help the clients. In the end, *both* are important, and the systemic therapist needs to be skilled in eliciting and hearing the content as well as understanding the function and meaning of the communication—the process. This chapter will discuss how to explore for and interpret the deeper meanings and interpersonal processes underlying content.

To become skilled in identifying process, the therapist needs to concentrate on developing more effective listening skills so as to uncover the "between the lines" meanings of clients' language. Concurrent with tracking the content, the couple therapist can listen for the meaning behind a certain tone of voice, the "why" of a specific word choice, and the overall intent of a message that is not fully expressed in words. Most readers will understand that people sometimes use incongruent communication such that the words they use do not match the tone or intent of the message. A couple therapist will be acutely attuned to the process of clients' communication.

This chapter will provide some suggestions on how to become a more perceptive listener of client process. Tone of voice will be discussed as a way to control relationship intimacy and as an expression of assertiveness, aggressiveness, submissiveness, or passive-aggressive behavior. Word choice and meaning will be emphasized as focal points of therapist intervention. The goal is for the therapist to track the content while simultaneously understanding the process of the communication at a number of different levels. Common language patterns between partners will conclude the chapter.

Tone of Voice

Clearly, tone of voice suggests to the therapist a great deal about the intent and meaning of communication. A difficulty for many couple therapists is that they do not

confront the *way* something is being said, but instead respond to and elaborate upon the *content* of a message. However, the partner who is listening will often respond *more* to tone of voice than to the content of his or her partner's communication, for the tone reveals the speaker's feelings about what is being said or their feelings about the partner. Thus, the therapist must be attentive and responsive to the tone as well. A negative tone of voice can be aggressive and invasive, inviting defensiveness in the listener. Invasive language violates the ego boundaries and identity of an individual. It is language that is aggressive and often controlling and manipulative. For example, one partner might say to the other, "You never are affectionate; you are selfish and uncaring and only think about yourself. Are you listening to me?"

These types of phrases said in an angry, aggressive tone will probably feel like an attack. They are difficult for the listener to simultaneously hear and respond to without becoming defensive. In general, invasive or attacking language and tone of voice, no matter how accurate the content, will not be heard and will provoke a defensive response. The content of such discussions is often misunderstood and misinterpreted. In other words, the couple can talk about many content areas in the same defensive manner and aggressive tone of voice and have the same negative result: *No one is listening, and destructive patterns are maintained.*

Before discussing the content of a message, couple therapists need to confront both the tone of voice and the invasiveness of the language, the defensive and aggressive attitude that probably masks deeper feelings of fear or pain, and the response or reaction of the listening partner. The confrontation could be in the form of a request: "Could you say the same thing and change your tone of voice?" or "Your tone of voice is aggressive, and I'm not sure your partner will be able to hear the message you are hoping she will understand. Try and say the same thing assertively." Or to the listener: "How are you hearing what your partner is saying?" Other possibilities include asking why the communication was verbalized aggressively, or inquiring about what the aggression elicits from the partner. The intention of such interventions is to help clients become more aware of the process of their interactions and the impact of both their words and tone in order to develop a process of communication that is less reactive and more cognitive and thoughtful, including the sharing of *vulnerability and feelings* on the part of the sender.

Another form of language that creates difficulty for the process of effective communication is, paradoxically, a tone that carries very little intensity or strength. Passive and unassertive language can be difficult because the listener must strain to hear and interpret what the communicator is trying to say. Often the result is a listener who might give up trying to understand the communicator. In this way a couple might be colluding to resist more intimate sharing.

To establish a healthy process of communication, the therapist might ask the communicator to speak louder, to intensify his or her speech, to become more assertive; or the therapist might ask the listener to respond in a more assertive, less reactive manner. Inquiry into the meaning of speaking with little intensity and the way the partner reacts to it may bring insight into deeper personal feelings and thoughts and a couple's dynamics.

Tone of voice often makes the difference as to whether or not the speaker is heard and understood. Effective communication is characterized by a tone of voice that is

assertive, not aggressive, and is sensitive to the emotional boundaries of others. Often, there will be a reflective quality to the tone. For instance, one partner might say,

"I understand that I . . ."
"I feel sad about . . ."
"I realize that I . . ."

A thoughtful, self-reflective tone invites listening, rather than resistance or defensiveness. Clarity without force or coercion and listening with the intent to understand and not defend are characteristics of effective communication.

Word Choice and Meaning

Client word choice and meaning constitute another area of concentration for the couple therapist. The specific words used by clients are major clues to underlying feelings and thoughts. Words that carry emotional weight or cognitive significance may well be the focus of an entire session, as deeper and more significant interpretations and feelings are sought. Such significance is evident with a client who expresses emotions in unqualified terms such as, "I am sad" instead of "I am sad today about . . . " or "I am stupid" instead of "I do not understand this." Feelings expressed in absolutes often have direct historical roots from the client's early experiences and relationships.

"I am *always* rejected by him/her."
"He/she has *never* loved me."
"Why do I *always* have to take care of you?"
"You *never* understand how I feel."
"He/she abandons me *all* of the time."

When feelings are communicated in the absolute, without qualification, a therapist should delve for deeper historical significance than what is apparent in the current relationship.

Therapists must make inquiries and pursue definitions actively to clarify a client's intent and to specify meaning between speaker and listener. *The same pursuit of meaning needs to be encouraged for both individuals of a couple.* It is important not to assume that the partners understand each other. For example, there are many ways a therapist could respond to the client who expresses these feelings:

I feel down.
I feel sad.
I feel happy.
I am scared all of the time.

Many therapists may think they understand the meaning of these feelings without obtaining more specific explanations and descriptions for increased insight and emotional expression. Although it may seem that the content of a message is clear,

the meanings behind and hidden within a communication affect the process a great deal. Much miscommunication occurs when the communicator is inadequately clear or the listener is hearing from a specific set of preconceived ideas. After the therapist shares empathy and understanding regarding how the partner is feeling, the next step could be to ask about the words "down," "sad," "happy," "scared," and "all of the time" to determine the deletions, distortions, and generalizations, which can help to characterize, expand, and further interpret the above expressions (Bandler & Grinder, 1990; Milliner, Grinder, & Bretto, 2000). The following illustrates this kind of inquiry.

Client: I feel down.
Therapist: Down about what?
Down about whom?
Can you describe down?
How far down?
Do you feel down some of the time or all of the time?
Client: I feel sad.
Therapist: Sad about what?
Sad towards or about whom?
What kind of sad?
How deep is the sadness?
How often do you feel sad?
Are you sad about everything?
Client: I feel happy.
Therapist: Happy about what?
Happy about whom?
How happy are you?
How often do you feel happy?
Client: I feel scared all of the time.
Therapist: Scared about what?
Scared about whom?
When do you feel scared?
How scared are you?
Are you truly scared every day?

The attentive and realistic therapist will not assume understanding of a client's specific meaning, but will be curious, ask questions, and share feelings to understand more deeply the intention, conscious or unconscious, and meaning of a word choice. *Of course, the skilled systemic therapist will teach each partner to inquire and seek deeper meaning from each other in the same manner the therapist might with each individual partner. It is of far more value to teach client couples this exploration skill and sensitivity than to simply model it in therapy.*

Because language is sufficiently inexact, the therapist or individual partner of a couple has to inquire as to meanings that are deleted, distortions that are present, and generalizations that exaggerate the true intention of the spreaker and the response of the listener. Consider the family characterized on p.72.

The Stewart family presented in therapy with their 12-year-old son, John, as the identified patient. John's older brother Paul and his mother and father all described John as being rebellious and a troublemaker. The therapist decided to orient part of the session around the meaning of the words "rebellious" and "troublemaker." The therapist realized that both words were packed with deletions, distortions, and generalizations, which if left hidden, would prevent family members from seeing how they had constructed a view of each other based on language and the lack of shared meaning.

Each family member was asked what these words meant. The father discounted the seriousness of his son's behavior and attributed his actions to those of a normal teenager; rebelliousness was a part of growing up. The mother interpreted "troublemaker" to mean John was heading down a path toward juvenile delinquency. Paul was jealous of the rebelliousness. For him, it meant that John could get away with so much more than he could at that age. He believed John was receiving preferential treatment. John thought that his "rebelliousness" was fine and normal, especially in comparison to the actions of his peers.

The alignments and coalitions within the family structure became quite clear as the meanings of the words were elicited from the family. The therapist watched as the mother said in an angry, anxious way, "John is so rebellious and a real troublemaker," while the father laughed in a condescending fashion and brother Paul sat in an angry sulk.

In addition to the therapist, clients may not understand the meaning and intent of their partner's words. Part of the therapist's job is to help facilitate active listening between partners so that words and meanings are more clearly understood. When one partner expresses a thought or feeling, therapists may guide the other partner not only in expressing empathy but also to be curious and seek for more understanding about their partner's experience. Too often, partners assume they understand what the other means, when they do not. Words communicate meaning but rarely reveal the complete meaning. Further elaboration and intention of the communication needs to be sought by the therapist and/or a partner through questions and active listening.

Common Language and Interaction Patterns in Couples

Couples often stress to the therapist the content, or details, of their interactions. As described in Chapter 5, partners often want to tell the therapist every detail of their negative experiences as a couple. The motivation for clients is often the underlying belief that if the therapist knows all the "facts," then he or she will see the problems in the same way and take their side. Effective couple therapy requires that clinicians attend to the process of clients' interactions, even when the couple emphasizes the content (Nichols, 2012).

Couples develop language patterns that are important for the therapist to identify and understand. Five general patterns will be discussed: Language as a Manager of Distance; Assertive, Aggressive, Submissive, and Passive-Aggressive Communication; Reactive and Responsive Listening; Reciprocal Language Patterns; and Hierarchical Intimacy Patterns.

Language as a Manager of Distance

Language is a powerful tool that can be used to determine the amount of closeness and distance in a relationship. The therapist must listen not only to the content, but also to the intent of a specific communication by focusing on the response it elicits. This will help the therapist determine whether the communication brings a couple closer or moves them farther apart, condescends or puts down, or places one of the partners on a pedestal and the other one down.

Assertive language often brings two people closer. "I" followed by an expression of how one feels and said in a reflective or sensitive tone of voice will frequently elicit a positive response. Even a message such as "I feel angry," which could be heard defensively, said with the intention of opening communication could be received positively and increase understanding between two partners. In order to communicate assertively, the sender must feel entitled to have feelings and thoughts, to speak, to be heard, and to feel that what he or she has to say is important. There needs to be a history of feelings of safety, trust, and respect within a couple's relationship for assertive communication to occur. If clients are not currently providing an environment of safety, trust, and respect for each, the therapist's role is to create such an environment in session so that assertive communication can occur.

Language that distances a partner is often characterized by *judgment* or *blame*. Such language *often* starts in an accusatory manner with the word "you," and the intention is to project or attribute blame and responsibility onto another person. A partner who says "You never hug me!" or "You aren't very sensitive or caring!" is ostensibly communicating a wish for closeness, but the defensive response it provokes creates distance. Separation and alienation are common outcomes in communication that unconsciously repeats early destructive patterns from one's family of origin. By harboring feelings of rejection or abandonment from the past, the partner believes that he or she is asking for closeness but in truth is establishing distance, perhaps to protect against further pain. Gottman's (1994) styles of communication dealing with criticism, contempt, defensiveness, and stonewalling can all be used to create distance in a relationship.

The following comparison of statements illustrates how the same basic content can be used in a healing, intimacy-enhancing way, or in a more regressive, alienating manner that pushes a partner away. The first statements can increase intimacy and are congruent with a wish to be nurtured and understood. The second set will probably create distance and are incongruent in that the partner is starving for closeness and struggling to be heard but uses words that alienate those around him or her.

Statements which invite intimacy:

- "I need you."
- "I need a hug."
- "I really want to spend some time with you."
- "I am really hurting inside."
- "I feel upset with you and want to talk."

Statements which establish distance:

- "Why aren't you ever there for me?"
- "You never hug me."
- "You never spend any time with me."
- "You always hurt me."
- "Why did you do this to me?"

The therapist needs to encourage and confront clients who use distancing language and help them recognize the underlying meanings and effects of their communications. Perhaps a client's fear or pain contributes to the trepidation of being too vulnerable with their partner. Feelings of rejection or abandonment from family of origin or originating in the current relationship might have helped this person to develop a defensive posture. Attachment injuries may inhibit one or both partners from feeling emotionally safe to express their feeling openly (Makinen & Johnson, 2006). Or perhaps the couple might be colluding to establish distance because of their internalized fears. *The goal in most effective communication is to be congruent in process and content. What is being said and the manner in which it is said are in agreement. "I need a hug" is congruent. "Why don't you ever hug me?" is incongruent because the request for a hug is masked in aggression.*

Language also can be used by a partner in an arrogant, condescending, and/or self-denigrating way. All three suggest underlying feelings of low self-worth in the communicator and perhaps, if believed, in the listener. Consider this dyadic communication between a husband and wife.

Husband: Why don't you ever do it the right way?
Wife: I tried, I really tried.
Husband: I've told you before how to do it; I don't know how many times I have to repeat myself.
Wife: I'll try and do better next time.
Husband: I hope so.

The arrogance of the husband and the self-denigration of the wife create distance and diminish feelings of safety and closeness in the dyad. Such language may indicate a parent-to-child dynamic in the couple's relationship. In such roles, there may be little intimacy and an absence of sexual relations. *Parent–child relationship dynamics often destroy feelings of wanting to be sexually intimate.*

The process-oriented couple therapist needs to be attuned to listening for arrogant or self-denigrating behavior, which are often paired together. Usually, one partner will take an arrogant position, and the other will take a complementary role of being angry, undermined, and hurt. Fearful of intimacy, the couple participate in this destructive communication in a collusive manner so that each person's behavior reinforces the other. If the therapist simply listens to the content of the message, she or he might very well side with the underdog against the condescending partner, without taking into account the one-down partner's passive-aggressiveness and distancing behavior. If the therapist remains attentive and balanced, she or he will recognize the

patterns of distancing as they are collusively established by both partners and confront them in order to increase understanding and encourage change. The therapist's attention and intervention should focus on the process of the couple's communication, not just the specific content of that communication. It is the role of the therapist to teach both partners the same sensitivity and awareness so that they can discuss their relationship process without intervention by a third party.

Assertive, Aggressive, Submissive, and Passive-Aggressive Language

Assertive language is direct, differentiated, subjective, and without judgment. Examples of assertive language usually begin with "I" and are followed by a clear statement of feeling, thought, need, or wish. "I feel very sad." "I need you to hold me." *Aggressive* language is confrontational and is invasive to the ego of the listener, often characterized by accusation, projection, blame, and *anger*. Examples often begin with "you" and have an attacking tone of voice. "You are never there for me!" A *submissive* communication uses tentative language and is spoken by someone from a one-down position. Examples might include a diminutive statement such as "I never can do it correctly." *Passive-aggressive* messages might at first sound quite assertive but the passive-aggressive person hides the fact that she or he shares the opposite feelings from those expressed directly. Although "I feel fine with the way things are" sounds assertive, the statement can be interpreted as passive-aggressive when the listener leaves the room and the communicator says, "I'm really not happy with the way things are."

Communication styles are often reciprocated between partners. Assertive styles often facilitate the listener-partner responding in an assertive manner. If the partner does not, the message probably was not perceived as assertive in the first place. Likewise, aggression in one partner often inspires aggression from the other. However, the partner might respond submissively and fearfully, passive-aggressively, or passive-resistantly. It takes a very insightful and differentiated person to be able to respond in an assertive, emotionally present way to a partner who is aggressive. A submissive partner often elicits aggression. Passive-aggressiveness almost always elicits aggression or passive-aggressiveness at first and can eventually lead to frustration, so that eventually the listener/partner no longer tries to relate.

Submissive, aggressive, and passive-aggressive styles of communication used by a member of a dyad could suggest that childhood dysfunctional relationships, characterized by rejection, abandonment, or low self-worth, remain unresolved and are being repeated in the dynamics of the couple's communication. The therapist who is sensitive to these patterns is able to intervene in a balanced and profound way. In order to increase client awareness, the therapist can confront each partner on what she or he is actually trying to elicit from her or his partner. Asking questions such as, "Can you understand what you are asking for?" or "Do you see what you are creating?" can lead to systemic understandings. The responses of both partners offer insight into the circular communication patterns of the couple.

The following process questions and statements might help improve couple communication and position clients to be more assertive.

"Try and say it without the aggression so that your partner can better hear you."
"Can you move out of the submissive position and be more assertive?"
"It sounds to me like you're not saying what you really mean and are being passive-aggressive."

After gaining insight into the meaning and effect of a communication, a couple—with the help of the therapist—must alter aggressive, submissive, and passive-aggressive language to make messages congruent with the healthier intentions and needs of the communicator and listener. *The therapist must teach each client to maintain assertiveness even amidst aggressive behavior. Assertive inquiry for meaning in responding to a partner's aggressiveness can often break down the aggression and turn it into more vulnerability.*

Reactive and Responsive Communication

Bowen's emphasis on differentiation highlights the influence that emotion has on the way partners respond to each other (Kerr & Bowen, 1988). A highly reactive person tends to easily feel attacked, insecure, and on the defensive. A reactive retort answers the statements of the communicator in primarily an emotional, not thought out, and defensive way. A *response*, on the other hand, defined as "an answer or reply," has elements of both emotion and thought and is intended to further the depth and meaning of the conversation. The responsive individual has more ability to listen and seek further clarification than one who is merely reacting.

A wife states:	"You did a very poor job."
A reaction:	"I did not."
	"You did just as bad a job."
	"I don't care what you think."
A response:	"What was poor about it?"
	"What do you mean by poor?"
A husband states:	"I don't like you."
A reaction:	"Who cares?"
	"I don't like you either."
A response:	"What about me don't you like?"
	"What do you mean?"
	"Could we talk about it?"

A person who is reactive perceives attack in most direct communications. She or he defensively assumes knowing the meaning and intent of the words used by the communicator. A responder will assume that meaning is person-specific and that understanding is important before an adequate response can be made. With a primary attitude of respect and interest, the responder seeks to build communication and mutual understanding. In terms of reciprocal patterns, reaction is likely to breed aggression, while response often calms down what was originally an aggressive communication and moves it toward assertion and deeper understandings. This is one of the most important abilities for couples to develop: to respond in a patient, caring,

and assertive way to emotional attacks or accusations from one's partner (Alberti & Emmons, 1983; Arbinger Institute, 2001, 2006).

The therapist who listens carefully will understand that if one partner reacts to a statement made by the other, there *probably* was a perceived attack or sensitive area touched. In reactive communication, the couple can get quickly enmeshed. A responsive communication, however, suggests a high level of differentiation and desire to understand the meaning one's partner is trying to convey. Healing, forgiveness, and couple intimacy are built on the foundation of responsive, nonreactive partners.

Couple therapists need to interrupt the reactive communications of clients. Intervention can take many forms: for instance, (a) inviting awareness of the origins of reactive patterns; (b) fostering insight into the emotions behind aggression; (c) examining the attributions of each partner, that is, what each partner thinks of the other; (d) restructuring the seating and redirecting the focus of conversation so that the therapist is more central; and (e) directly educating the clients about the difference between reaction and response.

One direct technique is an experiential exercise to teach clients just how reactive they are and how difficult and rewarding *responding* instead of *reacting* to one another can be. Amidst a couple's reactive argument, the therapist can say to both clients, "You know I don't like either of you!" This will probably stop their reactive communication and surprise the couple. Before they respond, the therapist can challenge them to respond to the statement and not to react. Often clients will think this so strange that they will laugh and parlay back a reaction such as, "I don't like you either!" The therapist can tell them this is a reaction and confront them until they begin to respond. A response would be for either partner to ask something like, "What don't you like about me?" thereby seeking understanding of the things left out of the original expression (Bandler & Grinder, 1990; Milliner et al., 2000).

After helping couples successfully respond to each other during the therapy session, a positive and direct challenge is to ask a couple to respond to each other at home, especially in communications in which reactions are commonplace. Another exercise, seemingly the opposite but often achieving the same result, is to send them home with the task of seeing if they can get the other to react, and to keep score. Paradoxically, this task can encourage the couple to respond, even during overt aggression. This exercise often sensitizes clients to their reactive instincts and begins the process of more responsive communication. However, this exercise should not be used with volatile or overtly aggressive couples. It is more appropriate for couples who are able to reflect and maintain some differentiation.

Reciprocal Language Patterns

A systems perspective recognizes that each person in a relationship plays a role in the relationship dynamics. The circular nature of communication lends itself to interactional patterns in which partners reciprocally influence each other. For example, a stressful event or situation in life may cause distress for one partner. When this partner reaches out for emotional connection, support, or a safe haven from the situation, the other partner may respond with withdrawal or criticism. The distressed partner may then increase pressure for emotional support, and the other may respond with

increased negativity or disinterest, leading to the couple becoming stuck in a rigid and negative interaction cycle.

Gregory Bateson (1972) used the terms *symmetrical* and *complementary* to characterize certain types of relationships and interactions between people (see also Becvar & Becvar, 1999; Nichols, 2012; Watzlawick, Beavin, & Jackson, 1967). In a symmetrical relationship partners engage in exchanges of similar behavior. For example, one partner yells, and the other yells back in a similar manner or with equal intensity. Such interactions may escalate in a reciprocal fashion. A complementary relationship is one in which the partners engage in opposite behavior, both verbal and nonverbal. For example, one partner may speak in a very animated way, while the other puts their head down and becomes withdrawn. Either type may be problematic for couples.

The process-oriented therapist needs to be knowledgeable and sensitive to reciprocal patterns in couple communication. With such awareness the therapist is able to anticipate and confront dysfunctional communication before it becomes too intense and hurtful. Several of the frequently observed patterns in communication are attack and defense, anger and withdrawal, pursuit and withdrawal, and thought followed by feeling or vice versa.

Couples in therapy often use an attack and defend communication pattern, which represents a common breakdown of communication. The mistake of many therapists is to wait quietly and passively, without intervening, while the couple intensifies this dysfunctional pattern.

Wife: You are never affectionate to me!
Husband: I am too. Last night I reached out to you.

This pattern of attack and defense creates distance and prevents the couple from being vulnerable with each other. The therapist who can intervene after an attack and ask the communicator to share the feeling behind the attack, or ask the listener to try to respond without defending, can begin to break into this process and aid the couple's discovery of more functional communication. For example:

Partner 1: You are never affectionate to me!
Therapist: Can you share the feeling behind what you just said?
Partner 1: I am feeling lonely and unloved! You are never affectionate to me!
Therapist: (to Partner 2) Try not to react or defend, but respond.
Partner 2: Will you help me understand what you mean?

Such interventions by the therapist provide the opportunity for breaking the destructive communication pattern and replacing it with one that is functional. Anger and frustration, identified by Johnson (2004) as secondary emotions, may be overt manifestations of underlying primary emotions, such as loneliness, hurt, or fear. It may require great persistence to change a partner's angry attacks into the more primary feelings of hurt, rejection, or powerlessness. *Beneath most aggression and anger are vulnerable feelings which, if shared instead of the aggression, often elicit a different, more intimate and soothing response and deeper understanding.* If the

therapist intervenes in a couple's reciprocal pattern in order to change reactions into responses, she or he must not be passive, but forthright and determined.

Another circular pattern frequently demonstrated by couples in therapy is vulnerability in one partner creating a reluctance in the other to share negative feelings or thoughts, and the subsequent lack of sharing resulting in further vulnerability in the other partner. A couple caught in a dysfunctional communication might justify their behavior by saying:

> "Of course I feel vulnerable. I don't know what he's thinking or feeling; he never shares anything with me."
> "Of course I hold back; she is always emotional and acts very fragile and vulnerable."

An inducted or unbalanced therapist is one who sides with one partner against the other and listens to or confronts the accusations of one partner and not the other. In contrast, a *systemic* therapist tries several techniques to challenge their self-justifications and break the clients' dysfunctional communication cycle. For instance, making a straightforward request that the clients take responsibility for their own behavior and recognize how one behavior elicits the other can help couples begin to break their ineffectiveor destructive patterns. Another helpful technique is to model self-justification and blame so that clients can hear what these sound like. The therapist can say, "My husband/wife and I had a huge fight last night and it was entirely his/her fault. I was blameless." If said in a lighthearted manner, the client often hears the one-sided nature of the accusation and begins to reflect.

Other common patterns observed in couples are those characterized by pursuer/withdrawer and blamer/distancer behaviors. These reciprocal patterns of behavior tend to create distance between partners and intensify relationship distress. In a pursue/withdraw cycle, couples become stuck in a pattern where one partner pesters the other to engage in the relationship, causing the other to withdraw, which encourages the first to pester even more. Engrained patterns such as this may lead couples to interact in detrimental ways which may be perceived as betrayal or abandonment (Makinen & Johnson, 2006).

Therapists are frequently inundated by the content of the blamer, who may recount a long list of dates and times when their partner was "not there" when they were needed. It is easy to become aligned with that individual and look at the withdrawer with a critical lens. However, a therapist who looks at the process, the manner in which the blamer speaks, the language used, and the hidden message behind the attacks will gain true insight into the couple's relationship. It is important that the therapist maintain a balanced approach so that each partner feels safe to explore their emotions and experiences in a secure environment in which both partners feel validated.

Therapists who are sensitized to process issues will recognize that no behavior exists in a vacuum. When one partner expresses anger or withdrawal, the therapist needs to look for the response or reaction in the other and determine the interrelationship.

Hierarchical Intimacy Patterns

There are hierarchies of intimacy which, when expressed, are experienced differently by people, often depending upon the depth and vulnerability of the relationship. Unfortunately, many couples relate to each other at the top of this hierarchy instead of in an in-depth intimate way. In other words, the communication is superficial rather than conveying deeper personal feelings. Consider the following set of greetings listed in a hierarchical fashion.

Hi!
How are you?
It's nice to see you.
I was thinking about you.
I was really thinking about you.
I missed you.
I missed you terribly.
I really love you.

Each intimate expression, intended to create some level of connection between two or more people, is appropriate depending on the depth and nature of the relationship. A couple in a long-term committed relationship could use each greeting listed. Distant acquaintances would probably use only the top three. The therapist's challenge is to assist clients in using more intimate language. Distant and emotionally estranged couples often only know how to use the top of the hierarchy and never express deeper words of affection and love to each other. This is often the case with couples in which one or both partners has a fear of intimacy or being emotionally vulnerable. The top part of the hierarchy is often used to maintain distance and individual safety, and the bottom potentially can break through resistance or fears of intimacy. In the chapter on intimacy (Chapter 10), we will discuss the nature of intimacy, how to deepen intimacy and some of the common blocks or fears that are used to maintain distance.

Conclusion

In conclusion, reciprocal patterns of communication and interaction are universal in couples. The therapist who recognizes these patterns and their circular nature can systemically intervene to help couples accept individual responsibility for their part in the pattern, reframe and deepen insights and feelings, and help couples break destructive patterns. Such intervention must be at the level of content *and* process. The content is important to give insight and orient the therapist to the correct topic areas. Attention to the process deepens the understanding of the feelings and thoughts behind the overt communication and helps the therapist gain a deeper knowledge and capacity to confront or inspire the couple's negative or positive systemic patterns. Couple therapists also help clients shift their attention away from content to the process of their interactions so that they can develop new, more constructive ways of interacting.

7

BUILDING AND MANAGING INTENSITY

In couple therapy, personal growth and relationship improvement are most enhanced by a dynamic *energetic* process in treatment. Aspects of such a process include active interaction, feedback, humor, confrontation, empathy, a full range of emotions, and intellectual and emotional sharing. The systemically oriented therapist attempts to create appropriate emotional intensity among partners and between the couple and the therapist. Too much intensity can inhibit a therapist's ability to intervene in a constructive manner and for a couple to communicate effectively. Too little intensity can cause a therapy session to lack focus and prevent a couple from truly engaging each other in an intimate way. This chapter focuses on the management of intensity for the purpose of creating a dynamic therapeutic environment for clients. In addition, the often observed phenomenon of therapist and client resistance to heightening emotional intensity will be reviewed.

Therapists working with couples need to have skills to build intensity and relatedness within a session so that the couple will generalize the cognitive and emotional experience to their everyday relationship outside of therapy. Generating intensity within a couple's therapy session requires sensitivity to process issues and the ability to use cognitions and emotions in the couple–therapist interaction. Johnson (2010) indicated that the therapist's role is to emotionally charge the therapeutic session, to maximize each partner's engagement in therapy, validate their experience, and facilitate direct, face-to-face interaction between partners. Using these techniques, the therapist builds intensity between the couple, allowing the couple to experience what Johnson (2010) refers to as a " 'safe emergency' which Perls (1973) suggested is at the heart of significant change" (p. 137).

The fundamental concept is that therapy is a dynamic process not to be reduced to an intellectual dissemination of information. When the session becomes limited to rational thinking and the passive reception of information, an individual will have difficulty integrating what she or he feels and applying insight into personal experience. Emotion can be a strong motivator of change in behavior and interaction in couple therapy, and a corrective emotional experience can bring a couple together in ways that an intellectual conversation cannot. However, the goal is not simply catharsis. Cognitive change will often follow emotional change, and emotional change, of necessity, involves change in cognition and action related to the emotion (Greenberg & Johnson, 1986, 1988). Building appropriate intensity can produce not only emotional and cognitive changes; it also facilitates deeper connection between partners.

Therapists must work to build and maintain the intensity of sessions in a manner that fits with couples and promotes movement toward their goals for therapy. If a couple comes to therapy with little affect or intensity, what can be done? How does a couple therapist turn seemingly meaningless small talk at the beginning of a session into energized, focused conversation? How can the disorganized ideas frequently contained in a client's description of the presenting problem be transformed into insight, primary emotions, and behavioral change? Conversely, how does a couple therapist effectively work when there is too much couple intensity that prevents any thoughtful communication?

Bugental's conceptualization of therapist skills into "four octaves" in responding to client sharing gives the reader a thorough description of how to manage intensity and facilitate joining, trust, depth, emotional and cognitive sharing, and structures for change (Bugental, 1987). These octaves consist of four major areas of therapist aptitude: (1) listening skills, (2) guiding and focusing, (3) instructing and teaching, and (4) requiring or confronting.

The octaves are interrelated, with each one building upon the previous octave, and the last point of each octave being the first point of the octave that follows. For example, the last point of the first octave is also the first point of the second octave. The *listening skills* (octave one) outlined by Bugental include the use of silence, bridging statements such as "I see," restating, summarizing, encouraging talking, reflecting the obvious, inviting expansion, and asking open-ended questions. The second octave, *guiding and focusing*, begins with open-ended questions, selecting a part on which to focus, sharing factual information, structuring information, pointing out alternatives, general structuring for how much focus a specific idea should take in a session, suggesting topics, and asking moderately focused questions. The third octave on *instructing and teaching* begins with asking moderately focused questions, rational advising, supporting, reassuring, teaching, weighing alternatives, limiting direction, and narrowing the questions. The fourth octave on *requiring or confronting* discusses narrowing the questions, urging-on the client, approving, challenging, reinforcing or disapproving, superseding, and commanding.

In addition to Bugental's therapeutic principles, therapists who incorporate the following four strategies will find that they can more effectively focus their sessions and create and manage intensity: (1) using images and analogies; (2) using client language, emotional expression, and silence; (3) using repetition; and (4) focusing on primary material and developing a theme. After discussing these four therapeutic strategies, the chapter will conclude with observations on the management of highly enmeshed clients who communicate with destructively high levels of emotional intensity.

Using Images and Analogies to Create Intensity

Couples who are unable to express or are fearful of emotions often communicate at a superficial level. In many cases, superficial expression of emotion or intellectual discussion can be transformed into dynamic interaction through a client's or therapist's use of images and analogies. Although thought and the written word can certainly carry intensity, images and analogies usually increase the depth and the

energy of an interaction. Napier wrote on metaphors, "It is in this way that our reality is transformed. A cluster of circumstances awakens in us feelings that become so charged and intense that they literally change what we are experiencing" (Napier, 1990, p. 2, as cited in Nichols & Napier, 1996). A couple therapist can use images and analogies in several ways: for more accurate diagnosis, for disclosing deeper meanings and encouraging behavioral change, and for teaching different marital and family therapy concepts without the use of professional jargon.

One such analogy technique is the invitation of the Grim Reaper into the therapy session (Odell, 2003). This often works when a couple is stuck on a particular point; however, it can create significant internal reflection on any point. The analogy is to invite the Grim Reaper into the session by asking the couple to pretend that one of them has been killed or has died suddenly. The couple chooses the person between them who died, and the therapist conveys to the "living" partner that the intense arguing, nagging, unattached feelings are now gone.

This analogy allows the therapist to dig deeper on an emotional level by asking the living partner, "How does the death affect you and your family? Are there emotions and thoughts you wish you would have had a chance to express? Are there things which you wish you would have done?" This opens the therapy door to circular questions and reflection regarding marital and familial impact. The therapy session then moves from superficial "stuck" points to an emotional experience, with clients now able to access the transformation described by Napier (1990) in which "feelings . . . become so charged and intense that they literally change what we are experiencing" (p. 2).

Diagnostically, images and analogies are crucial for an assessment of the depth and seriousness of a symptom or disorder. For instance, if a female client states that she is feeling very depressed, description through analogy can be very elucidating. Besides asking the client to describe the depression in feelings and thoughts, the therapist might ask for specific analogies to further describe the depth of the depressive feelings or possible suicidal ideation. The following examples will describe less critical to more serious feelings of depression. In this example, the bottom of the hierarchy might very well prompt the therapist to consider hospitalization of the depressed individual. The client might state, "My depression is like . . ."

- a mist that dulls all the colors around me.
- walking in mud; it takes so long to get anywhere.
- a huge hole in which I am holding on to the sides.
- a black cloud that is hovering over my head wherever I go.
- there is no floor beneath me, and I am free-falling out of control.

In addition to providing a richer description of one's struggle, the use of analogy may also be a projective device providing another view of innermost feelings and thoughts.

Diagnoses of the depth and intensity of anxiety and the possible need for medication are also improved by the use of images and analogies. After one male client stated that he felt very anxious, the therapist asked, "Can you tell me what the anxiety is like? What does it look like or feel like or sound like?" Consider the following hierarchy of

responses which, along with other corroborating data, might indicate the seriousness of the symptoms. "Anxiety is like . . ."

- an uneasy feeling which comes and goes.
- having an unsettling feeling of danger all of the time.
- having uncontrollable negative thoughts.
- being part of a crowd trapped in a fire.

Although the above issues of depression and anxiety present as individual problems, the relationship or couple-ship often experiences depression, anxiety, and other serious problems through unresolved conflict. As the therapist looks at the relationship as the "third person," the "relationship person," or the "person who is actually seeking help or a cure," the therapist must ask emotional questions of the couple-ship. Of course, the relationship can't speak for itself, but the words of the individuals convey the heart, soul, and feeling of the "relationship person." It is very important for the therapist to address the relationship through the couple and to find out what the conflict feels like. Just as we asked the questions about depression and anxiety of the individuals, the "feels like" images and analogies of the individual speaking on behalf of the relationship may indicate the seriousness of the symptoms and may reveal thoughts and feelings that may have never been expressed before. Just as the therapist would ask the individual to describe "what it looks or feels like," the therapist is now asking the couple, "Having conflict or unresolved differences between you is like . . ."

- looking at the night sky and seeing no stars, no moon, no light.
- saying a prayer and expecting God not to hear or answer.
- watching a car come at you and not being able to do anything to stop it.
- coming home from work to see the house on fire and my family is inside and the firemen won't let me in.

Differentiating the situational or more global character of the symptoms will help the therapist determine the seriousness of clients' individual or relationship issues. "I sometimes . . . " is different from "I am always . . . "; "She rarely . . . " is less severe than "She never . . . ". Absolutes such as "always," "never," "constantly," "incessantly," and "consistently" are clearly of higher concern than more qualified words such as "rarely," "sometimes," "occasionally," and "sporadically."

Images and analogies are helpful in understanding deeper meanings. One of the greatest mistakes a therapist can make is to assume they know what the clients are trying to say and therefore not seek further elaboration or clarification. The client's intellectual statement can be transformed into a more dynamic and meaningful expression when the therapist inquires about images or examples. Doing so can help the therapist move beyond specific complaints to underlying patterns in the relationship. The reader is directed to Chapter 6 of this volume for further discussion on moving from content to process.

The types of questions asked by the therapist are important for building intensity. If the client says "I feel very hurt," the comment carries intensity and meaning, but may be only a hint of deeper feelings. The therapist needs to follow up on such a

comment by inquiring further. "The surface structure the client has presented is incomplete, the next task is to help the client recover the deleted material. The most direct approach is to ask directly for what is missing" (Bandler & Grinder, 1990, p. 63). The questions below illustrate how the therapist might inquire about missing information or deeper feelings.

- About whom or what are you hurt?
- Can you describe the depth of the hurt?
- What is the hurt like?
- Can you compare the hurt to an earlier experience?
- What kind of hurt?
- Can you give me an image that describes the feeling?

A client might state in an intellectual or matter-of-fact manner that she or he feels very angry. The therapist can inquire:

- About whom or what are you angry?
- What is the anger like?
- Does the feeling come and go, or is it always with you?
- In what part of your body does the anger live?
- Can you draw or describe a picture of the anger?
- How does the anger sound inside of you?

Such inquiries can help the therapist and client understand that there is no universality of meaning in behavior or emotion and that inquiry for further depth of understanding is a necessity. With the use of images and enhanced descriptions, the intensity of a session can increase and carry more meaning for clients and therapist.

Both meaning and intensity are enhanced when intellectual concepts can be translated into image and experience. Couple therapists can help clients by translating the concepts of the various schools of thought and couple therapy models into everyday language, experiences, and examples. For most clients, the use of marital and family therapy concepts and jargon during a session is not very helpful. Telling the client that she or he has been "triangulated" for years in a "fused relationship" where little "differentiation" has taken place will probably be misunderstood. To gain a better understanding of the richness and depth of couple and family therapy concepts and to enhance the therapeutic impact of treatment, the therapist should work on creating images and analogies to use with clients. This language will raise the intensity and understanding of a particular couple's difficulty. Therapy is also enhanced when therapists use the language, images, and analogies of the clients.

Consider the following theories and concepts that have been transformed into more descriptive and applicable illustrations, insights, and analogies for use with clients.

Enmeshment or fusion is like . . .

- two people who hug in the deep end of a pool, trying to stay afloat while pulling each other down at the same time.

- two trains going in the same direction, on the same track; the speed of one is often determined by the speed of the other.
- two people shaking hands and not letting go.
- going scuba diving and sharing the same tank.

Being differentiated is like . . .

- being 30 years old and asked by your mother to get a haircut for the family picture and responding, "I do need one, I'd be glad to."
- holding onto yourself and your opinion when it seems that everyone around you wants to convince you of something else.

Lack of boundaries is like . . .

- adjacent backyards with no fences or markers; no one knows where to stop mowing their lawn.
- an inexperienced painter using watercolors.

Effective boundaries are like . . .

- fences with doors that are controlled from the inside.
- having the freedom to invite someone over and asking them to leave when you are tired.

Rigid boundaries are like . . .

- building a castle with a moat and no drawbridge.
- not letting new information influence long-standing opinions.

Intimacy is like . . .

- dancing with emotion when your heart tells your feet where to go.
- having mutual understanding and caring for each other's feelings.
- two swimmers, who swim together in a synchronized way for awhile, and then in an individual way swim apart.
- feeling a great sense of chemistry and compatibility

Positive entitlement is like . . .

- a father giving a child permission to go further in education than he did.
- a green light.

Negative entitlement is like . . .

- a red light
- when the final paper of the final class for your degree cannot quite be finished.

Such examples are as numerous as a therapist's and client's experience and imagination. Through images and analogies the theories and concepts that organize, explain, and/or describe the clients' experience can be communicated in ways that increase understanding and meaning.

Using Client Language, Emotional Expression, and Silence to Increase Intensity

As couple therapists attend to the content of a couple's communication, they need to listen to the specific words and language used by their clients. Inquiry and/or comment by the therapist should attempt to focus upon and mimic the language of the couple. For instance, if one partner states that she or he had a bad week, the therapist could ask, "What made the week bad?" By repeating the use of the word "bad" and not changing it to a word of the therapist's choice, a client can continue to elaborate with deeper personal explanation or meaning, without having to adopt the therapist's language or interpret the therapist's particular meaning placed on the word choice.

If the therapist were to ask, "Why was the week awful?" the meaning of the client's emotional word "bad" might be lost in trying to interpret or resist the therapist's use of "awful." By focusing on the client's language, the therapist can show respect for the client's view and interpretation of reality, instead of immediately superimposing another. Consider the following two dialogues, one in which the couple's understandings are consistently translated into the therapist's word choice (Dialogue 1), and one in which the couple's understandings were honored and enhanced (Dialogue 2).

Dialogue 1:

Husband: We seem to be fighting all of the time.
Therapist: What are your arguments about?
Wife: We don't really argue. We just walk away from each other.
Therapist: Why do you both withdraw?
Husband: I feel very angry.
Wife: I don't withdraw. I just need a little time to gather myself.
Therapist: What do you think you are scared about?
Husband: I'm not really scared. I am just discouraged.

Dialogue 2:

Husband: We seem to be fighting all of the time.
Therapist: Tell me about the fighting.
Wife: We both get very hurt and walk away.
Therapist: What kind of hurt? How do you walk away from each other?
Husband: For me it is a very deep hurt, a feeling of rejection.
Wife: Well, I usually walk away, but inside I feel more panicked and want to run.

By using the meaning and the language of the clients, a natural flow is created that increases the focus, intensity, and emotional depth of a session. If the therapist

constantly transforms the client's language, the client has to work to interpret the therapist's particular meanings, the client's intended meaning may be lost, and the conversation becomes very disjointed.

Sharing of feelings in a natural and open way is another technique used to enhance the depth and intensity of a session. Consider the following feeling responses to a couple's pain:

Husband: We seem to be fighting all of the time.
Therapist: I'm sorry.
or: How discouraging.
or: That makes me sad.

Brief emotional expression followed by silence often will allow the client to continue the description of the fighting as she or he feels that the therapist is emotionally present. Such expressions from the therapist often have a greater likelihood of tapping into the feelings of the clients than does a more cognitive inquiry. *Most questions, including "How do you feel?" tend to force a client to think about a response rather than express a feeling.*

A client came to therapy depressed and very angry that his wife of 48 years had Alzheimer's disease. The session began with the typical question and answer format. Questions were asked such as:

- How long has she been ill?
- What has it been like for you?
- How do you cope with the difficulties?
- What did the doctor say is the prognosis?

The client dutifully responded to each question, but became more depressed and angry about his situation as the session developed. What could the therapist offer? As the therapist stopped thinking about what question to ask next, he eventually expressed that he too was angry about the client's situation and that he was experiencing such pain. The session ended, and the client made an appointment for the following week.

At the next session, much to the surprise of the therapist, the man appeared considerably more at peace and less depressed. The therapist remained silent as the client said, "When I came in last week I felt alone and very angry. When I heard your anger *and feelings*, I realized that I was not alone and I felt better." The therapist's sharing of his anger normalized the client's angry feelings. Through the therapist's normalization of the client's feelings, other emotions of loneliness, guilt, and fear were given expression and calmed.

In addition to emotional expression, silence is perhaps one of the most effective techniques for enhancing the intensity of the client's statement. This is true especially when it is connected to a nonverbal indication that the therapist is present and emotionally available.

For example:

Wife: I am really hurting!
Therapist: (leans forward, unfolds his or her arms, and says nothing)
Wife: He doesn't seem to care about me.
Therapist: (empathetic expression)
Wife: (tears) I feel all alone!

As the therapist was perceived to be quiet, and emotionally present, the client allowed herself to become more open and vulnerable. Patience, silence, and an engaged body posture by a therapist will probably do more to elicit the emotion of the client than most questions. Silence can create a vacuum and permission for the client to go deeper into hurt and pain.

Using Repetition to Build Intensity

Couple therapists may find that insights and questions intended to lead the client towards more depth of feeling and vulnerability can be very difficult for the client to hear. Resistance and defense mechanisms can interfere with listening. There is often a highly developed collusion process within the couple which results in their not understanding or responding to the therapist's attempts to facilitate change. However, the therapist's use of repetition can raise the intensity of the therapist's interventions and can provide focus and a conceptual orientation that clients have trouble resisting. In the following communication, the therapist is using a systemic intervention that is at first difficult for the husband to hear.

Husband: My wife is never there for me; she avoids me constantly.
Therapist: Is it possible that you contribute to your wife's avoidance?
Husband: I don't. She is always off with her own friends.
Therapist: How do you help create the distance in the relationship?
Husband: It doesn't start with me. She leaves, and then I react.
Therapist: You'll be better able to change the pattern if you can figure out how you help create the distance.
Husband: My wife says that I am angry all of the time.
Therapist: Is that how you contributed to the distance?
Husband: I know I push her away when I get very hurt.

This last statement by the husband was his first reflective one, and it is the one that will begin the process of changing the circular patterns of the couple. Once the husband stops focusing on his partner and instead reflects on his own functioning and contribution to the problem, he begins to become empowered such that he can alter his behavior. It was the repetition that helped break through the husband's resistance.

In the next example the repetition of the client's words creates a helpful confrontation to the client's distorted way of thinking.

Wife: I simply am not smart enough to take that job.
Therapist: You aren't smart enough?
Wife: I am sure I'm not.
Therapist: I didn't realize that you weren't very smart.
Wife: Well, I am not stupid!
Therapist: However, you are probably correct that you need to have more intelligence to take that job.
Wife: I might be able to do it.
Therapist: I think that you will have to be smarter.
Wife: I think I can learn whatever I need to know to do it well.

By repeating and exaggerating the cognitive distortions of the client she was able to begin the process of altering her thinking.

Frequently, a beginning therapist does not trust him- or herself or have the personal confidence in his or her systemic interventions. Furthermore, beginning therapists might be uncomfortable with or fearful of emotional intensity. When encountering client resistance or an increase in intensity, therapists may abandon systemic interventions too quickly. Repetition can communicate that the therapist is focused and confident that another way of looking at things can be achieved. *Repetition often has the ability to break through successive walls of defense. Each defensive statement by a client is designed to stop the intervention. However, when the therapist persists, sensitively, the vulnerability behind the defense can often be uncovered.*

Focusing on Primary Material and Developing a Theme

Because the deeper issues of a couple are often painful and threatening, the real sources of their distress may remain hidden behind a veil of repression and denial (Napier, 1990; Nichols & Napier, 1996). In order to protect the vulnerability associated with such distress, a couple can present many topics and issues to the therapist. The intensity of a therapeutic session is lost when the couple and/or the therapist allow for many issues or topics to be covered. Such avoidance can take two predominant forms: one is client focused and one is initiated by the therapist.

As was mentioned above, marital patterns are resistant to change. One of the primary ways couples resist and thwart movement is to bring up many topics, change the focus of the conversation when it becomes too intense, and generally detour the therapist away from the most meaningful material. As a client communicates the broader picture, intensity can be raised if the therapist focuses on a singular theme, idea, or feeling within that picture. Generally speaking, almost any focus is better than none at all. The easiest way for the therapist to know whether he or she is focused enough is to review the important aspects of a session with another therapist. If the therapist cannot summarize the essence of a therapeutic session in a couple of sentences, then there was probably not enough focus.

Consider the following communication by a couple seen in therapy.

Wife: You are never available to me. I have to keep begging for some affection.
Husband: I feel closed in. You are always on my back.

Wife: The children need you home, not off somewhere else all day. Last weekend you watched football all day with your friends.
Husband: I work very hard and deserve to spend time on my own.

This couple expressed variations of these themes many times, which further entrenched the negative feelings in their relationship. The therapist who is seeking to create a focus might initially say:

- Let us focus on . . .
- What you just said is very important.
- Let's spend the rest of the session on this topic.

Possible topics to focus on are:

- The distancing patterns of the couple.
- The meaning of the words "begging" and "closed in."
- Exploration of patterns in clients' families of origin.
- A discussion of time alone or time together.
- The understanding of how intimacy is expressed and experienced.
- The role of entitlement.
- Issues of parenting.

The important factor is that the therapist or couple pick one topic and pursue it in depth. Deeper meanings explored in one area will almost always generalize to other important issues and concerns.

A lack of focus initiated by the therapist is indicative of the worst understanding and application of what a therapist might call an "eclectic approach." In such "eclecticism," a therapist knows a little about each school of thought, but not enough to actually orient his or her thinking and intervention. Without such focus the therapist will often confront superficially, be inducted into the resistance of the couple, and talk about a number of different topics at a meaningless level.

An excellent exercise for the therapist is to listen to the content of what a couple presents in therapy and to practice conceptualizing the material into a specific school and approach. Interventions can become more focused and purposeful once the therapist can conceptualize the clients' patterns. In the following examples, excerpts from client conversation are organized within different *conceptual* approaches. Each client statement can be organized into and understood from several theoretical perspectives.

Client: "My mother just walks into my house without even knocking."
Conceptualization: This could be a boundary problem, best approached *structurally.*
Client: "My daughter wakes up every night, and I bring her into my bed."
Conceptualization: This might be a reinforcement issue and might be approached *behaviorally.*
Client: "Every time we talk, we end up in a huge argument. We both get so defensive."

Conceptualization:	This couple might have few communication or conflict resolution skills and can be helped by *communication theory and practice.*
Client:	"I am not very smart or competent in most things."
Conceptualization:	These could be "automatic thoughts" which need to be addressed from a *cognitive* perspective.
Client:	"When I go home for the holidays, I seem to lose myself and get furious with my family."
Conceptualization:	This might be a differentiation issue which needs to be looked at from a *Bowenian* perspective.
Client:	"I don't know why I have the attitudes I do."
Conceptualization:	This could be a loyalty or a legacy issue which needs to be approached *contextually* in the family of origin.
Client:	"I don't know why I push away the people whom I most want to love me."
Conceptualization:	This could be a matter of early introjected patterns repeated compulsively which needs to be understood from an *object relations* perspective.

The list of examples is endless. The therapist needs to be able to organize the scattered information from the couple into concepts and theories that allow for both understanding and direction for change. If the therapist is conceptually focused, more energy for change and insight can be derived from specific intervention.

Managing Too Much Intensity

As mentioned above, too little intensity is often boring for both client and therapist. A lack of intensity can be resistance based and prevent change and growth from taking place. One the other hand, too much intensity can be very intrusive, destructive, and counterproductive. Couples sometimes choose a therapist on the basis of their perception of the therapist's ability to manage their intensity and stop potentially destructive communications. Some therapists are afraid of intensity in therapy sessions, and others are hindered by apprehensions or fear of making clients uncomfortable or offending them. Their desire to have their clients like them may interfere with the process of treatment. However, effective therapy requires that therapists appropriately challenge their clients, and the process of change may make clients (and therapists) uncomfortable at times. Therapists must learn to recognize the therapeutic benefits of building intensity in session and challenging clients to make the changes necessary to reach their goals for therapy.

The therapist needs to have the confidence to halt negative interactions. Without such confidence, the therapist's inclination might be to avoid intensity altogether and structure sessions with his or her ideas instead of allowing the couple's emotions to truly emerge. The less confidence the marital therapist has, the less likely it is that she or he is going to enhance couple interaction and to let the couple discuss their issues with the emotions typically accompanying such discussions. Research has demonstrated that some variability in psychotherapy outcomes is specifically linked to therapists' interpersonal skills (Anderson, Ogles, Patterson, Lambert, & Vermeersch,

2009), and the therapist's internal confidence plays a very important role in the therapist's interpersonal skills.

A couple therapist's confidence is enhanced by knowledge and proficiency in using specific techniques for managing emotional intensity. Four techniques for managing the intense interactions of a couple are: (1) asking process questions that demand the couple's reflection and insight; (2) using emotional interventions that seek the expression of primary feelings; (3) structuring a couple's conversation using stronger confrontation; and (4) changing the structure of the therapy. The following types of interventions are designed to manage the intense and judgmental communications of a couple.

(1) *Process questions* are designed to help the couple observe and reflect upon their own communication by helping them to become more thoughtful, hence less emotional and reactive, and objective observers of themselves. The therapist might ask:

- Is this what goes on at home?
- What is the purpose of the arguing?
- Do you want to get this out of control?
- Can you see what you are both doing?

(2) Certain *emotional interventions* take the focus off the anger and judgment of the couple interaction and redirect the discussion into more primary feelings of pain, hurt, or rejection. A therapist might say:

- This is very painful to watch.
- Please don't hurt each other like this.
- I really feel the pain behind the anger you both expressed.
- Talk about the feeling behind the anger.
- If anger is the tip of the iceberg above the water, describe the emotions that lie beneath the water.

(3) *Stronger confrontations and structuring the discussion* can interrupt harmful communication and decrease the emotional intensity. Some possible interventions to lessen intensity might be:

- Stop! (may be accompanied by the therapist moving forward in one's seat or holding one's hand out in a stop motion)
- I'm not going to let you continue to do this to each other!
- Don't speak; just listen right now!
- I want one of you to share and the other to listen.
- Start with "I" and try and leave out all of the attack.

(4) *Changing the structure of a session* helps clients avoid becoming more entrenched in conflict by stopping the interaction or moving the therapist into the center of the couple's interaction. The therapist might say:

- I am going to end the session now. It is too destructive.
- I am going to speak to one of you and then the other (while insisting the other partner does not respond).
- Would *one of you* please step out of the office for a minute?

The general rule is that the more destructively intense a couple is, the more central the therapist needs to be to the process. Such a couple needs the therapist to actively take control and calm the system.

Anticipating the depth of intensity before it gets out of control is an important skill. One of the greatest blocks for many therapists to overcome is to *change perspective* about what constitutes being polite. In a destructive communication between clients, it is not polite to wait until one of the partners has finished speaking. A five-minute husband/wife diatribe that keeps the therapist waiting for his or her turn can set the tone for the entire session and derail efforts to be helpful. Couple therapists need to understand that the rules of therapy are different to what is typically considered socially acceptable behavior outside of therapy. Although it is usually considered rude to cut someone off, therapists need to know that it is often appropriate and effective to interrupt, cut off, and prevent a client from finishing saying hurtful and destructive things in order to reduce potential harm between partners. Below are two examples.

(1) The "polite" therapist:

Husband to Wife: I'm upset with what you did. You really are insensitive to my needs. You never once asked me for what I wanted . . . as a matter of fact, you never have and you are always selfish! You are a real bitch!
Therapist: (turning to the wife) How are you feeling?

(2) An effective therapist who anticipates an evolving destructive interaction:

Husband to Wife: I'm upset with what you did. You really are—
Therapist: (interrupting) Your feelings are important; however, can you share them without attacking, and instead share what you want or need.

The therapist can then prevent expressions of aggression or judgment by intervening directly and quickly during an escalation of anger or hostility. *In general, inexperienced therapists process a couple interaction too slowly. To make the point, an extreme example would be that it is better to confront one partner as he or she is thinking about picking up a baseball bat with which to hit his or her partner than to ask the partner "How do you feel?" after he or she has been hit.*

The levels of intensity and their management in a therapy session are usually determined by the therapist's confidence and ability to remain detached from the affect of the client so that she or he is aware of the subtle communications and process issues. As mentioned previously, the more self-confidence the therapist has, the easier it is for him or her to trust interventions and follow through.

Two key issues related to a therapist's ability to handle clients' emotional intensity are the level of differentiation of the therapist and how anger was dealt with and processed in one's family of origin. Differentiation includes the ability to separate the emotional and intellectual processes and the ability to maintain clear, rational thinking even in the midst of intense emotions. Someone who is differentiated is flexible, adaptable, and independent of others. She or he can cope with the stresses of life (Bowen, 1976). If the therapist's family had the extremes of too little affect or too much intrusive arguing, the therapist might be greatly limited in his or her ability to manage intensity during a session. If anger was not allowed or punished or, conversely, if anger was rampant, a therapist could have a distorted reaction to client anger. Without adequate work on his or her own differentiation, a therapist will find it difficult to manage highly emotional clients, confront the collusion of an enmeshed couple's destructive communication, and reframe it and remold it into something more positive.

Conclusion

The management of intensity is an important part of couple therapy. Too much emotional energy can create destructive dynamics and enmeshment. Too little energy can prevent change, behavioral application of new ideas, and couple intimacy. Managing intensity is an essential skill for the couple therapist to develop.

8

SYSTEMIC THERAPY WITH INDIVIDUAL CLIENTS

For a period of time in the 1970s and 1980s, many therapists in the field of marriage and family therapy insisted that for therapy to be effective, all members of the family should be present. Currently, working with subsystems (e.g., parental subsystems, marital dyads, and individuals as part of a family system) is more widely accepted. If a system consists of the interaction of a group of individuals, and theoretically every individual affects the system, then it follows that working in a systemic way with an individual can alter the destructive reciprocal patterns within the couple or family of which the individual is a member (Bowen, 1966). A significant proportion of many couple and family therapists' caseloads are individual clients, many of whom are working on systemic issues (a survey of practice patterns indicates that on average, over 50% of MFTs' cases are individual clients; Simmons & Doherty, 1995). In many cases, spouses refuse to enter the therapeutic process, or individuals report that they want to work in therapy by themselves.

When working with one member of a relationship, the therapeutic task is to systemically address personal issues *of a relational nature*. If approached systemically, individual therapy can help the client *take responsibility for him- or herself* and become more constructively influential and differentiated within his or her family, thus having a positive impact on family relationships and leaving open the possibility that a spouse or other family members might become involved in the therapeutic process at some future time.

This chapter will explore the difficulties and opportunities for the therapist working with an individual member of a couple dyad. The ethical implications of aiding the growth of one partner without directly working with the other, combined with an understanding of the potential danger of the role of empathy when used to align with one partner against the other, will also be discussed. In addition, specific consideration will be given to the therapist's role of encouraging client self-responsibility and the development of personal power. Finally, the intermingling of individual and couple therapy will be discussed.

Ethical Implications of Individual Therapy

It is critical that therapists are aware of the potential negative implications of working with only one partner of a committed relationship. Unwittingly, individual therapy may exacerbate couple conflict and contribute to relationship dissolution or divorce.

By encouraging and enhancing one partner's growth without paying adequate attention to its effect on the other partner, the therapist can unbalance and disrupt the homeostasis of the couple system (Gurman & Kniskern, 1981a, 1991). Clearly, this growth could be positive or negative depending on the many perspectives of the persons involved.

Every individual issue or concern has systemic and relational ramifications for an individual client who is part of a intimate couple relationship. For instance, if a spouse is depressed, one systemic question that needs to be addressed is what role the depression plays in the couple's communication and overall relationship (Jessee & L'Abate, 1985). There are several possibilities. Through the process of overidentification, one partner might be experiencing depressive feelings similar to those found more severely in his or her partner. Perhaps the nondepressed partner colludes in deepening the feelings of depression in the other through criticism or withdrawal. For example, when one partner is depressed, there is little chance that the couple will be physically intimate or emotionally close. Often such collusion is derived from fears of intimacy and vulnerability.

Another possibility is that if one spouse is depressed, there is less likelihood that she or he will have the energy to leave the relationship. The less depressed partner, feeling fear of loss and a poor self-concept, knows this and unconsciously reinforces the depressive feelings. Whatever the presenting problem, whether it be anger, anxiety, weight, unemployment, self-punishment, or intimacy fears, each individual's behavior and subsequent dynamic have a multitude of systemic ramifications and possibilities.

Therapists must also be aware of the relationship implications of individual change through therapy. The couple therapist working with the individual member of a dyad has an ethical responsibility to share the fact that personal growth and change, which may be enriching and constructive for the client, might very well be debilitating or destructive for the couple or family relationships. When one partner changes, the couple's reciprocal patterns will change, and the partner will eventually have to readjust or alienation might ensue. The therapist might engage the client in a conversation about this issue saying, "If you decide to work in therapy, you might develop or change perspectives *concerning your relationship.* If you examine these issues in the absence of your partner, it might create tension, dissension, and/or general distance in your relationship." If the client understands the potential that individual therapy might disrupt the homeostatic balance of the couple dyad and still chooses to continue individual work, the therapy can continue.

Although being empathic is essential with the individual coming to therapy to work on relationship issues, it can also be problematic because of its potential to create tension and chaos when working with the couple. By not becoming emotionally involved in the dysfunctional interactions of the relationship, the therapist can often be perceived as being more patient, caring, and understanding than either of the partners. "Why can't my partner be more like you?" "Why can't he or she be as sensitive as you are?" Such statements should prompt the therapist to normalize imperfections, perhaps explaining that she or he is not perfect and has difficulties and successes in his or her own relationships.

The therapist might share some fallibility and personal history to decrease an exaggerated positive transference. The therapist might go on to say:

> One of the goals in my listening and supporting you is for you to learn that you are to be treated with kindness and respect. You need to learn to ask for what you need in more effective ways within your relationship.

Nevertheless, the therapist needs to be mindful that there are two members of the couple, thus there are multiple perspectives. Therapists should be careful not to make unilateral, one-sided, or linear interpretations based on being empathetic to one partner's explanation of the difficulty. For example, a woman comes to therapy with marital issues, looking for support and understanding. The dialogue is as follows.

Wife: My husband is totally insensitive to my needs.
Therapist: What does he do?
Wife: He yells and swears at me. He comes home late and never helps around the house.
Therapist: It sounds awful.

Such empathy from the therapist, which sides with one partner against the other, can be very destructive for the future of the therapy and for the stability of the couple's relationship. Because of this unilateral interpretation, the systemic framework is lost. What the wife's therapist did not know or predict is that the woman goes home after the therapy session and shares with her husband something like the following: "I talked with my therapist today and he thinks that what you do to me is really awful." The same week the husband went to *his* therapist and said:

Husband: I am very frustrated and alone.
Therapist: What is happening?
Husband: My wife refuses to leave our baby with a babysitter, and the baby is sleeping in the bed with us.
Therapist: It must be difficult. She is probably overattached to the children.

In this case, what the husband's therapist did not understand is that the husband went home to his wife and said: "The therapist thinks you are overly bonded with the children and you need to give me more attention. The therapist completely understood how I feel."

Through such examples of empathy and unilateral interpretations, therapists may unwittingly reinforce each spouse to be more self-justified, less reflective, and less understanding of the other's feelings. Furthermore, each spouse might attempt to triangulate the therapist into a coalition against the other. In such cases, neither partner at this point is cognizant of the systemic issues of circular causality, self-responsibility, and fairness. Circular causality involves a reciprocal model of causality in which a process of mutual, circular influence and responsibility is involved. However, when an empathic or supportive statement by the therapist is interpreted as agreement, clients may use this as reason to blame their partners for the relationship problems, rather than take responsibility for their own contributions.

With such cautions in mind, the therapist's empathy for a client is still very important (Rogers, 1957). The context for the expression of empathy in an individual

session focusing on relationship issues needs to be structured and well thought out. Empathy is essential for joining with the client and establishing a context for trust, openness, and hope (Feller & Cottone, 2003). However, empathy needs to be balanced with systemic interventions, such as requesting that the client take personal responsibility for her or his contributions to the couple's circular pattern of relationship discord. For example, "Can you see how your behavior is intensifying the challenges you are facing?" Furthermore, even when working with only one partner, a therapist can share empathy for both members of a dyad. *When the circular nature of communication patterns is understood, the therapist can be sensitive to a couple's difficulty in a balanced way.*

In conclusion, while empathy is essential for the client–therapist relationship in the development of a therapeutic alliance, it can be problematic when the therapist is deemed to be more empathic than the client's partner. Empathy can also imbalance a couple if it aligns one partner and the therapist against the other partner or inhibits reflection when personal responsibility is not encouraged.

Therapeutic Boundaries

An important area for consideration in working with one partner of a dyad concerns the issue of communication boundaries. A client reporting the substance and process of a therapy session to his or her partner may be disruptive to the couple's relationship as well as counterproductive to therapeutic goals. The following two suggestions help to inhibit the inadvertent, inappropriate use of therapy material in the couple relationship.

The first suggestion is to establish the contract and the boundaries of the therapy during the intake session. The therapist might say to the client, "It is very important that you do not say to your spouse, 'The therapist said . . .' or 'My therapist feels that you are . . .' " When a client triangulates a therapist in this way, the therapy can be used to gain a one-up position. A destructive coalition is formed between client and therapist, which may create animosity and may result in an attempt by the absent partner to denigrate the therapist. If the partner feels a comment by the therapist is important to share, then this idea should be integrated within the person's self and communicated as his or her own. Instead of saying "The therapist thinks," the spouse would say, "I believe" or "I have been feeling . . . " The spouse's response can then be focused on his or her partner, and the therapist is not destructively triangulated into the couple's discussion or relationship.

The second reason to establish individual session communication boundaries concerns lessening the energy of therapy and detracting from the potential power of a therapeutic intervention. For example, consider a case where the therapist confronted a husband by saying, "You may be judging your wife for imperfections and weaknesses in yourself." What the client should do is integrate this idea into his own thinking and have it make sense (or not) for himself. He should process the thought privately until he understands its truth or lack of truth when applied to self-understanding and personal experience. Instead, the husband went home and said without thinking, "The therapist thinks I'm judging you for weaknesses in me." The wife did not take the time to reflect on this statement and doubted its validity. She found it had no relevance for

their relationship. "That is ridiculous," she said. The husband, who sought validation and support from her, did not integrate the concept and dismissed it quickly. The power of the intervention was minimized because the husband did not keep it to himself long enough to have it affect his thinking or behavior. Apparently threatened with the growth of her husband and the change in the homeostasis of the couple, the wife later stated, "Going to that therapist is merely a waste of time."

Systemic Interventions with Individuals

While individual therapy typically pays attention to the intrapsychic issues of a client, it also needs to have strong systemic foundations. Intrapsychic issues manifest themselves in circular ways in relationships. "Individuals are best understood within their interrelational contexts. A comprehensive systemic view of the family focuses on the evolving relationships of the family members within their environmental, historical, developmental, and ideological contexts" (Fleuridas, Nelson, & Rosenthal, 1986, p. 113; see also Hoffmann, 1981; Silverstein, Bass, Tuttle, Knudson-Martin, & Huenergardt, 2006). A systemic perspective emphasizes cyclical sequences of interactions.

The following examples of therapist–client dialogue suggest several systemic and circular questions in response to individually expressed thoughts and concerns. Consider the systemic concepts and theoretical directions that could be taken by the therapist to deepen the understanding when an individual client states, "I feel very incompetent."

The client's feelings may reflect a low sense of positive regard for oneself:

Client: I feel very incompetent.
Therapist: That sounds very sad. How long have you felt this way?
Client: For what seems to be all my life.
Therapist: How did you learn to think like this?
Client: I suppose from my father. I was never good enough. He always criticized me. I don't remember any encouragement.
Therapist: In what ways did your father affect how you feel about yourself?

The client's feelings might suggest a lack of differentiation from his family of origin:

Client: I feel very incompetent.
Therapist: When do you feel incompetent the most?
Client: When I am around my father.
Therapist: Have you ever talked to him about your feelings?
Client: No. I wouldn't dare.

The feeling of incompetence might be part of a specific reciprocal interaction between spouses:

Client: I feel very incompetent.
Therapist: How does your spouse relate to you when you feel this way?
Client: He puts me down even more.

The client's feeling could best be understood as an automatic thought, a concept used in cognitive theory:

Client: I feel very incompetent.
Therapist: Do you think this way in every context?
Client: No.
Therapist: Then when do you think well of yourself?

By nonverbally empathizing and asking circular questions from different systemic perspectives, the therapist works toward client insight and systemic understanding (Penn, 1982). In terms of the couple dyad, the therapist who thinks in systemic ways can make an educated guess that the statement "I feel incompetent" reflects parental criticism and inferiority which was internalized by one spouse and then projected onto the other:

Therapist: You are very hard on yourself. How does your spouse respond and relate to your feeling of inferiority?
Client: She criticizes me all the time.

While such an intervention might initially place blame onto the spouse, the following intervention begins the steps toward true systemic understanding.

Therapist: Do you think you might "set up" your partner to criticize you?
Client: I never thought about that.
Therapist: The pattern does seem similar to your background, so I wonder what part you are playing in the repetition?

Systemic interventions, which seek personal responsibility, will also permit the client to examine his or her own behavior rather than undermining or criticizing an absent parent or partner.

A personal sense of power is often achieved through the ability to reflect upon and understand one's own functioning and responsibility in both the positive and negative aspects of a dyad. Taking personal responsibility for part of the difficulty in any relationship gives the individual an opportunity to stimulate change without waiting for the other's movement. Systems change most often when an individual understands his or her contribution to the relationship dynamics and works to alter his or her own behavior. In contrast, powerlessness is most often felt and enacted when a client is projecting all responsibility and blame onto another person.

A systemically oriented therapist practicing individual therapy will confront clients to help them become more personally insightful and self-responsible. Although the following interventions might seem harsh outside the context of therapy, clients frequently feel empowered when they sense that they can do something to change the current quality of their relationship. Personal insight and self-responsibility are the keys when the therapist confronts from a systemic perspective. Examples of interventions that ask a client to accept responsibility are:

1. *Client:* My wife is always critical.
Therapist: Can you think about what you might do that leads her to criticize you? Try to answer without talking about her.
2. *Client:* My boyfriend is never emotional.
Therapist: Would you be frightened if he were? Do you do anything that might contribute to it being safe or unsafe for him to express his emotions?

