FAMILY PROCESS

From Couple Therapy 1.0 to a Comprehensive Model: A Roadmap for Sequencing and Integrating Systemic, Psychodynamic, and Behavioral Approaches in Couple Therapy

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Couple therapy is a complex undertaking that proceeds best by integrating various schools of thought. Grounded in an in-depth review of the clinical and research literature, and drawing on the author's 40-plus years of experience, this paper presents a comprehensive, flexible, and user-friendly roadmap for conducting couple therapy. It begins by describing "Couple Therapy 1.0," the basic conjoint couple therapy format in which partners talk to each other with the help of the therapist. After noting the limitations of this model, the paper introduces upgrades *derived from systemic, psychodynamic, and behavioral/educational approaches, and shows how to combine and sequence them. The most important upgrade is the early focus on the couple's negative interaction cycle, which causes them pain and impedes their ability to address it. Using a clinical case example, the paper shows how all three approaches can improve couple process as a prerequisite for better problem solving. Additional modules and sequencing choice points are also discussed, including discernment counseling and encouraging positive couple experiences.*

Keywords: Couple Therapy; Psychodynamic Couple Therapy; Behavioral Couple Therapy; Integrative Couple Therapy

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THE CHALLENGES OF COUPLE THERAPY

Couple therapy is difficult! It is complex because therapists must deal with two clients, often at war with each other, with differing psychologies, histories, agendas, and commitment to therapy. It is emotionally demanding because it evokes intense emotions. The subject matter is challenging, including material topics like money, sex, and childrearing, and abstract ones like power, commitment, and love. Finally, it is difficult because there are many approaches to doing it, but a paucity of guidance in how to choose among them.

Each of the current, name-branded forms of couple therapy—Psychodynamic, Emotion-Focused, Emotionally Focused, Object Relations, Self Psychological, Narrative, Bowenian, Strategic, Behavioral, Cognitive–Behavioral, Integrative Behavioral, and Integrative Problem-Centered Metaframeworks—has much to offer. However, with so many choices available, therapists may cling for dear life to one theory or toss them all and go with the flow, two frequent errors observed by Weeks, Odell, and Methven (2005).

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Integrating therapeutic approaches provides the advantages of *integrating vocabularies* (Lebow, 2014); *giving common factors their due* (Sprenkle, Davis, & Lebow, 2009); *flexibly meeting client expectations* (Friedlander, Escudero, & Heatherington, 2006); and (most importantly) *providing more tools for working with diverse clients and complex, multidetermined problems* (Breunlin, Pinsof, Russell, & Lebow, 2011; Fraenkel, 2009).

This paper offers guidance concerning how to choose, sequence, and integrate tried-and-true therapeutic interventions within a comprehensive model. It is the outcome of my 40-plus years of treating couples, supervising students, observing other therapists, and studying the clinical and research literature. My goal is to provide a roadmap that emphasizes fundamentals and critical choice points. I say relatively little here about specific interventions or the challenges of intimate relationships, although both inform therapeutic choices (Nielsen, 2016).

My personal synthesis builds on, and substantially overlaps, the work of others who have presented integrative models for couple therapy (especially Berman, Lief, & Williams, 1981; Breunlin et al., 2011; Christensen, 2010; Fraenkel, 2009; Gurman, 2013, Lebow, 2006; Pinsof, 1995; Pinsof, Breunlin, Russell, & Lebow, 2011; Scheinkman, 2008; Scheinkman & Fishbane, 2004; Segraves, 1982; Snyder & Mitchell, 2008; Wachtel, 2017). After presenting my own model, I will make some comparisons with these other integrative models.

THE INTIMIDATOR AND THE NOVELIST: A PROTOTYPICAL CASE

Tom, a 35-year-old retired professional football player, and Jennifer, a 33-year-old novelist, presented with the manifest conflict of deciding whether to move to another city. There were clear pluses and minuses to relocating that they had "discussed" endlessly—he, using what he considered logical arguments, and she, becoming exasperated and shutting down. Jennifer remained unwilling to consider Tom's arguments, as she felt that her needs, though somewhat unclear even to herself, were not being considered. Both were despondent, not only about the deadlocked decision, but about their sex life, which had almost ceased, and about the viability of their 6-year marriage.

COUPLE THERAPY 1.0

Just Talk to Each Other

Had I seen Tom and Jennifer when I began doing couple therapy as a psychiatric resident in 1975, I would have suggested they meet with me to talk to each other while I watched and tried to mediate. I call this relatively unstructured, here-and-now, talk-to-each-other model *Couple Therapy 1.0*. It is the Model T of couple therapy and still provides the scaffolding for my work. It makes intuitive sense because, like Tom and Jennifer, virtually all couples coming for couple therapy complain of a breakdown in communication. As with many forms of instruction—music, sports, or dance—the model assumes that talking *about* how a person interacts (or plays) is insufficient for revealing what is going on. Rather, the therapist (or teacher or pro) must observe the client in action.

