20

Couples Therapy

An Overview

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Introduction

The turn of the century finds couples therapy in a strong position. The empirical foundation for the field established in the past 20 years enabled it to improve some of its methods, learn from its mistakes, and modify some of its exaggerated claims. Multiple clinical approaches have moved toward an intelligent integration, combining their strongest elements to produce innovative, multifaceted, pluralistic, clinical systems.

More people seek therapy for marital-related problems than for any other reasons (Veroff et al. 1981). It is estimated that 50% of those who enter psychotherapy do so primarily because of marital disorders; another 25% have marital difficulties in addition to other problems. Although marital affairs are usually pointed to as the reason for divorce, it is clear that for both men and women, the major factor for marital dissolution is a disparate sense of growing apart, followed by fighting and finally affairs (Gigy and Kelly 1992). Given this plethora of marital issues, the scope of couples therapy has also broadened to address these factors.

Whereas three decades ago, the function of a marital therapist was to preserve marriages at all cost, today, couples therapy has become a highly effective instrument to help spouses achieve a higher level of personal de-

velopment and maturity, whether the outcome is staying married or obtaining a divorce. A recent development has been the preventive application of marital therapy knowledge in marital enrichment programs, with the goal of increasing marital satisfaction and personality growth in spouses.

If the alarming rise in the divorce rate can be taken as a sign of both the fragility of marriages and the large number of unhappy ones, the field of marital therapy will continue to grow. In spite of the high prevalence of marriage-related emotional problems, surprisingly few training programs in psychiatry, psychology, or social work offer adequate didactic and supervised clinical practice in marital therapy. Reasons for this relative neglect of marital therapy training are unclear but may include the discipline's lack of a unified theoretical base, the domination of Western psychiatry by individual psychology, and the absence of a well-accepted diagnostic code. The uncertainty regarding the availability of reimbursement for couples therapy through medical insurance, the historically low professional status of marriage counseling, and the diverse professional backgrounds and disciplines of marital therapists may also be contributing factors. The effectiveness of couples therapy in a wide variety of disorders, however, has brought it to a more central position in the range of psychiatric interventions.

History

Marital counseling and couples therapy are truly children of the twentieth century. Attempts to strengthen marital relationships and to resolve marital conflicts, however, are as ancient as the institution of marriage. The function of helping young married couples resolve their marital conflicts traditionally belonged to the older, extended family members, whose perspective on marital stress was based on their own experiences. With the declining influence of the extended family around the turn of the twentieth century, clergy and physicians were called on to assist troubled couples. Both were natural groups to address marital problems because they had contact with family members at significant stressful times in the life cycle of families and had the advantage of ongoing rapport with the family before problems surfaced.

Professional marital counseling emerged in the 1920s and 1930s. The Marriage Consultation Center was established in New York City in 1929, the Marriage Council of Philadelphia was founded in 1932, and the American Institute of Family Relations was established in California in 1939 to offer counseling specifically for marital problems.

The theoretical foundation for marital therapy was established by a variety of theoreticians. C. P. Oberndorf (1938) published a classic paper

entitled "Folie à Deux," reporting on the existence of similar paranoid delusions in a husband and wife and proposing that a neurosis in a married person is strongly anchored in the marital relationship. He considered a complementary neurotic reaction in the marriage partner as an important aspect of the married patient's neurosis. B. Mittleman (1948) employed concurrent treatment of married couples and offered a psychoanalytic classification of marital problems based on a *complementary needs satisfaction* model of marriage. The empirical foundation of marital therapy was established when behavioral techniques were applied to marital disorders in the mid-1960s. Initially, desensitization and assertiveness training were applied, followed by the use of contingency management based on operant conditioning. Subsequently, cognitive and therapy concepts were broadly applied by behavior therapists. The 1990s marked the years of the integration of multiple theoretical models when eclectic interventions were applied by different practitioners and evaluated empirically.

The advances in the broader field of family therapy emerged in the 1950s. The concepts of homeostasis, communication, and family conflicts were applied to marital relationships. The dynamics of small groups in marital situations were explored in the 1950s.

Definitions

Couples therapy—the treatment of the couples relationship—refers to a broad range of treatment modalities that attempt to modify the marital relationship with the goal of enhancing marital satisfaction or correcting marital dysfunction. The marital dysfunction may assume the form of an overtly conflictual, dysfunctional marriage, or it may be covert but result in symptomatology or dysfunction in one or both spouses or their children. In couples therapy, the relationship is considered to be the *patient* rather than the individual spouses. This focus implies that two reasonably healthy spouses may form a symptomatic or dysfunctional marriage. The interlocking of the underlying "neuroticism" and emotional disorders of each spouse, however, is a common contributor to the formation of a dysfunctional marriage.