A common problem for couples is when one or both partners is critical or judgmental. Criticism and judgment can be turned into insight by exploring what part or role the client plays in creating or maintaining his or her partner's behavior. It may also help to have clients consider how their role in the negative relationship pattern may relate to issues in the client's family of origin. Further suggestions for interventions that seek to encourage personal responsibility are:

- What part do you play in what you describe?
- How do you contribute to that behavior in your partner?
- What is your investment in what your partner is doing?
- Do you look for verification of those negative thoughts?
- Is your partner responding to what you are asking for?
- How is what you are describing predictable from understanding your background?

An additional benefit is that interventions that seek to encourage self-responsibility help prevent the tendency of the therapist to become inducted into the individual client's way of thinking. For example, a woman comes to therapy complaining about what a tyrant her father has been all her life. The therapist, who has become inducted into the client's thinking over several sessions, develops a view that the father must be quite cruel. After several weeks, the daughter invites her father into the therapy session. Instead of meeting an aggressive, large man, as the therapist expected, the father is a diminutive, soft-spoken person who cried over the loss of his daughter. The image the daughter developed about her father when she was a child became fixed and never matured. If the therapist had asked some systemic questions such as "When your father is a 'tyrant' what do you do?" or "Have you tried to talk to him without being reactive yourself?", the client's perspectives might have been challenged in a new way. By asking the client to examine her responsibility in the parent–child relationship she might have developed a more accepting position.

Individual Sessions in Conjoint Therapy

In some couple therapy cases, the therapist may meet with individual partners. The intermingling of individual sessions with conjoint sessions can be challenging, and therapists need to be aware that doing so could have both positive, and complicating, if not negative results. Furthermore, the therapist must be clear on issues related to confidentiality and communicate clearly with clients the rules regarding confidentiality when combining individual and couple therapy sessions (see Chapter 3 for ethical considerations regarding confidentiality).

Positively, individual sessions can:

- create a closer tie between each partner and the therapist, often the result being an increased commitment to therapy.
- enrich the therapist's understanding of the clients' family of origin, thought processes, and emotional experience and how these are related to current dynamics.
- assess the individual client's manner of relating outside the marital relationship.
- allow for a deeper psychological or psychiatric assessment without the client being self-conscious of the partner's involvement.
- establish a clearer understanding of a client's commitment to the relationship.
- allow for ventilation of intense feelings that might block the interaction in conjoint therapy.
- learn about secrets that might be blocking the progress of the marital work.

Negatively, individual sessions can:

- create difficulties with confidentiality (see Chapter 18 on how to avoid ethical dilemmas with individual sessions).
- create an alignment between one partner and the therapist, possibly excluding the other partner.
- allow for one spouse to use the individual sessions as a weapon by putting the partner down.
- appear to or in fact label one partner as the "sick one."
- unwittingly split the couple as each partner begins to grow individually but apart.

(Berman, 1982)

When changing the structure of therapy from individual to conjoint work, the following issues should be considered. In many cases, one spouse has been asking the partner to enter therapy, but the partner has refused. With a sense of desperation, the individual goes into therapy alone to attempt to make progress in the relationship. If the therapist has been systemic in approach, the partner not in therapy often realizes that the therapist is not biased against him or her. The absent partner often observes his or her spouse working on the family of origin or taking personal responsibility for his or her part of the problem. The client might say to the spouse, "The therapist really confronted me about the way I ___ with you." If the therapy is approached systemically, the nonparticipating partner might grow to understand that the therapist can be fair and balanced. Although the absent partner might have interpreted being blamed, she or he now finds that the partner in therapy is growing and taking responsibility. This fact can change the status quo of the relationship.

Including a spouse or partner into an ongoing individual therapy can be challenging. Sometimes it simply should not be done. The alignment and loyalties of the individual spouse and therapist may be too strong. For example, if the duration of the individual therapy is over 2 or 3 months, a very positive transference might have developed. In such a transference, the relationship between client and therapist can be very strong. As the individual client works out unresolved past relationships

within the transferential relationship with the therapist, a level of inclusion is developed that seeks to boundary out other people, including a partner. The longer the duration of the individual work, the greater the likelihood that a different therapist should do the couples work (see Chapter 5 on keeping therapy balanced).

With this taken into consideration, an advantage of using the individual therapist for conjoint therapy is that the therapist already understands some of the systemic issues. Furthermore, due to the systemic approach in which the client was being asked to take responsibility for a portion of the marital dynamics, the nonparticipating spouse might have already gained some trust in the process of therapy and the fairness of the therapist. The following are some suggestions for including a spouse or partner after individual therapy has already begun.

1 The client who has already established a relationship with the therapist needs to understand that when his or her partner is added to the therapy, and the therapist establishes a balanced approach in the session, she or he might experience some loss or anger at the absence of what heretofore had been a private loyalty and relationship. Forewarning often eases the intensity of these feelings. The therapist might say, "When your partner comes to therapy, I will listen and attempt to understand both your perspectives, and you might experience this as loss. Please let me know if such is the case."
2 The joining spouse or partner might participate in two or three individual sessions to join with the therapist before the conjoint sessions begin. The therapist can share with this partner some concern about him or her possibly feeling sided against or not feeling fairly understood. Again, if the new client is encouraged to share those feelings with the therapist in the session, and the therapist is balanced, they are rarely disruptive to the therapy.
3 At the commencement of the conjoint process, and at pertinent times thereafter, the therapist might verbalize all of the above with both partners present. This tends to create a commonly understood goal of balance and fairness among all parties.

Conclusion

In conclusion, individual sessions can be conceptualized from a systemic orientation. If such is the case, personal responsibility and insight will be sought in order that the individual might contribute to his or her couple system in more effective and powerful ways. While it is sometimes difficult to create couples' cases out of individual ones, it can be done if a systemic approach has been practiced consistently.

9

COMMON FACTORS OF CHANGE IN COUPLE THERAPY

One of the most significant developments in couple therapy in the 21st century has been the research and theoretical debate about *common factors* of change in couple therapy. A review of the couple and family therapy history, particularly the first four decades, reveals a strong emphasis on the distinctiveness of therapy models rather than what they had in common (Sprenkle, Blow, & Dickey, 1999). Furthermore, a determined emphasis over the past 30–40 years on establishing a strong research base to support the effectiveness of couple therapy resulted in the empirical testing of a diverse array of therapy models and a discipline-wide "arms race" to determine which approach was most effective. The good news is that outcome studies have consistently demonstrated that couple therapy is effective compared to no treatment (Shadish & Baldwin, 2002, 2009). However, the results did not produce a clear winner, with all models tested showing effectiveness, and no specific model emerging as superior to the others. Researchers and clinicians alike wondered if there were variables associated with positive therapy outcomes that were independent of specific models of therapy. In other words, are there factors of change common across models of therapy that account for therapeutic effectiveness, rather than the unique aspects of the models themselves?

The purpose of this chapter is to review common factors of change in the psychotherapy literature and highlight specific common factors that therapists should be aware of as they work with couples. We first present a brief history of common factors, followed by a summary of some of the major common factor categories proposed in the psychotherapy literature. We will also discuss the debate surrounding common factors and arguments as to how they fit with therapy models. Finally, we describe the pragmatic implications of these factors and how the couple therapist can utilize them in treatment.

History and Review of Common Factors

Questions about whether or not psychotherapy is helpful have been debated for the past hundred years, with the debate gaining greater momentum in the latter half of the 20th century. Bruce Wampold's (2001) seminal text chronicles the historical debate regarding the effectiveness of psychotherapy. Hans Eysenck (1952) and Stanley Rachman (1971) set out to prove the ineffectiveness and possibly harmful effects of psychotherapy and indeed claimed to have success. On the other side of the

debate were researchers such as Saul Rosenzweig (1954), Lester Luborsky (1954), Allen Bergin (1971), and Michael Lambert (Bergin & Lambert, 1978; Lambert & Bergin, 1994), who dismissed the findings of Eysenck and of Rachman as based on flawed research designs/conclusions, while their own meta-analytic reviews showed the effectiveness of psychotherapy (Wampold, 2001). With outcome studies in the hundreds and the findings of numerous meta-analyses, we can confidently claim that psychotherapy is efficacious. According to Wampold (2001), a client receiving therapy is 79% better off than individuals who are untreated.

In addition to the substantial evidence of psychotherapy's effectiveness in general, a significant amount of research also supports the effectiveness of couple therapy. In one meta-analysis comparing individuals receiving marital therapy to an untreated sample, results show those receiving therapy to be 84% better off than those who are untreated (Shadish & Baldwin, 2002). This research on couple therapy also indicates that clients' changes are generally stable over time.

Interestingly, numerous studies have concluded that the therapeutic model employed, as well as the presenting problem (with few exceptions), have little impact on these results (Sprenkle & Blow, 2004a; Shadish & Baldwin, 2009). This indicates the possibility of similar underlying factors within all therapeutic models. Asay and Lambert (1999) hypothesized that "different therapies embody common factors that are curative, though not emphasized by the theory of change central to any one school" (p. 29). Jacobson and Addis (1993) further claim that "in their natural clinical form, there is considerable overlap among the major models of . . . therapy" (p. 88). These conclusions are the basis for the common factors movement.

Awareness of common factors within therapy can be traced back to the 1930s and the work of Rosenzweig (1936) who claimed that the efficacy of all types of therapies was due to common factors, leading to the argument that no one therapy is more successful than the next (Wampold, 2001). The idea that all types of therapy are effective is frequently referred to as the "Dodo bird effect," based on the Dodo bird's observation in *Alice in Wonderland*: "At last the Dodo said, 'Everybody has won, and all must have prizes' " (Rosenzweig, 1936, p. 412). Because all therapies demonstrate effectiveness, common factors proponents argue that it is not the unique aspects of the various models that are central to their effectiveness, but the aspects they have in common. Common factors have also been referred to as "necessary and sufficient" (Lambert & Ogles, 2004, p. 171), meaning the same common factors are efficacious within all forms of therapy and are the fundamental aspects of therapy that produce change. Norcross (1999) states that "the aim of common factors [research] is to determine the core ingredients that different therapies share, with the eventual goal of creating more parsimonious and efficacious treatments based on those commonalities" (p. xviii).

Lambert's Common Factors Model

Michael Lambert's influential work intended to establish an empirical grounding for the common factors argument (Asay & Lambert, 1999; Lambert, 1992). Based on his review of over 200 psychotherapy outcome studies, Lambert concluded that common factors of therapeutic change (i.e., client improvement) can be separated into four

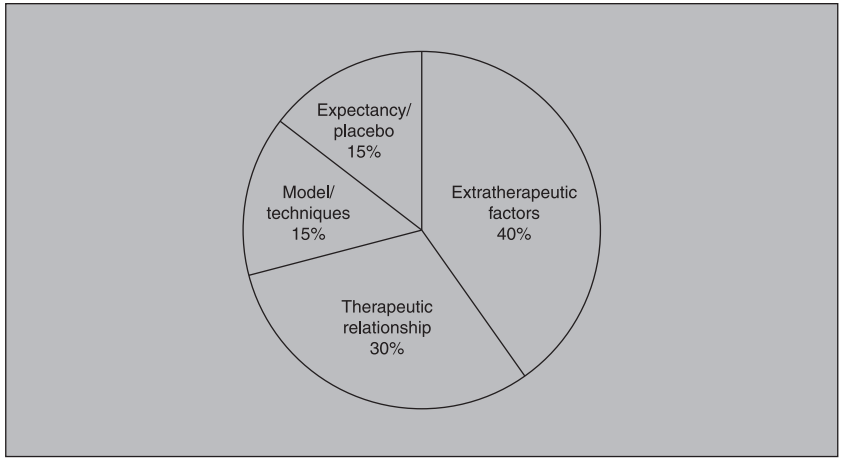


Figure 9.1 Lambert's Common Factors of Change

categories: extratherapeutic factors (i.e., client factors and extratherapeutic events), therapeutic relationship factors, expectancy and placebo effects, and technique/model factors (Asay & Lambert, 1999). Lambert (1992) attributes 40% of the outcome variance related to client change in therapy to extratherapeutic factors, 30% to therapeutic relationship factors, 15% to expectancy and placebo effects, and 15% to therapeutic techniques and models (see Figure 9.1).

Client Factors and Extratherapeutic Events

Clients who make the most progress in therapy and maintain treatment gains accept responsibility for bringing about the changes they desire. Although therapy training programs often emphasize effects of the model and techniques they use, Asay and Lambert (1999) claim that therapy outcomes are largely related to client factors and outside events (extratherapeutic factors). Some common client factors, or client variables, associated with clinical outcomes include: "severity of disturbance (including the number of physical symptoms involved), motivation, capacity to relate, ego strength, psychological mindedness, and the ability to identify a focal problem" (Asay & Lambert, 1999, pp. 30–31). Also included in extratherapeutic variables are self-help literature and environmental factors, such as social support. Because 15% of people show improvements *before* entering therapy, Asay and Lambert assert "in all likelihood, a significant number of people are helped by friends, family, teachers, and clergy who use a variety of supportive and hope instilling techniques" (1999, p. 33). They conclude that the nature of the problem, the makeup of the client, and the environment have a significant influence on the outcome of therapy. In fact, they reported that extratherapeutic factors have the greatest influence upon the outcome relative to the other factors they studied.

Therapeutic Relationship

Nearly every school of therapy agrees that the therapeutic relationship is an important aspect of successful treatment. Nevertheless, these approaches typically place the greatest emphasis on model-specific theory and techniques, assuming the relationship will naturally develop. In contrast, common factors researchers have placed the therapeutic relationship as central to the therapy process, rather than on the periphery (Sprenkle, Davis, & Lebow, 2009; Fife et al., 2013). Some of the important aspects of the therapeutic relationship are accurate empathy, positive regard, understanding, affirmation, nonpossessive warmth, congruence, and genuineness (Asay & Lambert, 1999; Najavits & Strupp, 1994; Rogers, 1957).

A key aspect of the therapeutic relationship is the therapeutic alliance. Numerous researchers have identified the therapeutic alliance as a common factor within all effective therapy practices. The alliance refers to the quality and influence of the co-operative relationship between the therapist and the client(s) (Fife et al., 2013). It is considered to be a necessary aspect of positive client outcomes regardless of the theory or approach used by the therapist (Horvath, 2001). Gaston (1990, p. 145) identified four dimensions of the client–therapist alliance:

1 The therapeutic alliance, or the patient's affective relationship to the therapist;
2 The working alliance, or the patient's capacity to purposefully work in therapy;
3 The therapist's empathic understanding and involvement;
4 The patient–therapist agreement on the goals and tasks of treatment.

Similarly Bordin (1979, 1994) identified three constructs in therapeutic alliance: the bond between clients and clinicians, the agreement on goals, and agreement on tasks.

Placebo and Expectancy Effects

It is likely that most, if not all, clients entering therapy carry some expectations about therapy in general and how it will help them (or not help them). Many clients expect that therapy will be beneficial, and expectations and hope for change are strongly associated with positive outcomes in treatment. This is affirmed, in part, by research looking at the effects of placebos on client change. For example, Lambert, Weber, and Sykes (1993) report that those receiving a placebo treatment were 66% better off than those receiving no treatment.

Therapeutic Techniques and Models

Ogles, Anderson, and Lunnen (1999, p. 202) provide a concise definition of models and techniques. Models are "a collection of beliefs or unifying theory about what is needed to bring about change with a particular client in a particular treatment context." Techniques are included within specific models and are defined as "actions that are local and logical extensions of the beliefs or theory." Graduate training programs and licensing exams tend to place great emphasis on the learning of models and techniques. Nevertheless, Lambert (1992) estimates that only 15% of therapy outcome variance is related to technique, while Wampold (2001) attributes 8%

(at most) to specific techniques. In comparison to other factors, specific techniques account for very little variance in outcome. In addition to the relatively small influence of specific models and techniques, there is very little evidence to support the claim that one theory or model is better than another (Asay & Lambert, 1999).

Frank and Frank's Common Factors Model

Similar to Lambert, Frank and Frank (1991) identified four features common to all effective therapies. The first characteristic of effective therapy is "an emotionally charged, confiding relationship with a helping person" (Frank & Frank, 1991, p. 40). Central to a relationship between client and therapist is the therapeutic alliance. The second characteristic is an appropriate setting for healing. According to Frank and Frank (1991), the therapeutic setting has two key roles in the outcome of the patient. First, the therapeutic setting increases the therapist's cachet, thereby enhancing the client's expectations of the therapist as being able to help. Second, the therapeutic setting provides safety. This safety allows clients to discuss personal matters with the assurance that what they reveal will remain confidential.

The third characteristic for effective therapy is a therapist who offers a credible rationale or plausible theoretical scheme for understanding the client's symptoms. The fourth characteristic is a therapist who provides a credible procedure or course of action for resolving the client's symptoms or problems. These rationales and procedures give hope and confidence to clients who often come into therapy discouraged and at the end of their rope. Frank and Frank (1991) emphasize that a credible framework for understanding and treating client problems will "combat demoralization by strengthening the therapeutic alliance, inspiring expectations of help, providing new learning experiences, arousing the patient emotionally, enhancing a sense of mastery or self-efficacy, and affording opportunities for rehearsal and practice" (p. 44). Davis and Piercy (2007b) also found that the therapist can have an effect on clients' expectations of therapy (i.e., expectancy effects) if they effectively offer a credible explanation and solution for client problems.

Wampold's Common Factors Model

Wampold (2001) conducted a meta-analysis of therapy outcomes studies in order to identify variables associated with clinical outcomes. The results of the meta-analysis attributed 70% of the outcome variance in psychotherapy to general factors (similar to those identified by Frank and Frank, 1991), and 8% to specific techniques or models, while 22% is left unexplained (see Figure 9.2).

Wampold (2001) concluded that the specific model or techniques a therapist uses account for a relatively small percentage of the outcome of therapy (see also Sprenkle & Blow, 2004a). He states, "The history of psychological treatments is littered with examples of treatments that are beneficial to clients but whose psychological explanation for the benefits have failed to be verified" (Wampold, 2001, p. 147). Evidence suggests that most approaches to psychotherapy are similarly efficacious, raising the question of whether specific treatment approaches are necessary for positive outcomes in psychotherapy (Wampold, 2001).

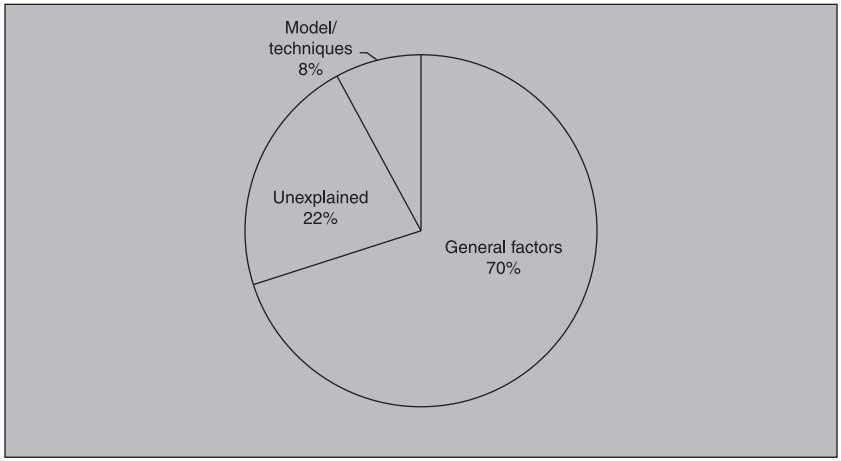


Figure 9.2 Wampold's Common Factors

Providing support to previous common factors research, Wampold (2001) found that the therapeutic alliance is highly associated with therapeutic outcomes. The therapeutic alliance is the most frequent common factor cited in the literature (Grancavage & Norcross, 1990) and is a significant predictor of clinical outcomes in many studies (Grencavage & Norcross, 1990; Horvath & Greenberg, 1994; Luborsky, 1994). Indeed, within almost all the common factors literature the therapeutic alliance is one of the most important aspects related to positive therapy outcomes.

Wampold's (2001) research also highlights the influence of the therapist's allegiance to the model they choose to use with clients. Wampold (2001) defines allegiance as "the degree to which the therapist delivering the treatment believes that the therapy is efficacious" (p. 159). Despite the fact that specific treatment models and techniques count for relatively little of the variance in outcomes, the therapist delivering the treatment seems to have a significant effect on outcomes within therapy (Wampold, 2001). This conclusion is supported by others who assert that the therapist is a key common factor of change in successful therapy (Blow, Sprenkle, & Davis, 2007; Fife et al., 2013; Grencavage & Norcross, 1990).

Summary

All of the common factors models and meta-analyses reviewed above reached similar conclusions. First, there are common factors of therapy that are related to positive therapy outcomes, regardless of the therapeutic model or techniques employed by the therapist. Second, the findings suggest that the specific therapy model or approach is less important (or *least* important, according to Lambert and Wampold) than other factors, such as the therapeutic alliance, client factors, and therapist factors. Much of

the research has concluded that the therapeutic relationship is the most significant therapist-influenced variable related to client outcomes (Safran & Muran, 2000).

Unfortunately, findings such as those presented above are often interpreted to mean that knowledge and skill in utilizing techniques or models are unimportant. However, the meta-analyses of common factors and clinical outcomes do not support this interpretation. Fife et al. (2013) argue that models and techniques are essential to effective clinical work, although they do not serve as the foundation or heart of therapy. In the end, common factors and models work together (Davis & Piercy, 2007b; Sprenkle & Blow, 2004a, 2004b). Models are implemented amidst common factors of change such as therapist qualities, client qualities, relationship factors, and contextual issues (Beutler & Harwood, 2002; Davis & Piercy, 2007b).

Common Factors in Couple Therapy

Prior to the 21st century, couple and family therapy researchers and clinicians largely ignored common factors of change and their connection to effective therapy (Sprenkle et al., 1999). Other than recognizing the importance of the therapeutic alliance, discussion of common factors was noticeably absent from the couple therapy literature. However, a significant shift occurred over the past 15 years, and much more attention has been given by researchers and clinicians to common factors of couple therapy. Beginning with the groundbreaking chapter by Sprenkle et al. (1999), the field has given significant attention to "common factors and other nontechnique variables" in couple and family therapy (p. 329).

Sprenkle et al. (1999) reviewed the couple and family literature in light of Asay and Lambert's (1999) categorizations of common factors (i.e., extratherapeutic factors, relationship factors, expectancy effects, and techniques), identifying variables within each of these categories pertaining specifically to couple and family therapy. They also discuss common factors that may be unique to the practice of couple and family therapy.

Extratherapeutic Factors

Sprenkle et al. (1999) identify variables within this domain: client factors, fortuitous events, and social support. They discuss three types of client factors.

1. *Static characteristics* of individuals refers to things like age, race, gender, sexual orientation, socioeconomic status, and so forth.
2. *Nonstatic characteristics* of individuals, couples and families refers to things like learning style, commitment level, family cohesion, and expressed emotion. There is the potential to influence or modify these characteristics in therapy.
3. *Motivational characteristics* refers to the motivation of individuals, couples, and families to engage in the treatment process. They include things like perseverance, cooperation, homework compliance, etc.

In their study of common factors in couple therapy, Davis and Piercy (2007b) also identified clients' willingness to accept responsibility for the problem and its

resolution, commitment to the relationship, and willingness to work as common client factors associated with therapy outcomes.

Fortuitous events refers to external events that occur independently of the therapists' interventions or the clients' participation in treatment. In spite of relatively little research on fortuitous events, Sprenkle et al. (1999) suggest that these events significantly influence therapy outcomes. The authors also concluded that clients' capacity to marshal social support is a significant extratherapeutic influence on the outcome of therapy.

Relationship Factors

Lambert (1992) estimates that relationship factors account for 30% of the variance in outcome. Sprenkle et al. (1999) purport that within marriage and family therapy this figure is probably much higher. They cite several studies in the couple and family therapy literature supporting the importance of the quality of the client–therapist relationship. For example, Alexander, Barton, Schiavo, and Parsons' (1976) research on systemic-behavioral therapy found that 44.6% of the outcome variance in the study was due to relationship factors, and Symonds and Horvath (2004) found a significant correlation between the alliance and outcome particularly when partners were in agreement about the strength of the alliance. Davis and Piercy (2007b) also concluded that the therapeutic alliance, characterized by mutual trust and respect, was an essential part of successful therapy with couples, particularly as a model for the clients' own relationship. The consistent findings on the positive effects of the client–therapist relationship should inspire couple therapists to pay particular attention to the quality of their relationship with each partner in therapy.

Expectancy Effects

Couple therapists often attempt to improve outcomes by encouraging optimism and self-efficacy. Sprenkle et al. (1999) report that client optimism is usually based on one or more of the following expectations: (a) what they hope to get out of therapy, (b) whether therapy is likely to help, (c) what they hope the therapist will do, and (d) whether they have the strength or capacity to change. They suggest that these expectations will have an influence on the outcome of therapy and that clients' expectations may change during the course of therapy. They also discuss the importance of the therapist being able to present therapy in a manner that is congruent with client expectations. Blow, Davis, and Sprenkle (2012) reaffirm this idea in their article on matching therapy to clients' worldviews.

Techniques

When speaking of techniques within couple therapy, we are referring to those techniques found within common couple therapy models such as Bowenian, structural, strategic, experiential, behavioral, solution-focused, narrative, etc. As reviewed above, there is not one couple therapy model that has demonstrated superiority over the others (Shadish & Baldwin, 2002, 2009), These findings, combined with Lambert's

conclusion that therapy techniques and models account for only 15% of the variance in client outcomes, have led some to erroneously conclude that models and techniques are unimportant or that technical proficiency is unnecessary for therapists (Fife et al., 2013). The therapy outcome literature affirms that models and techniques are an important part of effective therapy, but they do not constitute the foundation of therapeutic change (Fife et al., 2013).

Unique Common Factors in Couple and Family Therapy

As reviewed above, many of the common factors associated with positive client outcomes in individual therapy also apply to couple therapy. However, there are also several common factors that are unique to couple therapy (Davis, Lebow, & Sprenkle, 2012). In addition to highlighting the couple and family literature within Lambert's four common factors, Sprenkle et al. (1999) also discuss other common factors that are unique to the practice of couple and family therapy. We present a summary of these common factors below. Readers interested in a more in-depth discussion of common factors in couple therapy are referred to Sprenkle et al. (2009).

1 *Relational conceptualization.* Conceptualizing or understanding human difficulties in relational terms is central to the practice of couple therapy. As discussed in Chapter 4, the couple therapist adopts a systemic view and attempts to keep in mind the systemic context of clients' individual and relationship issues.
2 *Expanded direct treatment system.* In contrast to individual therapy, the couple therapist typically works with both partners simultaneously. Furthermore, treatment may take into account not only people present in the therapeutic setting but also those outside therapy who may affect or be affected by therapy.
3 *Expanded therapeutic alliance.* Instead of focusing on a single person, the therapeutic alliance is expanded in couple therapy. A couple therapist must work to join with both partners (see Chapter 5 on keeping therapy balanced). Sprenkle et al. (1999) suggest that therapy is enhanced as clients experience the therapist's warmth, empathy, and genuineness not only as individuals but as a couple.
4 *Behavioral regulation.* Although individual therapies may also focus on client behavior, couple therapy may target couples' behaviors that are part of interactional patterns or dysfunctional dyadic processes. Therapists may help clients develop new, constructive methods of communication or problem-solving as well as behaviors that effectively demonstrate love, support, and commitment.
5 *Cognitive mastery.* Couple therapists may help couples develop insight about interactional processes. Understanding the interconnected sequences of thoughts, emotions, and behaviors may help couples find ways to modify dysfunctional patterns in their relationships.
6 *Emotional experiencing.* A common part of couple therapy is helping partners make emotional connections with themselves, the therapist, and each other. The recent emphasis in the couple therapy literature on attachment underscores the importance of facilitating emotional connection between partners within the process of therapy.

Davis and Piercy (2007a, 2007b) also published the results of an in-depth study of couple therapy model developers (Susan Johnson: Emotionally Focused Therapy; Frank Dattilio: Cognitive–Behavioral Therapy; Richard Schwartz: Internal Family Systems Therapy), their students, and clients of the developers and students. The results of their research pointed to two distinct categories of common factors in couple therapy: model-dependent factors and model-independent factors. Model-dependent factors are those common factors found in distinct models. Model-independent factors refer to common factors that are not associated with a specific model.

Model-Dependent Common Factors

Model-dependent common factors are those that are directly informed by the specific therapy models, but they share common elements.

1 *Common conceptualizations.* An important factor associated with positive clinical outcomes is the therapist offering a coherent and credible understanding of couples' problems to which the clients are amenable. In other words, a common factor was that the client accepted the explanation of the problem in terms of the therapist's model rather than a vague explanation or description of problem that clients had when they entered therapy. The common conceptualizations also included the influence of the clients' families of origin on their current behavior.
2 *Common interventions to modify couple interactional processes.* Although the therapist interventions were model-informed, they looked pragmatically similar. One such intervention was disrupting the couple's dysfunctional interactional process or relational patters (Davis et al., 2012). According to Davis and Piercy (2007a), therapists did this by slowing down the process, helping clients look at their interactions from a meta-perspective, and encouraging personal responsibility. They also helped clients alter their interaction patterns through emotional regulation, cognitive reframing, and behavioral shifts.
3 *Common outcomes* were grouped into two categories: softening, and making space for others. Softening includes clients' awareness of their role in the system cycles and softening of thoughts, behavior, and emotional regulation. Making space for others included support for autonomy of partner, confidence, slowing down, and personal responsibility.

Model-Independent Common Factors

Model-independent variables are grouped into five categories: therapist variables, client variables, therapeutic alliance, therapeutic process, and expectancy and motivational factors.

1 *Therapist variables* identified include being patient and respectful of the client's space; being caring, but firm and boundaried; and being culturally and religiously sensitive.

2 *Client variables* include humility, commitment, hard work, and systemical and psychological awareness.
3 *Therapeutic alliance*. Davis and Piercy (2007b) found that this factor consists of mutual trust and respect and isomorphism, meaning the therapist's relationship with the clients served as a model for clients in their own relationship.
4 *Therapeutic process.* This factor includes processes variables such as: structure/flow, balance in the sessions, neutrality, repetition,collaboration and accommodation, and safety.
5 *Expectancy and motivational factors* identified were faith in the referral source, perception of the therapist as competent, fit of the therapist's model, and motivational beliefs and experiences.

Criticism and Debate Regarding Common Factors in Couple Therapy

In spite of enthusiasm for the idea of common factors of change, others have questioned the clinical relevance of this notion. Sexton, Ridley, and Kleiner (2004) agree that "the basic premise of the position is probably correct: There are central and common factors that contribute to successful outcomes that cut across seemingly different theoretical and practice models" (p. 134). This still begs the question of how common factors are important within the clinical framework. Sexton et al. (2004) contend that common factors do not provide the necessary guidance for successful clinical work. They argue:

> In its current form, the common factors perspective is . . . an inadequate solution to the current theoretical and research dilemma of MFT, because it does not . . . provide a conceptual or theoretical foundation to understand clients or change, or provide guidance for the practitioner.
>
> (Sexton et al., 2004, p. 146)

Those who are critical or skeptical of the value of common factors also worry that the common factors approach is overly simplistic and fails to address the important aspects of therapy such as the multilevel nature of clinical practice, the diversity among clients and therapeutic settings, and the complexity of therapeutic process and change (Sexton et al., 2004).

On the other hand, Sprenkle and Blow (2004a, 2004b) assert that a common factors framework provides direction for therapists, thus becoming a dynamic part of therapy rather than merely static lists of variables, as critics charge (Sexton & Ridley, 2004). Sprenkle and Blow (2004a, 2004b) argue that models work because they house the common factors of change. In other words, models serve as a vehicle or framework through which the common factors are applied (Davis et al., 2012; Davis & Piercy, 2007a; Sprenkle & Blow, 2004b). Additionally, Fife et al. (2013) propose a three-tiered meta-model which describes the relationship between two prominent common factors: models/techniques and the therapeutic alliance. They assert that the effectiveness of a therapist's model-based techniques will rest upon the quality of the therapeutic alliance. Furthermore, they propose an additional common factor, the

therapist's way of being, which constitutes the foundation of therapeutic practice and is the grounding for therapists' efforts to establish a therapeutic relationship and intervene with clients.

Instead of suggesting that therapists choose to either adhere to formalized couple therapy models *or* utilize common factors, Sprenkle and Blow (2004a, 2004b) proposed a moderate common factors approach in which common factors and therapy models work *together*, a position also accepted by Sexton et al. (2004). Davis and Piercy (2007a) found that the unique aspects of the therapy models have an important impact on therapy outcomes, in large part because "the client's chaos was replaced by the therapist's order (i.e., their model)" (p. 338). They conclude that without a model, a therapist will not know what to target for change, how to facilitate change, and when therapy is complete. The evidence suggests that models and techniques are important to therapy outcomes, but they do not constitute the foundation of change and successful couple therapy. Common factors provide a useful framework for understanding the aspects of effective therapeutic practice.

Conclusion: Clinical and Training Implications of Common Factors

Although common factors do not operate independently of family therapy models, they warrant the attention of therapists, researchers, and educators. Multiple researcher-clinicians strongly advocate that training on common factors be included in the education of couple therapists (Davis & Piercy, 2007a, 2007b; Fife et al., 2013; Sprenkle et al., 1999, Sprenkle & Blow, 2004a). For example, Blow et al. (2007) believe that a therapist's clinical training should be "grounded in common factors," and that "therapists should achieve positive outcomes in the areas of alliance building, client engagement, hope and expectancy generation, relational conceptualization of problems, changing meanings, matching to the unique worlds of clients, and the like" (p. 311).

As reviewed above, outcomes studies and meta-analyses have consistently concluded that aspects common to all therapy models, such as the therapeutic alliance and client factors, are more responsible for change and positive therapy outcomes than are the unique contributions of techniques or therapy models. Nevertheless, the positive impact of common factors is not an excuse for laziness or incompetence. The couple therapist must be well-versed in the models and techniques of couple therapy. The first part of this volume has emphasized general principles of couple therapy related to assessment, conceptualization, balanced intervention, and so forth. The remainder focuses on specific techniques that may be used when working with couples. As therapists develop their abilities to utilize the techniques presented in the second half of this text, they should keep in mind the important factors associated with positive client outcomes that couple therapy approaches have in common.

Part II

BASIC APPROACHES AND TECHNIQUES

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10

ENHANCING INTIMACY IN RELATIONSHIPS

Historically, couple and family therapists have focused primarily on eliminating pathology. Their interventions are usually designed to help resolve particular difficulties or problems such as marital conflict, poor communication, and conflicting sets of expectations. Such an emphasis is not surprising in light of the fact that most theories of marital and family therapy emphasize pathology and symptom resolution in the same way that traditional theories of individual therapy emphasize pathology. Renewed interest in the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-V, American Psychiatric Association, 2013) has refocused attention on pathology rather than on normalcy and health.

Most of the techniques presented in Part II of this volume address the question of how to reduce or eliminate pathology or relationship problems in couples. This chapter will do just the opposite. The purpose of this chapter is to present concepts and techniques that can be used to *promote healthy functioning* in couples. A clinician working from a problem-solving model is only concerned with the presenting problem(s), and therapy can become overly problem-focused. The clinician may not have a sense of how to proceed beyond symptom resolution because he or she is lacking a conceptual framework of intimacy and the skills to create higher functioning. The clinician may also lack a growth-oriented framework in which to use various techniques designed to enhance the couple's closeness and connection.

Intimate couple relationships are particularly important in meeting our need for connection to others (Alperin, 2001; Downey, 2001). Intimacy is an important aspect of an adult's health, happiness, and meaning in life (Popovic, 2005), with intimate relationships being "the principal arena within which adults live out their emotional lives" (Mirgain & Cordova, 2007, p. 983). Although couples usually desire a close relationship, many struggle to build or maintain intimacy. Intimacy can be diminished by destructive behaviors such as infidelity, abuse, conflict, neglect, or monotony (Fife & Weeks, 2010). Many couples seek out couple therapy out of the desire to regain the intimacy and love they once had in their relationship.

Marital and couple therapy is unique among the psychotherapies because it involves the treatment of relationships that are defined in a very specific way in our culture. The word that captures the essence of these relationships—love—has often been considered taboo in the professional literature. Marital and couple therapy involves the treatment of a *love*(ing), committed relationship, yet theories of marital/couple and family therapy rarely mention the word love. Love has been dismissed to softer

disciplines such as drama, poetry, music, and fiction. Therapists who adhere to the scientist-practitioner model find the use of love difficult because it cannot be operationalized or measured easily. Researchers have also found the concept of love elusive. When the topic emerges in treatment, clinicians find it troublesome because they usually think of asking only whether the partners love each other. This question is often responded to negatively at the beginning of therapy.

An exception to the limited clinical use of the concept of love is in the area of relationship enhancement and marital enrichment. The marriage enrichment movement predated and subsequently merged with the human potential movement of the 1960s. Although this movement never established a large foothold in the clinical field, many psychotherapy and psychoeducation programs were developed to promote healthier, happier, more loving relationships (see Berger & Hannah, 1999).

When two people are married or in a life-long committed relationship, the fact is that we are treating a type of relationship uniquely defined. Such relationships are voluntary, yet ideally permanent, as opposed to family which is also permanent, yet involuntary. The basis for marriage and life-long commitment is emotional, and the emotional attachment is defined in terms of love. Finally, marriage and committed relationships usually include sexual permission and expectation. This fact adds another dimension to the relationship, which in turn may become another area for relational problems.

In this chapter, we will focus not only on love, but also on sex and intimacy. These concepts are inseparable, in spite of the fact that marital therapists have indirectly claimed love and intimacy as their territory and sex therapists have claimed sex as theirs (Weeks, 2005). Committed couples do not split these concepts unless they are experiencing difficulties. However, clinical couples frequently split off certain aspects of their relationship. For example, a couple might split sex off so that they claim to be close without having sex, or partners might engage in an extramarital affair claiming the sexual relationship is meaningless. In spite of the negative implications of such fragmentation on individuals and relationships (Brown, 1991), couples may engage in this in order to preserve the relationship or to compensate for an empty or troubled relationship. These couples need an explicit idea of love just as much as the clinician. The psychological literature has provided relatively few models of love that are clinically useful. However, Robert Sternberg's (1986a) triangular theory of love is extremely useful when taken as one part of the comprehensive program that follows. This model of love consists of three components—commitment, intimacy, and passion.

The Triangle of Love

In working with couples, the first step is to ask them to describe what they think comprises a loving relationship. At this point, the clinician wants a general answer in order to move to a description of Sternberg's triangular theory of love (1986a, 1986b, 1997). After the couple has responded, the clinician begins a description by drawing a triangle with three equal sides and three points labeled Intimacy, Passion, and Commitment, as shown in Figure 10.1.

Sternberg's triangular theory of love is based on research in social psychology and personality. Love is defined as the combination of three components that need to be

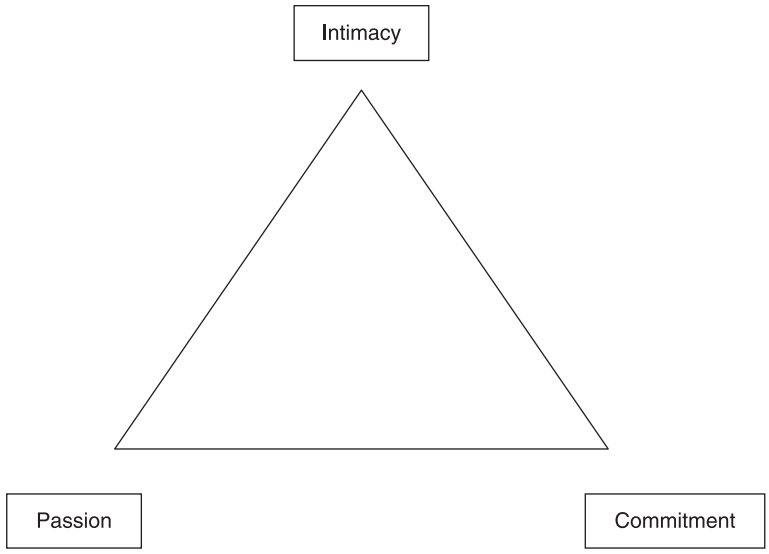


Figure 10.1 The Intimacy, Passion, and Commitment Triangle
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defined for the couple. He later expounded about the subtheory of love as a story and proposed that relationships with higher similarities on the three dimensions will be more likely to succeed (Sternberg, Hojjat, & Barnes, 2001). A couple's understanding of love may emanate from stories that are unique to their experience and oftentimes have recurring genres (Sternberg, 2006).

Definitions of the Three Components

Commitment

The first component is commitment. This component is primarily cognitive, rather than emotional. At some point in the couple's relationship, a decision was made to commit to each other. They made certain societally sanctioned promises to each other regarding exclusivity. Commitment may also be manifested through sexual fidelity, engagement, marriage, and so on (Sternberg, 1997, 2006).

The first issue to discuss with the couple is their definition of commitment. Do they share the same definition? Are they committed, uncommitted, ambivalent, or unequally committed? We believe one of the most important factors in the outcome of couple therapy is commitment. When a couple comes for therapy and they both say they are equally committed to the relationship, we usually see the couple resolve their problems. The couple can be congratulated for maintaining their commitment to

each other as people, in spite of the fact that each may be doing things the other does not like.

When the couple is ambivalent, has unequal commitments, or is lacking in commitment, an open discussion needs to take place so that each partner's thoughts and feelings are understood. In cases where there is ambivalence or lack of commitment to the relationship, we feel it is more effective to seek a commitment to treatment, rather than asking partners to make a commitment to the relationship, which may be premature or counterproductive. Having an open discussion allows the therapist to obtain a commitment to treatment long enough to explore the relationship. This will allow the couple to see whether positive functioning can be restored or whether there should be a separation. When couples end therapy prematurely, they frequently continue to go "back and forth" and never have an opportunity to thoroughly understand the part each played in the relationship not working out. This may manifest in several different ways, which include and are not limited to manipulative games, "pretense" intimacy for show around others, emotional withholding, egocentrism, or co-dependence (Layder, 2009). In short, when couples cannot commit to each other, they need to make a commitment to the therapeutic process.

In cases where the commitment is weak or one partner is ambivalent about continuing the relationship, a number of different approaches may be taken to help increase commitment. These approaches are based on social-psychological research. Harold Kelley (Kelley et al., 1983) reviewed major findings in social-psychological research related to the process of commitment, that is, those intra- and interpersonal processes that help to establish and to sustain stability. One way to sustain commitment is to improve the reward–cost balance in the relationship. In clinical terms, two approaches may be taken with the client. The first is to ask the partner to think back to what has been rewarding about the relationship. As the partner begins to remember these positive interactions, it helps to remind the person of past rewards. The partner is next asked whether, if those rewards could be reinstated, she or he would be willing to continue in the relationship. The second intervention is future-oriented. The partner is asked to think about what she or he would need to feel happy or satisfied in the relationship. The person's partner is asked whether he or she would be able to meet these needs. The less committed partner may be willing to sustain the relationship in the hope of receiving future rewards. Sometimes, however, this partner essentially asks for perfection in the other, which is unrealistic. This may result in discouragement, as this partner may overlook or minimize any effort that falls short of perfection. Thus, the therapist may also ask the less committed partner to identify small amounts of change that would give them hope that their needs can be met in the relationship (Wright, Watson, & Bell, 1996). This helps both partners understand that change is a process or journey that is taken one step at a time. The therapy would then involve working towards the fulfillment of the needs stated at this point.

Another factor related to commitment is that of irretrievable investments. In any relationship of significant duration, the partners have made intangible investments that will be lost if the relationship ends. It is useful to talk about these investments. The therapist might ask, "What kinds of investments have you already made in this relationship?" The most useful investments are those that tap into what the partner has contributed emotionally.

A third factor in commitment deals with the understanding that occurs between partners. Over time partners develop a sense of mutual understanding, a sense of "we-ness." They have an identity as a couple. They know their roles, develop a history and memories together, and create their own private language. All these attributes would be lost if the relationship were to end, and the process would have to occur again in any new relationship. Having the partner think about the value of this understanding and its replacement can further promote commitment.

A final factor that has clinical relevance is that of considering the attractiveness of alternative relationships. Any time a partner considers leaving a relationship, there is always the thought of whether there will be another to replace it. One way to increase commitment to the process of therapy, as well as the relationship, is to discuss the need for understanding what happened in the current relationship in terms of that person's contribution to the problems. The therapist may point out that ending a relationship without this understanding may result in a repetition of the same problem in the next relationship. By suggesting that the problem can be carried over into the next relationship, it is obvious that the attractiveness of the next relationship is being reduced. In addition, leaving a relationship with ambivalent feelings also may result in indecision and a pattern of moving in and out of the current problematic relationship. If the clinician can engage the ambivalent partner in treatment for an extended period of time, the prognosis for the couple is very favorable. Commitment should not be underestimated as a variable in the treatment process. A high degree of commitment to the process is highly correlated with a successful outcome.

Intimacy

The second component of the triangle is intimacy. More has been written about intimacy than about the other two components (Sloan & L'Abate, 1985). Prager (1995) lists 13 different concepts of intimacy and 45 measures of intimacy and related constructs, which Mashek and Aron lengthened by supplementing several other measures in their *Handbook of Closeness and Intimacy* (2004). Sternberg (1986, 1997, 2006) refers to intimacy as the sense of feeling close, connected, or bonded, having a sense of welfare for the other, wanting happiness for the other, regarding the other highly, being able to count on the other in times of need, experiencing mutual understanding, sharing oneself and other possessions, talking intimately, giving emotional support, valuing the other, expressing empathy for the other, communicating honestly, and finding the other person predictable (trustworthy). These feelings give rise to "the experience of warmth in a loving relationship" (Sternberg, 1997, p. 315).

Schaefer and Olson (1981) differentiate between two types of intimacy. An "intimate experience" is a feeling of closeness or sharing with another person in one or more of seven areas of what they define as intimate behavior. They define an "intimate relationship" as one in which an individual shares in several areas with the expectation that the experiences and relationship will persist. They believe intimacy is a process that can never be fully completed, one that requires constant attention and work. Seven types of intimacy are identified: (1) *emotional intimacy*, which involves experiencing a feeling of closeness; (2) *social intimacy*, which involves, among other things, having common friends; (3) *intellectual intimacy*, which involves sharing ideas; (4) *sexual*

intimacy, which involves sharing affection and sex; (5) *recreational intimacy*, which involves doing pleasurable things together; (6) *spiritual intimacy*, which involves having a similar sense regarding the meaning of life and/or religion; and (7) *aesthetic intimacy*, which involves sharing in the experience of a sense of beauty.

Crowe and Ridley (1990) divided intimacy into four categories that are basic and rely on common sense rather than any theoretical framework of discourse. These categories are: (1) *physical and nonverbal intimacy*, the giving and receiving of affection by means of hugging, general body contact or simple mutual grooming; (2) *sexual intimacy*, the ability of the partners to be comfortable with the level of sexual closeness acceptable to each other, including the partners' possible different needs for sexual intimacy in relation to frequency or intensity of sexual contact; (3) *operational closeness*, the daily relationship of the partners including possessions in common, the wish and right of knowing the whereabouts of each partner when apart, the sharing of tasks, the working together on upbringing of children, and the planning and organizing of time together; and (4) *emotional intimacy*, the wish to exchange feelings and confidences and the ability to relate empathetically to each other.

The Waring Intimacy Questionnaire (Waring, 1984) is a true–false self-report questionnaire containing 90 items that is used to measure the quantity and quality of intimacy in a marriage. Based on pilot studies, Waring defined eight components of intimacy: (1) *affection*, expression of emotional closeness; (2) *autonomy*, independence from family of origin; (3) *compatibility*, ability to play and work together; (4) *conflict resolution*, ease in how differences are resolved; (5) *cohesion*, commitment to the marriage; (6) *identity*, self-esteem and self-confidence of the couple; (7) *sexuality*, sexual needs are communicated and fulfilled; and (8) *expressiveness*, sharing beliefs, feelings, attitudes, and thoughts (Hickman, Protinsky, & Singh, 1997).

After mentioning a few words to describe intimacy, the clinician should point out that every couple and individual has his or her own definitions of intimacy, and ask each partner to briefly define intimacy with the idea that this question will be discussed later in much more depth.

Passion

The third component of the love triangle is passion. Passion has been described as romance, sex, physical attraction, affiliation, nurturance, and the longing to be with the other person. Other needs such as those for succor, self-esteem, self-actualization, dominance, and submission may also contribute to the experience of passion. Passion may be manifested through the actions of touching, making love, gazing, and so on (Sternberg, 1997, 2006).

Hatfield (1988) defines passion as "a state of intense longing for union with another. Reciprocated love (union with the other) is associated with fulfillment and ecstasy. Unrequited love (separation) with emptiness, anxiety, or despair. A state of profound physiological arousal" (p. 193). This passionate desire is a combination of cognitions, behaviors, and emotions. Fisher (2006) conceptualized passionate love and sexual arousal as separately developed but invariably linked. The Passionate Love Scale (PLS) (Hatfield & Sprecher, 1986) was developed to measure passion and includes questions related to cognitions, behaviors, and emotions.

Once again the technique is to describe this term briefly and then ask about the partners' definitions.

Clinical Application of the Triangle

The triangle serves as the structure for much of the subsequent work. It is used initially to explore commitment and for purposes of assessing where the love relationship is lacking. In the process of describing the triangle, the clinician should ask five diagnostic questions. These questions may be posed directly or indirectly, depending on the openness and sophistication of the couple and the style of the therapist.

1 The first question is *whether both partners desire all three components.* This is basically a yes/no question. Each partner either wants the three components or not. There are obvious cases in which one partner may deny any commitment (e.g., "I want a divorce") or deny having any sexual interest (passion) in the other (e.g., inhibited sexual desire). In less obvious cases, one partner may say he or she wants a particular component but fails to have any grasp of what that component involves. A common case is the husband who wants intimacy but equates intimacy with such things as sex, a backrub, or helping in his business.

2 The second question is whether each partner wants the same level of intensity for each component. The three components can occur in approximately equal intensities. If the strength or intensity of any one component is altered, then another kind of relationship is defined. Sternberg (1988) described eight kinds of love based on the presence of the three components: (1) nonlove, the absence of all three components; (2) infatuated love, the presence of only passion; (3) empty love, the presence of only commitment; (4) liking, the presence of only intimacy; (5) companionate love, the presence of commitment and intimacy but not passion; (6) fatuous love, the presence of commitment and passion but not intimacy; (7) romantic love, the presence of intimacy and passion but not commitment; and (8) consummate or complete love, the presence of all three components. The partners should be asked whether they believe they desire the same level of intensity in these three areas or whether they experience discrepancies. The clinician should note whether one or more areas is given too little or too much emphasis. For example, a couple might emphasize how great sex (passion) is to the exclusion of the other areas. When there are discrepancies, the therapist needs to guide the couple toward developing an agreed upon level.

3 The third question is what prevents the identification and expression of these three components? Each partner should be able to: (a) identify and define the components, and (b) express each component openly and freely. For many couples, there may be an intellectual identification and definition of a component without the concomitant ability to express the component emotionally or behaviorally. The therapist should ask the partners to think directly about what prevents him or her from being able to express certain feelings. The clinician should carefully examine the question from the perspective of the Intersystem Model described in Chapter 1 and fears of intimacy to be discussed later in this chapter.

4 The fourth question is whether each partner has a realistic perception of what love involves. Some partners think of loving relationships in ways that are highly distorted and unrealistic. As mentioned earlier, the clinician should ascertain whether the three components are given too much or too little emphasis. At this point, it is useful to listen for some of the common myths of marriage such as, "If she or he really loved me, she or he would automatically know what I want." In some relationships, partners do not desire intimacy or passion. They want a highly committed relationship that looks like a marriage, but in fact is a permanent friendship or companionate relationship.
5 The fifth question is whether each partner has a realistic perception of what she or he can offer or has been able to offer. As the couple talks about the three areas, it will become apparent whether an individual is able to actually deliver on what is being stated. The partner's feedback and the way in which the partners interact provide information about their limitations.

Teaching the model of love and asking these five diagnostic/therapeutic questions set the stage for the task of promoting intimacy in the couple. The next step involves asking the couple to identify the specific components of intimacy and then to think about what behaviors constitute an intimate relationship. In addition to the list generated by the couple, we add additional ideas from L'Abate's (1977) work on intimacy and marital enrichment and from the Aspects of Intimacy exercise developed by the second author. In this exercise, intimacy is framed as a multidimensional phenomenon. The handout reproduced below (Box 10.1) presents various aspects of intimacy and provides a way in which couples can reflect on and communicate about different ways in which they can create closeness and connection. This exercise can help couples examine their current level of intimacy, identify aspects that are important to each partner, and develop a plan for increasing intimacy in their relationship (Fife & Weeks, 2010).

Box 10.1 Aspects of Intimacy

Review the list and identify the top two to five aspects of intimacy that are strengths for you as a couple. Also, note two to three areas in which you would like improvement or growth. Share your reflections with each other in an open, nondefensive way. In the areas where you both desire improvement, discuss specific steps which can be taken to increase closeness in your relationship. You will likely find that some of your answers differ. In those areas in which only one partner wants improvement, seek to understand why that particular aspect of intimacy is important to him or her, what changes he or she desires, and what you can do to help intimacy grow. In areas where you are both satisfied, congratulate each other. Most successful couples develop a few (but certainly not all) core areas of intimacy that help keep their relationship strong. (Some items have been adapted from Schaefer and Olson [1981].)

Aesthetic Intimacy: Sharing experiences of beauty—music, nature, art, theater, dance, etc.

Communication Intimacy: Connecting through talking. Keeping communication channels open. Listening to and valuing your spouse's ideas. Being loving, compassionate, respectful, truthful, and open in your communication.

Conflict Intimacy: Facing and working through differences together. Using resolution of conflict to grow closer.

Creative Intimacy: Experiencing closeness through acts of creating together. Sharing expressions of love in creative ways.

Crisis Intimacy: Developing closeness in dealing with problems and pain. Standing together in tragedies. Responding unitedly to pressures of life such as working through problems, raising a family, aging, etc.

Emotional Intimacy: Feeling connected at an emotional level. Being in tune with each other's emotions. Being able to share significant meanings and feelings with each other, including negative feelings.

Financial Intimacy: Working together to balance differing attitudes about money. Developing a unified plan for budgeting, spending, and saving. Having shared financial goals.

Forgiveness Intimacy: Asking for and/or granting forgiveness to each other. Apologizing. Asking your spouse, "What can I do to be a better husband/wife?"

Friendship Intimacy: Feeling a close connection and regard for one another as friends.

Humor Intimacy: Sharing through laughing together. Having jokes between the two of you that only you share. Making each other laugh. Enjoying the funny side of life.

Intellectual Intimacy: Experiencing closeness through sharing ideas. Feeling mutual respect for each other's intellectual capacities and viewpoints. Sharing mind-stretching experiences. Reading, discussing, studying together.

Parenting Intimacy: Sharing the responsibilities of raising your children, including providing for their physical, emotional, and spiritual needs. Includes working together in teaching and disciplining them as well as loving them and worrying about their welfare.

Physical Intimacy: Closeness and sharing through physical touch. Experiencing your physical relationship (including sexual intimacy) with joy, fun, and a sense of becoming one. Being open and honest with each other in terms of desires and responses.

Recreational Intimacy: Experiencing closeness and connection through fun and play. Helping each other rejuvenate through stress-relieving and enjoyable recreation together.

Service Intimacy: Sharing in acts of service together. Growing closer as a couple as you experience the joy that comes from giving to others.

Spiritual Intimacy: Discovering and sharing values, religious views, spiritual feelings, etc.

Work Intimacy: Experiencing closeness through sharing common tasks, such as maintaining a house and yard, raising a family, earning a living, participating in community affairs, etc.

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Tolerance

In addition to Sternberg's model of love, Zick Rubin (1973) conducted an empirical study in which love was found to have four major components. These components are (1) *needing*, the desire to be with and cared for by the other; (2) *caring*, wanting to help the other; (3) *trusting*, exchanging confidences; and (4) *tolerance*, overlooking the other person's faults. Rubin also found that partners did not necessarily desire these four components in the same degree. In fact, in some relationships low correlations existed between some components. These components can all be incorporated in Sternberg's (1986a) model under the heading of intimacy.

The component of tolerance is one that should be more carefully considered here because it is not mentioned elsewhere in this chapter. Successful couples learn where each other's faults and perceived weaknesses lie. Of necessity, they need to find ways to work around these areas rather than continue to press or nag each other for perfection. The attention of a loving couple needs to be focused on the positives and not the negatives. Part of the process of couple therapy is learning to accept those aspects of the partner that this person does not desire nor need to change in order to improve the overall level of marital satisfaction. *The therapist can encourage the growth of tolerance by focusing the couple on expressing more caring, positive verbal and behavioral exchanges, and clarifying and fulfilling each other's expectations. When good feelings are being generated it becomes easier to overlook negative events and feelings.*

Components of Intimate Interactions

Our efforts to enhance intimacy in the clients' relationship then involve reviewing the seven components of intimacy listed below, followed by how the couple will move from a conceptual level to a behavioral level. The clinician first presents these items and then starts at the top of the list to allow the couple to discuss each one in order. The couple decides whether they like the ideas that have been generated and how to implement the ideas. The couple then starts with a new set of ideas or attitudes about what constitutes intimacy. Once they agree to these ideas mutually, the next step is behavioral. They are asked to describe exactly what they are willing to do to carry out the idea. In the following sessions, the therapist asks about the behavioral progress. In addition, an affective component is added by asking that the partners comment on how they feel when they receive some of the intimacy behaviors. In the session, they are also asked to discuss their feelings toward their partner in light of the behavioral changes.

The components of intimacy L'Abate (1977) has identified are as follows.

1 *Seeing the good.* Each partner should be able to see the good, both in him- or herself as well as in the other. Each should be able to say what is good in him- or herself and express what he or she likes about the other. The behavioral implementation could involve statements of *affirmation, appreciation*, and *affection.* We refer to this triad as "the three A's" and suggest couples practice it daily. The most difficult concept is affirmation. Statements of *affirmation* are "I like you" in nature. These statements affirm the value of the other person. For example,

saying "I'm glad I'm married to you" or "I like being with you" affirm one's love for the other person. Statements of *appreciation* deal with what the other person does. When the other person does something that is liked, it should be verbally noted. For example, a partner might say, "I appreciate that you brought me a cup of coffee this morning" or "Thank you for your thoughtfulness." The third A is *affection*. Affection refers to showing signs of liking and loving with words or actions. Touching, holding, kissing, and making verbal statements of affection are also important.

2 *Caring.* Caring means being concerned about another's welfare, happiness, needs, and feelings in a consistent and dependable way. It is an attitude of respect for our partner, which derives from our sensitivity to his or her needs and desires. Caring begins with an awareness of what is needed in order to feel safe, secure, esteemed, growing. Caring for another requires tuning in to what the other says she or he needs and being willing to meet some of those needs. As partners listen carefully to and respond appropriately to the needs their partner communicates, these actions will build intimacy and increase relationship satisfaction.

3 *Protectiveness.* A couple is a social system embedded within other social systems. Many forces impinge on the couple such as work, in-laws, and children. Mutual protection means seeing issues from the other's perspective and taking the other person's side when necessary. The couple must protect the integrity of their relationship by drawing boundaries around it. Protecting the relationship requires reaching some agreement on priorities (i.e., self, marriage, children, and work) and then carrying them out in ways that serve the relationship as a whole. They must also give each other the time required to be a couple.

4 *Enjoyment.* Enjoyment refers to spending time together and doing things together that are pleasurable. In our society, many people have been taught that pleasure is not a goal in itself nor is it desirable. These individuals have been trained to believe that performance is all-important. The emphasis is placed on doing, achieving, and competition. This need to perform in order to win approval and love needs to be examined and a healthy attitude about pleasure and enjoyment fostered to replace it. This new attitude should involve learning to appreciate pleasure and enjoyment as an end to itself. Achieving pleasure may be accomplished by doing by oneself or by sharing pleasure with another. Couples can be encouraged to negotiate activities they both enjoy just for the sake of pleasure. Part of this process also requires that each partner accept some responsibility for initiating enjoyable activities.

5 *Responsibility.* When problems emerge in a relationship, there is a tendency to deny personal responsibility by blaming one's partner. In an intimate relationship, each partner must take responsibility for his or her part in the relationship not working. Healthy interdependence rests on personal responsibility, not on one partner taking all the blame or on one partner giving all the blame. Partners must assume responsibility for making the relationship work. They realize relationships require maintenance and that partners are mutually responsible for relationship success.

We also think of responsibility in terms of being able to express emotions in a manner other than a reactive one. An emotionally reactive response usually

involves high emotional intensity without thoughtful consideration and expression. Emotional reactivity simply means that emotion rules. Being emotionally responsible means the partner is emotionally self-aware and is able to ask for what is needed in an assertive, rather than aggressive, manner in order to resolve the feelings.

6 *Sharing hurt.* L'Abate (1977, 1999b) believes that sharing one's hurt is a most intimate act. He points out that we can share our good feelings and success with almost anyone. With whom do we share our hurt feelings? Pain is difficult for a lot of people to feel; many defend against the feeling by denying it or by transforming the feeling into something else—often anger. It is no wonder we only share our pain when we trust someone deeply and can safely expect that person to be empathic. The sharing of pain with a caring partner can facilitate the development of mutual empathy and greater closeness. Mutual self-disclosure can also develop and enhance trust as well as show emotional investment (Layder, 2009).

An intense level of anger often characterizes unhealthy relationships. In such cases, the only feeling expressed or in evidence seems to be anger. In these relationships, all the underlying feelings have been buried by the anger. These buried feelings may include hurt, depression, resentment, frustration, guilt, remorse, fear, and so on. Hurt is especially prone to be buried because it is often seen as a weakness. When anger is used to cover over other feelings, the expression and resolution of the underlying problem(s) become impossible, rendering each partner powerless. Learning to share hurt rather than burying it is critical in promoting understanding and empathy. The therapist may ask the partners to consider all the feelings felt, but not expressed, and then facilitate the expression of the underlying feelings in the session, focusing on hurt.

7 *Forgiveness.* This concept is one that most couples overlook in their list of components of intimacy. Yet, it is implicitly working in every healthy couple relationship. It is impossible to live in a close relationship and not from time to time hurt the person we love. When this happens, it is essential to be able to deal with the hurt directly and not focus on some feeling used to cover it up. If the hurtful acts are not or cannot be forgiven, a state of resentment is established which erodes the relationship. Several questions are useful to facilitate forgiveness. Forgiveness is not achieved by making a simple apology. It is achieved through an understanding of self and others. First, the person who committed the hurtful act should question him- or herself about motivations. This self-inquiry is most salient when hurting the other is part of a pattern. Second, the partners must understand each other. The person who was hurt needs to be validated for feeling hurt, and the partner who did the hurting needs to be understood in terms of his or her motivations and intents. More detailed information about the process of forgiveness is presented in Chapter 18 on treating infidelity.

Once again, the review of these components is best accomplished over a number of sessions. The ideas are developed in session and then methods of implementing them are discussed. Each week, the therapist should follow up to see how progress is going on those items discussed.

One final note on intimacy has to do with how couples conceptualize closeness. Many couples simply equate intimacy with physical closeness. A technique to help make this expectation explicit is to ask them to draw two circles to show closeness, each circle representing one of the partners. The partners are told to draw two circles representing how they see themselves now and two circles representing how they would ideally like to be. The circles can then be used to facilitate a discussion and negotiation of intimacy in their relationship. The clinician should point out that intimacy is a balance between closeness and distance and that couples need to negotiate these two ideas in some practical way. The idea of negotiating distance is new to many couples. Usually they ask for distance indirectly or by creating a fight. In one young couple, the assumption was that all free time would be spent together. Each partner believed the other expected him or her to give up any interest that might take him or her away from the relationship. Once they realized how counterproductive this idea was, they were able to schedule time for personal interests and be in the house together without feeling compelled to be together.

Fears of Intimacy

Fear of intimacy is directly related to the issue of conflict in couples. Fear often leads to a fight-or-flight response in humans. Patterns of chronic fighting, intermittent fighting and making up, fighting and fleeing, or simple withdrawal from each other are common responses to a fear of intimacy. These patterns may regulate distance in relationships, but do so in a way that is unacceptable to most couples.

Many couples experience difficulty in becoming more intimate, although they have some awareness of what it means and what they want. When this problem is apparent from the outset, the Intimacy-Awareness technique should be used *first*. In addition, if the problem appears during the process of working through developing greater intimacy, work should be halted and the Intimacy-Fear Awareness technique used.

The technique involves making the implicit, and sometimes unconscious, fears of intimacy explicit. It is often helpful to normalize these fears by noting how some of them are found in almost everyone. The couple would then be asked to consider what fears each brought to the relationship. It is essential to keep the discussion framed in terms of fear. A slow and careful therapeutic examination will usually uncover one or more fears that can then be worked through.

The clinician may need to supply some ideas based on observations made of the couple and their individual dynamics, including family-of-origin information. A number of common fears may be historically based in the family of origin. The following list is helpful for the clinician to keep in mind. This list is not exhaustive. It represents some of the most common fears.

Fear of Dependency

This fear is found in partners who believe it is absolutely essential to be emotionally self-sufficient, insulated, and independent. In extreme cases, the partner exhibits counterdependency or the need to constantly remain aloof from the other as if to say she or he does not need the other at all, but finds the partner a financial or social

convenience. This pattern can be found in marriages which Sager and Hunt (1979) have called *parallel*. These couples do not rely on each other to fulfill their emotional needs. The marriage is characterized by emotional distance, with each leading separate lives. In some relationships, the counterdependent partner will select a very dependent partner who carries their dependency needs for them. They can then take care of the dependent partner without having to look at themselves, because the partner needs or demands so much.

The fear of dependence often stems from early parental influence. Parents, usually fathers, share the importance of being able to stand alone in the world without having to rely on anyone. During childhood, children who grow up to fear dependence are pushed to be on their own with little, if any, guidance or support from the parent. When these children do need help, they are told they are weak or that they should be able to do it alone. This fear appears in men much more often than in women and is often passed from father to son.

To illustrate this pattern, one 40-year-old man stated he could never ask his wife for anything. He believed to ask her for something meant he was weak and "a nothing." As a child, this man had been physically punished and ridiculed whenever he showed any emotional weakness such as crying, and he was criticized as being a baby when he expressed needs of his own. He had internalized his father's expressed emotions so strongly that he actually felt he would die should he express his needs. Although he realized this feeling was irrational, he could not stop this feeling on his own. It was based on the belief that only the strong will survive.

Fear of Feelings

Expressing intimacy involves sharing a feeling with another person. Self-disclosure is important and might include revealing thoughts, beliefs, attitudes, opinions, and especially, feelings. Some partners have learned to fear their feelings or the feelings of others. The feelings they fear are not specific ones such as the fear of hurt, rejection, and abandonment, but a general fear of *all* feelings. Originally, this general fear might have been related to fear of specific feelings. Unfortunately, the specific fear has generalized to include expressing any feeling.

Partners who have obsessive-compulsive personality structure often use their defenses to avoid feelings, and indeed these individuals seem devoid of feeling. They hide behind rationality, denial, projection, rationalization, intellectualization, and a rigid sense of what they believe to be right. Satir (1967) referred to these types of partners as "computers" because of their mechanical nonfeeling approach to others. "Computers" think rather than feel or act and stay detached from others in order to avoid having their own feelings touched. Being so devoid of an emotional life of their own, they sometimes enter into a relationship with a histrionic partner. On the surface, they act as if the other partner is sick or crazy, but unconsciously they derive some gratification. The feelings obsessive-compulsive partners find uncomfortable may be projected onto their partner so that they can then deal with the feeling in the other and not in self.

Individuals reared in families where feelings were out of control may also learn to avoid their own feelings. In situations where child abuse or alcoholism was prevalent

or if a parent suffered from depression, a manic-depressive pattern, or was emotionally unpredictable, the child might fear being overwhelmed by feelings and losing control or going crazy. In these partners' minds, the idea of feeling is synonymous with craziness. The same dynamic may also occur in individuals who have suffered from long-term depression. In several of our cases, men with long untreated depressions felt that allowing any feeling is the same as inviting an occurrence of depression.

A final pattern of fear occurs in those individuals who were emotionally discounted and/or told how to feel by their parents. Being emotionally discounted means the parents would ignore, criticize, or punish the child for having a feeling. Because emotional discounting is a verbal process and less severe than other types of abuse, it is often overlooked. However, repeated emotional discounting can have several long-term effects. Adults we have treated believe their partners will discount them should they attempt to express a feeling. They learn to ignore, minimize, and rationalize their feelings. The pattern is further complicated because these clients do not share their feelings with the therapist, giving the impression that everything is satisfactory. The therapist must learn to listen for what is not expressed as much as to what is expressed.

