A recent survey (Norcross, Pfund, & Prochaska, 2013) of expert psychotherapists’ predictions about future practices in psychotherapy showed couple therapy to be the format likely to achieve the most growth in the next decade, surpassing individual, family, and group treatment. This finding is all the more interesting in that very few of the experts polled were themselves couple (or family) therapists. Clearly, but not surprisingly, couple therapy has flourished in the last two decades. Important cultural changes in the last half-century have had a major impact on the expectations and experiences of people who marry or enter other long-term committed relationships. Reforms in divorce law, more liberal attitudes about sexual expression and same-sex relationships, increased availability of contraception, and the growth of women’s economic and political power have all increased the expectations and requirements of close relationships to go well beyond maintaining economic viability and assuring procreation. Committed relationships are 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 transformation of marital expectations has led the “shift from death to divorce” as the primary terminator of marriage (Pinsof, 2002, p. 139).

With such changing expectations, the public health importance of the “health” of marriage and other committed relationships has understandably increased. Whether through divorce or through chronic conflict and distress, the breakdown of intimate relationships exacts enormous costs. Recurrent couple conflict and relationship dissolution are associated with a wide variety of problems in both adults and children (Whisman & Uebelacker, 2003, 2006). Divorce and couple problems are among the most stressful conditions people face. Partners in troubled relationships are more likely to suffer from anxiety, depression, and substance abuse; both acute and chronic medical problems and disabilities, such as impaired immunological functioning and high blood pressure; and accident-proneness and health risk behaviors associated with sexually transmitted diseases. Moreover, the children of distressed marriages are more likely to suffer from anxiety, depression, conduct problems, and impaired physical health (Snyder, Castellani, & Whisman, 2006).

Although both physical and psychological health are affected by couple satisfaction and
health, there are more common reasons why couples enter 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 (Doss, Simpson, & Christensen, 2004; Whisman, Dixon, & Johnson, 1997).

It is in this evolving context that the fifth edition of this volume presents the central theoretical and applied aspects of couple therapy. There are two distinct categories of couple therapies. The first includes those originating early in the history of the broader field of family therapy. Although core attributes of these methods have endured over several generations of systems-oriented therapists, they have been revised and refined considerably. Examples of such time-honored approaches are structural (Chapter 13), brief strategic (Chapter 12), object relations (Chapter 8), and Bowen’s (Chapter 9) approaches. Couple therapies also include a second wave of more recent approaches developed within the last few decades that have become very influential in practice, training, and research—for example, cognitive-behavioral (Chapter 2) and integrative behavioral (Chapter 3); narrative (Chapter 10) and solution-focused (Chapter 11); emotionally focused (Chapter 4) and Gottman’s (Chapter 5); and integrative (Chapters 6 and 7) approaches.

Whether discussing earlier- or later-generation approaches, the contributors of chapters in Part I of this Handbook (“Models of Couple Therapy”) offer a clear sense of the history, current status, assessment approach, evidence base, and methods of the therapy being discussed, with their foundational ideas about relational health and dysfunction. The validity of the old adage that “there is nothing as practical as a good theory” endures.

Part II of the Handbook (“Applications of Couple Therapy: Special Populations, Problems, and Issues”) includes chapters focusing on common clinical problems that are either inherently relational (affairs, separation/divorce, and partner aggression) on the one hand, or still often viewed today as the problems of individuals (alcohol problems, depression, posttraumatic stress disorder, borderline personality disorder, sexual dysfunction, and medical issues) on the other. Other chapters focus on alternative forms of couple relationships (stepfamily couples and same-sex couples), as well as topics such as interpersonal neurobiology.

**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, but our own nets in which we try to catch the real world.

—KARL POPPER

This edition of the Handbook, like its predecessors, is organized around a set of guidelines for authors (especially those in Part I). These guidelines are presented here, with discussion of the rationale for inclusion of the content addressed within each section. Italicized questions below indicate content required of chapter authors. These (modified) guidelines, which have been included in every edition of the Handbook, have provided a valuable template for the comparative study of different approaches to couple therapy.

**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 within both 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 (e.g., 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 or family therapy?
3. Early theoretical principles and/or therapy techniques.
4. Sources of more recent changes in the evolution of the model (e.g., research findings from neuroscience, therapy outcome, or therapy process research).

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. Without such awareness, the student of couple therapy may find theories to be disembodied abstractions that seem to have evolved from nowhere, and for no known reason. Each therapist’s choice of a theoretical orientation ultimately reflects a personal process. An important aspect of a therapist’s ability to help people change lies not only in his or her belief in the technical aspects of the chosen orientation, but also in the worldview implicit in it (Gurman, 2011; Simon, 2006). Exposure to the historical origins of a therapeutic approach helps clinicians comprehend such an implicit worldview.

In addition to appreciating the 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 intellectual movement that extends well beyond the realm of external reality, arguing that all knowledge is provisional (Gurman & Snyder, 2011, for more detailed discussion of one’s education as a therapist. Without such awareness, the student of couple therapy may find theories to be disembodied abstractions that seem to have evolved from nowhere, and for no known reason. Each therapist’s choice of a theoretical orientation ultimately reflects a personal process. An important aspect of a therapist’s ability to help people change lies not only in his or her belief in the technical aspects of the chosen orientation, but also in the worldview implicit in it (Gurman, 2011; Simon, 2006). Exposure to the historical origins of a therapeutic approach helps clinicians comprehend such an implicit worldview.