Couples Therapy

There is a general tendency to blur the boundaries between couples therapy and counseling for couples on theoretical and technical bases, but the core of the practices in couples therapy and counseling can be differentiated. Couples therapists employ varied extensive assessment techniques and utilize their systematic knowledge of personality, behavioral, cognitive,

or communicational-systems theory to promote the therapeutic process. A thorough knowledge of the field of orientation enables them to assess the totality of the pathological and adaptive behaviors of the spouses and assist them through the use of marital, individual, or other therapeutic modalities. The goal of couples therapy can include the enhancement of the marital relationship and the treatment of any underlying emotional disorders in one or both of the spouses. Although the ultimate goals in marital treatment may remain unrealized, the eventual outcome should be a progression by the couple to a relationship on a higher developmental level.

Marriage Counseling

Marriage counseling includes a very broad range of technical interventions for reduction of marital disharmony. There are clear overlapping areas between marital counseling and therapy. These interventions can include giving advice on concrete problem solving. The focus and goals of the treatment are generally the resolution of the immediate presenting problems and the provision of the spouses with emotional support and enhancement of their self-esteem and optimism. The treatment goal does not include the restructuring of relational and personality structures.

Indications and Contraindications

Couples therapy is indicated in a wide range of situations in which relational dysfunction, symptomatology, or disability in a "married" person is present. The clearest indication for couples therapy is the presence of overt marital conflicts that result in the recognizable, severe discomfort of both spouses. Frequently, such spouses seek couples treatment because they fear divorce or because they recognize the limits of their effective problem management. In many situations, however, the presence of a marital disorder may be covert and may exhibit itself in symptomatology or dysfunction in one of the spouses or the children.

Poor communication and extramarital relationships are the most frequent reasons for referral for marital treatment. Marital therapy should be considered when individual treatment has failed, or is unlikely to succeed, because of the lack of an appropriate capacity in the patient, such as poor motivation or limited ability to negotiate a treatment contract. Marital treatment is also indicated when the eruption of symptoms in a family member coincides with the outbreak of marital conflicts, or when gross distortions of reality are held jointly by the couple, increasing the risk of marital instability in cases of individual treatment.

In the 1990s, couples therapy was increasingly applied to a wide range of psychiatric disorders, including depression, alcoholism, and schizophrenia, in recognition of the significance of the relational dimension of the mental disorder and the ability of marital therapy to enhance treatment efficacy.

Contraindications to couples therapy are relative and few. The premature exposure of the spouses to marital secrets, such as illegal actions of a spouse, homosexuality, or an extramarital affair, can result in abrupt interruption of treatment or termination of marriage. Therefore, the revelation of secrets in marital therapy should be encouraged only when a couple have committed themselves to treatment. Once a couple are involved in treatment, such secrets can be handled in the therapeutic context to enhance marital relationship and closeness.

If the spouses use the sessions consistently to attack each other and seek the therapist's assistance with their destructive efforts, conjoint marital therapy may become unproductive. The lack of commitment to continuation of the marriage may be another contraindication to conjoint marital therapy. Conjoint sessions, however, are useful in undermining the rationalization of ambivalent couples who claim they are living together merely for financial reasons or for "the children's sake."

Types of Couples Therapy

The most common types of couples therapy are individual therapy, conjoint couples therapy, and combined couples therapy. Group therapy with couples is practiced by some practitioners. Currently, conjoint couples therapy is the most favored type of couples therapy, in contrast to earlier times when concurrent couples therapy prevailed. There is little comparative research on the effectiveness of different modes of couples therapy, and what exists contains contradictory findings.

Individual Therapy

In individual therapy of marital disorders, the therapeutic focus is on the marital relationship and the conflicts with the marital partner. At the time of marital crisis, the therapist may choose to see the other spouse to gain a more comprehensive perspective on the immediate marital crisis. Individual therapy for marital problems can be recommended when one of the spouses is very resistant to psychotherapy, one of the spouses may be considering a divorce, or when the patient seeking treatment is suffering from a variety of other symptoms, such as phobia, in addition to marital dis-

satisfaction. Such therapy for marital problems can be quite helpful to the healthier spouses who exhibit highly integrated personalities with minimal self-destructive and masochistic tendencies. Individual therapy is a poor choice, however, in the presence of marital disturbance and severe psychopathology, such as psychosis and physical abuse.

Concurrent Couples Therapy

In concurrent couples therapy, both spouses are seen individually in separate sessions by the same therapist. The establishment of a strong therapeutic alliance with each spouse can be readily achieved and maintained in concurrent therapy. Concurrent couples therapy reduces interpersonal defensiveness and apprehension and promotes self-revelation and introspection in an empathic and therapeutic environment.

Conjoint Couples Therapy

Conjoint couples therapy is the treatment of both spouses in the same session by a therapist or a team of co-therapists. It has been the most commonly used mode of marital therapy for the past two decades, having been used by more than 80% of therapists. The advantage of conjoint therapy is that it focuses the therapeutic efforts directly on the couple's interactions where the problems manifest. This focus enables the therapist to recognize the subtle transactional configurations and feedback mechanisms that support marital dysfunction and symptomatology. The therapist can observe the marital interactional patterns, contradictions between overt and covert messages, and subtle reinforcements of coercive behaviors. Conjoint family sessions tend to mobilize optimally the rehabilitative capacity of the couple for constructive marital changes; however, the latent forces toward separation can also be mobilized, prematurely encouraging the couple toward a breakup.