Fear of Anger

A fear of anger may manifest in two ways. First, partners may fear the anger they have toward others. They may fear that getting too close to another person may elicit or release this hostility, aggression, anger, or rage. Individuals with this fear keep their distance from others. They realize anger is inevitable in a close relationship, so they rationalize that the only way to avoid it is to not have a close relationship. Several types of familial environments may create this type of fear in an individual. In one type of family, the child may be parentified. Parentified children are asked to assume responsibility far beyond their capacity. They must act like pseudo-adults, often cast in the role of taking care of a parent. The loss of the child's sense of security, the excessive demands, and the pent-up feeling of anger not allowed to be expressed build up over time. Many partners who were parentified carry deeply buried resentment and anger that are displaced onto their current partner.

Another family situation that generates fear of anger is one in which anger pervaded the client's family system. Child abuse, spouse abuse, or both of these may have taken place. As a child, this individual witnessed how anger got out of control and how members of the family got hurt. In an effort to never repeat this pattern, the adult partner tries to suppress anger. As a result of the model set by the parents, the partner believes anger can only have destructive consequences. The opposite type of family environment can have the same effect. In these families, the parents are reported to have never been angry or in conflict. The parents implicitly transmit the message that anger is bad, unacceptable, destructive, and so on. In many of these families, children are told directly it is not nice to be angry or that something is wrong with them if they feel anger.

In other cases, partners simply may not have the skills to deal with anger. As a result, angry feelings never get resolved and build up over a period of time. The feeling may escalate to the point of violence, scaring themselves and their partner so much they vow never to be angry again. Of course, this effort is doomed to fail, but the fear still remains.

The other major manifestation of this fear is that of being the recipient of angry feelings. These individuals are very fearful that their partners will become angry with them. They will go to great lengths to placate the partner in order to avoid anger. Just as in the above case where those persons fear their own anger, these individuals may have been reared in families where anger was expressed too much or too little. Most commonly, they were reared in families where the anger was explosively and unpredictably expressed. Children of alcoholic parents come to realize that the alcoholic's anger is unpredictable, unwarranted, and intended as destructive. These children then live in a state of constant fear, waiting for something bad to happen to them or to another family member.

Fear of Losing Control or Being Controlled

Control is an important part of every relationship. Healthy relationships are based on mutual control, as partners share the power and control in the relationship. When a partner fears losing control or being controlled by the other, she or he may actively resist or passively give in to the other. This fear has two levels of meaning. On the surface, it refers to the feeling that getting too intimate will result in a loss of control in one's life. This partner believes the other person will begin to take over and run his or her life. Essentially, it is a regressive feeling of being a child again with the other partner assuming a parental role. Individuals with this fear do not know how to assert themselves appropriately. They unconsciously sabotage themselves in order to have the other partner take control. This feeling parallels what happened in the person's family of origin. The parents were overcontrolling, did not promote competency and maturity, and may have actually set the child up to fail by pushing them into tasks beyond his or her capabilities and then withholding guidance and support. Intimacy suffers in adult relationships because of the parent–child nature of the relationship. Those who fear losing control will not let their guard down to let others know them. They assume this knowledge would be used against them to keep them in their place.

At a deeper intrapsychic level, losing control means feeling engulfed by the partner. Engulfment refers to losing oneself in a relationship; the person's tenuous sense of self-identity gets lost. These individuals are poorly differentiated, and they have a poorly defined sense of self. Paradoxically, they search out others to help them complete their sense of self, but then they need to recoil from the relationship to preserve the sense of self they already possess. They simply do not know who they are or what they want. They tend to move back and forth searching for a balance. These individuals must search out their own identity and actively seek others who will support them and respect individual boundaries.

Fear of Exposure

Early on in a relationship, partners only expose what they choose to expose. In some ways, partners only see the facade. As the relationship develops, the couple becomes closer and more self-disclosing.

The level of self-disclosure progresses to deeper levels, with partners taking turns risking more disclosure as trust builds. The question for every partner early on is,

"How much to disclose and when?" However, self-disclosure may stop at a surface level out of the fear that exposing oneself will be too risky or too painful. A partner with a low sense of self-worth or self-esteem will not want his or her partner to know about this. She or he will pretend to feel good about him- or herself.

The incongruence between how they feel inside and how they act leads them to see themselves as impostors: "If they only knew who I really am or what I really did, they would never . . ." For these partners, the family did not provide sufficient development of self-worth. In many of these families, the love for the child was contingent on performance and not the person. The parents were demanding, critical, and never satisfied with the child's performance. Contingent love teaches the child to value only doing well and not self. The child learns she or he is loved only when things are going well and that the parent's love is not for the child, but for what she or he can do, which is never enough. If a problem or unpleasant feeling is expressed, the child immediately loses sight of the fact that love can be a constant in the relationship. As an adult, in order to protect themselves from feeling unloved, they would not consider telling their partner how they feel if it were negative, and would expect their partner to do likewise. The basic assumption of these individuals is that if you really knew me, you would not like or love me (because I do not really like or love myself).

Fear of Abandonment/Rejection

Fear is created when situations arise that are unpredictable and uncontrollable. Abandonment anxieties and the potential for rejection can create a profound sense of powerlessness (Layder, 2009). The more a partner emotionally invests in a relationship, the greater the hurt is experienced should the relationship end. Partners who were hurt in the past by rejection/abandonment become sensitive to getting too close too soon or to getting close at all. In more serious cases, the partner has been traumatically rejected or abandoned. This situation might have occurred through death, divorce, or desertion of a parent. Children who have lost a parent and have not been aided in working through the loss sometimes carry a fear of abandonment into all subsequent relationships. Children who learn they were adopted may also carry a deep sense of rejection and abandonment. In other cases, the family of origin did not contribute to the fear. The fear may have evolved through adult relationships that were extraordinarily hurtful, thus creating attachment injuries (Johnson, Makinen, & Millikin, 2001).

In some cases, we have seen partners suddenly abandoned just prior to a wedding without any explanation or further contact with the person. In one case, a person's partner had been killed in an airline accident and, simultaneously, it was discovered that the partner was having an affair. These events left the living partner with a deep sense of loss, rejection, and hurt. In a case like this, never getting close to another person is seen as a way to protect oneself from ever having to relive such a painful trauma.

Fear of Emotional Vulnerability

Emotional vulnerability is an essential aspect of intimacy in couples. However, because of insecurities and past hurts (either from one's family of origin, past relationships, or

the current relationship), partners may be reluctant or fearful of allowing themselves to be emotionally vulnerable with each other. Although vulnerability can be a catalyst for building intimacy, it also brings with it the risk of being hurt (Cordova & Scott, 2001). Couples may avoid self-disclosure, sexual intimacy, asking for help, admitting mistakes, or other behaviors that create vulnerability.

Overcoming Fears of Intimacy

A fear of intimacy often leads partners to use a variety of methods of self-protection. These methods may be effective in keeping one relatively safe from the perceived threats or risks associated with intimacy. However, they usually have the side effect of keeping partners emotionally and physically distant from one another. The ironic result is that partners long for connection while at the same time undermining opportunities for intimacy in their relationship. Fife and Weeks (2010) outlined several interventions therapists can utilize to help couples overcome intimacy fears.

1 *Normalize fears of intimacy.* Helping partners understand that others share their struggles and have successfully overcome them can build hope for change.
2 *Address cognitive distortions and irrational fears.* A couple's fears of intimacy are often associated with maladaptive thought processes. The cognitive techniques described in Chapter 14 may help couples overcome fears and barriers to intimacy.
3 *Enhance communication.* Couples can address and overcome fears of intimacy through utilizing enactments (Davis & Butler, 2004) and other communication techniques (see Chapter 12).
4 *Intimacy exercises.* The exercises for building intimacy presented above can help couples overcome intimacy fears.
5 *Celebrating successes.* Overcoming fears and building intimacy can be challenging, and couples should be commended for their efforts. It is also important that therapists help couples see and recognize their successes and growth.

Conclusion

A number of concepts and techniques have been reviewed in this chapter. The clinician should use them flexibly, creatively, and according to the type of couple. There is no formula for developing intimacy that works for every couple. The ideas in this chapter constitute a blueprint, with the couple providing the bricks, mortar, and sweat.

11

REFRAMING

Reframing is perhaps the most broadly used strategy in the systemic therapy approaches as well as psychotherapy in general. Clients often view (or frame) problems in ways that constrain them or limit their possibilities for change. Clients see their situation as problematic and seemingly intractable, leading to the refrain well-known to couple therapists, "We're stuck." As noted by Erickson and Rossi (1980), clients have problems because they are caught in "frames of reference . . . that do not permit them to explore and utilize their own abilities to best advantage" (p. 38). However, a therapist who can help clients reframe their situation can help clients better utilize their abilities and open doors for personal and relationship change.

Reframing is fundamental for psychotherapy because it helps the client change perspective, give different meaning, or give different attributions to the same behavior(s), thereby facilitating changes in both attitude and behavior. Every psychotherapy approach attempts to change the meaning of the problem or symptom in some fashion (Nichols, 2010; Weeks, 1977, 1990). Systems therapists have referred to this concept by a variety of terms: *relabeling* (Haley, 1973; Minuchin, 1974); *reframing* (Watzlawick, Weakland, & Fisch, 1974); *content reframing* (Bandler & Grinder, 1982); *redefinition* (Andolfi, 1979); *seeing the good* (L'Abate, 1975); *positive connotation* (Palazzoli, Boscolo, Cecchin, & Prata, 1978); *ascribing noble intention* (Stanton, Todd, & Associates, 1982); *nonblaming* (Alexander & Parsons, 1982); *context markers* (Bateson, 1979; L'Abate, Ganahl, & Hansen, 1986; Viaro, 1980); *reconstructing reality* (Coyne, 1985); *redefining the symptom* (Brown & Christensen, 1999); and *restorying* (Ivey & Ivey, 2006).

Although many systemic therapies attempt to facilitate a change in the meaning clients give to their problems, for some reason, reframing has been virtually ignored in the secondary literature on couples and family therapy. Nichols and Schwartz's (1998) widely used textbook on the concepts and methods of family therapy virtually ignores reframing. In fact, their discussion of reframing suggests they believe it is a technique that makes the therapist appear phony. They make such statements as "reframing was often transparently manipulative" (p. 59) and that positive connotation was "often as sincere as a car salesman's smile" (p. 59). In their 555-page 1998 text, they devote less than a page to reframing. Although he still gives sparse attention to this topic, Nichols (2012) has for some reason changed his position on reframing and now views it in a positive light. Gurman (2008) edited another well-respected textbook on family therapy. Out of 717 pages, the contributors devote very little to

reframing. In a book that is so well researched, one can only wonder why they chose to ignore a topic of such importance. Likewise, Harway (2005) and Young and Long (1998) only offered a little over a page on reframing. We can only speculate that these authors have failed to recognize the importance of reframing in our field, they have a bias against this construct, or they assume that the concept is so well understood or easy to learn as to not need much discussion.

Our literature review for this chapter revealed a dearth of new writing and research on a concept that is central to the practice of couple and family therapy, regardless of clinicians' preferred treatment models. Although neglected by many in the couple therapy literature, this important concept is recognized by some in the general counseling literature. Erford, Eaves, Bryant, and Young (2010) devote an entire chapter to the concept of reframing in their book *35 Techniques Every Counselor Should Know*. In addition, reframing is highlighted as one of Ivey and Ivey's (2006) six counseling skills.

We have also noted that many marriage and family therapy professors believe that reframing is a technique that is easy to learn. They do not comprehend the difficulty of learning the art of reframing, nor do they appear to understand that it isn't something that is simply picked up by virtue of reading the marriage and family therapy literature or having some intuitive understanding of how to reframe. The authors' personal experience of teaching reframing for over 20 years has shown that students do not inherently know how to construct a therapeutic reframe and need a significant amount of class time, reflection, role play, and practice in order to master this skill.

Watzlawick and colleagues (1974) were among the first to discuss the central role of reframing in systemic therapy. They defined reframing as changing the conceptual and/or emotional meaning attributed to a situation and said that the reframe should focus on the problem or behavior that has been defined or framed by the client as symptomatic. When a problem is reframed, it is placed "in another frame which fits the 'facts' of the same concrete situation equally well or even better, and thereby changes its entire meaning" (Watzlawick et al., 1974, p. 95).

Some clinicians confuse reframing with offering clients an interpretation of their behavior or intrapsychic processes. However, a reframing statement is quite different from an interpretation. For example, an interpretation carries some truth-value, and the therapist actually believes the statement represents some aspect of reality. On the other hand, reframing statements are not intended to have the same validity. The theory of truth that is used by the therapist in reframing is pragmatic. In the pragmatic theory of truth, that which works is considered true (James, 1907). The therapist is attempting to construct a view of reality that is more conducive for change to occur, rather than replace the client's faulty worldview with one that is correct (Kelly, 1955). Tennen, Eron, and Rohrbaugh (1985) have stated, "Adaptive functioning does not require being in touch with reality and having an accurate view of the world. Rather, any world view that interdicts problem sequences is considered in planning interventions" (p. 199).

In the psychotherapy literature, reframing usually has two uses or meanings (Weeks & L'Abate, 1982). One is to change the way in which a symptom is defined in terms of some polarization such as good versus bad, crazy versus sane, or right versus wrong. People who are unhappy with others frequently attribute bad intent to behavior. In

couples, this attributional process leads one partner to the moral perspective that they are okay and the other is bad. Reframing can be used to change the meaning attributed to the problem or to the dynamic that exists in the relationship. For example, couples usually regard their fights in a negative light. They have framed their conflicts as destructive, negative, and so on and see them as representing negative intent and impact. In reframing the fighting behavior, the therapist wants to change the meaning attributed to the fighting from bad to good. The therapist may say, for example:

> The two of you must care a great deal about each other and yourselves, because you invest so much of your energy in fighting. Couples who don't care or are indifferent don't fight. Your fighting shows there is something worth fighting for in spite of the fact that you may end up on opposites sides of the conflict.

In addition to utilizing a reframe to invite a shift in clients' perspective from negative to positive, a second use of reframing is to move the focus from the individual to the system. When couples or families present with problems, there is usually a symptom bearer (identified patient) who is carrying the problem for the rest of the family. The other member(s) do not see the connection between what they do and the behavior of the "sick" one. In couples, the "healthy" spouse externalizes and/or denies any responsibility for the problem. The attributional strategy in such couples is linear, not circular. One of the consequences of a linear frame is that it is inherently limiting for couples—the only way for relationship change to occur is if the *other* changes. Therefore, one of the therapist's tasks is to get them to see how the problem stems from their interaction or relationship or both. Reframing is the method whereby the therapist can move the couple from a linear attributional strategy to an interactional or circular attributional strategy. In doing so, new avenues for change and new possibilities for relating are opened up for couples.

In other words, when couples present in therapy, there is often an overt or covert belief on the part of each partner that the other is wrong, sick, crazy, and so on. Thus, it is the other partner who needs to change. The symptom or problem is usually presented as "belonging" to just one partner and not a result of the partners' interaction. The therapist must find a way to get the couple to see the problem systemically. Unless and until they see the problem as shared or bilateral, couple therapy is impossible. This is the reason reframing is essential if any systems approach to therapy is to work.

When skillfully done, the two types of reframing described above are usually combined in a statement given to the couple. Palazzoli and co-authors (1978) called this technique *positive connotation*. The symptom is given a positive meaning and all the members of the system are linked together. Reframing changes the definition of the relationship, changes the meaning of the behavior by altering or disrupting the interpretative framework, and disrupts one's ability to predict another's behavior. It also puts the participants on the same level. One goal of the reframe is to prescribe a shared, positive meaning in the relationship (e.g., "fighting means you care"). It also increases unity and interdependence by suggesting they both want the same goal for the relationship.

Finally, one of the most significant effects is to change the attributions from linear to circular and from negative to positive. If the reframe is successful and the couple believe they both want and deserve the same thing, then they must ask themselves if there aren't better ways to achieve it than to engage in the same endless game. The result should be new efforts to create the relationship each partner desires by changing one's own behavior first.

Developing the Reframe

The art of reframing has been poorly described in the literature. Most literature describes the reasons for developing a new frame and some of the typical content of reframes, but not the process involved in creating new frames. Weeks and L'Abate (1982) reviewed the literature on reframing and gave numerous examples of reframes throughout their text. Many of these examples were couple-focused. In addition, Protinsky and Quinn (1981) developed a few standard reframes to deal with common couple and family dynamics. In one case, for example, a husband became suicidal after the last child graduated from high school and went to college. His wife had been overinvolved with rearing the children and felt a profound sense of loss. The couple was given the following reframe:

> The team is very impressed with the great lengths that Joe has gone to in order to protect his wife from her feeling of loneliness. It was Joe's intuitive belief that Mary could not survive the emptiness she felt when John graduated and left home. Thus, Joe acted in helpless ways so that Mary might fill her emptiness. This is a highly caring act on Joe's part. However, it is the team's belief that Mary does not need Joe to rescue her from loneliness in the way that he has chosen. The team perceives many hidden strengths to Joe; it is the team's belief that he will continue to act in his present protective way.
>
> (p. 139)

L'Abate and Samples (1983) developed an invariable reframe for couples with intimacy problems. They used the following statement:

> Dear ___ and ___:
> After working with you for so long, I am fairly convinced that you need to defeat each other to avoid getting too close. Intimacy can be a very scary and dangerous condition, and I can understand how it affects you in that way. For some people, intimacy means loss of control, loss of mind, loss of self, loss of strength, and in some cases, loss of life.
>
> (p. 38)

Weeks and L'Abate (1982) and Jessee and L'Abate (1985) also developed a paradoxical approach to treating depression that included reframing depression in the context of the relationship. Jessee and L'Abate (1985) used the following reframe in one case:

> I think you are to be congratulated for being depressed to help your husband. It is obvious that you have become depressed in an attempt to take his mind off being unemployed. I cannot think of anything else you could have done that would have demonstrated your caring and loyalty to him so convincingly.
>
> (p. 1139)

It should be noted that in many of the above-mentioned cases, the reframe was given to the couple in written form with instructions that they should read it on some ritualized basis. Reading and re-reading the reframe is a powerful maneuver that invites clients to reflect and helps the reframe "sink in." Commonly, one partner is pathologizing the other and needs to repeatedly get the message that he or she is part of the problem.

While examples may be helpful, the therapist cannot just offer up a reframe and expect it to be accepted. Therapists need to know the process involved in developing an effective reframe. Reframing is facilitated as therapists carry out four interrelated and overlapping steps: (1) joining, (2) understanding the clients' view or definition of the problem, (3) developing a reframe that entails a systemic view and positive connotation of the problem, and (4) communicating this to clients in such a way that they come to accept a new definition of the problem.

In order to effectively reframe the problem, the therapist must first join with the client and have a thorough understanding of the problem. Therapists who have joined with their clients are seen as an ally of each and both simultaneously. Joining is facilitated by genuine interest and careful listening in order to understand each partner's perspective and the couple's common goals. An effective reframe requires that the therapist understand the problem from the inside out. This means comprehending the meaning and function of the symptom as well as each partner's definition of the problem. Acquiring this information is an essential part of assessment and is grounded in the development of a therapeutic relationship.

In order for a couple to be receptive to a reframe, the ground must be properly prepared. Clients are unlikely to accept the therapist's reframe of their problem if they feel the therapist does not care about them or has not heard and understood them. Jones (1986) briefly touched on the importance of joining, using the client's language, and asking focused questions when developing a reframe. Similarly Erford et al. (2010) stressed the importance of nonjudgmental listening to gain understanding and create a bridge from the client's point of view to a new point of view.

Following joining and understanding the couple's view(s) of the problem, the therapist develops an idea or ideas about what kind of reframe would be helpful in facilitating change. As stated earlier, for systemic change to occur there must be a systemic definition of the problem adopted by the couple. The therapist may anticipate that several possible reframes may be useful and consider what is most likely to help promote change. The therapist must think ahead and then gently guide the couple toward a new definition of the problem. Again, the therapist cannot guide the couple unless he or she has joined with them.

Typically, the therapist's definition of the problem and the couple's definition of the problem start out as incongruent. The goal is to bring the couple into greater

congruence with the therapist, thus opening up new possibilities for change. The clinician begins the therapeutic process by redefining the problem, even if only slightly altering meaning at first. The slightest alteration in meaning can grow over time into a much larger alteration. The key way in which this task is completed is by slowly weaving together a series of questions that invites the couple to change their perceptions. Imagine the couple's relationship as a giant jigsaw puzzle. As the pieces are put together, several possible images begin to emerge and then one image dominates and sets the pattern for filling in the rest of the pieces. The therapist uses questions to elicit different pieces of the puzzle. The questions may be designed to elicit new information, to punctuate the information in a different way, or to change the meaning given to certain facts. The couple may spontaneously articulate a new frame as a result of considering these questions. If a spontaneous reframe is not forthcoming, when they are sufficiently "primed," the therapist may offer the reframe.

If the process has been carefully completed, the reframe will take root; if not, it will be rejected sooner or later. Some couples are ready to accept a reframe with little cultivation. Others require the careful process described above. Aside from the ideas presented above for developing a therapeutic reframe, we have identified three basic principles that are characteristic of an effective reframe.

Principles for Reframing

Principle I: When dealing with a couple or family, the reframe needs to change the couple's (or family's) perspective of the problem from an individual perspective to a systemic perspective. With couples, it is often the case that one partner believes the problem really belongs to the other partner. In fact, each one may secretly harbor the belief that, were it not for the other partner's problem everything would be fine. With families, it is often the child who is the identified patient, and the parents believe they play no role in the child's problematic behavior as they define it. The task of the therapist is a difficult one. It is to help the couple arrive at the conclusion that they both helped to create and/or maintain the problem. Sometimes the problem has been created and/or maintained unconsciously and is a replay of past history. Successfully reframing a couples' behavior enables them to "see" how they each participate in and benefit from what they are defining as the problematic behavior.

Principle II: Generally speaking, the other task involved in a reframe is to change the meaning of the symptom from that which is perceived as negative to something that is perceived as positive. When couples describe their problem, the mere fact that they see something as a problem means it has a negative connotation for them. They simply want the therapist to eliminate or remove the problem without understanding that the symptom plays some important function for them as a couple. This fact is the reason that couples resist change and do not respond to interventions that should help them change. Once they understand the positive function the symptom serves, they can begin the process of change. For example, each partner may carry an underlying fear of intimacy, as described in Chapter 10, that prevents them getting closer or being more intimate. The symptom of the underlying need for distance may be that they have frequent and uncontrollable fights. Once they understand this need, they can begin to work around the underlying fears of intimacy rather than simply work on

conflict resolution with the fallacious belief that all they need to do is to learn how to stop fighting.

Most reframes are constructed around finding the positive meaning in the symptom. There are also more advanced ways of constructing a reframe which we will mention, but not elaborate on in this volume. Another way to construct a reframe is to change the meaning of the symptom from one domain of psychopathology to another. The common domains of psychopathology are: personal distress, interpersonal dysfunction, statistical, moral, medical, environmental stressors, and the older psychoanalytic/psychodynamic perspectives. An example of changing models can be seen in one very religious couple in which the husband was engaging in voyeuristic behavior. He wanted to confess to his wife, and she would have certainly defined this behavior in moral terms. The therapist redefined the behavior as a medical problem that was treatable with the wife's "good Christian support." The wife accepted this reframe and worked to help her husband with his problem. Another common type of redefinition is to move from content to process. This type of reframe tends to be systemic and shifts the couple's focus from the content of their behavior toward the fact that they have established a dysfunctional dynamic between them.

Principle III: The reframe must focus on what the couple identifies as problematic in their relationship. The authors have had students write hundreds of practice reframes. We discovered through this experience that just understanding Principles I and II was insufficient. Many of the students would simply tell the couple what was positive about the relationship and what they could do to improve their behavior. Reframing must involve changing the meaning of the symptomatic behavior. The symptomatic behavior as the couple defines it must be understood by the therapist. The therapist then reframes the symptomatic behavior as something that is positive or useful for the couple. It is absolutely essential that the behavior that is being reframed is what they define as the symptom or the dysfunctional dynamic of the relationship. Initially, student therapists will have trouble comprehending this aspect of the reframe. This point must be discussed thoroughly and examples given to illustrate the point.

The case below helps demonstrate the steps and principles of reframing, as well as how this intervention can be viewed within the Intersystem Approach.

> A couple in their mid-30s presented with a variety of problems. The major problem was that they had been dating for several years but had not been able to decide whether to marry. One of the problems revealed later in therapy was Ann's insomnia. Insomnia has always been conceptualized as an individual problem in the clinical literature (Ascher, Bowers, & Schotte, 1985). Ann had tried a number of remedies to eliminate her insomnia but none had worked. In fact, she failed to mention this problem early on in treatment because she had given up on believing there was any help. It was her partner, Jeff, who mentioned it. Ann saw her insomnia as an individual problem, and Jeff agreed. Neither one saw any connection between her problem and their relationship problems.
>
> The goal of the reframe for her insomnia was to give it a positive meaning for her relationship and to help them see how the insomnia was an interactional phenomenon. After careful questioning about how the couple

managed conflict, the therapist suggested that Ann's insomnia served several very useful functions for their relationship. The most important function it served was to keep Ann from showing anger. A person who does not sleep does not have the energy to get angry, and her inability to become angry seemed to protect the relationship because Jeff, who always equated anger with rejection, could not deal with an angry partner. Rejection was a central theme in Jeff's history, as he felt both his parents had rejected him as a child.

The reframing statement was put in written form as follows: The insomnia protects your relationship by keeping you, Ann, from getting angry with Jeff. Jeff would see your anger as rejection and leave.

This reframe can be analyzed as follows.

Intrapsychic Components

1 *Definition*. The insomnia is redefined as protective for both partners. In a more general sense, the partners are defined as being in a relationship characterized by protection. They must now ask, "Are there better ways to be protective?"

Interactional Components

1 *Congruence*. Ann attempted to control her anger through insomnia in order to protect Jeff in the relationship. Jeff had sent her messages that he could not tolerate anger. Hence, they were in an incongruent relationship regarding the expression of anger. The reframe made this incongruence explicit, showed how they both participate in her symptom, and allowed them to share a common goal of protection.
2 *Interdependence*. By showing how they both satisfy certain needs in the other, the level of healthy interdependence is increased.
3 *Prediction*. Ann can no longer predict that she will experience greater loss of sleep when angry. This connection had been unconscious. Jeff can no longer predict how Ann will deal with her anger or how he will deal with his sense of rejection. In fact, he requested that she let him know when she was angry, even if it felt bad to him.
4 *Attribution and impression management*. The linear attribution strategy was disrupted. The change in definition changed how the symptom and relationship are interrelated. Both Ann and Jeff came to attribute a positive meaning to the symptom and to the other's intent. This in turn led them to invite the other to try something different. Ann was asked to express her anger, and Jeff was asked to express his sense of rejection more directly.

In summary, reframing the symptoms has multiple beneficial effects. The most important effects in systems therapy are its ability to change the linear attributional strategy of the couple to a circular attributional strategy, and to change the attribution of meaning given the symptom from one that is negative to one that is positive. "Positive" in this case actually refers to some aspect of the relationship that helps the

couple bond. The positive dynamic (e.g., protection) helps to create greater congruence by defining something that both desire. Once both partners see how they participate in the symptom, they are ready to work co-operatively rather than competitively. Additionally, by attributing positive intention(s), each partner is more open to try different strategies in dealing with the other—which means each partner can participate in relationship change.

Research on Reframing

Although recent research on reframing is sparse, several past studies have investigated the effect of reframing—used alone or in conjunction with other techniques—on changing behavior and well-being. Feldman, Strong, and Danser (1982) divided moderately depressed college students into several groups. Students who were told that depression was something useful and should be experienced demonstrated more symptom remission than those who received messages that their depression was a negative condition and should be avoided. Another group of researchers (Kraft, Claiborn, & Dowd, 1995) found that depressed subjects given a positive reframe had lower Beck Depression Inventory scores compared to those in the no-reframe condition. In a similar study using depressed college students, Beck and Strong (1982) told students that depression was something that should either be avoided because it was negative or should be embraced because it was positive. Both groups evidenced change, but the positive group had the lower relapse rate. Another group of depressed and lonely college women were divided into three conditions—reframing, self-control directives, and a waiting list group. Those in the reframing group experienced the greatest reduction in depression (Conoley & Garber, 1985). All four studies showed similar findings and were characterized by a high level of experimental control and objective outcome measures.

Akillas and Efran (1995) researched socially anxious males who were assigned to three groups: symptom prescription without reframing, symptom prescription with reframing, and a waiting list control group. The only group to show significant improvement was those who received reframing with prescription. In a similar study, Swoboda, Dowd, and Wise (1990) used a sample of 116 depressed clients from a mental health center. Three treatment conditions were used: paradoxical reframing, paradoxical restraining, and a pseudotherapy control group. Subjects in the paradoxical reframing group showed the greatest change.

In an attempt to broaden the theoretical scope of reframing, Morris, Alexander, and Turner (1991) experimentally manipulated blame using attribution theory. They found that messages that were positive significantly reduced the intensity of blaming attributions. These researchers suggested that "blaming schemata" may be developed predisposing family members to construe each other's behavior more negatively than would be so if the schemata did not exist.

Another study examined the effects of three therapy sessions with couples in conflict (Davidson & Horvath, 1997). Forty couples were treated in a mental health center. The therapists used two interventions. The first was a positive reframe of their conflict and the second was a message to go slow (a restraining message). Of the 40 couples, some received treatment immediately and others were treated after being on a waiting

list. Couples in the treatment group showed a 39% improvement compared to the 10% on the waiting list. Interestingly, when the couples approved of the reframe, they were more likely to benefit from treatment.

In summary, there is an unexplainable lack of research on a strategy that is so essential to the practice of couple and family therapy. The use of reframing in psychotherapy and couple therapy deserves increased attention. The reader who wishes to gain a greater understanding of reframes can consult several classic reviews: Jones (1986); L'Abate et al. (1986); Weeks (1977); and Weeks and L'Abate (1982).

Conclusion

Reframing is an essential part of psychotherapy and has been demonstrated to bring about change. Weeks and L'Abate (1982) were among the first to propose that reframing alone could effect change. Reframing is often associated with strategic therapy and can be used to set the stage for other interventions such as a restraining message or other paradoxical messages. However, as a broad-based intervention, reframing may be integrated with almost any couple therapy approach.

As stated above, helping couples frame their problems systemically is a critical step in facilitating systemic change. Unless the therapist pays careful attention to this important therapeutic stage of reframing, it may be difficult or impossible to proceed. A problem that is defined by the couple in a fixed, immutable way will be resistant to change.

In this chapter, we have stressed the concepts of moving from negative to positive frames and from individual to systemic frames. Many other frames are possible to co-construct with clients. These two are probably the most common and useful for the couple therapist. We also identified for the first time in the literature the three basic principles of effective reframing. The remainder of this volume describes additional techniques that may be used with couples.

12

COMMUNICATION TECHNIQUES

Communication is fundamental to couple relationships and is endemic to the process of couple therapy. Communication training does not belong to one approach in therapy. It is part of all therapeutic approaches and constitutes an approach in and of itself. The purpose of this chapter is to present a number of communication techniques that can be used as part of strict or exclusive communications work with a couple or as part of an integrated approach, for example, communication training blended with contracting. Techniques to improve a couple's communication cut across all models of couple therapy and all other techniques in this book.

Communication Problems

Perhaps the complaint most commonly heard by couple therapists is some version of "We have communication problems." Laurenceau, Barrett, and Rovine (2005) have noted that intimate relationships are characterized by "a feeling of closeness and connectedness that develops through *communication* between partners" (p. 314, italics added). Therefore, when a couple is struggling with communication, it is likely that this negatively affects their feelings about the relationship as a whole.

Gottman's (1994) research among married couples demonstrates the significance of communication in the longitudinal course of marriages, with studies identifying communication styles that are highly predictive of marital satisfaction and divorce. Gottman (1994) found that couples headed for divorce showed more negativity than positivity in their emotional behavior and marital interaction. Specifically, four negative marital interactions were most predictive of divorce. Gottman labeled these interactions as the "Four Horsemen of the Apocalypse" (1994, p. 110; Gottman & Gottman, 2008, p. 143), defined as:

> *Complaint/criticism*: Complaint as an expression of disagreement or anger about a specific issue which may escalate into criticism becoming more judgmental, global, and blaming after repeated and frustrating attempts to resolve the issue;
> *Contempt*: Mocking, insulting, derisive, or sarcastic treatment of another individual indicating incompetence or absurdity (e.g., disapproval, disdain, judgment, putdowns, etc.);
> *Defensiveness*: An attempt to ward off or protect oneself from perceived attack. A response may be denial of responsibility for a problem, a counterattack, or a whine;

Stonewalling: Listener does not provide any cues to the speaker that a stone wall is being placed between the listener and the speaker. Emotionally, the speaker perceives the listener as being detached, smug, hostile, disapproving, cold, or disinterested.

When couples are having communication problems they recast the entire relationship in terms of "the distance and isolation cascade" (Gottman & Gottman, 1999, p. 306). This is a pattern of (a) viewing the marital problems as severe; (b) believing there is no point in working out the issues with the other partner; (c) feeling flooded by the other partner's complaints; (d) arranging lives in parallel fashion so less and less time is spent together; and (e) loneliness.

Given that communication problems can readily cascade into other problems, it is imperative that therapists be able to help couples with their communication. Whether it is conducted explicitly or implicitly, communication training is the *sine qua non* of couple therapy. Because communication is an essential aspect of all therapeutic work, it is a transtheoretical concept. Much of the work on couple communication that has been reviewed shows that it is largely psychoeducational (L'Abate & McHenry, 1983; Oliver & Margolin, 2008; Young & Long, 1998). In other words, couples require a personalized training or coaching process to help eliminate deficits and to create more effective means by which to communicate.

Because the purpose of this chapter is to describe techniques of communication training and not theories of communication, only a basic framework of couples' communication will be presented to help guide the clinician in his or her work with couples. It was developed by Bernal and Barker (1979) in an effort to draw together different theories of communication. Part of what this theory addresses is the distinction between linear versus circular and content versus process communication.

Communication that is linear in nature reflects cause–effect thinking and is other-focused (i.e., outside of self). When a partner is engaging in this type of communication, she or he talks about others, rather than talking about or disclosing self. Or he or she talks about self as simply reacting to others. In contrast, circular communication reflects a more mature, differentiated, and abstract form of thinking and relating. With circular communication, partners can recognize and talk about their reciprocal, interlocking patterns of relating. For example, a husband might say he is angry over the tone in his wife's voice. She could clarify the meaning of her tone once she has this information and add that her tone was in response to his withdrawal. This couple can see how they each affect and are affected by the other. Patterns of communication begin to become clear to them through this type of discussion.

Content-oriented communication deals with just the specific topic or issue at hand for a couple. In content communication, the couple's attention is focused on *what* they are saying and not about *how* they are saying it. Process-focused communication is more mature, differentiated, and abstract. Partners can step outside themselves in order to observe their own interactions. They can talk about how they are talking (meta-communicate) and how they need to change dysfunctional patterns in their communication.

A couple therapist needs to facilitate moving from linear to circular and from content to process communication in order to promote healthy communication.

Unfortunately, there are few specific techniques able to accomplish this goal. A shift to circular and process communication unfolds during therapy as the clinician points out these different types of communication, asks different questions to invite couples to reflect on their communication, directs communication in different ways, and models these concepts.

Bernal and Barker's (1979) schema may also be used psychoeducationally with couples so they can begin to analyze their own level of communication. There are five levels of communication in this model. They are organized from the least mature and helpful to the most mature and helpful. A couple can be taught these levels with the idea that the first two levels are content-oriented and linear, while the latter three are more circular and process-oriented. They may be asked to work on developing themselves in the more mature/helpful levels by first developing greater awareness of themselves and then discussing these ideas with each other and the therapist. The five levels could be described in the following ways.

Object level: The couple focus on issues outside of self exclusively (e.g., money, work, in-laws). Issues related to self and the relationship are objectified and concretized. For example, an attorney is upset that he lost a case. He tells his wife he "feels bad" and then describes the events of the case in detail. He fails to talk about himself or his feelings and ends up telling her a boring story.

Individual level: Each partner focuses on the other as the cause of his or her behavior. Responsibility for one's actions is disowned and projected onto the other; for example, making statements such as, "You make me angry" or "You made me do that."

Transactional level: At this level, patterns of behavior can be observed and commented upon. The reciprocal nature of the relationship is recognized; for example, making statements such as, "You were angry with me, and I withdrew; and then you got angrier, and I withdrew even more."

Relational level: Couples who have achieved this level are aware of the underlying assumptions and rules that govern their relationship; for example, they may know that anger is triggered by not feeling loved or that a fear of intimacy leads one to push the other away.

Contextual level: The most important contextual factor would be awareness of how one's history, especially experiences in one's family of origin, affect the current relationship; for example, a wife who is angry with her husband might be displacing old anger toward her father.

Assumptions, Attributions, and Communication

Communication is a key component in the development of marital identities. Research shows that positive communication and self-disclosure between partners are associated with positive meanings attributed to the relationship and stable marital identities and thus satisfying marriages (Surra & Bartell, 2001). On the other hand, when communication is negative there are more negative attributions, which results in the development of negative marital identities. In any interaction, attributions are made by each partner based on their personal interpretation of what was being

communicated. These attributions may be relationship enhancing or relationship distressing (Manusov & Koenig, 2001).

Couples' negative attributions or misguided assumptions can derail couple communication before it even begins and constitute a major deficit in existing communication training models. Attempts to teach new ways of communicating will be met with resistance and eventually fail unless couples' underlying assumptions and negative attributions are addressed (Pearce & Halford, 2008). By the time many couples enter therapy, a long history of miscommunication, misinterpretation, and misattribution has developed and is rigidly held by each partner in a self-protective manner. Two techniques are useful in order to create a different attitudinal set and prevent the problem of miscommunication, misinterpretation, and misattribution from reoccurring. The first technique is to help the couple differentiate between intent and effect; the second is challenging and changing assumptions.

Unfortunately, many partners develop the idea that intent and effect are exactly the same, and thus a communication that was experienced as hurtful is automatically assumed to have been intended as hurtful. It is impossible to be in a close relationship without experiencing some communication as hurtful. When this experience occurs, it is essential to check out the intent of the sender. In order to do so, the couple must first understand the difference between intent and effect. The therapist can discuss these concepts until the couple understand the difference.

Examples of how these may differ are very useful. In one case, whenever a wife asked her husband how he felt, he became angry and withdrew. He would counter her question with the response that she was trying to put him down because she was more articulate in expressing her feelings. The fact was that he was the one ascribing hurtful intent to her because he was hurt by her question. The husband had been repeatedly punished whenever he expressed a feeling in his family of origin. The hurt he experienced over simply being asked how he felt was deeply rooted in his history and not in his wife's efforts to understand his feelings. Once they were able to check out her intent, her husband's negative attributions toward her stopped.

The ability to differentiate intent versus effect is essential in teaching couples reflective listening, which is described later. Differentiating intent and effect results in cognitive restructuring. Rather than thinking, "Because that message hurt, she or he must have wanted to hurt me," the partner now thinks, "I am feeling hurt by that message; what did my partner intend to say, and why am I feeling the way I am?"

The second technique, challenging and changing assumptions, is critical for the success of communication training. Many couples enter treatment assuming that their partner does not care about them, is trying to hurt them and, in spite of their best efforts, will never really be able to understand them. The therapist may challenge these assumptions by suggesting that both partners adopt three new assumptions to help their relationship:

1 The assumption of commitment
2 The assumption of goodwill and intent
3 The assumption of understanding.

The first assumption highlights the fact that the couple is committed to each other and to the therapeutic process. Fowers (2001) noted that commitment is a necessary virtue that helps couples stick with their efforts to communicate and improve the relationship, even when the work in therapy is hard. This assumption should of course be checked out and validated before proceeding. The second assumption addresses some of the issues in differentiating intent and effect: partners need to believe goodwill exists in the relationship. This assumption focuses on the basic goodness of each person and draws out their sense of caring for one another. They learn that even though a statement may be hurtful, its intent was not necessarily to hurt. Therapists may also reframe communication struggles as something other than hurtful intent or lack of caring. The third assumption is that of understanding. When couples begin therapy, they often feel their partner does not care about them or understand them. Then, when a miscommunication occurs, partners are ready to give up on the relationship and the communication stops. The point of this assumption is that no matter how muddled the communication becomes, if the partners keep trying, they will at the very least be able to understand each other. The assumption *normalizes miscommunication* and implies that communication is a difficult, time-consuming process. Nevertheless, this assumption does not imply agreement. The therapist should explain how understanding the other person does not mean agreement with the other person's perception or giving in to what she or he wants. Most couples will readily agree to these assumptions. The couple should remind themselves of these assumptions every day and then every time they feel their communication is deteriorating.

Gender Differences in Communication

A discussion of gender differences is far beyond the scope of this chapter and is much more complex than the few comments we will make at this point. However, we do recognize the complexity of gender differences and the roles they may play in communication. Men and women often have powerful expectations and attitudes regarding one another that influence how they interact in heterosexual couples. Over time couples develop distinct behavioral and communication patterns that maintain existing gender identities based upon functionality, often regardless of individual satisfaction. It is suggested that men are more likely to view communication as a way to convey information and status, whereas women are more likely to view communication as a way to interact and establish emotional bonds with others (Pasley, Kerpelman, & Guilbert, 2001). It will be important for each partner to recognize his and her own gender-related assumptions and expectations. Differences in vernacular and modes of expression will need to be addressed (Thompson, 2003). Definitions of what each partner desires and expects from the other's communication will also be very important to determine so that gender differences do not develop into problems for the couple (Brown & Brown, 2002).

Creating a Context for Communication

Effective communication requires a context with three basic structural elements. This context is taught and modeled in the therapist's office and then extended outside the

office. The first element is *partners should talk to each other*, rather than through other people or things. In the therapist's office, the task is to keep the partners focused on each other. It is easy for a therapist to unwittingly establish a habit of having partners talk through him or her, especially when the emotional intensity is high. However, therapists should remove themselves from the middle and be like a coach on the sidelines providing feedback and directives. At home, the couple needs to speak directly to each other without using the children or others to talk for them. They should not use the TV or other activities to dilute the intensity of their interactions or distract them. Communication should be as free of distraction as possible. The couple should be taught how to create "islands of experience" with each other by establishing boundaries around the dyad and setting limits when others attempt to intrude on those boundaries.

A second element of the context is *proximity and contact*. Partners should not attempt to talk from room to room or on the run. With current technology available, couples may also be tempted to communicate through email or texting. However, when it comes to sharing feelings and talking about the relationship, email and texts don't provide a context for effective communication and understanding. In fact, they are often used because couples either don't know how to communicate directly or have a fear of the intimacy that comes with this kind of communication. Couples need to give each other focused attention and eye contact. In the office, contact needs to be monitored and strengthened when necessary, possibly having couples turn their chairs toward each other and move closer together. At home, it is useful to have the couple agree on a talking place and time. The place should be comfortable, free of distraction, and associated with pleasant activities. Touching, if only hand-to-hand or fingertip-to-fingertip, can create even more intensity in the experience.

Third, communication is a *process* and takes time. A couple should not expect to resolve every problem in 5–15 minutes or build a relationship in such short bursts. The couple will need to make a commitment to talk on a regular basis every day. At first, the time spent talking at home should be short and gradually lengthened, as they become more successful communicators. If a regular time is not established due to fluctuating schedules, then after each talk a time could be agreed upon for their next communication. Consistency and repetition are important to the successful learning of new communication skills.

In addition to these three structural elements and techniques to improve couple communication (see below), Fowers (2001) suggests that therapists help clients cultivate personal qualities that can enhance communication between partners. He astutely notes that communication training presupposes personal strengths or virtues in clients, yet many models of communication training focus only on specific communication skills or behaviors. Fowers suggests that a technical conceptualization of communication (i.e., communication based on skills alone) is insufficient for effective communication. Rather, the successful use of communication skills rests upon certain virtues or character strengths such as self-restraint, courage, commitment, generosity, honesty, friendship, justice, and good judgment. Fowers suggests that training couples in the use of communication skills may be enhanced as therapists also help clients develop character strengths and virtues that are necessary for good communication.

Communication Techniques

In this section, we will describe the combination of techniques that usually promotes improved communication. Conversely, these techniques tend to diminish or to eliminate many of the common problems found in communication. A therapist's primary task is to teach and guide couples in their communication so they can develop new ways of interacting with each other.

"I" Statements

Partners want to be heard and understood, and couples should be taught to speak to each other in *listener-friendly* ways. Communication is often undermined by statements of blame or accusation. Being attacked or blamed is not conducive to listening; rather it invites defensiveness or counter-attacks. To avoid this, each partner should be encouraged to make "I" statements (Baucom, Epstein, LaTaillade, & Kirby, 2008). "I" statements refer to: *I* think, feel, believe, wish, wonder, and so on. An "I" statement reflects the fact that the speaker is taking responsibility for self. On the other hand, "you" statements (e.g., *you* said, *you* did) are blaming or provoke defensive reactions. "It" statements (e.g., *it* seemed to me) are either too logical, impersonal, or vacuous to be helpful. Each partner should practice using "I" language, avoiding "you" and "it" language. Whenever the couple catch themselves using the latter two forms, they should stop and convert the idea to "I" language. Each partner should monitor self and be open to reminders that he or she has lapsed into other styles, without getting caught in blaming the other partner when a lapse is made.

Reflective Listening

Many couples will state that their problem is one of not talking or communicating enough. There are times when it is useful to reframe this statement by saying that the problem is not one of talking, but of *knowing how to listen*. Listening is more than sitting quietly, nodding, or saying "uh-huh" now and then. Listening means letting the sender know that one has heard and understood what was said. Couples regard communication positively when they feel that they have been heard and understood (Laurenceau, Barrett, & Rovine, 2005).

The listener's responsibility is to reflect back the content and affect that were registered (Baucom et al., 2008). The content (literal) is the meaning that was extracted, while affect refers to the emotion stated or inferred in the statement. In order to do this well, the listener must (temporarily) set aside their own opinion or feelings about the matter and focus on what their partner is saying. To help listeners open their ears and hearts, they may need to be reminded that understanding does not mean agreement. Examples of what a listener might say include:

- "I heard you say you felt hurt because of my comment regarding what you said to your mother."
- "I heard you say you felt okay about my comment, but the way you said it gave me the feeling you were upset."

- "What I heard you say is that you want to spend time together, but your body language said to me that you weren't sure."

The purpose of reflective listening is for the couple to share the same meaning. Words by themselves are not always sufficient to communicate meaning, especially in cases where affect is essential as part of the understanding. The sender needs to provide a clear message that includes a statement of feeling. The sender should not assume the receiver will automatically know his or her feelings. It is the responsibility of the sender to communicate both affect as well as content. The couple need to be trained to follow a format that goes something like this: "I'm feeling ___ when ___ ." In other words, make an "I" statement. Once the sender has been coached to make this kind of statement, the receiver is next coached to reflect back the content and affect, without putting a spin on the meaning or injecting their own opinion.

If the reflected statement is accurate, then the discussion may proceed. However, the reflected statement may be discrepant with the intended communication. If this happens, the speaker is given the opportunity to clarify what was meant and have it reflected back.

When the communication has failed, many couples feel frustrated and want to give up or start blaming each other. An assumption couples make is that communication should be easy and problem-free. This assumption should be checked out with the couple and if it is present, it should be discussed. Miscommunications need to be normalized. The couple needs to see themselves as being on the same team with each partner willing to help the other when a miscommunication occurs. The therapist may predict miscommunications for the couple as a way to prepare them for dealing with these occurrences. Additionally, when couples begin to blame or attack, the whole process comes to a halt. Blaming should not be permitted.

Another common problem occurs when the sender gives contradictory verbal and nonverbal messages but denies that such messages were sent, perhaps because of a lack of awareness. Partners need to know that such communications are going to take place, and be given a strategy to handle mixed messages. Even when the receiver has accurately detected a discrepancy and reflected it back, the sender may continue to deny certain feelings. For example, a husband might deny that he is angry, although his nonverbal behavior reveals this feeling to the partner and the therapist. The receiver should be taught to reflect back the *specific behavior* that conveyed the feeling. In this example, the wife might say, "I thought you were feeling angry because your voice became loud, you clenched your jaw and fist, and your face turned red." The therapist may then validate these perceptions of the receiver. If the sender continues to deny the feelings, the therapist should deal with the issue by trying to explore the reason for the denial.

The therapist should also note that a denied feeling will keep resurfacing, which means further interaction will likely reveal the true feeling. If the sender of a contradictory message continues to deny certain feelings at home, the couple needs to have an agreement. The sender should agree to accept the feedback and think about it seriously. The receiver must be willing to stop after providing the feedback. If he or she insists the other agree, a no-win situation is created. The receiver must also consider whether he or she is reading a feeling not present. The couple may return to the

matter later to try to sort it out. If they are unable to do so by the next session, then it should be worked through with the therapist.

Reflective listening is essential when a couple get trapped in what has been termed the *self-summarization syndrome*. The concept refers to each partner saying essentially the same statement over and over again, usually with increasing emotional intensity. Therapists (and couples) should be aware that when this occurs, it usually means that the one who is speaking does not feel like they've been heard and understood.

Self-summarization is a misguided attempt to get the other person to understand. Repeating the same message does not create understanding. Interrupting this destructive process by using reflective listening will change the interaction. One partner might suggest starting over by going back to the original point and asking for a reflective statement. Self-summarization usually occurs when the partner fails to respond in an appropriate way, but it may also occur when an individual has a fixed agenda and will not consider negotiation and compromise. In these situations, the only voice the person hears is the one in his or her own head. For example, if the husband has the agenda of proving his wife wrong, all of his statements will be designed to prove his point. His wife might try to respond, but he is so fixed in his agenda he cannot hear her statements.

The therapist can help couples learn about these obstacles and learn how to work through them in the session. They may then begin to practice at home. When communication techniques fail to correct self-summarization, it is time to explore for hidden agendas. Using this concept alerts the couple to the existence of hidden agendas and may help them to do this type of exploration if they become hopelessly stuck.

Enactments

Enactments are therapist-guided couple interactions designed to facilitate constructive communication and enhanced intimacy. Enactments can be an invaluable tool when used by a skilled therapist. Not only do they help to assess structural parts of the system (Minuchin & Fishman, 1981), but they can be used by couples in session and at home to practice effective communication (Guerney, Brock, & Coufal, 1986) and enhance emotional expression (Greenberg & Johnson, 1988; Johnson, 1996).

Davis and Butler (2004) identify three phases of enactments.

1 The initiation phase introduces the goals and roles involved in the enactment, specifies topic(s) to be discussed, and establishes structure.
2 The intervention phase involves maintaining the interaction, coaching, and facilitating attachment-based interactions.
3 The final phase is the evaluation phase in which goals of the enactment are reviewed, assessed, and clients are invited to make commitments.

The ultimate goal of enactments (and therapy in general) is for couples to become self-sufficient in their interactions. However, the emotional reactivity and poor communication patterns of some couples require therapists to adapt enactments accordingly at the start. Butler and Gardner (2003) identify five developmental stages of enactments, moving from emotionally reactive couples to securely attached couples.

Stage 1: Shielded enactments are used with highly reactive and volatile couples. In this stage all the couple interaction passes through the therapist. The therapist uses modeling to coach and keeps distance between the couple.
Stage 2: Buffered enactments are used with couples who have the potential to become volatile or reactive. In this stage, the interaction continues to pass through the therapist who uses visual contact and closer spacing as well as direct coaching with the couple.
Stage 3: Face-to-face talk-turn enactments are used with moderately distressed couples. This stage marks the beginning of direct couple interaction and the therapist coaches the couple through their problems.
Stage 4: Episode enactments are used with distressed couples who are not reactive or volatile. Direct couple interaction continues in this stage with the therapist rarely assisting in the interactions.
Stage 5: Autonomous relationship enactments are used with nondistressed couples. In this stage the couple is able to direct and manage their own enactments.

Although the communication passes through the therapist in the beginning, the therapist should move to couples talking directly with each other as soon as possible (Butler & Gardner, 2003).

Nichols and Fellenberg (2000) identified behaviors used by therapists during effective enactments. They also identified client responses that indicated whether the enactments were productive. Some successful techniques used by therapists include: directing clients to talk to each other instead of to the therapist, physically moving self to be removed from client dialogue, explaining how conversation should look, not interrupting even when clients pause, directing clients to express feelings and emotions, using humor, blocking clients from interrupting, offering encouragement, interpreting problem dynamics, and giving advice on how to continue improving communication. Some signs that the enactments are productive can be seen in client responses and interactions such as: clients talking to each other, facing each other, expressing their feelings, listening and trying to understand each other, acknowledging their role in the problem, and attaining understanding or coming to a consensus.

Validation

Validation is related to "I" statements and reflective listening. To be validated means to be understood as a person (Oliver & Margolin, 2008). The opposite of validation is discounting. Discounting means being ignored or misunderstood. It also occurs when certain feelings or words are wrongly ascribed to a person. This concept is known as "mind raping" (e.g., "I know you really felt hostile even though you deny it"). Research by Lauranceau and colleagues (2005) found that disregarding or invalidating the feelings of another is associated with a decrease in relationship satisfaction.

Therefore, the first step in communication is to validate the other person. Then and only then can a discussion be held over differing perceptions, beliefs, opinions, and so on. *When couples try to skip the validation phase, they inevitably end up arguing*

over the content in an effort to get validated. Couples often confuse validation with agreement, thinking that if they see the other person's point of view, they must agree with him or her. Misunderstanding these concepts can be lethal to communication. The therapist must teach the couple how to validate and still be able to disagree or see things differently. Reflective listening and enactments can help facilitate this process. The therapist should constantly monitor communication in the session in order to point out when validation is needed.

Editing

Written communication is usually more concise and precise than the spoken word because the former has been thoroughly edited. As it pertains to couple communication, editing means to leave out unnecessary negative comments that convey blame, disdain,or overgeneralizations (Dimidjian, Martell, & Christensen, 2008; Gottman, 1994; Gottman, Markman, Notarius, & Gonso, 1979). Editing has several useful functions in verbal communication. First, when dealing with a difficult topic, it is best for partners to think through what they want to say before they say it. The couple can be instructed in the use of *mental rehearsal* as a way to prepare for a discussion. This involves carrying out a mental dialogue designed to clarify the ideas the person wants to communicate and avoid unnecessary negative remarks. Second, one can never say all that one thinks, nor should one have to. Extraneous, distracting, nonthematic comments only confuse the process of communication. The couple need to stay focused on the specific problem or theme. Each partner also knows what kinds of comments "push the other's button." These comments distract the couple by re-engaging them in a discussion or argument with no end. Both must agree to edit out comments likely to create conflict and sabotage the process. Each individual must also try not to take the bait if such a comment is made.

Time

Communication is a process that takes time. Couples need to learn that good communication requires not just their energy, commitment, and understanding, but also their time. They must learn how to create time to communicate. Communication should not be compressed to fit their time, but time should be expanded to fit the need to communicate. Getting couples to make dates or appointments with a specified amount of time is helpful. Sometimes the block of time will be insufficient, requiring one or more session on the same topic. The idea of doing a little at a time helps break communication up into manageable chunks and dispels the myth that every conversation should bring about closure. When communication is extended to another time, the need for continuity is absolute. Both partners must know when the dialogue will continue.

Assessing Communication

Couple therapists can assess the frequency and depth of communication between partners by asking clients specific questions about their relationship. For example:

- How often do you and your partner express positive feelings?
- How often do you and your partner express unpleasant feelings?
- How often do you and your partner express feelings of disagreement or complaints?
- Do you and your partner talk about things of mutual interest?
- How attuned do you think you are to your partner's nonverbal behavior?
- Do you discuss important decisions before making a final decision? How do these discussions go?
- What topics do you and your partner have difficulty with or avoid talking about (for example, sex, money, and so forth)?
- Do you find you frequently have to ask your partner what he or she is thinking?
- Are there certain thoughts or feelings you have a hard time expressing?
- Do you feel your partner really understands you?
- Do you find yourself saying the same thing over and over again?
- How well do you talk about intimate matters and issues that have emotional depth?

Answers to these questions can help the therapist understand deficiencies in communication and provide a focus for communications work.

Obstacles to Effective Communication

Effective communication does not just happen. Couples in treatment have likely learned many unhelpful ways of communicating and are not well-practiced in forms of effective communication. Through the therapist's coaching and the couple's practice, good communication can be learned. The role of practice can be emphasized repeatedly as each session begins. However, their learning may be undermined if couples are not aware of obstacles that prevent them from communicating more effectively. This information will allow each partner to do a personal self-analysis and to agree to self-monitor in order to stop destructive habits. In addition to Gottman's (1994) "Four Horsemen," a few of the common obstacles are reviewed below.

Mind Reading

Mind reading refers to the idea that one really knows what the other is thinking, feeling, and so on, without checking out those assumptions. In other words, a partner's assumption is elevated to the level of reality. The therapist may ask partners to think about how they know when they are mind reading (i.e., internal and external signals of mind reading) and agree to check out their assumptions. An internal signal might be a common assumption a partner makes when certain events are happening. For example, when one partner looks away during a conversation, the other assumes that they are not interested. A common external sign could be as simple as when one partner claims, "I never said that."

Personalization

This concept pertains to criticizing the person as well as the problem. The problem should be defined in terms of what a person does, not who he or she is. Thus, when discussing a problem in the relationship, the couple should stay focused on the behavior and not attack each other personally. Attacking the other person's character or blaming the other is counterproductive. The two most common types of personalization are labeling (e.g., "you're stupid") and generalizing (e.g., "you never listen to me").

Distracting

There are two ways of distracting. One involves leaving the theme of the discussion by bringing up other past, present, and possible future problems. Couples should adopt the rule of staying on one topic at a time. A related distraction involves one person bringing up an issue and the other person bringing up another issue, and so on. This strategy is one of attack and counterattack.

Polarized Language

Certain concepts in our language only serve to polarize couples. These include right versus wrong, always and never, truth versus a lie. Communication that partakes of these black and white categorizations should be avoided. We teach couples that these concepts are polarizing, judgmental, and troublemaking. A simple rule is to make these terms off limits when they speak. They may think in these terms, if they must, just avoid expressing them.

The couple will then be forced to find other language to convey their assessments and feelings. They might be encouraged to use more tentative language such as "it seems" or "often", and they might incorporate terms such as opinions, beliefs, perceptions, feelings, values, likes, and so on. For example, a wife might say she thinks oral sex is wrong, which implies there is something wrong with her husband for suggesting it. He might reply that it isn't wrong and that something is wrong with her for not wanting it. They are now polarized around the issue of rightness and wrongness. Had she said she didn't like it because it made her feel embarrassed, then a discussion of her feelings could take place.

Conclusion

The practice of communication skills training with couples appears deceptively simple. This chapter has demonstrated multiple factors involved in carrying out this task effectively. Once the therapist has a grasp of these techniques, it is then a matter of monitoring the communication process, assessing it moment-to-moment, and intervening actively and directively when communication fails. This last requirement of active, immediate, and directive intervention may not be comfortable for some therapists. Examination of the therapist's own beliefs and methods of working may be needed if these simple techniques are to be used effectively.

13

CONFLICT RESOLUTION

Conflict is inevitable in every close relationship. The question is not whether couples will have conflict, but how they manage conflict when it arises. Virtually every couple coming for treatment is in a state of conflict (even when they deny it). They may be in conflict over a variety of issues, from expectations, needs, and wants, to money, sex, children, in-laws, and so on. The conflict may be expressed overtly or covertly and with varying degrees of emotional intensity. When the level of intensity is high and the couple lacks the skills to successfully resolve the conflict, the first task of the therapist is to de-escalate the feelings, to teach the couple conflict resolution skills, and to help them resolve their particular issues.

The exception to this approach would be when the level of intensity is so high and the propensity to blame each other is so entrenched that the couple are not yet ready to work together. It is best in these situations to see the partners separately until the level of anger can be reduced and the blaming can be curtailed. Of course, in cases involving spouse abuse, the type of conflict must be carefully assessed. In cases where the conflict and anger are instrumental or purposeful (i.e., designed to control/coerce), or there is ongoing violence, couple therapy should not be undertaken (Mack, 1989; Stith, McCollum, & Rosen, 2011).

The first step in helping the couple deal with conflict is to inform and to help them recognize that conflict exists in all close relationships, thereby normalizing the existence of conflict (Gottman, 1994; Gottman & Silver, 1999; Sween, 2003). Some couples have the idea that their marriage should be conflict-free. In their minds, any hint of conflict means they have made a serious mistake or have failed. The therapist can point out that it is not a question of whether conflict exists, but rather whether the couple has managed it destructively or constructively. The couple can be asked directly, "How do the two of you manage conflict?" The therapist is probably going to hear that conflict results in getting stuck, unresolved hurt, and angry feelings. At this point, the therapist can begin the change process by suggesting the idea that conflict can be a constructive force in their relationship. Toward this end the therapist may point out how constructive management of conflict can help each of them get what they want; allows each of them to be heard, understood, and respected; and leads to a sense of competence and closeness.

This initial discussion of conflict is designed to challenges a couple's attitude that conflict is bad and can only have destructive consequences. In addition to the work done in the sessions and the homework, it is useful at the outset to use some

bibliotherapy. Although a number of popular books are available on this topic, some books we commonly suggest to couples are *The Dance of Anger* by Harriet Goldhor Lerner; *Your Perfect Right: A Guide to Assertive Living* by Robert Alberti and Michael Emmons; *Fighting for Your Marriage* by Howard Markman, Scott Stanley, and Susan Blumberg; *Why Marriages Succeed or Fail* by John Gottman; or *The Seven Principles for Making Marriage Work* by John Gottman and Nan Silver. The second book is not exclusively about assertiveness in couples and covers many of the basics, including communication techniques, conflict resolution, and anger.

Before talking more about what the therapist does, it is essential to consider how the therapist uses his or her self in dealing with conflict. Beginning therapists are often afraid of losing control of a session or of not knowing how to manage intense conflict. The therapist may have the mistaken idea that his or her job is to prevent or minimize conflict and consequently, to rescue the couple from their conflict. Some therapists will experience a strong countertransference reaction in which they fear anger emerging in the session because of their own difficulties in experiencing anger. All of these possible reactions mean that the therapist must believe what she or he is proposing and be free of fear of conflict and anger. The therapist may need to seek supervision or therapy to deal with personal issues. Conflict resolution is actually not that difficult a process, yet we have seen many beginning marital therapists find it impossible to implement this type of approach due to their own personal limitations. The therapist should keep a watchful eye on them to determine whether they are avoiding, minimizing, or denying the conflict and anger present in the couple.

Anger

Anger is a common emotion that is closely related to conflict. Where there is conflict, there is usually anger. It is usually the anger that frightens the couple and the therapist. According to Kassinove (1995), anger is defined as:

> a negative, phenomenological (or internal) feeling state associated with specific cognitive and perceptual distortions and deficiencies (e.g., misappraisals, errors, and attributions of blame, injustice, preventability, and/or intentionality), subjective labeling, physiological changes, and action tendencies to engage in socially constructed and reinforced organized behavioral scripts.
>
> (p. 7)

Anger is associated with losing control and being destructive. Much of what has been emphasized in conflict resolution work focuses on the mechanics of resolving conflict in a behavioral way, assuming that developing these skills will reduce anger. Yet this approach does not address the problem of dealing with conflict that begins with anger. In working on this problem, a significant amount of time needs to be spent exploring attitudes, beliefs, and feelings before the behavioral work is started.

Therapists must first help the couple understand the meaning and function of anger in their relationship. A number of questions may help couples discover the meaning of anger. These questions may be asked as the exploratory process unfolds; however, they should not be asked as a simple list of questions.

Meaning and Function of Anger

1. What is anger?
2. What does it mean when you are angry?
3. What does it mean when you are angry with your partner?
4. What does it mean when your partner is angry?
5. What does it mean when your partner is angry with you?
6. How do you respond to your partner's anger?
7. How do you respond to your own anger?
8. How do you let your partner know you are angry?
9. How long does your anger usually last?
10. What other feelings are associated with anger?

Several sources may contribute to the meanings attributed to anger. The two most important are experiences with one's mate and with one's family of origin. Along with the questions above, getting some history from the couple will reveal their beliefs and attitudes about anger. If a person's partner uses anger destructively, that fact will certainly influence the perception of what anger means. Individuals also learn a great deal about anger and conflict from what they see, or fail to see, in their parents' behavior. The strength of this influence cannot be overstated. It is therefore useful to know what those experiences were for each partner. Preparing a focused genogram regarding anger will further illustrate these influences (DeMaria et al., 1999). The following questions will help the therapist develop an anger genogram.

1. How did your parents deal with anger/conflict?
2. Did you see your parents work through anger/conflict?
3. When members of your family (name each one) got angry, how did others respond?
4. What did you learn about anger from each of your parents?
5. When a parent was angry with you, what did you feel/do?
6. When you got angry, who listened or failed to listen to you?
7. How did members of your family respond when you got angry?
8. Who was allowed and not allowed to be angry in your family?
9. What is your best/worst memory about anger in the family?
10. Was anyone ever seriously hurt when someone got angry?

These questions often reveal two patterns in the family of origin. In one pattern, a family member, usually the father, was the only person allowed to be overtly angry, using anger to manipulate and control family members. In many of these cases, this pattern is associated with drinking. Mother and the children responded in fear, not knowing if father would lose control. In adulthood, these children might use this same pattern or might be so frightened of anger that they go to great lengths to avoid anger altogether.

A second common pattern is the family that attempts to deny anger and conflict. Parents limit or forbid the expression of emotion, particularly anger. As adults, children from these families do not understand their experience of anger or that of their

partner. Thus anger is an unknown and fearful feeling and often is out of awareness or leads one to feel overwhelmed.

Experiences in one's family of origin may actually play a significant role in the selection of one's dating and marriage partners. A partner who grew up in a home pervaded by anger might choose a partner who appears to be devoid of anger and perhaps all feelings. Another partner might choose a spouse perceived as weak and dependent so she or he can safely displace old, unresolved feelings of anger. Helping partners understand the influences of early experiences can be validating and enlightening. They might have been told as children that they should never be angry, which invalidated their experience and led them to question and doubt their perception of the world. They may be unconsciously repeating old patterns or carrying out a mission for a parent. The therapist may see the same dynamic in the couple that was present in the parents. These unconscious scripts and repetitions cannot be effectively treated with a set of behavior-based communication skills. This work involves family-of-origin exploration, awareness, and an understanding of psychodynamics.

Another facet of understanding the meaning of anger is how it can be used as a shield to protect the person from experiencing feelings that are more difficult or painful. In short, the overtly expressed and felt anger may act as a defense and, at the same time, the anger may serve to give the person a sense of power and control. Anger, identified by Johnson (2004) as a secondary emotion, may be used to cover up many other feelings, or primary emotions. In many cases, clients will not know what the underlying feelings are, making some exploration necessary. Some of the common feelings underlying anger are sadness, loneliness, frustration, guilt, depression, dependence, powerlessness, and mistrust. The therapist should keep these possibilities in mind, exploring those that appear plausible.

Many partners are not in touch with these feelings or find it unacceptable to feel or to express the underlying emotion. For example, one man from a cold and rejecting family entered his marriage with strong unresolved dependency needs. Yet, he could not admit that he needed anyone or wanted anything. He could not ask for what he wanted out of fear of being rejected, so he expected his wife to automatically know and give him what he desperately desired. He became chronically angry toward her for failing to meet his unexpressed needs.

There are two underlying feelings that deserve special note. One is hurt. When there is anger there is almost always hurt. Hurt, unlike anger, usually elicits an empathic response, yet it is difficult for many partners to say they feel hurt. Not surprisingly, expressions of anger do not elicit empathic or compassionate responses (the very thing the hurt partner needs in the moment). Rather, anger is usually met with defensiveness, discounting, or some form of counterattack.

In addition to hurt, the other emotion, which has been generally ignored in the literature on couple therapy, is fear. Organisms seem to have an innate response to fear, which leads to fighting or fleeing (or in couples, attacking or withdrawing). Discussion of this fight or flight response may help couples understand their behavior during conflict and explore the basis for fears that are elicited. What is so fascinating about this concept is that some of the fears may be related to intimacy (described in Chapter 10). For example, a partner may have been reared in a destructive family where he felt neglected and abandoned. A fear of being rejected follows him to his

current relationship. As this person gets closer to his partner, a paradoxical situation occurs. He wants closeness, yet wanting closeness in the past was associated with rejection. During conflict (or opportunities for closeness), the partner's fear of rejection is triggered and results in an angry fight. This type of trigger reaction is another reason we say skills alone will not resolve the problem.

As illustrated in the previous example, anger may result from a fear of intimacy. Anger then may function to regulate distance in a relationship. When a partner is getting too close and eliciting unconscious fear, there is a need to create distance. Because the need is unknown and fear is experienced as anger, the partner has no conscious methods to negotiate for the distance. A fight can serve to alleviate the underlying feeling of fear by creating distance, but has negative consequences for the relationship. Conversely, when partners become too distant, anger can be used in order to serve as a means of gaining the attention of and interaction with the other partner, thus bringing the pair closer.