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A Brief History of Couple Therapy

Couple therapy has evolved through several rather distinct phases (see Gurman & Fraenkel, 2002; Gurman & Snyder, 2011, for more detailed discussions of the history of the field). In the “Atheoretical Marriage Counseling Formation” phase (c. 1930–1963), “marriage counseling,” as it was called, was practiced by service-oriented professionals (e.g., obstetricians, gynecologists, family life educators, clergy) who today would not be considered “mental health experts.” Provided to clients who were neither severely maladjusted nor struggling with diagnosable psychological disorders, marriage counseling often had a strong value-laden core of advice giving and “guidance” about proper family and marital roles and life values. It was typically very brief and didactic, present-focused, and limited to conscious experience.

Conjoint therapy, the dominant format in which couple therapy is now practiced, was not common until the mid- to late-1960s, during the phase (c. 1931–1966) of “Psychoanalytic Experimentation” that, at different times, both paralleled and intersected the “Atheoretical” period. Marriage counseling, having no theory or technique of its own to speak of (Manus, 1966), grafted onto itself a loosely held-together array of ideas and interventions from what was then the only generally influential approach to psychotherapy (i.e., psychoanalysis). Novices to the world of couple therapy may find it 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 seems to be the self-evident limitations of trying to help dysfunctional couples by working with individuals (Gurman & Burton, 2014), risked expulsion from psychoanalytic societies by meeting jointly with members of the same family—a forbidden practice. Their focus was on the “interlocking neuroses” of married partners. Marriage counseling, marginalized by both psychoanalysis and the field of clinical psychology that emerged after World War II, was understandably attempting to attach itself to the most prestigious “peer” group it could. Unfortunately, it had “hitched its wagon not to a rising star, but to the falling star of psychoanalytic marriage therapy” (Gurman & Fraenkel, 2002, p. 207), which was largely about to evaporate in the blazing atmosphere of the rapidly emerging revolutionary psychotherapy movement known as family therapy.

The “Family Therapy Incorporation” phase (c. 1963–1985) was deadly for the stagnating field of marriage counseling. The majority of the early pioneers and founders of family therapy (e.g., Ivan Boszormenyi-Nagy, Murray Bowen, Don Jackson, Salvador Minuchin, Carl Whitaker, Lyman Wynne) were psychiatrists (many, not surprisingly, with formal psychoanalytic training) who had become disaffected with the psychiatric establishment because of its conservatism about exploring new models of understanding and treating psychological disturbance. These leaders railed against the individually oriented Zeitgeist of psychoanalytic thought and what they viewed as unwar-
ranted pathologizing of individuals in relational contexts. In distancing themselves from psychoanalytic circles, they inevitably left the marriage counselors behind. Haley (1984) caustically argued that there was not “a single school of family therapy which had its origin in a marriage counseling group” (p. 6). Capturing the implicit views of other leaders within family therapy, he also 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” (c. 1975–1985) (Nichols & Schwartz, 1998, p. 8), marriage counseling and therapy (e.g., Sager, 1976) became functionally invisible.

**Early Influential Voices in the Field**

Four early voices in family therapy had significant short- and long-term influence on clinical work with couples. Don Jackson (1965)—a psychiatrist trained in Sullivanian 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 bind,” “family homeostasis,” and “family rules.” The “marital quid pro quo” became a cornerstone concept in couple therapy, linking interactional aspects of couple life with aspects of individual self-concept.

Another seminal clinical thinker was Virginia Satir (1964), the only visible woman pioneer in the couple/family therapy field. Her eclectic therapy, like many current approaches, emphasized both relational skills and connections; she was always aware of what Nichols (1987) referred to as “the self in the system.” She was both a humanistic healer and a wise practical teacher, urging self-expression, self-actualization, and relational authenticity. Sadly, for the field of couple (and family) therapy, Satir’s views were marginalized by more “male” therapeutic values such as rationality and power. Indeed, she was even referred to by a senior colleague in family therapy as a “naive and fuzzy thinker” (Nichols & Schwartz, 1998, p. 122). It would not be for about 20 years, following a 1994 debate with one of the world’s most influential family therapists who criticized her for her humanitarian zeal, that there would emerge new approaches to couple therapy that valued affect and attachment (Schwartz & Johnson, 2000).

Murray Bowen was the first family therapy theorist to address multigenerational matters with couples. Although his early contributions emphasized unlocking the relational dimensions of schizophrenia, his most enduring contributions may center on the marital dyad. Bowen family systems theory (Chapter 9) emphasized blocking pathological multigenerational transmission processes by enhancing partners’ differentiation, and drew attention to the ways in which distressed couples intuitively recruit in (“triangulate”) third forces (e.g., an affair partner) to stabilize a dyad in danger of spinning out of control. Unlike Satir, Bowen operated from a stance of an 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” (1978, p. 177). Bowen died in 1990, leaving behind a rich conceptual legacy, but a relatively small number of adherents to his theories.

The “golden age” family therapist whose work had the most powerful impact on the practice of couple therapy was Jay Haley. His 1963 article, succinctly titled “Marriage Therapy,” marked the defining moment at which family therapy usurped what little was left in the stalled-out marriage counseling and psychodynamic marriage therapy domains. That article, and many subsequent writings, challenged virtually every aspect of psychodynamic and humanistic couple therapies. It disavowed widespread beliefs about the nature of marital functioning and conflict, what should constitute the focus of therapy, the role of the therapist, and the nature of preferred therapeutic techniques.