The limitations of the use of conjoint couples therapy include impending divorce, in which the issues confronting the spouses may be radically different, or situations in which the couples have different therapeutic goals. At times, conjoint therapy can be used destructively by the spouses for the purpose of mutual blaming and power struggles, and a temporary or permanent shift to concurrent therapy may be advisable. In deeply divided couples in whom mistrust and resentment run deep, it may be technically impossible for the therapist to maintain an effective neutral posture while developing a therapeutic alliance with both spouses.

Combined Couples Therapy

Combined couples therapy refers to the mixing of conjoint and concurrent marital therapies, although it can include other combinations, such as couples' group therapy. Conjoint couples sessions can be held at regular intervals, at the time of marital crisis, or when progress in concurrent treatment is impeded. The combined treatment has the advantage of allowing the use of fantasies in individual sessions while providing easy access to transactional and communicational patterns in joint sessions.

Couple Group Therapy

Couples can participate with a group of other couples in couple group therapy. The couples can learn from each other, render marital support, and serve as models for marital role modification. Some couples groups include didactic teaching about marriage in addition to traditional group therapy process (Coché 1995). Couple group therapy is contraindicated when a spouse lacks sufficient ego strength—that is, has a borderline personality—and is threatened by the group.

Concurrent marital therapy was the most widely practiced type of marital therapy throughout the 1950s and 1960s. Currently, the majority of marital therapists tend to favor conjoint therapy, as it provides observable information on the crucial marital interactional patterns.

Theories of Couples Therapy

Psychodynamic Theories

Psychoanalytic theories emphasize the concepts of complementarity of needs, self, object, early identifications, introjections, and projective identification. In projective identification, the person with a faulty sense of self as a victim, who has internalized pathogenic persecuting introjects, splits off the criticizing internalized introjects and projects them onto others. These split-off introjects create a polarization in which the spouse is seen as a victimizer and the self is seen as the victim (see Chapter 4, "Psychodynamic Family Therapy," and Chapter 21, "Psychodynamic Couples Therapy," for a more detailed description). In marriage, persons may choose to act according to one polarized half of their conflicted selves and project the other half onto their partners (projective identification). The introjected parts of the self are disavowed, split off, and projected onto the other person, who complies with the wishes of the partner. For the projective iden-

tification to take place and continue, the object should periodically exhibit the behavior projected on him or her by the subject. The selection of a mate is strongly weighed toward choosing one who can provide optimal gratification for unconscious neurotic needs. Therefore, the internalized intrapsychic conflicts of the spouses result in a tradeoff, leading to marital conflicts. It has been pointed out that the marital relationship is profoundly shaped by mutual transference reactions between the spouses. Consequently, the treatment of the marital relationship should address the projections and introjections of the spouses, in addition to their real differences. The preponderance of projection in intimate relationships explains the difference between marriage and other relationships.

From the field of eligible or potential mates, individuals choose a partner reflecting their unfulfilled personality needs. Normal couples tend to share more similarity of needs and traits than do conflicted couples. For neurotic couples, the complementarity of needs is more extreme, and the developmental immaturity of the needs may be greater than in normal couples. Therefore, the needs may be so intense that the couples can be labeled mutually *compensatory* and overfunctioning in the areas where each spouse is extremely weak and conflicted. Another way of differentiating couples with healthy functioning from dysfunctional couples is by observing the types of objects they choose. Well-functioning couples tend to choose an object of the dependent anaclitic type. The object choice of neurotic couples is based on that quality that enhances one's self-esteem (narcissistic). The idealization may be extreme, and the object can become a substitute for some of the subject's unobtained goals.

Neurotic couples are psychodynamically similar and are attracted by shared developmental failures. Spouses adopt opposite patterns of defensive organization to deal with similar conflicts and with equivalent levels of immaturity. Therefore, they appear as different personality types while they share similar dynamic conflicts. The example of The Odd Couple in film and television is a graphic depiction of this phenomenon. The different traits that initially attract the couple can later become the focus of conflicts.

Marital conflict can occur in the absence of significant individual psychopathology in either or both spouses. This phenomenon, described as *marital neurosis*, occurs when a neurosis develops in one or both spouses in connection with the marriage. Marital neurosis should be distinguished from the *marriage of interlocked neurotic spouses*, both of whom exhibit neurotic character traits that give rise to neurotic interactions in the marriage.

