CHAPTER 1

A Framework for the Comparative Study of Couple Therapy

History, Models, and Applications

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This volume presents the core theoretical and applied aspects of couple therapy in modern clinical practice. These core couple therapies are those that form the conceptual and clinical bedrock of therapeutic training, practice, and research. There are two quite distinct categories of such couple therapies (Gurman & Fraenkel, 2002). First, there are those whose origins are to be found in the earliest phases of the history of the broad field of family and couple therapy. Although central attributes of these methods have largely endured across several generations of systems-oriented therapists, they have been revised and refined considerably over time. Examples of such time-honored approaches are structural and brief strategic approaches, and object relations and transgenerational (e.g., Bowenian, Contextual, and Symbolic–Experiential) approaches. Second, core couple therapies include several visible and increasingly influential approaches that have been developed relatively recently; have had undeniably strong effects on practice, training and research; and are likely to endure long into the future. Examples in this category are cognitive and behavioral, narrative and emotion-focused, and integrative approaches.

As intended in its first edition in 1985, this *Handbook* has become a primary reference source for comprehensive presentations of the most prominent contemporary influences in the field of couple therapy. Although one could identify large numbers of differently labeled couple therapies, there appear to be only about a dozen genuinely distinguishable types. Some among these are obviously closely related in their conceptual and historical bloodlines, though having enough significant differences to warrant separate coverage here.

In all these cases, whether involving earlier or later generation approaches, the authors contributing to this fourth edition have brought us what is not only basic and core to their ways of thinking about and working with couples but also new and forward-looking. These contributors, all eminent clinical scholars (all practicing clinicians, as well) have helped to forge a volume that is well suited to exposing advanced undergraduates, graduate students at all levels, and trainees in all the mental health professions to the major schools and methods of couple therapy. Because all the chapters were written by cutting-edge representatives of their approaches, there is something genuinely new to these presentations that will be of value to more experienced therapists as well.

Offering these observations here is not motivated by self-congratulatory puffery. Rather, it is a way of acknowledging to the reader that there is a

lot in these pages, a lot to be considered and absorbed, whether by novices or seasoned veterans. And that is perhaps the main reason for this introductory chapter, which is to provide a comprehensive framework for the study of any given "school" of couple therapy, and for the comparative study of different couple therapies.

As in earlier editions of the *Handbook*, each of the chapters in Part I ("Models of Couple Therapy") offers a clear sense of the history, current status, assessment approach, and methods of therapy being discussed, along with its foundational ideas about relational health and dysfunction. The old adage that "there is nothing so practical as a good theory" is still valid, and so each chapter balances the discussion of theory and practice, and emphasizes their interplay. And since this is the 21st century, in which testimonials no longer are acceptable as adequate evidence of the efficacy or effectiveness of psychotherapeutic methods, each chapter addresses the evidence base, whatever its depth or nature, of its approach.

Part II of the *Handbook* ("Applications of Couple Therapy: Special Populations, Problems, and Issues") includes nine chapters that focus on very specific, clinically meaningful problems that on the one hand are either inherently and self-evidently relational (affairs, separation and divorce, intimate partner violence, and remarriage) or, on the other, are still often viewed (even in the year 2008) as the problems of individuals (alcoholism and drug abuse, depression, personality disorders, sexual dysfunction, and illness).

To facilitate the study of both the major models of couple therapy and the application of these approaches to significant and common clinical problems, this edition of the *Handbook*, like its predecessors, was organized around a set of expository guidelines for contributing authors. These guidelines represent a revised version of similar guidelines originally set forth in the Gurman and Kniskern's (1991) *Handbook of Family Therapy*. Teachers and students have found these guidelines to be a valuable adjunctive learning tool. They are presented here along with contextualizing discussion of the rationale for inclusion of the content addressed within each broad section of these chapters.

The various models of couple therapy appearing here have grown out of different views of human nature and intimate adult relationships, about which there is nothing approaching universal agreement. These therapy approaches call for many fundamentally different ways of getting to know clients, and encompass rather distinctly different visions of both relational "reality" and therapeutic coherence. They also differ in the degree to which they assume that fundamental change is possible, and even what should constitute clinically relevant change with couples.

Given this diversity and variety of views on such cornerstone issues, it is important for the field to continue to respect the different perspectives each model of couple therapy exemplifies, even while there appears to be more and more interest in the identification, elucidation, and application of common principles in theory and practice.

In this ecumenical spirit, a brief note on the organization of the chapters in Part I of the *Handbook* ("Models of Couple Therapy") is in order. The sequence of these chapters was not determined according to some complex and very arbitrary dimensional or categorical scheme, or according to some midlevel distinguishing characteristics of the models (e.g., "Traditional," "Integrative," "Postmodern," as appeared in the third edition of the *Handbook*). Instead, they are sequenced by the most unbiased method available: alphabetical order (granted, random sequencing by drawing names out of a hat could be argued to have been inherently less biased, but no matter the results of such a series of "draws," inevitably some readers would have inferred from the outcome some telling significance). Although it is true that the very naming of these six "types" of couple therapy (Behavioral, Humanistic–Existential, Psychodynamic–Transgenerational, Social Constructionist, Systemic, and Integrative) itself may reveal the unconscious biases, predilections, and favoritisms of the editor (not to mention his ignorance and/or linguistic deficits), this appeared to be the most "level playing field" at hand.

THREE FOUNDATIONAL POINTS

Why Couple Therapy Is Important

Significant cultural changes in the last half-century have had an enormous impact on marriage, and the expectations and experiences of those who marry or enter other long-term committed relationships. Reforms in divorce law (e.g., no-fault divorces), more liberal attitudes about sexual expression, the increased availability of contraception, and the growth of the economic and political power of women have all increased the expectations and requirements of marriage to go well beyond maintaining economic viability and ensuring procreation. For most couples nowadays, marriage

is also expected to be the primary source of adult intimacy, support, and companionship. and a facilitative context for personal growth. At the same time, the "limits of human pair-bonding" (Pinsof, 2002, p. 135) are increasingly clear, and the transformations of marital expectations have led the "shift from death to divorce" as the primary terminator of marriage (p. 139). With changing expectations of not only marriage itself but also of the permanence of marriage, the public health importance of the "health" of marriage has understandably increased. Whether through actual divorce or chronic conflict and distress, the breakdown of marital relationships exacts enormous costs.

Recurrent marital conflict and divorce are associated with a wide variety of problems in both adults and children. Divorce and marital problems are among the most stressful conditions people face. Partners in troubled relationships are more likely to suffer from anxiety, depression and suicidality, and substance abuse; from both acute and chronic medical problems and disabilities, such as impaired immunological functioning and high blood pressure; and from health risk behaviors, such as susceptibility to sexually transmitted diseases and accident-proneness. Moreover, the children of distressed marriages are more likely to suffer from anxiety, depression, conduct problems, and impaired physical health.

Why Couples Seek Therapy

Although physical and psychological health are affected by marital satisfaction and health, there are more common reasons why couples seek, or are referred for, conjoint therapy. These concerns usually involve relational matters, such as emotional disengagement and waning commitment, power struggles, problem-solving and communication difficulties, jealousy and extramarital involvements, value and role conflicts, sexual dissatisfaction, and abuse and violence (Geiss & O'Leary, 1981; Whisman, Dixon, & Johnson, 1997). Generally, couples seek therapy because of threats to the security and stability of their relationships with the most significant attachment figures of adult life (Johnson & Denton, 2002).

Common Characteristics of Couple Therapy

Modern approaches to couple therapy include important concepts from general systems theory (the study of the relationship between and among interacting components of a system that exists over time), cybernetics (the study of the regulatory mechanisms that operate in systems via feedback loops), and family development theory (the study of how families, couples, and their individual members adapt to change while maintaining their systemic integrity over time). In addition, extant models of couple therapy have been significantly influenced, to varying degrees, by psychodynamic (especially object relations) theory, humanistic theory, and cognitive and social learning theory (see Gurman [1978] for an extensive comparative analysis of the psychoanalytic, behavioral, and systems theory perspectives), as well as more recent perspectives provided by feminism, multiculturalism, and postmodernism (Gurman & Fraenkel, 2002).

Despite this wide array of significant influences on the theory and practice of couple therapy, a number of central characteristics are held in common by almost all currently influential approaches to conjoint treatment. Gurman (2001) has identified the dominant attitudes and value systems of couple (and family) therapists that differentiate them from traditional individual psychotherapists, as well as four central technical factors common to most models of couple therapy. Most couple therapists value (1) clinical parsimony and efficiency; (2) the adoption of a developmental perspective on clinical problems, along with attention to current problems; (3) a balanced awareness of patients' strengths and weaknesses; and (4) a deemphasis on the centrality of treatment (and the therapist) in patients' lives. These common attitudes significantly overlap the core treatment attitudes of brief individual therapists (cf. Budman & Gurman, 1988) and help most couple therapy to be quite brief.

Gurman also identified four central sets of technical factors that regularly characterize couple (and brief) therapy. First, the meaning of time is manifest in three particular ways. Although couple therapists generally adopt a developmental perspective on clinical problems, they see an understanding of the *timing of problems* (i.e., "Why now?") as essential to good clinical practice, but with little attention paid to traditional history taking. As Aponte (1992) stated, "A therapist targets the residuals of the past in a (couple's) experience of the present" (p. 326). In addition, most marital therapists do not expend a great deal of effort in formal assessment; thus, the *timing of intervention* usually seems quite early by traditional individual psychotherapy standards, with active,

change-oriented interventions often occurring in the first session or two. Moreover, the *timing of termination* in most couple therapy is typically handled rather differently than the ending of traditional individual psychotherapy, in that it is uncommon for couple therapists to devote much time to a "working through" phase of treatment. Couples in therapy rarely find termination to be as jarring an event as do patients in individual therapy, in part because the intensity of the patient–therapist relationship in couple therapy is usually less than that in individual therapy.

Second, the clear establishment of treatment focus is essential to most couple therapists (Donovan, 1999). Many couple therapists emphasize the couple's presenting problems, with some even limiting their work to these problems, and all couple therapists respect them. Couple therapists typically show minimal interest in a couple's general patterns of interaction and tend to emphasize the patterns that revolve around presenting problems, that is, the system's "problem-maintenance structures" (Pinsof, 1995).

Third, couple therapists tend to be eclectic, if not truly integrative, in their use of techniques; to be ecumenical in the use of techniques that address cognitive, behavioral, and affective domains of patients' experience; and increasingly, to address both the "inner" and "outer" person. Moreover, couple therapists of varying therapeutic persuasions regularly use out-of-session "homework" tasks in an effort to provoke change that is supported in the natural environment.

Fourth, the therapist–patient relationship in most couple therapy is seen as far less pivotal to the outcome of treatment than in most individual therapy because the central healing relationship is the relationship between the couple partners. Moreover, the usual brevity of couple therapy tends to mitigate the development of intense transferences to the therapist. In contrast to much traditional individual psychotherapy, the classical "corrective emotional experience" is to be found within the couple-as-the-patient.

A FRAMEWORK FOR COMPARING COUPLE THERAPIES

Our theories are our inventions; but they may be merely ill-reasoned guesses, bold conjectures, hypotheses. Out of these we create a world, not the real world, built our own notes on which we try to catch the real world.

—Karl Popper

The guidelines that follow include the basic and requisite elements of an adequate description of any approach to couple therapy or discussion of its application to particular populations. In presenting these guidelines, the intent was to steer a middle course between constraining the authors' expository creativity, and providing the reader with sufficient anchor points for comparative study. Contributors to the *Handbook* succeeded in following these guidelines, while describing their respective approaches in an engaging way. Although authors were encouraged to sequence their material within chapter sections according to the guidelines provided, some flexibility was allowed. Authors were not required to limit their presentations to the matters raised in the guidelines, and certainly did not need to address every point identified in the guidelines, but they were urged to address these matters if they were relevant to the treatment approach being described. Authors were also allowed to merge sections of the guidelines, if doing so helped them communicate their perspectives more meaningfully.