For Haley, the central marital dynamic of relationship concerns involved power and control: “The major conflicts in marriage center in the problem of who is to tell whom what to do under what circumstances” (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 on the symptom of one person, power was at issue, and the “hierarchical incongruity” of the symptomatic partner was central, as the symptom bearer was assumed to have gained an equalization of marital power through his or her difficulties. Symptoms were seen as ways to define relationships and as metaphors for and diversions from problems that were too painful to address explicitly.

Thus symptoms of individuals in marriage, as well as explicit relationship concerns, were seen as mutually protective and as serving “functions”
for the dyad. Therefore, resistance to change was seen as almost inevitable, leading to Haley’s (1963) “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 change” (p. 234). His view of the tendency of couple systems to resist change led to the position that the therapist, in attempting to induce change, often must work indirectly. For Haley, 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 was largely downplayed.

Also viewed negatively by Haley were common and theretofore unchallenged clinical beliefs such as the importance of discussing the past (“It is a good idea to avoid the past . . . because marital partners are experts at debating past issues” [p. 166]); 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]); and the usefulness of interpretation (“the therapist should not make any interpretation or comment to help the person see the problem differently” [p. 28]). Haley valued the expression of feelings in a very particular way—that is, not for reasons common to other therapies (e.g., catharsis), but because expressing emotion in a new way within a relationship would lead the partner in turn to respond in a new way. The expression of feelings was not for the enhancement of attachment through safe self-disclosure. The therapist “should not ask how someone feels about something, but should only gather facts and opinions” (p. 28).

Haley emphasized planned, pragmatic, present-focused interventions to disrupt patterns of behavior that maintained the couple’s major problem, so that symptoms or other presenting problems no longer served maladaptive purposes. Directives were the most important change-inducing tools. Some directives were straightforward, but Haley also helped to create a rich fund of indirect, resistance-oriented directives (e.g., prescribing the symptom).

Haley’s theoretical and technical contributions were enormously influential in the broad field of family and couple therapy. More than anyone else, he influenced large numbers of therapists to see family and couple dynamics as products of a “system,” rather than as features of persons. The anthropomorphizing of the 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 sum, Haley urged therapists to avoid discussing the past, resist temptations to instill insight, and downplay direct expression of feelings. As Framo (1996), an object relations-oriented family therapist, would venture three decades after Haley’s famous 1963 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. 225).

**Couple Therapy Treading Water**

Family therapy had now not merely incorporated marriage counseling and psychoanalytic couple therapy; it had engulfed, consumed, anddevoured them both. The conceptual development of couple therapy remained rather stagnant during family therapy’s “golden age.” The most influential clinical thinkers during that period were Clifford Sager (1976) and James Framo (1981), whose contributions were both in the psychodynamic realm. Although neither Sager, a psychiatrist, nor Framo, a clinical psychologist, was in a marginalized profession, their contributions, though highly respected in some circles, never had the impact they deserved in the overwhelmingly “systems-purist” (Beels & Ferber, 1969) era of family therapy. And, as noted, Satir’s humanistic–experiential emphasis struggled to maintain its currency.

**Couple Therapy Reinvigorated**

By the mid-1980s, couple therapy began to reemerge with an identity rather independent of family therapy. Couple therapy’s fourth phase (c. 1986–present), “Refinement, Extension, Diversification, and Integration,” has been a period of sustained theory and practice development and advances in clinical research on couples’ relationships and couple therapy. The “Refinement” of couple therapy over the last few decades has been noticeable in two realms. First, there has been significant growth in three therapy orientations—behavioral/cognitive-behavioral therapy, humanistic and attachment-
oriented therapy, and object relations therapy—that all derive from long-standing psychological traditions (social learning theory, humanism–existentialism, and psychodynamicism, respectively) that were never core components of the earlier family therapy movement. Relatedly, couple therapy has also been influenced by a growing research base (e.g., Gottman, 1999, 2011) never dreamed of in its formative years.

Behavioral couple therapy (BCT), launched by the work of Weiss (1975), Stuart (1969), and Jacobson and Margolin (1979), has itself passed through several conceptually distinct periods (Gurman, 2013). Its first phase emphasized skills training (e.g., communication and problem solving) and changes in overt behavior, and the therapist’s role was highly psychoeducational and directive (see Chapter 2). The second phase, marked by the development of integrative behavioral couple therapy (see Chapter 3), shifted a former emphasis on changing the other to a more balanced position of changing the self as well; this shift was marked by new interventions to facilitate the development of mutual acceptance, especially around repetitive patterns of interaction and persistent partner characteristics, that Gottman (1999) calls “perpetual issues.” The third BCT phase has expanded its clinical focus to working with “difficult” couples in which, for instance, one of the partners suffers from a significant psychiatric or medical disorder in the context of their intimate relationship, e.g., depression, an alcohol use disorder, posttraumatic stress disorder, or a bipolar disorder (Snyder & Whisman, 2003; see Chapters 20–22, this volume).

The reascendance of the humanistic tradition in psychology and psychotherapy is most evident in the attachment theory-oriented approach known as emotionally focused couple therapy (Chapter 4), which has been influenced somewhat by Satir’s views. This approach, which includes a mixture of client-centered, gestalt, and systemic interventions, fosters affective expression and immediacy, together with relational availability and responsiveness. Beyond its initial use with generic couple conflicts, this approach, like some BCT approaches, has also been applied to the treatment of “individual” problems, especially those likely to be positively influenced by an emphasis on secure interpersonal attachment (e.g., posttraumatic stress disorder).