The paramount goal in psychoanalytic marital therapy is restructuring and reconstruction of both spouses' internally based perceptions and expectations of, and reactions to, each other, which are patterned after their early experiences and interfere with their present communications and re-

lationship. Marital partners need to develop a sense of self that is more differentiated and internally integrated and to experience the other spouse as a safe and real person. In terms of practice, psychodynamic therapists tend to be quite pragmatic and eclectic in the selection of actual therapeutic interventions. Although active and directive at times, the therapist's basic posture remains one of acceptance, to allow the emergence and integration of the unacceptable aspects of the inner perceptions of both spouses into their personalities. The therapist's interpretations should be more integrative than regressive, considering the relatively brief character of marital therapy. It has been proposed that both neurotic and normal couples are extremely prone to think and experience relationships in dyadic terms, and the triadic relationship in the conjoint marital sessions does not disturb the spouses' dyadic perception of the therapist. Therefore, the therapist can interpret effectively the marital transference between the spouses as well as the therapeutic transference manifestations in the sessions (Sonne 1986).

The major deficiency in psychoanalytic marital therapy is its insufficient attention to the current issues in marital interactions that serve as grounds for projections and that maintain the distortions engendered by the marital transference.

Marital Contract Theory

Marital contract theory, developed by Sager (1976), is one of the few theoretical systems specific to marital therapy. The word contract is used to describe a set of assumptions and expectations of self and partner with which each person approaches the marital relationship. Each contract is conceptualized by the person in reciprocal terms, and each person behaves as if the partner had explicitly agreed to this exchange. Because much of the contract is not shared and some parts of it are unconscious, there are considerable possibilities for confusion. Three levels of contracts are described: 1) *verbalized*—the part of the contract verbally stated to the other person; 2) *secret*—the part of the contract not shared with the partner because of the fear of consequences of the revelation; and 3) *beyond awareness*—preconscious or unconscious needs that are unknown to the person. Marital conflicts in this model evolve from incongruent or nonfulfillable contracts. Contracts may be unacceptable to the partners, or there may be internal conflict between the conscious and unconscious part of the contract. The contract may be nonfulfillable by anyone, including the particular partner. The complexity of marital dynamics and marital conflict is primarily due to the level of contract that involves each person's individual needs and is beyond awareness.

Intergenerational Systems Theory—Bowen Theory

The central theoretical construct of Bowen's theory is differentiation of self or its opposite fusion. Undifferentiated people remain attached to their families of origin and tend to fuse with other people in order to reduce anxiety. They seek spouses who operate on the same developmental level and repeat with their spouses the same style of relating that they had with their families of origin. The goal of marital therapy is for the spouses to differentiate from their families of origin by detriangulating themselves from their parental families. Other critical variables are the degree of emotional cutoff from the previous generation and the ability of the spouses to bridge the gap and resolve the emotional attachment.

Bowen uses three basic intervention strategies. The first is defining and clarifying the relationship between the spouses. He asks the spouses to talk directly to him in the most calm, low-keyed, and objective way. This intervention is usually sufficient to undermine the marital fight and fusion. The second strategy is the didactic teaching of the spouses about the functioning of emotional systems. Bowen distinguishes between feeling and intellectual properties. The third stage is taking an "I position" stand, in which the therapist is clearly defined in relationship to the marital pairs and asks the marital partners to assume the same position while making therapeutic voyages back to their families of origin.

Systems Theories

Systems theories—or more accurately, *communication* approaches to family therapy—encompass a diverse group of theories and practices. The group of systems theories described here is composed of strategic therapies, in which structural and triadic-based family therapists usually focus on two hierarchical generations. The systems theorists use systems concepts, such as *wholeness*, *circular causality*, *homeostasis*, *positive and negative feedback*, and *family interactional patterns*. *Interaction*, the central notion of the systems theory, is considered explanatory of marital conflicts. Conflicted couples communicate at report and command levels simultaneously. Contradictions between different levels of messages are the root of the symptomatic behavior.

Systems theorists differ from each other in their conceptualization of marital problems. For Haley, the central focus in marital conflict is the power struggle between the spouses, and the treatment process is a way of working out overt, shared agreements on previously undiscussed issues. For Watzlawick, the major problematic dimension is a cognitive one, in which the spouses fail to differentiate between a common difficulty and a serious

problem or in which an inept solution to a minor problem becomes a severe problem itself.

Therapeutic strategies include redefining the couple's problem through the use of reframing and relabeling as well as paradoxical tasks that help change the spouses' outlooks and therefore their subjective experiences. The use of paradoxical tasks or therapeutic double-binds is based on the notion that rules or the realities are relative, and when the therapist permits or encourages the usual or symptomatic behavior, the patient tends to discontinue it. Strategic marital therapy has given rise to recent postmodern approaches such as solution-focused therapy and narrative solutions couples therapy (Eron and Lund 1996). The conceptual and technical aspects of these approaches are described in Chapter 4.