BACKGROUND OF THE APPROACH

History is the version of past events that people have decided to agree on.

—Napoleon Bonaparte

Purpose

To place the approach in historical perspective both within the field of psychotherapy in general and within the domain of couple–family therapy in particular.

Points to Consider

1. The major influences contributing to the development of the approach—for example, people, books, research, theories, conferences.
2. The therapeutic forms, if any, that were forerunners of the approach. Did this approach evolve from a method of individual therapy? Family therapy?
3. Brief description of early theoretical principles and/or therapy techniques.
4. Sources of more recent changes in evolution of the model (e.g., research findings from neuroscience).

People's experience and behavior can be changed for the better in an inestimable variety of ways

that have a major, and even enduring, impact on both their individual and relational lives. And although many naturally occurring experiences can be life-altering and even healing, none of these qualify as "psychotherapeutic." "Psychotherapy" is not defined as any experience that leads to valued psychological outcomes. Rather, it refers to a particular type of socially constructed process. Though written almost four decades ago in the context of individual psychotherapy, Meltzoff and Kornreich's (1970) definition of psychotherapy probably has not yet been improved upon:

> Psychotherapy is … the informed and planful application of techniques derived from established psychological principles, by persons qualified through training and experience to understand these principles and to apply these techniques with the intention of assisting individuals to modify such personal characteristics as feelings, values, attitudes and behaviors which are judged by the therapist to be maladaptive or maladjustive. (p. 4)

Given such a definition of (any) psychotherapy, it follows that developing an understanding and appreciation of the professional roots and historical context of psychotherapeutic models is an essential aspect of one's education as a therapist. Lacking such awareness, the student of couple therapy is likely to find such theories to be rather disembodied abstractions that seem to have evolved from nowhere, and for no known reason. Each therapist's choice of a theoretical orientation (including any variation of an eclectic or integrative mixture) ultimately reflects a personal process (Gurman, 1990). In addition, an important aspect of a therapist's ability to help people change lies not only in his or her belief in the more technical aspects of the chosen orientation but also the worldview implicit in it (Frank & Frank, 1991; Messer & Winokur, 1984; Simon, 2006). Having some exposure to the historical origins of a therapeutic approach helps clinicians comprehend such an often only-implicit worldview. Moreover, having some exposure to the historical origins and evolving conceptualizations of couple therapy more broadly is an important component of a student's introduction to the field.

In addition to appreciating the professional roots of therapeutic methods, it is enlightening to understand why particular methods, or sometimes clusters of related methods, appear on the scene in particular historical periods. The intellectual, economic, and political contexts in which therapeutic approaches arise often provide meaningful clues about the emerging social, scientific, and philosophical values that frame clinical encounters. Such values may have subtle but salient impact on whether newer treatment approaches endure. Thus, for example, postmodernism, a modern, multinational intellectual movement that extends well beyond the realm of couple therapy into the worlds of art, drama, literature, political science, and so forth, questions the time-honored notion of a fully knowable and objective external reality, arguing that all "knowledge" is local, relative, and socially constructed. Likewise, integrative approaches have recently occupied a much more prominent place in the evolving landscape of couple therapy, partly in response to greater societal expectations that psychotherapy demonstrate its efficacy and effectiveness, and partly as a natural outgrowth of the practice of couple and family therapy having become commonplace in the provision of "mainstream" mental health services to a degree that even a couple of decades ago could only have been imagined.

A brief historical review of the evolution of the history of couple therapy may help to put a great deal of the rest of this volume in context. Readers interested in a more detailed and nuanced discussion of the history of the field are referred to Gurman and Fraenkel's (2002) "The History of Couple Therapy: A Millennial Review," which describes the major conceptual and clinical influences and trends in the history of couple therapy, and chronicles the history of research on couple therapy as well. But, as urged by Alice when she was adventuring in Wonderland, we "start at the beginning" before proceeding to the middle (or end).

Every chronicler of the history of couple therapy (present company included, e.g., Gurman & Fraenkel, 2002) notes that as recently as 1966, couple therapy (then usually referred to as "marriage counseling") was considered "a technique in search of a theory" (Manus, 1966), a "hodgepodge of unsystematically employed techniques grounded tenuously, if at all, in partial theories at best" (Gurman & Jacobson, 1985, p. 1). By 1995, the field had evolved and matured to such a degree that Gurman and Jacobson saw adequate evidence to warrant asserting that couple therapy had "come of age" (p. 6). Although this assessment was thought by some (Johnson & Lebow, 2000) to be "premature," certainly the last decade of both conceptual and scientific advances in the understanding and treatment of couple and marital problems has included some of the most significant, coher-

ent, and empirically grounded developments of the last 20 years in *any* branch of the broad world of psychotherapy (Gurman & Fraenkel, 2002), as a reading of this volume demonstrates.

A Four-Phase History of Couple Therapy

Couple therapy has evolved through four quite discernibly different phases. The first phase, from about 1930 to 1963, was the "Atheoretical Marriage Counseling Formation" phase. "Marriage counseling," practiced by many service-oriented professionals who would not be considered today to be "mental health experts" (e.g., obstetricians, gynecologists, family life educators, clergymen), was regularly provided to consumers who were neither severely maladjusted nor struggling with diagnosable psychiatric/psychological disorders, often with a rather strong value-laden core of advice giving and "guidance" about proper and adaptive family and marital roles and life values. Such counseling was typically very brief and quite didactic, present-focused, and limited to conscious experience.

Of tremendous significance, conjoint therapy, the almost universally dominant format in which couple therapy is practiced nowadays, did not actually begin to be regularly practiced until the middle to late 1960s, during the second phase (c. 1931–1966) of couple therapy, which Gurman and Fraenkel (2002) call "Psychoanalytic Experimentation." "Marriage counseling," having no theory or technique of its own to speak of, grafted onto itself a sort of loosely held together array of ideas and interventions from what was then the *only* influential general approach to psychotherapeutic intervention, that is, psychoanalysis, in its many shapes and varieties, including less formal psychodynamic methods. Novices to the current world of couple therapy may find it more than difficult to imagine a world of practice and training in which there were no cognitive-behavioral, narrative, structural, strategic, solution-focused, or humanistic–experiential, let alone "integrative" or "eclectic" approaches from which to draw.

A few daring psychoanalysts, recognizing what now seem like such self-evident, inherent limitations of trying to help dysfunctional couples by working with individuals, had begun in this phase to risk (and often suffered the consequence of) professional excommunication from psychoanalytic societies by meeting jointly with members of the same family, a forbidden practice, of course. In a phrase, the focus of their efforts was on the "interlocking neuroses" of married partners. And now, marriage counselors, completely marginalized by the world of psychoanalysis, and even by the field of clinical psychology that emerged post–World War II, was understandably attempting to attach itself to the most prestigious "peer" group it could. Unfortunately for them, marriage counseling had "hitched its wagon not to a rising star, but to the falling star of psychoanalytic marriage therapy" (Gurman & Fraenkel, 2002, p. 207) that was largely about to burn out and evaporate in the blazing atmosphere that would begin with the rapid emergence of the revolutionary psychotherapeutic movement known as "family therapy."

The third phase of couple therapy's history, "Family Therapy Incorporation" (c. 1963–1985) was deadly for the stagnating field of marriage counseling. The great majority of the early pioneers and founders of family therapy (e.g., Boszormenyi-Nagy, Bowen, Jackson, Minuchin, Whitaker, Wynne) were psychiatrists (many, not surprisingly, with formal psychoanalytic training) who had become disaffected with the medical/psychiatric establishment because of its inherent conservatism, in terms of its unwillingness to explore new models of understanding psychological disturbance and new methods to help people with such difficulties. These leaders railed against the prevailing, individually oriented *zeitgeist* of almost all psychoanalytic thought and what they viewed philosophically as unwarranted pathologizing of individuals in relational contexts. And so, in distancing themselves from the psychoanalytic circle, they inevitably left the marriage counselors behind. Haley (1984) has caustically argued, moreover, that there was not "a single school of family therapy which had its origin in a marriage counseling group, nor is there one now" (p. 6). Going still further, and capturing the implicit views of other leaders within family therapy, Haley noted tersely that "marriage counseling did not seem relevant to the developing family therapy field" (pp. 5–6). As family therapy ascended through its "golden age" (Nichols & Schwartz, 1998, p. 8) from about 1975 to 1985, marriage counseling and marriage therapy (e.g., Sager, 1966, 1976), while certainly still practiced, receded to the end of the line.

Four Strong Voices

Four especially influential voices arose in family therapy in terms of influence, both short and long-term, on clinical work with couples. Don Jackson (1965a, 1965b), a psychiatrist trained in Sulliva-

nian psychoanalysis, and a founder of the famous Mental Research Institute in Palo Alto, California, made household names of such influential concepts as the "report" and "command" attributes of communication, the "double bend," "family homeostasis," and "family rules." And the "marital quid pro quo" became a cornerstone concept in all of couple therapy. This notion, linking interactional/systemic dimensions of couple life with implicit aspects of individual self-definition and self-concept, was a very powerful one. Its power on the field at large, unfortunately, was limited to a major degree because of the untimely death of its brilliant creator in 1969, at the age of 48. Had Jackson lived much longer, he no doubt would have been the first significant "integrative" couple therapist. In this sense, his premature death certainly delayed the advent of such integrative ideas for at least a decade (cf. Gurman, 1981).

Another seminal clinical thinker in the third phase of the history of couple therapy, whose work was decidedly eclectic and collaborative with new ideas, was Virginia Satir (1964). Her work, like many current approaches to couple therapy, emphasized both skills and connection, always aware of what Nichols (1987) would many years later, in a different context, refer to as "the self in the system." She was both a connected humanistic healer and a wise practical teacher with couples, urging self-expression, self-actualization, and relational authenticity. Sadly for the field of couple (and family) therapy, Satir, the only highly visible woman pioneer, was soon marginalized by decidedly more "male" therapeutic values such as rationality and attention to the power dimension of intimate relating. Indeed, Satir was even referred to by a senior colleague in family therapy as a "naive and fuzzy thinker" (Nichols & Schwartz, 1998, p. 122). Not for about 20 years, following a 1994 debate with one of the world's most influential family therapists, who criticized Satir for her humanitarian zeal, would there emerge new approaches to couple therapy that valued, indeed privileged, affect, attachment, and connection (Schwartz & Johnson, 2000).

Murray Bowen was the first family therapy clinical theorist to address multigenerational and transgenerational matters systematically with couples. Although his early forays into the field of family disturbance emphasized trying to unlock the relational dimensions of schizophrenia, in fact, his most enduring contributions probably center on the marital dyad, certainly his central treatment unit. His emphasis on blocking pathological multigenerational transmission processes via enhancing partners' self-differentiation was not entirely individually focused, and, indeed, placed a good deal of clinical attention on the subtle ways in which distressed couples almost inevitably seemed to be able intuitively to recruit in ("triangulate") a third force (whether an affair partner, family member, or even abstract values and standards) to stabilize a dyad in danger of spinning out of control. Unlike Satir, Bowen (1978) operated from a therapeutic stance of a dispassionate, objective "coach," believing that "conflict between two people will resolve automatically if both remain in emotional contact with a third person who can relate actively to both without taking sides with either" (p. 177). Bowen died in 1990, leaving behind a rich conceptual legacy, but a relatively small number of followers and adherents to his theories.

Without doubt, the "golden age" family therapist whose work most powerfully impacted the practice of couple therapy was Jay Haley. His 1963 article, efficiently entitled "Marriage Therapy," undoubtedly marked *the* defining moment at which family therapy incorporated and usurped what little was left in the stalled-out marriage counseling and psychodynamic marriage therapy domains. Haley's ideas are considered here in some detail because they were, and continue to be, the most pervasively influential and broad-scope clinical perspective on couple functioning and couple therapy to have emerged from the family therapy movement.

Beyond its very substantial content, Haley's (1963) article (and many subsequent publications) challenged virtually every aspect of extant psychodynamic and humanistic therapy principles. It disavowed widespread beliefs about the nature of marital functioning and conflict, about what constituted the appropriate focus of therapy and the role of the therapist, and what constituted appropriate therapeutic techniques.