Psychodynamically oriented approaches have reascended in recent years via two separate pathways. First, object relations theory (e.g., Dicks, 1967; see Chapter 8) has been undergoing slow but consistent development both in the United States and abroad, and has reestablished an earlier (e.g., Framo, 1965) connection with a conceptual thrust in couple and family therapy that had met with disfavor and largely died out. Second, psychodynamic concepts have reemerged in couple therapy through their incorporation into more recent integrative and pluralistic models of treatment (e.g., Gurman, 2008; Fraenkel, 2009; Snyder & Mitchell, 2008; see Chapters 6 and 7, this volume).

The second wave of refinement in couple therapy approaches has appeared in more “traditional” schools of thought that had strong early connections to the wider field of family therapy, including such varied approaches as structural (Chapter 13), brief strategic (Chapter 12), and Bowen family systems (Chapter 9) couple therapies. The most current and cutting-edge developments, modifications, and applications of these approaches are addressed in this volume.

The recent “Extension” of couple therapy refers to efforts to broaden its purview beyond helping couples with obvious relationship conflict to the treatment of individual psychological disorders. Although family therapy was initially developed in an effort to understand major mental illness (Wynne, 1983), the political fervor that characterized much of family therapy’s “golden age” curtailed attention to the study and treatment of individual psychiatric problems, even (ironically, to be sure) in familial-relational contexts. A great deal of attention in recent years has been paid to studying the role of couple factors in the etiology and maintenance of such problems, and to the use of couple therapy intervention in the management and reduction of their severity. These developments are described in several chapters in this volume (see Chapters 20–24).

“Diversification” in couple therapy has been reflected by the broadening perspectives offered by feminism, multiculturalism, and postmodernism. Feminist and multicultural perspectives have been most visible within the narrative therapy tradition. Feminism has cogently drawn attention to the many subtle ways in which the process of couple therapy is influenced by gender stereotypes of both therapists and clients—for instance, the paternalistic aspects of a hierarchical (therapist-as-expert) therapy relationship; differing partner experiences of the relationship, based on differential access to power; and different expectations regarding intimacy and autonomy (Knudson-Martin, 2008).
Multiculturalism has provided couple therapists the base for a 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. This perspective has also emphasized that norms about such issues as intimacy and the distribution and use of power vary tremendously across couples. Both the feminist and multicultural perspectives have influenced couple therapy to become more collaborative and are reflected in most of the chapters in this volume.

Finally, the postmodern perspective, seen most clearly within the narrative tradition, has introduced profoundly interesting and practically important 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” (see Chapter 10).

The “Integration” component of this phase of the evolution of couple therapy was aptly described by 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 (Spremkle, Davis, & Lebow, 2009) and the limited evidence of differential effectiveness and efficacy of various couple therapies (Lebow & Gurman, 1995). Proponents of integrative positions assert that a broad base for understanding and changing human behavior is necessary. Evolving integrative approaches allow for greater treatment flexibility and thereby potentially improve the odds of positive treatment outcomes (see Chapters 6 and 7).

Research on Couple Therapy

Despite the 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 the field. Just as Manus (1966) had 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). For decades, what little was written about treatment outcomes largely consisted of single author-clinicians reporting on their own (uncontrolled) clinical experiences.

The period from about 1975 to 1992 saw a degree of exuberance in the field, based on the appearance of the earliest comprehensive reviews of empirical research on the outcomes of couple therapy (Gurman, 1973; Gurman & Kniskern, 1978; Gurman, Kniskern, & Pinsof, 1986). Couple therapy had now established a reasonable empirical base to support its efficacy.

The most recent phase (c.1993–present) has been marked by more sophisticated and clinically relevant questions about couple therapy than earlier “Does it work?” inquiries. Studies now address questions such as these: (1) How “large” are the effects of couple therapy in terms of their everyday impact on couples? (2) How durable are these effects? (3) Are these effects sometimes negative? (4) What are the relative efficacy and effectiveness of different methods of couple therapy? (5) What therapist and couple factors predict responsiveness to treatment? (6) Is couple therapy helpful in the treatment of “individual” problems? (7) By what mechanisms and processes do couples’ relationships improve in therapy?

Four Profound Shifts

Four major shifts in couple therapy have occurred in recent times that constitute not mere trends in the field, but a profoundly altered shape of the field. First, there has been a reincorporation of the individual—a renewed interest in the psychology of the individual, which complements the nearly unilateral emphasis on relational systems that marked the field for many years. The application of findings from the field of modern neuroscience (see Chapter 26) to the practice of couple therapy provides the most recent illustration of this rebalancing, and has helped couple therapy become more genuinely “systemic.” Second, there has been greater acknowledgement of the reality of psychosocial disorders, and of the reality that such problems, while both influenced by and influencing core patterns of intimate relating, are not reducible to problems at systemic levels of analysis (see Chapters 20–24). Third, the major energies that have fueled the growth of couple therapy in the last two decades have not come 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.

The final, and ironic, shift identified by Gurman and Fraenkel (2002) is that despite its long history of struggles against marginalization and
professional disempowerment, couple therapy, with its continuing refinement of clinical theory and practice and the establishment of a strong empirical foundation, “has emerged as one of the most vibrant forces in the entire domain of family therapy and of psychotherapy-in-general” (p. 248). These developments help to explain the penetration of couple therapy into the overall practice of psychotherapy, as described in the first sentence of this chapter.