Anger may also be used in a similar manner to test the degree of commitment in a relationship. If a woman believes her partner may reject or abandon her, then it is possible to test this belief by trying to push the person away through anger. If he keeps coming back, then the partner knows she will not be rejected. In more extreme cases, the partner may discover that he or she can engage in highly disruptive behavior because of the other person's high dependency needs. Such situations occur among people with low self-esteem, especially for those in a relationship with an addict. For example, the alcoholic husband may be chronically abusive to his co-dependent wife. She is in need of therapy just as much as he is because of her dependence on the relationship.

In addition to regulating distance and testing commitment, anger may be used to assert power and control in a relationship. The partner who needs to bolster his or her sense of power by controlling another will usually find that anger is an effective method. This partner may also choose someone who can be intimidated by anger. The therapist should consider the individual dynamics and pathology of such a partner. These partners may fall into diagnostic categories such as narcissistic, paranoid, aggressive, or sociopathic.

Anger may also function in at least two additional ways in a relationship. When a boundary is violated, anger is likely to emerge. The two most common boundaries are associated with self and marriage. In the first case, an individual may feel she or he is having personal rights violated. For example, a couple might agree that the husband can have an evening to work at home before a major presentation the next day. As the evening unfolds, his wife begins to interrupt him. He might assert himself with anger to let her know that she has violated the agreement they made. Anger may also stem from a violation of a marital boundary. In one case, a young married couple came to therapy because the husband would tell his parents things that his wife considered private. They had never discussed this problem calmly in order to clarify expectations, but they had fought over it many times after getting certain information back from his parents. It is useful to help such a couple think about both the meaning and function of their anger. Once they have developed some awareness, it is much easier and usually much more successful to learn and to utilize fair fighting skills.

Therapists and couples must also recognize anger when it is disguised as something else. Anger is not always expressed openly. Anger may be so well disguised that even the therapist has trouble seeing it. On such disguise is passive-aggressive behavior. As the term implies, the aggression is expressed indirectly or passively. Some of the common methods of being passive-aggressive are forgetting, procrastinating, misunderstanding, and over-reading the other person's behavior.

An example of passive-aggressive behavior involved a husband who forgot to pick his wife up at a designated time. He claimed he forgot the time. Procrastinating in doing something for one's partner is another expression of anger. For example, a wife promised to organize some household files, and six months later it still was not done. Misunderstanding and over-reading the partner's behavior are similar. If one partner has been clear, but the other continues to misunderstand, then a payoff is to be found in not understanding. Likewise, a partner may read certain things into the other partner's behavior and despite that partner's protest that it is not true, insist that it is in order to justify the behavior.

A second way to disguise anger is to take a position of righteousness or moral superiority. By asserting that one is right, moral, true, good, and so on, the other person is cast in the role of being wrong, immoral, deceitful or lying, and bad. This hostile and indirect way of putting one's partner down allows the partner to try to get away with his or her anger.

A third method to hide anger is through self-victimization. The victimized partner (e.g., "You absolutely must take care of me and not upset me") may either pretend to be sick or develop psychosomatic problems. In one of our cases, a woman had married a distant, cold, and self-righteous husband who was totally inaccessible. His wife developed numerous aches and pains that could never be medically diagnosed. Because of her history, she had not learned to express anger in direct form and her various ailments served to get her husband's attention and also served as a way for her to express her discontents, albeit indirectly.

The final method is the most difficult to see as anger, because in this strategy the partner uses the ploy of reason and rationality to vent anger. These partners tend to be obsessive-compulsive individuals who use intellectualization as both a defense and as an offense. One case demonstrates this point in a dramatic way. The wife had been decorating the house and decided to purchase new curtains. When the husband discovered how much money she had spent, he was unquestionably upset. However, when he discussed the curtains with his wife, he gave her one logical reason after another why the curtains had to be returned. He even claimed they lacked the proper thermal properties. In addition, he said she could not be trusted to make good decisions without him, so he took away all of her credit cards. When initially confronted in therapy about his anger, he vehemently denied any feelings of anger toward her. This case points out how difficult it can be to help partners recognize and acknowledge their anger.

Giving clients permission and providing a safe, secure environment to explore emotions facilitates the expression of emotion. Although the focus may be on one partner, the reactions of the other partner should be monitored. Partners may actually collude to keep certain patterns of conflict intact. They may be too frightened of anger to deal with it openly.

Expressions of Anger

Recent literature has described two types of anger expression: anger-in and anger-out expression. Anger-in expression is demonstrated when an individual inhibits his or her expression of anger and holds the emotion in (Suchday & Larkin, 2001). An example of anger-in expression may be when a wife grows angry with her husband for not washing the dishes as he promised. Instead of the wife expressing her unhappiness with her husband, she hides her anger from him and silently fumes for hours about how he did not wash the dishes. Anger-out expression is demonstrated when an individual expresses his or her anger and lets the emotion out (Suchday & Larkin, 2001). Anger-out expression would look quite different using the same example above. With anger-out expression, instead of the wife keeping her frustration to herself, she would express her anger openly to her husband. In their research, Suchday and Larkin (2001) found that holding anger in tended to cause more stress for the participants than letting it out, except when participants noticed their expression of anger upsetting another person. This also caused stress to the individual expressing anger.

There are also differences in anger expression between men and women. Newer models of anger expression, specifically those studying gender differences, categorize anger expression into diffusion and explosion (Campbell & Muncer, 2008), or diversion and explosion (Cox & St. Clair, 2005). The difference between diffusion/diversion and explosion/explosion is the social norm behind the behavior. Campbell and Muncer (2008) found that women exceeded men in defusing acts of anger and tended to avoid direct aggression whenever possible. Women were also more likely to view aggression as a loss of self-control and therefore not an acceptable form of emotional expression. Men, on the other hand, generally exceeded women in explosive acts of anger and did not make conscious attempts, like the women, to avoid acts of aggression. Men were also more likely to view aggression as a means of control over others and physically or verbally act out their anger expression. The intent behind the two different types of anger expression here are polar opposites.

Many women receive the cultural message that women are not to display negative emotions such as anger. The difference in the expression of anger for men and women is due largely to differences in gender roles and societal norms (Crawford, 2006). Women in many cultures are viewed as less of an authority figure than men are and assume a lesser position of power. With men being in this one-up position over women, many men view anger as a means of control over others (Campbell & Muncer, 2008). With men assuming a powerful position over women and exerting aggression as a force of control, it is easy to see why many women avoid feelings of anger and try to pacify aggressive situations.

In a couple relationship, the view of anger can be complimentary or destructive. If one partner believes that anger means losing control and the other partner believes that anger is a means of gaining control, they may exist co-operatively if each honors the other's beliefs. This situation may turn around when the partner who wants to avoid anger is taken advantage of by the other who wants to use anger as a means of control. This dysfunction must be addressed in therapy, bringing attention to the different views of anger and means of expression. The research on the expression of anger can be useful to therapists in assessing the nature of couples' angry responses

and dealing with them appropriately. The questions used to assess the meaning and function of anger listed above and the anger genogram provide further clues to how the individual partner may be expressing their anger.

General Principles of Constructive Conflict and Fair Fighting

As mentioned above, conflict itself is not detrimental to a relationship. Rather, it is how a couple handles their disagreements that makes the difference between constructive and destructive conflict. Gottman (1994) found that certain behaviors can undermine a couple's chance of managing conflict in a productive way. He called these the Four Horsemen of the Apocalypse: contempt, criticism, defensiveness, and stonewalling. Gottman (1994) also found that when partners are warm, supportive, interested in the other, and open to being influenced by their partner, couples can successfully resolve conflicts in a manner that preserves closeness and connection.

In order to have a fair fight, a number of principles must be remembered. A fair fight starts with the individual who has the problem doing a self-assessment. Prior to saying anything to the partner, it is important to sort out one's own feelings, including the primary emotions underlying anger. During the first part of a fair fight, the underlying feelings need to be expressed. If anger is the only expressed feeling, the other person is likely to become defensive, dismissive, or angry. In many cases, the angry person wants the partner to see how hurt she or he is, but when the partner fails to acknowledge the hurt, she or he does not get what is needed, feels frustrated, and becomes even angrier. Taking time to explore one's feelings in some depth helps to facilitate the expression of those feelings.

The second major task of the angry person is to identify the source of the anger before beginning an argument. In some cases the source of anger is clearly unrealistic. For example, a man might be angry because his wife spent a few minutes talking to another man at a party. He expected her to stay with him and talk only to couples or other women. This expectation is unrealistic and engenders anger. It is each partner's responsibility to determine if there is a rational basis for his or her anger. If there is not, they may benefit from the cognitive therapy approach (see Chapter 14) discussed in this volume.

On a practical level, several ideas need to be discussed before the actual steps to fair fighting are reviewed. First, the couple needs to be reminded that in a fair fight the attitude must be one of win–win. This attitude consists of being willing to give up something in order to bring about a compromise. The therapist can point out that unless each person feels she or he has given up something, they probably do not have a compromise solution.

Second, learning to apply the principles of fair fighting takes practice. During the process, mistakes will be made. When mistakes are made, partners should not blame each other or give up. In fact, they may agree to help each other learn to use the principles. We suggest the couple divide their disagreements into three categories based on the emotional intensity of the issue: cool, warm, and hot. They begin to use fair fighting with the cool issues in the session, practice more at home, and then move on to the warm issues. The couple can be reminded that fair fighting requires practice, practice, and more practice.

The third principle deals with time. Fair fighting requires time. Ideally, the couple would be able to discuss a disagreement as soon as it occurs. The reality is that many

fights occur when there is not time to talk or the conditions are not ideal (e.g., when guests are over). In these situations, the partner may express the feeling discreetly and agree to talk later. A fixed time needs to be set in order to contain the problem. If a time is not set, the partner is likely to keep bringing up the issue. When the discussion does take place, resolving the fight may take more time than was allotted. Some disagreements take many hours to resolve. A fight can be broken up into segments. Fights should not be hurried in order to meet some time limit or the need for quick resolution.

Having a fair fight assumes the anger is under conscious control. Sometimes a fight will deteriorate into a destructive situation because of escalating anger and decreasing self-control. A rule we suggest is that either partner may call a time out during an argument unilaterally and without question. The partner who is getting angry may call a time-out to cool off. The partner on the receiving end of the anger may call a time-out because he or she is afraid of the anger or sees a deterioration in the argument. The cooling-off period should be as short as possible but as long as is needed to bring the emotion down to a manageable level. The person who calls the time-out is also responsible for setting the time to resume the argument.

The couple should understand and be in agreement with these ideas before proceeding to implement the steps of fair fighting. Fair fighting consists of a number of

Box 13.1 Essential Do's and Don'ts

1. Be specific when you introduce a gripe.
2. Don't just complain, no matter how specifically; ask for a reasonable change that will relieve one gripe at a time.
3. Confine yourself to one issue at a time. Otherwise, without professional guidance, you may skip back and forth, evading the hard ones.
4. Always consider compromise. Remember, your partner's view of reality is just as real as yours, even though you may differ. There are no totally objective realities.
5. Do not allow counterdemands to enter the picture until the original demands are clearly understood, and there has been a clear-cut response to them.
6. Never assume that you know what your partner is thinking until you have checked out the assumption in plain language. Never assume or predict how your partner will react, or what your partner will accept or reject.
7. Never put labels on your partner. Do not make sweeping, labeling judgments about your partner's feelings, especially about whether or not they are real or important.
8. Sarcasm is dirty fighting.
9. Forget the past and stay with the here-and-now. What either of you did last year or month or that morning is not as important as what you are doing and feeling now. The changes you ask for cannot possibly be retroactive. Hurts, grievances, and irritations should be brought up at the very earliest moment; otherwise your partner may suspect that they may have been saved carefully as weapons.

do's and don'ts. The first task of the therapist is to make each partner responsible for how he or she interacts. We give each partner a copy of the Essential Do's and Don'ts (see Box 13.1). They are asked to read this list and rank order the items where they have trouble. In the next session, each partner is asked to talk about their bad habits and how she or he might change the habits. The therapist may praise their constructive comments as well as offer additional suggestions to help overcome habits that are not helpful.

After the Essential Do's and Don'ts, the next task is to go over the steps of constructive conflict resolution (see Box 13.2). These steps are broken down so they

Box 13.2 Steps to Fair Fighting

1. The person who has the problem is responsible for bringing it up as soon as possible. Before you bring the problem up, think it through in your own mind.
2. State the problem to your partner as clearly and concretely as possible. Use the following format: "I am feeling (e.g., angry) because of (e.g., the way you put me down at your parents' house)."
3. It is important that you both understand the problem being brought up. The partner who is on the receiving end should reflect back what was said using the following format: "I hear you saying you feel ___ because of __ ." After reflecting back what was said, ask clarifying questions so you know exactly what your partner meant. For example, "Describe." "Tell me." "What is it that upsets you?"
4. When both partners agree on what is being said, the first partner may proceed.
5. The partner who brings up the problem should take responsibility for offering a possible solution in terms of changes both can make (e.g., "I can make sure you know what I want. I would like to suggest you ___ .").
6. This solution can be discussed and then your partner may offer a counter-proposal. Again, the solution should involve changes both of you can make.
7. Discuss several options until you agree that one proposal is most workable (not right or wrong, but workable).
8. Once you have agreed on an idea, proceed to talk about how you will put it into action. This means being able to clearly answer the question: Who will do what, when, and how?
9. Once everything has been worked out, think about what could happen to undermine it. Each of you can think of how you might sabotage the agreement.
10. Working through a conflict may stir up some emotions because it likely means you had to give up something. Congratulate each other for the hard work and willingness to compromise. Reaffirm your relationship in as many ways as possible. You have good reason to celebrate.
11. Agree to come back to this problem after some specific period of time to reassess how the agreement is working. You may need to change it or fine-tune part of it.

are easy to understand. The therapist may wish to point out that Steps 1 through 4 deal with feelings about the problems and mutual understanding. Before a problem is "solved," it is essential to acknowledge the other person's feelings about it first. Couples make two common mistakes in this area. The first, as we have implied, is to fail to discuss their feelings about the problem. Acknowledging the feelings of the other does not imply accepting the other's position. However, concern about this often keeps partners from acknowledging the other because they worry that understanding will be taken as agreement by the other.

In reality, the person who expressed the problem may just want to talk about his or her feelings and not about the problem. This situation frequently occurs when the problem is outside the relationship. In a typical scenario, a wife may be having a problem at work. When she tells her husband how she is feeling he begins to give advice or problem-solve. The wife in turn feels discounted emotionally. At times it is not necessary to proceed to the problem-solving steps (Steps 5–11) in this model. One partner might just need the other to listen.

As we said earlier, at the beginning these steps should be put into practice in the session in which the couple are working on easy issues or just role-playing some dispute. Because the behaviors may be new, the first attempt may take part or all of a session for just one disagreement. After they have practiced the steps, the pace usually increases, and the steps will become less mechanical and more natural. In order to help the reader pull together the techniques described in this chapter in a systematic way, we have developed a flow chart that shows when various techniques should be used (Figure 13.1).

In addition to the behavioral techniques of fair fighting discussed in this chapter, negotiation is also an important technique to teach partners wanting to resolve anger and conflict. Fisher and Ury (1981) and Ury (1991) stress the following principles for effective negotiating: (a) differentiating the problem from the persons involved, with each person treating the other in an empathic and respectful manner; (b) actively listening to oneself as well as the other while attempting to resolve the issues on merit in an objective, unbiased fashion; (c) avoiding polarized and combative stances, focusing instead on specific concerns; (d) creating a variety of potentially mutually satisfying outcomes; and (e) using standards of judgment that are fair, reasonable, and impartial.

Ury (1991) developed the negotiation model further by focusing on modifications that need to be made when the other person is strongly confrontational. He emphasizes the following: (a) maintain the ability to mentally separate oneself from the interaction and "observe" what is happening rather than responding in an oppositional or aggressive manner; (b) to respond in an empathic manner to the ideas, issues, and feelings raised by the other person; (c) positively reframe the issue at hand; (d) search for ways to enable both persons' expressed and unexpressed interests to be met in a win/win manner, avoiding I win/you lose or I lose/you win outcomes; and (e) openly and clearly identify the consequences for both parties if a mutually satisfying, negotiated agreement cannot be reached. Negotiation can also be helpful with marital contracting (see Chapter 15).

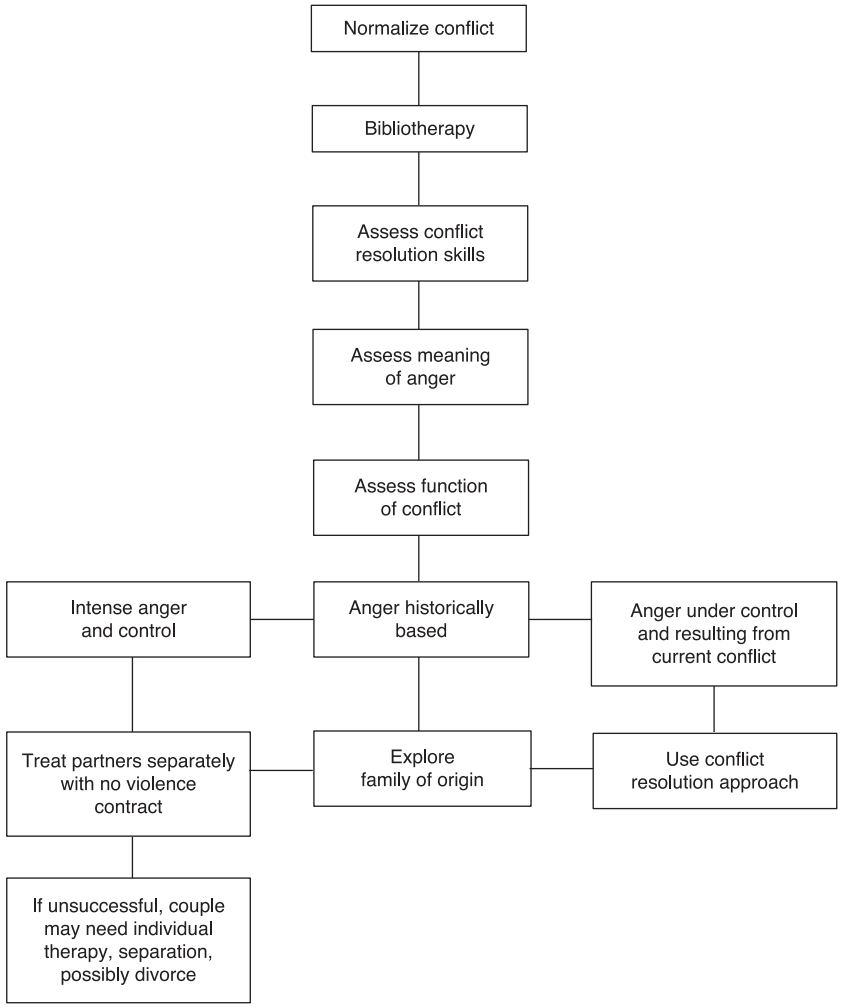


Figure 13.1 Flow Chart for Conflict Resolution

Origin of Conflict Management Skills

Ecological, social learning, and systems theories promote the idea that many of the adult behaviors one exhibits are influenced by one's family of origin and the environment one grew up in. This includes one's ideas about how to deal with conflict (Feldman, Masalha, & Derdikman-Eiron, 2010). Some individuals experience conflict in a particular way because they have learned to model the behavior of parental figures. Others experience conflict in a certain way due to personality traits, or emotional patterns that have developed over time.

Many studies have been interested in the influence of the family of origin on the adult child's conflict management styles in a couple relationship (Gardner, Busby, & Brimhall, 2007). Studies show that adult children tend to have the same type of emotional reactivity as their parents did. Because it is common for an adult child to continue handling conflict in the same way their parents did, those who grew up in homes where conflict was dealt with poorly would likely have difficulty resolving conflict in their own marital/couple relationships (Gardner et al., 2007). It has also been found that although conflict resolution is learned in part from parents, it is also influenced by peers and experiences with conflict resolution in adolescence (McIsaac, Connolly, McKenney, Pepler, & Craig, 2008).

Attachment and Conflict

Another important factor in understanding how a couple has learned to handle conflict is attachment styles (Eğeci & Gençöz, 2006; Gardner et al., 2007). People are constantly seeking security from their partner (Shi, 2003). When this security is threatened by conflict in the relationship the partner may revert back to behavioral patterns that relate to the attachment style they developed as a child. Any threat to the safety of a relationship causes the partner to take a defensive position which often exacerbates the conflict situation (Sells, Beckenbach, & Patrick, 2009). Partners with secure attachment styles are open to relying on their partner for security, and are able to talk about problems when they arise because they are confident in their relationship. Those with anxious or ambivalent styles are open to the relationship, but tend to be less confident in the relationship. As a result, when conflict arises, these partners tend to be more angry and aggressive, blame their partner, and can end up becoming demanding or withdrawn. Partners with an avoidant attachment style are not as willing to enter into close relationships and tend to avoid the conflict situations when they arise (Shi, 2003). This makes it difficult for them to apply conflict resolution skills when they might be needed (Eğeci & Gençöz, 2006). Overall, many studies have concluded that partners with a secure attachment style will be able to utilize their problem-solving skills more easily because of their sense of security (Shi, 2003).

Deeply Rooted Conflict

Although the fair fighting approach is highly effective for most arguments, when the conflict resolution model described above fails to work, it is usually because there is an underlying issue or hidden agenda in the couple's relationship. In conflict resolution models, a basic assumption is that the couple lack the interpersonal or social skills needed to fight constructively. However, this assumption does not fully take into account the intergenerational factors described in this chapter and in Chapters 1 and 2, nor does it recognize potential individual pathology that might be a contributing factor.

It is therefore helpful to view conflict within the Intersystem Model as having multiple dimensions. Traditional conflict resolution programs focus on the conflict from a behavioral and interactional perspective. Some will also look at the intergenerational influences on conflict. However, in some cases, work at the couple and

intergenerational levels is not sufficient. Couples who do not respond to a traditional approach need to be examined more closely from an individual perspective. They may carry intrapsychic issues that make them appear "impossible" or difficult to manage as a couple. In these cases, the conflict needs to be examined at the individual level in terms of intrapsychic components. The conflict could be an expression of a personality disorder such as the passive-aggressive personality or as an expression of depression.

Feldman (1982) developed one of the most clinically useful intrapsychic models to account for marital conflict. In Feldman's model the underlying cause is what he calls narcissistic vulnerability (which is discussed at length in Chapter 19 of this book). The phenomenon refers to low self-esteem, self-fragmentation, and a lack of sense of identity. This weakness in the partners leads to hypersensitivity and narcissistic expectations. The partners are very sensitive to rejection, disapproval, and criticism and have difficulty controlling their emotions and behavior. To compensate for their vulnerability, they develop unconscious expectations that the other partner will be totally admiring, attentive, loving, and so on. Because these expectations are so pervasive and unconscious, each partner is wrapped up in self and appears unempathic to the other.

Obviously, no partner could fulfill these expectations, and so this leads to narcissistic rage and anxiety. If the process stops at this stage, the other partner becomes the scapegoat for the vulnerability. However, for some individuals the process involves a phenomenon known as projective identification (Scharff & Scharff, 2008). This defense mechanism involves splitting off some disowned or unacceptable part of self and projecting it onto the partner. The other person may become all good, or more commonly, all bad. The "all bad" partner holds those parts that cannot be allowed in self. Once this unacceptable material has been projected onto the other person, the partner interacts with this person so as to elicit the negative quality. The projector then attempts to destroy this behavior in the partner. The image of the partner is now grossly distorted and results in an escalation of conflict.

In order to address narcissistic vulnerability, Feldman (1982) developed a model which shows where each partner is vulnerable and follows a particular sequence of interpersonal dynamics. He linked each dynamic with an approach or treatment technique. His model begins with narcissistic vulnerability, which he says should be treated with emotional awareness training and dream work. The second dynamic is blocked empathy, which is to be treated with communications and empathy training. The third dynamic is narcissistic expectation, for which he recommends cognitive awareness training. This leads to the fourth dynamic, narcissistic rage, which is to be treated with what he called self-instruction or self-control training. The fifth dynamic would be extreme cognitive distortions which are treated with cognitive therapy and focusing on the positives. The final dynamic is the expression of overt and intense marital conflict where he recommended behavioral contracting and problem solving. The most important feature of this model is the description of the dynamic between partners. This approach involves both seeing the couple together and the partners individually. A model such as this requires in-depth, insight-oriented work over an extended period of time.

In addition to this model, it is useful to remember couples operate in collusion. They may both use conflict and anger in order to protect themselves from dealing with other feelings. They may both fear intimacy and need a relationship in which

intimacy is set up to be impossible. In examining the conflict from an intrapsychic perspective, the therapist must explore the unconscious needs being met by maintaining the pattern of conflict.

Theoretical Approaches to Conflict Utilization

In the literature on conflict, two terms are commonly used to refer to work in this area. These terms are "conflict resolution" and "conflict utilization." Turner (1982) suggests that the term conflict resolution denotes that the goal for a couple to achieve is to resolve conflict. On the other hand, conflict utilization refers to an active, dynamic process that connotes the idea that the couple can make use of the conflict for more than simply resolving a problem. He believes conflict can be positive, productive, and growth enhancing, and he lists eight positive functions of conflict: (1) using energy rather than repressing it; (2) using conflict creatively to raise new questions and ideas; (3) surfacing heretofore hidden thoughts and feelings; (4) creating new methods in the couple for handling conflict; (5) reassessing power in the relationship; (6) creating a climate of co-operation; (7) learning to see problems rationally; and (8) renegotiating old contracts and changing expectations in the relationship.

One of the first tasks in dealing with conflict is to help the couple develop some positive ideas about subjects they have been avoiding or dealing with poorly. The therapist should ask the couple about their beliefs regarding conflict. Once these beliefs have been made explicit, the therapist may suggest looking at conflict as a positive and constructive force in the relationship, one that could be intimacy enhancing if handled well, but relationship debilitating if handled poorly. The couple can be asked to list positive aspects of conflict. As we suggested earlier, if the couple does not have an open attitude toward conflict and anger, no amount of education, coaching, or therapy will help. The couple will resist efforts to begin the work because their belief system tells them it is something to be avoided.

At the beginning of therapy, some bibliotherapy may help to instill this positive attitude. A book such as *The Intimate Enemy: How to Fight Fair in Love and Marriage* (Bach & Wyden, 1983) makes this point both implicitly and explicitly. A positive attitude can also be demonstrated through the therapist self-disclosing or sharing specific case examples demonstrating the benefits of conflict.

Cognitive Approaches to Conflict

In spite of the fact that cognitive therapy is a major force in psychotherapy, very little has been written on cognition and conflict. Doherty (1981a, 1981b) published two articles describing cognitive processes in conflict, and although there are many practical applications both articles were primarily theoretical in nature. His work helps us to better understand the nature of conflict from the inside out. He clarifies the underlying mental processes that occur when conflict exists and identifies the factors that inhibit and facilitate conflict being utilized.

One of Doherty's key concepts is attribution. Attribution theories focus on how we attribute meaning to an event and the information on which it is based (Kelly, 1963). For partners in a relationship, the basic question is, "Who or what is causing this

problem?" This question is ubiquitous in couple therapy. Couples may attribute their conflict to several possible sources, assigning blame and responsibility to self, partner, relationship, context, God, or to just plain luck, fate, or chance.The therapist must discover how the partners conceptualize the conflict, that is, the "who" and "what." In most couples, blame is assigned to the other partner. Perhaps the most common reason that anger is not owned is because individuals do not see it as belonging to them. One of the deceptive characteristics of anger is that it inherently feels like it is caused by something or someone else (e.g., "You *made* me angry"), and therefore I have no responsibility for it (Laughlin & Warner, 2005). As long as this kind of linear attributional strategy is present in the couple, change will not occur.

In a previous book, Weeks and Hof (1995) discuss the importance of helping the couple shift from a linear to a circular attributional strategy. A linear strategy involves the partners blaming each other or externalizing responsibility. A circular strategy involves partners defining the problem in terms of their relationship or system. In order to help couples make this shift, the therapist may utilize reframing (see Chapter 11), so that couples no longer see behaviors in terms of cause and effect but rather as circular, interlocking, or reciprocal. An in-depth description of reframing is given in Chapter 11.

Doherty (1981a) also identifies several other attributional dimensions and strategies that contribute to marital conflict and need to be examined, namely, intent, stability, voluntariness, and specificity. *Intent* refers to the meaning attributed to the person who performed the behavior. The partner is trying to determine the real meaning of the behavior. In most cases, intent actually refers to the judgment the partner makes regarding whether a behavior was perceived as positive or negative. For example, if a wife tells her husband to change his clothing because the outfit does not match, he might ascribe negative or positive intent to her statement. He could say to himself that she cares about him and how he looks. On the other hand, he might feel personally criticized and ascribe negative intent to her statement. Intent and effect often become confused in couples. Just because something "feels" negative, or is perceived to be negative, does not mean it was intended to be negative.

In couple therapy, it is important to help the partners eliminate distortions and projections around intent. Having each other discuss what is intended is a beginning. If partners persist in seeing the behavior differently, then the two issues need exploration. Perhaps the response to a behavior is over-determined. For example, if he or she had learned to respond only one way to a particular behavior in a family, the original conceptualization and its corresponding responses may persist, regardless of partner or context. The other possibility is that the initiating partner does not know the real intent of his or her behavior. He or she may be in denial of the actual intent or may distort the meaning of the behavior. The therapist will have to use some judgment in sorting out what the real intent might be.

The second attributional dimension is *stability.* Stability refers to the extent to which the behaviors represent stable personality characteristics in the other person. A behavior may be viewed as an isolated event related to some environmental situation, such as getting angry when the car has a flat tire. It may also be viewed as representing some stable characteristic in the other person as "he is always angry; therefore, he is an angry person."

This attributional phenomenon helps explain why therapists find it useful to frame problems in terms of behaviors rather than personality traits or characteristics. By definition, a personality trait is seen to be rather stable and probably not changed easily. When a partner believes that a trait is being dealt with, as opposed to a behavior, he or she may be less likely to attempt to change the situation. The couple may feel they cannot change and give up when problem behaviors are defined as immutable traits. By redefining the problem in terms of behaviors, which are transitory, a greater sense of hope and change potential is inspired.

Voluntariness or deliberateness of a person's behavior is the third dimension of attribution. Partners make assumptions about how voluntary behaviors may be, and are likely to believe the behavior was voluntary or involuntary, controllable or uncontrollable, spontaneous or contrived. When the behavior is defined as voluntary, or in any of the parallel ways listed, the behavior carries much more import. If one partner has done something perceived as hurtful, and the behavior was deliberate, the other partner will feel personally attacked. It may be easier to forgive a hurtful behavior if it is defined as involuntary.

The final attributional dimension is *specificity*. The attributions made may generalize to the person or the relationship; they may range from global to specific. More problems occur when the attributions generalize, assuming these are negative attributions. For example, a newly married couple may have a few fights. They may begin to believe that all they ever do is fight. They come to see or define themselves as a "fighting couple," and they believe they should divorce because that is all they will ever do. The generalization could also have been to the individual in this example. One partner could be defined as always wanting to fight. Global negative attributions are demoralizing for the couple and represent a distortion.

The therapist can work toward specificity by challenging these distortions directly. A cognitive therapy approach may be used in which the couple is taught about distortions, how to identify them, and how to stop them (Burns, 1980). The therapist's use of language and the questions asked also lead the couple in the direction of seeing the problem specifically rather than globally. Specific questions about the "who, what, where, when, and how" of the argument encourage less global thinking in the partners.

Doherty (1981b) uses the concept of *efficacy* to refer to beliefs about future events, a central aspect of readiness to change. He proposes that "efficacy refers to the individual's expectation for the couple or family as a group to engage in effective problem-solving activity" (p. 4). Bandura (1977) proposed that it was the individual's expectation of being able to bring about a particular outcome. Efficacy is similar to having hope, feeling masterful and competent, and being able to make a positive prediction happen. For the couple, the question is, "Can the problem be solved by us?" Doherty (1981b) suggests that if the efficacy expectations are low, partners will not persist in trying to solve their problems and eventually give up. Individuals with high efficacy expectations will predict positive outcomes and be very persistent in their problem-solving efforts. One of the goals of therapy, therefore, is to help create a generalized high efficacy belief and response, a sense of hope.

Rational-Emotive Behavior Therapy

Albert Ellis (1976) described how the theory and techniques of his Rational-Emotive Therapy (RET; updated in 1995 to REBT, emphasizing the behavioral component) can be applied in working with anger. His theory is based on the assumption that anger stems from irrational beliefs held about one's partner or relationship. It is an individually oriented approach that focuses on change within the individual, rather than the relationship. The dissipation of the anger is accomplished through the A-B-C-D theory of rational therapy. A is the activating event, B is the belief system, C is the emotional and behavioral consequences, and D refers to the act of disputing the irrational belief.

Ellis (1976) proposed that much marital anger grows out of the "shoulds," "oughts," and "musts" in relationships. For example, if one partner thinks, "I absolutely must feel loved by my partner all the time and he or she must verbalize it," then disappointment, anger, and conflict will result when those needs are not met. By eliminating the irrational ideas, the basis of the anger and conflict is removed.

He suggests two strategies for dealing with anger, the first of which simply involves a cooling off period in order to set the stage for thinking the anger through. The second strategy incorporates the following eight steps: (1) acknowledging the anger of oneself; (2) assuming full responsibility for the anger; (3) accepting oneself with the anger; (4) putting an end to making oneself anxious and depressed, and being self-deprecating; (5) looking for the belief leading to the anger; (6) differentiating among wishes, demands, and commands; (7) removing the absolute "musts"; and (8) changing the behaviors and emotions that support the feelings of anger.

This model can work well when applicable. In some cases, the anger and conflict are certainly being driven by irrational thoughts, and an individually oriented approach is appropriate. Each partner may need to change some thinking in order to remove the anger. The disadvantage of the REBT approach, in our opinion, is that it is asystemic, and thus nonrelational. In the Intersystem Model (Weeks, 1994), the partners co-determine the relationship and the relationship influences the partners. Ellis's approach does not examine how the relationship influences the thinking or actions of the partners.

Affective Approaches to Conflict

L'Abate (1977) states that in most cases anger is the result of feeling hurt and the fear of being hurt. The hurt feelings may be based in unresolved grief, past frustrations, and feelings of personal inadequacy. The failure to recognize these feelings means the clinician only treats the symptom and not the underlying emotional difficulties. L'Abate (1977) and L'Abate and L'Abate (1977) suggest five steps for dealing with hurt. The first step is to recognize that when anger is experienced, there is also an underlying feeling of hurt. The second step is for the partner feeling the hurt to express it directly and appropriately to his or her partner (e.g., "I felt hurt when . . ."). Third, the individual with the feeling must assume responsibility for the hurt and not project it onto the partner. Often, it is the anger that is projected in terms of blaming the partner as the source of the anger. Fourth, the person must be able to forgive

him- or herself for denying the hurt and not being invulnerable to this feeling. Finally, one must recognize that feeling hurt is a human reaction. It is important to redefine oneself as having weaknesses and vulnerabilities. Only by accepting this can the person stay in touch with the hurt. This aspect of conflict utilization, dealing with the feelings of hurt and anger, too often has been underemphasized or ignored in the literature.

Greenberg and Johnson (1988), developers of emotionally focused couple therapy (EFT), also argue for the salience of emotions in resolving couple conflict. With EFT, the experience and expression of emotions are at the heart of resolving couple differences and restoring the bond between partners. The expression of secondary emotions such as anger, defensiveness, or frustration, which have a more attacking or accusatory quality, may interfere with conflict resolution. Therapists attempt to bring about safe emotional interactions between partners so that they can calm, comfort, and reassure each other (Johnson et al., 2006). Therapists may draw upon techniques from EFT to facilitate the experience and expression of primary emotions (e.g., loneliness, rejection, or fear). When these emotions are heard and understood in a non defensive manner by the partner, it may have a softening effect, such that they see the other partner as hurt or lonely, rather than mean-spirited or being intentionally hurtful, for example. Similar to L'Abate, EFT interventions help facilitate the expression of emotions between partners in a constructive manner such that the couple is better able to discuss differences and resolve conflicts.

Paradoxical Approach to Conflict

Another way to deal with conflict in couples is to employ paradoxical intervention. Weeks and L'Abate (1982) describe cases that involve the use of one or several paradoxical strategies. The two most common techniques are to positively reframe the conflict and then prescribe it. The positive reframe helps the couple see that there is something they derive from the conflict, that it serves some function in the relationship. The prescription paradox brings the heretofore out-of-control conflict under control.

For example, the therapist might say the following: "It is clear the two of you care a great deal for each other. You keep a fight going almost constantly in order to protect each other from having to confront your depression. For now, you should continue to help each other by carefully noticing when the other person looks 'down' and picking a fight immediately. If you miss how your partner is feeling, then you should co-operate fully by fighting back when your partner picks a fight with you." If the couple follows this directive, they learn to see how fights are connected to depression and begin to take some control over the process. If they do not follow the directive, then they do not fight, which was one of the goals of therapy. A well-constructed paradoxical intervention is a win–win proposition.

Conflict Utilization: A Synthesis of the Whole

The practicing therapist needs to integrate ideas from all the approaches discussed (cognitive, affective, and behavioral) to develop a comprehensive conflict utilization

model. We hope to provide a basic framework in which this integration may occur. The following ideas are presented to help synthesize much of what has already appeared in the literature on conflict, communication, problem solving, and contracting. Not all of the ideas are original, but the particular combination of ideas is new and comprehensive.

A word of caution: this approach is effective when anger and conflict have not reached the level of abuse. If violence is ongoing, this approach may be contraindicated. Safety is always the primary concern in these cases. As mentioned above, in situations where violence exists, it is necessary to first assess the nature of the violence. If the violence is instrumental, then the partners should be seen separately or referred for individual therapy. A description of how to work with spouse abuse or intimate partner violence can be found in *Treating Couples: The Intersystem Model of the Marriage Council of Philadelphia* (Weeks, 1989a) and *Couples Therapy for Domestic Violence: Finding Safe Solutions* (Stith et al., 2011).

Another factor that must be considered is the therapist's own ability to work with anger and conflict. Beginning therapists are sometimes afraid of losing control of the session so they keep feelings of anger to a minimum and do not encourage enough emotional intensity to emerge. The therapist must balance how much affect occurs at any given time and pace the couple in how quickly they move into conflicted areas. It would be inappropriate to move into highly conflicted areas in the evaluation phase of therapy. During this phase the therapist is collecting information about the different conflicts, but not actually encouraging the couple to work on conflict resolution until certain conditions have been met (i.e. setting up some ground rules for fighting).

The therapist may also have a number of countertransferential reactions to dealing with anger and conflict. We believe it is also useful for the therapist to do their own anger genogram (DeMaria et al., 1999) and to answer the questions regarding the meaning and function of anger and conflict. Perhaps there is an inclination on the part of the therapist to minimize, ignore, or deny some of the anger and conflict in couples. He or she may have grown up in a family that minimized anger or where conflict was out of control, resulting in the therapist fearing these feelings just as much as the clients. Therapists in training need to be monitored carefully and asked about these types of reactions directly. Some therapists may need supervision or therapy to help them work through unresolved feelings of anger, fear of conflict, or other feelings that hinder doing this kind of work effectively.

Levels of Conflict

Before beginning direct work with the couple in the area of conflict utilization, it is important to assess the level of conflict that is present within the couple. Stages of marital conflict are discussed in *The Evaluation and Treatment of Marital Conflict: A Four-Stage Approach* (Guerin, Fay, Burden, & Kautto, 1987).

Low-Level Conflict

Low-level conflict is often issue-focused with minimal projection. The individuals are able to maintain a responsible, balanced, and differentiated view of the situation,

themselves, and their partner. There is usually a strong sense of "coupleness" present and a willingness (though skills are often lacking) to engage each other affectively, cognitively, and behaviorally. There are legitimate differences or preferences, and the negotiation process generally works quite well. This level of conflict responds well to education and skill-building efforts alone.

Medium-Level Conflict

Medium-level conflict often involves deeply ingrained family-of-origin patterns of relating and significant individual life "script" issues (James & Jongeward, 1971). There is a modicum of projection and some loss of "self focus" (Guerin et al., 1987) with an increase in emotional reactivity and blaming. One or both partners appear less differentiated, responsible, objective, and balanced (affectively, behaviorally, and/or cognitively) than individuals in the low-level conflict category. Historically based, unresolved issues may have prevented the individuals and/or the couple from learning or employing the appropriate conflict utilization skills. This level of conflict often responds well to insight. At this level of conflict, techniques that may be used include Hendrix's (1988) approach to the resolution of projection-related issues; the resolution of life "script" and family-of-origin issues through "reparenting" (James & Jongeward, 1971); and significant focusing on differentiation and individuation with an appropriate emphasis on addressing deficits in social learning through remodeling, skill practice, and reinforcement.

High-Level Conflict

High-level conflict has a chronic quality to it. There is a high degree of emotional reactivity, blaming, and vilification. The couple is consistently polarized, and there is little sense of positive "we-ness." In one or both partners, differentiation is low, as is responsibility, objectivity, and balance within and among the affective, cognitive, and behavioral dimensions of the individuals.

High-level conflict generally requires long-term therapy including a conjoint emphasis to build the "coupleness"; provision of a buffer against the intrusion of the early trauma; experiences of healing intimacy; and frequent individual sessions to provide individual support and nurturance to diminish the severity of the emotional wounds and to promote healing. The relationship therapist may not be able to do the individual therapy for several reasons, including narcissistic vulnerability, fear of abandonment, or jealousy of one or both partners. Even if there is a positive transference and scrupulous balance and fairness on the part of the therapist, the narcissistically vulnerable individual may feel abandoned or rejected by the therapist. Great care must be exercised if the therapist endeavors to do both aspects of the therapeutic work. An appropriate referral for concurrent individual therapy is often the best course of action.

At all levels, skill deficits, unhelpful patterns learned in the family of origin, and intrapsychic issues may be at work, contributing to the perpetuation of the conflict. In order to decide at which level(s) to intervene, the therapist needs to assess the individuals and the couple from an Intersystem perspective. The nature of the individual/

intrapsychic issues and the psychosocial/whole-world context issues (e.g., issues of race, ethnicity, and spirituality; current economic conditions) involved in the couple and the conflict must be evaluated.

Once an assessment has been made of the meaning and function of the anger and conflict, the extent of the couple's conflict utilization skills, and the level of conflict, the therapist can utilize appropriate steps and creatively incorporate the conflict into the therapy.

Conclusion

The reduction of conflict and anger is one important step to enhancing couples' intimacy. Couples who move through conflict resolution successfully begin to feel a greater sense of competence and relationship bonding. They begin to realize conflict is a challenge that they can overcome as a couple. This process affirms their relationship.

The model presented in this chapter is more comprehensive than most other models (L'Abate & McHenry, 1983). From the model presented in the flow chart, the clinician can see that we view the problem from multiple perspectives consistent with the Intersystem Model. For example, at the *individual* level we might think about the meaning of anger for the individual partner; at the *couple* level we might consider the function of the conflict for the couple; and at the *intergenerational* level we might see how familial patterns of dealing with anger are being repeated. Keeping all these levels in mind gives conflict a complexity not often appreciated in working with this issue. Of the various theories and couple therapy approaches discussed, meta-analytic studies have failed to show that one theoretical approach is superior to another (Wood, Crane, Schaalje, & Law, 2005). For this reason, we continue to suggest a multidimensional approach that provides the best therapeutic fit to the couple rather than insisting all couples fit with one theory.

14

COGNITIVE TECHNIQUES AND INTERVENTIONS

When working with couples, therapists have the choice of using interventions that are affectively, behaviorally, or cognitively oriented. The first two categories of interventions have been widely discussed in the marital therapy literature (Long & Young, 2007). In spite of the fact that cognitive approaches have been highly influential in individual psychotherapy, the use of cognitive interventions in couple therapy has received little attention (Dattilio & Epstein, 2005). For the most part, cognitive approaches have primarily been applied to individuals. Nevertheless, there has been increased attention in couple therapy to the momentary thoughts partners have about each other and their more stable relationship beliefs (Dattilio, 2010), and more has been published on cognitive therapy and couples during the past decade than in all prior times.

Most of Albert Ellis's (1962) early work in Rational-Emotive Therapy (RET) and Aaron Beck's (1976) early work in Cognitive Therapy (CT) was individually oriented, and the application of their theories continues to be primarily focused on the individual. The exception is Ellis and Harper's (1961b) book on how Rational-Emotive Therapy might be applied in understanding and treating marriages, and the more recent text by Ellis, Sichel, Yeager, DiMattia, and Digiuseppe (1989). Likewise, Beck has also discussed how Cognitive Therapy might be applied to couples (1988).

However, the application of Ellis's and Beck's cognitive theories clearly did not take hold in the field of marital therapy. We believe the reason for this is twofold. First is that both approaches were developed within an individual psychological framework which did not incorporate a systemic view of partners and relationships. Second, Ellis promoted RET as a singular treatment approach, just as Beck did later with Cognitive Therapy. Cognitive approaches have their utility, but they also have limitations. In fact, for most couples the use of any single approach is too narrow and ineffective. In our opinion, promoting change and growth in a couple requires the clinician to be integrative and to fit the approach to the couple, not force the couple to fit the approach.

Although this chapter will describe cognitive techniques, we do not advocate that they be used exclusively. These techniques need to be blended with the techniques found in other chapters of this book. Baucom, Epstein, and Rankin (1995) note that "cognitions, behaviors, and emotions are inextricably interwoven" (p. 65), and that the quality of couples' intimate relationships is impacted by their cognitions, behavioral interaction patterns, and emotional responses (Epstein & Baucom, 1993, 1998;

see also Fincham, Bradbury, & Scott, 1990; Gottman, 1993; Weiss & Heyman, 1990). Thus, each should be considered when working with couples. The marital therapist must be skillful in integrating the couple's internal cognitions with their overt interactions, which include the behavioral interchanges as well as the affective expressions of each partner (Epstein, 1982). We also note that some cognitive therapists may adopt too much of an expert role in challenging clients' views of reality, but cognitive approaches actually emphasize nondirective interviewing to enter a client's subjective world, understanding their personal constructs, and coaching them in examining available logic and evidence for their cognitions.

Cognitive Theory and Its Application in Couple Therapy

In spite of historical precedence, there has been an increase in the use of cognitive approaches in couple therapy during the past decade, particularly in conjunction with behavioral techniques. Merrick and Dattilio (2006) note that a cognitive–behavioral perspective gives therapists a way to understand individual and interpersonal dynamics within the context of treating couples across various cultures. Ellis acknowledged the role of behavior in both individual life and interpersonal relationships when he renamed his Rational-Emotive Behavior Therapy (REBT) in 1995. Beck also recognized the importance of behavior in his theory. Schuyler (2003) states that Beck's goals for Cognitive Therapy include:

1 Identify cognitions relevant to the presenting problem;
2 Recognize connections among cognitions, emotions, and behaviors;
3 Examine the evidence for and against key beliefs;
4 Encourage the clients to try out alternative conceptualizations;
5 Teach the clients to carry out the new cognitive processes.

These goals can be effectively applied to a variety of problems from which couples may suffer.

In order to use cognitive interventions, the clinician must be familiar with the basic theory and principles of both Rational-Emotive Behavior Therapy and Cognitive Therapy. Both of these theories obviously focus on cognition—that is, what and how people think. These theories postulate that behavior and affect follow from thinking. The clinical implication of this notion is that if the clinician wants to help clients change what they do or how they feel, the first step is to facilitate a change in the person's thinking.

What has not been explained well in the literature is the basic difference between the rational-emotive and cognitive theories.The cognitive therapist focuses more on *how* the person is thinking, while the rational-emotive behavior therapist focuses more on *what* the person is thinking. Thus, rational-emotive behavior therapists are *content-oriented* and cognitive therapists are *process-oriented*. Inasmuch as thinking is both content and process, a combination of these two approaches may be helpful when applying them with couples.

For example, a wife concluded that her husband did not love her because he was acting sad and withdrawn following the funeral of a friend. A cognitive therapist

would examine the process of her thinking and might conclude she had made what is called an arbitrary inference—drawing a conclusion without substantiating evidence. A rational-emotive behavior therapist would examine the statement itself along with the irrational belief (s) on which it is based, and help her change the self-statement: "I absolutely must have everyone's love and approval."

Rational-Emotive Behavior Therapy

Albert Ellis's (1962) basic theory consists of the A-B-C-D model (see Figure 14.1). *A* stands for *actions.* An action is an event that can be observed. *B* refers to the person's *belief* or *belief system*. *B* is commonly referred to as the person's self-statement. The self-statement is what the person says (thinks) to self about *A*. The self-statement gives *A* its meaning. At the same time, it also determines *C* in the formula. *C* is the *consequence* of *B* (consequence means: what the person does and how the person feels). *D* is short for *dispute*. Once the person understands *B* is an irrational or nonproductive thought, she or he may dispute the original belief and substitute a rational or productive statement. In sum, the basic theory can be outlined as shown in Figure 14.1.

A therapist can easily explain this theory and the model to clients. It is also useful to give an example, either a general example or one drawn from the client's own experience. One such example involves a husband who comes home angry and begins to displace his anger onto his wife. He might be critical of her and get angry about minor occurrences such as the house not being clean enough, dinner not being ready, or his mail not being in the right place. His wife might respond to his behavior by going to another room and crying. Given her behavior, what must she be thinking about his actions? She might be making self-statements like, "It's all my fault" or "I'm a bad wife" or "He doesn't love me." None of these statements is rational or productive. She needs to change her belief about what happened so she does not feel bad, withdraw from him, and make further assumptions about his actions. She might think, "He had a tough day and is irritable, so it's not me he is angry with, but his situation." A therapist working with this couple might also ask the husband to consider the action and belief that preceded his angry interactions with his wife.

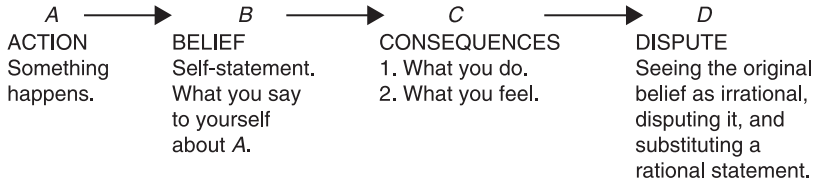


Figure 14.1 A-B-C-D Model

Common Irrational Thoughts

In addition to the basic theory of REBT, it is also useful to know some of the common irrational thoughts and self-statements that creep into people's thinking.

Ellis and Harper (1961a) have catalogued some of these thoughts in their book, *A Guide to Rational Living*. The following is a general list of irrational thoughts, followed by some of the ways in which these thoughts get played out in couple relationships.

Irrational Idea #1: Thinking that it is a dire necessity for one to be loved or approved of by virtually every significant other person for everything she or he does

This thought is common in couple relationships. The partners usually expect acceptance, approval, agreement, and love for virtually everything they do. When this idea is taken to the extreme, every action is equated to love and approval. An action that does not meet the expectation is then seen as rejection and disapproval, which creates an emotionally intense situation. In couples, this irrationality can be succinctly stated as, "My partner must absolutely love and approve of everything I do." Of course, this belief is a prescription for not feeling adequately loved, since it cannot be totally and completely met.

Irrational Idea #2: Thinking that one should be thoroughly competent, adequate, intelligent, and achieving in all possible respects

Failure, says Ellis, is construed as disastrous, and the fear of making a mistake brings unhappiness plus a refusal to take risks. The rational individual strives to *do*, not to *do perfectly*, and accepts himself or herself as a fallible creature that is imperfect because of human limitations. In couples, this idea translates into the "perfect partner syndrome." The perfect partner should be able to do everything that is expected of them. These partners overachieve, push themselves to the limit, rarely ask for help, and pretend to be forever cheerful. One of the most destructive ways in which this particular idea manifests itself is when the partner is not only trying to do all that is expected, but also guesses (mind reads) what is expected and not said. In short, the partner tries to anticipate the needs of the other and imagines needs where none exist. In spite of striving for perfection, this partner always feels that he or she is failing.

Irrational Idea #3: Thinking that certain acts are wrong or wicked or villainous and that people who perform such acts should be severely punished

In couples, this idea gives partners a right to punish each other because it legitimizes the idea that when there is a victim, there is a villain. Thus, if one partner does something the other defines as wrong, the wronged partner has the right, if not the obligation, to punish the other. This situation does not allow for forgiveness and healing—only punishment and revenge. Affairs are a classic example. The person who committed the affair is often seen as wicked, while the other partner is just an innocent bystander. By polarizing the thinking into right versus wrong, there is no way for the betrayed partner to see his or her role in the marital pathology that corresponded with the affair. The partner who had the affair may also believe that they deserve to be severely punished.

Irrational Idea #4: Thinking it is terrible, horrible, and catastrophic when things are not going the way one would like them to go

According to Ellis, frustration is normal and events in life can be unpleasant or unfortunate, but rarely are they catastrophic unless we think they are. The rational person accepts the fact that it is too bad when things are not the way one would like them to be and one should certainly try to change or control conditions so that they become more satisfactory. However, one realizes that if changing or controlling an uncomfortable situation is impossible, it is better to accept its existence and stop telling oneself how awful it is.

All partners have expectations of each other. Under normal conditions, couples recognize that not all expectations will be fulfilled. However, some partners enter relationships with little tolerance for frustration, disappointment, or impulse control. They expect things to be as they desire. They are so narcissistically vulnerable that if something does not turn out their way, they feel personally injured or attacked. This type of partner makes such situations into catastrophes. In one case, a husband expected his wife to keep her personal items on the chest in the bedroom in exactly the way he had shown her. When she failed to follow his instructions, his immediate reaction was to believe the marriage was a mistake and that she did not love him.

Irrational Idea #5: Thinking that unhappiness is externally caused and is forced on one by outside people and events

Partners frequently use this idea to blame their unhappiness on the other person. By placing responsibility for happiness onto another, they do not have to examine their own behavior or beliefs. In couple therapy, the partners may only want to talk about the other person or the relationship and never themselves. The other person becomes an object who acts upon them in a purported cause–effect manner. A person thinking rationally recognizes that virtually all human unhappiness is caused or sustained by our interpretation of things rather than by the things themselves. However, because of irrational self-statements, the unhappy partner is unable to see how his or her interpretation of the event or person creates the feeling.

Irrational Idea #6: Thinking that if something is or may be dangerous or fearsome, one should be terribly occupied with and upset about it

In couples, the idea that one should be upset and preoccupied with fear is enacted in two ways that initially may appear to be opposite. The first way involves the fear of intimacy or getting too close. Many partners may be unaware of this fear initially. For others, they may keenly know it. For example, a partner who has been rejected by two previous husbands may fear rejection again. This partner may set up a situation in which she rejects first or remains so distant that rejection is perceived as making little difference to her.

At the other end of the spectrum is the partner who fears too much distance or divorce. Partners with this concern are in a chronic state of fear over loss and being alone. Co-dependent partners fit this description. They marry troubled or addicted

people and stay with them because of their own fears of being alone and unlovable and because of their extremely low self-esteem.

Irrational Idea #7: Thinking that it is easier to avoid facing many of life's difficulties and self-responsibilities than to deal with them directly

Ellis links this irrational belief to our tendency to seek pleasure now, rather than delay pleasure in order to work for long-range goals which may be more difficult to achieve. The rational individual realizes that a challenging, responsible, problem-solving life is an enjoyable life and that self-discipline is required to face difficult problems.

One of the common myths of marriage is that all will be bliss after the honeymoon. Partners who ascribe to this myth assume marriage is or should be easy. Love, they believe, will be the great panacea. When confronted with the reality that relationships are difficult and require constant attention, effort, and hard work, they sometimes choose escape or distraction through work, substance abuse, affairs or divorce. The understanding that one builds a relationship over time is missing. Couples operating with these myths believe problems must be solved immediately; if they aren't, it means they will never be resolved. In many cases young couples believe conflict is all bad and that all problems must be solved immediately and without angry feelings. To fail in this task represents a failed marriage.

Irrational Idea #8: Thinking that the past is all-important and that because something once strongly affected one's life, it should do so indefinitely

This idea can lead a person to overgeneralize from past events to present situations so that she or he does not look for new options, but rather transfers feelings about others from the past onto people in the present. The rational person learns from past experiences, but is not overly attached to or prejudiced by them.

Couples can use this irrational idea in a variety of ways. One way would be for a partner to focus on one specific event in the history of the relationship and use that event as the basis for the relationship. For example, a wife believed her husband was very controlling sexually on their honeymoon. From that point onward she construed every comment in terms of how controlling her husband was. This line of thinking tends to be based on relationship trauma, such as a major fight, affair, or difference in values, which is never resolved and is played out again and again around different content. Another way in which couples use this idea is to justify their behavior on the basis of childhood experiences. For example, a woman who was abused by her brother claimed she could never trust any man in spite of the fact only one man had mistreated her.

Irrational Idea #9: Thinking that human happiness can be achieved by inertia and inaction or by passively and uncommittedly "enjoying oneself"

Ellis often saw inertia as a defense against an irrational fear such as failure. Rational individuals realize that they are happiest when they are actively absorbed in creative pursuits, or when they are devoting themselves to personal growth or people or projects outside of themselves.

In couples, this idea is similar to Irrational Idea #7. With this belief, partners assume no responsibility for their own happiness, expecting the other to now take on this responsibility. The key to treatment in such a case is to get each partner to identify and work toward taking care of their own needs. In one case a husband assumed his marriage would somehow magically cure a long-standing depression. He had not sought treatment nor taken any responsibility for his mood. He thought the occasional good feelings he felt in being with his wife would "take over his personality" and heal his depression.

Irrational Idea #10: Thinking that one should be quite upset over other people's problems

Ellis says that being involved with others' problems that do not directly affect us is a way to avoid facing our own behavior and problems. Partners cross over the line of normal concern when they become engrossed in the other partner's problems in order to avoid dealing with their own. This pattern is classic in dysfunctional couples. One partner will be defined as the sick one, while the other one is well. What is not obvious is the pathology in the "well" partner. Often, these partners have selected a sick mate who actually unconsciously carries or manifests their underlying problem. For example, a partner who cannot confront depression himself may marry a depressed individual.

Irrational Idea #11: Thinking that there is a right or perfect solution to every problem and it must be found or the results will be catastrophic

There is no perfect solution to every problem, and a desire for perfection only results in not seeing the alternatives. The rational person attempts to find various solutions to a problem and accepts the best answer, recognizing there is no perfect solution.

Some individuals and couples can get hooked on the idea of absolute right and wrong. If there is a right and wrong, then every problem has a right and a wrong answer. Such a couple is not capable of generating alternative solutions or being creative. They think the right answer must be somewhere. It may be in logic, authority, divine wisdom, an expert, or part of family tradition. The only way to avoid this problem is to discard absolute right and wrong thinking, replacing it with likes, preferences, needs, opinions, and so on.

Irrational Idea #12: Thinking that one has virtually no control over one's emotions and that one cannot help feeling certain things

Partners may claim they don't have control over how they feel. When partners make this claim, it is often with the idea that their partner should overlook their feelings because they can't help having them. When partners make assertions like these, they must be challenged with information on how to take control of their emotions and confronted on the process of not accepting personal responsibility. Some partners believe marriage gives them permission to give up emotional control.

Rational partners see that they have enormous control over their emotions if they choose to work at controlling them and choose to practice saying the right kinds of self-statements.

Irrational Beliefs About Love and Approval

Ellis (1987) supplemented the list of irrational thoughts above with an additional list of irrationalities that focuses exclusively on love and approval. The irrational statements in this list are framed in terms of absolute *musts.* Ellis has pointed out how statements that include *must, ought*, and *should* create trouble. Whenever these words or ideas are detected, they need to be immediately challenged. The client can be asked to eliminate these words and insert statements such as "I would prefer" or "I would like." A simple change in wording can create a major change in thinking and lessen the severity of consequences. For example, changing "I must have his approval" to "I would like his approval" brings about a lessening of the behavioral and emotional consequences if approval is not forthcoming.

Ellis and Harper (1961a) laid the foundation for the application of REBT to couples. They proposed that marital problems occur when spouses have unrealistic (irrational) expectations of each other and then make extreme negative self-statements on the basis of these expectations. To illustrate, a husband might think his wife should spend *all* her time with him. When she fails to do so, he thinks that because she does not want to spend her time with him, she does not love him. The clinician's work is to expose the irrational thinking and the negative judgments made on the basis of it and replace the irrational thoughts with more productive thinking.

Cognitive Therapy

Cognitive therapy is an approach to treatment that was first developed by Aaron Beck (1976) and later popularized by David Burns (1980, 1999) in his self-help book entitled *Feeling Good*. In contrast to Ellis's focus on the *content* of thought, Beck and Burns focus on the *process* of thinking. They assert that certain ways of thinking may be *automatic. Automatic thoughts* are moment-to-moment ideas, beliefs, or images an individual manifests which are often elicited by specific events (Dattilio, 2010). These thoughts are often stereotypes or biased ideas and may be either positive or negative, but they tend to be negative when elicited in situations of conflict, disappointment, confrontation, fear, and so forth. An individual will commonly accept these thoughts as reasonable rather than questioning their validity (Dattilio, Epstein, & Baucam, 1998). Over time, a person comes to automatically use a habitual pattern of thinking in assessing a situation. These patterns of automatic thinking are called *cognitive distortions.*

Cognitive Distortions

Cognitive distortions are at the heart of cognitive therapy, and a thorough understanding of the various types of cognitive distortions is critical. Burns (1999) has described these in terms that are easily comprehensible for the layperson. The chapter

in his book that reviews these concepts is recommended bibliotherapy for couples when a cognitive approach is being used. The following list summarizes the cognitive distortions that Burns considers most common.

1 *All-or-nothing, either/or thinking.* The person's thinking is dichotomous and polarized. For example, a wife might ask her husband to sit down and talk with her. When he agrees to talk—but at a later time—she might conclude, "He never wants to talk with me."
2 *Overgeneralization.* A single event may be viewed as establishing a pattern over one's marriage. For example, a husband brought his wife flowers only to be told there was not a vase in which to put them. The husband generalized from this event that he could never do anything nice for his wife because she would always find some problem with it.
3 *Mental filter.* This distortion involves allowing one negative event to color all subsequent events. This distortion means all new experiences are filtered through the original negative experience. For example, after many years of a husband never being turned down sexually, his wife finally became sexually assertive and said "no" on one occasion. Thereafter, the husband believed his wife would never again be interested in him sexually.
4 *Discounting the positive.* A positive change is not accepted as real, and negative behaviors continue to receive attention. For example, a husband started to give his wife compliments after starting therapy. His wife discounted his remarks as an act designed to get her off his back and to placate the therapist, choosing instead to focus on the times he was still critical.
5 *Jumping to conclusions.* This distortion involves drawing inferences without checking out the other person's intent (i.e., mind reading or fortune telling). For example, a separated couple was working on getting back together. Because the primary cause of the separation had been defined as sexual, the wife believed the first time they had sex would be a pass-fail test for her. She had assumed (without asking him) that her husband would be grading her performance and determining the outcome of the marriage based on one sexual encounter.
6 *Magnification (catastrophizing).* An event is given more emotional weight than it should, or the event is evaluated with the worst possible meaning or conclusion. For example, a wife had lunch with a male colleague whom she knew her husband envied. He reacted to the lunch with great jealousy, claiming the other man had it all, including his wife's love and attention, and he had nothing.
7 *Emotional reasoning.* This idea deals with emotionally based logic. The person believes that because he or she feels a certain way, life must really be that way. For example, a divorced man said, "My wife rejected me; my mother rejected me. I feel rejected by women. Women do not really like men, they just use them and reject them." The emotional experience becomes one's reality. If something feels a certain way, it must be that way.
8 *Should statements.* This distortion involves raising a wish, want, or preference to the level of a *should*. In one case, a husband wanted his second wife to have the same close relationship to his children that his first wife had. He insisted that she *should* make this happen.

9 *Labeling* and *mislabeling*. This distortion involves putting a label on another person rather than being descriptive and behavioral. For example, a husband made an insensitive remark to his wife. Rather than saying, "Your remark hurt me and was insensitive," she said, "You are an insensitive person." The label placed on the person usually describes the unacceptable behavior; the label serves to magnify the perceived negative intent.
10 *Personalizing*. Taking responsibility or blame for an event that is outside of one's control. For example, a couple went on their dream vacation. The husband acted depressed and angry throughout. His wife said, "I should have known what to do to cheer him up. I'm sure I did something to make this happen." She took responsibility for his moods, although she had no control over them.

Dattilio (1998a) and Dattilio and Padesky (1990) identified a few additional common cognitive distortions.

1 *Arbitrary inference*. Individuals draw conclusions without substantiating evidence.
2 *Selective abstraction*. Information is taken out of context with certain details emphasized while others are ignored.
3 *Minimization*. Opposite of magnification, something is perceived to have less significance than appropriate.
4 *Tunnel vision*. An individual sees only what he or she wants to see or what fits his or her current state of mind. This often serves to support or justify a particular viewpoint.
5 *Biased explanation*. In times of distress, a polarized type of thinking develops with the automatic thoughts focusing on the partner having a negative ulterior motive.
6 *Mind reading*. One partner "magically" knows what the other partner is thinking.

Schemas

In addition to cognitive distortions, another core construct of cognitive therapy is that of *schemas*. Schemas are understood to be underlying core beliefs that one holds about the characteristics of the world and how it functions. Rather than being fleeting inferences or perceptions, schemas are stable, cognitive structures (both positive and negative) that provide a means of categorizing and evaluating experiences (Dattilio, 2006, 2010; Dattilio & Bevilacqua, 2000). Among other topics, schemas are developed by individuals regarding family membership, marital or couple relationship patterns, roles and responsibilities, and one's place in the family unit (Dattilio, 1993, 2010; Dattilio et al., 1998). Even though schemas are relatively stable, they may become detrimentally unconditional and inflexible.

Many schemas are learned early in life, being influenced by family-of-origin interactions as well as outside sources. Dattilio (2010) also explains that cognitive schemas may be related to levels and understandings of attachments, as well as patterns of emotional regulation and early childhood experiences. They can also be inherited

across generations. Such transgenerational schemas may be increasingly difficult to change as they gather strength and reinforcement over time, especially across generations (Dattilio, 2010). For example, anything learned about gender roles, parent responsibilities, authority, and child rearing can come from generations of traditions that are passed on and may go unnoticed until significant problems develop. This addition to the cognitive therapy literature is congruent with the intergeneration focus of the Intersystem Model.

Schemas that are held by couples not only come from their families of origin but also from their relationship experiences, worldviews, values, culture, gender, and behaviors (Dattilio, 2010). Cognitive theory proposes that partners bring schemas with them into the couple's relationship. An individual's schemas will influence how he or she reacts to new situations.

Although a partner's inferences and perceptions about current events in a relationship may be influenced by previous family-oriented schema, schemas may be modified by current experiences (Epstein & Baucom, 1993). However, if strong emotions are associated with the pre-existing schema, modification may be difficult, especially with schemas that are negative (Dattilio, 2006). Furthermore, individuals may be unaware of the schemas that they hold and how these influence their perceptions, emotions, and interactions (Dattilio, 2010). Dattilio (2010) stresses that evaluation of clients' schemas needs to occur during the initial phase of treatment, as they may be central to issues the individual and couple face.

A typology of relationship-related cognitions based largely on schemas and automatic thoughts was defined by Baucom and Epstein (1990; Baucom, Epstein, Sayers, & Sher, 1989; Baucom, Epstein, LaTaillade, & Kirby, 2008) and such cognitions have been implicated in relationship distress and conflict.

1 *Standards*: Family members' beliefs about how relationships (in particular their own relationship) "should" be. Standards are typically used to evaluate whether or not each member's behavior is appropriate or acceptable (Dattilio, 2010).
2 *Selective attention*: Each member of a relationship tends to notice only some aspects of events in the relationship while ignoring others.
3 *Assumptions*: Beliefs about the characteristics and workings of relationships. When events or others' actions are in opposition to these strongly held viewpoints, it can create distress (Dattilio, 2010). For example, a man who grew up with a father who provided for the family and a mother who stayed at home may have difficulty dating a woman who wants to work outside the home and have the father stay with the children.
4 *Expectancies*: Predictions about the probability of future events actually happening.
5 *Attributions*: Inferences individuals make about what caused events in their relationship. They may be intertwined with expectancies (Dattilio, 2010). Inference errors can have especially harmful effects when one person attributes another's actions to negative characteristics or misjudges how others will react to their own actions (Dattilio, 2010).

These types of cognitions can contribute to dissatisfaction in family relationships resulting in dysfunctional family interactions (Dattilio et al., 1998).

Cognitive therapy with couples may focus on core schemas associated with problematic relationship dynamics (Dattilio, 2010). Therapists may encourage clients to conduct an introspective examination of personal schemas in relation to intimate attachments and experiences within their family of origin, as these may affect how and why they currently attach to those around them (Dattilio, 2010).

Cognitive Therapy and Systems Thinking

Cognitive approaches have traditionally focused on the treatment of individual clients. With the exception of Epstein (1982, 1986), none of the cognitive theorists in the early days of cognitive therapy comprehended the need to integrate their approach with systems thinking. Beck's (1988) book, *Love Is Never Enough*, is a classic example of how an individualistic approach to treatment is applied to a relationship system without a systemic perspective. However, treating couples requires more than doing cognitive therapy with two individuals in a room who happen to be married or in a committed relationship. A couple must always be understood as an interactional system. The cognitions within that system need to be conceptualized as part of an interactional, not just an individual, system.