For Haley, the central relational dynamic of marriage involved power and control. As he put the matter, "The major conflicts in marriage center in the problem of who is to tell whom what to do under what circumstances" (Haley, 1963, p. 227). Problems arose in marriage when the hierarchical structure was unclear, when there was a lack of flexibility, or when the relationship was marked by rigid symmetry or complementarity. When presenting complaints centered explicitly on the marital relationship, control was seen by Haley as the focal clinical theme. More subtly, though, Haley also believed that even when the presenting

problem was the symptom of one person, power was at issue: The hierarchical incongruity of the symptomatic partner's position was central, in that the symptom bearer was assumed to have gained and maintained an equalization of marital power through his or her difficulties. Symptoms of individuals, then, became ways to define relationships, and they were seen as both metaphors for and diversions from other problems that were too painful for the couple to address explicitly.

In this way, symptoms of individuals in a marriage, as well as straightforwardly relational complaints, were mutually protective (Madanes, 1980), and were significantly seen as serving functions for the partners as a dyad. Because symptoms and other problems were seen as functional for the marital unit, resistance to change was seen as almost inevitable, leading Haley (1963) to formulate his "first law of human relations"; that is, "when one individual indicates a change in relation to another, the other will respond in such a way as to diminish that change" (p. 234, original emphasis omitted).

Such a view of the almost inherent property of marital (and family) systems to resist change was not limited to the husband–wife interaction. This view necessarily led to the position that the therapist, in his or her attempts to induce change, must often go about this task indirectly. Thus, for Haley (1963), the therapist "may never discuss this conflict (who is to tell whom what to do under what circumstances) explicitly with the couple" (p. 227). Haley (1976) believed that "the therapist should not share his observations … that action could arouse defensiveness" (p. 18). Achieving insight, although not entirely dismissed, was enormously downplayed in importance, in marked contrast to psychodynamic models.

Also viewed negatively by Haley (1976) were such commonplace and previously unchallenged clinical beliefs as the possible importance of discussing the past ("It is a good idea to avoid the past … because marital partners are experts at debating past issues. … No matter how interested a therapist is in how people got to the point where they are, he should restrain himself from such explorations" [p. 164]); the importance of making direct requests ("The therapist should avoid forcing a couple to ask explicitly for what they want from each other. … This approach is an abnormal way of communicating" [p. 166, original emphasis omitted]); and the possible usefulness of interpretation ("The therapist should not make any interpretation or comment to help the person see the problem differently" [p. 28]). Nor was the expression of feelings, common to other couple treatment methods, valued by Haley:

> When a person expresses his emotion in a different way, it means that he is communicating in a different way. In doing so, he forces a different kind of communication from the person responding to him, and this change in turn requires a different way of responding back. When this shift occurs, a system changes because of the change in the communication sequence, but this fact has nothing to do with expressing or releasing emotions [in the sense of catharsis]. (p. 118)

Nor did Haley value expression of feelings for the enhancement of attachment or to foster a sense of security through self-disclosure. Indeed, feeling expression in general was of no priority to Haley ("He should not ask how someone feels about something, but should only gather facts and opinions" [p. 28]).

In contrast, Haley's preferred therapeutic interventions emphasized planned, pragmatic, parsimonious, present-focused efforts to disrupt patterns of behavior that appeared to maintain the major problem of the couple. The strategic therapist was very active and saw his or her central role as finding creative ways to modify problem-maintaining patterns, so that symptoms, or other presenting problems, no longer served their earlier maladaptive purposes. Directives were the therapist's most important change-inducing tools. Some directives were straightforward, but Haley also helped to create a rich fund of indirect, and sometimes resistance-oriented, paradoxical directives (e.g., reframing, prescribing the symptom, restraining change, and relabeling: "Whenever it can be done, the therapist defines the couple as attempting to bring about an amiable closeness, but going about it wrongly, being misunderstood, or being driven by forces beyond their control" [Haley, 1963, p. 226]).

Haley's theoretical and technical contributions were enormously influential in the broad field of family and couple therapy. More than any other individual, Haley influenced sizable portions of at least an entire generation of marital (and family) therapists to see family and couple dynamics "as products of a 'system,' rather than features of persons who share certain qualities because they live together. Thus was born a new creature, 'the family system'" (Nichols & Schwartz, 1998, pp. 60–61). The notion of symptoms serving functions "for the

system" was a hallmark of the strategic approach that pervaded clinical discussions, presentations, and practices in the late 1960s through the 1970s and beyond. The anthropomorphizing of the family or couple "system" seemed to "point to an inward, systemic unity of purpose that rendered 'the whole' not only more than the sum of its parts … [but] somehow *more important than its parts*" (Bogdan, 1984, pp. 19–20).

In summary, Haley urged clinicians to avoid discussing the past, to resist temptations to instill insight, and to downplay couples' direct expression of wishes and feelings. As Framo (1996) would venture three decades after Haley's (1963) concept-shifting marriage therapy article, "I got the impression that Haley wanted to make sure that psychoanalytic thinking be prevented from ruining the newly emerging field of family therapy" (p. 295).

Treading Water

Family therapy had now not merely incorporated, merged with, or absorbed marriage counseling and psychoanalytic couple therapy; it had engulfed, consumed, and devoured them both. Although none of these four family therapy perspectives ever resulted in a separate, discernible "school" of couple therapy, the central concepts in each have trickled down to and permeated the thinking and practices of most psychotherapists who work with couples.

The conceptual development of couple therapy, it must be said, remained quite stagnant during family therapy's "golden age." The most influential clinical thinkers during that period were Clifford Sager (1966, 1976) and James Framo (1981, 1996), whose contributions were in the psychodynamic realm. Although neither Sager, a psychiatrist, nor Framo, a clinical psychologist, were in marginalized professions, their work, though highly respected in some circles, never had the impact it deserved in the overwhelmingly "systems–purist" (Beels & Ferber, 1969) *zeitgeist* of family therapy. And, as noted, Satir's humanistic–experiential emphasis struggled to maintain its currency. The antagonistic attitude of many pioneering family therapists toward couple therapy was all the more bizarre when considered in the context of the unabashed assertion by Nathan Ackerman (1970), the unofficial founder of family therapy, that "the therapy of marital disorders (is) the core approach to family change" (p. 124).

Renewal

By the mid-1980s, couple therapy began to reemerge with an identity rather different from that of family therapy. This beginning period of sustained theory and practice development and advances in clinical research on couples' relationships and couple therapy signaled the onset of the fourth phase in the history of couple therapy, "Refinement, Extension, Diversification, and Integration" (c. 1986–present).

The attribute of "refinement" in couple therapy of the last two decades has been highlighted primarily by the growth of three treatment traditions in particular: behavioral/cognitive-behavioral couple therapy, attachment-oriented emotionally focused couple therapy, and psychodynamic couple therapy. Details of these clinical methods aside, their most noteworthy commonality is that they all fundamentally derive from longstanding psychological traditions (i.e., social learning theory, humanism–existentialism, and psychodynamicism) that were never core components of the earlier family therapy movement.

Behavioral couple therapy (BCT), launched by the work of Stuart (1969, 1980) and Jacobson (Jacobson & Margolin, 1979; Jacobson & Martin, 1976), has itself passed through quite distinct periods. The "Old BCT" phase emphasized skills training (e.g., communication and problem solving) and change in overt behavior (e.g., behavioral exchanges), and the therapist's role was highly psychoeducational and directive. The second or "New BCT" phase, marked by the development of "Integrative Behavioral Couple Therapy" (Christensen, Jacobson, & Babcock, 1995) shifted a former emphasis on changing the other to a more balanced position of changing self as well, marked by new interventions to facilitate the development of greater mutual acceptance, especially around repetitive patterns of interaction and persistent partner characteristics (e.g., broad personality style variables), or what Gottman (1999) called "perpetual issues." The third BCT evolutionary phase, the "Self-Regulation Phase," focused on the very salient impact of partners' affective self-regulation capacity, as sometimes highlighted in clinical work with volatile, "difficult" couples, in which, for example, one of the partners has with a demonstrably significant personality disorder, often, but not always, borderline personality disorder. Indeed, this self-regulation phase overlaps with the very current phase of BCT's evolution,

which has made significant contributions to the treatment of a wide variety of psychological/psychiatric disorders in their intimate relational context (e.g., alcoholism and drug abuse, sexual dysfunction, depression, and bipolar disorder).

The reascendance of the humanistic tradition in psychology and psychotherapy has been heralded by the development and dissemination of the attachment theory–oriented approach known as emotionally focused couple therapy (Johnson & Denton, 2002), and it has not been without the influence of Satir's clinical epistemology and methodology. This approach, which includes a mixture of client-centered, Gestalt, and systemic interventions, fosters affective expression and immediacy, and relational availability and responsiveness. Beyond its initial use with generic couple conflicts, this approach, like some BCT approaches, has been applied recently to the treatment of "individual" problems and disorders, especially those thought to be likely to be influenced positively by an emphasis on secure interpersonal attachment, such as posttraumatic stress disorder. At a more "macro" level, this approach has led the way in the field's "shaking off its no-emotion legacy" (Schwartz & Johnson, 2000, p. 32), and is reminiscent of Duhl and Duhl's (1981) telling comment, "It is hard to kiss a system" (p. 488).

Psychodynamically oriented approaches have reascended in recent years via two very separate pathways. First, object relations theory (e.g., Dicks, 1967; Scharff & Bagnini, 2002) has been undergoing slow but consistent development both in the United States and abroad, and has reestablished a connection with a conceptual thrust in couple and family therapy (e.g., Framo, 1965; Skynner, 1976, 1980, 1981) that had, as noted earlier, largely died out, or at least had gone well underground, in earlier times. Second, psychodynamic concepts have reemerged in couple therapy through their incorporation into more recently developing integrative (e.g., Gurman, 1981, 1992, 2002) and pluralistic (e.g., Snyder, 1999; Snyder & Schneider, 2002) models of treatment, paralleling the very strong movement in the broader world of psychotherapy fostering the process of bringing together both conceptual and technical elements from seemingly incompatible, or at least historically different, traditions to enhance the salience of common mechanisms of therapeutic change and to improve clinical effectiveness.

The "Extension" phase of couple therapy in recent years refers to efforts to broaden its purview beyond helping couples with obvious relationship conflict to the treatment of individual psychiatric disorders, some of which were mentioned earlier. Although family therapy was initially developed, to an important degree, in an effort to understand major mental illness (Wynne, 1983), the political fervor that characterized much of family therapy's "golden age" seriously curtailed attention to the study and treatment of individual psychiatric problems, even (ironically, to be sure) in familial–relational contexts. A great deal of study in recent years has focused on the role of couple/marital factors in the etiology and maintenance of such problems on the one hand, and the use of couple therapy intervention in the management and reduction of the severity of such difficulties on the other.

"Diversification" in couple therapy has been reflected by the broadening perspectives brought to bear by feminism, multiculturalism, and postmodernism. The feminist perspective has cogently drawn attention to the many subtle and implicit ways the process of couple therapy is influenced by gender stereotypes of both therapists and patients/clients (e.g., the paternalistic aspects of a hierarchical, therapist-as-expert, therapy relationship; differing partner experiences of their relationship based on differential access to power, and different expectations regarding intimacy and autonomy).

Multiculturalism has provided the base for couple therapists' broader understanding of the diversity of couples' experience as a function of differences in race, ethnicity, religion, social class, sexual orientation, age, and geographic locale. A modern multicultural perspective has also emphasized that the norms relative to intimacy, the distribution and use of power, and the role of various others in the couple's shared life vary tremendously across couples depending on many of the sociocultural variables noted earlier. The influence of both feminist and multicultural perspectives has no doubt made couple therapy a more collaborative experience than was likely in earlier times.

Finally, the postmodern perspective has introduced profoundly interesting and important practical critiques of how people come to know their reality, with a strong emphasis on the historical and social construction of meaning embodied in many important aspects of being a couple in a long-term relationship. Like feminism and multiculturalism, postmodernism has pushed therapists to recognize the multiplicity of ways in which it is possible to be "a couple."