1. The Theory and Practice of Couple Therapy

THE HEALTHY/WELL-FUNCTIONING VERSUS DYSFUNCTIONAL COUPLE RELATIONSHIP

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

Purpose

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

Points to Consider

1. Does this 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 such areas as problem solving, communication, expression of affect, sexuality, the balance of individual and couple needs, the role of individual psychological health, and so on.)

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 cultural factors such as gender, ethnicity, class, and race figure significantly in this model’s understanding of couple satisfaction and functioning?

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?

The term “couple therapy” has recently replaced the historically more familiar term “marital therapy” because of its emphasis on the bond between two people, without the judgmental tone of social value implied by the traditional term. In the therapy world, the terms are used interchangeably. 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, and thus possesses significance well beyond the interactions between clients and therapists.

At the same time, couple therapy may be a barometer of those customs and outlooks. The relationship between culture and couple therapy is one of reciprocal influence. For example, a currently important cultural phenomenon affecting (some would say afflicting; see Hoyt & Gurman, 2012) the practice of couple therapy is the medicalization of psychological distress and its treatment. Biological ways of understanding and treating emotional suffering have had their effects on the practice of couple therapy. Clients and therapists are more likely to consider having medication prescribed, and psychologists and other nonmedical therapists collaborate more frequently with physicians in treating patients.

Any method of couple therapy implicitly reveals its aesthetic and moral values by how it conceptualizes mental health and psychological well-being, including relational well-being. As Messer and Gurman (2011, pp. 9–10) have noted,

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 than others.

Interestingly, while all couple therapies are attempts to change or improve some aspect of personality or problematic behavior, the majority do not include a concept of individual 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.

Given the variety of approaches to couple therapy, it is not surprising that therapists of different theoretical orientations define the core problems of couples quite differently. These range from whatever a couple presents as its problem to relationship skill 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. Clinical perspectives on what constitutes relational health versus pathology or dysfunction are no mere academic abstractions, as they influence treatment goals, therapeutic interactions, and outcome evaluation.

**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**

**Purpose**

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

**Points to Consider**

1. *Besides the couple, are children or extended family members ever included?*
2. *Are psychotropic medications ever used within this method of couple therapy? What are the indications and contraindications for such use?*
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? In this approach, what are the advantages (or disadvantages) of using cotherapists?*
5. *Is therapy typically time-limited or unlimited? How long does therapy typically last? How often are sessions typically held?*

The two central matters involved in the structure of couple therapy are these: (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.” Thus therapy with an individual that focuses on that person’s couple issues is individual therapy about the couple. It is not therapy of the couple, though it may be conducted in such a way as to be systematically aware and contextually sensitive (Gurman & Burton, 2014).

Although nonpartners are not commonly included in couple therapy, configurations other than two partners plus one therapist (or two therapists, if there is a cotherapist) are hardly rare. For example, some couple therapists hold individual meetings with each partner during the early (assessment) phase of the work. And some therapists are also open to intermittent individual meetings, usually briefly, for specific strategic purposes (e.g., to help calm partners in a volatile relationship when little is being accomplished in three-way meetings). Still, many couple therapists never meet with individual partners.

The matter of whether and under what conditions individual sessions may occur is one of the most important practical decisions to be made by couple therapists. How therapist policies and procedures about this decision are addressed and implemented carry profound implications for the maintenance of therapeutic alliances and even basic positions on what (or who) is (or has) “the problem.” It is a complex clinical issue that each therapist must think through carefully (Gurman & Burton, 2014).

As for the length of treatment, it is clear that couple therapy is usually brief (Doherty & Simmons, 1996; Gurman & Kniskern, 1978). Couple therapy was brief long before managed care administratively truncated therapy experiences (Gurman, 2001). It is important to note that most of this naturally 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 (Hoyt & Gurman, 2012), but because of the dominant treatment values of most couple (and family) therapists—for example, 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 (Gurman, 2001).
The Role of the Therapist

We need different thinking 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 this 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 clients 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?

In the last couple of decades, a great deal of effort has been put into identifying empirically supported treatments (ESTs) in couple therapy. Although such efforts are helpful for public policymaking, they tend to focus on one particular domain of the therapy experience, therapeutic techniques. Lately, EST-oriented efforts have been counterbalanced by attempts to understand the essential characteristics of empirically supported therapeutic relationships (Norcross, 2002). And there is now 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 that are attributable to treatment techniques per se (Wampold, 2001).

The kind of therapeutic relationship required by each approach to couple therapy includes the overall “stance” the therapist takes toward the experience (e.g., how working alliances are fostered; how active, self-disclosing, directive, and reflective the therapist is). Different models of couple therapy call forth and call for different therapist attributes and interpersonal inclinations. For instance, therapists with a more or less “take charge” personal style may be better suited to practicing therapies that require a good deal of therapist activity and structuring than to those requiring a more reflective style (Gurman, 2011).

Given the apparent overall equivalence (Lebow, Chambers, Christensen, & Johnson, 2012) in effectiveness of the major methods of couple therapy, it is not surprising that idiosyncratic personal factors influence therapists’ preferred ways of practicing. Thus Orlinsky, Botermans, and Konnestad (2001) 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.

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. Describe any formal or informal system 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 are routinely assessed (e.g., violence, substance abuse, extramarital affairs, sexual behavior, relationships with extended family, parenting)?
3. At what levels (e.g., intrapsychic, interpersonal) 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 cultural factors included in assessment? Developmental/life cycle changes?
6. Are couple strengths/resources a focus of assessment?
7. Is the assessment process or focus different for couples with problems about both relational matters and “individual” matters (e.g., depression, anxiety)?