Couples in committed relationships experience ups and downs and work through problems in conjunction with their individual and shared cognitions. Within a systemic framework, family relationships, cognitions, emotions, and behavior are believed to have a mutual influence on each other. For example, a partner's cognitive inference can evoke emotion and behavior, and this can likewise influence the cognitions, emotions, and behaviors of the other (Dattilio, 2001). A systemic perspective on cognitive therapy recognizes the circular nature of relationships, and understanding how couples and family members mutually influence each other's cognitions and behaviors is paramount in facilitating change (Dattilio, 1998a, 1998b).

It is our belief that there are two basic ways in which cognitions can be conceptualized systemically. First, the couple may share many of the same irrational or unworkable ideas and cognitive distortions. These ideas may serve both to bind them together and to create dysfunction. For example, the couple may believe conflict should be avoided at all costs. The belief serves to protect each of them from having to deal with anger and conflict. This idea binds the couple together, but it also creates a pathological condition in the relationship.

The second way in which cognitions can be understood systemically is in terms of their interlocking and complementary nature. The beliefs held by one may be complemented by the beliefs of the other. For example, one partner may think, "I must have my way," and the other may think, "I must be the perfect partner and let him or her do what she or he wants." Or a partner might think, "My partner is responsible for my moods," and the other partner may think, "I am responsible for my partner's happiness."

Symmetrical or complementary cognitions must be processed within the context of the relationship as part of the interactional field. The impact of such cognitions can be discussed in session. If one partner thinks about something in the relationship in a certain way, how does this influence the way in which partners interact with each other? If one spouse changes a cognition, what will the impact be on the other? How

will the relationship be different? How might the other need to change his or her thinking or behavior? These questions require careful consideration in order to shift the focus from individual therapy to systems or couple therapy.

Techniques and Interventions

Education

Teaching couples the basic principles of REBT and cognitive therapy is a significant part of a cognitive approach. Therapists should review the fundamentals of cognitive theory with the couple and answer questions they might have. It is essential that the partners understand the relationship between their cognitions *and* their feelings and actions. An important part of using a cognitive approach is helping clients understand that changing their thinking will help facilitate changes in their emotions, their behaviors, and their relationship. Bibliotherapy can also be used to facilitate this learning process. The clinician may use handouts or recommend books written for the public such as *Feeling Good* by David Burns (1999).

Learning to Self-Monitor

Cognitive approaches have a purpose of helping couples learn to identify their own individual and relational cognitive distortions and irrational thoughts. This process starts with education and is worked on in the office with the therapist's help. Couples are then instructed on how to continue the work at home. Homework is an essential part of cognitive therapy, as it helps the couple expand on what they learn in the therapy session and utilize it in real-life settings (Dattilio, 2005; see Chapter 17 in this volume for an expanded discussion of homework). Eventually, couples should learn to identify when they are using distortions and irrational thoughts. They also learn how to challenge and disrupt irrational thoughts and distorted thinking patterns and learn how to replace negative or unproductive thinking with positive and constructive thoughts (see below). Interventions designed to enhance couples' abilities to evaluate and modify their own problematic cognitions can help couples develop skills for constructive communication and solving problems (Dattilio & Epstein, 2005).

Identifying and Challenging Cognitive Distortions, Irrational Thoughts, and Problematic Schemas

Identifying cognitive distortions, irrational thoughts, and unhelpful schemas is central to a cognitive approach with couples. The intention behind examining couples' cognitions is not just to change the negativity behind them, but to focus on how the incoming information is being understood in such a distorted way (Baucom et al., 2008). Therefore, therapy focuses on assisting couples to view the cognitions about their relationship and the behaviors that happen or do not happen in a more rational and balanced fashion (Baucom et al., 2008). Cognitive techniques not only help partners identify common thinking patterns but also help them understand the relational connection and influence of their thought processes.

Therapists may use Socratic questioning, a hallmark of cognitive therapy (Beck, 1976; Beck, Rush, Shaw, & Emery, 1979), to acquire information on the unique cognitive processes of clients that cannot be obtained through standardized questionnaires (Dattilio, 2010; Baucom et al., 2008). One application of Socratic questioning is called the "downward arrow" technique (Beck et al., 1979; Dattilio, 2010). This technique helps identify the underlying core beliefs or schemas (e.g., relationship standards and assumptions) beneath clients' automatic thoughts, thereby helping them become aware of how related chains of thought can lead into erroneous conclusions that reinforce long-standing assumptions (Dattilio & Epstein, 2003; Baucom et al., 2008). This technique requires asking a series of questions that lead to the core negative thoughts and catastrophic beliefs. After a client articulates a thought that the therapist recognizes as a distortion, the therapist asks the client a series of questions such as "If so, then what?" in order to get to the underlying belief (Dattilio, 2010).

An example is shown in Figure 14.2, where a wife who does whatever her husband desires and overlooks his mistreatment of her to the point of sacrificing her own welfare might think something like, "I must do whatever is necessary to make my husband happy." The therapist might ask a question such as, "What would happen if you don't do what he wants?"

The "downward arrow" technique is beneficial in helping couples eventually reach the foundational negative belief or assumption and to assist them in evaluating how likely their worst fear is to happen (Dattilio & Epstein, 2003). This technique can be used to help clients challenge their assumptions and restructure their beliefs and cognitive patterns (Dattilio, 2010).

Another intervention designed to help clients learn to identify automatic thoughts is the Dysfunctional Thought Record (Dattilio et al., 1998; Dattilio & Padesky, 1990), which is a version of the Daily Record of Dysfunctional Thoughts developed by Beck et al. (1979). Partners may be instructed to individually record their

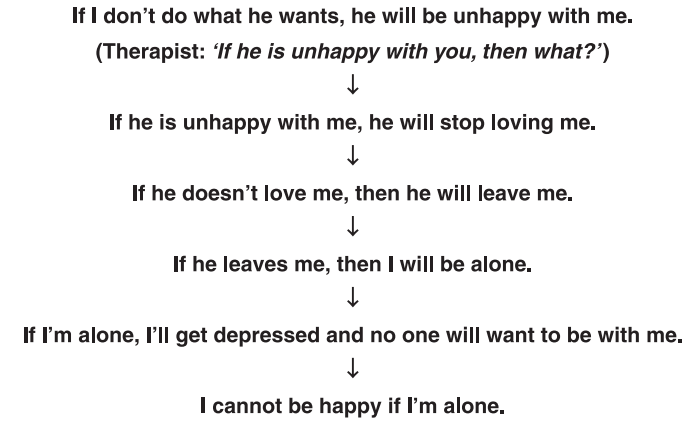


Figure 14.2 The "Downward Arrow" Technique
Source: Beck et al., 1979; Dattilio, 2010.

Table 14.1 Individual Record of Automatic Thoughts

Situation/ Event	*Automatic Thoughts*	*Feelings/ Emotions*	*Cognitive Distortions*	*Alternative Response*

automatic thoughts about negative or confrontational events in their relationship (see Table 14.1). This record would include a description of the situation, the automatic thought(s) that occurred, the accompanying emotion, and the cognitive distortion(s) the client engaged in. The therapist would use this information to demonstrate how thoughts are linked to emotional responses resulting in the negative framing of others. Additionally, clients are asked to identify possible alternative (rational or non-distorted) responses to the event. Once the couple understands the link between thoughts and emotional and behavioral responses, progress can be made to counteract the common tendency of disowning any responsibility of being able to influence their own feelings (Dattilio et al., 1998).

It works best to first teach couples this process in session by walking through it with them. Schuyler (2003) suggests that it may be helpful for the client to have it written out on paper or a board during session so they can visually see the direct relations between the events, their thoughts, and emotional responses. A partner is asked to identify a negative event, the automatic thought they had, and the corresponding emotions. As the process unfolds, the therapist carefully monitors the couple to detect their distortions and negative statements. When a distortion is identified, it is reflected back to the couple so they may begin to examine and process it. The therapist then asks them to identify the cognitive distortion(s) that fits with the automatic thoughts. Finally, they can brainstorm possible alternative cognitive responses. The couple is then instructed to keep a record of events during the week. This information is then brought in for discussion in the next therapy session.

Dealing with each partner's individual thoughts is central to working with couples in therapy (Dattilio, 2006). However, it is also essential to help partners understand how their respective thinking is connected to their relationship problems. A technique to help couples focus on the relational impact of their cognitions is to ask them to consider how their automatic thoughts or distortions affect the way in which they view and interact with their partner. Therapists may also have couples reflect on their cognitions in relation to the principles presented in the section on systems thinking. Specifically, in what ways do their thoughts affect how they interact with their partner? Does the other partner share the same or similar cognition or distortion (i.e., symmetrical) or do they have one that is complementary? In other words, when a distortion or irrational thought is found for one partner, the therapist should work on developing a complete picture of the interconnected pattern (see Figure 14.3). One

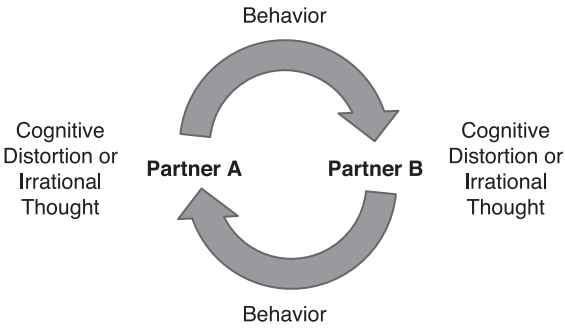


Figure 14.3 Circular Pattern of Cognitive Distortions

partner's thoughts lead to certain behaviors. In response, these behaviors are associated with cognitions and related behaviors in the other partner.

Identifying the negative cognitions associated with specific problems in the relationship will provide additional understanding of the couple's struggle to improve their relationship. Once the unhelpful cognitions have been made explicit, both partners may then be asked to work on changing their thinking. The cognitions are either neutralized or changed in a positive direction by utilizing the techniques described above.

For example, if the problem is constant fighting, the underlying thought might be that the only way to preserve one's sense of self is to stay distant, with anger being used to create the needed distance. Or a wife might complain that her husband doesn't tell her he loves her enough. The fact is that he rarely says anything. Her complaint is legitimate, but the problem is also escalated by her. She begins to think he does not love her and is rejecting her by not saying something she has told him she would like. Her behaviors arising from this distortion (alternating between criticism and demanding his attention) are met with further distancing by her husband.

In this instance, it is important to change her cognition and, in turn, the behavior within the system. If she changes her thinking, then she might be nicer to him, treating him in a way that invites his engagement. He also needs to change his behavior by expressing more love and affection to her. His part of the problem could be a fear that telling his wife he loves her means he will be engulfed by her. His irrational thought might stem from a family of origin in which his mother was constantly manipulating the male partner for his approval and love. Once the husband can change his cognition, his attitude toward his wife will change and he will be freer to express his feelings.

After clearing up the irrational ideas and cognitive distortions, it may be useful to obtain the couple's thoughts and beliefs about the relationship in general. The following questions can be asked to clarify their thinking.

1 What did you expect of marriage before you got married?
2 What did you expect of marriage just after you were married?
3 What do you expect of marriage now?

In addition, the couple may be asked to complete the following statements about gender role expectations:

"A good husband ___."
"A good wife ___."

Couples may be asked to write out responses to the questions between sessions, and their answers are then processed in the next session. The couple would be asked to consider whether their thinking is realistic, productive, and workable. The clinician should not frame any of these thoughts as true or false or right or wrong. They can be framed as preferences, likes, or beliefs. This examination will help the partners to identify their distortions, enabling them to consider necessary changes in their way of thinking and how these changes might positively impact the relationship. Additionally, Baucom et al. (2008) suggest the following steps when addressing relationship standards: clarify existing standards, discuss advantages and disadvantages, help revise standards into new acceptable ones, problem-solve how new standards will be taken into account behaviorally, and if standards still differ, discuss with partners how they can work on accepting those differences.

Couples should be reminded that old thoughts are deeply ingrained and relatively automatic. It is important to point out how the new thoughts will counter the old thoughts, but only with continued practice. Slips and regressions are to be expected. However, by identifying the commonly occurring distortions and irrational thoughts, the clients become more aware of when this type of thinking starts. Initially, it is useful to have clients do a daily review of what was discussed in the session in order to be more alert to the presence of problematic thinking.

Other Techniques

An individual's cognitions about an intimate relationship are often projections of his or her own conflicts, which need to be addressed in therapy sessions to help restructure any negative cognitive distortions. The therapist may utilize Socratic questioning and related procedures for this purpose. In relation to potentially biased attributions and expectancies, Socratic questioning can also be utilized to aid clients in ascertaining alternative determinants for their partner's behaviors or other possible unanticipated outcomes to particular situations (Dattilio et al., 1998).

There are several additional techniques which therapists can teach partners. Burns (1999) identified ten techniques in his book, two of which are particularly applicable to couples. The first is what he calls the *alternative interpretation method*. An event can be interpreted in a number of ways. Negative interpretations are harmful to the relationship, while positive interpretations are helpful. Couples need to master the art of positively reframing each other's behaviors. The reframe should be believable and consistent with the facts.

For example, a couple may share the belief that intimacy requires sharing all their time together. When one violates this assumption, a negative judgment is made. A positive frame would be that separateness and individuality are as much a part of intimacy as togetherness. Traits, characteristics, and attributes may all be given a positive

frame with a little effort. The therapist should model positive reframing and then encourage the partners to look for new ways of thinking about each other. The more they stress the positive, the more they feel better about their partner and the relationship.

In addition to identifying alternative interpretations of events, a second helpful technique is to *examine the evidence* for a particular thought. Do the facts point in only one direction? Are the facts even known? Assumptions by their nature are often not checked out or verified. The interpretation of an event may be made by one partner without the other's input. Partners must learn to identify when they are making assumptions and then to keep an open mind until these assumptions are confirmed or disconfirmed. Assumptions may be so entrenched that the partner is only able to hear the voice in his or her head and not the input from the other person. When conversations become monologues, such that each keeps saying the same thing over and over, it is time for the partners to recognize that they are each captives of their own thinking. They need to turn attention outward in order to find out what the other person said.

Another technique is that of *guided discovery*, in which the therapist helps partners question their thinking and create a new view of their partner or the relationship (Baucom et al., 2008). This is done by drawing on the aforementioned techniques for the purpose of assisting the couple to experience the relationship in a different way without necessarily changing the behaviors. Therapists may begin with Socratic questioning to invite couples to consider their interpretation of their partner's actions and identify alternative interpretations. Beck (1988) proposed the following questions.

- What is the evidence in favor of my interpretation?
- What evidence is there contrary to my interpretation?
- Does it *logically follow* from my partner's actions that my partner has the motive that I assign to him or her?
- Is there an alternative explanation for his or her behavior?

Clients may also be directed to ask their partner for an explanation of their behavior. Based on the answers to the therapist's questions and the information from the partner, partners are then invited to consider new perspectives on each other and the relationship.

Conclusion

Couple therapy requires attending to the behavior, affect, and cognitions of couples in treatment. In the literature, emphasis on the cognitive aspect of the couple relationship has been lacking. This chapter stressed the clinical usefulness of learning more about each partner's way of thinking and actual thoughts regarding the relationship. The essential point to remember from this chapter is that thoughts must be considered from a systemic frame of reference. The question is how the partners' thoughts form an interlocking system that leads to or maintains problems in the relationship. Taken separately out of their relational context, the thoughts may seem acceptable. Considered together, the couple may be engaging in thoughts that put them at odds

with each other or place barriers to sharing greater intimacy. Just as with other issues, processing and changing the thoughts require that the therapist maintain a balance between partners. It is not a matter of a thought being right or wrong, but, rather, a question of whether the thinking is productive for their relationship.

This chapter provides a succinct overview of cognitive therapy and focuses on systemic application to couples. The reader who is interested in an in-depth perspective on cognitive–behavioral therapy should consult *Cognitive–Behavioral Therapy with Couples and Families* (2010) by Frank M. Dattilio.

15

TECHNIQUES OF RELATIONSHIP CONTRACTING

In addition to utilizing cognitive interventions with couples, therapists will want to help couples focus specifically on making behavioral changes in their relationship. In clinical practice, cognitive and behavioral interventions are often paired together when working with couples (Baucom et al., 2008; Dattilio, 2010). Behavioral therapy, by definition, focuses specifically on the couple's behaviors. Jacobsen and Margolin (1979) produced perhaps the most comprehensive text on behavioral couple therapy (BCT). BCT is grounded in Thibaut and Kelley's (1959) social exchange theory. This theory asserts that satisfaction in a relationship is connected to the ratio of benefits and costs partners experience in the relationship (Nichols, 2010). The higher the ratio, the more satisfied partners will be. One of the primary purposes of BCT is to increase the ratio of positive interactions to negative interactions. Behavioral couple therapy has been evaluated in many controlled outcome studies with results that have generally supported its effectiveness (Gordon and Christman, 2008; Jacobson, Follette, & Pagel, 1986).

There are many different techniques involved in BCT. The two most common forms of behavioral intervention with couples are communication techniques (addressed in Chapter 12) and contracting. The purpose of this chapter is to discuss several techniques of relationship contracting. A contract makes explicit those behaviors that are wanted in a relationship. The contract is usually written and identifies the agreed-upon behaviors of each partner in specific, concrete, and behavioral terms.

The use of contracts can be traced to the development of behavior therapy. According to L'Abate and McHenry (1983), five factors contributed to the development of contracting. First, as behavior therapy increased in use, behaviorists began to consider ways to use this approach with couples. The result was the development of behavioral marital therapy with the emergence of several contractual approaches. Second, some therapists were becoming disillusioned with intrapsychic approaches. These approaches were not active and directive enough to deal with couple difficulties. Third, as any field develops, it must produce reliable methods and demonstrate effectiveness. Contracting was a technique that could be scientifically replicated among clinicians. Fourth, the field of marital therapy needed to demonstrate that it produced the results claimed. Because contracting is replicable, it can be empirically evaluated for outcome. Finally, many couples coming for treatment were neither interested in nor suitable for approaches that were cognitively or affectively oriented. These couples were primarily interested in changing the behaviors within the

relationship. The reader interested in a comprehensive overview of behavioral couple therapy should consult Jacobsen and Margolin (1979).

The basic theory of relationship contracts is that behavioral change leads to affective and cognitive change in the couple. An underlying assumption of this idea is that behavior, emotions, and thoughts are interconnected. The primary purpose of a marital contract is to increase the number of positive exchanges in the relationship, thus positively impacting partners' emotional and cognitive experience. By increasing positive exchanges, the therapist is simultaneously decreasing punishing or coercive exchanges.

Couples who seek therapy often find themselves stuck in negative cycles of behavior, with each partner contributing to the destructive pattern and blaming the other for the problems (see Chapter 4 on systemic conceptualization of problems). Couples who are trapped in these negative cycles try to get what they want but become frustrated when their needs are not met. Partners' mutual attempts to get their needs met often have the opposite of their intended effect, with each person doing more of what the other does not want, or retaliating when their needs are frustrated. Such a situation can create a power struggle in the relationship. Each partner attempts to "win" as a substitute for having his or her needs met.

Contracting is an ideal solution for obviating power struggles and creating a positive pattern of exchanges. Contracting shifts partners' attention away from blaming or finding who is at fault and invites them to put energy into creating solutions for a better relationship. Because both partners contribute equally to the contract, they are creating a system of perceived equity and fairness. The contract or system they create diffuses the power struggle. With the power struggle being diffused, it is easier to begin making the positive changes specified in the contract.

The use of a contracting approach is more likely to work under certain conditions. First, both partners should be fully engaged in the therapeutic process. A contract cannot be developed by just one spouse. Both must be present and be working toward the same basic goal—to create a mutually satisfying relationship where both partners' needs are being met. Second, the partners must be relatively compliant, co-operative, and caring. If the couple is too angry, focused on externalizing or blaming each other, or locked in a power struggle or impasse, this approach is not indicated. Third, each spouse must be willing to change his or her own behavior. They must both agree to try something different. Compromise is an important concept for the couple to comprehend. Each must know that by giving up something they value, they will gain other benefits individually and as a couple.

Finally, the couple must be motivated to take control of their own relationship. A contract does not involve being told what to do, nor is it as mystical as just talking with a therapist who has charisma or gives them a pep-talk that inspires them to change. The contract represents the *couple's* effort to take control of their own marriage in a way that appeals to common sense and increases their sense of empowerment. Unconscious forces or possible underlying issues are not worked on directly. The personal commitment to change must be strong, and the therapist needs to reinforce each partner's individual commitment and effort to change.

Research confirms that the likelihood of compliance with behaviors increases when clients are active in the process with their opinions and these opinions are made public

(such as in a written contract) (Cialdini, 1984, as cited in Otto, Reilly-Harrington, Kogan, & Winett, 2003). Minimization of the role of the therapist to help complete the contract is important as well as increasing the clients' motivation for its success (Otto et al., 2003).

The effectiveness of the strategies outlined in the contract is not to be underestimated during times of distress in the relationship, as they produce adaptive behavior when it is most needed (Otto et al., 2003). It can also be helpful to identify the consequences of disregarding the contract, not as a scare tactic, but as inspiration for success. At times contingency contracts are developed for clients who are addicted to drugs and/or alcohol where the consequences are specified as to what will happen if the person decides to return to using. The purpose of identifying consequences is to enhance the motivation to resist the temptation to use and avoid the negative consequences (Otto et al., 2003). This approach may be paralleled with marital contracts to include a reminder that the couple is better off complying with the terms established in the contract as opposed to reverting back to their old, maladaptive behaviors.

General Principles of Contracting

Execute a Written Document

The term contract refers to a written agreement. A relationship contract should also be placed in writing. Several reasons may be given clients in order to explain the need for a written contract. First, all important events in life are documented in writing. Birth certificates, death certificates, academic records, diplomas, all mark progress or events. The written word is permanent and has greater psychological import than the spoken word alone. It could be argued that the written word is more binding than the spoken word. Second, because the written word is permanent it is not easy to "forget" the agreement. Verbal statements may be ignored, repressed, confused, distorted, or otherwise minimized or sidetracked. A written record may be read and re-read with the same meaning if it is clearly written. (Although written words can also have their meanings distorted until a mutually agreed upon interpretation of them is reached.)

Third, the fact that the message is permanent also allows the couple to use it as a constant reminder of their commitment. The contract may be displayed in some visible location or read daily as a reminder to help change the old habitual routine. It can be a landmark for couples to keep their eyes on, particularly during challenging times, as a lighthouse can be a beacon for a ship that is in the dark or caught in a stormy sea. Couples are usually asked to read the contract daily for the first few weeks until it is committed to memory. Fourth, the contract should be carefully worded. Statements should be short, concise, and behavioral. The answer to the question of "who does what, when, and how" should be clear for each behavioral exchange. Finally, the contract should be presented as an evolving document. The couple may renegotiate or modify items over time. The key point is that the couple has a clear, practical agreement to provide them with direction, rather than constantly working toward something that is never clear and explicit.

Be Equitable and Realistic

The behaviors to be exchanged must be perceived as being fair and equitable. A contract that is perceived as being one-sided will only serve to generate more resentment and anger. The contract is designed to create equity and justice in the relationship. In order to create this sense of equity, both partners must be willing to make a contribution. These contributions may sometimes be felt as sacrifices for the greater good of the relationship. In its simplest form, the contract represents each partner's needs for giving and getting. What one partner wants to receive should be what the other ideally wants to give or, realistically, what the other is willing to give for the sake of reciprocity and marital satisfaction.

The behaviors to be exchanged must be under conscious control. One should not ask for that which the other cannot or is unable to give. For example, in one case a husband demanded his wife have sex with him to meet his requirements of equity and justice in the marriage. He agreed to give her friendship, which is what she wanted and he, in turn, expected her to give him sex. However, his wife was experiencing very low sexual desire, and her ability to simply give him sex was thus impossible. He had to be educated regarding her present limitations in order for therapy to proceed on the basis of an exchange other than the one that he originally wanted.

Be Positive and Accepting

Specific behavioral commitments should be framed in positive language. The contract should avoid the use of punishment. Punishment involves withholding, taking away, and coercive acts. In order to formulate a positive emotional environment in the relationship, the contract needs to be worded as positively as possible, for example, "I want to give you ___ ," "I will do ___ for you," and "I agree to ___ ."

Along with being positive is the important principle of acceptance (Jacobson et al., 2000). Research that identified the limitations with BCT prompted Jacobson and Christensen (1996) to revise the approach by adding the principle of acceptance, what they deemed to be "the missing link in traditional behavior therapy" (p. 11). Acceptance is not intended to promote resignation to the relationship as it currently is; rather it can help utilize problems as vehicles to build and enhance closeness or intimacy during difficult times of change for the couple (Jacobson et al., 2000). Acceptance also serves to help couples "'let go' of the struggle to change each other" and the notion that differences between partners are intolerable (Jacobsen & Christensen, 1996, p. 13). Jacobson et al. (2000) propose that the contextual change that follows successful acceptance work may create an environment which supports spontaneous relationship changes.

Be Inclusive

Many contracts we have seen specify only one exchange behavior between partners. These contracts fail to address the complexity of a relationship. A couple may focus on one particular problem area, but this may not be the only change they desire.

Additionally, if they fail at their one-item contract, their contract fails. While it is much easier to develop a one-item contract, it is not advisable.

Developing a thorough and meaningful contract will require several sessions. The couple should be told the contract is not complete until they have all the items they believe to be important. By being inclusive rather than narrowly focused, more aspects of the couple's relationship come under scrutiny and more substantive change can occur after implementation. This approach is consistent with the concept of first-order versus second-order change. In second-order change, the relationship itself changes, not just superficial elements of the relationship.

Discuss Problems with Implementation

After the contract has been developed and the couple is ready to implement it, the therapist should take time to discuss things that might prevent them from successfully executing the contract. The couple is asked to re-read the contract in the session and to discuss potential obstacles or ways they might fail to live up to their part. The partners are asked to speak only for themselves. The therapist may also add ideas that have emerged during previous discussions. The most common idea is that of the other partner not living up to his or her side, which is viewed as making the contract null and void. One couple we worked with expressed frustration after limited success with their contract. Both partners essentially told the therapist, "I'm not going to change if she (or he) is not going to change first." The therapist responded, "If you both sit around waiting for the other to change first, there is going to be a lot of sitting and not much changing." Each partner needs to make a personal commitment to contribute 100 percent, irrespective of what the other partner does. The failure of a partner to fulfill his or her part will be addressed in the session following his or her failure to live up to the commitment.

Monitor Progress

An important ingredient of contracting that is often underemphasized is that of monitoring progress. Monitoring one's efforts to implement the contract can help couples bring about the changes they desire in their relationship. However, one interesting phenomenon that sometimes occurs with couples is that they begin to change, but do not "see" or recognize the change. In short, a lag may exist between the behavioral change and the perception of change. This phenomenon is consistent with evidence that suggests people are often more theory-driven than data-driven when monitoring events; that is, spouses may have a theory about how and why each one behaves. New data are often made to fit the theory or are discarded if they are not consistent with the theory. In one case a wife described her husband as incapable of having feelings. When he started to discuss his feelings in the couple's sessions, she dismissed his effort as an act designed to impress the therapist. Other times partners will minimize the efforts of the other because they don't believe the changes will be long lasting, but are just short-lived or insincere efforts to appease them.

For systematic self-monitoring to occur, each spouse must do a daily review of his or her effort and progress. The question the partners should ask themselves is, "How

am I doing?" To answer this question, the items on the contract are used as behavioral criteria. Each item is reviewed in order to assess whether it was fulfilled, the frequency with which it was done, and the satisfaction derived from fulfilling the item. This assessment leads to the development of an ongoing log, which is brought to the session where the therapist can monitor and reinforce the progress with the couple.

In the previous paragraph, a non behavioral assessment or subjective assessment was recommended, namely, the satisfaction derived from fulfilling the item. The contract is seen as providing equity in the relationship and helping the relationship become more satisfying for both partners. As partners put forth effort to respond to the desires of each other, they should find the relationship more rewarding. However, these rewards are not the only compensations available. Partners should be asked to reinforce each other when agreements are fulfilled. When partners notice one of the agreements being enacted, they need to express their appreciation. Partners may feel good about their efforts when they are acknowledged and appreciated by the other. The act of expressing appreciation may be discussed in the session. Once it is clear the couple are in agreement about this principle, they can discuss different ways and phrases they use to express appreciation. Discussing the phrasing is important because partners sometimes feel their spouse is being patronizing. The statements of appreciation create a positive reinforcement loop in the couple, further reinforcing the utility of the contract.

General Guidelines

In successful contract making there are some important things to consider. Stewart (2006) explains that most contracts are stated in terms of outcomes, or changes in behavior that are wanted, rather than in terms of actions, or behaviors that will meet the outcomes. He further states that contracts may be outcome or action focused. However, if a contract is outcome focused it must be backed up with an action contract because stating a desired outcome will not facilitate change without a behavior identified to reach that outcome (Stewart, 2006).

Sills (2006, p. 18) outlines some helpful questions that can be asked while creating and implementing contracts.

1 What do you want that would enhance your life?
2 How would you need to change to get what you want?
3 What would you be willing to do to effect this change?
4 How would other people know when this change has been made?
5 How might you sabotage yourself?
6 How will you prevent this sabotage?
7 How will you reward yourself on completion and how will you make sure that you maintain the level of stimulus and attention that you were accustomed to getting from old behavior?
8 How will you spend your time when you have changed?

Stewart (2006, p. 64) also offers some valuable questions to ask when creating a contract.

1 *Is the contract feasible?* It is important that the contract be realistic and achievable (Erford, Eaves, Bryant, & Young, 2010; Stewart, 2006) Each partner must be able and willing to perform their part of the contract (Weeks & Treat, 2001).
2 *Is it safe?* Safety refers to both physical and legal safety of the clients and therapist. This may also include the social acceptance of the goals of the contract. For example, it is not socially acceptable in all cultures for women to be assertive in relationships or the workplace. This may in fact put the woman in a dangerous place. Stewart (2006) further points out that people maintain homeostatic states through habitual behavior and defense mechanisms. Taking away these defense mechanisms may alter the system in such a way as to leave a person vulnerable or in danger.
3 *Is it stated in positive words?* Typically clients will use negative language to state their goals. For example, clients may say "We want to stop fighting." This negative language needs to be turned into positive statements. This can be accomplished through asking what they want to do instead of what they do not want to do. Thus instead of saying "we want to stop fighting" the clients can say "we want to be kinder to each other" (Stewart, 2006).
4 *Is it sensory-based?* Rather than using the idea of the contract being clear, measurable, and observable, Stewart (2006) recommends that contracts be stated in such a way that progress can be noted by one of the five senses: seeing, hearing, touching, feeling, or smelling. Stewart (2006, p. 67) identifies three reasons for a contract to be sensory-based. First, sensory-based contracts allow the client and therapist to mutually and explicitly agree on goals. Second, they allow the client and therapist to unambiguously know when their work together is complete. Finally, sensory-based contracts act as a "sensory-rich visualization" of the completed goal or contract.
5 *Is it finishable?* The contract should be designed in a way that it can be completed. For example, a couple can say "we will be nicer to each other" but this cannot be finished. Rather the contract should say "we will say ten nice things to each other." In addition, Erford et al. (2010) point out that the goal should allow for successive approximations. Partners do not have to reach completion all at once. This allows clients to feel success with improvement and gain confidence to work further on their goals.
6 *Is it placed in a clear context?* Stewart (2006, pp. 70–72) offers some valuable questions to consider when developing a contract that fall under three broad categories: where, when, and under what conditions will the contract be completed?

   (a) Where will the contract be completed?
   (b) Will it be done at home? In public? Everywhere? Etc.?
   (c) When will the contract be completed?
   (d) Is there a particular date it will be completed by?
   (e) How many weeks, months, years, will the contract be in effect for?
   (f) How many times will the behavior be done?
   (g) Who is involved in carrying out the contract? One partner? Both partners?
   (h) Is it a *quid pro quo* contract? Does someone have to do something first?

Houmanfar, Maglieri, Roman, & Ward (2008, pp. 55–56) have also offered guidelines to aid in the implementation of contracts.

1 First, the contract must clearly specify the goals to be met. These goals must be languaged at a level the couples can understand or the contract will certainly fail.
2 Second, short-term and long-term goals should be specified. Goals should start simple to give the clients confidence in obtaining their goals and meeting their contracts. When a small goal is reached a bigger goal can be implemented.
3 Third, the contract should identify specific target behaviors that are to be changed. The more specific the easier it will be to follow the contract. These target behaviors may include undesired behaviors that need to be decreased or desired behaviors that need to be increased (Erford et al., 2010).
4 A monitoring system should be put in place to track progress in completing goals. In order to monitor behavior the target behaviors identified must be quantifiable. Monitoring may be done by the couple, therapist, or some other specified person.
5 Fifth, rewards and consequences should be identified for compliance and noncompliance with contractual agreements.
6 Finally, the contract should be agreed upon and be signed by both partners.

Techniques of Contracting

Five basic approaches to contracting may be found in the couple therapy literature. The first two discussed below are derived from behavioral couple therapy; the third from a combination of therapeutic approaches; and the fourth is embedded within an integrative cognitive–behavioral approach to couple therapy. We also present a fifth type of contract that uniquely focuses on the development and implementation of in-session contracts, which can be adapted to couple therapy.

Quid Pro Quo Contracts

This type of contract is one in which the behavioral exchanges are cross-linked (O'Leary & Turkewitz, 1978). *Quid pro quo* literally means "something for something." Based on the idea of reciprocity (Dattilio, 2010), a *quid pro quo* contract allows one partner to request that the other partner behave in certain ways with the understanding that the other partner will also require certain behaviors from them. Each partner's behavior is contingent upon the other partner's behavior. A failure to carry out part of the contract voids the agreement. In contingency contracting a token system may also be put in place to ensure there is balance in positive interactions (Schroeder, 1991). In order for this agreement to work, the behavior offered must be reinforcing to the other spouse. For example, George wants Mary to stop working at 3:00 p.m. on the dot and then together they will go to do something they both find enjoyable. Mary wants George to help her for 2 hours or to do 2 hours of chores each day of the weekend. They agree that if George does 2 hours of work, Mary will stop at 3:00 p.m. and they will do something enjoyable.

There are several significant problems that may arise with *quid pro quo* contracts. First, there is the question of who goes first. If this is not clear, some couples will remain stuck, with each partner waiting for the other to begin. This issue should be settled in the session. It is also important to define a behavioral cycle, that is, when the behaviors are expected to occur and the period of time in which the two behaviors are linked. Within that cycle one partner may have the first turn. It may be that partners can alternate turns or that no one needs to be specified as going first. If one person does not meet the terms of the agreement, the other is under no obligation within the specified behavioral cycle.

When such a failure occurs, the couple should not respond to the event with anger, but with disappointment. One partner may note his or her disappointment. In contracting, if anger occurs the partners are advised to acknowledge it, but then to ignore it until the next session. Otherwise, the couple will likely get trapped once again in their cycle of blaming and counter-blaming. In the session the anger may be explored as a block to prevent change, as a hidden agenda, and so on (see Chapter 13 on conflict resolution). The fact that a behavioral cycle for the contract has been defined allows the partners an opportunity to try to fulfill the agreement during the next cycle. If the cycle is day-by-day, then a new cycle and new opportunity would be available each day. Having short behavioral cycles enhances the chances for successful interaction during the week. Thus, the couple should be encouraged to think of daily exchanges.

Good Faith Contracts

Weiss, Hops, and Patterson (1973) introduced this type of contract. Unlike the *quid pro quo* contract, this technique does not make the agreed-upon behaviors contingent upon the other partner's behaviors. These types of contracts, sometimes called parallel contracts (Erford et al., 2010), are characterized by behavioral exchanges independent of another's behavior. Each partner makes a commitment in good faith to carry out particular behaviors which the other partner has identified as desirable. The behavior of one partner will be carried out whether or not the other partner carries out their end of the agreement. If the discussed behavior is given, the person receives a reward that is independent of the other partner's behavior. Each partner's independent behavior is reinforced independently (Nichols, 2012). For example, if a husband wants his wife to go biking with him on Saturday and his wife goes with him, she chooses a reward she would like, such as going out one evening during the week with her friends. Good faith contracts are easy to formulate when the number of behaviors is small. However, as the contract grows, the number of reinforcements becomes more and more difficult to find.

A variation of the good faith contract is to ask the partners to help each other without any extrinsic reward. The reward would be the intrinsic satisfaction experienced from the improved and happier relationship. We employ this technique frequently because it is simple and agreeable to most couples. When using this technique it is very useful to have the partners verbally reward each other with recognition and appreciation, as was pointed out earlier. Ideally, couples will move in the direction of intrinsic satisfaction regardless of the type of contract that is employed.

Covenant Contracts

This method of contracting was developed by Clifford Sager (1976). It is different from behavioral contracts because of its much broader form. Emotions as well as behaviors are included in this contract. To use Sager's approach it is necessary to understand two components of his theory.

Sager (1976) stated that all couples have an implicit and explicit interactional contract which determines the behavior of each spouse within the relationship. The individual contracts may be conscious and verbalized, conscious and nonverbalized, or unconscious and nonverbalized. It is clear from this theory that much of what determines the behavior within a relationship is not known to the partners. The contract is implicit and unconscious. One of the purposes of covenant contracting is to make those nonverbalized and unconscious expectations known to oneself and one's partner.

As the couple becomes clearer about their unconscious contract, they may find three types of situations. Their contracts may be congruent. A *congruent contract* is based on healthy needs and emphasizes a trading-off of needs, wants, and desires. A second possibility is the *complementary contract.* In this case the partners use the traits of the other to complete some missing part in self. For example, a shy person might use the extroversion of her or his mate to compensate for his or her deficiency. A third possibility is the *conflictual contract.* This contract makes effective and rewarding interactions impossible. Unfortunately, much of this conflicted material is unconscious and gradually emerges in the relationship. A couple might marry knowing some problems exist, but not the full extent of the problems.

The covenant contract involves making the implicit and unspoken expectations explicit. For example, a woman who feels her husband will leave her when he becomes angry because of her history of having partners who had actually done so might need her husband to reassure her or affirm his commitment during or after a fight. Assessment and treatment are viewed as inseparable dialectic processes. The process of making the expectations explicit is diagnostic and also therapeutic in that the expectations may be changed or renegotiated.

In doing this type of contract each partner is asked to address four sets of issues: self, marriage, spouse, and children. For each issue, a want list is constructed. In addition to these four sets of issues, Sager (1976) has developed lists of questions that help to stimulate thinking about different aspects of the marriage. These questions are given to the couple early in the process so the partners may have time to consider their answers. Following each partner's reading of his or her list, the therapist helps the couple determine what is realistic and what can be negotiated. The process of doing the covenant contract may be fairly specific in format. Once the expectations are explicit, the therapist may choose to proceed in a less structured way.

Of the three types of contracts described, covenant contracting is the most complex and time consuming. The therapist assumes there are unconscious expectations. Time is needed to help the partners become aware that such expectations exist. Giving them the questions to consider helps to raise these expectations into awareness. Educating the partners that such expectations exist and giving them the questions to consider helps raise their awareness. The process of therapy itself promotes self-awareness, allowing for the emergence of unconscious expectations.

However, not all of these expectations will become apparent to the partners. As the therapist gets to know how the couple relates, especially in conflictual situations, these expectations can be inferred by the therapist. Once an inference is made, the therapist may suggest to the couple that such an expectation exists. Additional inferences can be drawn from genogram information. Patterns, messages, and other key family-of-origin experiences tend to create specific expectations.

In one case a wife complained that she wanted her husband to be able to listen to and understand her, yet she said he had never been able to do so. The fact was that when he did understand her, it either did not register or did not count because she said it was about something trivial. Her behavior suggested she expected her husband would never have the qualities needed to listen to her. In her family of origin she felt the same way, that is, no one cared enough about her to listen. In spite of the fact that this woman said she wanted understanding, she was the one who could not allow it to occur, and she was unconsciously sabotaging herself. When confronted about this pattern, she denied that such a thing was possible.

The problem for the therapist is that when some of these expectations are discovered, it can be difficult to get the client to accept them. Such a client would need gentle, yet persistent confrontation over time. This task is best accomplished through enactments in the office. In the case above, the therapist would (a) ask the wife to state what she needed, (b) teach and encourage her husband to respond, and (c) note her reaction. When she begins to discount his ability or sincerity, she should be confronted. Video playback in the session might be useful also to help her see the way she refuses to acknowledge her husband's attempts to communicate with her.

Behavioral Exchange

Jacobson and Christensen (1996) published a text entitled *Integrative Couple Therapy: Promoting Acceptance and Change*. This book stressed the concepts of helping the couple to accept what was unlikely to change and to work from an integrative perspective, and included a behavioral exchange intervention as an adjunct to their integrative approach. Behavioral exchange is an intervention that focuses on the interactions of a couple in terms of cost to benefit ratio with positive and negative features (Clark-Stager, 1999). The techniques of behavioral exchange theory aim to increase the positive to negative ratio of partners' behavior, which will in turn enhance the marital satisfaction, allowing the couples to start experiencing greater benefits in their relationship (Clark-Stager, 1999).

In spite of the positive reinforcement that couples typically experience early in their relationship, as the couple moves forward the rate of positive behavioral exchange begins to erode. Jacobson and Christensen (1996) suggested that "reinforcement erosion" is a natural rather than pathological phenomenon in all couples. The purpose of the behavioral exchange contract is to help increase the rate of positive interactions. Jacobson and Christensen (1996) offer an example of how behavioral exchange would look.

The first step consists of asking each partner to generate a list of items that would generate greater marital satisfaction if she or he did them. Each partner is to generate this list independently without any input from the other. Jacobson and Christensen

summarized the assignment by saying, "Ask not what your partner can do for you; ask what you can do for your partner" (p. 156).

The second step involves the therapist going over each list with each partner. The therapist wants to ensure the list is comprehensive and that the partner can actually do what appears on the list. As is true in all behavioral approaches, partners sometimes make comments that are not behavioral and need to be operationalized. The therapist insists that the partner who is listening to this discussion remain absolutely silent, including nonverbal comments. At the conclusion of this session, the therapist asks each partner to pick one or two items to focus on during the next week, either increasing or decreasing a behavior. The person who provides the behavior is to monitor the effect it has on the relationship in order to see whether it increases satisfaction. Additionally, neither partner is to tell the other which items from the list were chosen to be worked on that week.

The third step involves evaluating how well the intervention worked with the task discussed from an interactional perspective. The therapist asks which items were chosen, which ones the recipient noticed, and which ones contributed to increased marital satisfaction. For the first time, the recipient is asked to comment or give input about the items. Further, the recipient is allowed to comment on all the behaviors on the list in terms of how important they are to them. This commentary gives the provider a better idea of what will help the most. The therapist also asks about the "costs" to the provider for each item. If an item costs too much to give, it is likely to become aversive and stop. The therapist encourages the provider to give only those behaviors which they enjoy giving.

The authors believe that if behavioral exchange is to work, it must involve the couple's compliance. In order to facilitate compliance, they state each partner must believe they are choosing what they want to give and choosing to give freely. Otherwise, they would feel they were being coerced into giving some behavior, and the result would be noncompliance.

Process Contracts

A final type of contract is a process contract (Lee, 2006). Process contracts are made and carried out "moment-by-moment during the counseling or psychotherapy session" (Lee, 2006, p. 74). These types of contracts are developed by asking the client at each point in therapy what they want. By finding out what clients want, the therapist can find a way to fulfill the contract within the therapy session (Lee, 2006). Through the therapist's keen observation of the clients' thinking, feelings, and behaviors and noting each change in process, the therapist and the client can move on in the session to the next process contract.

Conclusion

The techniques of contracting described in this chapter represent varying types of behavioral approach. There exists ample evidence to suggest that changing behavior eventually leads to changes in affect and cognition. The therapist's choice is whether to focus on behavior, cognition, or affect from the outset. A behavioral approach

utilizing a contract is useful with concrete, less verbal, and less psychologically sophisticated couples. There also must be sufficient motivation to change. In addition, the therapist should offer ample praise to help facilitate the changes and to stand as an all-important model for the couple. When the partners see the therapist being positive and offering praise, they may begin to internalize that behavior as part of their own. Approaching one another positively further invites change from the other, which in turn creates even more positive behavior exchanges.

16

WORKING WITH EMOTIONS

Emotions are a core aspect of any committed relationship, and therapists must know how to manage and utilize emotions in their work with couples. In individual psychotherapy, there are approaches to treatment devoted solely to affect or emotion. Gestalt therapy, for example, has been a major force in psychotherapy and deals extensively with emotional awareness and expression. However, when we wrote the first edition of this book (Weeks & Treat, 1992), there was very little attention paid by marital therapists to the role of feelings in therapy. Of all the major approaches to systems/marital therapy prior to 1981, not one gave serious attention to the role of feelings (Gurman & Kniskern, 1981b), despite the fact that marriage is fundamentally an emotional attachment. In fact, in some major approaches such as paradoxical, strategic, and behavioral, feelings are viewed as a hindrance to effective therapeutic work. Proponents of these approaches often speak of the need to avoid dealing with feelings because they are seen as a distraction.

However, similar to the increased focus on cognition in couple therapy, much more attention has been given during the last two decades to working with emotions in couple therapy. Greenberg and Safran (1987) identify three specific reasons for addressing emotion in psychotherapy: processing information in an experiential manner produces productive client involvement in some forms of therapy; emotional arousal and expression are related to change in specific circumstances; and anxiety can be reduced by maintaining a high level of emotional arousal in specific circumstances. In fact, Johnson and Greenman (2006) call emotions "the principal organizers of behavior," and highlight the importance of attending to emotions when working within the context of couple therapy because "emotional signals are the music of the dance between partners" (p. 599). Greenberg and Goldman (2008) suggest that the ability of couples to access core maladaptive emotion schemes, learning how to self-soothe, dealing with pains from unmet needs of the past, and regulating and transforming deep emotions are essential to the therapeutic change process and the maintenance of that change.

Facilitating positive feelings in therapy is a crucial step. Helping couples move past their negative or unpleasant feelings is often needed to get to the positives. As recent studies reveal, increasing positive emotions often leads to improvement in physical and mental functioning to the extent that they predict lower risks of mortality (Xu & Roberts, 2010). Fredrickson's (2001) Broaden-and-Build theory depicts how people's psychological resilience to effectively cope with negative experiences has much to do

with positive emotion. According to this theory, positive emotions broaden our "thought-action repertoire," expanding the range of cognitions and behaviors that "build an individual's physical, intellectual, and social resources" (Tugade & Fredrickson, 2004, p. 321). Thus, positive emotions such as joy and satisfaction broaden and build up the resources we use to deal with conflict, and promote health and longevity.

In many cultures throughout the world, couples enter relationships on a voluntary basis and form the relationship on the basis of one overtly stated feeling—*love*. Close relationships such as marriage frequently evoke the strongest emotions an individual ever experiences. Joy, happiness, comfort, love, and satisfaction may be deeply felt. Rage, anger, fear, and hatred may also be felt in shocking intensity. Close relationships can also distort perceptions and feelings. During the idealization stage of courtship, partners may be "intoxicated" with feelings of love to the point of overlooking other feelings they have toward the partner and significant problems that might deter commitment or marriage. In an effort to sustain a close relationship, other feelings might be ignored, denied, suppressed, or repressed. For example, a partner who fears anger might suppress it in order to avoid harming or losing the other partner.

The role emotions play in a relationship is obviously complex and not predictable until the partners are understood. The nature of emotions themselves is not clear. Several theories are available to define and explain them and were reviewed by Greenberg and Johnson (1986) in an article on the use of affect in marital therapy. In 1994, Johnson and Greenberg identified eight reasons why emotion is relevant in intimate relationships.

1 Emotional experience and expression is the primary building block of adult intimate relationships.
2 Emotions, such as love, are adaptive in human functioning.
3 Emotion is a primary signaling system.
4 Emotion primes and organizes people for action in general, and for interpersonal responses in particular.
5 Emotions play a powerful role in structuring interactional positions.
6 Experienced emotion provides access to needs and desires.
7 Emotions organize perceptions of self and other.
8 Emotion links self and system.

Greenberg and Goldman (2008) also proposed that relationships are primary regulators of affect, as they can help people feel secure, calm, and happy. They also believe that emotions are signals of fundamental human needs related to self-esteem, identity validation, and attachment. In committed relationships, positive emotions can serve to enhance the motivation of one partner to meet the needs and desires of the other. Therefore, partners are linked and motivated by the positive effects each receives, which promotes the continuance of the relationship. Thus, emotions and relationships are connected in a circular fashion, as people's emotions regulate the process of coupling which in turn regulates emotions (Greenberg & Goldman, 2008). They assert that relationship satisfaction depends on the patterns of emotion or affect developed in the relationship. Therapy is sought when these patterns become distressing to

the couple, with the primary problem being related to the regulation, communication, and patterning of emotions (Greenberg & Goldman, 2008).

The purpose of this chapter is to discuss some of the models and techniques that help facilitate the use of emotions with couples in treatment. We will begin by presenting a brief overview of emotion focused therapy (EFT), an approach to couple therapy developed by Greenberg and Johnson (1988) with a deliberate emphasis on emotions. A complete review of Johnson and Greenberg's work is beyond the scope of this chapter (interested readers are referred to Greenberg & Goldman, 2008; Greenberg & Johnson, 2010; Johnson, 2004). However, we will review some of the fundamental principles and findings. The remainder of the chapter will present practical interventions and techniques to use with couples.

Emotion-Focused Therapy

Emotion-focused therapy (EFT) is a couple therapy approach developed by Leslie Greenberg and Susan Johnson (1988, 2010) and further refined by Johnson (2004) and Greenberg and Goldman (2008). It is a systemic approach with theoretical ties to attachment theory (Bowlby, 1988) that emphasizes both the emotional experiences of couples as well as their patterns of interaction. Attachment theory holds that "the primary motivation of human beings is seeking and maintaining contact. Connection, the primary need, is maintained through a 'safe haven' to rest in and a 'secure base' (Bowlby, 1969), from which to move out into the world" (Verseveldt, 2006, p. 217). A therapist using this approach seeks to identify the couple's patterns of conflict, or "dance," and help the couple broaden their emotional experience and develop new ways of interacting. Johnson (2007) proclaimed, "If emotions are the music of the dance between couples, to change the music is the most direct, powerful, and often only route to change" (p. 10). The ultimate goal of EFT is to help couples have a corrective emotional experience (Greenberg, 2010) such that they create new patterns of interaction and emotional connection. EFT therapists facilitate emotionally connecting experiences by helping couples express their feelings in terms of attachment needs and primary emotions.

Since their original publication on EFT in 1998, Johnson and Greenberg have each published therapy books or manuals on the practice of EFT. Johnson's model uses nine steps in three stages (Johnson, 1996, 2000, 2004).

1 *Cycle de-escalation:* identification and de-escalation of the negative cycle that maintains attachment insecurity.
2 *Restructuring the interactional positions:* helping both partners to shift their interactional positions to facilitate secure attachment.
3 *Consolidation and integration:* the treatment process is summarized in a manner that empowers the couple and consolidates the new responses that structure a more secure bond.

Treatment involves the identification and tracking of cycles of interaction with each partner's underlying emotional experience identified for each step of the cycle. Problems are reframed by the therapist in terms of attachment needs and circular (rather than linear) processes, with the partners learning to accept both his or her

response as well as the partner's response. Through time, new requests and solutions are generated for the presenting problems. The old cycles are disrupted with more adaptive cycles developed (Greenberg & Johnson, 1988; Johnson, 1996). Greenberg and Goldman (2008) present a model of EFT with a framework of five stages and fourteen steps. This model includes a more in-depth focus on the individual emotional process and self-change within the overall interactional changes. The five stages are: validation and alliance forming, negative cycle de-escalation, accessing underlying feelings, restructuring the negative interaction, and consolidation and integration (Greenberg & Goldman, 2008).

Fundamental Principles

Although there have been various adaptations of EFT, there are some basic principles that are at the heart of emotion-focused approaches. The first principle is awareness of emotion. Clients must first become aware of their emotions and learn to tolerate them before working on transforming maladaptive emotions (Greenberg & Pascual-Leone, 2006). Due to the human tendency to avoid negative emotional experiences, emotions may become repressed and distorted in ways that result in counterproductive, sometimes destructive, behaviors. In order to lead people toward emotional awareness, it is necessary to help clients accept emotions. Attending to and accepting one's emotions has positive implications for one's perception of well-being and also improves the way in which one interacts with others.

The second principle is that of learning to regulate emotion. Partners can learn to express their emotions in terms of attachment needs and primary emotions (e.g., loneliness, fear, or rejection), rather than secondary emotions (e.g., anger, defensiveness, or frustration). In the context of couple therapy, regulation of emotion can be an interpersonal task in which both partners become more aware of each other's emotion and more attuned to each other's affect (Greenberg, 2006; Greenberg & Pascual-Leone, 2006).

The third principle involves reflecting on emotion.This involves each partner learning to reflect on both their own and their partner's emotional experience. Partners are taught how to increase their ability to express how they feel to each other and to reflect back understanding of the other's emotional experience. When partners are capable of actively reflecting on emotions and are able to construct meaning out of them, they are more likely to communicate in an effective way with another by providing a clearly constructed story of their experiences. Furthermore, if partners are able to hear and understand how the other is feeling, they are more likely to respond with empathy, support, or compassion.

The final principle is called transforming emotions. Transforming emotion involves replacing maladaptive emotions with more adaptive emotions. In other words, focusing on emotions, rather than thoughts, helps transform emotions (Greenberg, 2006; Greenberg & Pascual-Leone, 2006). Fredrickson (2001) essentially denotes that people may utilize positive emotions to more effectively regulate and cope with the negative experiences. The maladaptive emotion of bitterness, for example, can be transformed into the more adaptive feeling of acceptance by means of encountering the deeper emotions of pain or loss.

These principles can all be applied to couples, and in fact, have been for a number of years without the benefit of a formal theory. Interestingly, one iteration of this approach to therapy demonstrates some of the historical underpinnings which have a long tradition in psychotherapy. Process-experiential/emotion-focused therapy (PE-EFT) is an approach that integrates person-centered, Gestalt, and existential therapies, governed by five essential principles: neo-humanistic values, process-experiential emotion theory, person-centered but process-guiding relational stance, therapist exploratory response style, and marker-guided task strategy. This approach is dialectical in nature as it ties together many aspects of the therapeutic process to form a comprehensible, growth-oriented model that allows for a new sense of productive change (Elliot & Greenberg, 2007).

Expectations and Feelings

In Chapter 14 on cognitive techniques, the relationship between cognition and emotion was described. From a cognitive perspective, emotions arise from one's cognitions. In a close relationship, a number of strong and stable expectations come into play. When these expectations are met, partners feel satisfied, happy, fulfilled, gratified, contented, respected, cared for, and loved. On the other hand, when expectations are not met or are in conflict, other less pleasant emotions emerge. These feelings are an indication that expectations and experience are not meshing. The therapist may wish to focus on a particular emotion to understand what is being felt and to validate the feeling and then move on to uncover the expectation on which it is based. In some cases, the expectation is unknown to the partner. The only indication of its existence is its emotional effect. The feeling is much like the devastation resulting from a storm. One cannot see the wind, only its effects. Giving the feeling reality serves to give heretofore unknown expectations authenticity.

The therapist's use of empathic listening during the process of discovery not only can help the client become more aware of feelings but also provides a corrective emotional experience for the client. Often, clients who have learned to repress their emotions have experienced deprivation of appropriate emotional attunement early in their lives. In addition to these clients repressing negative emotions, the therapist also must be aware that a client may have difficulty accepting or dealing with "positive" emotional experiences. Corrective emotional experiences often are experienced as incongruent with previous relationship experiences. Most clients look to the therapist for re-education and reframing of their emotional experience. This requires the therapist to move comfortably between cognitive and affective dimensions of emotion.

Partners can create greater emotional closeness as they express deeper primary emotions in a safe, accepting environment. Greenberg and Goldman (2008) suggest that therapists need to facilitate the process of disclosing underlying vulnerabilities, owning vulnerabilities, taking self-focus, and soothing self and other. They also suggest it is important to facilitate the experience and expression of compassion, the acceptance of difference, and encourage the appreciation and expression of positive feelings toward the other (Greenberg & Goldman, 2008).

Promoting Awareness and Expression of Feelings

Unfortunately, some marital therapists have dealt with the issues of feelings in an oversimplified way. The therapist has simply asked, "How do you feel?" The client responds, and then the issue is dropped until the therapist asks the question again. Apparently, the therapist believes that ventilation of the feeling alone is enough. Some people are more emotionally repressed than others, and these people need more help and support to become aware of their feelings. Gordon (1993) identified three levels of emotional awareness: Level one: "I am aware of my feelings, and I can share them with you"; Level two: "I am aware of my feelings, but I choose not to share them with you"; and Level three: "I am not aware of my feelings, so I cannot share them with you." In each case the emotions have an impact on interpersonal behavior, regardless of the level of awareness.

Working with feelings always involves two steps. The first is to help the person to be aware of the feeling, and the second is to help the person express the feeling. One of our colleagues, Larry Hof (Hof & Miller, 1981), developed a communications exercise for couples to help with both of these aspects. He calls this exercise "My World of Feelings"[1] (Table 16.1).

The purpose of the exercise is *to help clients become more aware of the whole range of their feelings, to begin to express them appropriately, and to accept these feelings in themselves and in others.* This exercise is used with couples who are having some trouble getting in touch with their feelings and are not at the extremes of being suppressed or

Table 16.1 The "My World of Feelings" Exercise

15 minutes	1. Personal Reading: "The World of Feelings."
15 minutes	2. Individuals complete statements on "My World of Feelings" form.
20 minutes	3. Couple sits facing each other, knees touching, and decides who will start.
	4. The person starting says, "In our marriage, when we relate together, I am happiest when . . ." Having completed the statement, the person maintains eye contact as much as possible.
	5. Partner is to listen attentively to the feelings being expressed, and to accept them. The only comment acceptable is a question for clarification of what the person means. Statements are not to be discussed nor disagreed with. Hear them, accept them, and receive them as a gift of the one person to the other.
	6. After the first person has shared her/his response to item number 1, the partner then shares her/his response to the same item.
	7. Repeat the process until all the items have been completed.
10 minutes	8. Talk together with your partner about what you experienced, thought, and felt as you went through this experience. Discuss the value of this experience for you and for your relationship.

Source: Hof & Miller, 1981.
All efforts were made to track the copyright holder.

angry. The exercise is described below. The first part consists of instructions for the partners followed by a couples exercise. This exercise was designed to be done at home in roughly one hour.

Personal Reading: The World of Feelings

The world of feelings is the world of affection and sentiment, the world of emotion and passion. It is the world of happiness and sadness, of joy and anger, of excitement and boredom. My feelings are my spontaneous emotional responses to the events that occur in the world around me, the emotional responses associated with, and triggered by, my fulfilled or unfulfilled expectations, and my interpretations of events and behaviors. My feelings are expressed in and through my body; I may speak faster and louder when I am excited, and slower and softer when I am sad; my body may shake when I laugh, and my eyes may fill with tears when I am in pain. Even when I am not consciously aware of my feelings, my body is frequently giving off clues that I am feeling something, clues that other people may sense.

During any given day, I will feel a variety of feelings. The list could be expanded almost endlessly, with subtle variations and differing degrees of each feeling being present at different times. I can feel several feelings at once, and those feelings can conflict with each other.

> *My feelings are a very real and valuable part of me. They are just as important as my thoughts, my senses, and my behaviors. They can help me to deepen my understanding of life and the impact of people and events upon me. My joy helps me to celebrate and to identify things and people I like. My boredom gives me clues that I would rather be doing something else. My fears help me to protect myself. Without my feelings, I would live a greatly impoverished life.*

Yet, for some reason, many of us have been taught to disregard our feelings—all of them, or a select few "bad" feelings. Some people have been taught to be "rational." Some have been taught to deny or avoid anger, pain, pride, or sexual feelings. Perhaps, each of us has a little list that we keep inside of "acceptable" and "unacceptable" feelings. Others feel them internally, but we don't permit ourselves to express them

Table 16.2 Feeling Words

Happiness	Confusion	Relief	Satisfaction
Sadness	Loneliness	Hope	Boredom
Joy	Apathy	Fear	Love
Pain	Anger	Confidence	Suspense
Suspicion	Remorse	Silliness	Contentment
Pride	Irritation	Peacefulness	Tiredness
Hopelessness	Anticipation	Reverence	Surprise

without words or actions. For example, we want to avoid conflict, so we don't express our anger. We don't want to be "soft," so we withhold our warmth. We don't want to appear "weak," so we don't disclose our fears.

> *If my feelings are to serve me and help me make sense of life, I must be aware of them and their heights and depths, and be able to express them appropriately in words and actions. If I deny or avoid them, I lose the ability to control them and they can gain control of me. Then, they may emerge when I don't want them to, perhaps inappropriately. Or, they may literally "eat a hole in my stomach" or "give me a pounding headache." In some way, I pay a great price when I refuse to let my feelings have an appropriate and natural place in my life.*
>
> *When I accept the fact that it is normal to feel a whole range of feelings, I am freed from justifying my feelings or apologizing for them. I simply recognize that, "I am human; therefore, I feel. You are human; therefore, you feel, too." As I accept that fact, and increase my awareness of my feelings, I can express them in many ways. The choice of how I will express them is mine to make. I can change old ways of expressing them. The more I practice, the more I will become used to expressing my feelings.*

In a marital relationship, the ability of two individuals to be aware of the whole range of feelings, to express them appropriately, and to accept them in themselves and in each other can pave the way for increased self-awareness and for stronger bonds of trust and deeper intimacy. It may make each partner more vulnerable, too. But, perhaps the potential for self-awareness and growth, and for increased trust and intimacy, is worth the risk!

Statement Completion: My World of Feelings Exercise

Please complete the following statements.

1 In our marriage, when we relate together, I am happiest when . . .
2 In our marriage, when we relate together, I am saddest when . . .
3 In our marriage, when we relate together, I am angriest when . . .
4 The best thing about our marriage is . . .
5 I feel most afraid when . . .
6 I feel loved when you . . .
7 My greatest concern/fear for our marriage is . . .
8 What I like most about myself is . . .
9 What I dislike most about myself is . . .
10 What I like most about you is . . .
11 My greatest concern/fear for you is . . .
12 The feelings that I have the most difficulty sharing with you are . . .
13 The feelings that I can share most easily with you are . . .
14 Right now I feel . . . towards you.
15 Right now I feel . . . towards myself.
16 I feel . . . sharing these feelings with you.

Getting in Touch

As we indicated earlier, some partners are more emotionally repressed than others. For those partners, more work is needed. One intervention is to ask clients to define a feeling and to keep a feeling diary. Partners are first asked to define a feeling because they often confuse thoughts, judgments, and feelings. L'Abate presents an exercise in *Programmed Writing* (1992) that helps identify and define feelings and emotions and their importance. Clients must learn how to differentiate these by questioning themselves and by getting assistance from the therapist and, in many cases, from their partner. The type of confusion one commonly comes across is exemplified by the client who says, "I feel good (bad, okay, etc.)." Or a client may say, "I feel like I cannot do this." Just because the word "feel" is used in the sentence does not mean a feeling is being described. These examples involve value statements, thoughts, or judgments. The partner could have said, "I feel happy (unhappy, contented, afraid, etc.). '' These terms represent feelings.

The therapist and client review the daily diary in their weekly session. The partners are asked to note their feelings and the triggers for those feelings. Furthermore, they are asked to let the feelings "register" by staying with them for a few minutes. For some people, feelings are fleeting. As a consequence, the feeling is not registered or discussed later with one's partner.

As they become more in touch with their feelings, clients move on to the second half of this exercise, which involves the partner choosing one or two feelings to share with the other person. With couples who have a difficult time identifying emotions, we give them a handout with a long list of possible feelings and variations of these feelings and have them circle the ones they experienced during the day. Couples should set aside uninterrupted time in the evening for this activity. After one partner shares their feeling, the other partner should reflect back the feeling and discuss it with the partner who shared it. Couples can be asked to do this daily and then discuss with the therapist how they did with the activity.

These exercises are simple homework for the couple that needs straightforward emotional assistance. As easy as these exercises may seem, they can be difficult for the couple who have not been expressing feelings. The therapist should spend as much time in the sessions as needed to help them master this awareness and skill before assigning it as homework.

Filtering Emotions

One of the most common problems in couples is that they filter all their emotions through one emotional channel—the most usual of which is anger. In other words, all the emotions experienced are either experienced and/or expressed as anger. A partner may experience guilt, fear, hurt, depression, insecurity, and so on, yet express any one of these emotions as anger. Anger becomes a defense to protect the partner from having to deal with an emotion she or he is ill-equipped to handle.

When the therapist observes one emotion being used to cover up others, it is time to explore the other underlying feelings, or primary emotions (Johnson, 2004). It is usually not difficult to identify what those feelings are likely to be. Continued

explorations, with the client beginning to attend to and express the underlying feeling, are helpful.

The problem, of course, with revealing and expressing the underlying feeling is what the partner believes will happen if she or he does so. Once the unexpressed feelings have been identified, the partners may be asked what makes their expression so difficult. They may believe the other partner will not hear them or will use the feelings against them. This belief can be processed objectively by the therapist, checked out with the partner, and then an enactment can take place in the session in which the couple deals with the feelings while being coached by the therapist (see Chapter 12 for a description of therapist-facilitated enactments).

Genograms and Feelings

Helping clients access and express their emotions can be difficult, particularly when a partner believes certain feelings should not be felt or expressed. In such cases, a feelings genogram may help to uncover the reason. The purpose of a feelings genogram is to trace the emotional history of the individual and the family system to help the client become more aware of patterns of emotional expression in the family in terms of both pleasure and pain so that effective and satisfying emotional experiences can take place in the present. The first school of emotional learning comes with family life. This emotional schooling is provided by the role model parents present to their children for not only how they handle their feelings with the children, but also the feelings shared by the husband and wife. The parents may be gifted emotional teachers or atrocious examples (Goleman, 1995). Emotional expressiveness in both nonverbal and verbal patterns appears to be socially shared within families (Berry & Pennebaker, 1993). To help promote therapeutic change, it is important to have a deeper understanding of the emotional connections in couples and families and how these connections can become disrupted (Greenberg & Marques, 1998).

Attitudes and decisions about expressing feelings usually are learned during childhood and adolescence. Feelings genograms can help uncover the reasons for these attitudes and beliefs. Questions about how feelings were handled in the family, which feelings were acceptable or not acceptable, and how different feelings were expressed elucidate the historical basis of these attitudes. Partners can then begin to see how certain feelings were blocked, forbidden, encouraged, or supported. Attitudes that may have been functional and useful in growing up may not be functional in someone's life today.

New research derived from EFT also supports the use of the feelings genograms in exploring the intergenerational transmission of emotions. Kim, Pears, Capaldi, and Owen (2009) are probably some of the first to examine the role of emotion dysregulation in the intergenerational transmission of relationship conflict through a longitudinal study of men and their mothers and fathers. They chose emotion dysregulation as a focus of their research due to previous evidence pertaining to the negative impacts on children of conflict within the parental subsystem. These interactions were said to result in "maladaptive interpersonal repertoires that generalize to other relationships outside the family of origin" (Kim et al., 2009, p. 585). The idea is that those who lack regulatory skills in childhood and adolescence, skills which are primarily shaped

by caregivers, will consequently experience difficulty coping with distress in interpersonal relationships later in life, especially in marital relationships. These ideas are concurrent with the processes of social learning; however, this study was aimed at discovering the developmental origin of relationship conflict across generations, highlighting the transmission of parents' emotional dysregulation (Kim et al., 2009). The findings of this study supported the hypothesis that parents' and sons' emotional dysregulation are strongly associated. The findings further demonstrate that it is a key underlying structural component that shapes romantic relationships over generations. It is to be deduced that individuals who exhibit poor emotion regulation skills are more prone to difficulty in dealing with negative emotions, resulting in "inappropriate strategies when interacting with romantic partners" (Kim et al., 2009, p. 592).

The Feelings Genogram

The feelings genogram may be used to collect considerable information about feelings in the family and may take several sessions to complete. Some questions the therapist may ask include the following.

1 What were the dominant feelings or emotions for each member of your family?
2 What was the predominant feeling/emotion in your family? Who set the mood?
3 Which feelings were expressed most often, most intensely?
4 Which feelings were not allowed? How were members punished when an unallowed feeling was expressed?
5 What happened to the unexpressed feelings in the family?
6 Who knew or did not know about how others felt?
7 What happened to you when you expressed the taboo feeling or feelings?
8 How did you learn how to deal with these so-called unacceptable feelings?
9 Did others try to tell you how you should feel?
10 Did you ever see anyone lose control over his or her feelings? What would happen? Did anyone get hurt? How?
11 If corporal/physical punishment was used in your family, what feelings did your parents express? What feelings were allowed for children?
12 Do you find yourself having feelings you cannot explain, but are close to feelings you have had in the past?

Additional information on genograms can be obtained from *Focused Genograms* (DeMaria, Weeks, & Hof, 1999).