"Integration" is the final component of this fourth phase in the development of couple thera-

py. Significant in its emphasis on bringing to bear on clinical practice the best the field has to offer in terms of using validated clinical theories and treatment methodologies and interventions, this dimension of couple therapy has been aptly described (Lebow, 1997) as a "quiet revolution" (p. 1). The integrative movement began in response to the recognition of the existence of common factors that affect treatment outcomes (Sprenkle & Blow, 2004) and the limited evidence of differential effectiveness and efficacy of various couple therapies (Lebow & Gurman, 1995). Proponents of integrative positions (e.g., Gurman, 1981, 2002; Lebow, 1997) assert that a broad base for understanding and changing human behavior is necessary, and that evolving integrative approaches allow for greater treatment flexibility and thereby improve the odds of positive therapeutic outcomes.

The Three-Phase History of Research in Couple Therapy

Statistics are like bikinis … what they reveal is interesting, what they conceal, vital.

—Paul Watzlawick

Despite the increasing recent importance of the scientific study of therapeutic processes and outcomes in working with couples, research on couples' clinically relevant interaction patterns and on clinical intervention itself has not always been a hallmark of this domain within psychotherapy. Just as Manus (1966) called marriage counseling a "technique in search of a theory," Gurman and Fraenkel (2002) described the period from about 1930 to 1974 as "a technique in search of some data" (p. 240). In a 1957 article, Emily Mudd, a marriage counseling pioneer, discussed the "knowns and unknowns" in the field and, in a word, concluded that there were none of the former and a plethora of the latter. By 1970, Olson reported that the majority of marriage counseling research publications were "mostly descriptive" (p. 524), and what little had appeared on treatment outcomes largely comprised single author–clinicians reporting on their own (uncontrolled) clinical experiences with couples.

In its second phase (c. 1975–1992), beginning in the mid- to late 1970s, there was a decidedly upbeat tone (which Gurman and Fraenkel [2002] called the period of "Irrational Exuberance"), in the field, justified, if not overly justified, by the appearance of the earliest comprehensive reviews of (actual) empirical research on the outcomes of couple therapy (Gurman, 1971, 1973; Gurman & Kniskern, 1978a, 1978b; Gurman, Kniskern, & Pinsof, 1986). Couple therapy had now established a reasonable empirical base to warrant assertions of its efficacy.

The third phase of the research realm (c. 1993–present), also known as the period of "Caution and Extension," has evidenced attention to a wide variety of much more sophisticated and clinically relevant questions about couple therapy than older "Does it work?" inquiries. Such matters investigated in the last 15 years address questions such as

1. How powerful is couple therapy? (i.e., how "large" are its positive effects in terms of its impact on couples and the percentages of couples whose relationships improve from treatment?)
2. How durable are the effects of change from couple therapy?
3. Does couple therapy ever bring about "negative effects," also known as "deterioration"?
4. What is the relative efficacy and effectiveness of different methods of couple therapy?
5. What therapist factors and what couple factors predict responsiveness to treatment (or, to which treatments)?
6. Is couple therapy helpful in the treatment of "individual" problems and disorders?
7. By what mechanisms do couples' relationships improve in therapy, when they do improve?
8. What are the most essential, core therapeutic change processes that, in general, should be fostered in therapy with couples?

Many of these theoretically and practically important questions had not even been formulated within the field of couple therapy early in the previous decade.

Four Profound Shifts

None of us understand psychotherapy well enough to stop learning from all of us.

—Frank Pittman

Four major shifts in couple therapy that have occurred over time constitute not simply "trends" in the field, but an altered shape of the field that is profound. First, there has been a reinclusion of the individual, a renewed interest in the psychology of the individual that complements the rather unilateral emphasis on relational systems that marked the field for many years. In this sense, couple therapy has become more genuinely "systemic." Second, there has been greater acknowledgment of the

reality of psychiatric/psychological disorders, and of the reality that such problems, although both influenced enormously by and influencing core patterns of intimate relaxing, are not reducible to problems at systemic levels of analysis. Third, the major energies that have fueled the growth of couple therapy in the last two decades in terms of both clinical practice and research have come not from the broader field of family therapy, but from the more "traditional" domains of psychological inquiry of social learning theory, psychodynamic theory, and humanistic–experiential theory. This third shift, at once lamentable and renewing, carries profound implications for the field of couple therapy, and nowhere more notably than in the domain of clinical teaching and training.

The final, and ironic, shift identified by Gurman and Fraenkel (2002) in their millennial review of the history of couple therapy, was described as follows:

> No other collective methods of psychosocial intervention have demonstrated a superior capacity to effect clinically meaningful change in as many spheres of human experience as the couple therapies, and many have not yet even shown a comparable capacity. Ironically, *despite its long history of struggles against marginalization and professional disempowerment, couple therapy has emerged as one of the most vibrant forces in the entire domain of family therapy and of psychotherapy-in-general*. (p. 248, emphasis in original)

It is this vibrancy that this *Handbook* is intended to convey.

THE HEALTHY/WELL-FUNCTIONING VERSUS PATHOLOGICAL/DYSFUNCTIONAL COUPLE/MARRIAGE

A successful marriage requires falling in love many times, always with the same person.

—Mignon McLaughlin

A healthy marriage is one in which only one person is crazy at a time.

—Heinz Kohut

Do married people really live longer, or does it just seem that way?

—Steven Wright

Purpose

To describe typical relationship patterns and others factors that differentiate healthy/well-functioning and pathological/dysfunctional couples/marriages.

Points to Consider

1. Does your approach have an explicit point of view on the nature of romantic love?
2. What interaction patterns, or other characteristics, differentiate healthy/satisfied from unhealthy/dissatisfied couples? (Consider relationship areas such as problem solving, communication, expression of affect, sexuality, the balance of individual and couple needs, and the role of individual psychological health.)
3. How do problematic relationship patterns develop? How are they maintained? Are there reliable risk factors for couple functioning and/or couple longevity?
4. Do sociocultural factors, such as ethnicity, class, and race, figure significantly in your model's understanding of couple satisfaction and functioning? Gender factors?
5. How do healthy versus dysfunctional couples handle life-cycle transitions, crises, and so forth? How do they adapt to the inevitable changes of both individuals and relationships?

"Couples" and "Marriages"

The term "couple therapy" has recently come to replace the historically more familiar term "marital therapy" because of its emphasis on the bond between two people, without the associated judgmental tone of social value implied by the traditional term. In the therapy world, the terms are usually used interchangeably. Whether therapeutic methods operate similarly with "marriages" and with "couple" relationships in which there is commitment but no legal bond is unknown but is assumed here. Although there are philosophical advantages to the term "couple therapy," the more familiar term "marital therapy" is still commonly used, and both terms are intended to refer to couples in long-term, committed relationships.

Clarifying the sociopolitical meaning of "couple" versus "marriage" points to a much larger issue; that is, psychotherapy is not only a scientific and value-laden enterprise but is also part and parcel of its surrounding culture. It is a significant source of our current customs and worldviews, thus possessing significance well beyond the interactions between clients and therapists.

At the same time, psychotherapy is a sensitive barometer of those customers and outlooks

that the different modes of practice respond to and incorporate within their purview. The relationship between culture and psychotherapy, including couple therapy, to be sure, then, is one of reciprocal influence. For example, a currently important cultural phenomenon affecting the practice of all psychotherapy, couple therapy not excepted, is the medicalization of the treatment of psychological distress and disorder. Thus, the language of medicine has long been prominent in the field of psychotherapy. We talk of "symptoms," "diseases," "disorders," "psychopathology" and "treatment." As Messer and Wachtel (1997) remarked, "It is a kind of new narrative that reframes people's conflicts over value and moral questions as sequelae of 'disease' or 'disorder,' thereby bringing into play the prestige (and hence curative potential) accruing to medicine and technology in our society" (p. 3). Thus, the spread of the biological way of understanding psychopathology, personality traits, and emotional suffering in general, as well as the biological mode of treating emotional disorders, have had their effects on the practice of psychotherapy. Couple therapy is not immune to such cultural phenomena. Clients and therapists are more likely to consider having medication prescribed. Psychologists and other nonmedical therapists, including couple therapists, are collaborating more frequently with physicians in treating their patients. Courses in psychopharmacology that are now routinely offered or even required in clinical and counseling psychology and psychiatric social work training programs are at times also available in programs dedicated to the training of couple and family therapists. Most of the work of couple therapy, of course, is not readily reducible to psychopharmacological therapeusis.

Moreover, any method of couple therapy probably implicitly reveals its aesthetic and moral values by how it conceptualizes mental health and psychological well-being, including relational well-being. As Gurman and Messer (2003, p. 7) have put it,

> The terms of personality theory, psychopathology and the goals of psychotherapy are not neutral. … They are embedded in a value structure that determines what is most important to know about and change in an individual, couple, family or group. Even schools of psychotherapy that attempt to be neutral with regard to what constitutes healthy (and, therefore, desirable) behavior, and unhealthy (and, therefore, undesirable) behavior inevitably, if unwittingly, reinforce the acceptability of some kinds of client strivings more so that others.

Interestingly, while all approaches to couple therapy are attempts to change or improve some aspect of personality or problematic behavior, the majority of these theories of therapy neither include a concept of personality nor are they closely linked, or at times even linked at all, to a specific theory of personality. In the world of couple therapy, the de facto substitute for personality theory is usually a theory that defines the "interactive personality" of the couple dyad (and its contextual qualifiers). The old family therapy saw that captures this position is the notion that "a system is its own best explanation."

Given the variety of theoretical approaches to couple therapy discussed in this volume, it is hardly surprising that therapists of different theoretical orientations define the core problems of the couples they treat quite differently. These range from whatever the couple presents as its problem to relationship skills deficits, to maladaptive ways of thinking and restrictive narratives about relationships, to problems of self-esteem, to unsuccessful handling of normal life cycle transitions, to unconscious displacement onto the partner of conflicts with one's family of origin, to the inhibited expression of normal adult needs, to the fear of abandonment and isolation.

Despite these varied views of what constitutes the core of marital difficulties, marital therapists of different orientations in recent years have sought a clinically meaningful description and understanding of functional versus dysfunctional intimate relationships that rests on a solid research base. Quite remarkably, and perhaps uniquely in the world of psychotherapy, there has accumulated a very substantial body of research (on couple interaction processes) that has been uniformly praised by and incorporated into the treatment models of a wide range of couple therapies. These findings, on aggregate (Cassidy & Shaver, 1999; Gottman, 1994a, 1994b, 1998, 1999; Johnson & Whiffen, 2003), provide a theoretically and clinically rich and credible description of the typical form and shape of "healthy" and "unhealthy" couple–marital interactions. They are cited as having influenced several of the models of therapy presented in this *Handbook*.

THE PRACTICE OF COUPLE THERAPY

All knowledge is sterile which does not lead to action and end in charity.

—Cardinal Mercier

The Structure of the Therapy Process

Who forces time is pushed back by time; who yields to time finds time on his side.

—The Talmud

Purpose

To describe the treatment setting, frequency, and duration of treatment characteristic of your approach.

Points to Consider

1. How are decisions made about whom to include in therapy? For example, besides the couple, are children or extended family members ever included?
2. Are psychotropic medications ever used within your method of couple therapy? What are the indications–contraindications for such use? Within your approach are there any particular concerns about a couple therapist referring a patient to a medical colleague for medication evaluation?
3. Are individual sessions with the partners ever held? If "yes," under what conditions? If "no," why not?
4. How many therapists are usually involved? From your perspective, what are the advantages (or disadvantages) of *using* cotherapists?
5. Is therapy typically time-limited or unlimited? Why? Ideal models aside, how long does therapy typically last? How often are sessions typically held?
6. If either partner is in concurrent individual therapy (with another therapist), does the couple therapist regularly communicate with that person about the couple?
7. How are out-of-session contacts (e.g., phone calls) handled? Are there any especially important "ground rules" for proceeding with therapy?