**Goal Setting**

**Purpose**

To describe the nature of therapeutic goals established 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 this approach is appropriate, regardless of between-couple differences or presenting problems? Does a couple’s marital status influence goal setting?
2. How are the central goals determined and prioritized with a given couple?
3. Who determines the goals of treatment? Therapist, couple, other? How are differences in goals resolved? Are therapist values involved in goal setting?
4. 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?
5. How are couples with “mixed agendas” (e.g., one partner wants to preserve the relationship, the other is ambivalent about ongoing commitment) addressed in setting goals?

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). Therapists typically are interested in understanding what previous steps clients have taken to resolve or improve their difficulties, and what adaptive resources a couple has for doing so. They also pay attention to the cultural context in which clinically relevant concerns arise. Such contextualizing factors can play an important role in how a therapist collaboratively defines the problem at hand, selects a strategy for addressing the problem, and adapts the therapy as needed to the cultural specifics of the couple (Bernal & Domenech Rodriguez, 2012). 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 engage in clinical assessment and treatment planning varies from approach to approach. The majority of couple therapists emphasize the therapist–client conversation as the source of understanding the couple, and direct observation of the couple problem is, of course, available in the clinical interview itself. Multigenerationally oriented therapists may also use genograms to help discern important family legacies. Some therapists include client self-report questionnaires or inventories, and some use structured research-based interview guides. Generally, therapists who use such devices have specialized clinical practices (e.g., focusing on a particular set of clinical disorders, in their relational context), for which such measures have been specifically designed (e.g., measures of alcoholism and sexual dysfunction).

The place of standard psychiatric diagnosis in the clinical assessment phase of couple therapy varies widely. Most couple therapists consider the traditional diagnostic psychiatric status of patients according to the criteria of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994, 2013), at least to meet requirements for financial reimbursement, maintenance of legally required treatment records, and other such institutional contingencies. Although such diagnostic considerations may provide a useful general orientation for a subset of couples in therapy, every method of couple therapy has developed its own idiosyncratic ways of understanding each couple’s problem. Moreover, some approaches 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. Some therapists see diagnostic labeling as reflecting an unfortunate assumption of the role of “expert” by therapists, which may inhibit genuine collaborative exploration between therapists and “patients” (or “clients”). For them, what matters more are the more fluid issues that people struggle with, not the diagnoses they are given.

Most couple therapists cast a fairly wide net in their assessments, raising questions about the possible presence 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 might even preclude couple therapy (e.g., severe physical or verbal aggression).

Different couple therapy approaches emphasize different types of goals, but they also share a number of goals. 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 in cases where such symptoms are not a major focus of treatment, improvement in presenting problems, especially in relation to interactional patterns that maintain such 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 patterns of interaction influence couples’ everyday effectiveness in living, as well as how such patterns affect and are affected by the psychological health and satisfaction of individuals. In some approaches, certain ultimate goals are considered important in all cases, whereas other approaches aim almost exclusively at change in the presenting problem.

In addition to ultimate goals, a variety of “mediating goals” are emphasized in the various couple therapies. Mediating goals are of a shorter-term nature and include changes in psychological processes through which it is presumed an individual or couple goes in order to reach treatment objectives. They are sometimes referred to as “process goals.” Common forms of mediating or process goals are the achievement of insight and emotional self-awareness; the teaching of various interpersonal skills; and the identification and blocking of problem-maintaining behavior patterns, to allow opportunities for more adaptive responses. Mediating goals may also be more abstract and are not necessarily made explicit by the therapist. Mediating goals are less likely to be discussed between the couple and therapist in some approaches, and even the extent to which ultimate goals of treatment are discussed varies across treatment approaches.

### 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 this 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?** How are “transference–countertransference” reactions dealt with?
3. **What techniques or strategies lead to changes in structure or transactional patterns?** Identify, describe, and illustrate major commonly used techniques.
4. **Is psychoeducation (e.g., about parenting or sexuality) part of this approach?**
5. **How is the decision made to use particular techniques at a particular time?** Are some techniques more or less likely to be used at different stages of therapy?
6. **Are different techniques used with different types of couples?** For example, are different or additional techniques called upon when the therapy is addressing problems involving individual psychopathology, difficulties, or disabilities, in addition to interactional/relational problems? Or, alternatively, in work with more dysfunctional, distressed, or committed couples?
7. **What kinds of cultural adaptations of the usual assessment process, treatment techniques/strategies, or therapeutic relationship-building approach are used in work with couples whose ethnic, racial, socioeconomic, or other backgrounds differ from those with whom this approach was originally created?**
8. **Are “homework” assignments or other out-of-session tasks used?**
9. **What are the most commonly encountered forms of resistance to change?** How are these dealt with?
10. **If revealed to the therapist outside conjoint...**
sessions, how are “secrets” (e.g., extramarital affairs) handled?

11. What are both the most common and the most serious technical or strategic errors a therapist operating within this approach can make?

12. 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 may seem daunting and dizzying: acceptance training, affective down-regulation, behavioral exchange, boundary marking, communication training, circular questioning, enactment, empathic conjecture, exceptions questioning, externalizing conversations, genogram construction, interpretation of defenses, jamming, joining, ordeal prescription, paradoxical injunction, positive connotation, problem-solving training, reattribution, reframing, scaling, sculpting, Socratic questioning, softening, unbalancing, unified detachment training, unique-outcomes questioning, and witnessing (all used, of course, with zeal).