Postmodern or social constructionist family therapy has produced two collaborative couples therapy models—namely, solution-focused and narrative approaches. The solution-focused approach, based on the work of de Shazer et al. (de Shazer 1985; de Shazer et al. 1986), shifts the focus of the treatment to talking about solutions to the problems, *exceptions* to the present problems, and the future without the problems. It emphasizes the couple's strength and competencies. The narrative approach (Eron and Lund 1996) uses the reframing search immediately for both spouses to understand their *stuck* situation, separate themselves from their problems, and coauthor a new narrative for themselves through *collaborative conversation* with the therapist. The new narrative is based on how the spouses like to see themselves and be seen by others. The way they prefer to see themselves is usually very different from their problem-saturated way of viewing themselves when they arrive for treatment.

Behavioral Couples Therapy

Behavioral couples therapy (BCT) employs a range of learning theories and techniques based on operant and social learning principles in the evaluation and treatment of marital transaction and disorder. The scope of contemporary BCT was significantly enlarged in the 1990s. The foundations of BCT were established in operant conditioning, social learning, and social exchange models. Operant conditioning conceptualizes behavior in terms of its specific antecedents and consequences. The major emphasis of behavior analysis is on four basic types of behavior. Two types are reinforcements that increase or maintain the likelihood of the responses (behavior) they follow; the other two types are punishments that decrease the likelihood of their antecedent behaviors. The first type of behavior, *positive reinforcement*, is performed to reward a person with something that he or she wants. The

second type of behavior, *negative reinforcement*, involves the reduction or elimination of an unpleasant stimulus. For example, the cessation of unpleasant behavior in one partner could increase the possibility of pleasing behavior in the other. The third type of behavior, *punishment*, is the presentation of an aversive condition in order to decrease or eliminate unwanted behavior. The fourth type of behavior, *time-out*, is a form of punishment that involves removing or withholding something the other partner wants. These four types of behavioral contingencies can form at least two major kinds of reinforcement patterns: reciprocity and coercion. *Reciprocity* involves the mutual exchange of reinforcement in a way the partners see as equitable over time. The second social reinforcement pattern is *coercion*, which involves the use of aversive control to force desirable responses from one's partner. Punishment and coercion may be effective in controlling one's partner temporarily, but sooner or later punishment begets punishment or avoidance.

Dysfunctional marriages can be differentiated reliably on the basis of the concurrent relative strengths of reciprocity and coercion, the absence of sufficient reinforcements, and the prevalence of punishment, time-out, and avoidant behaviors. Marital difficulties arise from faulty behavior change efforts such as the demand for immediate change in the behavior of the other person and the use of coercion for noncompliance from the partner.

Behavioral Techniques

Behavioral couples therapists vary widely in the techniques they employ. Each of the operant, respondent, and cognitive approaches includes a variety of procedures. Each approach focuses on changing concrete behaviors to maximize the interactions that both spouses find subjectively satisfying. Specific techniques are described in Chapter 22, "Behavioral Couples Therapy," and include building communication skills, taking assertiveness training, exchanging behaviors, and contracting of *quid pro quo* or *good faith* types for contingencies. The research suggests that quid pro quo and good faith contracts are equally effective. The current emphasis is on informal marital agreements.

Cognitive-Behavioral Therapy

This approach addresses the irrational, unrealistic, and unconscious beliefs of spouses about themselves and their partners who serve as the mediators of their unadaptive behavioral response to each other. The basic cognitive model pos-

tulates that the person responds to perceptions and appraisals of an event rather than to the objective characteristics of the situation. Self-instructional training can be used to interrupt destructive spouse interaction based on irrational assumptions. In the 1980s, behavioral marital therapies (BMTs) began to introduce an emphasis on cognition to enhance the effectiveness of treatment with a larger group of patients who did not respond to traditional BMTs (Christensen 1987; Weiss 1980). They explored the areas of attributions, selective attention, assumptions, expectancies, and standards (see Chapter 22, "Behavioral Couples Therapy," for more information on BMT and BCT).

The role of emotions was subsequently introduced in some of the new BCT approaches. Some exciting new models emerged in BCT in the late 1990s that incorporate some of the recent developments in the broader fields of couples therapy and family therapy. Emotionally focused couple therapy (Johnson 1999) is an empirically validated approach that focuses on distressed affects and constrained interactional patterns, expands a couple's interactional position, and fosters emotional engagement to unearth attachment-related affects and bonding needs. The goal of fostering a secure emotional bond is based on Bowlby's attachment theory.

Integrative couples therapy (Jacobson and Christensen 1996; Lawrence et al. 1999) has introduced strategies to help the couple to emotionally accept each other before trying to implement changes in communication and problem-solving patterns. Preliminary outcome data show increased relationship satisfaction after 1-year follow-up (Jacobson et al. 2000).