The two central matters involved in the structure of couple therapy are (1) who participates and (2) for how long (and how often?). As noted earlier, "couple therapy" is nowadays considered to be redundant with the term "conjoint," that is, therapy with an individual that focuses on that person's marital issues is individual therapy focused on marital issues. It is not couple therapy, though it certainly may be conducted in such a way as to reasonably be considered "systematically aware" or "contextually sensitive." Still, it is not couple therapy. Therapy *about* the couple is not synonymous with therapy *of* the couple.

And although nonpartners (e.g., parents, children) are not commonly included (cf. Framo, 1981) in therapy sessions during couple therapy, configurations other than the obvious two partners plus one therapist (or two therapists, if there is a cotherapist) are hardly rare. Specifically, many approaches to couple therapy, with a very cogent rationale, and as a matter of standard protocol, arrange for individual meetings with each partner during the early (assessment) phase of the work. Other approaches are very open to intermittent individual meetings for very focused and clear reasons, albeit usually only quite briefly, for very specific strategic purposes (e.g., to help calm down each partner in a highly dysregulated, volatile marriage when little is being accomplished in three-way meetings). At the other end of the continuum are couple therapy models that, for equally compelling reasons, never, or almost never, allow the therapist to meet with individual partners.

This specific aspect of the structure of couple therapy regarding whether, and under what conditions, individual sessions may occur is one of the most important practical decisions to be made by couple therapists, regardless of their preferred theoretical orientations. Although a seemingly simple matter on the surface, therapist policies and procedures about how the decision is addressed and implemented can carry truly profound implications for the establishment and maintenance of working therapeutic alliances, therapeutic neutrality–multilaterality, and even basic positions on what (or who) is (or has) "the problem." It is a recurrent clinical situation that each therapist working with couples must think through carefully and about which it is important to maintain consistency.

As to the matter of the length of couple therapy, it is clear, as discussed earlier, that couple therapy is overwhelmingly brief by any temporal standards in the world of psychotherapy. Three decades ago, Gurman and Kniskern (1978b, 1981) found that well over two-thirds of the courses of couple therapy were less than 20 sessions, and almost 20 years later, Simmons and Doherty (1995; Doherty & Simmons, 1996) found reliable evidence that the mean length of couple therapy is about 17–18 sessions. In contrast to the history of individual psychotherapy, the dominant pattern in couple (and family) therapy has been that "brief" treatment by traditional standards is "expected, commonplace, and the norm" (Gurman, 2001).

Couple (and family) therapies were brief long before managed care administratively truncated therapy experiences, as Gurman has demonstrated.

It is important and interesting to note, moreover, that most of this naturally (vs. administratively) occurring brevity of couple therapy has not included planned, time-limited practice. In no small measure this has occurred not because of arbitrarily imposed treatment authorization limits, but because of the dominant treatment values of most couple (and family) therapists (e.g., valuing change in presenting problems, emphasizing couples' resourcefulness and resilience; focusing on the "Why *now*?" developmental context in which couple problems often arise; viewing symptoms as relationally embedded; and emphasizing change in the natural environment).

The Role of the Therapist

> Some people see things as they are and ask, "Why?"; others see things as they could be and ask, "Why not?"
>
> —George Bernard Shaw

> We need different thinks for different shrinks.
>
> —A. C. R. Skynner

Purpose

To describe the stance the therapist takes with the couple.

Points to Consider

1. What is the therapist's essential role? Consultant? Teacher? Healer?
2. What is the role of the therapist–couple alliance? How is a working alliance fostered? In your approach, what are the most common and important errors the therapist can make in building early working alliances?
3. To what degree does the therapist overtly control sessions? How active/directive is the therapist? How should the therapist deal with moments of volatile emotional escalation or affective dysregulation in sessions?
4. Do patients talk predominantly to the therapist or to each other?
5. Does the therapist use self-disclosure? What limits are imposed on therapist self-disclosure?
6. Does the therapist's role change as therapy progresses? As termination approaches?
7. What clinical skills or other therapist attributes are most essential to successful therapy in your approach?

In the last couple of decades, a great deal of effort has been put into identifying empirically supported treatments (ESTs) among the many existing forms of psychotherapy, including couple therapy. Although such efforts are helpful for public policy-making, they tend to focus heavily on one particular domain of the therapy experience, the role and power of therapeutic techniques. Increasingly, but only quite recently, EST-oriented efforts have been counterbalanced by attempts to investigate and understand the essential characteristics of ESRs (i.e., empirically supported therapeutic relationships; Norcross, 2002). Indeed, such efforts now rest on a solid empirical base for arguing that the therapist as a person exerts large effects on the outcome of psychotherapy, and that these effects often outweigh the effects attributable to treatment techniques per se; in addition, the relationship established between therapist and patient may be more powerful than particular interventions (Wampold, 2001). Even very symptom-focused and behavior-focused therapy encounters, which emphasize the use of clearly defined change-inducing techniques, occur in the context of human relationships characterized by support and reassurance, persuasion, and the modeling of active coping.

The kind of therapeutic relationship required by each approach to couple therapy includes the overall "stance" the therapist takes toward the experience (how working alliances are fostered and how active, how self-disclosing, how directive, and how reflective, etc., the therapist is). Different models of couple therapy may call forth and call for rather different therapist attributes and interpersonal inclinations. Thus, therapists with a more or less "take charge" personal style may be better suited to therapy approaches that require a good deal of therapist activity and structuring than to those requiring a more reflective style.

Given the presumed effectiveness equivalence of the major methods of psychotherapy and the absence within couple therapy of any evidence (Lebow & Gurman, 1995) deviating from this recurrent pattern of research findings, it is not surprising that idiosyncratic personal factors influence therapists' preferred ways of practicing. Thus, Norcross and Prochaska (1983) found that therapists generally do not advocate different approaches on the basis of their relative scientific status, but are more influenced by their own direct clinical experience, personal values and philosophy, and life experiences.

The therapist's role in couple therapy varies along several dimensions, most noticeably in

terms of emotional closeness–distance relative to the couple. Three gross categories of the therapist's emotional proximity can be discerned: the educator/coach, the perturbator, and the healer. These relational stances vary as a function of the degree to which the therapist intentionally and systematically uses his or her "self" (e.g., by self-disclosure of fantasy material, personal or countertransferential reactions, or factual information) or explicitly addresses the nature and meaning of the therapist–partner relationship. The therapist as educator/coach sees him- or herself as possessing expert, professional knowledge about human relationships and change processes, and attempts to impart such knowledge to couples as a basis for inducing change. The couple therapist as perturbator possesses expert understanding of problematic family processes, but tends to use this awareness more from an outside stance to induce change in the couple system, without giving partners information, concepts, or methods they can take away from therapy for future use. The couple therapist as healer places special value on the transformative power of the personal relationships in treatment.

Assessment and Treatment Planning

If you are sure you understand everything that is going on, you are hopelessly confused.

—Walter Mondale

Purpose

To describe the methods used to understand a couple's clinically relevant patterns of interaction, symptomatology and adaptive resources.

Points to Consider

1. Briefly describe any formal or informal system (including tests, questionnaires) for assessing couples, in addition to the clinical interview.
2. In addition to understanding the couple's presenting problem(s), are there areas/issues that you routinely assess (e.g., violence, substance abuse, extramarital affairs, sexual behavior, relationships with extended family, parenting, etc.)?
3. At what unit levels (e.g., intrapsychic, behavioral) and psychological levels (e.g., intrapsychic, behavioral) is assessment done?
4. What is the temporal focus of assessment (i.e., present vs. past); for example, is the history of partner/mate selection useful in treatment planning?
5. To what extent are issues involving gender, ethnicity, and other sociocultural factors included in your assessment? Developmental/life cycle changes?
6. Are couple strengths/resources a focus of your assessment?
7. Is the assessment process or focus different when a couple presents with problems about both relational and "individual" matters (e.g., depression, anxiety)?
8. Likewise, is the assessment process or focus different when the therapist perceives the presence of individual psychopathology in either–both partners, even though such difficulties are not identified by the couple as central concerns?

The practicality of a coherent theory of couple therapy, including ideas about relationship development and dysfunction, becomes clear as the therapist sets out to make sense of both problem stability (how problems persist) and problem change (how problems can be modified). As indicated earlier in Meltzoff and Kornreich's (1970) definition of psychotherapy, couple therapists are obligated to take some purposeful action in regard to their understanding of the nature and parameters of whatever problems, symptoms, complaints or dilemmas are presented. They typically are interested in understanding what previous steps patients have taken to resolve or improve their difficulties, and what adaptive resources the couple, and perhaps other people in the couple's world, has for doing so. They also pay attention to the cultural (ethnic, racial, religious, social class, gender) context in which clinically relevant concerns arise. Such contextualizing factors can play an important role in how therapists collaboratively both define the problem at hand and select a general strategy for addressing the problem therapeutically. As Hayes and Toarmino (1995) have emphasized, understanding the cultural context in which problems are embedded can serve as an important source of hypotheses about what maintains problems, and what types of interventions may be helpful.

How couple therapists actually engage in clinical assessment and treatment planning vary from approach to approach, but all include face-to-face clinical interviews. The majority of couple therapists emphasize the therapist–patient conversation as the source of such understanding. Couple

therapists also inherently complement such conversations with direct observations of the problem as it occurs between the couple partners in the clinical interview itself. Multigenerationally oriented therapists may also use genograms to help discern important transgenerational legacies. In addition, some therapists regularly include in the assessment process a variety of patient self-report questionnaires or inventories, and a smaller number may also use very structured interview guides, which are usually research-based instruments. Generally, therapists who use such devices have very specialized clinical practices (e.g., focusing on a very particular set of clinical disorders, in their relational context) for which such measures have been specifically designed (e.g., alcoholism and drug abuse, sexual dysfunction).

The place of standard psychiatric diagnosis in the clinical assessment phase of psychotherapy varies widely. The majority of couple therapists of different theoretical orientations routinely consider the traditional diagnostic psychiatric status of patients according to the criteria of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV; American Psychiatric Association, 1994), at least to meet requirements for financial reimbursement, maintenance of legally required treatment records, and other such institutional contingencies. Although considering such diagnostic dimensions may provide a useful general orientation to concerns of a subset of couples seen in therapy, proponents of every method of couple therapy develop their own idiosyncratic ways of understanding each couple's problem. Moreover, proponents of some newer approaches to couple therapy argue that "diagnoses" do not exist "out there" in nature, but merely represent the consensual labels attached to certain patterns of behavior in particular cultural and historical contexts. Such therapists consider the use of diagnostic labeling as an unfortunate and unwarranted assumption of the role of "expert" by therapists, which may inhibit genuine collaborative exploration between therapists and "patients" (or "clients"). For such therapists, what matters more are the more fluid issues with which people struggle, not the diagnoses they are given.

The major differences among couple therapists are more likely to appear in their conceptualizations of what they experience and observe. Therapists of different theoretical orientations can be rather reliably differentiated in terms of the levels of assessment on which they focus. Two dimensions of these levels may be identified—the unit level and the experiential level. The "unit level" refers to the composition of the psychosocial unit(s) on which the assessment focuses. The individual, the couple, the parental subsystem, the whole family, and the family plus nonnuclear family social entities (grandparental subsystem, school system, etc.) may all be given attention. Psychodynamic, experiential–humanistic, and intergenerational therapists tend to be interested in assessing the potential treatment-planning role (even if only by reference, rather than face-to-face) of a larger number of units, whereas proponents of orientations that focus more on resolving presenting problems (e.g., cognitive-behavioral, narrative, structural, and strategic approaches) tend to assess a less complex array of these units. The "experiential level" refers to the level of organization at which assessment occurs (e.g., molecular/biological, unconscious, conscious, interpersonal, and transpersonal), and couple therapists also differ quite significantly on the related dimension of past- versus present-centeredness. The more pragmatic (Keeney & Sprenkle, 1982) therapists, who focus more on presenting problems (e.g., cognitive-behavioral, strategic, and structural approaches), tend to show little to no significant interest in either unconscious psychological processes, or the couple's or its individual members' past. By contrast, more aesthetically oriented (Keeney & Sprenkle, 1982) therapists (e.g., psychodynamic–object relations, humanistic, and symbolic–experiential therapists), who tend to espouse a more relationship-based style of intervention in which the "real" problem is believed initially to be hidden, are more attuned to psychological events that are not so immediate. Such therapists' assessments tend to emphasize inference, whereas the more pragmatic therapists' assessments tend to emphasize observation.