When the emotions of the partners are not consistent with the situation, it is useful to think about emotional displacement from the family of origin. In one extreme case, a husband always found reason to be critical and angry toward his wife. Genogram exploration revealed he was carrying unresolved anger toward his parents. Conversely, his wife had felt guilt and depression for many years. She was the peacemaker in her own family, yet she was told she had failed in this role. She was unconsciously compelled to keep trying until everyone felt happy again.

In another case, a man was a "pseudospouse" to his mother during his childhood. He learned that his mother desperately needed his love and admiration. He eventually

discovered that by always being cheerful and loving, he could win his mother's approval. In his marriage, he gave the appearance of being emotionally well, but was seething with frustration, anger, and resentment. In this case, the underlying emotions directed toward his mother were actually being displaced onto his wife.

Comfort with emotional intensity is an important part of working through the issues raised through the feelings genogram. When someone grows up in a family that is conflict-avoidant, emotional intensity can be very uncomfortable. Likewise, those who grow up in volatile families are more likely to be volatile themselves.

Emotional Congruence

Much of what has been discussed up to now assumes that clients really are feeling what they say they are feeling. However, feelings may also be distorted or absent. The therapist's use of self is a primary way to comprehend these two situations. As the therapist listens and resonates to the clients' situations emotionally, she or he may notice a lack of affect or an affect that does not quite fit. *Empathy between therapist and client is crucial. Emotional resonance fosters self-awareness and attunement as the self–other dialectic is processed through treatment. Empathic skills can aid the therapist in exploring feelings with the client.* Asking a question about feelings is most appropriate at this time. If the partner does not identify the feeling, the therapist may give the client time to safely explore the question, ask questions to guide the client, or supply the missing affect. The therapist could say, "If I were in your place . . ." or "I can't imagine you didn't feel . . ." If the client agrees with the emotion, the therapist knows he or she is successfully tracking the feeling or mood of the client. Once the feeling has been identified more exploration can be done. The therapist may want to know what it means to feel " ___ ," whether the person has felt that way before, what made it so hard to identify the feeling, and what she or he fears about expressing it. During this exploration, the partner is kept actively involved. Obviously, one partner is sharing this information with his or her mate, and the other partner reflects the feeling back and may be asked to discuss how she or he deals with the feelings in question, too.

In one case, a woman became very upset and started to cry when her partner told her he did not want her to make love to him when she was not interested. In the early part of this relationship, the woman had frequently had sex with him when she did not feel the desire. On the surface, his statement should have made her feel accepted and respected. However, her response was actually a distortion, because she could not allow herself to believe him. Her father and first husband were both narcissistic individuals who were only interested in meeting their own needs. When she started to hear her partner take care of her, she was reminded of the emotional betrayal and abandonment of the previous men in her life, and this reminder provoked her tears.

Managing Inappropriate and Intense Affect

Just as with all other issues that emerge during the therapy hour, the therapist has a responsibility to provide an emotionally safe environment for both partners. The security and validation provided by others are a strong source of affect regulation for most

people (Greenberg & Goldman, 2008). Greenberg and Goldman (2008) believe that partners attend and respond to the affective tone of each other's messages more than to the content of what the other is saying, and this reading of emotions dominates their interactions. When anger is being expressed through inappropriate behaviors such as snide remarks, critical remarks, shouting, or demanding, the therapist can intervene to establish some rules about what is appropriate behavior. The partner would then be asked to discuss the feelings behind those behaviors in a more constructive or assertive way. Many partners will have no idea about alternative modes of expression. The therapist may coach the partner through or model the expression of the underlying feeling. The partner who is helped to express the feeling assertively allows the other partner to reflect back this feeling. The other partner may have equal difficulty in reflecting the feeling. They may have problems in hearing certain feelings, whether these be appropriately or inappropriately expressed.

When affect is too intense, the therapist needs to cool the session down. The therapist can accomplish this task by slowing down the pace. Usually the couple heat up emotionally when they talk directly to each other. The therapist can take a much more assertive role in diffusing the couple's interaction by asking the couple to address the therapist, not each other (see discussion on *shielded* and *buffered* enactments in Chapter 12). Additionally, the therapist can ask questions that are factually oriented. Asking about who does what, in what sequence, takes the partners away from their immediate feelings and directs them to take a more detached perspective.

Intensifying Affect

Conversely, if the therapist wants to intensify affect, it is essential to promote talking and to focus on the partner's implicit or explicit feelings. This technique basically involves asking a couple to enact a problem. They are directed to discuss some problem that is known to be emotionally laden. As they discuss the problem, the therapist asks the partners to talk specifically about feelings. When feelings are not expressed directly, but are detected or inferred by the therapist, the process may be interrupted so the therapist can draw out the feeling. When the feeling(s) has been sufficiently amplified, the therapist directs the couple to continue their dialogue.

In one case, a wife felt her husband's parents were too intrusive. When she brought the issue up, she made a statement that they spent too much time at their house. The therapist had her talk about how she felt, and through the use of an enactment facilitated communication between the partners. Fifteen minutes later, the wife took a strong stand, realizing just how distressed and resentful she was about the situation. The therapist kept encouraging her to express her feelings, which her husband initially said were "not true." He did not like the fact that she was resentful. However, as the therapist supported her in the expression of her emotions, he came to understand the consequences of her feelings in terms of the marriage.

Conclusion

The therapist has the task of managing the emotional environment in the session. This task involves intensifying affect where necessary, changing the mode of expression

when inappropriate, and facilitating a controlled release over time when the affect might otherwise get out of hand. Given the vulnerability that often accompanies emotional expression, the therapist has an important responsibility to maintain safety for the couple.

Bringing feelings into couple therapy can add a dimension of humanness and connection among all parties that may not experience this in other situations. At first, it may be frightening for couples because they are fearful of emotions. Once this fear has been challenged, the couple feels stronger and the therapist experiences a unique emotional bond with them.

Note

1 This technique was developed by Larry Hof and appears in Hof and Miller's *Marriage Enrichment*, pp. 96–98. Copyright © 1981. Reprinted with permission.

17

HOMEWORK

Extending Techniques from the Office to Home

In addition to the in-session techniques and interventions described in the previous chapters, giving couples homework assignments is a very important way to help clients achieve their treatment goals and experience the relationship changes they desire. Facilitating work by couples outside of the therapy setting has been recognized for several decades as an important part of marital therapy (Sheldon & Ackerman, 1974). Homework makes use of the time between sessions to keep the client engaged in therapeutic activity and further enables the therapist to check the couple's progress toward their goals in therapy (Kazantzis & Lampropoulos, 2002). It helps the couple expand on skills and learning from the therapy session and experiment with them in real-life settings (Dattilio, 2005). Homework is also said to assist the couple to take responsibility for change in the relationship (L'Abate, 2003).

Our research and clinical experience affirm that substantive change can take place in between sessions with couples. When couples report on significant changes that take place during therapy, they often highlight moments of change that occur outside of the therapy office (Fife, 2004). Broder (2000) goes so far as to suggest that the main premise of homework is the recognition that real changes occur outside the office, rather than during the therapy sessions. Interpretation, analysis, and reflection, while integral parts of individual therapy, are insufficient in and of themselves as means of implementing solutions to the day-to-day problems faced by most couples. According to L'Abate (1986) and Andolfi (1980), the therapist must play an active and directive role both during the clinical hour and in the delegation of assignments at home.

Clients learn by doing and therefore need the opportunity to repeatedly practice new behaviors and to process their results in order to develop alternative, more functional attitudes, cognitions, behaviors, and feelings. Additionally, couples in treatment have usually developed ineffective communication and behavioral habits during their relationship, and developing new, more effective interpersonal behaviors takes time. Homework serves several important therapeutic purposes. It helps clients transfer what is learned in therapy to day-to-day living (Dattilio, 2002; Epstein & Baucom, 2007), enables clients and therapists to gather more information about the problem, and heightens awareness of issues within therapy (Dattilio, 2002; Nelson, Castonguay, & Barwick, 2007). Furthermore, out-of-session tasks increase motivation (Dattilio, 2002), communicate the role of the client in therapy (i.e., they must be active participants rather than passive beneficiaries), increase active involvement in

therapy (Dattilio, 2002; Prochaska, DiClemente, & Norcross, 1992), help clients engage in independent work without the therapist, and allow clients to integrate in-session changes (Nelson et al., 2007).

Much of what is written on the subject of homework in psychotherapy is vague and confusing. Authors contradict each other, and research results are varied and limited. Some studies report a statistically significant difference in outcome between therapies that assign homework and those that do not, while others find no difference (e.g. Kazdin & Mascitelli, 1982; Marks et al., 1988). Despite this, a number of different studies report high levels of therapists using homework as a therapeutic technique. For example, Kemmler, Borgart, and Gärke (1992) report that 87% of therapists from a range of theoretical backgrounds use homework; Kazantzis, Busch, Ronan, and Merrick (2007) reported homework use among psychotherapists at 83%; and Kazantzis, Lampropoulos, and Deane (2005) found that 68% of APA members used homework in therapy.

Sheldon and Ackerman (1974) were pioneers in stressing the importance of homework assignments to facilitate desired behavior change through education and skill building. Their book was individually focused and the first to design tasks to match specific difficulties. The authors discussed the importance of establishing rapport between client and therapist to promote compliance, and emphasized the development of a clear understanding of problems and goals. Homework, they stated, must be clear and manageable, its logic explained, and the work reviewed in the next session. When tasks were not completed, the reasons for this must be explored carefully. Clients were told what and how often to do the tasks, to record the results, and to bring them to the next session. Sometimes the scheduling of the next appointment was contingent upon completion of the assignment. However, these assignments were addressed to the individual and his or her problem area.

Others have written on the topic of homework. For example, Warburton and Alexander (1985) focused on the establishment of the therapist's credibility, clarity, and specificity in assigning tasks, and the utilization of methods to deal with resistance. Nelson et al. (2007) identified 10 guidelines for effective use of homework in therapy, including things such as communicating the assignment and rationale clearly and in a nonthreatening manner; working collaboratively with the client in creating homework assignments; and tailoring assignments to each client in terms of capabilities, situations, and needs. According to Strong and Claiborn (1982), compliance is enhanced when clients understand the rationale in following the therapist's directives and when they perceive that there is a choice in carrying out the homework. More on the topics of compliance and resistance is presented later in the chapter. Although the psychotherapy literature has provided some information on homework and out-of-session tasks, clear guidance is lacking for couple therapists, and the complex needs and responses of couples and families are often neglected.

Model-based and Trans-theoretical Tasks and Assignments

Much of what is written about homework in the marital and family therapy literature is grounded in model-specific ideas about family problems, healthy relationships, and change. Tasks are often geared to the theoretical framework of the many and varied

models of marital and family therapy, rather than being more generally applicable. For example, Hertlein and Viers (2005) provide a compilation of homework assignments based on theoretical approaches organized into sections based on work with couples, families, and larger systems. Similarly Kazantzis and L'Abate (2007) also present ideas for homework in therapy based on numerous approaches as well as specific problems.

Therapists utilizing the structural model of family therapy prescribe homework that is designed to modify aspects of family structure. Aponte and Van Deusen (1981) regarded task setting as a means of redirecting dysfunctional interactional patterns in families. Such tasks were used as vehicles for establishing appropriate boundaries, alliances, and hierarchies. Minuchin (1974) also suggested a variety of out-of-session restructuring activities along similar lines. Such interventions, although not unhelpful, are the outgrowth of a school of thought rather than a reflection of the unique problems and goals of each couple or family.

Consistent with its theoretical underpinnings, Bowenian therapists (Bowen, 1978) use homework to teach or coach individuals in reconstructing relationships with members of their families of origin in a healthier way in order to develop a more differentiated self. Tasks outside of sessions are designed with this goal in mind, rather than simultaneously addressing couple/family interaction directly. For example, a wife might be instructed in how to resolve an old conflict with her father that was getting re-enacted with her husband. Therapy and homework both focus primarily on individual work, rather than as a couple.

In contrast to Bowen's focus on insight and differentiation, behavioral marital therapists and social learning theorists like Jacobson (1981) and Stuart (1980) proposed that couples' utilization of positive reinforcement, behavioral exchange contracts, problem-solving, conflict resolution, and communication training are the foundations of successful marital relationships (see also Jacobson & Margolin, 1979). A behavioral approach highlights the importance of pretreatment assessment in the office and at home, the establishment of measurable treatment goals, and a focus on behavioral change. Homework is designed to help couples practice at home the skills learned in the therapy sessions and to implement the behavioral exchange contracts. The role of the symptom, the history of each partner, the families of origin, and the impact of other stressors are, for the most part, ignored by the behavioral therapist in designing homework assignments.

Strategic therapists, on the other hand, will often assign homework tasks without explanation. Homework prescribed by strategic marital/family therapists often takes the form of paradoxical interventions and may be indirect, reframe, restrain change, and even prescribe the symptom in order to outwit clients' resistance to change (Weeks & L'Abate, 1982). Here, although the function of the symptom is well understood, skill building, education, and insight are underplayed.

Therapists who are using emotion-focused therapy (EFT) will focus on exploring negative emotions and responses, such as anger or withdrawal. Emotionally focused couple therapy focuses on helping partners have new or corrective emotional experiences with each other with the goal of generating positive forms of communication and restructuring interactions. Homework assignments will include activities that build on the new emotional experiences. Once the therapist begins to introduce new

or rarely occurring responses from the couple, the therapist can suggest the couple discuss the therapy experience at home in order to reinforce the progress made in therapy. Additionally, the couple is encouraged to practice new emotional experiences at home by positively communicating and responding to the emotional needs of the partner, such as holding each other to reinforce closeness and safety. As these emotional experiences are exercised, new bonding events can take place in order to establish a secure base for the relationship (Johnson, 2004).

Although many models offer theory-specific homework assignments, other scholars have presented trans-theoretical ideas about therapy (Fife et al., 2013) and homework. Such ideas are not tied to any one model and may be utilized with couples regardless of the primary therapy model guiding the treatment. For example, homework may include observation, journal keeping and other writing, experimental learning tasks, individual or conjoint assignments, and bibliotherapy (Dattilio, 2005).

A more formalized example is Openshaw's (1998) SEA methodology (Summarization, Empowerment, and Active involvement), which utilizes common therapeutic techniques to facilitate clients' engagement in their homework and enhance compliance. Summarization is utilized in the therapy session to clarify direction, demonstrate understanding of what was learned in the therapy session, and maintain focus. In relation to homework, it is used to reiterate, in an abridged fashion, the foci and key patterns developed during the session. Empowerment is used to strengthen clients' confidence by pointing out their unique talents, perspectives, and coping strategies. The intent is to instill hope and encourage motivation, thus reinforcing the couple's joint efforts to resolve problems in the relationship. Clients are also encouraged to contribute to the creation of homework assignments. Clients' active involvement in developing the homework further insures the assignments will be successfully completed.

L'Abate (1986) described the use of Systematic Homework Assignments (SHWAs), the primary vehicle through which his approach to family therapy is implemented. In this approach, treatment issues are broken down into specific elements that are systematically organized for the family to work through at home. Writing, whether structured (i.e., programmed) or personal journal keeping, can be utilized for this purpose (L'Abate, 1992, 1999a; Pennebaker, 1997). This process is intended to facilitate treatment and increase outside work, thus reducing the time spent in the office.

In spite of some direction, the literature on tasks, assignments, and homework leaves the therapist with considerable confusion about what to do and how to do it. How does he or she give assignments that flow smoothly and logically from the session and from the interaction between therapist and clients? How does the therapist create a customized fit between the partners' history, capacity, and commitment to work as a unit toward desired goals and the step-by-step process used to attain these goals? Exactly how does the therapist enhance compliance, deal with resistance, and learn from failure?

Types of Homework

Homework assignments fall under two basic categories. The first type of homework is known as *bibliotherapy*. This type of homework is designed to provide partners with

information that promotes awareness, challenges attitudes, and supplies the tools necessary to establish new skills and improve the couple's relationship. A number of self-help books are currently available which may be prescribed to couples. These books should be used with those clients who are motivated to read, discuss, and apply the material. Therapists may ask the couple to read small segments at home each week and to discuss them before the session. During the session the therapist may ask which ideas stood out or seemed most relevant for them.

One of the authors was once asked, "With so many books on marriage available, how do you know the difference between the books that are good and those that are not?" After a moment's reflection, the therapist answered, "The biggest thing that determines whether a book on marriage is good or not is whether or not the book is read. Those books that are read and applied are likely to be helpful. Those that stay sitting on the bookshelf are not going to be much help." Clients may identify reading material on their own, or the therapist can recommend books or readings for the couple. Therapists who are looking for texts in different couple problem areas can use the bibliotherapy appendix in *The Couples Psychotherapy Treatment Planner* (O'Leary, Heyman, & Jongsma, 2011). Therapists should only recommend books with which they are familiar, especially if the couple and therapist intend to incorporate the information directly into the therapy.

The second type of homework is *task-oriented* and is designed to facilitate change in the couple's behavior and relationship. These tasks may be paradoxical or linear (Weeks & L'Abate, 1982). Paradoxical tasks are those that seem contrary to common sense and produce quantum leaps in behavior change. Linear tasks are those that change behavior in a systematic, step-by-step fashion. The assumption is that behavior may be changed slowly over a period of time, given the proper conditions, appropriate experiences, and practice. In short, the client system changes by doing. The majority of this chapter will focus on task-oriented homework.

Although examples of homework have been widely discussed in family therapy (Nichols, 1984), very little has been written on how to actually give homework. Assigning homework is a complex process involving knowing how and what to suggest, being able to facilitate compliance, and dealing with resistance. One of the most common errors new therapists make is to prescribe homework because it is "the thing to do" without actually understanding the process or giving much thought to the assignment. In such cases, the homework is usually an idea gleaned from the professional literature, a case study, or a colleague's suggestion, and may not be appropriate or relevant to the couple or individual being treated.

Effective homework assignments are tailored to the individual and couple in regard to their needs, strengths, and goals for therapy. Because the term "homework" may have a negative connotation for some clients, many therapists have reframed the word into more positive terms such as out-of-session assignments, experiments, data collection, or task assignments (Dattilio, 2005). Within couple therapy it is important to determine whether the couple would best be served by individual or conjoint homework assignments. A possibility may be to start out with individual assignments and as the couple grows more comfortable begin conjoint assignments.

Creating Homework Assignments

The content of the homework assignment should emerge organically from the session. The homework should not simply be assigned to the client at the end of a session. Nor is it suggested that "practice planners" or predetermined homework be used because this does not allow for individualized homework assignments, which may decrease compliance (Kazantzis, Macewan, & Dattilio, 2005). Creating a homework assignment is best achieved through collaboration with the client. During the session the therapist and the couple are working toward a specific change or outcome. The question is how to bring about the change. When the clients have a clear definition of the desired change, they can then become participants in the collaborative process of creating homework to achieve that end. The therapist asks what type of change is wanted and how the client-system envisions this change being facilitated outside the session.

Therapists and clients should approach the desired change in a systematic fashion. Goals must be broken down into small steps from simple to complex, from less threatening to more threatening, and from more behavioral to more affective. The homework also should be congruent with the clients' style of learning. Some clients respond best when mechanical or highly structured assignments are developed. Others need experiences that are basically unstructured and promote creative engagement. As couples are made up of two individuals, it is imperative to recognize that partners may have different learning styles. Therefore, the homework must be adapted accordingly. Dattilio (2005) also suggests that the assignment can include the clients' distinctive style of language and metaphors.

One of the purposes of homework is to provide the couple with successful experiences, which in turn promote a greater sense of accomplishment, achievement, hope, and a spirit of co-operation for those involved (Fife, 2004). It also counters the sense of learned helplessness and hopelessness, which may emerge over time after a series of perceived failures in the client-system. Asking clients to perform a homework task without having first demonstrated readiness is setting the couple up for failure. In order to increase the chances of success, therapists may practice with the couple the assignment that they are given to work on during the week. In addition, the client-system should demonstrate that it possesses the motivation and fundamental skills to necessary to continue practicing it at home.

Commitment and responsibility are important ingredients for beginning the process of assigning homework. Commitment is a critical factor in whether homework is completed and for the success of therapy in general. The therapist needs to ask each member of the client-system to make a commitment to carry out his or her part of the work. This should be done initially in the beginning of therapy and reaffirmed periodically as needed. By asking each partner to make a personal commitment, responsibility remains clearly within each individual for his or her success or failure. In many cases, a member of the system will wait for his or her partner to initiate the homework and then blame the other for noncompliance. When discussing commitment, the therapist should include how each person deals with his or her own resistance (e.g., "What might get in the way or lead to you failing to get this done in spite of your good intentions now?") and with the resistance of his or her partner ("How

will you do your part to complete the assignment, even if you don't see your partner doing his or her part?").

Dattilio (2005) suggests assignments work best when there is a collaborative approach with couples in creating their assignments. It helps to increase their interest and investment as they are an active part of developing the assignment. Strong and Claiborn (1982) argued that change occurs more readily when viewed as an emergence of what is already within the individual and as growth in his or her personal power and control.

Scheel, Hanson and Razzhavaikina (2004) developed a six-phase model for giving homework. The phases are described below.

- Phase 1: The therapist and the client work on formulating the homework assignment. It is viewed as a collaborative process, and the fit to the problem is carefully considered.
- Phase 2: The therapist makes the final homework recommendation. The therapist is also explicit about the fact that this is homework, gives the rationale for the homework, and discusses possible problems in carrying it out.
- Phase 3: The homework is received by the client. The therapist and client discuss the acceptability of the homework.
- Phase 4: The implementation of the homework assignment is discussed. This process involves making sure the client fully understands the homework and any barriers to the implementation of the homework.
- Phase 5: In the next session, the therapist asks the client about the homework experience.
- Phase 6: The client reports about the homework.

Phases 5 and 6 are viewed as feedback about the experience and information about how to move forward. We believe that homework can be therapeutic when clients successfully follow through and diagnostic when clients' attempts are not successful. It is useful to point out to the couple that no matter what happens, they should try the homework because it will generate useful information for their therapy. The therapist also asks for a detailed description about the homework effort and experience—what they did, how they felt about the experience, whether they had distracting or unpleasant thoughts, and meta-ideas about the homework. For example, on the meta-ideas a couple might say they were successful in doing a sensate focus exercise (one of the standard exercises in sex therapy), but report that there are much bigger issues such as the partners not really wanting to be with each other in spite of the fact that the exercise "felt good."

Assessment is also a critical part of effectively using homework exercises. Robinson (2009) recommends using 12 questions to assess the quality of homework assignments. These are common-sense questions that relate the initial, middle, and end phases of treatment. For example, during the initial phase of treatment a question might relate to the best method of self-monitoring, during the middle phase it might relate to the skills required to implement the homework, and during the final phase of therapy it could relate to which assignments have been most beneficial.

Structural Elements

Homework assignments have several structural elements: time, duration, frequency, and place. Being specific about these elements helps increase the likelihood that clients will successfully complete their homework by reducing possible ambiguities that might prevent them from following through on the assignment. The task should be carried out at a particular time of day, protected from distraction or interference. During the session the couple should discuss when they can schedule the task and what each/both need to do to avoid any disruptions. This discussion has the effect of giving the task priority, thus giving the relationship priority as well.

The duration of the task refers to how long the client-system stays engaged around the assignment. A common error is to prescribe a task that is too long or too complicated. For example, many couples cannot tolerate more than a few minutes of talking with each other. Asking a couple to talk for even 30 minutes is impossible for most couples in the beginning phase of therapy.

Frequency is the third element: "How many times during the day/week is the assignment to be done?" Again, the therapist needs to take a conservative approach at the beginning of treatment. For example, a couple might be able to manage three, 10-minute circumscribed talks during a week.

The final element is place. In order to change old habits, new associations are helpful, including where a couple interacts. Couples who have argued intensely in the bedroom or living room need to change location for talking. A location that is comfortable and free of distraction and old destructive associations is preferable.

Therapists should also discuss the importance of practice and the benefit of even small changes. Clients often overestimate the gains to be made from homework and underestimate the effort required to make such gains. One of the authors' favorite sayings is "practice, practice, and more practice." Sometimes it helps to talk about how long and how much practice is involved in learning such things as tennis, golf, proper grammar, and so on in order to help clients understand that change and improvement take time and effort.

The therapist should point out to the clients that homework is always a no-lose proposition. If the homework is done and the outcome is good, then the purpose has been achieved and the clients have likely benefitted from it. If the homework is not done or a good outcome is not achieved, then more data have been obtained. Therapists and clients can use this information to understand the factors contributing to success or failure. In a sense, homework is an experiment. Regardless of the results, everyone learns something.

At the end of the session, the assignment should be repeated to make sure everyone is clear about what is to be done. Some clients benefit by taking notes. The therapist should also make notes of the assignment in detail in order to follow up at the next session.

It is imperative that therapists ask clients to report on their assignments in the following session. Failing to follow up at the beginning of the next session or forgetting it altogether communicates disinterest in the homework and sends the message that completing homework is unimportant or optional. Bryant, Simons, and Thase (1999) report the best predictor of homework compliance is the therapist's reviewing the outcome of the previously assigned homework in the following session.

If the homework is done, whether successfully or unsuccessfully, the couple should be praised. It is natural to praise clients who are successful. Clients who attempt but fail can still be commended for their effort, for taking responsibility, and for following through on the commitment. The entire experience is evaluated in order to extract as much information as possible about the positive and negative outcome. In the case of a successful experience, another assignment is then created which builds on the first. A failed assignment may be reassigned once obstacles have been examined and removed, or a different assignment may be developed. The processing of resistance will be more fully addressed in the last section of this chapter.

Examples of Homework Assignments

Several examples of homework assignments for couples are described below. Although this certainly is not a comprehensive list of homework, the tasks that follow, when properly selected and delivered to couples in treatment, can address problems on several different levels simultaneously.

1. Communication is one of the most common problems couples bring to therapists. Helping couples improve their communication, including using more effective problem-solving processes, is a worthy goal for therapy. However, therapists often prematurely attempt to have couples apply at home the communication skills they are learning in therapy by asking them to discuss and try to work through some problem or disagreement in their relationship. Instead of jumping to problem-solving, having each member of a couple talk for 5 minutes about himself or herself and share their feelings and perspectives on a nonconflictual topic while his or her partner simply listens and reflects is an effective task for building the foundation of empathetic listening and constructive problem solving. The couple need to set aside 10 minutes (5 for each partner) free from distraction several times a week to practice this skill. They first perform this task during the therapy hour so that the clinician can coach the couple through the process. The clients decide how often, when, where, and for how long they can realistically complete this assignment. It might also help to discuss what might interfere with task completion.

Successfully completing this task requires some (albeit short) period of time when the relationship is a priority, promotes some level of intimacy, and decreases the amount of projection between the pair. It may help realign hierarchies and detriangulate unhealthy alliances. Performance of the assignment can be diagnostic of the nature of the commitment between partners and to the therapeutic process. If the task is completed successfully, the therapist explores in detail feelings, thoughts, and behaviors and builds upon the success in designing future assignments. However, if the task has failed in some way, or has not even been attempted, the task may be repeated, perhaps in smaller steps, or redesigned. The couple is asked what would enable them to carry out the assignment and what concerns they might have if the exercise, in fact, has a positive outcome or leads to the resolution of a problem they have.

Once a couple has successfully completed the homework to talk with each other about nonconflictual topics, the homework can move to communication and problem solving around topics that are more difficult for the couple to handle.

The communication exercise described above prepares the couple for success in these more difficult assignments. Communication, negotiation, and problem solving are discussed in more detail in Chapters 12 and 13.

2. Another effective out-of-session task is to have each member of a couple complete and share a genogram. Doing so assists partners in learning how the patterns of the past are being acted out in their current struggles with each other in the present (DeMaria, Weeks, & Hof, 1999). Awareness of one's own and one's partner's history promotes greater empathy and less reactivity as well as the possibilities of alternative ways of perceiving, feeling, and acting in a given situation. For example, learning that a partner's parents were neglectful and lacked concern for their child, now an adult, can help that person and his or her spouse understand the confusing desire for and yet rejection of affection and approval. With this awareness, the partner's ambivalent behavior may feel somewhat less like a personal affront to the person on the receiving end of the anger and hurt.

This task also addresses the issues of expectations and communication on psychodynamic, cognitive, and affective levels. It brings the past into the present in a useful way. The discussion about family of origin allows for understanding of less realistic expectations on the part of the person who unconsciously yearns for his or her partner to make up for all the wounds of the past. In sessions, the clinician guides the couple through the process of creating a genogram or family history, taking detours where necessary, but always directing them back to the main highway. Between office visits, clients are instructed to gather information about parents, grandparents, aunts, uncles, and other relatives, setting in motion the process of change in perceptions, feelings, and patterns of behavior with individuals outside of but influencing the couple dyad.

3. When couples have problems, they tend to get focused on the negatives in the relationship and in their partner. A helpful homework assignment is to have couples spend the week noticing the positives in the relationship and in each other. This can help reverse the negative momentum, which has probably been escalating for some time prior to treatment. Each partner is instructed not to discuss the findings but to bring a list to the next session. If the task has been completed, clients build on and process its success. If not, the assignment may be repeated or altered. Obstacles to progress are removed and fears about success examined.

4. Observational tasks are more passive assignments in which clients collect information that can help them become more aware of what is going on in their relationship. An example of this would be self-monitoring, or keeping track of positive gains or problem behaviors in their relationship, which can help clients realize what they think, feel, and do and how these things affect themselves and others (Dattilio, 2002, 2005). Journal writing is another example of an observational assignment (Dattilio, 2005). Clients may be asked to reflect in writing on their own thoughts, emotions, and behaviors.

5. Experimental or behavioral learning tasks require clients to try to implement new behaviors (Dattilio, 2002, 2005). Some examples include pleasing behaviors, caring days, behavioral rehearsal, assertiveness exercises, and role reversal.

6. Activity scheduling is a third type of homework assignment that incorporates communication, interacting, and problem-solving skills. Couples can build on the positive changes they have made as they set aside time to participate in an activity together. Date nights are one example of this.

7. As mentioned above, bibliotherapy is also a common assignment.

Promoting Compliance with Homework

Client compliance with homework, or the lack thereof, is a challenge that many therapists face in their work with couples. It is not reasonable for clients or therapists to believe that significant growth and change will occur in a couple's relationship if couples do not follow through with assignments and put into practice the things they are learning in therapy. Therapists can help clients be more engaged between sessions as they learn ways in which they can effectively invite clients to follow through on homework assignments.

Compliance is facilitated as therapists assign tasks that fit with clients' progress and pace of change in therapy. A common mistake made in assigning homework is to give too much homework, too soon, that is too complex and demanding. It is better to start with small tasks that fit with the clients' perspective of their problem in order to increase the clients' acceptance of the homework and reduce resistance (Scheel, Hanson, & Razzhavaikina, 2004). When barriers to compliance arise it is suggested to perhaps hold off for the time being, modify the assignment, or possibly implement other approaches that may be more effective with the clients (Dattilio, 2005). Homework is also a way of assessing whether the change that the therapist perceives in the session is being maintained and practiced at home (Stricker, 2006). A couple may demonstrate changes in their communication during the session, for example, but when given an assignment that relates to communication may revert to their old patterns at home.

Strong and Claiborn (1982) discussed three principles that are useful in increasing client compliance. These principles should be particularly useful when resistance is high and the clients do not believe they have control over their behavior. The first principle is *choice*. It is important to give the prescription in such a way that the clients perceive they have a choice in how to respond. Common techniques include asking the client to think of alternatives, asking focused questions that point out various directions or possibilities, and providing latitude for what the client does. The use of language is important in creating a sense of choice. The therapist should avoid terms that have a polarizing and/or pejorative effect. Absolutes such as right versus wrong, good versus bad, sane versus crazy, and truth versus fabrication need to be avoided. These terms imply that the client and therapist know the "facts" of a situation, facts that represent an immutable reality and demand certain consequences or behaviors.

Language suggests choice by giving clients a sense that reality is something that happens interactionally and may be interpreted differently by each partner. The therapist can communicate this concept by talking about perceptions, opinions, beliefs, viewpoints, and appearances. The therapist can discuss what will "work," "be

useful," "be productive," and "fit," rather than what would be the "right" or "perfect" solution, or giving a directive that implies no room for alternatives.

Therapists' language may be particularly critical when presenting tasks for clients to do between sessions. Consider what happens when the word "homework" is used with a school dropout or with someone who feels homework was a forced behavior in school. This term stimulates resistance immediately and thus suggests an attempt on the part of the therapist to force compliance. On the other hand, consider the person who believes that homework is an efficient way to learn. Many teachers and professionals, for example, may view the idea of homework as quite practical. They are anxious to comply with the task.

Extrasession labeling and prescriptions must be congruent with the client's perception of how change occurs. These extrasession tasks may be called prescriptions, tasks, assignments, chores, experiences, exercises, experiments, and so on. This point has also been made by others. In couple therapy clients often assume that something called homework is going to be unpleasant, and for this reason many therapists use other terms such as out-of-session assignment or experiment (Kazantzis, Deane, Ronan, & L'Abate, 2005). The prescriptions may be given with more or less structure, more or less input from the client, and more or less flexibility, depending on what provides the best fit with the couple.

Additionally, Kazantzis, Macewan, and Dattilio (2005) advocate for the clients to receive a written copy of the assignment, based on empirical evidence pointing to greater compliance in those clients receiving a written copy of the assignment (Cox, Tisdell, & Culbert, 1988). This task may be facilitated with the use of a homework assignment form such as the one created by Kazantzis, Deane, and Ronan (2005). Their form includes a description of the assignment, the goal, when, where, how often and for how long the task needs to be done, as well as a confidence rating scale for the client to determine their confidence in completing the assignment.

The second principle that can be used to increase compliance and attribution of change to self is called *personalism*. Personalism refers to the idea of suggesting homework in a way that clients take responsibility for change and thus take greater ownership of change efforts and outcomes. Rather than provoking feelings in clients of being coerced or personally directed by commanding or demanding that they complete homework, therapists should empower clients by talking about the action needed to respond to the situation. The therapist might say, "This problem requires that you . . ." or "Part of the treatment for this problem involves ___ doing ___ at home." The therapist can also avoid provoking defensiveness by softening statements such as, "I know" to "I think," "You're wrong about that" to "Let's take a look at what was just said," and "You should do . . . '' to "It seems one choice is . . ."

When giving a prescription, the therapist can also emphasize the need to do certain things as a function of the couple's situation. For example, when a couple begins treatment with a power struggle in the relationship, each partner perceives that the other is trying to force him or her to be a certain way or to do certain things. If the therapist then tells them they "must" do certain homework tasks, the pattern will be replicated, as clients perceive that the therapist is trying to control them as well. In order to avoid a power struggle with a client-system, the locus of power must be shifted away from individual members and the therapist.

Contracting approaches accomplish this goal by shifting the power to the contract. The contract diffuses this power struggle by placing control in the mutually developed contract. By giving control to a mutually agreed upon contract, the partners believe they created control for themselves. An "external" system is now in control, thus diffusing the previous power struggle. Many systems of therapy rely on this principle. The therapist is seen as implementing a program, system, technique, and so on—not as imposing his or her own will on the client.

The degree of *implicitness versus explicitness* is the third principle. An implicit prescription produces greater compliance and self-attribution. An example of an implicit form of prescription is the Rogerian technique of reflective listening. Although it may appear that the therapist is exercising little control with this technique, the content of the material reflected back to the client and the way in which the material is reflected is indeed a form of influence, albeit indirect.

In summary, the therapist wants to decrease resistance and increase compliance. Compliance is enhanced if the client's sense of freedom is augmented (e.g., the therapist offers several alternatives) and the degree of difficulty is reduced (e.g., the therapist accepts the client's pace). Compliance is also increased in the context of a strong therapeutic relationship and trust in the therapist's motives and abilities. Kamins (2006) suggested that clients who were most compliant with completing homework assignment were those who perceived the therapist as empathetic. Therefore, just as in all therapy, attention to building strong rapport, confidence, and trust with the therapist is important. It is important to remember that "In all cases, homework requires collaboration, judicious preparation, and careful timing in order to promote compliance and prevent relapse" (Gambescia & Weeks, 2007, p. 365).

Resistance to Homework

In behavioral marital therapy, resistance was seen as an expression of ambivalence and as a reaction to the difficulty of change, rather than as a desire to maintain the status quo. Homework compliance is a good predictor of commitment to change. When homework is not performed or is not successful it may suggest that the assignment was too difficult, nonspecific, poorly planned, or misunderstand (Kazantzis et al., 2005). Two strategies may be employed when clients fail to complete their homework. The first is to process the homework assignment with the couple in order to make explicit the reasons why they did not attempt it or abandoned it. In some cases, one partner does not believe the other will change, so he or she does not follow through. In other cases, one partner will be feeling so resentful or angry that failure is certain. Fear of failure (or fear of success) may also undermine their efforts. At other times one or both partners may be ambivalent, tenuous, or unequally committed to treatment (Gambescia & Weeks, 2007). Explanations may reside in the individual, in the couple system, or in the intergenerational system (Weeks, 1989b). The exploration of the meaning of change to the system and the reasons for resisting homework may then free the client(s) to move forward.

When attempts at homework have failed repeatedly and the in-office sessions are stalled, it might be an appropriate time to try some paradoxical techniques (Weeks & L'Abate, 1982). The first strategy to be used is what Weeks and L'Abate (1982) call

negative consequences of change. This involves asking the client-system to describe what kinds of negative consequences would result from making the kinds of changes that have been stated as desirable. The therapist then poses each desired change from the clients' perspective in a negative light.

For example, conflict resolution homework might have been given to a couple who desire to learn how to resolve conflict effectively rather than fight. When their homework fails, the couple would be asked to describe what would be negative about not fighting. The client(s) would probably say they would just "feel better," which is not really a response to the question. The therapist would challenge this statement with a rebuttal. For example, he or she might say, "It seems the only way to be close is to fight. Without it there might be nothing between you. Being really close without the negative emotions of fighting might be too threatening for both of you at an emotional level." The point of this strategy is to get the client(s) to resist not changing by pointing out the danger, risks, and in extreme cases the impossibility of change.

Other paradoxical techniques can be employed when clients resist change and do not follow through, such as symptom prescription and restraint (Weeks & L'Abate, 1982). These strategies are specifically designed to turn resistance against itself. Elaborating on paradoxical techniques goes beyond the scope of this book, but they have been described extensively elsewhere (Weeks, 1991; Weeks & L'Abate, 1982).

Conclusion

The change that is discussed and practiced in therapy sessions must extend beyond the therapist's office. In order to facilitate this change, the therapist may choose to assign homework. Homework involves couples doing something on a prescribed basis that is systematically laid out and designed to achieve a particular therapeutic goal. Homework assignments should grow from the sessions in an organic fashion. Many examples of homework can be found in the literature, but it works best to develop assignments that are tailored for each couple and developed collaboratively. Given this fact, predetermined assignments are usually not indicated. We may use standardized assignments as guides, but should not be limited by them. Giving homework is a therapeutic skill just like any other. Knowledge and experience combine to contribute to more effective, successful, and appropriately timed experiences for the couple.

18

TREATING INFIDELITY

Very few issues in couple therapy are as challenging and as emotionally laden as treating infidelity. When a couple presents this issue in therapy, it is almost always with considerable emotional turmoil. In fact, it is one of the most charged experiences in couple therapy and has the potential for tremendously destructive emotional, relational, familial, and financial consequences. On the other hand, if the couple is committed to working together, an affair can be a turning point for an individual and a couple, offering the prospect of new growth, understanding, and commitment.

Although there is much in the literature about the feelings experienced by couples when an affair has taken place, we often overlook the feelings engendered in the therapist who is treating the couple. Therapists report that infidelity is one of the most difficult problems to treat, and many therapists are apprehensive and uncertain about how to work with such a challenging issue (Fife, Weeks, & Gambescia, 2008; Whisman, Dixon, & Johnson, 1997). The senior author once conducted a week-long training in couple therapy. The fifth day contained the training unit on affairs. On the fourth day, he noticed the participants were becoming anxious and beginning to ask questions regarding the content of the fifth day. When the group was asked to discuss how they were feeling, almost all expressed concern that we would not have enough time to cover infidelity, and many expressed concern over how they had been handling this issue with their clients. In this chapter we provide a thorough description of how to work with couples in treatment for infidelity. Interested readers are referred to Weeks, Gambescia, and Jenkins (2003) for a more comprehensive text on this subject.

For clarification purposes, the following identifiers will be used in this chapter:

Affair partner = client having the affair
Betrayed partner = client not having the affair
Extramarital or extradyadic partner = individual with whom client is having the affair.

Challenges for the Therapist

For most therapeutic issues, the therapist is concerned about which model, technique, or strategy will produce the best result. However, treating extramarital affairs raises other concerns and anxieties in the therapist that are unique in treating this problem. Two of the most common issues raised are countertransference and ethical questions

regarding confidentiality with so much at stake. Therapists must understand the potential challenges related to these issues and how to successfully manage them in order to effectively work with clients in treatment.

Countertransference

Countertransference refers to feelings and responses within the clinician, both conscious and unconscious. When conscious, these feelings may be beneficial to therapy. However, when unconscious, they may be a significant road block to helping clients recover from infidelity. Unconscious countertransference can be subtle such as a therapist favoring one partner, being harsh or impatient, or avoiding painful affect. It can also be less subtle, such as being late, running over time, missing appointments, and billing incorrectly (Silverstein, 1998). Unfortunately, no empirically based studies have been conducted regarding therapists' reactions and feelings in this area. Our experience in supervising hundreds of therapists over the years and in observing the attitudes of others has shown us that therapists bring a variety of attitudes about what affairs mean and how to treat clients. Attitudes range from permissive (even encouraging) to moralistic and judgmental.

In all likelihood, these attitudes do not have any professional grounding, but represent the life experience and viewpoint of the therapist. For example, one seasoned therapist would encourage women to have an affair in order to test their commitment and feelings for their partner. If this therapist's female client were already involved in an affair, she would presume it was because the extramarital partner was more suitable for the client than the partner, thereby supporting the client's wish to leave the relationship to be with the extramarital partner. Obviously, this therapist is overlooking the numerous factors that can contribute to engaging in an affair, such as conflicts arising within the individual client. Not incidentally, this therapist had divorced her first husband (an alcoholic) after becoming involved in an affair. Clearly, in the therapeutic setting, the therapist unconsciously superimposed her experience on her clients. In effect, this therapist attempted to justify her personal choices through an over-identification with her clients.

At the other extreme are those therapists who take a moralistic and judgmental stance toward the affair partner. They tend to assume these partners have done irreparable damage and should be punished by forfeiting the relationship. They assume the relationship is beyond repair and their task is to help the betrayed partner leave. Through our supervisory experiences, we have noted that some of these therapists have strong religious convictions related to infidelity and others have experienced hurtful divorces in their own marriages and in those of their parents. In cases when therapists took a strong moralistic or judgmental stance, they often reached a conclusion without assessing the many factors that contributed to the affair. Also, working on the relationship was overlooked as a therapeutic option, as the therapist failed to ascertain what the clients wanted from therapy. We suggest that every therapist examine his or her attitudes about infidelity in order to avoid getting caught in the emotional web of their own countertransferences. When necessary, therapists should address issues of countertransference with a supervisor or personal therapist.

There are several common situations related to infidelity that evoke strong feelings in the therapist. Affairs can "sneak up" on us. In many cases, the therapist has worked

with a couple for several weeks or months before an affair is discovered or revealed. When such an event occurs, the therapist may feel betrayed and foolish for not being able to see through the deception. When the clients keep this information from the therapist, strong negative feelings may develop toward the affair partner. The therapist may need to process these feelings with the clients, but also keep them under control and in perspective. The default assumption is that virtually everyone lies about having an affair initially, whether it is deception directed toward the betrayed partner or the therapist. The therapist must maintain a detached personal attitude about this deception and deal with it therapeutically. The therapist needs to be vigilant when assessing the relationship, looking for signs that might reveal the presence of a hidden affair. In addition, the therapist may be afforded an opportunity to model for the betrayed partner how to deal with the revelation of such information.

Infidelity tends to place therapists in an emotional bind in more ways than one. First, the affair requires *immediate* confrontation. Many clients will try to minimize the impact an affair has had or is having on their relationship. Some partners may argue that if the therapist can improve their relationship, the affair will stop. Unfortunately, the betrayed partner sometimes "goes along with" this idea, hoping to save the relationship without confronting the fact that an affair has happened or is happening. Our experience has taught us that no real or lasting change can occur in a couple as long as an affair is ongoing. Some couples will give the appearance of change, offering hope to the therapist, but will then relapse into the same patterns. Sometimes the couple will want to work on all kinds of other issues before addressing the infidelity. *The therapist cannot ignore the affair, nor can the couple.* It takes priority over all other issues. We are asserting that the therapist may need to take control of the therapy and be clear about the need to deal with the affair first. This tactic may make the therapist uncomfortable or produce anxiety over whether the clients might terminate treatment, particularly for therapists who prefer a collaborative approach, because of the need to assert control or purposefully structure the therapy to focus on the affair. Nonetheless, most clients will appreciate the forthrightness of the therapist's position and understand the need to talk about the affair before taking on other relationship issues. For those who reject the therapist's position, we believe that since no change can occur unless the affair is addressed, suspension or termination of therapy may be an appropriate course of action. It is almost always the affair partner who rejects dealing with the affair first. In such cases, betrayed partners might be offered individual treatment so that they can decide on their own course of action. The strategies for confronting the affair are covered later in this chapter.

Confidentiality

Confidentiality is likely the most ethically problematic and anxiety-provoking aspect of dealing with infidelity. Information about affairs may be revealed in myriad ways. Ideally, the couple begins therapy with an admission of what has happened or is happening. However, in many cases, the affair is revealed or discovered during the course of therapy. What happens when just one partner reveals this information to the therapist in confidence? What happens if the therapist sees one of the partners on the street with someone other than his or her partner and it is clear they are acting in

a physically or emotionally intimate way with them? What happens if a friend of the couple or another client reveals this information?

Karpel (1980) has offered some useful guidelines about establishing the rules of confidentiality. Before discussing his concepts, it is essential that therapists understand the importance of establishing guidelines for confidentiality in the first session. Although much of therapists' work with couples occurs with both partners present, there are legitimate reasons for meeting with partners individually. Regardless of what approach a therapist takes regarding confidentiality, she or he should discuss with clients how confidentiality will be handled so that everyone is on the same page moving forward. Without a clear understanding of the rules of confidentiality, the therapist and clients may be placed in a position that interferes with effectiveness of therapy, thereby preventing the therapist from helping the couple. For instance, the therapist may find that he or she has information and does not know how to deal with it, or feels uncomfortable with the information because of the assumption that *all* information revealed to the therapist must be kept confidential (the default position). This position renders the therapist ineffective and powerless.

Karpel's (1980) work on therapeutic confidentiality suggests the therapist may take one of three positions. The first is the classic position of keeping *all* information confidential. In other words, any information gained outside the conjoint sessions is considered confidential. Thus, if partners are seen separately and one of the partners admits to an affair, the therapist would be obligated to maintain that client's confidence. The second, opposite, position is that all information received regarding the couple is open for discussion. Whatever one partner says in private is considered the same as if it were said to the other partner; this position assumes there are *no* secrets and ensures secrets will and should be revealed. Such an approach would require the therapist to get written consent from both parties at the beginning of treatment.

The third position the therapist may take calls for both accountability and discretion. Our interpretation of this principle is that the therapist will agree to maintain information in confidence, but will, at the same time, require that each partner assume responsibility for any behavior which might impede the therapy such as an addiction, individual issues, infidelity, etc. Accountability involves the partner in question being honest with the therapist and earnestly working on changing the behavior in question. Typically, when a partner is having an affair and is unable or unwilling to discuss it with his or her partner, he or she is encouraged to admit to being "unsure about commitment to the relationship." This kind of announcement to the partner enables the therapist to temporarily interrupt conjoint sessions while the individual client decides what to do about the affair. The couple will then continue via individual sessions with another therapist or the couple's therapist. Typically, we prefer that each partner work with the same couple's therapist in individual sessions. This strategy allows the therapist to stay fully informed. If the change in format creates suspicion in the partner who has not been told about the affair, the couple is encouraged to discuss their concerns together. This approach creates pressure for the person having the affair to assume responsibility rather than keep a secret from the partner. Furthermore, the therapist is not colluding with one partner in conjoint sessions by protecting the secret, thereby triangulating the unknowing partner. The onus of responsibility is on

the affair partner to decide about his or her commitment to the relationship. This third approach will be discussed in greater detail later.

A fourth approach offered by Butler, Seedall, and Harper (2008) involves letting each partner, at the onset of therapy, decide whether they would like to know nothing, know partial, or know full details of secrets disclosed during separate sessions. This approach is based on the idea that the partner should be able to decide if they would like to know information that could be potentially harmful to the relationship.

The position we take in working with couples is the third one mentioned above: discretion and accountability. The first two positions are simple, and the therapist ostensibly does not get caught in any binds, nor does the therapist have to experience any anxiety or dissonance over carrying a secret. Our experience has been that less experienced couple therapists prefer the first two positions because of their simplicity and the comfort level they afford the therapist. Unfortunately, when the first position is adopted, the therapist may have knowledge of an affair, but his or her hands are tied. The therapist is without maneuvering room: she or he must pretend not to have this information, get the partner to reveal the infidelity, or find some way to terminate therapy. With the second position, all information is shared. This has a significant deterring effect on a partner revealing a secret affair to the therapist. The therapist may operate in the dark, not knowing what is actually happening. After several months of treatment, it sometimes becomes apparent that some secret must be in the system due to a lack of change without apparent reason. But the client will not bring it up because of the "no secrets" rule. In the third approach, accountability and discretion, rules of confidentiality give the therapist access to the most information and create some room for the therapist to maneuver. The therapist has an opportunity to intervene with the affair partner in order to try to stop the affair or at the very least expose what is happening indirectly. The third option is the most complex and produces the most discomfort in the therapist. As we stated, the rules of confidentiality must be stated in the first session and clearly defined. Regardless of approach taken, the wise couple therapist will discuss the matter with clients at the beginning of therapy so they fully understand the rules and limits of confidentiality and will get written consent from the clients to proceed with treatment.

Suppose the third option is in place, and one member (or both members) of the couple reveals a past or present affair to the therapist in an individual session. In either case, the therapist would want to spend time with that partner(s) discussing the infidelity. When there is an ongoing affair, the affair partner should be given the following information.

1 The therapist will not divulge this information, but expects accountability.
2 Accountability means taking responsibility for the affair by understanding why it is occurring.
3 The affair partner should be told quite clearly than an active affair will impede any progress being made in the couple therapy, and if it is their intention to work on the relationship, the affair must stop quickly, within no more than 4 weeks from the session.
4 If the affair partner is unwilling to stop the affair, then the therapist suggests that he or she is not really motivated to work on the marriage or relationship. The

affair partner is given the options of informing the betrayed partner about the affair and/or discussing divorce, or informing the betrayed partner that he or she has a personal issue which will not permit couple therapy to move forward at that time. The affair partner is informed that if he or she does not choose one of these options, the therapist will remind the couple of the rules of confidentiality agreed on at the beginning of therapy and tell the betrayed partner that couple therapy cannot proceed because of a personal issue the affair partner revealed in the individual session. In our experience, it is rare for a client to be unwilling to stop the affair. However, Humphrey (1985) found that 24% of husbands and 23% of wives were still involved in an affair at the end of a course of brief therapy. He does not mention what type of treatment was provided, nor does he suggest any individual sessions were held to help the affair partner break the bond with the extradyadic partner. The therapist tells the couple that due to the rules of confidentiality, this information will be kept in confidence, and that it is their responsibility to arrive at some understanding as to why termination of couple therapy occurred. At this point, the betrayed partner will be thinking about all the possible reasons the other partner cannot proceed with couple therapy. He or she knows there is a secret and begins to investigate more vigorously the nature of this secret. Although this situation has been rare in our experience, partners have no trouble ascertaining that a third party must be involved. This suspicion leads to a confrontation, and in all but one case we can recall, an admission of the truth.

5 The therapist recommends that each partner begin individual therapy in the hope that some individual movement can be made that will enable them to return to couple therapy.

This rule of confidentiality has worked consistently in our cases. The fear that many therapists have expressed is that the betrayed partner will be angry with the therapist for keeping the secret. In fact, it is our experience that the betrayed partner typically understands the agreement and is appropriately angry with the affair partner, not the therapist, for keeping the secret. Fortunately, most couples that come to therapy do want to improve the relationship or save it. Because they are motivated by this goal, each partner is usually willing to do what is required to make the couple therapy work for them. The affair partner is then seen for several sessions in order to help him or her understand why the affair began and learn how to stop it. In addition, the betrayed partner might require some individual work in order to deal with the intense emotions he or she experiences when the affair is revealed. Treating the individual partner is a therapeutic issue that will be described later in this chapter in the treatment section.

Definition and Prevalence

Infidelity has been defined by clinicians and scholars in myriad ways. One of the earliest writers to grapple with the definition of an extramarital affair was Thompson (1983). According to him, "Extramarital sex is defined as genital sexual involvement outside the marriage without express knowledge or consent of one's partner" (p. 240). The advantage of this definition is that it is fairly easy to behaviorally ascertain whether a sexual affair has occurred or not. Of course, there are those who believe that certain

acts such as oral–genital sex are functionally the same as a handshake and do not count as extramarital involvement. Unfortunately, a definition as simple as Thompson's still presents many problems for the clinician and the couple in treatment. As we just mentioned, one partner may try to redefine what genital involvement means, declaring that if there was no intercourse, oral–genital sex, mutual masturbation, or fondling, then there was no affair. For most couples and therapists, however, the definition of infidelity encompasses more than intercourse or genital involvement.

Another issue is whether the betrayed partner really knew about the affair. Charny and Parnass (1995) surveyed therapists who had extensive experience in treating affairs and found that most therapists believed the spouse knew the "secret" affair was occurring and was in collusion with its continuation. They stated, "Even the majority of the betrayed spouses who claimed consciously that they opposed their spouses' behavior were unconsciously in collusion with them" (p. 100). The respondents believed that only 10% of the spouses were genuinely and actively opposed to their partner's affair. Many partners wish to deny the existence of an affair because of the emotional, marital, familial, and economic consequences that might follow if the issue was confronted. Those partners who "know but choose not to know" represent an interesting problem as far as the definition goes. If a partner has given implicit approval for the affair, does it invalidate the concept that an affair has actually occurred?

Another problem obviously has to do with what have been called emotional affairs. Glass and Wright (1992) attempted to correct the shortcomings of Thompson's (1983) definition by offering three categories of affairs: primarily sexual, primarily emotional, and a combined type (emotional and sexual). These categories make sense from an intuitive and clinical perspective, but again it is difficult to operationalize the types. For example, clients and therapist may be uncertain about how to define an emotional affair. In our practice, these affairs are characterized by: (1) considerable emotional intimacy; (2) sharing thoughts and feelings which are not revealed to one's partner; (3) a strong urge to spend time with the extramarital partner; (4) maintaining secrecy around the relationship; and (5) a sense in the betrayed partner that a line or boundary has been crossed whereby matters that are private to the couple are discussed with the extramarital partner.

Individual partners may draw different lines regarding these criteria that are sometimes quite different from the lines the other partner or the therapist might draw. For example, what if a man is viewing pornography? Some partners we have worked with define this as infidelity. Or what if a wife has a close male friend with whom she spends time and shares feelings—does that automatically mean that relationship is an affair? Some husbands would feel this kind of friendship is inappropriate and would demonstrate considerable jealousy. Technology and the advent of the Internet, chat rooms, online dating sites, social media, and cellphones create additional opportunities for extradyadic interaction and the possibility of infidelity (Internet infidelity is addressed specifically later in the chapter). At the extreme are exceptionally jealous partners who believe that if their partner looks at or has a brief conversation with an individual of the opposite sex it is the same as an affair. At the other end of the spectrum from Thompson (1983) is a definition offered by Don-David Lusterman (1998). He states, "Once a committed relationship is established, if there is a secret sexual and/or romantic involvement outside of the relationship, it is experienced as an infidelity"

(p. 186). This definition stresses commitment and secrecy rather than passion and intimacy.

We believe that with most couples in committed relationships there is a stated or implied commitment to both sexual and emotional fidelity between partners. We define infidelity as "any form of betrayal to the implied or stated contract between partners regarding intimate exclusivity. With infidelity, emotional and/or sexual intimacy is diverted away from the committed relationship without the other partner's consent" (Fife et al., 2008, p. 101). Infidelity may also be conceptualized by clients to include not only another relationship, but the secrecy, lies, possibility of introducing disease, and putting the partner in harm's way (Fife, Weeks, & Stellberg-Filbert, 2011).

Having a definition that can be operationalized may be more important to researchers than clinicians. As clinicians, we must deal with ambiguity on a daily basis. In most cases, it is not difficult to tell when a relationship has become inappropriate. In fact, once the discussion begins most couples do not quibble over definition, but agree that something was inappropriate. This is not to suggest that partners do not deceive or deny that an affair has occurred or is occurring. Once the admission has been made that "something happened," it is usually with the idea that it was inappropriate.

Finally, the term *extramarital sex* fails to capture the problems encountered by those partners who are in a committed dating relationship. Many unmarried couples present for treatment with the same issue. One partner had assumed there would be fidelity only to discover the other partner had gone outside the relationship. Recent research and literature on infidelity have used the more inclusive terms *extradyadic sex, extradyadic relationships*, and *extradyadic involvement*.

The prevalence of infidelity is difficult to determine because affairs are almost always concealed. Even though researchers promise confidentiality, some subjects are reluctant to reveal their affairs. Some studies have utilized methodologies that would suppress reporting of such data. In some of the earliest research on infidelity, Kinsey, Pomeroy, and Martin (1948) and Kinsey, Pomeroy, Martin, and Gebhard (1953) reported that an estimated 50% of husbands and 26% of wives had had an extramarital relationship during the course of their marriage. Many other researchers have examined the frequency of affairs and found the following:

- 40% for men and 36% for women (Athanasious, Shaver, & Travis, 1970)
- 20% for men and 10% for women (Johnson, 1970)
- 41% for men and 18% for women (Hunt, 1974)
- 50–70% for men and 35–55% for women (Marret, 1990; Martin, 1989; Thompson, 1984 as cited in DiBlasio, 2000)
- 60% for men and 45% for women (Glass & Wright, 1992)
- 24.5% for men and 15% for women (Laumann, Gagnon, Michael, & Michaels 1994).

One difficulty inherent in understanding these results is that the researchers used varying definitions and methodologies, which makes comparison and confidence difficult.

Two large-scale studies utilizing sophisticated sampling techniques and data collection deserve special attention. The 1993 National Opinion Research Center conducted

a study with approximately 1,200 respondents. On average, about 15% of married or ever married individuals reported having had an extramarital affair. When broken down by sex, the percentages were 21% for men and 12% for women. Wiederman (1997) analyzed data from the General Social Survey conducted in 1994. This sample consisted of over 2,000 respondents. He found that 22.7% of men reported an affair compared to 11.6% for women. Additionally, he found that for the members of the sample under 40 years of age, there was no difference in the incidence of affairs. The incidence for affairs tended to increase for men as they age (at least up to age 70), whereas for women the highest incidence was between 30 and 50 years old. Similarly, the 2006 General Social Survey conducted a study of approximately 1,700 respondents. On average, about 18% of married or ever married individuals reported having sex with someone other than their spouse. In averaging numbers from past General Social Surveys that have been conducted since 1991, of nearly 15,000 respondents 16.7% of married or ever married individuals admit to having had an extramarital affair. For more information on the General Social Survey visit www.norc.org.

In addition to the statistics mentioned above, a few other studies help us understand the frequency and nature of affairs. Thompson (1984) found 43% of the subjects in his study had been involved in one of the three types of affairs mentioned earlier. Primarily sexual affairs were reported by 21% of the subjects. Comparisons between men and women found that men were more likely to be involved in sexual affairs and women more likely to be involved in emotional affairs. One item of information that is missing from all these studies is the duration of the affairs, particularly prolonged affairs.

Finally, it is important to have some understanding of the prevalence of extradyadic affairs in those couples seeking treatment. Humphrey and Strong (1976) did a survey of clinical members of the American Association of Marriage and Family Therapy. The therapists reported that 46% of the couples coming for help reported an affair in their marriage. A replication of this study in 1984 showed higher rates, with some therapists reporting that the majority of their caseload has experienced an affair (Humphrey, 1985). Atkins, Baucom, and Jacobson (2001) reported that 50–65% of couples presenting for therapy were the result of infidelity. These results underscore the importance of the therapist having sufficient knowledge and training to work with couples who have experienced infidelity.

Dimensions of Extradyadic Affairs

As indicated above, defining the term infidelity is a difficult matter. Not all affairs are alike and are presented in many different variations. Assessing an affair presupposes an understanding of the various dimensions in which an affair may be presented. Several authors have attempted to identify these various dimensions, and their ideas have considerable overlap (Humphrey, 1987; Westfall, 1989, 1995). The therapist should consider the following dimensions of affairs and assess these during the evaluation phase of treatment.

1 *The frequency, duration, and location of the affair.* Some affairs are one-night stands only. Many of the clients we have seen had just one sexual encounter,

sometimes with a prostitute, and became frightened by what they had done. Other individuals had sex frequently or had frequent contacts with the extradyadic partner. Duration is an extremely important factor. Just how long did the affair last? Was it a week or two decades? The dynamics involved in these situations would be very different. Long-term affairs tend to stabilize a relationship that is not working and are very difficult to stop. The attachment between the affair partners has grown strong to the point the affair partner cannot choose between partners. The third element is the location of the affair. If an affair occurred in a person's home (i.e., in the bedroom), the symbolic meaning for the betrayed partner is quite significant. Partners will sometimes comment angrily, "How could you have sex in our bed with him/her?" Sometimes affairs occur in a motel/hotel or in a person's office. In one recent and unusual case, the affair was primarily emotional with a lot of sexual talk and was conducted almost entirely by voicemail. Each person had such a busy schedule that they would exchange up to 60 short messages a day between meeting with their clients. They were also reluctant to enter into a sexual affair, fearing people would find out and their careers would suffer. The Internet is another place where more and more people are meeting for emotional and "cybersex" affairs. Texting (or "sexting") also is a medium by which infidelity may occur.

2 *Number of past and present sexual partners.* One client of this author reported he had 150 partners prior to marriage and 150 after his marriage. Partners who report large numbers of sexual partners should be evaluated for a sexual or love addiction. For the nonaddicted individuals who report only a few extradyadic partners, their need for other partners should be explored. This need will be discussed further in the section on treatment.

3 *The gender of the extradyadic partner.* We usually think of an affair as involving a person of the opposite sex. Sometimes affairs are with members of the same sex. In some cases, this fact indicates that the partner is gay or bisexual but living in a heterosexual relationship. In other cases, it represents having explored a curiosity. One case involved a man who had an affair with another man because they both shared an interest in cross-dressing. The affair provided validation for his transvestism, a particular type of fetishistic behavior.

4 *The level of the sexual activity.* Sexual activity can occur along a continuum from verbal or written exchanges to intercourse for the purpose of impregnation. The therapist will want some idea about the actual behaviors that were experienced. It could range from a lap dance in a public bar to sexual intercourse in the back seat of one's car behind a nightclub.

5 *Whether the affair(s) was unilateral or bilateral.* For most couples, the affair has involved just one partner. In other couples, both partners have had affairs. It is uncommon to find that when couples present for treatment they are both in an affair. However, the history may reveal that each one has had one or more affairs. It is also important to determine whether an affair may have been a retaliation against the other partner's affair. One client, for example, discovered her husband was once again having an affair with one of his secretaries, and it had become common knowledge at the office. She responded by having an affair of her own which involved a public tour through Europe with a man. On another occasion,

she responded to one of his affairs by flagging a ride with a truck driver on an interstate highway and having sex with him. This particular couple happened to consist of a narcissistic husband and a histrionic wife.

6 *The degree of emotional involvement and attachment.* This is a critical factor. Glass and Wright (1992) found that men tend to have affairs more for sexual reasons and women more for reasons of emotional involvement. Women are more likely to link sex and love while men are more likely to keep the two separate. Therefore, it is useful to explore the level of emotional sharing which has occurred and how attached the partners feel toward each other. A one-night stand at a convention or sex with a prostitute does not usually represent much emotional involvement when compared to a long-term affair with frequent contacts.

7 *Each partner's relationship to the extradyadic partner.* This relationship affects the affair's impact on the couple. Generally speaking, it is easier for a couple to handle an affair when the extradyadic partner is someone the betrayed partner does not know. Unfortunately, many affairs involve persons who are close to both partners, such as a friend, family member or fellow church member. When the extradyadic partner falls into one of these categories, the other partner's sense of betrayal is much greater—it is a double betrayal: by one's partner and by the friend. One husband, for example, came home early from work one day to find another man in his bedroom with his wife. It turned out he was the cantor in his synagogue. The husband was a deeply religious man who attended services on a regular basis and considered this man a friend and religious mentor. The affair shook his trust in both his wife and marriage and in his faith.

8 *The degree of secrecy, lies, and deception around the affair.* A continuum of secrecy, lies, and deception may surround the affair and impact the ability to restore trust. Some partners will admit to having had or even thinking about an affair. For the most part, however, partners will deny the affair until they are confronted. Those affairs which have a long history (several weeks to months) usually involve considerable deception. The person having the affair must keep compounding his or her lies in order to maintain the secrecy. This pattern of deception creates an overlay on the affair. The betrayed partner is upset about the affair and also upset over the fact that his or her partner deliberately and consistently lied to them in order to conceal it. Such behavior is severely and catastrophically related to a loss of trust that may be impossible to rebuild.

9 *The degree of implicit approval or consent by the betrayed partner.* Without question, most partners strongly disapprove of affairs when asked or confronted with the reality that it is happening. However, the research of Charny and Parnass (1995), mentioned earlier, suggests there are some situations when spouses collude in allowing this behavior to continue without confrontation. There are also some couples who both clearly know about the affair and state that it is acceptable. There are usually conditions to these affairs, such as being told about an affair before it happens, being assured that it is for sex only, and keeping the affair discreet. There are also open marriages, and couples may swing with other couples provided that everything is out in the open. In a sense, the partners give each other permission to have sex with others and sometimes participate in a group sex experience. An Internet search will show that some cities have clubs

devoted to swinging. These couples may come to therapy when one partner is consistently breaking the rules they have agreed to or when one feels threatened that an emotional involvement is taking place. We suspect that a small percentage of couples tolerate each other's affairs in order to preserve the appearance of a marriage and for financial reasons. One woman who was married to a famous and wealthy man said she did not mind his affairs as long as he was discreet. They came to therapy because he broke the rule and had an affair with an employee that became public knowledge. His relationship resulted in her losing face in the community, and she was insisting he terminate the relationship immediately. She admitted that her marriage had been dead for many years, but she liked the wealth and the prestige she received from being married to such a well-known person.

10 *The tolerance for infidelity within the couple's social group, community, ethnic/cultural group, and religious affiliation.* Each one of these factors plays a role in how the partners perceive and deal with infidelity. Some couples, for example, belong to sexually permissive social groups such as swinging clubs. Affairs are tolerated and even accepted to the extent they conform to the norms of the group. The group may operate autonomously in terms of the greater community or culture. While religious communities typically sanction marriage and disapprove of affairs, some groups exhibit less tolerance than others. Fundamentalists tend to take a firm position equating the act with sin. Penn, Hernandez, and Bermudez (1997) are some of just a few researchers to describe infidelity from a religious (specifically Catholicism, Eastern Philosophy, Islam, and Protestantism) and ethnic (African-American, Hispanic, and Asian-American) perspective. Clinicians need to assess infidelity within each of these contexts, keeping in mind that partners will sometimes have different interpretations of their cultural norms. One couple who had immigrated to the United States from the Middle East presented for therapy due to the husband's affair. The husband claimed it was his right to have an affair and that it was extremely common in his culture. His wife strongly disagreed. The therapist suggested they both seek advice from a senior family member or religious advisor for help in understanding whether this behavior was acceptable in their culture. They did in fact seek out an elder in the family who explained that such behavior did occur, but was neither common nor acceptable. Apparently, the husband was trying to exploit his culture to justify his behavior and hoped the therapist might be sufficiently uninformed to accept this claim.

Relational and Emotional Consequences of Infidelity

An affair is a very serious event in the life of a marriage or committed relationship. The consequences generally fall into two categories. The first is the potential the affair has for dissolving the relationship and the second is the emotional impact on the couple. Divorce is one of the most common outcomes of infidelity. Betzig (1989) conducted an ethnographic study of 160 cultures and found that infidelity was the most common reason for divorce given across cultures. Divorce studies in Western culture have shown that between 25% and 50% of couples who divorce state infidelity was the primary reason (Hunt, 1974; Kelly & Conley, 1987; Levinger, 1976). Humphrey (1987)

examined the divorce and separation rates for couples during and after therapy. He found that when the husband had the affair the divorce rate was 10% and when the wife had the affair the rate was 17%. Additionally, when the husband had the affair, 45% of couples separated and when the wife had the affair 31% separated. It would appear that many of those who separated would eventually divorce. Unfortunately, Humphrey was not able to track these clients long enough to determine the eventual outcome. He had previously conducted the same study in 1976 and found the divorce rates were higher, which suggests more tolerance of affairs in the mid-1980s.