Behavior change techniques are used to modify observable behavior at the individual or dyadic level, and insight-oriented techniques focus on awareness and understanding of oneself and one’s partner. Emotion-focused techniques may emphasize either improving access to one’s own emotional experience and responsiveness to one’s partner’s experience, or developing more effective ways of dealing with dysregulated emotion in either partner. In contrast to insight-oriented individual psychotherapy, in which self-understanding is generally assumed to precede behavior change, in couple therapy the opposite sequence is often preferred. Most couple therapists are multidirectional in their thinking; that is, they believe that change can be initiated in any domain or at any level of psychosocial organization. For pragmatic reasons, such as instilling hope, initial change is often sought at the interactional level.

We can also distinguish between couple therapy techniques that focus on in-session versus out-of-session experience. The wide use of techniques that emphasize clients’ experiences away from the consultation room reflects most couple therapists’ respect for the healing power of intimate relationships; it also reflects their belief that therapy-induced change that endures and generalizes to everyday life is not achieved primarily in the substitutive relationship between therapists and their clients, but rather between relationship partners in their natural environment.

**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 (i.e., mechanisms of change) that lead to change in couples, and to assess their relative importance.

**Points to Consider**

1. Do clients need insight or understanding in order to change?
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 as a pragmatic tool for effecting change (as in shifting perceptions or attributions)?
3. Is the learning of new interpersonal skills seen as important? If so, are these skills taught didactically, or are they shaped more in process?
4. Does the therapist’s personality or psychological health play an important part in the process and outcome of therapeutic approach?
5. Are there certain kinds of therapists who are ideally suited to work according to this approach, and others for whom the approach is probably a poor “fit”?
6. How important are techniques compared to the client–therapist relationship?
7. 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? Or vice versa?

A major controversy in individual psychotherapy and, more recently, in couple therapy (Simon, 2006; Spenkle et al., 2009) is whether change is brought about more by specific ingredients of therapy or by factors common to all therapies. “Specific ingredients” refer to specific technical interventions such as communication training, paradoxi-
cral injunctions, cognitive reframing, interpretations, or empathic responding, which are said to be the ingredient(s) responsible for change. At times, these techniques are detailed in manuals to which the clinician is expected to adhere in order to achieve the desired result. This 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 relational dysfunction.

“Common factors” refer to features of couple therapy that are not specific to any one approach. Outcome studies comparing different couple therapies have found few differences among them, and it has been inferred that this finding is due to the importance of therapeutic factors held in common by the various therapies. Thus, instead of running “horse race” research to discern differences among the therapies, it is argued that efforts should be redirected to identifying their commonalities. These include client factors, such as positive motivation and expectation for change; therapist qualities, such as warmth, the ability to form good alliances, and empathic attunement; and structural features of the treatment, such as providing a rationale for a person’s suffering and having a coherent theoretical framework for interventions.

In addition, as Sexton and colleagues (2011) emphasize, there is a need to further our understanding of core intervention principles that transcend the treatment methods available today. Such core principles may be used to facilitate change across therapeutic methods. For example, a core change mechanism in couple therapy may involve a changed experience of one’s partner, which leads to an increased sense of emotional safety and collaboration. This change might be activated by the use of techniques from such varied therapy models as cognitive-behavioral treatment (e.g., reattribution methods), object relations therapy (e.g., interpretations used to disrupt projective processes), and emotionally focused therapy (e.g., restructing interactions by accessing unacknowledged emotions in problematic cycles).

Identifying mechanisms of change that are shared by different methods of couple therapy is of both academic interest and practical value. Gurman and Burton (2014) have suggested the operation of several such mechanisms: enhancement of partners’ systemic awareness of the circularity and contextual embeddedness of their conflicts; establishment of the premise of partners’ shared responsibility for bringing about change; improved mutual acceptance; interruption of maladaptive conflict-maintaining interactions, allowing for new adaptive sequences; refinement of communication and problem-solving skills; and normalization of couple conflict via psychoeducation about intimate relationships. It is not yet clear whether there are a finite number of universally relevant change principles that cut across various approaches to couple therapy, and/or whether different methods call upon different principles of change.

1. **TREATMENT APPLICABILITY AND EMPIRICAL SUPPORT**

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

**Purpose**

To describe those couples for whom an approach is particularly relevant, and to summarize existing research on the efficacy and/or effectiveness of this 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?** For instance, is it less relevant for severely disturbed couples or couples with a seriously disturbed member, for couples with nontraditional relationship structures, and so on?
3. **When 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. **Do any aspects of this approach 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?**
6. Is there any empirical evidence of the efficacy (e.g., randomized clinical trials) and/or effectiveness (e.g., survey research) of this approach? Summarize such evidence. If multiple studies exist, cite a review of that research, if available.

In the end, questions about the applicability and helpfulness of particular couple therapy approaches to particular kinds of problems, issues, and symptoms are best answered through research on treatment efficacy (based on randomized clinical trials) and treatment effectiveness (based on naturalistic field studies). Testimonials, appeals to established authority and tradition, and similar unsystematic methods are insufficient. Still, new therapy approaches rarely if ever make only modest and restrained claims of effectiveness, issue “warning labels” for “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 therapies continue to grow in number, the ethical complexities of the field may also grow. There are generic kinds of ethical matters that all couple therapists must deal with (e.g., confidentiality, adequacy of record keeping, duty to warn, respect for personal boundaries regarding dual relationships). Multiperson therapies raise ethical matters that do not emerge in traditional modes of practice—for example, balancing the interests and needs of more than one person against the interests and needs of another person, while trying to help maintain the viability of the relationship itself (Gottlieb, Lasser, & Simpson, 2008).