Of course, it is essential for couple therapists to cast a fairly wide net in the opening assessment–treatment planning phase of the work, routinely raising questions about the possible presence in the couple's relationship of patterns and problems that in fact often go unstated by couples, even though they might become essential treatment foci (e.g., substance abuse), or that might even preclude couple therapy (e.g., severe physical or verbal aggression).

Goal Setting

Every calling is great when greatly pursued.
—Oliver Wendell Holmes

Purpose

To describe the nature of therapeutic goals and the process by which they are established.

Points to Consider

1. Are there treatment goals that apply to all or most cases for which your approach is appropriate regardless of between-couple differences or presenting problem? Relatedly, does a couple's marital status influence your goal setting?
2. How are the central goals determined for/with a given couple? How are they prioritized?
3. Who determines the goals of treatment? Therapist, couple, other? How are differences in goals resolved? To what extend and in what ways are therapist values involved in goal setting?
4. Are treatment goals discussed with the couple explicitly? If "yes," why? If "no," why not?
5. How are the goals (initial and longer-term) of therapy affected when the couple's presenting problems focus on matters of violence, infidelity, or possible separation/divorce?

Different theoretical orientations to couple therapy emphasize different types of typical goals, but a number of goals are also shared across couple therapy approaches. Most couple therapists would endorse most of the following ultimate goals (desired end states), regardless of the nature of the presenting problem: (1) reduction of psychiatric symptoms, or, when such symptoms are not a major focus of treatment, reduction of other presenting problem behavior or experience, especially in relation to interactional patterns that maintain the problem(s); (2) increased couple resourcefulness (e.g., improved communication, problem-solving, and conflict resolution skills, and enhanced coping skills and adaptability); (3) improvement in the fulfillment of individual psychological needs for attachment, cohesion, and intimacy; increased trust and equitability; and enhanced capacity to foster the development of individual couple members; (4) increased ability to interact effectively with important, larger social systems; and (5) increased awareness and understanding of how couples' patterns of interaction influence their everyday effectiveness in living, as well as how such patterns affect, and are affected by, the psychological health and satisfaction of individuals.

Within some approaches to couple therapy, certain specific *ultimate goals* are considered important in all cases, regardless of differences among couples. For example, in Bowen family systems therapy, a universal goal is the differentiation of the self from the system. Other approaches (e.g., brief strategic and solution-focused approaches) aim almost exclusively at solving the presenting problem.

In addition to ultimate goals, a variety of *mediating goals* are emphasized in the various couple therapy approaches. Mediating goals are shorter-term and include changes in psychological processes through which it is presumed an individual or couple go to reach treatment objectives. They are sometimes referred to as "process goals." Common forms of mediating or process goals are the achievement of insight; the teaching of various interpersonal skills, such as communication and problem solving; and the description of interlocking pathologies or blocking of rigid symptom and problem-maintaining patterns of behavior to allow opportunities to experiment with more adaptive responses. Mediating goals may also be more abstract and, in any case, are not necessarily made explicit by the therapist. Mediating goals are particularly unlikely to be discussed between the couple and therapist in a wide variety of approaches, and even the extent of the discussion of ultimate goals of treatment varies enormously across the many influential methods of couple therapy.

Process and Technical Aspects of Couple Therapy

It is only an auctioneer who can equally and impartially admire all schools of art.

—Oscar Wilde

Purpose

To describe techniques and strategies always or frequently used in your approach to couple therapy, and their tactical purposes.

Points to Consider

1. How structured are therapy sessions? Is there an ideal (or typical) pacing or rhythm to sessions?
2. What techniques or strategies are used to join the couple or to create a treatment alliance? Howare"transference"–"countertransference" reactions dealt with?
3. What techniques or strategies lead to changes in structure or transactional patterns? Iden-

tify, describe, and illustrate major commonly used techniques.
4. How is the decision made to use a particular technique or strategy at a particular time? Are some techniques more or less likely to be used at different stages of therapy?
5. Are different techniques used with different types of couples? For example, different or additional techniques called upon when the therapy in addressing problems involving individual psychopathology, difficulties, or disabilities, and so forth, in addition to interactional/relational problems, or, alternatively, with more dysfunctional, distressed, or committed couples?
6. Are "homework" assignments or other out-of-session tasks used?
7. Are there techniques used in other approaches to couple therapy that you would probably never use?
8. What are the most commonly encountered forms of resistance to change? How are these dealt with?
9. If revealed to the therapist outside conjoint sessions, how are "secrets" (e.g., extramarital affairs) handled?
10. What are both the most common and the most serious technical or strategic errors a therapist can make operating within your therapeutic approach?
11. On what basis is termination decided, and how is termination effected? What characterizes "good" versus "bad" termination?

To a newcomer to the world of couple therapy, the variety and sheer number of available therapeutic techniques no doubt seem daunting and dizzying to apprehend: acceptance training, affective downregulation, affective reconstruction, behavioral exchange, boundary marking, communication training, circular questioning, dream analysis, enactment, empathic joining, exceptions questioning, exposure, externalizing conversations, family-of-origin consultation, genogram construction, interpretation of defenses, jamming, joining, meta-emotion training, ordeal prescription, paradoxical injunction, positive connotation, problem-solving training, reattribution, reframing, scaling, sculpting, Socratic questioning, softening, unbalancing, unified detachment training, unique outcomes questioning, witnessing (all used, of course, with *zeal*).

Yet, appearances to the contrary notwithstanding, there is actually less technique chaos than might be obvious at first to a newly arrived Martian. Overall, behavior change is probably the dominant mode of change induction in couple therapy, in contrast to insight–reflection. "Behavior change techniques" refer to any therapeutic techniques used to modify observable behavior, whether at the level of the individual or the dyad (or larger family), whereas "insight-oriented techniques" refer to those techniques that lead to change in awareness or perhaps affective experience, without any automatic change in overt behavior. In contrast to much traditional individual psychotherapy, in which insight is generally assumed to precede therapeutic change, the opposite sequence is often preferred in most couple therapy. In addition, couple therapists are usually more bidirectional in their thinking; that is, they believe that change can be initiated in any domain of psychosocial organization. For pragmatic reasons, though, initial change is more often sought at the interactional, public level of experience.

We can furthermore distinguish between couple therapy techniques that focus on in-session versus out-of-session experience. The wide use of techniques that emphasize patients' experiences away from the consultation room reflects couple therapists' respect for the healing power of intimate relationships and their belief that change that endures and generalizes to everyday life is not achieved primarily in the substitutive relationship between therapists and their patients but, rather, between relationship partners in their natural environment. What is especially striking about the centrality of out-of-session techniques in couple therapy is that it also reflects the modal couple therapist's view that the dominant site of action in therapy change is within the couple relationship.

Therapeutic techniques in couple therapy are heavily influenced by techniques focused on cognitive dimensions of experience, such as meaning and attribution, and those focused on action. The former may emphasize a therapist's attempts to *change meaning*, to *discover meaning*, or to *co-create meaning*. Such efforts can range, for example, from one therapist's attempts to influence a partner to see that his or her partner's general inexpressiveness reflects not that person's lack of loving feeling but internal discomfort regarding intimate conversation, to another therapist's "positive reframing" of such inexpressiveness as an understandable attempt to maintain a tolerable level of affective arousal in a marriage to a highly expressive mate, even with the unfortunate self-sacrifice that it requires. Some meaning-oriented interventions in couple therapy assume that the therapist's mean-

ing is correct and reflects a "knowable reality" and psychological truth. Others are 180 degrees from this position, and believe that because there is no knowable external reality, all of therapy involves the making of meanings ("co-construction of reality") rather than their discovery. For these latter approaches, "truth" is pragmatic—in other words, it is a meaning or explanatory framework that leads to clinically relevant change.

Action-oriented techniques can be further meaningfully divided into techniques that assume couple partners already have the requisite behaviors in their repertoire and those that assume that they presently lack such skills or knowledge. Action-oriented techniques involve either therapeutic directives or skills training. Directives can involve either in-session or out-of-session (often referred to as "homework tasks") actions.

Since the 1990s, there has been a strong movement within couple therapy toward combining elements of different methods, leading to the increased borrowing of techniques across scholastic lines. Some of this borrowing has been in the form of technical eclecticism—that is, using techniques presumed to be relevant and effective, without regard to the originating theories' basic assumptions or the contradictions therein contained. Other borrowing has grown out of the search for the so-called "common ingredients" of effective therapy, as discussed earlier, and has paid considerable attention to matters of conceptual clarity and coherence. In addition, the general practice of couple therapy has become increasingly more comprehensive and increasingly less doctrinaire (in the use of individual therapy plus couple therapy, couple therapy plus [child-focused] family therapy, etc.). Moreover, the field's early history of disdain for psychiatric and psychodiagnostic perspectives and practices has perceptibly changed as clinicians increasingly coordinate the use of psychopharmacological agents with flexible psychosocial treatment plans. As couple therapy has generally become more accepted in mainstream health and mental health care treatment systems, its varied methods have been increasingly combined with both other psychosocial interventions (e.g., individual psychotherapy) and other sorts (e.g., psychopharmacological) of intervention.

Curative Factors/Mechanisms of Change

You can do very little with faith, but you can do nothing without it.

—Samuel Butler

Purpose

To describe the factors, that is, mechanisms of change, that lead to change in couples and to assess their relative importance.

Points to Consider

1. Do patients need insight or understanding to be able to change? (Differentiate between historical-genetic insight and interactional insight.)
2. Is interpretation of any sort important and, if so, does it take history into account? If interpretation is used, is it seen as reflecting a psychological "reality" or is it viewed rather as a pragmatic tool for effecting change, shifting perceptions or attributions, and so forth?
3. Is the learning of new interpersonal skills seen as important? If so, are these skills taught in didactic fashion, or are they shaped as approximations occur naturalistically in treatment?
4. Does the therapist's personality or psychological health play an important part in the process and outcome of therapeutic approach?
5. What other therapist factors are likely to influence the course and outcome of your approach? Are certain kinds of therapists ideally suited to work according to this approach? Are there others for whom the approach is probably a poor "fit"?
6. What other factors influence the likelihood of successful treatment in your approach?
7. How important are techniques compared to the patient–therapist relationship?
8. Must each member of the couple change? Is change in an "identified patient" (where relevant) possible without interactional or systemic change? Does systemic change necessarily lead to change in symptoms and vice versa?

A major controversy in individual psychotherapy and, more recently, in couple therapy (Simon, 2006; Sprenkle & Blow, 2004) is whether change is brought about more by specific ingredients of therapy or factors common to all therapies. "Specific ingredients" usually refer to specific technical interventions, such as communication training, paradoxical injunctions, cognitive reframing, interpretations, or empathic responding, which are said to be the ingredient(s) responsible for clinical change. At times, these techniques are detailed in manuals to which the clinician is expected to adhere to achieve the desired result. The specific

ingredient approach is in keeping with a more "medical" model of therapy, insofar as one treats a particular disorder, or particular interaction pattern, with a psychological technique (akin to administering a pill), producing the psychological rough equivalent of a biological effect. Followers of the EST movement are typically adherents of this approach, advocating specific modes of intervention for different forms of psychopathology.

"Common factors" refers to features of couple therapy that are not specific to any one approach. Because outcome studies comparing different therapies have found few differences among the common different extant therapies, it has been inferred that this finding is due to the importance of therapeutic factors common to the various therapies. Thus, instead of running "horse race" research to discern differences among the therapies, proponents argue that effort should be redirected to their commonalities. These include client factors, such as positive motivation and expectation for change; therapist qualities, such as warmth, ability to form good alliances, and empathic attunement; and structural features of the treatment, such as the provision of a rationale for a person's suffering and having a coherent theoretical framework for interventions.