In his seminal work on marital dissolution, John Gottman (1999) based his approach on observation and painstaking assessments in his laboratory. Specifically, Gottman noted that, in his words, there are four horsemen of the apocalypse, referring to the demise of the marriage. These are 1) criticism, 2) defensiveness, 3) contempt, and 4) stonewalling. Gottman noted that once the cascade of interactions was indicated by these four indices, the marriage had difficulties, particularly with the inclusion of contempt and stonewalling. Gottman uses behavioral exercises that combine with cognitive approaches but relies on teaching couples how to broach issues and maintain dialogue and to recognize the escalations and cascade responses that impede and overwhelm couples.

Classification of "Marital" Disorders

There is no widely accepted classification system for marital disorders, partly due to the diversity of the theoretical concepts and techniques used by different marital therapists. Only two classification systems of marital disorders are described here.

Marriage Type

Cuber and Harroff (1992) proposed the following classification for marital disorders:

The Conflict-Habituated Marriage

The conflict-habituated marriage is characterized by constant strife, tension, and undermining of one spouse by the other. Significant dependence and loyalty often tie the spouses to their families of origin. The couple's fear of loneliness binds them together. Other terms for such marriages are unstable-unsatisfactory, schismatic, or pseudohostile.

The Devitalized Marriage

In the devitalized marriage, the family atmosphere is pleasant, but the actual source of emotional support is derived from outside interests and the social network.

The Vital Marriage

In the vital, or total, marriage, the couple is highly enthusiastic about joint activities and raising children. The mutual involvement is more multifaceted in the total marriage.

Personality Type

There are several classification systems based on personality styles and the psychodynamic factors underlying the personality traits. The marriage becomes symptomatic only when role flexibility, or capacity for adaptation and enjoyment, is moderately to severely compromised.

The Obsessive-Compulsive Husband and Hysterical Wife

This type is generally known as the pattern of *cold-sick* man and *love*sick woman. The marital union is based on the husband's wish to become energized through his wife and the wife's desire to become more organized through his companionship. The underlying fear of intimacy is identical for both partners; however, for the hysterical personality, narcissism is largely in the service of dependency, whereas for the obsessional person, dependency is in the service of narcissism.

The Passive-Dependent Husband and Dominant Wife

The husband's feeling of inadequacy leads him to an aggressive and seemingly competent woman, with the unconscious wish of gaining strength from her. Being controlled by her, however, he feels more inadequate and fights with her in a passive-aggressive fashion. The wife becomes hostile, due to her own unconscious, unmet dependency needs and her inability to dominate him.

The Paranoid Husband or Wife and Depression-Prone Wife or Husband

There is significant ego-restriction and limited coping capacity in both spouses. They both feel suspicious of each other but too inadequate to be assertive. So they become depressed.

The Mutually Dependent Marriage

The spouses are immature, dependent, passive, and competitive with each other for attention, and their overreactions to minor difficulties make their marriage stormy.

The Neurotic Wife and Competent Husband

This is the pattern of the *inadequate-overadequate* marriage described by Bowen. The woman is chronically symptomatic and unable to function adequately. The husband derives extreme feelings of adequacy and competence caring for his *ill* wife and countering his own unconscious feeling of inadequacy.

Denial of Conflict

There is an additional major category of marital disorders termed *stable-unsatisfactory marriage*, *skewed marriage*, and *pseudomutuality* by different theorists. Here, the spouses are extremely frightened by the possibility of marital breakup in case of disagreements. Therefore, they deny any conflicts to the point of distorting or reinterpreting reality. A delusional or unreal familial atmosphere prevails. The couple consults a psychiatrist only when severe emotional disorders surface in the children.

Spouse Abuse

Spouse abuse has been recognized as a major threat to the welfare of American families (see Chapter 10, "Gender-Sensitive Family Therapy").

Common Marital Problems

Communication Problems

Communication problems refer to a host of problems, which include lack of talking and affection, mutual blaming, mind reading, and lack of problem solving. Clear and positive communication between the spouses expressing care, requesting need satisfaction, and validating each other's identities is the cornerstone of a healthy marriage. For clear communication to occur, the couple should accept responsibility for sending and receiving clear messages, paying attention to multiple levels of communication, and commenting on the incongruities between the overt and covert levels of messages when they occur. Attention to the nonverbal aspects of the communication is essential for the full understanding of messages.

Disturbances of communication include the summarizing self syndrome (Gottman et al. 1977; Markman 1992), in which both spouses are invested in proving the superiority of their own viewpoint and repeatedly restate their position rather than listening to their partner. This type of interaction generally results in escalating quarrels.

Extramarital Affairs

In more than half the couples requesting marital therapy, one or both had been involved in extramarital affairs with another person. The nature, duration, significance, and outcome of the affairs vary widely. They might represent a temporary activity on the part of a spouse at the time of marital crisis or might indicate a deep lack of satisfaction in and commitment to the marriage. There has been an increasing tendency in the field to view extramarital affairs as situationally based, rather than as a sign of a neurotic disorder in the involved spouse. It is initially essential to hold at least a diagnostic individual session with each spouse to explore the existence of extramarital affairs and to maintain such information confidentially. The decision and the timing for revealing the affair(s) to the other spouse should be left to the spouses in the course of treatment. The treatment process should include the exploration of the reasons and the meaning of the extramarital affairs, the deficiencies and strengths of the marriage, and the function of the affair in relation to the marital relationship. The exploration and expression of feelings of ambivalence, guilt, anger, and narcissistic injuries are necessary for the satisfactory resolution of the affairs. The outcome in terms of the continuity of marriage is a function of the strengths and weaknesses of the marriage and the effectiveness of the therapeutic management rather than the quality of the affair.