A survey of couple therapists also showed that affairs are one of the most damaging events in the life of a marriage. Affairs ranked second in negative impact after physical abuse (Whisman, Dixon, & Johnson, 1997). The same researchers asked therapists to rank couples' problems in terms of the difficulty of treatment, and infidelity was ranked as one of the most difficult problems to treat.

Charny and Parnass (1995) surveyed 62 therapists who had an intimate knowledge of at least one affair in their caseload. In those couples presenting with an affair, 34% of these marriages ended in divorce primarily due to the affair. The researchers were also interested in those marriages that were preserved following an affair. Of the 43.5% of marriages that continued, the overall atmosphere was dysphoric or negative. Another 6% reported the marriages appeared empty and the couple was not hopeful about the future.

Only a small fraction of the couples (9%), were characterized by improvement and growth, and many of those in this category had experienced a one-time affair. Humphrey (1987) reported that 26% of husbands and 21% of wives were improved at the end of treatment, even though treatment only averaged about 10 sessions. As grim as these statistics appear to be, the researchers did not address the issue of treatment longevity or type of treatment provided. Thus, we do not know whether treatment lasted only a few sessions, as is common in these studies, or what type of therapy was provided.

The emotional impact of an affair can be devastating. The therapists in Charny and Parnass' (1995) study observed injuries to self-esteem and confidence, feelings of abandonment, a betrayal of trust, feelings of exclusion and rejection, rage, and a sense of justification in leaving the spouse. Humphrey (1987) found that shock, anger, and denial were common initial reactions. When the husband had the affair, shock was ranked first (45%) followed by anger (35%). When it was the wife who had the affair, husbands ranked anger first (38%) followed by shock (19%). About 7–8% of spouses initially responded with denial. Charny and Parness (1995) identified a long list of negative consequences flowing from an affair including, "breaking of religious teaching; the breaking of trust; guilt; dishonesty; lies; anger; humiliation; depression; suicide; homicide; marital conflict; separation; divorce; anxiety; regret; lost respect and love; disruption of careers, marriage, and families" (pp. 161–162). Furthermore, he also mentions that many marriages continue to suffer for years and some eventually end in divorce.

The Typological Approach

Several writers have tried to develop typologies of affairs. All the typologies are loosely constructed and are based on clinical observation rather than research. Generally speaking, they either attempt to simply describe the nature of the affair or suggest the motivation for the affair. These typologies are clinically useful in that they give us

some clues as to the motivations partners have for violating their relationship. Emily Brown (1991) developed one of the earliest and best known of these typologies. Brown describes five types of affairs.

1 *Conflict avoidant affairs.* These affairs are designed to help the couple avoid having to deal with their conflict. Emotional energy is drained from the marriage and invested elsewhere. The fights that might occur are distracted by the affair. Unfortunately, attempts to resolve disagreements are also circumvented.
2 *Intimacy avoidant affairs.* Many couples can only tolerate so much closeness. When they begin to get too close, someone must do something to create more distance. An affair is just one of many strategies which serves the purpose of creating distance, thereby maintaining an equilibrium that is safe but lacking in intimacy.
3 *Sexual addiction.* Sometimes a partner is a sex or love addict (Turner, 1995). These partners have a compulsion to seek love or sexual experiences. Their sexual acting-out has little to do with the quality of the relationship and is related first and foremost to their addiction.
4 *Empty nest affairs.* This type of affair is similar to intimacy avoidance. As long as children are in the house, they may be used to avoid closeness. Once gone, the couple must face the emptiness in the marriage. The affair serves to fill the void within the marriage by becoming the new distraction. The marital intimacy equilibrium, therefore, remains undisturbed.
5 *Out the door affair.* Sometimes one partner wants to leave the relationship, but cannot leave without having another partner. They cannot tolerate being alone or thinking that they may never find anyone else. Thus, they must have an extradyadic partner in order to transition from the relationship.

Pittman (1989) identified four common patterns.

1 *The accidental encounter.* A one-time encounter which usually occurs while drinking, being with friends at a bachelor party, strip club, massage parlor, etc., or being propositioned by someone.
2 *Habitual philandering.* These partners show a consistent pattern of changing sexual partners and being disloyal to a primary partner. Pittman also agrees that such a pattern is addictive.
3 *Romantic affairs.* These affairs are about being in love with love. The person wants to recapture the intense feeling of being in love in order to escape from life's difficulties.
4 *Marital arrangements.* The partners implicitly agree they need to create distance and avoid the problems of their marriage. One or both partners engage in an affair to accomplish this goal.

Don-David Lusterman's (1998) typology deals primarily with the *motivations* for having affairs. Much of what Lusterman has to offer has been described in the other typologies. He identifies affairs that result from mid-life events, entitlement, sexual identity or orientation, sexual addiction, exploratory affairs, tripod affairs, retaliatory

affairs, and exit affairs. Three of his terms may be unfamiliar to the reader. An entitlement affair simply means the person having the affair feels entitled to engage in this type of behavior. Some men, for example, sometimes compartmentalize affairs by believing that they are entitled to have sexual relationships in which there is no emotional attachment. The tripod affair refers to the phenomenon of using the affair to stabilize a relationship that is not working. Finally, the exploratory affair is used to explore another relationship when the relationship is not working, but the affair partner has not decided whether to stay or leave the relationship.

Israel Charny (1992) has one of the most extensive clinical classifications for extradyadic affairs. He lists 18 types of affairs. We will list them using his headings and provide a brief description.

1. *Corruption, including sadism/masochism.* The affair is carried out with hostile intent, often serving narcissistic needs in the person having the affair.
2. *Superficiality and apathy.* The affair itself is devoid of emotional connection. These types of affairs are usually repetitive and sexual.
3. *Escapism.* The affair allows the partner to escape from the tensions of the relationship.
4. *"A matter of no importance."* The affair is for sexual release alone and the person claims it is of no emotional significance.
5. *"Search committee."* The purpose of this type of affair is to find a replacement partner.
6. *Falling in love to threaten spouse.* The purpose of this affair is to force some change in the mate.
7. *Falling in love to complete missing qualities in oneself.* The extradyadic partner is supposed to fill in the missing parts perceived in oneself.
8. *Enable continuation of the marriage.* The affair compensates for what is missing in the relationship and thereby stabilizes it.
9. *Challenge to improvement and recreation of the relationship.* The affair is designed to create a crisis in the relationship that may help to save it.
10. *Renewal of excitement and adventure.* The affair partner hopes to bring home some of the excitement of the affair.
11. *Desire-daring-survival.* This type of affair is experienced as a test of courage and power.
12. *Sexual excitement plus "safe" opportunity.* These affairs take place under "safe" conditions where the possibility of discovery is minimal.
13. *Fun and variety, anti-boredom, social contagion.* The purpose of the affair is to introduce variety into one's life.
14. *Release of nonmarital tensions.* The purpose of this type of affair is to flee from the problems of everyday life.
15. *Hope at difficult moments.* The affair is an escape from some intolerable life situation such as a death or illness in the family.
16. *Freedom and independence.* The mate who has the affair feels a lack of freedom and independence in the relationship. The affair is a way to assert one's freedom.
17. *Open marriage.* These partners both agree to have affairs under specified conditions.

18 *Hedonism—an insistence on the pleasure principle.* The partner who has this type of affair subscribes to hedonism as a basic life principle.

Intersystemic Assessment

As presented in Chapter 1, Weeks (1977, 1994) developed the Intersystem Model for couple and family therapy which has been applied more specifically to the treatment of infidelity by Weeks et al. (2003) and Fife et al. (2008). In this comprehensive model, every client system is evaluated and possibly treated from multiple perspectives, including the individual, the couple, and the intergenerational. Westfall (1995), a colleague and author in the field of affairs, utilized this model when describing the assessment of affairs. This section will provide a brief overview of her application of the Intersystem Model in assessing infidelity. Of course, there is overlap between the factors and some factors could be listed under two or more headings.

Individual Factors

At the individual level, some of the more common or salient factors associated with cases of infidelity are: (1) developmental crises, (2) psychiatric problems, (3) sexual orientation, and (4) major medical illness. A developmental crisis occurs when the couple or family is having difficulty moving from one lifecycle stage to another. For example, most couples experience a "honeymoon stage" in their relationship. When the relationship has matured some, this phase comes to an end, and the partners are no longer idealizing each other or being driven by their initial fantasies about the other person. Some partners may experience an intense feeling of disappointment to the point they feel the need to dissolve the relationship.

Psychiatric problems such as drug, alcohol, and sexual addictions, depression, anxiety, bipolar disorder, and many of the personality disorders may interfere with the functioning of the relationship. For example, a partner with untreated bipolar disorder is unpredictable, and it is difficult to stay emotionally connected to someone who is so labile. The addict is essentially married to the drug or behavior of their choice. They are incapable of having an adult–adult relationship, but form addict–co-addict relationships. Many couples have partners with personality disorders such as narcissistic–borderline or passive aggressive that predispose them to conflicts.

The third factor that may appear is that of sexual orientation. One partner may have conflicts about his or her sexual orientation that may interfere with the relationship. A person may marry in order to "look normal" and deny his or her homosexuality. Eventually such relationships lose their passion (assuming any was there from the beginning), and the secret may be revealed to or discovered by the partner. In such cases, when the affair partner is of the same sex, the betrayed partner knows he or she cannot compete because the affair partner's interest is based on gender and not on the qualities of the mate.

The final individual factor is that of medical illness in one of the partners. A partner may develop a chronic and potentially life-threatening or life-shortening illness. The mate may not know how to cope with this illness and turn elsewhere as an escape. Sometimes it is the ill mate who has the affair in order to feel young and healthy

again. Also, it is a way of affirming life or starting over, and it may serve to bolster their denial. Sometimes partners just think they are going to die and they want to experience as much from life as possible.

Couple Factors

Couple or dyadic factors are those that have to do with the dynamics of the relationship. Westfall (1995) identified three sets of factors that are commonly connected with infidelity:

1 infertility problems;
2 problems in establishing a loving relationship; and
3 gender role conflict.

Infertility is a problem that affects a sizeable number of couples, especially those who have waited until their 30s to have children. Sexual problems may grow from the regimen of having to engage in sex on schedule. Moreover, sex acquires a singular meaning, procreation instead of recreation. Month after month of disappointment creates a sense of personal and relationship failure as well as grief over the anticipated lack of having a biological child of one's own.

Weeks (1995) and Fife et al. (2008) published a more extensive theory about intimacy and love than what was originally published in the first edition of this volume in 1992. In Chapter 10 we discussed Sternberg's (1986a, 1986b, 1999) model of love, including the implications of having insufficient commitment, intimacy, and passion. Problems in any one or several of these areas may predispose a partner toward having an affair. The couples that share little emotional intimacy are at risk when one partner desires more affective sharing than the other can provide. Sometimes, the affair partner will comment on the friendship part of the affair and how they can tell the extradyadic partner things they cannot share with the husband or wife. Often the affair partner will describe a yearning or quest for sexual passion that is typical of the early stages of a relationship. Failing to appreciate the less intense yet highly fulfilling value of a long-term stable relationship, he or she fears that he or she has fallen "out of love."

A major part of relationship satisfaction depends upon having one's expectations met. Many of our relationship expectations are gender based: men do one thing, and women do another. Conflict, anger, and disappointment emerge when the couple cannot agree on these expectations. For example, in some couples, men work and women stay at home to take care of the family. If one partner does not want this system and the other does, major conflict will arise.

Intergenerational Factors

This set of factors deals with events that have occurred or are occurring within the family of origin. They include, but are not limited to:

1 family life cycle issues;
2 death in the family;

3 issues of individuation and enmeshment; and
4 incest.

Family life cycle issues are similar to the developmental issues discussed earlier. With family life cycle issues, the problems are usually related to the age(s) of the children. For many couples, the birth of the first child and departure of the last child are crisis points in their relationship. The couple must now restructure the relationship or confront the lack of relationship that exists. When this confrontation begins to take place, some partners will avoid it and start an affair in order to find what they feel is missing to stabilize a relationship devoid of feeling.

A death in the family can also contribute to an affair. When a family member, such as a parent, dies, the adult child is confronted with his or her own mortality. In an effort to recapture a feeling of youthfulness and vitality, some will have an affair. A parent who was a pivotal or all-important figure may be replaced with a fantasy figure that can supply what the parent had to offer.

The level of differentiation of partners is also crucial to relationship functioning in many ways. Differentiation can be defined in several ways, but one simple way to describe it is related to the degree of individuation or enmeshment in the family. In one of our cases, a man was highly enmeshed with his mother. When this man married, he immediately began having affairs and did so for over 20 years of his marriage. His affairs were a way to avoid enmeshment with his wife. He feared that should he truly commit himself to his marriage, he would repeat the same pattern and become enmeshed in two relationships. The affairs allowed him to maintain emotional distance from all women except his mother.

Incest in the family is a final factor that can lead to an affair. The experience of incest can have long-lasting consequences. Some incest survivors become sexually disinterested. While the partner may tolerate this lack of interest for some period of time and hope that it will change, continued lack of interest may lead the other partner to seek sexual satisfaction elsewhere. Sometimes the survivors are sexually limited; they will only allow "patterned" sexual activities or sexual expression within a limited range that becomes frustrating to the partner. On the other hand, some survivors become sexually compulsive and driven to act-out. They are searching for sexual validation, but, in fact, re-create their original sexual trauma in that they are being used simply for sexual satisfaction. This type of relationship is based on what Turner (1995) has described as a trauma bond. A number of these individuals also become love or sex addicts and are mistaken for being immoral and bad.

At the beginning of this chapter, we stated that we would be focusing more on treatment than etiology because etiology has been covered extensively in a prior volume (Weeks & Hof, 1995). The reader desiring a more in-depth analysis should consult Westfall's (1995) chapter.

Intersystemic Treatment

As we stated earlier, few events in a couple's relationship stir up as much emotional turmoil as an affair. Our research suggests that couples benefit from having a "road

map" that helps them understand the course of treatment and healing regarding infidelity (Bird, Butler, & Fife, 2007; Fife et al., 2008). Our experience in training therapists suggests that therapists benefit as well from knowing how to go about treating this difficult presenting problem. In this section, we will deal with various treatment issues and offer strategies that encourage recovery from the trauma of the affair. Couples present for treatment with a variety of issues. For some couples the affair is a secret, in others it has just been revealed, for others it is revealed or discovered during therapy, and for some it is suspected, but never revealed nor discovered. The therapist must be prepared to deal with all kinds of contingencies when affairs are involved. Additionally, the emotional climate of a relationship in which an affair has occurred can be volatile. One of the most common presentations is when the couple enters therapy shortly after an affair has been revealed or discovered and the affair partner has not actually severed the relationship or is unsure about whether he or she wants to end the extradyadic relationship.

The first issue to explore is whether the partners want to preserve the relationship. They may be enraged and unhappy with each other at this point and making threats about leaving. A great deal of emotional reactivity may stand in the way of being able to rationally work through the affair. The question is really one of whether they want to maintain their commitment to each other and to a process (therapy) which will help them sort out whether they will be able to preserve and build a satisfying relationship. The therapist might say, "As hurt, unhappy, and angry as you may be right now, would you like to be able to save this relationship?" The therapist must listen carefully to whether there is sufficient commitment to continue working with the couple toward recovery. Gaining some statement of commitment is important at the outset, even if it is only to the process of therapy. Many couples yo-yo between being in the relationship and out of the relationship. In other words, they go back and forth between wanting to stay and wanting to leave. Such a pattern can go on endlessly until one partner is exhausted. At a minimum, the therapist can argue that at the conclusion of therapy the couple will have made a rational decision about what they want to do.

Some couples will proclaim immediately that they want the relationship to work. In fact, some will initially report that the relationship has been in the best shape ever since the affair because they have both been trying so hard. Unfortunately, these couples have taken a flight into health and have not yet confronted the underlying unhappiness and problems between them. If both are committed, the therapist can move quickly to the next issue. If one or both are not committed, then the therapist may need to spend time helping them decide what they want to do. This might include staying with the therapy long enough to come to some self-understanding about why they might want to flee the situation immediately or feel ambivalent about staying. Sometimes individual sessions help the uncommitted or ambivalent partner sort out his or her feelings without worrying about the implications of what they say in front of their partner. It will be necessary to allow time and opportunity for the expression of intense feelings of guilt, pain, and betrayal. Such intense feelings can become overwhelming in and of themselves. The partners need to be reminded that the decision to remain committed to each other can be influenced by these intense emotions, but should not be made solely on the basis of the *reactions to* the affair.

Factors that predisposed the betrayal also need to be considered when deciding to stay with or to exit the relationship.

Individual Sessions

In individual sessions, the betrayed partner might focus on how deeply he or she was hurt, but does not wish to risk being this vulnerable in the presence of the affair partner. Vulnerability involves trust and in this situation, the trust between partners has been violated. Also, the betrayed partner might talk about how he or she had a parent who had an affair that ended the parents' marriage. Exploring these strongly held fears and feelings about leaving can often help the partner see he or she is running from a situation rather than dealing with it. The betrayed partner must be encouraged to *stay with* the intense feelings in order to understand and ultimately control them.

When the emotional reactivity is less intense, the affair can be reframed as a *relationship* problem. That is, the affair may have been a symptom of a *relationship* that was not working rather than a symptom of a *partner* who is impaired. It takes two to make a relationship work or not work. Framing the affair in this way suggests the problem is in the relationship, not just one partner. Further, it suggests that the same thing can happen to any relationship that is not working and that *both* parties changing could help the relationship. Eventually, the betrayed partner will be helped to see that the affair is partly of his or her own making, although it is crucial that he or she never be blamed for another partner having an affair. Moreover, the therapist *must* say that nothing excuses the affair. More attention will be devoted to reframing the affair later in this section. The partner who received the individual session(s) will eventually return to the couple sessions to either stop the relationship or to proceed to see what the next step will be.

The affair partner may have stopped the affair or be in the process of trying to stop it. We believe the therapist must take a firm stance regarding the continuation of the affair. The therapist must inform the couple that the affair must stop and stay stopped if they are serious about working on the relationship. In fact, we will guarantee that as long as the affair continues, even if intermittently, no real progress can be made in the couple's relationship. Stopping the affair means that all contact, albeit incidental, must cease—including brief discussions, e-mail, voice mail, and signals such as "hang-ups," etc. Should the affair partner affirm the affair is over, some individual work still needs be done to assess the reasons that partner had for becoming involved in the extradyadic relationship. The reason the work is done individually is so that the affair partner does not have to hold back any information that he or she thinks might be hurtful to the betrayed partner. Also, the discussion partly revolves around the attraction of the affair partner. Should the betrayed partner hear some of the descriptions and graphic details such as "she gave me the best blow jobs of my life," these pieces of information would compound the sense of anger and competition with the extradyadic partner. Moreover, if the affair partner truly gives up all contact with the lover, the loss of this relationship predictably results in profound sadness and sometimes depression. The betrayed partner often has little empathy for this experience of sadness and in fact may be wounded by the recognition of the importance of the affair to his or her significant other.

The Secret Affair

In some couples, the affair is a secret at the beginning of therapy. Two situations are likely to occur. The first is that the partner(s) ask for an individual session or the therapist asks for individual sessions to gain more information. Sometimes, the therapist has a sense that an affair is occurring. These individual sessions are usually held at the beginning of treatment after a few conjoint sessions to get some sense about how the partners operate as a couple.

The second situation is when therapy has proceeded for a number of sessions and the change expected by the therapist has not occurred. An unexplained lack of change is an indicator of a secret—most commonly an affair. The therapist may suggest an individual session or two in order to gain background information that might have been missed and which is important in getting the couple unstuck.

In the individual session, the therapist should state that something appears to be missing that might explain the lack of change. If a partner has expressed concerns about an affair, this should be stated, emphasizing the importance of honesty in the therapy sessions. Recall the therapist has already defined the rules of confidentiality, but it might be useful at the beginning of the individual sessions to repeat the rules so that the partner feels free to divulge information. The client might then reveal that he or she has been and still is involved in an affair. The therapist needs to take a nonjudgmental stance toward this behavior, otherwise, the client will reveal very little more and will write the therapist off as taking a moral rather than helpful psychological stance. The therapist should also remind the affair partner that no lasting change will occur as long as there is an affair. Because the affair is still continuing and the client is coming in for couple therapy, the client is either ambivalent about stopping the affair or has tried to end it but found this cannot be easily accomplished. The client is asked to talk about what he or she really wants for the relationship. Again, the therapist is trying to establish, without the betrayed partner's presence, how much commitment there is to the relationship.

Assuming the betrayed partner is still in love with the affair partner and states he or she wants the relationship to work, but is uncertain as to its outcome, the therapist must proceed by suggesting that therapy can only be accomplished if the affair partner is working toward severing the affair in a timely manner. We usually give a client 3–4 weeks to stop the affair, before ending the therapy due to a lack of change by stating that one partner has individual issues which are preventing change from occurring. Of course, if the therapist has to end therapy, this is also an indication to the betrayed partner that things are not going to improve and they should plan accordingly. It is perceived by the betrayed partner that a secret is the cause for termination of treatment.

The relationship the therapist has to the affair partner is isomorphic with the relationship between the affair partner and the extradyadic partner—both are secret relationships. Partners who are in denial must at this point confront the reality of the situation. In many cases, the betrayed partner confronts the affair partner with the ultimatum that he or she must know what is going on or they will leave. When the affair partner is confronted in this manner, he or she may then admit to the affair and will either wish to end the relationship by default or say he or she wants to stop the affair, but has been unable to terminate it.

Hopefully, the affair partner will want to work on the relationship, realizing he or she must stop the affair. The therapist will then need to explore the motivations for the affair with the client. One aspect of this exploration is to ask about the dimensions of the affair described at the beginning of the chapter such as how long it has been occurring, with whom, what is the extradyadic partner's relationship with the betrayed partner, etc. In short, the therapist will want to gather a good deal of factual information about the affair. The other focus of the individual sessions is on being able to stop the affair and help the client understand why it began. The therapist can ask questions such as the following.

1 How did you meet this person?
2 What was the attraction?
3 Who initiated the relationship?
4 How were you feeling about yourself when this relationship started?
5 How were you feeling about your marriage when this relationship started?
6 What was going on in your life about the time this relationship started?
7 How attached have you become to this person? Do you think you love this person?
8 What has this relationship meant to you?
9 How has this relationship helped/hurt your marriage?
10 How has this relationship helped/hurt you?
11 Did you ever imagine that you would have an affair?
12 How has this relationship challenged your ethical, moral, or value system?
13 What do you like most about this person/relationship?
14 What do you like least about this person/relationship?
15 How do you feel about ending this relationship?
16 How do you think your extradyadic partner will feel about this relationship ending?
17 Do you think he/she will be able to let go of this relationship if you end it or do you think they will continue to pursue you?
18 Who else knows about this relationship?
19 Have you thought of ending this relationship or unsuccessfully tried to end it?
20 Has your partner thought of ending this relationship or unsuccessfully tried to end it?
21 How much mental energy does it take to keep both of your relationships going? Are you feeling worn down by this situation?
22 How do you think you will feel when it is over?
23 Do you think you might resent your husband/wife for having to end this relationship?
24 Have you ever had to end a relationship?
25 What has it been like when relationships have ended for you in the past?
26 Are you prepared to grieve over the loss of this person?

These questions will provide the therapist with the information needed to process the motivations for the affair as well as help the client end the affair. The therapist may need to validate that the client has developed a strong sense of attachment for the

extradyadic partner and that to lose this partner will cause grief. Most affair partners do not want their partner to know how strongly attached he or she has become to the extradyadic partner, nor do they want the betrayed partner to see them grieve over the loss of the relationship with the extradyadic partner. Hence, most affair partners will minimize the emotional involvement when the betrayed partner is in the room.

Part of the therapist's task in the individual sessions is to help the affair partner grieve over the loss of the relationship and to ensure that the relationship does not start again. The affair partner will need to be encouraged and coached about what to say to the extradyadic partner. The affair partner might say that they are working on their primary relationship and need to be fully committed. This necessitates ending the affair and having no further contact with the extradyadic partner. Sometimes affair partners are unwilling to end the affair immediately and permanently. In those cases, we suggest putting the other relationship on hold for 6 months in order to give the primary relationship a chance. During that time, no contact is allowed. The rationale we provide the client is that by putting the affair on hold and making a commitment to work on the relationship for 6 months, he or she will either experience the marriage as working or beginning to work, or he or she will not experience significant change or growth. If after 6 months (in some cases sooner) the relationship is not working, the affair partner can leave the relationship knowing that he or she tried their best. The affair partner can leave the relationship with less guilt knowing the affair did not cloud the decision to stay or go. Removing the affair as an issue helps the client move in one direction or another with more conviction that the decision was properly made.

The motivations for an affair may vary according to the assessment criteria mentioned in the earlier section and the type of affair. Due to the secret nature of most affairs, the two parties have relatively little time to spend together. In fact, it is much like dating. When they do get together it is for a meal, to talk, or to have sex in finite periods of time. The relationship is not challenged by the normal day-to-day events that most couples face, such as children and having to solve problems as they come along. It is also a new relationship. One of the greatest sources of sexual desire is that of novelty of a new partner. We often point out that the established relationship does not have a chance compared to a new relationship because the brain is awash in "feel-good" chemicals. These chemicals are so powerful they are like addictive drugs—we crave more and more. Information such as this puts the intensity of feelings in perspective for the client.

Finally, the time-limited and artificial nature of an affair, plus the fact that most affair partners will not see any flaws or shortcomings in the extradyadic partner, suggests a considerable amount of projection. In many of the cases we have treated, the extradyadic partner was a projection of a parental figure or an idealized figure. The parental figure projection involves seeing qualities in the extradyadic partner which were loved and admired in a parent, but perceived as missing in the partner. Obviously, some of the characteristics perceived are those of being taken care of, cared about, and accepted. The idealized figure projection means seeing the extradyadic partner in idealized terms. They are the embodiment of goodness and kindness. Moreover, the idealized figure often has traits that the other person would like to have but feels he or she is missing. For example, affair partners are sometimes attracted to extradyadic partners because they are seen as outgoing and socially skillful. They have friends and

are good listeners. The affair partner will sometimes comment about how the extradyadic partner has "brought them out." They may be referring to bringing out their feelings or bringing them out socially with his or her closest friends who know about the affair. The projective aspects of the relationship require exploration and the affair partner must be helped to see these qualities in the betrayed partner, if they exist. When the idealized projection is a search for that which is missing in oneself, then the therapist needs to help the client develop that aspect of self. A client who is emotionally repressed could be assisted in exploring his or her feelings and discovering the reasons for his or her repressions. A client who has never felt he or she could expose his or her real self may be aided in self-exploration and acceptance.

The Affective Phase of Treatment

Beginning the Couple Work

In addition to the couple affirming their commitment to work on the relationship or to the therapy, there are a few other issues that require immediate attention. If the partner knows about the affair, the first task is to deal with the affair.

One of the tasks is to deal with the feelings generated by the affair. In most partners, there are intense feelings of anger, shock, betrayal, and so on. The intensity of these feelings may be frightening to both partners because the feelings seem endless and irrational. The betrayed partner must be given an opportunity to discuss these feelings in the couple session and the affair partner must be willing to acknowledge and validate these feelings. For most couples, the betrayed partner's feelings have not been adequately acknowledged. This may be due, in part, because the couple have different definitions of what constitutes infidelity. The affair partner may have offered an apology or stated he or she could understand how the betrayed partner felt but not sufficiently discussed the feelings. A great deal of time is spent in session just talking about the feelings. First, the betrayed partner has an opportunity to talk about his or her feelings and then the affair partner has an opportunity to talk about how he or she feels. The couple also needs to agree that when they have a need to express some of these feelings at home they should set aside time to talk about them. When these feelings are discussed at home, they should be contained and not the topic of continuous conversation.

Because most couples have avoided this painful emotional conversation, the focus has shifted to an endless search for facts. Facts have been substituted for feelings. The betrayed partner will want to know every detail of the affair—with whom, how long, when did they meet, how many times, what did the extradyadic partner look like, what did they talk about, where did they go, what gifts were given, and what happened sexually. We strongly believe this endless search for facts is a substitute for discussion about feelings. Some facts are useful for the betrayed partner to know. We generally think the betrayed partner should know:

- who the extradyadic partner was;
- how long the affair lasted;
- how often they meet; and
- where they meet.

The search for sexual details represents a voyeuristic interest providing memories and images of what the affair partner did which are difficult for the betrayed partner to overcome.

Beyond these basic facts, we suggest that every time the betrayed partner wants to start asking questions, he or she should express these feelings and needs. We often say, "Talk about the feelings and needs, not the facts. You already know what happened; hearing it again will not help you." The need that many betrayed partners have is that of emotional reassurance that the affair has ended. They should think about how they are *feeling* and what they *need*. They usually desire to be reassured that the affair partner wants to work on the relationship and still finds them attractive and lovable. We encourage affair partners to become more vocal in expressing how they feel about their partner on an ongoing basis. The more that feelings are discussed, the less the need for facts.

The emotional turmoil surrounding an affair can last from several weeks to several months. A significant amount of time may be spent in session discussing feelings as they emerge and change. The couple needs to be forewarned that feelings will be quite changeable, and just when they think one feeling has subsided it may reappear. This phase of therapy cannot be accelerated. Trying to go around rather than through the feelings will just keep the therapy stuck at the level of searching for facts and accusations. Two additional points may be mentioned here. First, the betrayed partner may have feelings that do not subside and which appear to have another or deeper source. Part of the discussion around the betrayed partner's feelings is to discover past betrayal in that person's life, including experiences in the family of origin. For example, Christine reported that when she was growing up her father had had multiple affairs she knew about but which apparently her mother did not. She was determined that she would never experience an affair in her own marriage, but was told by her husband that he had been having an affair. Her feelings about her situation resonated with her old feelings toward her father and exacerbated her reaction. In another case, Jonathan had been married three times. All three of his marriages ended due to his wives' affairs. Of course, he was in a state of disbelief that such an occurrence could happen again and assumed his current marriage would end.

Second, sometimes the betrayed partner will develop obsessive-compulsive behaviors or may have obsessive-compulsive personality traits. The affair will become an obsession for them. The therapist should assess the premorbid functioning in this area and if the feelings about the affair persist beyond what seems reasonable, concurrent treatment, including medication, should commence for that client.

The grief reaction may also include depression and anxiety. In some cases, these symptoms predated the affair and have not been treated. A psychiatric referral may be useful. The SSRIs can be very useful in lifting the depression as well as reducing the obsessional thinking when prescribed at higher doses.

Accountability and Trust

An affair is highly disruptive to the feelings of trust in a relationship. Not only is the betrayed partner injured by the affair, but also by the lies and deception that accompany most affairs. Rebuilding trust is not an easy matter. An affair partner cannot

simply apologize and say he or she is trustworthy again. We emphasize that trust will be rebuilt slowly, and through experience and communication. The betrayed partner will be wondering what is really going on in the life of his or her partner. Communication can give the betrayed insight regarding the inner life of their partner, which is essential for trust to be reformed. Affair partners must also recognize and take responsibility for the rejection sensitivity they have created by having the affair. Their actions destroyed the trust and led to the ongoing hypervigilance and suspicions of their betrayed partner. In order to alleviate these suspicions and demonstrate accountability, affair partners must be careful to explain their comings and goings. When traveling, they need to make calls home and be reachable by telephone. The information previously provided about the extradyadic partner (i.e., where and when they met) helps the betrayed partner know that the affair has not restarted. For example, one man met the person for lunch almost every day. He would always have an excuse for being out of the office for a long lunch and could not be reached, even by cellular telephone. Part of his accountability to his wife was to either eat lunch in or be reachable by telephone around lunch. He was also told it would be helpful if he could go home for lunch since home was nearby, or to call his wife during lunch for a little chat.

The basic information provided by the affair partner is actually for the purpose of helping the betrayed partner know whether he or she has reason to suspect the affair has begun again. Additionally, we tell the couple that absolute honesty is important. Any communication with the extradyadic partner should be reported. In many cases, this person will call, send a letter, or just be seen in the office or neighborhood. An innocent meeting on the street could be reported back to the betrayed partner and cause alarm if the meeting is not mentioned. In other cases, the affair partner will violate the agreement and call the extradyadic partner. This information should also be reported in the couple session, since the therapist needs to know in order to help the affair partner who is struggling with stopping the affair, and the betrayed partner needs to know where he or she stands in the process. Restoring trust and a sense of loyalty can only be accomplished through honesty, even if the news is not always what the couple would like to hear.

The Cognitive Phase of Treatment

Once the feelings about the affair have been discussed and the affair is not such an emotionally charged event, the second phase of therapy can be integrated, with the couple agreeing to work on the relationship with openness and honesty. The phases may overlap, but for conceptual clarity they are separated. The couple needs to find:

1 some way of making sense of what happened;
2 what the affair meant and means to the couple; and
3 what they can learn from the affair to prevent it from happening again.

In the assessment section of the chapter, we reviewed a number of individual reasons why a partner might have an affair, such as mid-life crisis, psychiatric disorders, chronic illness, etc. For some couples, the explanation is as simple as identifying the factors in the individual which led to the affair. Then it is a matter of helping that person remedy those factors and restoring the trust in the relationship.

In our experience, the vast majority of affairs have resulted from relationship dysfunction or dissatisfaction. From a systemic perspective, it takes two to create relationship dysfunction. While we say quite clearly to the couple that nothing justifies the affair, the relationship was vulnerable to infidelity, and both partners likely contributed in some ways to the vulnerability. We also believe the couple need an explanation which helps them make sense of the situation and gives them a sense that if those problems are rectified another affair will not occur. Thus, the therapist has the task of systemically reframing the affair.

Reframing is a generic strategy in couple and family therapy. It involves helping the couple find another way of viewing their problem, which has the effect of putting everyone on the same level. In other words, both members are defined as having some part in creating the problem. Based on the study mentioned earlier in this chapter, which stated that couples collude in allowing the affair to continue, it is clear that the partners can be told they both were unwilling to confront the unhappiness or dissatisfaction contributing to problems appearing elsewhere. In order to reframe the affair, the therapist needs to elicit information about the couple's relationship. As bits and pieces of information are gathered, a picture begins to emerge which points to their dissatisfaction or dysfunction. These pieces of information can be given emphasis by the therapist to help the couple have "insight" as to why the affair happened. If the couple is unable to draw some conclusion from the facts emphasized by the therapist, the therapist may need to state the reframe and ask the couple to react to it.

The reframe needs to focus on some dysfunctional dynamic in the relationship or on each partner's problems that have led to an interlocking dysfunctional pattern of behavior. In the first case, the therapist might reframe their dynamic as one in which both partners failed to engage in effective communication or conflict resolution. A pattern such as this is likely to erode the quality of relationship satisfaction until one partner decides to have an affair. In the second case, the therapist might reframe each partner's problems. For example, in one case the wife was chronically depressed and refused treatment. Her husband was resigned to her depression, having grown up with a depressed mother. He felt powerless to effect any change or get what he needed from his wife. He began to withdraw from her and to overwork. Interestingly, it was the wife who had the affair, thinking it might help her depression because she felt so alone. In another case, the partners colluded in forming a parent–child relationship. Over time, this pattern created conflict and relationship dissatisfaction that contributed to the affair.

Intergenerational factors may also play into the affair. The most common pattern we have observed is a partner having an affair in order to create distance in the relationship due to parental enmeshment. Mark, for example, was 45 when he entered therapy. At this time, the truth was revealed that he had had affairs since the beginning of his marriage at the age of 23. Mark was from an Italian family and extremely enmeshed. He would see his mother every day. The cover story was that his mother needed help in the house with repairs and so forth that justified his daily visits. When Mark married, he was unable to extricate himself emotionally from his family. Knowing that he needed some emotional and relationship space of his own, he began having a sequence of 2-year affairs. The affairs helped him maintain stability in the marriage by allowing him to stay emotionally disengaged. His wife had never suspected

an affair, but was certainly aware of the fact that he was close to his family and not emotionally engaged with her. She had been reared in an abusive family. The only time family members became close was in order to be angry and violent. Thus, she feared that closeness might bring more of the same and unconsciously needed the distance in the marriage. Family-of-origin work was indicated for this couple.

An effective reframe allows the couple to find *meaning* in the affair. They can both see a connection between their behavior and the affair as a symptom. Once this connection has been established, they can begin the final phase of therapy. The cognitive or reframing phase of therapy is usually brief, lasting only a few sessions. This phase lays the groundwork for the final phase. Both partners can now participate in the therapy, often with them sharing responsibility for allowing problems to continue in their relationship.

Reconciliation, Recovery, and Restructuring

Having worked through the first two phases of treatment allows the partners to gain some understanding of each other's dynamics, vulnerabilities, and humanness. In order to reconcile with each other, they must grasp the complexity of their relationship and each other in such a way as to see the struggle that every relationship endures. The partners need to feel they are working together toward a common goal of building the relationship out of liking and loving each other. This phase of treatment may take anywhere from a few months to a couple of years. The research cited earlier suggested that a brief treatment of affairs is ineffective. No research has been conducted on longer-term treatment. Our experience in treating affairs over many years has taught us that a quick fix is not possible. Couples must be willing to make a long-term commitment to the therapeutic process if they are to achieve a satisfactory relationship.

Worthington and Drinkard (2000) have published one of the most comprehensive models for facilitating reconciliations. The purpose of reconciliation is to restore harmony in the relationship while acknowledging that differences may continue to persist. Reconciliation is similar to forgiveness, but not the same. McCullough, Worthington, and Rachal (1997) suggest that a person experiences forgiveness from within when the person (a) no longer desires to avoid or withdraw from the individual who offended him or her; (b) lets go a sense of revenge or just anger; and (c) desires a reconciliation if it is prudent, possible, and safe to do so.

Worthington and Drinkard's (2000) model of reconciliation consists of six "planks".

1 *Decide whether to reconcile.* Reconciliation may not be possible or desirable, especially if a person's safety or health might be threatened by such action. Safeguards must first be established. The likelihood of successful reconciliation should be assessed by the therapist.
2 *Softness.* An attitude of mutual softness must be created between the partners or reconciliation will not occur. The therapist must stress that both parties must drop his or her wall of defense that was erected as protection from further injury by the other partner. Two-way concessions will be needed for a successful reconciliation.

3 *Forgiveness.* After a soft environment is created, forgiveness is promoted. Worthington (1998b) presents a five-step pyramid model of forgiveness.

   (a) *Recall the hurt.* Recall the specific hurtful and offensive events. In free flowing conversation, the couple discuss the events, utilizing the therapist to prevent escalation of anger.
   (b) *Empathize with the offending partner.* Empathy is expressed for the other's situation by having the partners describe the events from the other partner's point of view. Each partner's empathetic understanding of the event is discussed.
   (c) *Altruistic gift of forgiveness.* Partners recall when he or she offended or hurt someone other than his or her partner and was subsequently forgiven. The resulting feelings of gratitude and freedom from being forgiven are discussed.
   (d) *Commit to forgive.* A verbal commitment to forgive the partner is necessary. The therapist invites the partners to forgive each other when they are ready.
   (e) *Holding onto forgiveness.* The therapist informs the partners that offenses and hurts will not be totally forgotten, but it does not mean forgiveness has not been granted if a forgiven hurt is recalled.

4 *Reverse the negative cascade.* Relationships deteriorate, usually in steps—criticism, defensiveness, contempt, and stonewalling (Gottman, 1994). Partners seek and find new negative interactions as the nonlinear change in perception of the relationship becomes negative, global, and stable (Fincham & Bradbury, 1993), negating any possible interactions. For successful reconciliation, good times must be recalled to reinforce the positive aspects of the relationship.

5 *Deal with failures in trustworthiness.* Partners must be made aware that failures in trustworthiness are inevitable, but it does not mean the reconciliation program has failed. Failures can be positively reframed by the therapist as opportunities to practice forgiveness and a positive maintenance of reconciliation behaviors.

6 *Actively build love.* Reconciliation is more than just resolving conflicts, but also involves the rebuilding of love that has been damaged by hurtful acts that offended and devalued a partner. Devaluing behavior must be avoided and behavior communicating value of the partners must be increased to rebuild love.

Weeks et al. (2003) were the first to present a systematic model which included a strong emphasis on forgiveness. Fife et al. (2008) have also developed a five-phase approach for the treatment of infidelity.

1. *Crisis management and assessment.* Often after infidelity clients present for treatment with intense emotions about the betrayal. It is important to be able to process the feelings that are present (Cano & O'Leary, 1997) as well as maintain a therapeutic balance with clients (Fife et al., 2008). Clinicians should also assess for the level of commitment while suggesting that clients wait to make decisions regarding their relationship while in the midst of the initial shock of infidelity. Furthermore, assessment of the couple should include things such as: the type of infidelity, the time frame and duration, the frequency and location, a history of past infidelity, relationship of extradyadic partner to both partners, degree of collusion by betrayed partner,

perceived attractiveness of the extradyadic partner, and social and cultural context of infidelity (Weeks et al., 2003; Fife et al., 2008).

2. *Systemic factors.* In this phase individual, relational, and intergenerational factors should be considered. Individual factors that may contribute to infidelity include: mental and emotional disorders, illness and age-related conditions, and situational factors like a mid-life crisis. Relational factors should be considered since often infidelity is related to relationship problems. The relationship prior to the betrayal should be assessed, including "expectations, communication dynamics, problem-solving efforts, emotional closeness, and physical intimacy." Finally, family-of-origin issues such as previous infidelity, triangulation, and enmeshment should be considered through techniques such as a focused genogram (Weeks et al., 2003; Fife et al., 2008).

3. *Facilitating forgiveness.* Murray (2002) defines forgiveness as "the conscious choice to abandon ill will and desired retribution and carries neither implication about the worthiness of the forgiven nor the status of the reconciliation." Some see forgiveness as a single event, but it should be seen as a process including "empathy, humility, remorse, apology, softening, accepting responsibility, and extending forgiveness" (Fife et al., 2008). Forgiveness can be attained through maximizing unifying factors such as empathy, humility, relational commitment, and hope (McCullough, 2000; Worthington, 1998a). Empathy helps to decrease defensiveness and increase softening. Humility allows the unfaithful partner to take responsibility for their actions. As empathy and humility are increased commitment and hope for the relationship also increase. A sincere apology is also important. The apology should acknowledge the wrong and harm done, be genuine, and make a commitment to change (Couch, Jones, & Moore, 1999; Fincham, 2000; Fitness, 2001; Flanagan, 1992; Gold & Weiner, 2000).

While forgiveness is a vital part of the healing process there are a few key points to remember in its application to the clinical setting. In a study done by Olmstead, Blick, and Mills (2009) therapists report that they do not even mention forgiveness until well into therapy. Second, the concept of forgiveness is accepted more by clients when the therapist uses language that highlights that forgiveness is beneficial for the betrayed partner (Butler, Dahlin, & Fife, 2002). Case (2005) reports that forgiveness is a process that involves at least four distinguishable phases:

1 ceasing to seek/demand justice or revenge;
2 ceasing to feel anger/resentment;
3 wishing the other person well;
4 restoring relational trust.

4. *Treat the factors that contribute to infidelity.* It is important for clients to understand the factors associated with the infidelity and work to prevent future infidelity. Some of the problems associated with this are: inability to develop intimacy, commitment problems, a deficiency of passion, and inability to communicate and resolve conflicts and anger. To combat these problems they suggest treating commitment, passion, and intimacy. Levels of commitment should be assessed and if commitment levels are unequal between partners the clinician should facilitate a discussion on what

commitment means to each partner and also ask the couple to talk about how they first met and the positives within the relationship (see Chapter 10 on intimacy). To combat problems with passion, clinicians should explore issues of "romance, physical attraction, sexual desire, and desire to be together" (p. 321). Finally intimacy should be addressed by exploring closeness, concern for the well-being of each other, trust, honesty, openness, and feelings of support (Fife et al., 2008).

5. *Enhance intimacy through communication.* Communication problems can lead to infidelity by limiting closeness and intimacy. It may be helpful to educate couples on the circular nature of communication as well as developing communication skills such as using "I" statements and reflective listening (Fife et al., 2008).

An affair is a traumatic event for both partners. They have both experienced intensely painful emotions, felt threatened over losing the relationship, and have in fact lost a great deal of trust and certainty that they had previously enjoyed or taken for granted. A hidden loss is that of losing the image and dreams that each one carried at the beginning of the relationship. Many couples begin the relationship with the idea that their partner is almost perfect and they will have the storybook marriage. An affair shatters this fantasy with an ugly reality that does not pass. Occasionally in session, the couple will benefit from talking about this traumatic aspect of the affair. Debriefing and feeling heard and supported are crucial elements in trauma recovery.

An important aspect of recovery is that of forgiveness. Forgiveness is a topic that has eluded most writers in the field of marital and family therapy even though it is a basic human need and needed nowhere more that in the violation of a relationship through infidelity. During the first few sessions, the affair partner usually asks for some understanding and forgiveness and it is often granted. At that stage of treatment, not enough work has been done to create a foundation for a deeper level of forgiveness. The insights gained into each partner help provide this foundation. As the couple begins to comprehend and appreciate how they failed to address various issues in their relationship, they begin to see how they made themselves vulnerable to the experience of an affair. A deeper level of forgiveness is possible once a deeper level of understanding has been achieved. In those cases where one partner clearly has a problem such as alcoholism or bipolar illness, the other partner may come to see how they served as a co-addict or an enabler by allowing the illness to continue through their care-taking or overresponsibility rather than confrontation and constructive action.

As we pointed out earlier, trust and accountability are important from the beginning of therapy. The therapist should expect that it will be difficult for the affair partner to stop the affair with finality. Telephone calls, visits, and encounters in the office or community are commonplace even though the intent is to stop the affair. These are to be reported to the betrayed partner and processed in the session with the appropriate reassurance that the encounter was not at the affair partner's initiation. If it were, he or she would accept responsibility for it and work with the therapist individually to stop the relationship.

The restructuring of the relationships may involve work on the individual partners, the dyadic relationship, and some family-of-origin work. Restructuring refers to the changes that need to be made in order for the relationship to thrive. In the Intersystem

Model described earlier, a treatment plan (Weeks & Hof, 1995) is developed which allows for the systematic integration of whatever treatment issues need to be addressed. Unless there is severe pathology or addiction in one partner, we generally prefer to do most of the work with the couple together with occasional individual sessions. The exception to this rule is when the affair partner needs help at the beginning of therapy to stop the affair. The couple work allows each partner to learn about the issues of the other, how some of these patterns are interlocking, and how they must work jointly to create a working relationship. Each partner's perspective is also useful in working on individual issues. Sometimes one partner will be unaware of some of his or her symptoms, particularly the severity of their symptoms. In one recent case, the husband pointed out that he believed his wife had been depressed for years. She initially disagreed with his assessment, but as she learned more about depression and her symptoms, she began to understand that she was in fact depressed.

The following case illustrates the initial phase of treatment.

> Marta Jo and Henry had been married 24 years. Marta Jo learned that Henry had been having an affair for about the last 12 years of their marriage with a woman in his office. The affair was discreet in that they would travel on business and they worked on various projects together. Only one or two people in his office suspected what was happening. The affair started just after the birth of Marta Jo and Henry's second and last child. Henry only wanted one child, not two, because he was an only son. The couple had met when they were in their mid-20s. Henry had established himself as a successful businessman, and Marta Jo was also on a career path headed for success. Each one had had several failed relationships prior to meeting and each partner was beginning to wonder if he or she would ever find the right person.
>
> This case was filled with a variety of issues. Henry had suffered depression for many years, but had never been prescribed medication, in spite of analytic treatment with a psychiatrist. He was also an undiagnosed adult with ADD that made it difficult for him to stay in conversations with his wife. Marta Jo did not have any diagnosable conditions.
>
> The relationship had been a difficult one from the beginning. Henry worked long hours and Marta Jo became pregnant right after marriage and stopped her career. It was obvious that he was over-involved in work and she was over-involved with the child. They did not communicate much and what communication they had was superficial. They both tried to avoid anger, which allowed resentments to build. A major resentment on Henry's part was Marta Jo's insistence on a second child.
>
> Henry's major complaint was that his wife always got her way and needed to be the center of attention. Interestingly, Henry could not conceive the fact that for many years in his marriage he was so passive he could not ask for the smallest thing. He took every wish of his wife to be a demand and virtually every comment about her dissatisfaction was perceived as a criticism. How could such a relationship have survived for so many years?
>
> Henry grew up in a Christian Science family with two very critical parents. He was constantly told he was selfish and that his unhappiness was his own

doing. He was trained to be passive and responsible for all "bad" feelings from his earliest years. A father and stepmother reared Marta Jo. Her father was an extremely narcissistic man who demanded that she do and be everything he wished. If she did not conform to his wishes, he would withdraw his love from her. Neither Marta Jo nor Henry had experienced intimacy in their respective families. They needed a relationship that was emotionally safe and distanced. Unfortunately, Marta Jo violated the unconscious dictum that she not want anything from Henry. The more she wanted for herself, the smaller and more inadequate he felt. This would have been a rich case to treat because it involved individual, couple, and intergenerational issues. Although Marta Jo was interested in continuing the marriage, Henry decided he wanted no part of marital therapy once his secret was learned. He externalized full responsibility for the problem onto his wife and stated she would never change. It seemed he only had two choices: either he was fully responsible or she was fully responsible. Either way would have been doomed to failure. The couple proceeded to divorce, with the husband moving quickly to solidify the affair relationship.

This case is an exception in our experience.

Another case illustrates a couple that successfully moved through the initial phases of treatment and was committed to staying together.

Jeff and Susan had been married 17 years and had two teenage children. They came to therapy because Jeff learned Susan had been having an affair with a married man for a period of about 2 years. This couple had what is typically called a parent–child relationship. They were traditionally oriented in terms of gender roles and Susan had always been a passive partner. She worked part-time, but was primarily a mother and homemaker. She felt under-appreciated by Jeff and stated that he had always had the control in their relationship. She also talked about not knowing what she wanted in life and having a poor sense of self-worth. In addition, she had become depressed over the years, but did not recognize her depression. The couple accepted the reframe that what contributed to the affair was their dissatisfaction over having created a parent–child relationship. The therapy focused on helping each partner understand their individual issues and how they feed into each other's dysfunctional individual need to be taken care of or to take care of another. As they began to understand their pattern, they could see they were eventually headed for disaster. The mental template for their relationship was established in their families of origin, that necessitated an analysis of these early patterns. This couple needed about a year of work in the restructuring phase in order to change their dynamic and feel secure that another affair would not happen. Susan was also referred to a psychiatrist and began taking an antidepressant.

Most couples who come for help with an affair, whether the affair is known at the beginning or not, do commit to working on the relationship for an extended period of time. While we have not collected hard data on the percentage of couples that stay

together, it is our impression that over 80% of couples complete the therapy successfully and stay together. Clearly, this model of treatment needs to be subjected to empirical scrutiny.

Internet Infidelity

With the use of the Internet increasing, so too are cases of Internet infidelity. Given the prevalence of electronic communication and the potential impact on couples' relationships, it is imperative that therapists become knowledgeable about technological developments and the related concerns and issues, such as Internet infidelity, that couples might bring to therapy (Hertlein & Blumer, 2013). Long and Young (2007) define Internet infidelity as a romantic or sexual relationship that takes place mainly through electronic exchanges. Pornography may also be considered a form of Internet infidelity since it is usually guarded with secrecy (Hertlein & Piercy, 2006). One main question is whether cybersex is considered infidelity or not. In a study done by Whitty (2005) the majority of respondents indicated that cyber cheating is still a real betrayal. Whitty (2003) also noted that Internet infidelity did not fall into a discrete category, indicating that online sexual acts were still considered to be infidelity. According to Schneider (2002), partners consider cybersex to be infidelity because it involves lying, secrecy, decrease in sexual relationship with the real partner, and decrease in time and emotional attachment. While there are many similarities between Internet infidelity and face-to-face infidelity there are also some major differences. In a review of online infidelity studies, Hertlein and Piercy (2008) found that five of eight studies reported that online infidelity affects offline relationships, and two of eight studies report that online infidelity is as hurtful as face-to-face infidelity. Hertlein and Piercy (2012) identify what they term the 7 A's which make Internet-related problems unique. The Internet:

1 Is *acceptable* as a form of communication (King, 1999). This is seen through social networking sites, smartphones, and even online gaming.
2 Is widely *accessible* (Cooper, 2000; 2002). The Internet is available almost everywhere and to almost anyone. It can be accessed at home, work, school, and even on the go through cellphones.
3 Is *affordable* (Cooper, 2000; 2002). Gone are the days when dates involved dinner and a movie. The Internet allows communication for one small monthly fee.
4 Has the ability to make the user *anonymous* (Cooper, 2000; 2002). Internet users have the ability to choose what they reveal about themselves and what they keep hidden. It even allows falsification of information about themselves.
5 Facilitates an *approximation* to real-life interactions (Ross & Kauth, 2002). With the rise of technology such as web cameras, video streams, and computer hardware such as Realtouch, communication through the Internet is becoming more lifelike.
6 Provides *ambiguity* in defining problematic behavior (Hertlein, 2009a). For example, one partner may believe viewing pornography is infidelity while another does not.

7 Allows people varying degrees of *accommodation* in terms of their real vs. ideal selves (Hertlein, 2009b; Hertlein & Stevenson, 2010). The Internet creates an opportunity for individuals to act a certain way in real time while creating an opportunity for them to exhibit whatever behavior they want through use of the Internet.

Internet addictions can have detrimental effects for the betrayed partner. Not only does the amount of time spent online detract from the relationship, but often the addict lies about sexual behaviors, leading to distrust. The sexual relationship may also suffer because the betrayed partner ends up comparing themselves to the online person. In addition, the betrayed partner may feel hurt, betrayed, abandoned, devastated, lonely, ashamed, isolated, humiliated, and jealous (Schneider, 2002).

The treatment of Internet infidelity still lacks a specific theoretical foundation. Hertlein and Piercy (2012) suggest this may be due to the difficulty in defining Internet infidelity. Is infidelity a strictly sexual act or is it also emotional betrayal? By some, infidelity is seen as a sexual encounter, while by others emotional intimacy is also considered infidelity. Interestingly, Henline, Lamke, and Howard (2007) report that emotional infidelity causes more distress than sexual infidelity. The lack of a concrete definition makes it difficult to form a treatment approach to combat this problem.

Hertlein and Piercy (2008) did a qualitative study to determine assessment and treatment procedures among therapists treating Internet infidelity. Their sample consisted of 11 therapists who, on average, treated 16 cases of Internet infidelity. Results from this study suggest that something was missing from the couple's relationship which led to one partner seeking gratification elsewhere. The participants also reported they believed Internet infidelity was a symptom of an underlying problem such as a decrease in communication, intimacy, boundaries, and commitment between partners. These problems give therapists a guide for treating Internet infidelity. Similarly five of 11 participants reported using transgenerational theories and emotionally focused theories. Five participants reported they would use a genogram and search for patterns in the family of origin. There were other commonalities found across treatment approaches. Foremost was the use of forgiveness and first-order strategies such as moving the location of the computer in the home or the use of an Internet filter to block access to pornographic sites. Participants also reported that age, physical health, and gender would affect their treatment approaches.

There have also been books written that include treatment approaches for Internet infidelity and addictions (Cooper, 2002; Maheu & Subotnik, 2001). Maheu and Subotnik (2001) have outlined four steps to recovering from Internet infidelity. The first step is to *cope with emotions*. Coping with emotions involves reducing emotional reactivity, especially reducing the obsessive review of the infidelity. Maheu and Subotnik (2001) offer a number of ideas for reducing obsessive thinking about the infidelity.

1 *Writing the love letter* involves having the affair partner write a love letter to the betrayed partner. Every time the betrayed partner begins to obsess they should take this letter out and read it.

2 *Challenging distorted thinking* by decreasing self-defeating thoughts and increasing self-reassuring and calming thoughts.
3 *Relieving anger* is suggested by participating in vigorous physical activity by both the betrayed partner and the affair partner.
4 *Journaling* can be a safe way to express thoughts and feelings and can also help the betrayed partner look at the obsessive thoughts more objectively.
5 *Nurturing yourself* can also help. This includes things like taking personal time, exercising, eating well, remaining in contact with loved ones, etc.
6 *Active solitude, social action, and distraction* can help to distract obsessive thinking through a change in activities. This can include anything from renting a video, working on a new project, or participating in sports.
7 *Remembering your resourcefulness* is helpful in difficult times. This is done by remembering previous hard times and how you made it through them.

The second step is to *search for understanding*. It is important to understand why the affair happened in order to prevent future occurrences. Partners should learn how to talk and listen appropriately. Next certain details of the affair may need to be discussed. Third, looking at the family of origin can be helpful in uncovering past infidelities within families and views about infidelity. Finally there is learning to communicate and finding the miscommunications within the relationship.

The third step is to *restructure the relationship*. This is done through renegotiation of relationship agreements such as not using the Internet for sexual behavior. It may also include lifestyle changes.

The fourth and final step is to *find closure*. Closure can be achieved through an apology and promise never to do it again. Again, this may take some time as forgiveness is a process and not a one-time event.

Hertlein and Piercy (2005) identify a theoretical framework for treating Internet infidelity. It begins with assessment. The first step in the assessment phase is to learn about each partner's expectations in the relationship and to define what Internet infidelity means for each of them. The second step of assessment is to determine the problematic Internet behavior (e.g. pornography, time spent online with another person, etc.).

After assessment comes the treatment phase, which is based on transgenerational theory. The therapist will first examine the infidelity behaviors, paying close attention to anxiety, differentiation, and triangulation. Interventions should focus on detriangulation and individuation. A genogram may be helpful to explore and identify transgenerational patterns surrounding infidelity.

Parker and Wampler (2003) indicate that the betrayed partner may experience feelings similar to those seen in a couple presenting for a face-to-face affair, such as jealousy or fear. For this reason it is important not only to treat the affair partner, but also the betrayed partner. In Cooper's (2002) *Sex and the Internet*, Schneider makes some recommendations for therapy with the betrayed partner.

1 Confirm the partner's feelings.
2 Help the partner to understand that it is useless to try to compete with fantasy sex partners.

3 Empower the partner to help them make real decisions about the relationship.
4 Help the partner to set appropriate boundaries regarding the cybersex addict's sexual behavior.
5 Make known the availability of support groups for the partner.

Schneider (2002, p. 182) also identifies potential mistakes made by uninformed clinicians:

1 To underestimate the adverse consequences of the behavior, for both the user and the family;
2 To fail to make it a priority for the cybersex addict to stop illegal or dangerous behaviors;
3 To omit the partner or spouse, if one exists, from the treatment process;
4 To diagnose the compulsive user's problem or that of his partner as sexual anorexia; and
5 To recommend that the cybersex user limit the time devoted to cybersex activities to some predetermined number of hours, or to have the partner join in the addict's cybersex activities.

Conclusion

The first edition of this volume did not contain a chapter on the treatment of infidelity. The focus of the text has been on general treatment issues such as the process of therapy and the application of specific techniques and treatment methods to couples. Since the publication of the first edition, we realized that affairs were a common dilemma presented by couples coming for treatment. We also realized that the treatment of affairs provoked uncertainties in therapists about what to do, as well as anxiety over strategic, ethical, and personal issues.

Although this chapter is the longest in the book, we have only offered essential information about the definition, prevalence, countertransference issues, ethical and etiological factors, and basic treatment issues. Understanding and treating infidelity is one of the most complex issues confronting the couple therapist. We did not touch on the fact that significant gender differences exist in the motivations for affairs and in their impact, nor did we fully explore some of the theoretical issues underlying treatment or the newly evolving literature that would support our approach to treatment. We hope to elaborate on these issues in our subsequent writing. What we have been able to provide is a basic blueprint for the treatment of affairs based on the Intersystem Approach that the senior author has been developing over the last 20 years. We have tried to impart some clarity to the issues of confidentiality and ethical concerns and the motivations for affairs, and we have tried to lend a sense of direction, purpose, and focus to the process of treatment. Material found in previous chapters of this book will be useful in treating affairs, especially as it relates to the issue of commitment and the techniques used in the recovery and restructuring phase of treatment. Additionally, the enhancement of intimacy work can help to prevent the occurrence or reoccurrence of an affair.

19

WORKING WITH HIGHLY REACTIVE COUPLES

The chapters in Part II have been devoted to basic approaches and techniques for working with typical couples in therapy, including communication, conflict, cognitions, and emotions. However, there is one particular type of couple interaction—characterized by an extreme level of emotional reactivity—where applying some of these principles and interventions may not be appropriate or effective. In this chapter, we will describe this type of couple interaction and the therapeutic processes that are more likely to produce a positive outcome. Couples who are highly reactive, aggressive, angry, and judgmental in their interaction often present the greatest challenge to a conjoint therapist (Nichols & Schwartz, 1998; Paolino & McCrady, 1978). Attempts to modify the couple process are difficult, emotionally draining, and often unsuccessful. Because the emotional reactivity is so reciprocally driven by both partners, the homeostatic persistence of the dynamic is very strong. This type of couple interaction pattern is characterized by narcissistic vulnerability and deep attachment wounds. Narcissistic vulnerability "is manifested by a propensity to react to actual or imagined rejection or disapproval with conscious or unconscious self-fragmentation, identity diffusion, and/or diminished self-esteem" (Feldman, 1982, p. 417). Each spouse expects the other to be totally devoted to the gratification of his or her own narcissistic needs (Feldman, 1982). However, the narcissistic wounds, characterized by egocentric or psychic pain, inhibit or prevent an individual from being able to be sensitive to the needs or the perspectives of another. It is not that the individual does not care about the other person's needs, but it is as if they are out of emotional oxygen and they cannot recognize or meet the needs of the other until they get the emotional oxygen they need (Chamberlain & Steurer, 2011). Working with such couples can be challenging because both spouses feel wounded and have a very difficult time recognizing and responding to the emotional needs of the other. Over the years, a couple may work with a number of different therapists without success trying to heal narcissistic vulnerability and pain.

Attachment theory can be very useful when working with these types of couples. In attachment theory it is believed that all people have an inherent need for emotional connection and that an emotional attachment relationship is initially formed between a child and their primary care giver(s) (Bowlby, 1988). During the early years of development, a person grows to feel secure in relationships if they learn that their primary attachment figure is available, responsive to their needs, and engaged in their well-being. If the primary attachment figures are unavailable or unresponsive and these needs are not consistently met, a person may experience this as neglect, abuse, trauma, or

abandonment, and he or she may develop one of two types of insecure attachment. They may become *avoidant*, meaning they withdraw from emotional connection due to a fear of being rejected, or they may be *anxious*, which often looks like neediness and nagging in adult relationships. Because basic emotional needs were not adequately met early in life, partners may bring insecure attachments with them into their relationship (Bowlby, 1988), which may create struggles with skills related to emotional regulation and interpersonal conflict (Dattilio, 2010) and foster negative cycles of reactivity. It is common for highly reactive couples to be opposite (avoidant vs. anxious) in their insecure attachment styles, which may contribute to the destructive patterns of reactivity (Johnson, 2004).

Couples that are highly reactive are often attempting to get their legitimate needs for comfort, safety, and connection met in unhealthy ways, or ways that do not work in their relationship. In most cases, highly reactive couples have common underlying process dynamics, albeit from different backgrounds. A process approach to working with them will be presented in this chapter. While the approach takes into consideration the insights and techniques of the previous chapters, more sophistication is needed when hurt and pain are a couple's core interpersonal dynamic. The interpersonal dynamics of these couples include: (a) narcissistic or attachment wounds in both partners; (b) highly developed and organized introjects such as feeling abandoned or criticized; (c) a process of interpersonal repetition compulsion fed by negative projections that deepen the wounds; (d) an attributional process which feeds the reciprocal patterns of hurt and rejection; (e) relationship incongruence which prevents an individual or couple from sharing vulnerability; (f) a lack of safety which increases their sense of vulnerability; and (g) few skills to break the regressive slide from a couple's present dynamic or content discussion into understanding the early regressive painful emotions, attachment wounds, and introjects that have created such a dysfunctional relationship.

The aforementioned process dynamics often work simultaneously in both partners to prevent differentiation, emotional support, safety, and healing. Individuals often find partners with similar narcissistic vulnerability and who are at similar levels of differentiation. The therapist who understands the power and persistence of these dynamics will approach such cases with different interventions than might be seen in typical conjoint therapy. Some specific differences that are more effective with these types of couples are (a) they might be encouraged in the early stages of treatment to suppress communication of what they feel; (b) the content of clients will be deemed as far less important than the process of communication; (c) couples will be asked to continually reframe the same experience to see it in a different light; (d) direct couple interaction may not be encouraged until understanding and new process communication skills are developed; (e) each individual receives more attention as to their attachment injuries, painful reactions, and feelings of rejection; and (f) each partner may be encouraged to receive some individual therapy, depending on the level of narcissistic vulnerability and reactivity.

Highly Reactive and Enmeshed Couples

Narcissistic Wounds and Attachment Injuries

The early underdeveloped self is highly susceptible to emotional wounds from parents, siblings, or friends. While some wounds are incurred via isolated traumatic events

such as a car accident or sexual abuse, most narcissistic wounds are actually the result of ongoing patterns of neglect, abuse, invasiveness, denigration, lack of safety, etc., from early childhood. Such woundedness occurs before and during identity formation and often prevents the psyche from developing a strong, balanced, integrated sense of self. *As a result, a person may lack trust, fear abandonment, be hypersensitive to criticism, and become reactive in their attempts to get emotional needs met such as acceptance, belonging, comfort, and safety.*

Such lack of safety for the psyche in early childhood often produces shame, destructive automatic thoughts, negative expectations, and low self-worth. The defenses against psychic vulnerability can create distant and reactive interactional patterns in later interpersonal relationships. The list of individual defenses is long and ranges from denial and suppression to rationalization, grandiosity, or intellectualization. Interpersonally, the major defenses are anger and different styles of reactivity such as defensiveness, attack, and withdrawal.

Narcissistic wounds can be exacerbated by attachment injuries experienced at other points in life, particularly within intimate adult relationships. An attachment injury is "characterized by an abandonment or by a betrayal of trust during a critical moment of need" and may occur when one partner fails to meet the other's expectation that he or she will be there and offer comfort, support, safety, or caring during a time of significant distress, vulnerability, or danger (Johnson, Makinen, & Millikan, 2001, p. 145). If experienced within the current relationship, such experiences may come to define the relationship,and the damage caused by them may be seen as irreparable by one or both partners (Johnson et al., 2001). Couples may also be negatively affected by attachment injuries experienced in previous relationships.

Aggressive communication, emotional outbursts, and rage are common signs of narcissistic wounds and attachment injuries (Feldman, 1982). Through aggressive communication, an individual attempts to hide his or her wounds and distance an intimate partner for the purposes of trying to create individual safety. There is a need not to be seen as wounded or needy. Closeness increases the likelihood that the neediness is felt and perceived. The more intimate a relationship, the more a person is potentially vulnerable and exposed.

Aggressive communication usually creates one or all of the following reciprocal patterns with a partner: (a) aggression creates more aggression; (b) aggression creates passivity and withdrawal in a partner, which in turn leaves the aggressive partner feeling rejected or unloved; or (c) aggression creates passive aggression. For example, a wife asks her husband to get milk, bread, and eggs at the store and he returns with milk, bread, and yogurt; she gets angry, he feels unappreciated, and they both become reactive. She says, "Just go to the store and get medium brown eggs," and he returns with extra large white eggs. Reactive and aggressive feelings are the end interactional result, with the pain of feeling unheard, unloved, and criticized so deeply felt.

As described above, narcissistic wounds and attachment injuries are often grounded in early childhood experiences and are frequently communicated through reactivity and aggression in adulthood. These wounds need to be explored in therapy so that clients understand their origins and how they play out in their present relationships. Healing can take place through self-dialogue, insight, and the development of new processes of healthier interaction and a secure attachment bond with one's current

partner. In some cases, the reactivity may be so high that clients cannot process the early attachment wounds as a couple, but must do so individually before focusing on relationship healing. These processes are discussed later in this chapter.

Introjects and Couple Interaction

Introjects are the early emotions and thoughts developed and incorporated into a young child's self-concept through the interaction and quality of nurturing of his or her significant relationships with caregivers. These emotions and thoughts, organized as life experiences, tend to repeat and exaggerate themselves. In the development of identity, such emotions and thoughts became part of the self-concept with the corresponding negative automatic thoughts becoming ways of characterizing the self. For example, imagine that both parents of an individual are unable to nurture and express warmth. The child experiences this lack of emotional care with the feeling of being rejected. These feelings of rejection are organized over time and become labels of automatic thought such as "I am rejected" or "I am unloved." A second example is a parent who criticizes a child on a continuous basis. Responding to continual criticism, the child feels low self-worth and begins to think and say, "I can't do anything right," "I am unimportant," or "I am a failure."