Moreover, as Sexton et al. (2008) have recently emphasized, there is a very great need within both the research and conceptual realms of couple therapy to further our understanding of core intervention principles that "transcend the treatment methods that are available today for classification" as has been attempted within individual psychotherapy (Beutler, 2003). These core principles "facilitate meaningful change across therapeutic methods" (Sexton et al., 2008). For example, a core change mechanism in couple therapy may involve a changed experience of one's partner that leads to an increased sense of emotional safety and collaboration. Such a change might be activated by the use of techniques from such varied therapy models as cognitive-behavioral (e.g., reattribution methods), object relations (e.g., interpretations used to disrupt projective processes), and emotionally focused therapy (e.g., restructuring interactions by accessing unacknowledged emotions in problematic partner cycles).

Treatment Applicability and Empirical Support

If all the evidence as you receive it leads to but one conclusion, don't believe it.

—Molière

All who drink this remedy recover in a short time, except those whom it does not help, who all die and have no relief from any other medicine. Therefore, it is obvious that it fails only in incurable cases.

—Galen

Purpose

To describe those couples for whom your approach is particularly relevant and to summarize existing research on the efficacy and/or effectiveness of your approach.

Points to Consider

1. For what couples is this approach particularly relevant? For example, is it relevant for couples in which one partner has a medical or psychiatric disorder as well as for couples with primarily "relational" concerns?
2. For what couples is this approach either not appropriate or of uncertain relevance (e.g., is it less relevant for severely disturbed couples or couples with a seriously disturbed member, for couples with nontraditional relationship structures, etc.)? Why?
3. When, if ever, would a referral be made for either another (i.e., different) type of couple therapy, or for an entirely different treatment (e.g., individual therapy, drug therapy)?
4. Are there aspects of this approach that raise particular ethical and/or legal issues that are different from those raised by psychotherapy in general?
5. How is the outcome of therapy in this model usually evaluated in clinical practice? Is there any empirical evidence of the efficacy or effectiveness of your approach?

In the end, questions about the applicability, relevance, and helpfulness of particular couple therapy approaches to particular kinds of problems, issues, and symptoms are best answered through painstaking research on treatment efficacy (as determined through randomly controlled trials) and treatment effectiveness (field studies). Testimonials, appeals to established authority and tradition, and similar unsystematic methods, are insufficient to the task. Couple therapy is too complex to track the interaction among, and impact of, the most relevant factors in therapeutic outcomes via individuals' participation in the process alone. Moreover, the contributions to therapeutic outcomes of thera-

pist, patient, and technique factors probably vary from one approach to another.

If Galen's observations about presumptively curative medicines are applied to couple therapy nowadays, they are likely to be met with a knowing chuckle and implicit recognition of the inherent limits of all of our treatment approaches. Still, new therapy approaches rarely, if ever, make only modest and restrained claims of effectiveness, issue "warning labels" to "customers" for whom their ways of working are either not likely to be helpful or may possibly be harmful, or suggest that alternative approaches may be more appropriate under certain conditions.

If couple therapy methods continue to grow in number, the ethical complexities of the field may also grow. There are generic kinds of ethical matters that couple therapists of all persuasions must deal with (confidentiality, adequacy of record keeping, duty to warn, respecting personal boundaries regarding dual relationships, etc.). Multiperson therapies, such as couple therapy, raise practical ethical matters that do not emerge in more traditional modes of practice, for example, balancing the interests and needs of more than one person against the interests and needs of another person, all the while also trying to help maintain the very viability of the patient system (e.g., marriage) itself.

Such potential influences of new perspectives on ethical concerns in psychotherapy are perhaps nowhere more readily and saliently seen than when matters involving cultural diversity are considered. Certainly, all couple therapists must be sensitive in their work to matters of race, ethnicity, social class, gender, sexual orientation, and religion, adapting and modifying both their assessment and treatment-planning activities, and perspectives and intervention styles as deemed functionally appropriate to the situation at hand (Hayes & Toarmino, 1995). To do otherwise would risk the imposition, wittingly or unwittingly, of the therapist's own values onto the patient (e.g., in terms of the important area of setting goals for their work together).

A culture-sensitive/multicultural theoretical orientation has been predicted by experts in the field of psychotherapy (Norcross, Hedges, & Prochaska, 2002) to become one of the most widely employed points of view in the next decade. And feminism, which, as noted earlier, shares many philosophical assumptions with multiculturalism, is also predicted to show an increasing impact on psychotherapy (Norcross et al., 2002). Together, these modern perspectives have usefully challenged many normative assumptions and practices in the general field of psychotherapy, forcing the field to recognize the diversity of social and psychological experience and the impact of relevant broader social beliefs that often confuse clinical description with social prescription. Critiques of various psychotherapies from these contemporary perspectives have sensitized the therapist to the potential constraining and even damaging effects of a failure to recognize the reality of one's own necessarily limited perspective. Certainly, couple therapists have also become deeply involved in such social and therapeutic analyses and critiques, as discussed in the earlier historical overview of the field.

It must be recognized, nonetheless, that such critiques of established therapeutic, including couple therapeutic, worldviews do not necessarily provide clear guidelines about the ways in which culture-sensitive and gender-sensitive therapists should actually practice couple therapy. As Hardy and Laszloffy (2002) noted, a multicultural perspective "is not a set of codified techniques or strategies … but rather a philosophical stance that significantly informs how one sees the world in and outside of therapy" (p. 569). Relatedly, Rampage (2002) has stated that "how to *do* feminist therapy is much less well understood than is the critique of traditional … therapy" (p. 535).

Like other attitudes, perspectives and worldviews, multiculturalism and feminism, then, are not clinical couple methodologies to be taught and refined. As couple therapists of all theoretical orientations strive to enhance their awareness of and sensitivity to the kinds of societal concerns brought to their attention by such modern perspectives, it is ethically incumbent on them to focus on the larger lesson of these perspectives. This larger lesson is that their responsibility and primary loyalty are to their clients, not their theories, strategies, or techniques.

COUPLE THERAPY AND THE PROBLEMS OF INDIVIDUALS

This last point about the primary clinical responsibility of couple therapists leads to a brief consideration of another extremely important issue.

Given that couple therapists generally have had little to say about the treatment of many common, diagnosable adult psychiatric/psychological disorders, it is ironic that these disorders have recently come to comprise one of the most scien-

tifically based areas of clinical practice in the entire couple–family therapy field. Recognizing the existence of real psychiatric disorders has not, as some in the couple–family therapy field feared, led to a negation of the relevance of couple therapy. Rather, as discussed in the earlier historical overview, by drawing upon the canons of traditional scientific methodology, clinical researchers have actually enhanced the credibility of couple therapy interventions for these problems.

Research on the couple treatment of such disorders in the last decade has shown strikingly that individual problems and relational problems influence each other reciprocally. These data have important implications for what is still perhaps the most controversial issue in the realm of systems-oriented treatment of psychiatric disorders, that is, whether individual problems are functional for relationships. Neil Jacobson and I suggested in the first edition of this *Handbook* that the more appropriate form of the question might be "*When* do symptoms serve such functions?" A thoughtful reading of several of the chapters in this volume seems to confirm, as suggested earlier, that some individual symptoms (1) seem often to serve interpersonal functions; (2) seem rarely to serve interpersonal functions; and (3) are quite variably interpersonally functional. Recent research has confirmed what some of us in the field (e.g., Gurman et al., 1986) have long asserted, against prevailing clinical wisdom, that functions are dangerously confused with consequences.

The Science and Practice of Couple Therapy

The process of being scientific does not consist of finding objective truths. It consists of negotiating a shared perception of truths in respectful dialogue.

—Robert Beavers

As in the broader world of psychotherapy, there is a long history of disconnection between couple therapy practitioners and couple therapy researchers. Researchers typically criticize clinicians for engaging in practices that lack empirical justification, and clinicians typically criticize researchers as being out of touch with the complex realities of working with couples. Though reflecting caricatured positions, such characterizations on both sides are unfortunately not entirely unwarranted.

The broader world of psychotherapy has seen an increased pressure placed on the advocates of particular therapeutic methods to document both the efficacy of their approaches through carefully controlled clinical research trials and the effectiveness of these methods via patient evaluations in uncontrolled, naturalistic clinical practice contexts. This movement to favor ESTs has even more recently been challenged by a complementary movement of psychotherapy researchers who assert the often overlooked importance of ESRs (Norcross, 2002).

At the risk of oversimplification, ESTers tend to be associated with certain theoretical orientations (e.g., behavioral, cognitive, cognitive-behavioral) and styles of practice (brief), whereas ESRers tend to be associated with other theoretical orientations (e.g., object relations, person-centered, experiential, existential–humanistic), with still other influential approaches (e.g., integrative, pluralistic) standing somewhere in the middle.

The questions raised by such unfortunately competing points of view are not at all insignificant:

1. Will ESTs, which tend to emphasize technical refinement, symptomatic change, and changes in presenting problems, not only survive, but thrive?
2. Will ESR-oriented approaches, which tend to emphasize enhancing client resources and resilience, and self-exploration and personal discovery, fade from view?
3. Will the influence of brief approaches continue to expand, while the influence of long-term approaches continues to contract?
4. Can research better inform us how not only to disseminate effective couple therapy methods, but also to better identify effective couple therapists?
5. Can both qualitative and quantitative research methods be brought to bear on theoretically and clinically important questions, or will they, like researchers and clinicians, tend to operate quite independently?

In the end, the field of couple therapy will benefit by fostering more evidence-based practice, without prematurely limiting the kinds of evidence that may help to inform responsible practice.

CONCLUSION

Start at the beginning, proceed through the middle, and stop when you get to the end.

—Lewis Carroll, *Alice in Wonderland*

REFERENCES

Ackerman, N. W. (1970). Family psychotherapy today. *Family Process*, *9*, 123–126.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Aponte, H. (1992). The black sheep of the family: A structural approach to brief therapy. In S. H. Budman, M. Hoyt, & S. Friedman (Eds.), The first session in brief therapy (pp. 324–341). New York: Guilford Press.

Beels, C. C., & Ferber, A. (1969). Family therapy: A view. *Family Process*, *8*, 280–318.

Beutler, L. E. (2003). David and Goliath: When empirical and clinical standards of practice meet. *American Psychologist*, *55*, 997–1007.

Bogdan, J. (1984). Doctor Pangloss as family therapist. *Family Therapy Networker*, 8(2), 19–20.

Bowen, M. (1978). *Family therapy in clinical practice*. New York: Aronson.

Budman, S. H., & Gurman, A. S. (1988). *The theory and practice of brief therapy*. New York: Guilford Press.

Cassidy, J., & Shaver, P. (Eds.). (1999). *Handbook of attachment: Theory, research, and clinical applications*. New York: Guilford Press.

Christensen, A., Jacobson, N. S., & Babcock, J. (1995). Integrative behavioral couple therapy. In N. S. Jacobson & A. S. Gurman (Eds.), *Clinical handbook of couple therapy* (2nd ed., pp. 31–64). New York: Guilford Press.

Dicks, H. V. (1967). *Marital tensions*. New York: Basic Books.

Doherty, W. J., & Simmons, D. S. (1996). Clinical practice patterns of marriage and family therapists: A national survey of therapists and their clients. *Journal of Marital and Family Therapy*, *22*, 9–25.

Donovan, J. (Ed.). (1999). *Short-term couple therapy*. New York: Guilford Press.

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

Framo, J. L. (1965). Rationale and techniques of intensive family therapy. In I. Boszormenyi-Nagy & J. L. Framo (Eds.), *Intensive family therapy* (pp. 143–212). New York: Harper & Row.

Framo, J. L. (1981). The integration of marital therapy with sessions with family of origin. In A. S. Gurman & D. P. Kniskern (Eds.), *Handbook of family therapy* (pp. 133–158). New York: Brunner/Mazel.

Framo, J. L. (1996). A personal retrospective of the family therapy field: Then and now. *Journal of Marital and Family Therapy*, *22*, 289–316.