Depression and Marital Dysfunction

The high level of coincidence between marital stress and depression in one or two spouses is increasingly recognized. The range of clinical manifestations of this complex phenomenon and their therapeutic management are discussed in Chapter 28 ("Depression and the Family: Interpersonal Context and Family Functioning").

Divorce and Divorce Therapy

Divorce and divorce therapy became important issues as the rate of divorce in the United States steadily increased in the twentieth century. There were 5.3 divorces per 1,000 population around 1980. After that decade, the rate began to decline. By 1997, the last year when national statistics were available, the rate was 4.3 divorces per 1,000 population. Divorce therapy has emerged as a clinical field or orientation in recognition of the need to help divorcing couples achieve a psychic or emotional divorce in addition to a legal one. The phenomenon of *psychic divorce* refers to the successful resolution of marital bonds so both spouses can emerge with their own separate identities and pursue an autonomous life in the future. Ahrons (1994) has used the term *good divorce* to describe divorce in those families that continue to be a family, maintain good relationships between parents and children, and raise the children in a multiparent binuclear family. The typology of postdivorce relationships between the spouses is described in Chapter 23, "The Divorcing Family: Characteristics and Interventions."

The goal of divorce therapy is to assist the divorcing couple to resolve their remaining conflicts—including grief reaction for marriage and spouse—so the divorce procedure becomes less acrimonious and future adjustment of the spouses and their children is enhanced. In the process of divorce therapy, the therapist attempts to develop a therapeutic alliance with each spouse, gain his or her trust and confidence, and help all parties with two sets of concerns: 1) the decision to divorce or not and 2) the negotiation of issues, such as child custody. The therapeutic strategies used by divorce therapists include understanding the perspective of each spouse on the issues, promoting a climate conducive to decision making by the clarification of issues, and assuming a direct and active role in prompting agreements on substantive matters.

The strategy and technical interventions of divorce therapy are different according to the stage of marital resolution. In the *predivorce, decision-making stage*, the therapist generally helps the couple to look at divorce as one of the alternatives to their problems and apprise them of the consequences of different options. The therapist attempts to promote progres-

sive and constructive communication and enhance negotiation during this stage. In the *second stage of divorce restructuring*, the therapist helps the family with the multitude of emotional, financial, legal, childcare, and social arrangements necessary at the time of divorce. The involvement of the lawyers at this stage of the marriage may be necessary and in the best interest of the couple. However, the therapist should help the couple use the lawyer as a legal expert rather than as a weapon to fight each other or detour their anger into unrealistic expectations. In the stage of postdivorce recovery, the therapeutic task is to facilitate the growth of the divorced spouses as autonomous individuals with stable social relationships and satisfactory lifestyle independent of the former marriage. The achievement of psychic divorce is necessary for the accomplishment of this goal. *Psychic divorce* refers to the phenomenon of coming to terms with the ending of the marital relationship, which allows the spouses to pursue their independent courses. The lack of psychic divorce is usually manifested by preoccupation with the previous marriage and the ex-spouse, which results in feelings of anger and disappointment. The anger is in turn channeled through continuous fights over financial and custody arrangements.

Divorce Mediation

Divorce mediation refers to a particular type of intervention by a trained psychotherapist or lawyer with the goal of helping the couple resolve conflicts over custody, visitation, child support and financial settlement. It can be effective in addressing postdivorce disputes related to the above issues as well as ones emerging during the remarriage stage. There are similarities in the goals between divorce mediation and litigation, but the mediator acts as a neutral facilitator to help the couple resolve their problems. It is common that the solutions reached through mediation are written up by lawyers as a legal document. The mature spouses find mediation a constructive alternative to the adversarial legal process.

Marital and Sex Therapies

The behavioral treatment (marital and sex therapies) of sexual dysfunctions in married couples has yielded encouraging results. Sex therapy is optimally helpful within the context of marital therapy, because 75% of couples exhibit a combination of marital and sexual dysfunctions. The use of conjoint marital sessions and a heterosexual co-therapy team can be an invaluable part of the therapeutic intervention. Careful assessment of the marital communication patterns can shed light on complex sexual dysfunctions. Sex therapy outcome research has produced encouraging results, although

it has not supported the exaggerated claims of many sex therapists (see Chapter 26, "Sex Therapy at the Turn of the Century: New Awareness and Response," for a full discussion of sex therapy).