The format of *conjoint* meetings to deal with marital problems was uncommon until the 1960s, although "marriage counseling" began in the 1920s (Gurman & Fraenkel, 2002). Couple Therapy 1.0 builds on simple couple counseling by adding here-and-now interactions between the partners. It is distinguished from the upgraded forms I will describe later by the absence of sophisticated methods for attending to and improving the interpersonal couple process. I chose to make this conjoint, talk-to-each-other model the basic 1.0 version (rather than the earlier couple counseling version or a later systemically informed version) for two reasons: first, because many untrained counselors (peer or religious) and

individual therapists still use it; they know that they must encourage couples to interact, but do not know what to do beyond simple mediation; and second, because it is the foundation for the various approaches that improve on it.

The Basics of Couple Therapy 1.0

Prior to tackling our central topic—the integration and sequencing of advanced options—I will outline some basic guidelines for Couple Therapy 1.0 that also inform more complex versions. Here and throughout, recommended interventions will be shown as italicized bullet points.

- *As in all forms of psychotherapy, offer empathy, hope, safety, and containment in a professional environment that prioritizes the therapeutic alliance* (Friedlander et al., 2006; Sprenkle et al., 2009).
- *Allow the couple to choose problematic topics and attempt to work them out* (Pinsof, 1995).
- *Observe, monitor, and sometimes question partners about what their spouses have said.*
- *Assist clients who do not want to talk to each other.*

Most clients prefer to talk to you, rather than to *each other*. They want to tell you how they see things and why their partners are wrong, bad, or mentally ill (Christensen & Jacobson, 2000). To counter their desire to talk only to me, I tell them, "As in music, sports, or dance lessons, I need to see you doing what you do to help you improve."

- *Assert control and manage the emotional room temperature.*

In the ideal session, the couple respectfully engages emotionally significant issues. "Getting feelings out," while necessary, risks being only destructive. Couple therapy requires far more structuring than individual therapy. Several interventions are helpful for adjusting the emotional room temperature and providing "containment." I include these under Couple Therapy 1.0 not only because they are basic and powerful, but because they will quickly occur to almost any novice therapist and, thus, do not deserve more advanced upgrade status.

- *Cool things down by putting yourself in the middle.*

Exploiting clients' preference for talking to you, reduce the room's emotional temperature by coming between them (sometimes literally) and allowing them to return to what feels less intense: talking to the empathic therapist or, more soothing still, listening to you talk to them.

- *Heat things up by applying the interventions used in psychodynamic individual therapy to reduce anxiety and defensiveness.*

These include gently encouraging clients to describe the calamities they fear will occur if they become more emotionally present and forthcoming.

- *Heat things up by moving out of the middle and instructing the partners to interact with each other directly*, an option not available in individual therapy.
- *Work to remain neutral.*

Couple therapists must not be perceived as *consistently* biased in favor of one of the partners, a situation correlated with poor outcomes (Lebow et al., 2012), even as

maintaining overall neutrality while encouraging partners to change can be challenging (Friedlander et al., 2006).

When Couple Therapy 1.0 is Sufficient: Rarely

The unadorned conjoint model of Couple Therapy 1.0 may be successful when couples must resolve important disagreements (e.g., dealing with a difficult child) or discuss their feelings about a recent stressful life event (e.g., undergoing chemotherapy). It works well when the conflicts and feelings are not proxies for deeper, more longstanding issues, and when the discussion is not impeded by serious character pathology or maladaptive patterns of relating. More often, however, it fails because it lacks the power for dealing with these complications (Gurman, 2008; Snyder & Mitchell, 2008).

THE FIRST UPGRADE: FOCUS ON THE INTERPERSONAL PROCESS

"Upgrades" here are analogous to technological advances that increase the functionality of computer operating systems. This metaphor avoids the problem of name-branding, since existing brands of therapy and new innovations can all contribute improvements to the underlying, bare-bones, Couple Therapy 1.0 model. As with computer upgrades, we must be sure the elements work together.

The first upgrade to Couple Therapy 1.0 is focusing on the couple's interpersonal process. The "pathological dance," in which the emotional music generally matters more than the lyrics, must become the principal concern of both the therapist and the couple. Virtually all experienced couple therapists agree on this, though, as discussed below, they approach it from different angles. This is a systems theory upgrade that views much couple behavior as *an emergent property* of individual interactions, where what emerges is more than the sum of the individual contributions. While Couple Therapy 1.0 emphasizes the here-and-now of couples talking to each other, it does not specify that the *process*, rather than the *content*, should be the early and primary focus. While no news to readers of this journal (whose name foregrounds this emphasis), this process focus should be considered a crucial upgrade to working with couples, as it was at the dawn of the family therapy movement. Indeed, a failure to utilize this upgrade probably explains the disappointing results obtained by untrained counselors and individual therapists undertaking conjoint therapy.

Why Process Should Precede Content

There are many reasons to focus on process. Most importantly, research shows that negative process predicts poor outcomes in marriage and interferes with problem solving (Gottman, Coan, Carrera, & Swanson, 1998; Lebow et al., 2012), whereas improved collaboration reduces the number of problems to be solved, facilitates problem solving post therapy, and correlates with positive outcomes (Gurman & Fraenkel, 2002; Sullivan & Baucom, 2005, cited in Baucom, Epstein, Taillade, & Kirby, 2008). Improving system dysfunction is also easier than changing personality dysfunction (Pinsof, 1995), while "solving the moment" strengthens intimacy (Wile, 2002), "shared purpose" (Friedlander et al., 2006), and "we-ness," independent of resolution of couple problems that can be "perpetual" (Gottman & Levenson, 1999).