Frank, J. D., & Frank, J. B. (1991). *Persuasion and healing*. Baltimore: Johns Hopkins University Press.

Geiss, S. K., & O'Leary, K. D. (1981). Therapist ratings of frequency and severity of marital problems: Implications for research. *Journal of Marital and Family Therapy*, *9*, 515–520.

Gottman, J. M. (1994a). *What predicts divorce?* Hillsdale, NJ: Erlbaum.

Gottman, J. M. (1994b). *Why marriages succeed or fail*. New York: Simon & Schuster.

Gottman, J. M. (1998). Psychology and the study of marital processes. *Annual Review of Psychology*, *49*, 169–197.

Gottman, J. M. (1999). *The marriage clinic: A scientifically based marital therapy*. New York: Norton.

Gurman, A. S. (1971). Group marital therapy: Clinical and empirical implications for outcome research. *International Journal of Group Psychotherapy*, *21*, 174–189.

Gurman, A. S. (1973). The effects and effectiveness of marital therapy: A review of outcome research. *Family Process*, *12*, 145–170.

Gurman, A. S. (1978). Contemporary marital therapies: A critique and comparative analysis of psychoanalytic, behavioral and systems theory approaches. In T. Paolino & B. McCrady (Eds.), *Marriage and marital therapy* (pp. 445–566). New York: Brunner/Mazel.

Gurman, A. S. (1981). Integrative marital therapy: Toward the development of an interpersonal approach. In S. H. Budman (Ed.), *Forms of brief therapy* (pp. 415–462). New York: Guilford Press.

Gurman, A. S. (1990). Integrating the life of an integrative family psychologist. In F. Kaslow (Ed.), *Voices in family psychology* (Vol. 2, pp. 250–266). Newbury Park, CA: Sage.

Gurman, A. S. (1992). Integrative martial therapy: A time-sensitive model for working with couples. In S. Budman, M. Hoyt, & S. Friedman (Eds.), *The first session is brief therapy* (pp.186–203). New York: Guilford Press.

Gurman, A. S. (2001). Brief therapy and family/couple therapy: An essential redundancy. *Clinical Psychology: Science and Practice*, *8*, 51–65.

Gurman, A. S. (2002). Brief integrative marital therapy: A depth-behavioral approach. In A. S. Gurman & N. S. Jacobson (Eds.), *Clinical handbook of couple therapy* (pp. 180–220). New York: Guilford Press.

Gurman, A. S., & Fraenkel, P. (2002). The history of couple therapy: A millennial review. *Family Process*, *41*, 199–260.

Gurman, A. S., & Jacobson, N. S. (1985). Marital therapy: From technique to theory, back again, and beyond. In N. S. Jacobson & A. S. Gurman (Eds.), *Clinical handbook of marital therapy* (pp. 1–9). New York: Guilford Press.

Gurman, A. S., & Jacobson, N. S. (1995). Therapy with couples: A coming of age. In N. S. Jacobson & A. S. Gurman (Eds.), *Clinical handbook of couple therapy* (2nd ed., pp. 1–6). New York: Guilford Press.

Gurman, A. S., & Kniskern, D. P. (1978a). Deterioration in marital and family therapy: Empirical, clinical and conceptual issues. *Family Process*, *17*, 3–20.

Gurman, A. S., & Kniskern, D. P. (1978b). Research on marital and family therapy: Progress, perspective and prospect. In S. L. Garfield & A. E. Bergin (Eds.),

Handbook of psychotherapy and behavior change (2nd ed., pp. 817–901). New York: Wiley.

Gurman, A. S., & Kniskern, D. P. (1981). Family therapy outcome research: Knowns and unknowns. In A. S. Gurman & D. P. Kniskern (Eds.), *Handbook of family therapy* (pp. 742–773). New York: Brunner/Mazel.

Gurman, A. S., & Kniskern, D. P. (Eds.). (1991). *Handbook of family therapy*. New York: Brunner/Mazel.

Gurman, A. S., Kniskern, D. P., & Pinsof, W. (1986). Process and outcome research in family and marital therapy. In A. E. Bergen & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (3rd ed., pp. 565–624). New York: Wiley.

Gurman, A. S., & Messer, S. B. (2003). Contemporary issues in the theory and practice of psychotherapy. In A. S. Gurman & S. B. Messer (Eds.), *Essential psychotherapies* (2nd ed., pp. 1–23). New York: Guilford Press.

Haley, J. (1963). Marriage therapy. *Archives of General Psychiatry*, *8*, 213–234.

Haley, J. (1976). *Problem-solving therapy*. San Francisco: Jossey-Bass.

Haley, J. (1984). Marriage or family therapy. *American Journal of Family Therapy*, *12*, 3–14.

Hardy, R. V., & Laszloffy, T. A. (2002). Couple therapy using a multicultural perspective. In A. S. Gurman & N. S. Jacobson (Eds.), *Clinical handbook of couple therapy* (3rd ed., pp. 569–593). New York: Guilford Press.

Hayes, S. C., & Toarmino, D. (1995, February). If behavioral principles are generally applicable, why is it necessary to understand cultural diversity? *Behavior Therapist*, pp. 21–23.

Jacobson, N. S., & Margolin, G. (1979). *Marital therapy: Strategies based on social learning and behavior exchange principles*. New York: Brunner/Mazel.

Jacobson, N. S., & Martin, B. (1976). Behavioral marriage therapy: Current status. *Psychological Bulletin*, *83*, 540–566.

Jackson, D. D. (1965a). Family rules: The marital quid pro quo. *Archives of General Psychiatry*, *4*, 589–594.

Jackson, D. D. (1965b). The study of the family. *Family Process*, *4*, 1–20.

Johnson, S. M., & Denton, W. (2002). Emotionally focused couple therapy: Creating secure connections. In A. S. Gurman & N. S. Jacobson (Eds.), *Clinical handbook of couple therapy* (3rd ed., pp. 221–250). New York: Guilford Press.

Johnson, S. M., & Lebow, J. (2000). The "coming of age" of couple therapy: A decade review. *Journal of Marital and Family Therapy*, *26*, 23–28.

Johnson, S. M., & Whiffen, V. (Eds.). (2003). *Attachment processes in couple and families*. New York: Guilford Press.

Keeney, B. P., & Sprenkle, D. H. (1982). Eco-systemic epistemology: Critical implications for aesthetics and pragmatics of family therapy. *Family Process*, *21*, 1–19.

Lebow, J. (1997). The integrative revolution in couple and family therapy. *Family Process*, *36*, 1–17.

Lebow, J. L., & Gurman, A. S. (1995). Research assessing couple and family therapy. *Annual Review of Psychology*, *46*, 27–57.

Madanes, C. (1980). Marital therapy when a symptom is presented by a spouse. *International Journal of Family Therapy*, *2*, 120–136.

Manus, G. (1966). Marriage counseling: A technique in search of a theory. *Journal of Marriage and the Family*, *28*, 449–453.

Meltzoff, J., & Kornreich, M. (1970). *Research in psychotherapy*. New York: Atherton.

Messer, S. B., & Wachtel, P. L. (1997). The contemporary psychotherapeutic landscape: Issues and prospects. In P. C. Wachtel & S. B. Messer (Eds.), *Theories of psychotherapy: Origins and evolution* (pp. 1–38). Washington, DC: American Psychological Association.

Messer, S. B., & Winokur, M. (1984). Ways of knowing and visions of reality in psychoanalytic therapy and behavior therapy. In H. Arkowitz & S. B. Messer (Eds.), *Psychoanalytic therapy and behavior therapy: Is integration possible?* (pp. 53–100). New York: Plenum.

Mudd, E. H. (1957). Knowns and unknowns in marriage counseling research. *Marriage and Family Living*, *19*, 75–81.

Nichols, M. P. (1987). *The self in the system*. New York: Brunner/Mazel.

Nichols, M. P., & Schwartz, R. C. (1998). *Family therapy: Concepts and methods*. Boston: Allyn & Bacon.

Norcross, J. C. (Ed.). (2002). *Psychotherapy relationships that work*. New York: Oxford University Press.

Norcross, J. C., Hedges, M., & Prochaska, J. (2002). The face of 2010: A Delphi poll on the future of psychotherapy. *Professional Psychology*, *33*, 316–322.

Norcross, J. C., & Prochaska, J. (1983). A study of eclectic (and integrative) views revisited. *Professional Psychology*, *19*, 170–174.

Olson, D. H. (1970). Marital and family therapy: Integrative review and critique. *Journal of Marriage and the Family*, *32*, 501–538.

Pinsof, W. M. (1995). *Integrative problem-centered therapy*. New York: Basic Books.

Pinsof, W. M. (2002). The death of til death do us part: The twentieth century's revelation of the limits of human pair-bonding. *Family Process*, *41*, 133–157.

Rampage, C. (2002). Working with gender in couple therapy. In A. S. Gurman & N. S. Jacobson (Eds.), *Clinical handbook of couple therapy* (3rd ed., pp. 533–545). New York: Guilford Press.

Sager, C. J. (1966). The development of marriage therapy: An historical overview. *American Journal of Orthopsychiatry*, *36*, 458–467.

Sager, C. J. (1976). *Marriage contracts and couple therapy*. New York: Brunner/Mazel.

Satir, V. (1964). *Conjoint family therapy*. Palo Alto, CA: Science and Behavior Books.

Scharff, J. S., & Bagnini, C. (2003). Object relations couple therapy. In A. S. Gurman & N. S. Jacobson (Eds.), *Clinical handbook of couple therapy* (3rd ed., pp. 59–85). New York: Guilford Press.

Schwartz, R., & Johnson, S. M. (2000). Commentary: Does couple and family therapy have emotional intelligence? *Family Process*, *39*, 29–33.

Sexton, T. L., Gordon, K. C., Gurman, A. S., Lebow, J. C., Holtzworth-Munroe, A., & Johnson, S. M. (2008). *Guidelines for evidence-based treatments in family psychology*.

Simmons, D. S., & Doherty, W. J. (1995). Defining who we are and what we do: Clinical practice patterns of marriage and family therapists in Minnesota. *Journal of Marital and Family Therapy*, *21*, 3–16.

Simon, G. M. (2006). The heart of the matter: A proposal for placing the self of the therapist at the center of family therapy research and training. *Family Process*, *45*, 331–344.

Skynner, A. C. R. (1976). *Systems of family and marital psychotherapy*. New York: Brunner/Mazel.

Skynner, A. C. R. (1980). Recent developments in marital therapy. *Journal of Family Therapy*, *2*, 271–296.

Skynner, A. C. R. (1981). An open-systems, group analytic approach to family therapy. In A. S. Gurman & D. P. Kniskern (Eds.), *Handbook of family therapy* (pp. 39–84). New York: Brunner/Mazel.

Snyder, D. K. (1999). Affective reconstruction in the context of a pluralistic approach to couple therapy. *Clinical Psychology: Science and Practice*, *6*, 348–365.

Snyder, D. K., & Schneider, W. J. (2002). Affective reconstruction: A pluralistic, developmental approach. In A. S. Gurman & N. S. Jacobson (Eds.), *Clinical handbook of couple therapy* (3rd ed., pp. 151–179). New York: Guilford Press.

Sprenkle, D. H., & Blow, A. J. (2004). Common factors and our sacred models. *Journal of Marital and Family Therapy*, *30*, 113–129.

Stuart, R. B. (1969). Operant–interpersonal treatment of marital discord. *Journal of Consulting and Clinical Psychology*, *33*, 675–682.

Stuart, R. B. (1980). *Helping couples change: A social learning approach to marital therapy*. New York: Guilford Press.

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods and findings*. Mahwah, NJ: Erlbaum.

Whisman, M. A., Dixon, A. E., & Johnson, B. (1997). Therapists' perspectives of couple problems and treatment issues in couple therapy. *Journal of Family Psychology*, *11*, 361–366.

Wynne, L. C. (1983). Family research and family therapy: A reunion? *Journal of Marital and Family Therapy*, *9*, 113–117.

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