Couples Therapy Research

There has been a quantum leap in the quality and quantity of couples therapy research in the past two decades. The first broad review of results of marital therapy in 1973 identified 15 studies in this area (Gurman 1973). The studies have proliferated since and are summarized in Chapter 37, "Couples Therapy Research: Status and Directions," in this volume.

The studies in the past two decades have been methodologically sound, and outcome criteria have become more rigorous. The nature of marital distress is increasingly being reconceptualized. In addition to an increasing number of BCT studies, a few on nonbehavioral interventions have been reported with favorable therapeutic outcomes.

In addition to outcome research on marital distress, marital therapy with spouses with several identified emotional disorders such as agoraphobia, alcoholism, depression, and sexual disorders has been the focus of rigorous investigation. The research data have been particularly informative on the nature and characteristics of marriage and response to marital therapy in those experiencing depression and alcoholism. When marital distress and depression are simultaneously present, marital therapy can be at least as effective as alternative treatment modalities.

Johnson (Johnson and Lebow 2000) has identified the lack of a theory for the nature of adult intimacy, marital distress, and therapeutic change as a major barrier to more satisfactory progress in marital therapy investigation. She proposes attachment theory as a potentially useful theoretical model that can provide a framework for understanding marital interactions as well as cognitive and emotional processes with an intimate adult relationship.

Gottman's (1999) longitudinal research makes considerable effort in approaching marital therapy from a scientifically based endeavor. His work has shed light on enduring myths endemic to couples therapy but clearly not supported by sound interactional and multifaceted research. His efforts point to the many factors that need further clarification for successful treatment.

Conclusion and Future Directions

Couples therapy has consolidated its role as an effective therapeutic tool for reduction of marital stress, enhancement of interpersonal relationships, and

a preventive measure against future relational conflict and dysfunction in marriage. The past two decades (1980–2000) have been especially productive in the exploration of the contributions of marital dysfunction to the maintenance and possible causation of certain emotional disorders. The role of marital disorders in depression and alcoholism and the employment of marital therapy as part of a multimodal intervention to enhance therapeutic results of these disorders have been increasingly clear.

Schools of family and couples therapy have enriched each other's approach while continuing along their own differentiated path. The major beneficiary of this eclecticism has been BCT, which has enlarged its focus significantly by emphasizing the importance of cognition and emotions in understanding the nature of marital distress and providing productive change strategies. The recognition of the limitations of contingency contracting and problem solving as the basic model for BCT has helped to enlarge the treatment focus. The concept of skill deficiency in communication and problem solving as a major explanatory basis for marital distress has also been questioned through the observation of adequate skills in many distressed couples.

The psychodynamic approach to couples therapy has incorporated the methodology of BCT and cognitive therapy to a lesser degree, although some recent empirical studies have emphasized its efficacy with couples therapy. A major integrative development has been the approach of emotionally focused therapy (Johnson 1999; Johnson and Lebow 2000), which uses attachment theory and the concept of insecure attachment to get past defensive effects to reach for the underlying *soft* effects: attachment effects. Integrative couples therapy (Jacobson et al. 1996; Lawrence et al. 1999) has also recognized a major concept in psychodynamic couples therapy—namely, the importance of accepting the symptoms before attempting to change them.

There are many tasks to be addressed by couples therapy as we enter the new century:

- The search for a comprehensive theory that can incorporate the empirical findings of different couples therapy schools, such as BCT, and maintaining healthy or dysfunctional marital interactions.
- Operationalization of key concepts to allow empirical validation of their role in marital distress and therapeutic change. Such an approach is applicable to many concepts in all schools of family therapy. The psychoanalytic model can operationalize concepts such as *projective identification*, *the nature of marital transference*, and the *evolutionary course of intimate adult relationships*.
- Exploration of the relationship between individual (intrapsychic) personality patterns and marital interaction: to what degree do the intrapsy-

chic characteristics shape the marital interactions, and to what extent do marital interactions organize each person's behavioral patterns?
- A comprehensive perspective on the role of the wide range of emotions—positive and negative effects—as signals of affective communication system promoting.

Chapters on Related Topics

The following chapters describe concepts related to couples therapy:

- Chapter 10, "Gender-Sensitive Family Therapy" (with extensive discussion of spouse abuse)
- Chapter 14, "The Family Life Cycle: A Framework for Understanding Family Development"
- Chapter 21, "Psychodynamic Couples Therapy"
- Chapter 22, "Behavioral Couples Therapy"
- Chapter 23, "The Divorcing Family: Characteristics and Interventions"
- Chapter 24, "The Remarried Family: Characteristics and Interventions"
- Chapter 25, "Marital Enrichment in Clinical Practice"
- Chapter 26, "Sex Therapy at the Turn of the Century: New Awareness and Response"
- Chapter 28, "Depression and the Family: Interpersonal Context and Family Functioning"
- Chapter 33, "Family Therapy With Personality Disorders"
- Chapter 37, "Couples Therapy Research: Status and Directions"