The influence of new perspectives on ethical concerns in couple therapy is perhaps nowhere more saliently seen than when matters involving cultural diversity are considered. Couple therapists must be sensitive to matters of race, ethnicity, socioeconomic status, gender, sexual orientation, and religion, adapting their assessments and interventions as deemed functionally appropriate to the situation at hand (Bernal & Domenech Rodriguez, 2012). To do otherwise risks the imposition, wittingly or unwittingly, of the therapist’s own values onto the patient (e.g., in terms of setting goals for their work together).

Feminism shares many philosophical assumptions with multiculturalism. Together, these modern perspectives have 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 perspectives have sensitized therapists to the potential constraining and even damaging effects of a failure to recognize the reality of their own necessarily limited views of the world. Certainly couple therapists have also become deeply involved in such social and therapeutic analyses and critiques.

It must be recognized, nonetheless, that such critiques of established therapeutic worldviews do not necessarily provide clear guidelines about the ways in which culture-sensitive and gender-sensitive therapists should actually practice therapy. As Hardy and Lasloffy (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). Ultimately the primary loyalty of therapists must be to their clients, not their techniques, theories, or treatment philosophies.

Couple Therapy and the Problems of Individuals

Given that couple therapists generally have had little to say about the treatment of many common psychological disorders, it is noteworthy that such disorders have recently come to constitute one of the most scientifically based areas of clinical practice in the field. Acknowledging the existence of psychological disorders has not, as some early family therapists feared, led to a negation of the relevance of systemic couple therapy. Rather, using traditional scientific methods, clinical researchers have indeed enhanced the credibility of couple therapy for these problems. Research on the couple treatment of such disorders repeatedly demonstrates the reciprocal relationship between individual problems and relational patterns. Against prevailing clinical wisdom, some in the field (e.g., Gurman et al., 1986) asserted long ago that the presumed functions of individual symptoms and problems are too easily confused with their observed consequences. Given the premise of behavioral psychology that behavior is maintained by its consequences, there is a likelihood that the symptomatic behavior of individuals is in fact maintained in part by its social context. Such a view is fully consistent with a systemic perspective. Such a view is not, however, tantamount to ascribing unspoken or out-of-awareness motiva-
tions of protection or control to those who suffer such symptoms (e.g., self-sacrifice to preserve the relational system) and inferring the implicit collusion of their intimate partners for such a larger systemic purpose.

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 (Gurman, 2011). 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.

Increased pressure has been 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 patients’ evaluations in uncontrolled, everyday clinical practice contexts. This movement to favor ESTs, as noted earlier, has been challenged by a complementary movement of psychotherapy researchers who assert the often overlooked importance of empirically supported relationships (ESRs) (Norcross, 2002).

At the risk of oversimplification, “EST’ers” tend to be associated with certain theoretical orientations (e.g., behavioral, cognitive, cognitive-behavioral) and styles of practice (brief), whereas “ESR’ers” tend to be associated with other theoretical orientations (e.g., object relations, person-centered, experiential, existential–humanistic), with advocates of other influential approaches (e.g., integrative, pluralistic) somewhere in the middle. To date, traditional outcome research designs have showed that couple therapy’s efficacy has been well established in the treatment of both general couple conflict and distress (Lebow et al., 2012) and a number of “individual” disorders such as depression (Beach, Dreifuss, Franklin, Kamen, & Gabriel, 2008; see Chapter 22, this volume), posttraumatic stress disorder (Monson & Fredman, 2012; see Chapter 20), and alcoholism (Birchler, Fals-Stewart, & O’Farrell, 2008; see Chapter 21).

The questions raised by these unfortunately competing points of view are not 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 resilience, self-exploration, and personal discovery, fade from view? (3) Can research better inform us not only how to disseminate effective couple therapy methods, but also how to better identify effective couple therapists? (4) 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 (Lambert, 2013), without prematurely limiting the kinds of evidence that may help to inform responsible practice. Efforts have been made to improve the empirical basis for couple therapy beyond familiar reliance on randomized clinical trials. For example, Sexton and colleagues (2011) offer an approach that promotes diverse research methods and varied methodological criteria to answer questions that are specific to different clinical contexts. Their model illustrates the way in which the traditional researcher–clinician gap may be closed by doing research that is ecologically meaningful.

CONCLUDING COMMENTS

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

—FRANK PITTMAN III

This fifth edition of the Clinical Handbook of Couple Therapy presents the diversity of today’s most prominent approaches to couple therapy. Experts representing divergent methods and theoretical traditions articulate the essence of therapy in each approach, describe how to conceptualize and intervene, and discuss how advocates of each approach think about and respond to a transtheoretical set of questions about couple therapy. Here we have the many voices of couple therapy. There is much to learn from in each chapter. Across chapters, there are clear points of agreement in which universal principles for couple therapy emerge
(e.g., the need to develop a therapeutic alliance with both partners), and yet also clearly other questions around which there is much debate and difference (e.g., what is the essential ingredient of couple therapy?). Surely readers will be drawn to one approach or another, but it is hoped that all the approaches will stimulate thought and reflection, and also provide something that readers will find useful in the complex task that is the practice of couple therapy.

REFERENCES


1. The Theory and Practice of Couple Therapy