Such feelings can organize more and more of the individual's life experiences, with the interpretation of such experiences deeply affecting interaction in later intimate relationships. In many cases, the introjected emotions and thoughts can be sufficiently repressed or behaviorally controlled as long as the person is not in an intimate relationship. Once an individual becomes involved in an intimate relationship,however, the underlying and unmet narcissistic needs come into play with all the accompanying dynamics. For this reason, the dynamics between partners sometimes can change quite precipitously when they become more committed to each other, live together, get married, or have a child. Once again, it is often the experience of emotional closeness that triggers the underlying feelings of vulnerability. As long as emotional distance can be maintained, the pattern may not be revealed or manifested in a pronounced way.

The key issue is that, in later relationships, the individual—having organized these emotions and self-thoughts in early childhood through young adulthood—begins to perceive and understand more and more interactions through the "lens" of these emotions; such that, the more rejection or criticism one feels, the more rejection or criticism one sees in interactions and interpersonal relationships, which may perpetuate itself in a vicious cycle, as described in the section below.

Repetition Compulsion

Repetition compulsion is the tendency of an individual to allow early negative feelings and thoughts about oneself and have them first define self-concept and then affect interpersonal and interactional dynamics in adulthood. The early organized emotional experiences, consequent feelings, and associated thoughts tend to repeat and sustain themselves throughout life, specifically in more intimate relationships. A client perceives that he or she was rejected as a child. He or she organizes this emotion

around many different experiences and projects it into many behaviors and interactions with a partner. Projection in this case refers to the dynamic of taking an internal negative emotion or thought and placing the cause or blame for the experience onto another. An example of this would be with trust. For example, an individual learns in childhood that he cannot trust his parents to meet his needs or be there for him, and then later in life transfers this belief to his spouse or partner. This can be very confusing to a partner because they are attempting to meet the individual's needs, but the other person still does not trust them.

The first step of repetition compulsion is when a person feels rejected and then rehearses the cognitive statement of "I am rejected." The rejection is then projected onto a partner, and many behaviors—which could be interpreted from a variety of perspectives—are now seen as examples of rejection. For instance, a husband or wife making a suggestion to the other is no longer experienced as giving helpful advice or caring, but as critical and judgmental. One partner refusing a request for sexual relations is no longer interpreted as a situational lack of desire, but a powerful statement of rejection to the individual who made the request.

Now that the person feels rejection, he or she rehearses the rejecting thoughts and sees the partner as a co-conspirator, if not the cause of the rejection. He or she then defends him- or herself against the "partner's rejection." Possible defenses are to withdraw, get angry, attack, or became aggressive in some manner. Another tactic used if one is feeling rejected is illustrated by a husband trying to convince his wife of his goodness or worthiness while accusing her of not accepting or loving him. As she perceives these dynamics and feels hurt, she in return gets angry that she is being treated in such a manner. Once the partner returns such anger and reactivity, reciprocal cycles of reactivity and defense take over in increasing intensity within a couple. Over time, these patterns became highly organized and very difficult to change. It is as if each partner was playing out a well-rehearsed script.

These patterns of couple interactions can be even more challenging when both partners bring wounded and rejected selves and insecure attachments to the relationship. The result may be, and usually is, mutual projection and subsequent feelings of rejection, hurt, and anger. Both partners want closeness and acceptance but cannot risk asking due to a fear of rejection. They use different strategies in hopes of getting their needs met or defend themselves from possible rejection by lashing out or distancing themselves. Instead of trying new behaviors and expressing underlying emotions and needs, they get stuck in a negative and rapidly escalating desctructive cycle. Ultimately, couples need to develop new interactions and new patterns of communication.

Negative and Externalizing Attributions

In addition to the powerful persistence of narcissistic wounds and repetition compulsion, there may be other interpersonal dynamics that maintain the dysfunctional couple communication. For instance, the constant feelings of rejection are fed by automatic thoughts of, "I am rejected." Individuals wounded by early life rejections will project negative behaviors or motives (attributes) onto an intimate partner and then use this perceived rejection as a reason to get angry or to distance themselves

from that partner. Consider the following examples, illustrated by what figuratively could be called "above the line" interpretation, meaning understanding the input for what it is without personalization or agenda, or "below the line" interpretation, meaning understanding the input through the attributions of rejection, abandonment, criticism, etc.

1 Wife to husband: "Would you pick up your shoes?"

   (a) Without an attribution of criticism: "I'd be glad to, sorry."
   (b) With an attribution of criticism: "Nothing I ever do is right. Why are you always criticizing me?"

2 Husband to wife: "I'll be working this Saturday."

   (a) Without an attribution of rejection: "I'll miss you, sorry you have to work."
   (b) With an attribution of rejection: "Why don't you ever want to be with me?"

When people interpret behavior "below the line," they are personalizing information and attributing negative intentions to a partner. *The ability to change these attributions is crucial, even if a partner's behavior has not changed to date.* Attributions create circular patterns that increase narcissistic woundedness and negative interpersonal enmeshment. It can be beneficial if both partners work to heal the problems by focusing on the attributions or cognitions they are making regarding their partner's behavior. Therapists can help couples do this by (a) bringing to light the way in which clients may be personalizing information, and (b) pointing out alternative attributions and responses. It may also be helpful to reframe a partner's behavior and intent such that it can be seen as loving or neutral instead of rejecting. The power of altering attributions in interpersonal relationships is that it can interrupt and decrease patterns of emotional reactivity as each partner individually takes responsibility for his or her own negative attributions, even if the other partner has not reached that point yet.

Incongruence of Interpersonal Communication

The incongruence of content and process is almost a universal dynamic with couples who are deeply wounded and undifferentiated. Neither partner in the relationship is able to ask congruently for what he or she needs to heal or to create intimacy. Because of this mutual dynamic, dysfunctional dynamics repeat, and what should be simple requests come out defensively and aggressively. The listener hears the negative tone and responds negatively, often aggressively, with the couple remaining distant and hurt. Instead of being able to state, "I really want to talk with you," what is incongruently said is, "You never want to talk!" Negative judgments then reciprocally create more negative judgments.

Lack of Emotional Safety

A core lack of trust and safety in highly reactive and enmeshed couples prevents most partners from being able to give forthright caring, share honest feedback, or

effectively listen. Safety is built on many dynamics, including an attribution of a partner caring, an ability to be vulnerable and cared for, feeling heard and acknowledged, and a predictability of positive behavior. When feeling deeply hurt and vulnerable, safety is replaced with distance, doubt, fear, aggression (most common), and other defenses for safety.

The couple therapist should not be discouraged if he or she is unable to help couples break out of their reactive interactional patters and establish a self-responsible stance in the couple interaction. The reciprocal negative dynamics in wounded couples often leave partners without feelings of safety, trust, or mutual understanding. Without safety, the couple will have a difficult time responding to interventions intended to facilitate softening and empathy. Thus, a pattern of mutual misunderstanding, negative attributions, defensiveness, anger, and hurt continues.

In summary, a flow chart of two wounded and emotionally reactive partners might look like as shown in Figure 19.1.

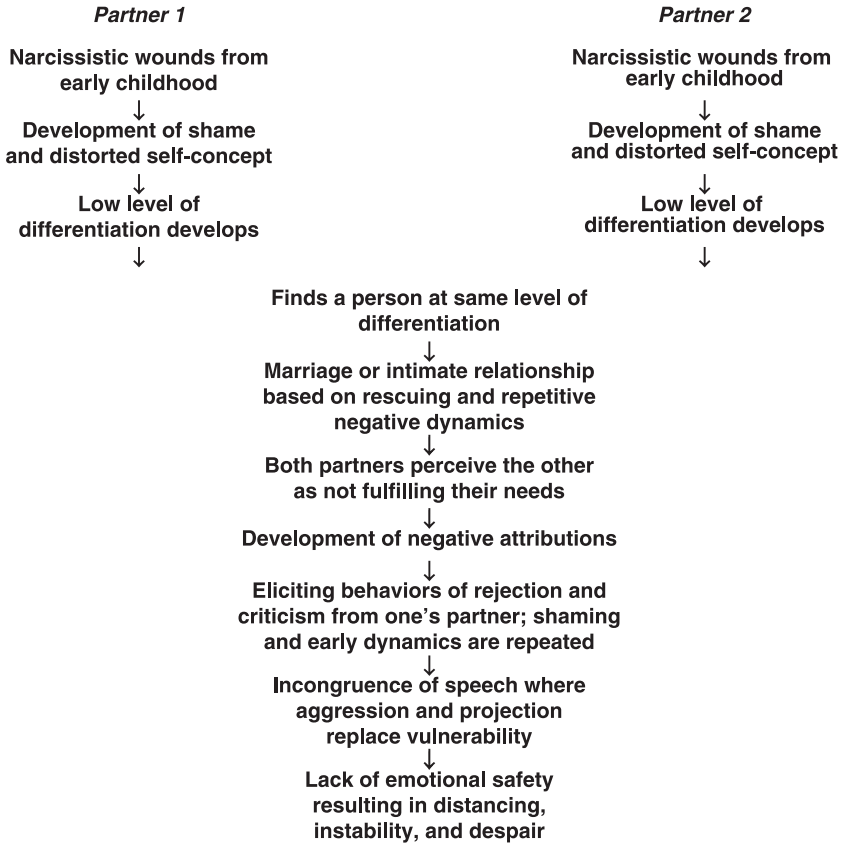


Figure 19.1 Flow Chart of Two Wounded and Emotionally Reactive Partners

Interventions to Heal Reactive Interactional Patterns

In order to help couples break free of reactive interactional patterns, an important transitional step is to help clients develop an understanding of their attachment injuries and introjected feelings, gain an awareness of how they repeat the same destructive patterns of communication, and create new ways of thinking and behaving with each other. The couple must move away from the content of "who did what to whom" and move into relationship process issues, becoming more self-aware and self-responsible for their own projections. In the following proposed treatment, insight and cognitive, emotional, and behavioral skills will be emphasized for the purpose of helping couples overcome the repetition of early childhood pain in the later adult life and relationships. General skills needed by the therapist include: (1) helping clients develop insight into family-of-origin issues; (2) helping couples understand the connection between their family of origin and the emotions and interactions in their current relationship; (3) teaching differentiation and how to be responsive rather than reactive, communication with a balance of thought and emotion, and a desire to truly understand the perspectives and emotions of one's partner; (4) encouraging counter-instinctual behavior—behavior which is not defensive or projective in both communicator and listener—in order to break reciprocal patterns; and (6) encouraging and supporting the couple through the establishment of safety, hope, and patience. The therapist must become a mirror for each partner, with the power to offer reflection, which could initially be perceived as adding to the narcissistic wound. Such mirroring is done through the use of an assertive tone of voice, a hopeful stance, and persistent encouragement to change existing patterns.

It is difficult to alter a partner's sense of woundedness and vulnerability when it has become an organizing force within the couple's relationship. Not only are these core emotions born of present day negative experience, there are also historical self-concept and shame issues, cognitive distortions, and interpersonal process issues at work. Behavioral distance and destructive non-verbal language are also being re-enacted from the distant past. Similar interpersonal patterns repeated later in life feed and perpetuate early introjected emotions. Couples tend to want to share emotions and the experiences or stories that justify how they feel. However, in most of these cases, the sharing is not helpful nor does it function as a catharsis by which both parties feel better after the sharing, but instead becomes a way of deepening the painful and negative feelings. These dynamics can be interrupted and replaced with positive experiences and healing as therapists utilize the techniques described in this section. Clients can take personal power over the intergenerational transmission of vulnerability, hurt, and pain.

Steps to Break Dysfunctional Patterns

The process of changing such highly charged dysfunctional patterns is one that cannot be haphazard. Both the therapist and clients share responsibility for bringing about change. Therapists must create structure and safety in session and provide appropriate homework for practice outside of therapy. Both partners are expected to do their part to be self-reflective and alter their reactive communication patterns. Because of the

volatility of highly reactive couples, some of this work is best carried out in individual sessions. When meeting with partners together, it may be best to channel couple communication through the therapist until the partners are able to interact directly with each other in a safe and constructive manner (Butler & Gardner, 2003; see discussion of shielded enactments in Chapter 12).

Each of the steps listed below is part of the therapeutic process used in treating these types of couples. The steps do not necessarily need to be used in the order in which they are presented. After the assessment has been done and the therapist is aware they have a highly reactive, narcissistically wounded couple, it is important to explain the treatment process to the couple. The therapist needs to explain that it appears each partner is replaying old patterns learned early in life in an unconscious way in their relationship. With other couples, we usually tell them to trust their feelings and perceptions. However, with these couples, the therapist must tell them not to trust their feelings and perceptions because they are so organized by early life experiences. Each partner must agree that they own part of the problem, be willing to accept the feedback provided by the therapist, and trust that the therapist will maintain control in the sessions. Further, the clients must agree to be self-responsible, be reflective, and be willing to change themselves.

Step 1: The therapist must show empathy, a constancy of care, and model differentiation, and be patient with the wounded couple. No couple interactional movement will be continuous, and there will be many reversals and regressions. A couple therapist who normalizes the reversals for the client and paradoxically predicts the reversals will help a couple remain hopeful and persistent. The therapist may note and predict that regressive behavior is likely to occur after a more intimate couple communication or at the conclusion of a more vulnerable and honest therapeutic session.

Step 2: Relate the many content arguments, disagreements, and fights a client has to certain organizing emotions or thoughts, which are often unrecognized by clients and stem from the earliest of years. Some examples of the unconscious mental schema (Beck, Freeman, Davis, & Associates, 2004) are criticism, rejection, abandonment, incompetence, ignorance, etc., or thoughts such as, "I am unloved," "I am uncared for," and "He always rejects me." Highly vulnerable clients usually group or arrange experiences and interactions into one or two core vulnerable feelings and thoughts. These become highly organized and develop into highly generalized, all-or-nothing, repeated self- and other statements. For example, the automatic self thought of, "I am rejected" creates insecurity and self-doubt, and the attribution of, "he or she rejects me" creates withdrawal and/or anger.

Step 3: Relate the organized emotions and thoughts to family history. In almost all cases, an individual who, for instance, feels constantly rejected or unintelligent will find the roots of these feelings in his or her family of origin. It is crucial that the client begins to understand that the feelings, usually attributed to the behavior of a partner, are actually grounded in historical experience. When there is a cognitive connection between historical experience and current emotional and behavioral patterns, a spouse can begin to understand the power and longevity of such introjects or organized emotions beyond the current relationship, and will remove some blame and negative attributions toward the partner. The therapist might ask each client whether he or she experienced earlier in life the feelings currently attributed to his or her partner. The

therapist can then help the client make the connection between their history, early introjects, and how these introjects create a false image of the partner.

Step 4: Have the couple label the emotional journey into these organized emotions or thoughts. Naming and labeling begins the process of externalizing, controlling, bounding, and objectifying what prior to this was internal undifferentiated hurt and vulnerability. Through a process of externalizing, writing in a journal, discussing, and describing, partners can begin the process of becoming more differentiated. Couples might say, "I was in my rejection feelings," "I was on my journey," or, perhaps, actually give the emotional or cognitive distortion a name. By labeling the emotions and the "journey" into the vulnerability, the clients begin to externalize the dynamic and assume more control over their emotions and attributions. Additionally, therapists can help clients externalize negative interpersonal patterns, such that the patterns become the enemy, not the partner. Such externalization creates an opportunity for partners to become more unified as they come together against a common foe: the externalized pattern of behavior or projection (White & Epston, 1990).

Key to this process is having the client understand that they are most often not victims, but co-creators of their emotional journeys into pain and hurt. As victims, they are not responsible and a partner is rejecting them. As creators, they recognize that the feelings of rejection are in large part created in their history and re-enacted interpersonally through their interpretations and reactions. Partners need to learn why certain behaviors or comments from partners spark emotional reactivity. When they begin to understand their insecure attachment and more importantly their attachment needs, they can express to their partner the way they are feeling from a position of vulnerability rather than aggression. This will allow their partner to reassure them of their love and concern, and it will allow them to have an emotional experience that is connecting and fulfilling. With practice partners can recognize when their attachment injuries are being triggered, and they can risk vulnerability and ask for their needs to be met in healthy ways, rather than manipulating or demanding them in ways that do not work.

Step 5: When emotional intensity is high and the defenses against vulnerability and introjected emotions and thoughts are enacted interpersonally with the partner, it is important that the therapist use different process skills than they might with other couples. In other cases, for example, a therapist might facilitate communication by encouraging one client to express their emotions to their partner, while the other is coached in reflective listening. However, in most cases where there are deep attachment wounds, having clients express their anger and hurt is counterproductive. Instead of having partners interact directly with each other and encouraging them to share their emotions, couple interaction is at first discouraged and replaced with individual reflection, therapeutic mirroring and feedback, and a constant comparison of the currently felt emotion to early life experience. The hardest thing for clients to learn is that at one level, negative thoughts and emotions seem very appropriate for the interpersonal circumstance, but at another, they are not appropriate at all. They are actually the mechanism that maintains the negative repetitive cycles and continually creates a client's woundedness in their relationships.

Step 6: Once insight, historical roots, and labeling have been identified, the therapist needs to encourage a client to reframe and reinterpret an experience in a healthier manner. What once led a partner to feel wounded, rejected, or criticized now contains

other possibilities for reinterpretation and different responses. For example, a spouse coming home late from work is not a sign of rejection, but is interpreted as a simple miscommunication or an indication he or she is working hard to provide for their family. An important concept in differentiation is that the client begins to choose different interpretations and develops new responses to a partner's behavior. The therapist must constantly help the partner avoid regressing to prior cognitive and emotional patterns of being rejected, unlovable, and so forth. When a secure attachment bond has been established between partners they no longer automatically shift into worry or reactivity, rather they assume more logical reasons rather than negative or insecure ones. The therapist knows that the client is beginning to disengage from past patterns when he or she can interpret a partner's behavior from a number of different perspectives rather than the singular negative perspective that was once so firmly entrenched. Partners' behaviors or words are not being taken personally because each recognizes the historical roots of their emotional reactivity, and they are more secure in their partner's love.

Step 7: The behavior that eventually is most successful in breaking the repetition compulsion is one that is often the opposite or counter to what was previously an automatic response by the client. The therapist explores with the client behaviors that would break the reciprocal cycles of the couple. For instance, instead of feeling rejected and then withdrawing, the client learns to reach out. Even if old emotions of rejection are experienced, there is new safety in the relationship, and the partner can reach out to ask what was meant by the behavior or communication. He or she can express feelings of rejection and a desire to withdraw, thus allowing their partner to provide reassurance of their care and desire for closeness. Partners can also express their needs in a more straightforward manner, rather than indirectly or passive-aggressively. In the place of feeling invisible, a spouse expresses what he or she needs in a congruent fashion, with requests shared vulnerably not aggressively. By asking for more positive and creative options for a response, the therapist assists the client to develop more constructive healing behaviors. The client learns to say, "I missed you," instead of, "Why don't you care for me?"

Emotion-Focused Therapy with Highly Reactive Couples

As discussed in Chapter 16, emotion-focused therapy (EFT) is an approach to couple therapy that has strong ties to attachment theory (Greenberg & Goldman, 2008; Greenberg & Johnson, 1988; Johnson, 2004). As described above, a fundamental tenet of attachment theory is that individuals have an inherent need for attachment and may develop insecure attachment styles when early attachment figures are unresponsive to their needs. Attachment wounds can also arise from experiences of trauma, abuse, or other significant betrayals of trust or safety. Insecure attachment and attachment injuries may be a significant part of the emotional volatility and dysfunctional patterns of highly reactive couples. In such couples, patterns of negative interaction develop such that attempts to secure connection and closeness by one partner are carried out in ways that invite unwanted, hurtful behavior from the other. Each partner wants closeness and connection, but they do not know how to ask for it, nor do they feel safe enough do to so. Furthermore, they lack insight into how early life experiences may have led them not to trust emotional connection.

EFT was developed for the purpose of helping couples overcome and heal negative patterns of conflict and emotional reactivity, especially those which are grounded in insecure attachment and attachment injuries. Narcissistic wounds and attachment injuries can be healed through a secure attachment bond to a primary attachment figure (i.e., one's partner). In order for this to occur, safety needs to be established so that couples are willing to express their vulnerabilities and attachment needs and connect in a fulfilling emotional way. For individual and relationship healing to take place, partners first have to become de-escalated from their positions of reactivity.

Emotion-focused therapists help couples come to an awareness of their attachment needs and how to express these needs in ways that invite compassionate and caring responses from their partners. Couples also learn to recognize their negative patterns of interaction. And they come to see that what each of them does invites behaviors in the other that make them feel unloved, rejected, or not good enough. The therapist simultaneously heightens emotional experience while creating an environment of emotional safety so that clients will risk being vulnerable with each other and learn to ask for the emotional connection they so desperately want and need. The therapist also teaches couples how to create safety for each other in the relationship so they can be vulnerable and ask for their real needs to be met instead of using anger or manipulation.

Ultimately, the goal of EFT is to help the couple have corrective emotional experiences (Greenberg, 2010) and establish new patterns of interaction that build and sustain positive emotional connection. An EFT therapist attempts to facilitate emotionally connecting experiences by helping couples risk vulnerability and express their true needs and feeling in terms of attachment needs. An important part of this process is helping partners respond to these expressions of emotions in partner-affirming, empathic ways. As couples learn to do this, they create greater emotional safety in their relationship, which allows for greater emotional vulnerability. This process leads to an increase in emotional connection and intimacy between partners. Further information about EFT can be found by reading Johnson (2004) and Greenberg and Johnson (1988).

Conclusion

The therapeutic process of altering negative patterns with highly reactive and narcissistically vulnerable clients is some of the hardest work a couple therapist may do. It can also be the most rewarding. There is great power and hope when clients begin to change patterns and heal the wounds and the repetition of the wounds that may have been transmitted from generation to generation. Couples who so firmly believed that their spouse was intentionally hurting them learn that much of the dynamic is of their creation. Such self-responsibility and self-understanding helps to break the projective process and creates insight into how early wounds can be re-enacted in later intimate relationships.

20

SOLIDIFYING CHANGE AND MAINTAINING PROGRESS

As discussed in Chapter 9, a significant body of research supports the effectiveness of couple therapy (Shadish & Baldwin, 2002, 2009). Nevertheless, many couples struggle to maintain the gains that they make while in treatment (Carlson & Ellis, 2004), and some experience relapse into old emotional, cognitive, behavioral, and interpersonal habits. Therapists can work with couples, particularly near the end of treatment, to solidify changes, maintain their progress, and avoid relapse. The purpose of this chapter is to outline some steps therapists can take to help clients maintain and build upon their success and growth in therapy. The chapter will include interventions and strategies to help therapists and clients build on couples' strengths and successes experienced during treatment. It will also include suggestions for preventing relapse, handling setbacks, and promoting continued growth beyond therapy.

Helping Couples Accept Responsibility for Their Success

It is exciting and rewarding for both the clients and therapist when a couple experiences meaningful changes and growth. Couples who have experienced significant gains and healing while in treatment often give therapy or the therapist a great deal of credit for their successes. They may also have developed a sense of reliance on the therapist, who has provided a safe environment, given them support, and helped them heal and grow.

Although the couples may come to rely on the therapist in some ways during treatment, therapists should be wary of couples becoming too dependent upon them to solve their problems or take care of their relationship, especially toward the end of therapy. Ultimately, the therapist hopes to help the couple become self-sufficient and independent. From the first session, the therapist is trying to work her- or himself out of a job. Therefore, therapists must help couples develop the individual and interpersonal abilities necessary to move forward on their own.

One way to help couples accept responsibility for their successes is to encourage clients to accept responsibility for their relationship. The therapist should highlight couples' efforts as the key to their success and express confidence that they will be able to maintain the gains they experienced in therapy. Commendations can be used liberally throughout treatment to help clients understand that *their* efforts (not the therapist's) are at the heart of relationship success. We share our opinion with clients that good, healthy marriages do not come about by accident. Rather, they are the result of

consistent and deliberate effort by both partners. The very efforts that helped the couple come to experience the benefits of therapy and the fruits of an improved relationship are the same things that will help them maintain the gains they made in therapy and continue to grow beyond the conclusion of treatment. The therapist should review with couples specific things they did throughout the time they participated in therapy that helped them solve their problems and grow as a couple. For example, when a couple makes a change the therapist can ask them to discuss what they each did to contribute to the change or the lesson they learned about how to avoid a problem and resolve it. Rather than taking credit for the changes, therapists should help couples accept responsibility for their efforts, recognize that they have the tools to succeed in their relationship, and understand that a mutually satisfying relationship rests in their hands.

Stuart (1980) also argues that therapists can help clients maintain change by teaching them the logic of the interventions that are used in treatment. He believes that if clients are taught the rationale for each step in their treatment then they will be able to better understand the logic behind it and grow in their ability to generalize the application of solving this problem across other areas of their lives. The purpose is to build greater self-reliance by teaching clients to resolve issues on their own outside of the therapist's office (see also Collier & Marlatt, 1995).

Tapering Sessions and Maintenance Check-ups

When clients are close to reaching their goals and therapy is nearing a close, we prefer to taper sessions, rather than ending therapy abruptly. Instead of meeting once a week, the therapist may suggest to clients that they come every other week for a few sessions. Appointments can then be spaced out to every three weeks or once a month. This is to help couples have time to continue to apply what they learned in therapy and develop greater self-reliance. Therapists can follow up with clients to see if they continue to apply the relationship principles and skills developed during treatment. Carlson and Ellis (2004) recommend that therapists incorporate follow-up procedures into their treatment in order to increase the effectiveness of their interventions. Tapering sessions also serves as a way for couples and therapists to catch setbacks early before clients relapse deeply into old, destructive patterns.

Even after the conclusion of treatment, some of our clients return every 6 months or so for a maintenance session. Sometimes we suggest this to couples and use the analogy of a routine medical check-up or routine maintenance on a car to illustrate the benefits. People may see their doctor regularly to monitor their physical health, or they may take their car in regularly for an oil change or to get it tuned up in order to keep it running well. These kinds of preventative efforts help keep things working properly, and they allow for early detection and timely treatment of problems. This kind of work is usually less costly and painful than if small problems were neglected and grew into more significant and destructive medical or automotive issues. The same is true for couples who have been in therapy. It may be wise (and less costly or painful) to catch small issues early and address them before they grow into more difficult challenges. If couples come in for a maintenance check-up and all is going well, then the therapist can congratulate them for their progress, reinforce the benefits of

their efforts, and discuss what they can do to continue to grow as a couple and experience further success in their relationship.

Continued Relationship Nourishment and Enrichment

Although many couples benefit from therapy, adherence to the planned treatment procedures following the conclusion of treatment can be low (Carlson & Ellis, 2004). Once they have experienced the desired changes in their relationship and their satisfaction has grown significantly, couples sometimes become casual (and perhaps lazy) in their efforts to nourish their relationship. Much of maintaining gains and preventing relapse involves keeping the relationship strong, healthy, and nourished. Couples may neglect their relationship, shifting their focus away from their relationship and onto their kids, work, hobbies, and so forth. We encourage couples to commit to regular, ongoing relationship enrichment efforts. We warn them of the tendency to ease up on their efforts once things start to get better or after the completion of therapy.

We sometimes use the experience of a close physician friend to illustrate to couples the risks of not continuing with consistent efforts to nourish their relationship. Physicians often find that patients do not follow through with the completion of treatment once they start feeling better. For example, a patient might be prescribed an antibiotic to treat a case of strep throat. The patient is instructed to take one pill every day for 10 days. However, at about day five or six, the patient finds that he feels significantly better and is not experiencing painful symptoms any more. Therefore, he stops taking the medicine—before the infection is completely treated—which leads to the infection and painful symptoms returning. We encourage couples to keep applying what they learn in therapy, even when they are feeling better, so that they can maintain relationship health and avoid the return of old, painful symptoms.

Couples need to make their relationship a priority (Carlson & Sperry, 1993) and to set aside time on a regular basis to nourish their marriage. The Aspects of Intimacy worksheet (see Chapter 10) can be used to help couples plan ways in which they can nourish and strengthen their relationship. When couples indicate that their lives get so busy that they do not have time for each other, therapists may have them set aside time each week for a calendaring meeting. The purpose is twofold. One, it gives couples the opportunity to plan their week together and know what each other needs to do. Two, it gives them the chance to specifically plan time to be together and nourish their relationship. In fact, we often suggest that couples put time for their relationship on the calendar *first* before they schedule other things in their week. Couples who plan to spend time together when they have "free time" during the week often find that they end up spending very little time together. The reality for many couples is that their lives are so busy that they do not have any free time. Thus, the couples must deliberately and specifically plan time in their week for them to be together. This may include a weekly date night, working on a project together, watching a favorite TV show, or time for sexual intimacy. Some may worry that this approach lacks spontaneity. But for many couples this may be the only way they are able to consistently have time together during the week—and planned time together is better than no time at all.

Gottman and Gottman (1999) also emphasize the importance of continued relationship nourishment beyond the completion of therapy. In order to build upon the

gains made in therapy, they recommend that couples continue to be curious about their partner and seek to know about their life and their feelings. Partners also can continue to nurture fondness and admiration for each other. Gottman and Silver (1999) suggest that having a positive view of one's partner can serve as an important buffer when a couple experiences difficulties in their relationship.

Avoiding Relapse and Handling Setbacks

Often couples' efforts at change and growth are short-lived or are undermined by persistent behavioral, cognitive, emotional, and interpersonal patterns. Couples experience desired growth and positive outcomes during treatment, only to find that they struggle to retain the things they learned and the gains they made with therapy. Therapists must be aware of these possibilities and work with couples to avoid relapse or effectively handle setbacks, should they occur.

Many couples express anxiety or fear about ending therapy because they worry they will not be able to sustain the progress they made or are concerned they will fall back into old destructive habits. Therapists should discuss these fears with clients and help them plan how they will avoid setbacks and relapse. Prochaska and DiClemente's (1982) well-known model of change suggests that change is a process that progresses through various stages: precontemplation, contemplation, preparation, action, maintenance, and termination. Prochaska (1999) discusses maintenance as clients "working to prevent relapse" (p. 231). He said that maintenance usually lasts anywhere from 6 months to 5 years. During this time, couples build on the gains they made in therapy and become more and more confident that they can continue their growth without the therapist.

A common reason that clients relapse quickly after treatment is that they are not well-prepared for the continued work required to maintain the progress they make in therapy. Prochaska (1999) indicates that if clients relax their efforts, they increase their risk of relapsing. He suggests that the metaphor of a marathon can be helpful with clients when explaining the process of change, which extends beyond the period of treatment. He said that only those runners who are well-prepared will be able to keep running mile after mile and finish the race. Therapists must help couples prepare to give the necessary effort to maintain a healthy relationship that continues to grow and develop well after therapy has concluded. This includes not only behavioral change, but changes in the attitudes and feelings that partners have for each other (Christensen & Heavey, 1999).

Carlson and Sperry (1993) define relapse prevention as "intervention consisting of specific skills and cognitive strategies that prepare clients to cope with inevitable slips or relapse in compliance to a change program" (p. 451; see also Carlson & Ellis, 2004). They suggest that a majority of relapses occurs because clients are put in stressful situations that involve negative emotional states that often are a result of interpersonal conflict or social pressure. The point of relapse prevention is to help the individual catch a slip early when it occurs so it does not escalate into a full relapse that will set them back in their progress (Carlson & Sperry, 1993).

Clients can be forewarned of things that may provoke relapse. Some common situations that increase the risk of relapse are times of emotional distress, such as

depression, anxiety, anger, boredom, loneliness, and stress (Prochaska, 1999). Other stressful life events such as moving/relocating, changing jobs, job loss, illness, death of a loved one, newborns, life cycle transitions, or problems with children can increase a couple's vulnerability to falling back into old negative relationship patterns. With infidelity specifically, partners may be especially sensitive to issues related to trust, and violations of trust (intentional or unintentional) can cause couples to fall into a tailspin, even if a significant amount of time has passed since the affair and the couple successfully completed treatment.

Carlson and Sperry (1993) assert that many stressors couples face are directly related to relationship and family life stages and are predictable and normal. Couples may benefit from a foreknowledge of the times at which stress is likely to occur (Stuart, 1980), and discussing potential challenges can help them prepare ahead. Carlson and Sperry (1993) believe that relapse prevention strategies need to be initiated in the early stages of counseling and continue throughout treatment. Therapists should discuss with couples possible pitfalls, stressors, and roadblocks they may run into on their journey forward. Together, the therapist and couple can anticipate and prepare to successfully navigate around or through these challenges should the couple face them in the future.

Teaching stress management strategies and facilitating problem-solving skills can also help couples effectively resolve problems that may arise as they move forward in their relationship (Collier & Marlatt, 1995). Therapists can also encourage couples to develop external supports to help them in their efforts to maintain change and manage setbacks (Carlson & Ellis, 2004; Stuart, 1980). One type of external support is social support. Family members, friends, religious communities, and others can support couples in their efforts to build and maintain a strong relationship. Couples can also participate in marriage enrichment groups or seminars, or read and apply the principles from a self-help book on relationships.

Should the therapist believe the couple is at high risk of a relapse, two strategies are available, as discussed by Weeks and L'Abate (1982). Although not applicable to every couple or problem, these may help couples realize their ability to maintain progress and avoid relapse. The first strategy is to have the couple spend a week at the end of therapy purposefully enacting the patterns they were experiencing at the beginning of therapy. The rationale given to the couple is that when they first started therapy they were behaving in ways that seemed out of their control and were experienced as automatic or involuntary. By voluntarily enacting some prescribed patterns of behavior, they are demonstrating the ability to do so volitionally. They are instructed to become observers of their behavior in order to learn what used to be beyond their control. When the week is over each partner is asked to describe what they learned about how they contributed to the problem and what they are now doing to prevent the problem from reoccurring.

The second strategy does not involve an enactment of any problem, but a pessimistic statement from the therapist that some couples experience relapses and these are normal. Following this statement, the first question for each partner is what they could do to provoke a relapse. For example, "If you are not careful, what behaviors, mistakes, or patterns might you engage in to help bring about a relapse?" Once each partner had identified some mistakes they might make, the second question is what

they can do to prevent these mistakes. The therapist also asks the couple for permission to ask the other partner to list some mistakes they think the other might make. It is important to gain permission from both partners to comment on the other's mistakes. Permission to comment on what the other did in the past will help the receiver of this information be less defensive. The partner receiving this information is asked whether they were aware of these patterns, how they might monitor themselves regarding the mistakes they might make, and what strategies they can use to avoid or stop the pattern from escalating. The therapist can also point out that should one partner begin to slip, this does not give the other partner permission to slip back into their old pattern. If one partner is slipping back into the old pattern and they have an agreement that the other partner can point out when the partner is doing something on their list of mistakes, it may help to stop the old pattern.

Therapists cannot predict the future, and many couples will face future challenges and possible setbacks. Carlson and Sperry (1993) suggest that relapses should be reframed as a mistake rather than a factual error or a moral shortcoming in one or both partners. This can help the couple get back on track and learn from their experience. When couples do experience setbacks, they can also be encouraged to utilize the skills and strategies they learned in therapy in order to manage current or future challenges. Of course, the therapist should let clients know that if they struggle to manage things on their own or find that they are falling into old (or new) destructive patterns, they can contact the therapist and resume treatment.

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INDEX

Note: 'N' after a page number indicates a note; 'f' indicates a figure; 't' indicates a table.

abandonment, fear of 135
A-B-C-D model 177, 184
Abroms, M. 4
abstraction 16–17, 191
abuse 179, 259
acceptance 204
accidental encounter 255
accountability 266–7, 272
Ackerman, J. 229
activity scheduling 238
Addis, M. E. 106
aesthetic intimacy 124
affairs. *See* infidelity
affect: controlling 18; and emotional congruence 225; managing 225–6. *See also* emotions; feelings
affection 124, 128–9
affirmation 128–9
aggressive language 75–6, 281
Akillas, E. 145
Alexander, J. 112, 145, 229
all-or-nothing thinking 190
alternative interpretation method 198–9
analogies 82–7
Anderson, T. 108
Andolfi, M. 228
anger: and conflict resolution 161–7; as defensive 163; definition of 161; disguised 165; as distancing mechanism 164; expressions of 166–7; and family-of-origin issues 162–3; fear of 133–4; and filtering emotions 222–3; genograms for 162; and hurt 163; meaning and functions of 162–5; and Rational-Emotive Behavior Therapy (REBT) 177; and reframing 144; sharing feelings of 130
Aponte, H. 230
appreciation 128–9
approval, irrational thoughts about 189
arbitrary inference 191
Aron, A. 123
Asay, T. P. 106, 107
assertive language 75–6
assessment 13–20; balanced approach in 55–6; case formulation 20–32; common mistakes in 14; genograms 29–30; guidelines for 14–20; and homework 234; and Intersystem Model 13; overview of 13–14; presentation of problems during 17. *See also* case formulation
assumptions 149–51, 192, 199
Atkins, D. 250
attachment styles 172
attachment theory 216, 279–80
attack/defend pattern 78
attributions: and conflict 174–6; negative and externalizing 283–4; and reframing 139, 144; and schemas 192. *See also* blaming
automatic thoughts 189, 192, 195–6, 196t, 282. *See also* cognitive therapy (CT); irrational thoughts
autonomy 124

Babcock, J. 4
balanced approach 55–67; and conjoint sessions 57–60; educating clients about 56–7; inclusive language 60–1; and intensity of interventions 61–3; in joining with clients 55–6; loss of 67; and office set-up 63–4; and psychopharmacology 64–5; and systemic thinking 55; techniques for ensuring 65–7. *See also* objectivity
Balderrama-Durbin, C. 4
Bandler, R. 85
Bandura, A. 176
Barker, J. 148, 149
Barrett, L. F. 147
Barton, C. 112
Basseches, M. 9
Bateson, G. 78
Baucom, D. 182, 192, 198, 250
BCT. *See* behavioral couple therapy (BCT)
Beck, A. 182, 183, 189, 193, 195, 199
Beck, J. 145
behavioral approaches, to homework 230, 237
behavioral couple therapy (BCT) 200, 204
behavioral exchange 211–12
Bergin, A. 106
Berman, E. 4
Bermudez, J. M. 253
Bernal, G. 148, 149
Betzig, L. 253
biased explanation 191
bibliotherapy 231–2, 238
blamer/distancer pattern 79
blaming: and communication 44, 73, 79, 149–51; vs. "I" statements 153; methods of 28–9; and powerlessness 101; and reactive couples 283–4; and reframing 145; vs. shared responsibility 35; and systemic approaches 49. *See also* attributions
Blick, R. 271
Blow, A. J. 112, 115–16
Bordin, E. S. 108
Borgart, E.-J. 229
boundary issues: analogy describing 86; and anger 164; distractions 38–9; in individual therapy 99–100; lateness 38; missed appointments 38; payment 39–40; session lengths 37–8; telephone calls 38–9
Bowen, M. 76, 230
Bowlby, J. 216
Broaden-and-Build theory 214–15
Broder, M. 228
Brown, E. 255
Bryant, E. 138
Bryant, M. 235
Bugental, J. 82
Burns, D. 189, 194, 198
Butler, M. 246
Butler, M. H. 43–4, 155

Campbell, A. 166
cancellations 38
Capaldi, D. 223–4
caring 128, 129
Carlson, J. 292, 294, 295, 296
Case, B. 271
Case, E. 4
case formulation 13, 20–32, 27f. *See also* assessment
catastrophizing 190
change: clients' responsibility for 10–11; common factors of, in therapy 105–16; homework compliance as indicator of 240; maintaining 291–6; systemic thinking about 53
Charny, I. W. 248, 252, 254, 256
choice 239
Christensen, A. 4, 204, 211–12
circular approaches: to communication 148–9; to conflict 175; in individual therapy 98–9; learning 50–1; linear vs. circular questions 48–9; and objectivity 49; overview of 46–8; and reciprocal language patterns 77–9. *See also* systemic thinking
Claiborn, C. 9, 10, 28–9, 229, 234, 238
Clark-Stager, W. 4
clients: commitment of, to therapy 16; context of 11; and control in therapeutic relationship 11; educating 56–7; as initiators of sessions 41–3; interpretations by 19; mirroring language of 88–9;

partners of, as resistant 35; passivity of 42; physiological limitations of 26; responsibility of 10–11, 35–6, 41–3; seating positions of 63–4; storytelling by 19; therapists' relationship with 9–10, 33–4; and treatment effectiveness 107; unrealistic expectations of 33–6
closeness 131
codependence 186–7
cognition 218
cognitive approaches: and conflict 174–6; and couple therapy 182, 183–4, 193–4; and homework 194; identifying irrational thoughts 194–8; Rational-Emotive Behavior Therapy (REBT) 184–9; REBT vs. cognitive therapy (CT) 183–4; and systems thinking 196–7; techniques for 194–9
Cognitive-Behavioral Therapy with Couples and Families (Dattilio) 200
cognitive therapy (CT): cognitive distortions 189–91, 194–8, 197f; overview of 189; schemas 191–8; and systems thinking 193–4
cohesion 124
Colangelo, N. 4
commitment: and anger 164; assumptions of 150–1; and homework 233; and infidelity 260; and triangular theory of love 121–3
common factors: in couple therapy 111–16; debate about 115–16; Frank and Frank's model of 109; Lambert's model of 106–9, 107f; model-dependent 114; model-independent 114–15; overview of 105–6; Wampold's model of 109–10, 110f
communication: active listening in 72; aggressive language 75–6, 281; analogies and images 82–7; assertive language 75–6; assessments of 157–8; attack/defend pattern 78; blamer/distancer pattern 79; and blaming 44, 149–51; common patterns in 72–80; content- vs. process-oriented 148–9; contexts for 151–2; contextual level of 149; and distance/intimacy 73–5; and emotions 76–9; enactments as technique for 155–6; facilitating, as focus of therapy 43–4; focused 90–2; "Four Horsemen of the Apocalypse" 147–8; gender differences in 151; hierarchical intimacy patterns 80; and homework compliance 238–9; homework for improving 236–7; incongruence 284; individual level of 149; linear vs. circular 148–9; object level of 149; obstacles to 158–9; and office set-up 63–4; passive-aggressive language 75–6; problems in 147–9; pursuer/withdrawer pattern 79; and quoting therapists 44; reactive and responsive 76–7; reciprocal patterns of 75–9; and reframing 141; relational level of 149; repetition 89–90; silence 82, 88–9; submissive language 75–6; techniques for 153–7; and tone of voice 68–70; training in 148, 150; transactional level of 149; using client language 87–8; word choice and meaning 70–2. *See also* enactments; intensity; listening
communication techniques 147–59
compatibility 124
complaint/criticism 147
complementary contract 210
complementary relationships 78
compliance 229
confidentiality 40–1, 244–7. *See also* ethical concerns
conflict: affective approaches to 177–8; and attributional strategies 174–6; circular approaches to 175; cognitive approaches to 174–6; deeply-rooted 172–4; levels of 179–81; and narcissistic vulnerability 173; normalization of 160; positive aspects of 174; and reframing 175; therapists' role in managing 161, 179
conflict-avoidant affairs 255
conflict resolution: and anger 161–7; and attachment styles 172; as component of intimacy 124; and differentiation 180; fair fighting principles 167–71; and family-of-origin issues 171–2; and Intersystem Model 181; and negotiation 170; and reframing 139
conflictual contract 210

conflict utilization: affective approaches to 177–8; cognitive therapy 174–6; definition of 174; emotionally-focused couple therapy (EFT) 178; paradoxical intervention 178; Rational-Emotive Behavior Therapy (REBT) 177; synthesis of 178–81
confrontation 244
congruence: emotional 225; and reframing 144
congruent contract 210
conjoint sessions: balanced approach in 57–60; and individual sessions 102–4. *See also* couple therapy
contempt 147
content-oriented therapy: and process-oriented therapy 68–80; Rational-Emotive Behavior Therapy (REBT) as 183–4
content reframing. *See* reframing
context. *See* interpersonal context
context markers. *See* reframing
contextual level communication 149
contracts, relationship: and behavioral couple therapy (BCT) 200; behavioral exchange 211–12; complementary contract 210; conflictual contracts 210; congruent contracts 210; covenant contracts 210–11; definition of 202; development of 200; good faith contracts 209; guidelines for 206–8; optimal conditions for 202–3; parallel contracts 209; principles of 203–6; process contracts 212; quid pro quo contracts 208–9; techniques for 208–12; as written document 203
control: and anger 164, 166; of emotions 18; fear of losing 134; and open- vs. closed-ended questions 42–3; in therapeutic relationship 11, 19–20
Cooper, A. 277
Cordova, J. V. 119
countertransference 31–2, 161, 179, 243–4. *See also* transference
couple: as individuals 7, 26; interactional system of 7–8
Couples Psychotherapy Treatment Planner, The (O'Leary et al) 232
Couples Therapy for Domestic Violence: Finding Safe Solutions (Stith et al) 179
couple therapy: cognitive approaches to 182, 183–4, 193–4; common factors in 111–16; development of 4–5; effectiveness of 5, 105–6, 291; and emotions 214; individuals treated in 34–5; as political 5–6; and Rational-Emotive Behavior Therapy (REBT) 182; transition from individual to 57–8. *See also* conjoint sessions; therapy
covenant contracts 210–11
Cross, C. L. 11, 12
Crowe, M. 124
CT. *See* cognitive therapy (CT)
cultural norms 253

Dance of Anger, The (Lerner) 161
Danser, D. 145
date nights 238
Dattilio, F. M. 4, 20, 26, 183, 191, 192, 200, 208, 233, 234, 239
Davis, S. D. 109, 111–12, 114–15, 116, 155
Deane, F. 229, 239
death 259
debilitation 28
DeClemente, C. C. 294
defensiveness 147
DeMaria, R. 31
dependency 131–2
depression 140–1
Diagnostic and Statistical Manual of Mental Disorders DSM 119
dialectic metatheory 9
diaries. *See* journaling
difference, normalization of 17–18
differentiation: analogy describing 86; and conflict resolution 180; definition of 259; and infidelity 259; and reactive couples 280, 286, 289; and reactivity/responsiveness 76–7; and therapists' management of intensity 95
Digiuseppe, R. 182
DiMattia, D. J. 182
discounting 156–7, 190
distance: and anger 164; and communication patterns 73–5; and fear of dependency 131–2

distracting 159
diversion/diffusion 166
divorce 253–4
Dodo bird effect 106
Doherty, W. J. 4, 12, 14, 16, 174, 175, 176
Dowd, E. 145
"downward arrow" technique 195
Drinkard, D. T. 269
Duhl, J. 4
Duhl, P. 4
Dysfunctional Thought Record 195

Eaves, S. H. 138
eclecticism 4, 91
editing 157
efficacy 176
Efran, J. 145
EFT. *See* emotionally-focused couple therapy (EFT); emotion-focused therapy (EFT)
either/or thinking 190
Eldridge, K. 4
Ellis, A. 177, 182, 183, 184–9, 292
emotional congruence 225
emotional discounting 133
emotional intimacy 123, 124, 258
emotionally-focused couple therapy (EFT) 178, 223
emotional reactivity. *See* reactive couples
emotional reasoning 190
emotional vulnerability 135–6
emotion-focused therapy (EFT) 216–18, 230–1, 289–90
emotions: and cognition 218; and communication 76–9; control of 18; and couple therapy 214; and expectations 218; and family-of-origin issues 223–5; filtering 222–3; and genograms 223–5; inappropriate 225–6; and infidelity treatment 265–7; intense 225–6; and irrational thoughts 188–9; and journaling 222; managing intensity in 92–5; "My World of Feelings" exercise (Hof) 219–21; positive 214–15; in relationships 215–16; and safety 284–5; sharing of 88; therapists' role in managing 219. *See also* affect; feelings; intensity; specific emotions
empathy: in individual therapy 97–9; and narcissistic vulnerability 173
empowerment 101–2. *See also* responsibility
empty nest affairs 255
enactments: as communication technique 155–6; and direct communication 44; and emotions 226; therapeutic functions of 54
enjoyment 129
enmeshment: analogy describing 85–6; and infidelity 259, 268–9. *See also* differentiation
entitlement 86
entitlement affairs 256
Epstein, N. B. 20, 182, 192
Erford, B. T. 138, 141, 207
Erickson, M. H. 137
Eron, J. 138
ethical concerns: confidentiality 244–7; in couple therapy 40–1; of individual therapy 96–9
Evaluation and Treatment of Marital Conflict: A Four-Stage Approach (Guerin et al) 179
expectancies 192
expectations 218
exploratory affairs 256
explosion 166
exposure, fear of 134–5
expressiveness 124
externalization 283–4, 288
extradyadic partner 242, 262–5
extramarital affairs. *See* infidelity
eye contact 64
Eysenck, H. 105

fair fighting 167–71
fairness. *See* balanced approach; objectivity
family life cycle issues 259
family-of-origin issues: and anger 162–3; and conflict management skills 171–2; and emotions 223–5; and fear of abandonment 135; and fear of anger 133–4; and fear of exposure 135; genograms 29–30; and infidelity 266, 268–9; and intergenerational system 8; and narcissistic wounds 280–2; and

reactive couples 287–8; and schemas 191–2; and systemic thinking 53. *See also* genograms
family therapy, as political 5–6
fear: of abandonment 135; of anger 133–4; and anger 163–4; of dependency 131–2; of emotional vulnerability 135–6; of exposure 134–5; of failure 187; of feelings 132–3; and homework resistance 240; of intimacy 131–6; and irrational thoughts 186–7; of losing control 134; of rejection 135
Feeling Good (Burns) 189, 194
feelings: fear of 132–3. *See also* emotions
fees. *See* payment
Feldman, D. 145
Feldman, L. 173, 279
Fellenberg, S. 156
Fife, S. T. 115, 136, 249, 258, 270
Fighting for Your Marriage (Markman et al) 161
Fisher, H. 124
Fisher, R. 170
Fleuridas, C. 100
focus 90–2
forgiveness 130, 270, 271, 272
foundational constructs 9
"Four Horsemen of the Apocalypse" 147, 167
"four octaves" of skills 82
Fowers, B. 151, 152
frames. *See* reframing
Frank, J. B. 109
Frank, J. D. 109
Fraser, J. 4
Fredrickson, B. L. 214, 217

Gambescia, N. 4, 240, 242
Gardner, B. 155–6
Gärke, R. 229
Gaston, L. 108
Gebhard, P. H. 249
gender: bias in 36; and communication 151; and expressions of anger 166; and infidelity 251, 252, 258
generalizing 159, 176, 190
genograms: for anger 162; and emotions 223–5; as homework 237; overview of 29; sexual 30
Gestalt therapy 214
Glass, S. 248, 252
goals, identifying 16
Goldberg, M. 26, 28
Goldman, R. N. 214, 215, 216–17, 218, 226
good faith contracts 209
Gordon, K. C. 219
Gottman, J. M. 5, 73, 147–8, 167, 293, 294
Gottman, J. S. 147–8, 293
Gray, J. 5
Green, A. 4
Green, R. 4
Greenberg, L. 178, 214, 215, 216–18
Greenberg, L. S. 226
Greenman, P. 214
Grim Reaper analogy 83
Grinder, J. 85
guided discovery 199
Gurman, A. 3, 4, 137

habitual philandering 255
Haley, J. 14
Hanson, W. 234
happiness 186–8
Harper, J. 246
Harper, R. 182, 185, 189
Harway, M. 138
Hatcher, C. 4
Hatfield, E. 124
Heller, J. 13
Hendrix, H. 180
Henline, B. 276
Hernandez, S. L. 253
Hertlein, K. M. 4, 230, 275, 276, 277
hierarchical intimacy patterns 80
Hof, Larry 4, 29–30, 175, 219
Hoffman, G. 4
homeostasis 53, 67, 97, 100, 207, 279
homework: and assessment 234; assigning 232; behavioral approaches to 230; bibliotherapy 231–2, 238; and cognitive approaches 194; communication skills 236–7; and compliance 229, 238–40; creating 233–4; date nights 238; and emotion-focused therapy (EFT) 230–1; examples of 236–8; following up on 235–6; genograms as 237; journaling

222, 231, 237; model-based 229–31; and negative consequences of change 241; purpose and benefits of 228–9, 233; resistance to 240–1; self-monitoring 237; structural elements of 235–6; Summarization, Empowerment, and Active involvement (SEA) methodology 231; Systematic Homework Assignments (SHWAs) 231; task-oriented 232; terminology 239; trans-theoretical 231; types of 231–2
Hops, H. 209
Horvath, A. O. 112
Houmanfar, R. 208
Howard, M. 276
Humphrey, F. G. 247, 250, 253–4
Hunt, B. 132
hurt feelings 130, 163, 177–8
hypotheses 31

identity 124
images 82–7
implicitness 240
incest 259
inclusive language 60–1
incongruence: of interpersonal communication 284; and reframing 144
individual level communication 149
individual system 7, 257–8
individual therapy: boundary issues in 99–100; and conjoint sessions 102–4; and couple therapy 26, 28, 34–5; ethical considerations for 40–1, 96–9; and Rational-Emotive Behavior Therapy (REBT) 177; systemic approaches for 96–104; systemic interventions 100–2; transference in 97–8, 103–4; transition from, to couple therapy 57–8
infertility 258
infidelity: and commitment 260; consequences of 253–4; definitions of 247–9; and differentiation 259; dimensions of 250–3; and divorce 253–4; emotional 248; and emotional intimacy 258; and family-of-origin issues 266, 268–9; and gender 251, 252, 258; individual factors in 257–8; interactional factors in 258; intergenerational factors in 258–9, 268–9; and Internet 251, 275–8; and Intersystem Model 257–9; and irrational thoughts 185; prevalence of 249–50; reconciliation and recovery from 269–75, 276–7; and trust 266–7; typologies of 254–7
infidelity, treating: affective phase of 265–7; challenges of 242–7; cognitive phase of 267–9; and confidentiality 244–7; and countertransference 242–4; effectiveness of 254; and extradyadic partner 242, 262–5; and forgiveness 270, 271, 272; individual sessions 261; intersystemic 259–65; intersystemic assessment 257–9; length of treatment 269; and reframing 268–9; and secret affairs 262–5
insomnia 143–4
integrational constructs 9
Integrative Couple Therapy: Promoting Acceptance and Change (Jacobson and Christensen) 211
intellectual intimacy 123
intellectualization 165
intensity: and balanced approach to interventions 61–3; creating and managing 81–95, 225–6; excessive 92–5; images and analogies 82–7; and repetition 89–90; results of 81. *See also* emotions
intent 175
interactional system 7–8, 258
interchanges, counting 66
intergenerational system 8, 258–9, 268–9
Internet 251, 275–8
interpersonal context 11, 46–54
interpretations: alternative interpretation method 198–9; by clients 19; premature 18; vs. reframing statements 138; and systemic thinking 51–3
Intersystem Model 8f; and assessment 13; and case formulation 27f; and conflict resolution 181; individual system 7; and infidelity treatment 257–65; as integrative approach 11–12; interactional system 7–8; intergenerational system 8; as meta-framework 6; overview of 6–7; therapeutic principles of 9

interventions: balanced approach in intensity of 61–3; cognitive approaches 194–9; premature 15–16, 26; for reactive couples 286–90; systemic, for individuals 100–2; and systemic thinking 51–3
intimacy: analogy describing 86; aspects of 126–7; vs. closeness 131; and communication patterns 73–5, 80; components of 128–31; enhancing 119–36; fears of 131–6; overcoming fears of 136; and tolerance 128; and triangular theory of love 123–4; Waring Intimacy Questionnaire 124. *See also* fear; love; sexuality
intimacy-avoidant affairs 255
Intimate Enemy: How to Fight Fair in Love and Marriage (Bach & Wyden) 174
introjects 282
irrational thoughts 184–9, 194–8
"I" statements 153
Ivey, A. E. 138
Ivey, M. B. 138

Jacobson, N. 4, 204, 211–12, 230, 250
Jacobson, N. S. 106, 201
Jenkins, R.E. 242
Jessee, E. 140
Johnson, S. 5, 178, 214, 215, 216
Johnson, S. M. 78, 81, 163, 281
joining with clients 9–10, 55–6, 141. *See also* therapeutic relationship
Jones, W. 141
journaling: and emotions 222; as homework 231, 237; and infidelity treatment 277
jumping to conclusions 190
justification 28

Kamins, R. 240
Karpel, M. A. 245
Kaslow, F. 3, 4
Kassinove, H. 161
Kazantzis, N. 229, 230, 239
Kelley, Harold 122
Kelley, H. H. 200
Kemmler, L. 229
Kim, H. 223–4
Kinsey, A. C. 249
Kleiner, A. J. 115
Kniskern, D. 3
Kolevzon, M. 4

L'Abate, L. 126, 128, 130, 140, 146, 177, 200, 222, 228, 230, 231, 240–1, 295
labeling 159, 191, 288
Lambert, M. 106–9, 112
Lamke, L. 276
Lampropoulos, G. 229
language. *See* communication
Larkin, K. T. 166
lateness 38
Laurenceau, J. P. 147, 156
Lawrence, E. 4
Lebow, J. 4, 5
Lee, A. 212
Levant, R. 4
Lief, H. 4
linear approaches: linear vs. circular questions 48–9; overview of 46–7
linear tasks 232
listening: active 72; nonjudgmental 141; reflective 150, 153–5; as therapist skill 82. *See also* communication
Long, L. 138, 275
love: clinical use of concept 119–20; and commitment 121–3; and intimacy 123–4; irrational thoughts about 189; and passion 124–5; triangular theory of love 120–6, 121f; types of 125. *See also* intimacy
Love Is Never Enough (Beck) 193
Luborsky, L. 106
Lunnen, K. M. 108
Lusterman, D. 248, 255

Macewan, J. 239
Maglieri, K. 208
magnification 190
Maheu, M. 276
maintenance check-ups 292–3
Makinen, J. A. 281
Margolin, G. 201
marital arrangements 255
marital therapy. *See* couple therapy
marriage enrichment movement 120

Martin, C. E. 249
Mashek, D. J. 123
McCullough, M. E. 269
McHenry, S. 200
meaning, and word choice 70–2
medication 64–5
mental filters 190
mental rehearsal 157
Merrick, P. 183, 229
Millikin, J. W. 281
Millon, T. 28
Mills, L. 271
"mind raping" 156
mind reading 158, 185, 190, 191
minimization 191
Minuchin, S. 230
Mirgain, S. A. 119
mislabeling 191
Morris, S. 145
Muncer, S. 166
Murray, R. 271
"My World of Feelings" exercise (Hof) 219–21

Napier, A. 19, 83
narcissistic vulnerability: and conflict 173; definition of 279; and irrational thoughts 186; in reactive couples 280–2. *See also* reactive couples
needing 128
negative consequences of change 241
negotiation 170
Nelson, D. 229
Nelson, S. 100
neutrality. *See* balanced approach; objectivity
Nichols, M. 137, 156
nonblaming. *See* reframing
non-verbal intimacy 124
Norcross, J. 106

objectivity: and circular questions 49; of therapists 14–15, 18, 36. *See also* balanced approach
object level communication 149
obsessive-compulsive personality 132
office set-up 63–4
Ogles, B. M. 106, 108
Olmstead, S. 271
Olson, D. 123, 126
Openshaw, D.K. 231
out-the-door affairs 255
overgeneralizing 190
Owen, L. 223–4

Padesky, C. A. 4, 191
Palazzoli, M. 139
paradoxical intervention 178, 232, 240–1
parallel contracts 209
parallel marriages 132
Parker, T. 277
Parnass, S. 248, 252, 254
Parsons, B. 112
passion 124–5
Passionate Love Scale (PLS) 124
passive-aggressive language/behavior 75–6, 165
passivity: of clients 42; of therapists 34
past events 187
patients. *See* clients
Patterson, G. 209
payment 37, 39–40
Pears, K. 223–4
PE-EFT. *See* process-experiential/emotion-focused therapy (PE-EFT)
Penn, C. D. 253
perfectionism 188
Perls, F. 81
personalism 239
personality disorders 28
personalization 159, 191, 284
physical intimacy 124
Piercy, F. P. 109, 111–12, 114–15, 116, 275, 276, 277
Pittman, F. S. 255
polarized language 159
politeness 94
Pomeroy, W. B. 249
pornography 275
positive connotation 139. *See also* reframing
positive emotions. *See* emotions
powerlessness 101
Prager, K. J. 123
prevention strategies 294–5
process contracts 212
process-experiential/emotion-focused therapy (PE-EFT) 218

process-oriented therapy: cognitive therapy (CT) as 183–4, 189; and content-oriented therapy 68–80; tone of voice 68–70
Prochaska, J. O. 294
procrastination 165
Programmed Writing (L'Abate) 222
projection 264–5, 283
projective identification 173
protectiveness 129
Protinsky, H. 140
psychiatric referrals 31, 64–5, 266
psychopathology 143
psychopharmacology 64–5
psychotherapy. *See* couple therapy; therapy
pursue/withdraw pattern 79

questions: about word choice and meaning 70–2; closed- vs. open-ended 42–3; open-ended 82; Socratic 195, 198
quid pro quo contracts 208–9
Quinn, W. 140

Rachal, K. C. 269
Rachman, S. 105
Rankin, L. 182
Rational-Emotive Behavior Therapy (REBT): A-B-C-D model 177, 184; as cognitive approach 184–9; compared to cognitive therapy (CT) 183–4; and couple therapy 182; irrational thoughts 184–9
rationalization 28
Razzahavaikina, T. 234
reactive couples: aggression in 281; and attachment theory 279–80; automatic thoughts 282; and differentiation 280, 286, 289; emotion-focused therapy (EFT) 289–90; family-of-origin issues 287–8; incongruence of communication 284; interventions for 286–90; introjects 282; narcissistic vulnerability in 280–2; negative and externalizing attributions 283–4; repetition compulsion 282–3, 289
reactivity, vs. responsiveness 75–6
REBT. *See* Rational-Emotive Behavior Therapy (REBT)
reciprocal patterns, in communication 75–9
reconciliation 269–75
reconstructing reality. *See* reframing
recreational intimacy 124
redefining the symptom 143. *See also* reframing
redefinition. *See* reframing
reflective listening 150, 153–5
reframing 137–46; and blame 145; and conflict 139, 175; and conflict resolution 139, 178; definition of 138; and depression 140–1; development of 140–2; example of 143–5; focus of 143–4; as fundamental technique 137–8; and infidelity treatment 268–9; vs. interpretations 138; as learned skill 138; from negative to positive 139, 142–5; and positive connotation 139; principles for 142–5; research on 145–6; and systemic thinking 139, 142, 144
rejection, fear of 135
relabeling. *See* reframing
relapses 294–6
relational level communication 149
relationship contracts. *See* contracts, relationship
relationships: emotions in 215–16; maintaining 293–4
religion 253
repetition 89–90
repetition compulsion 282–3, 289
resistance 90–2
responsibility: acceptance of 35–6; vs. blaming 35; of clients, for therapeutic change 291–2; as component of intimacy 129–30; and happiness 186, 188; and homework 233; and systemic thinking 10–11, 53, 101–2; and therapeutic process 41–3
responsiveness, vs. reactivity 75–6
restorying. *See* reframing
Ridley, C. R. 115, 124
Riegel, K. F. 9
Robinson, N. 4
Robinson, P. 234
Rohrbaugh, M. 138
Roman, H. R. 208
romantic affairs 255

Ronan, K. R. 229, 239
Rosenthal, D. 100
Rosenzweig, Saul 106
Rossi, E. L. 137
Rovine, M. J. 147
Rubin, Zick 128

safety 284–5
Safran, J. 214
Sager, C. 132, 210
Samples, G. 140
Satir, V. 132
Schaefer, M. 123, 126
Scheel, M. 234
schemas 191–8, 287
Schiavo, R. 112
Schneider, J. P. 275, 276–7
Schuyler, D. 183, 196
Schwartz, R. 137
SEA. *See* Summarization, Empowerment, and Active involvement (SEA) methodology
seating arrangements 63–4
secret affairs 262–5
Seedall, R. 246
seeing the good. *See* reframing
selective abstraction 191
selective attention 192
self-disclosure 134–5
self-monitoring 194, 205–6, 237
self-summarization syndrome 155
self-victimization 165
separation 253–4
sessions: initiated by clients 41–3; length of 37–8; therapists' control of 19–20. *See also* therapy
setbacks 294–6
"7 A's" of Internet 275–6
Seven Principles for Making Marriage Work, The (Gottman and Silver) 161
Sex and the Internet (Cooper) 277
Sexton, T. L. 115, 116
sexual addiction 255, 259
sexual intimacy: as component of intimacy 123–4; and infertility 258; and Internet 276; and parent-child relationship dynamics 74
sexuality: as component of intimacy 124; genograms 30
sexual orientation 257
Sheldon, J. 229
should statements 190, 192
SHWAs. *See* Systematic Homework Assignments (SHWAs)
Sichel, J. L. 182
silence 82, 88–9
Sills, C. 206
Silver, N. 294
Simons, A. 235
sliding scales 39–40
Snyder, D. K. 4
social exchange theory 200
social interaction model 9
social intimacy 123
Socratic questioning 195, 198
specificity 176
Sperry, L. 294, 295, 296
spiritual intimacy 124
Sprenkle, D. H. 111–12, 113, 115–16
stability 175–6
standards 192
Stanton, M. 4
Sternberg, R. 120, 123, 125, 258
Stewart, I. 206–7
stonewalling 148
storytelling, by clients 19
Strong, F. 250
Strong, S. 9, 10, 28–9, 145, 229, 234, 238
Stuart, R. 230, 292
submissive language 75–6
Subotnik, R. B. 276
Suchday, S. 166
Summarization, Empowerment, and Active involvement (SEA) methodology 231
swinging 252–3
Swoboda, J. 145
Sykes, J. D. 108
symmetrical relationships 78
Symonds, D. 112
Systematic Homework Assignments (SHWAs) 231
systemic thinking: and balanced approach 55; and change 53; as circular 46–8; cognitive approaches to 193–4, 196–7; educating clients about 57; and family-of-origin issues 53; and interpersonal context 46–54; and interpretations

51–3; and interventions 51–3; vs. linear thinking 46–9; and reframing 139, 142, 144; and responsibility 53, 101–2. *See also* circular approaches
systems theory: development of 3; and individual therapy 96–104; integrative approaches 3–4; linear vs. systemic (circular) approaches 46–8; schools of 3. *See also* Intersystem Model

technology. *See* Internet
telephone calls 38–9
Tennen, H. 138
Thase, M. 235
therapeutic relationship: alliance 108, 109, 110, 112, 115; choice and responsibility 10–11; control in 11, 19–20; joining with clients 9–10, 55–6, 141; and treatment effectiveness 108, 109, 110–11
therapists: active vs. passive 34; during assessment 14–20; challenges for, in treating infidelity 242–7; clients' quoting of 44; and countertransference 31–2, 161, 179, 243–4; differentiation of 95; emotional sharing by 88; "four octaves" of skills 82; hypotheses developed by 31; and intensity 81–95; and managing conflict 161, 179; and managing emotions 219, 226; objectivity of 14–15, 18, 36; office set-up of 63–4; during treatment 34; treatment plans created by 31; verbose 66. *See also* therapeutic relationship
therapy: clients' commitment to 16; common factors of change in 105–16; effectiveness of 105–6; identifying goals for 16; length of 31, 36–7, 269; maintenance check-ups 292–3; partners resistant to 35; process- and content-oriented 68–80; as safe place 17–18, 34; successful outcomes 107–16; tapering sessions 292; treatment plans 31. *See also* sessions
Thibaut, J. W. 200
Thompson, A. P. 247, 250
"three A's" 128–9
time: and communication 157; monitoring of, in balanced approach 66
tolerance 128
tone of voice 68–70. *See also* communication
transactional level communication 149
transference 97–8, 103–4. *See also* countertransference
trauma bond 259
Treating Couples: The Intersystem Model of the Marriage Council of Philadelphia (Weeks) 179
treatment. *See* couple therapy; therapy
tripod affairs 256
trust: between client and therapist 10; and infidelity 266–7, 270, 272; and intimacy 128
tunnel vision 191
Turner, C. 145
Turner, M. 259
Turner, N. W. 174–5
typological approach 254–7

Ury, W. 170

validation 156–7
Van Deusen, J. 230
Viers, D. 230
vilification 28
violence 179
voice, tone of 68–70
voluntariness 176

Wachtel, E. 4
Wachtel, P. 4
Wampler, K. 277
Wampold, B. 105–6, 108–9
Warburton, J. 229
Ward, T. A. 208
Waring, E. M. 124
Waring Intimacy Questionnaire 124
Watzlawick, P. 138
Weber, T. 108
Weeks, G.: and attributional strategies 175; on client change 10; on control 11; and fears of intimacy 136; and forgiveness 270; homework assignments 240–1; on integrative models 9; and Intersystem Model 4, 6, 12, 257–8; on reframing 140, 146; and relapse 295; and sexual genogram process 30

Weiss, R. 209
Westfall, A. 257, 258
Whitaker, C. A. 19
Whitty, M. 275
Why Marriages Succeed or Fail (Gottman) 161
Wiederman, M. W. 250
Williams, A. 4
Wise, S. 145
word choice and meaning 70–2
Worthington, E. L., Jr. 269, 270
Wright, L. M. 19
Wright, T. 248, 252
written documents. *See* contracts, relationship

Yeager, R. J. 182
Young, K. 138
Young, M. 138, 275
Your Perfect Right: A Guide to Assertive Living (Alberti and Emmons) 161

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