Improved Process as Shared Target

The common target of remediating negative interaction cycles can help us begin to integrate systemic, psychodynamic, and behavioral approaches, including those of Wile (2002), whose interventions center on establishing "collaboration"; Sue Johnson (2008)

and other EFT therapists whose research shows the benefits of "pursuer/blamer softening" and "distancer engagement"; and Markman, Stanley, and Blumberg (2001), who teach the speaker–listener technique. Consequently, rather than referring to specific authors or branded therapies, we can classify interventions into three broad categories: *Systemic theories* stress how negative process can stem from the cyclical amplification of initial conditions (somewhat independent of the partners' individual psychology) and the structural challenge of sharing power equitably in a two-person polity (among other things); *psychodynamic theories* explain maladaptive process via hidden issues, divergent meanings, transferences, and projective identification; and *psychoeducational and behavioral theorie*s add that people can be taught better approaches to managing difficult conversations, regulating emotions, and solving problems.

The Cheshire Cat Complication

Having just declared that interpersonal process should usually be the early focus of therapy, we must acknowledge that it is impossible to discuss process in the abstract, without *some* concrete content. In *Alice in Wonderland,* the Cheshire Cat's smile existed without the cat, but in real life, "process" always requires "content," if it is to be seen. This suggests a recommendation sometimes at variance with the guideline of letting couples choose topics for discussion:

- *To improve the benefit and sustainability of focusing on process, encourage couples to begin with more workable, less emotionally charged content.*

This may not always be possible, especially when the consultation is driven by a serious rupture of trust, such as infidelity. In such cases, we should begin with the topic that is most pressing, even though it may render examination and remediation of the couple's process more difficult. Emotional intensity aside, there are many days when we should follow the problem-centered focus of Couple Therapy 1.0 and allow couples to focus on content, rather than spotlighting process. Although improved process fosters more successful management of most marital problems, thorny problems *are* important (Fincham & Beach, 1999) and will eventually need to be addressed.

Systemic Interventions That Begin to Alter Negative Interaction Cycles

- *Focus on the cycle and label it as the enemy.*

Focusing on the pathological cycle will usually, in and of itself, improve that process. It accomplishes this in three interrelated ways. Giving the vague marital problem a diagnostic label ("a systems problem") defines and demystifies it (just as diagnosing a physical malady does). Objectifying it makes it a shared enemy the couple can attack jointly, in what White (2007) termed an "externalizing conversation." And, focusing on the pathological dance reduces blame by countering linear narratives of victim and villain.

- *Use the chemical reaction metaphor.*

To convey the idea of a systemic problem—one with additive, circular, and emergent properties—I use the metaphor of a chemical reaction. The partners are likened to two colorless reagents in separate beakers that, when mixed, become drastically altered: perhaps becoming explosively hot, ice cold, or foul smelling. One of the reagents might think, "I

was just fine before: not hot, cold, or smelly. This sudden change, in which I don't even recognize myself, must be due to that other damn chemical!" This metaphor powerfully illustrates how group process is not reducible to individual behavior and is experience-near for individuals who are feeling blamelessly victimized by their partners.

• *Explain that the "punctuation" of negative cycles is arbitrary.*

Most people "punctuate" their narratives by beginning with some misdeed or insensitive action of their partner. Therapists can point out that this starting point is usually arbitrary.

• *Normalize off-putting demands: drowning swimmers.*

Escalation commonly consists of one or both partners speaking increasingly loudly, impatiently, and aggressively, perhaps while nagging, guilt-tripping, or swearing. These ineffective attempts to influence a partner tend to occur and intensify when the partner appears unresponsive. Therapists can normalize these counterproductive behaviors by explaining them in systemic terms. One metaphor I use is of a drowning swimmer calling for help. The more the swimmer fears drowning, and the longer the lifeguard fails to respond, the louder the swimmer screams. Often, in escalating negative couple cycles, it is more accurate to characterize *both* partners as drowning swimmers, even though one may superficially appear to be an unresponsive lifeguard.

• *Normalize flight: firefighters battling forest fires.*

Just as escalating anger can seem appropriate in some situations, so can flight. Withdrawal becomes more comprehensible and acceptable if one remembers that firefighters facing a raging forest fire must sometimes retreat temporarily. Therapists can help couples consider the perspectives of metaphorical fleeing firefighters (Why do they think the situation is hopeless?) and advancing forest fires (What is making the pursuer so hot and insistent?).

• *Introduce the goal of "making a short story long."*

After giving the couple a preliminary outline of the cycle that is simultaneously captivating and torturing them, I explain that we can gain a deeper understanding by "making a short story long" (Scheinkman & Fishbane, 2004): slowing things down, as in a slow-motion video replay.

SEQUENCING ADDITIONAL UPGRADES

My additional sequencing preferences, diagrammed in Figure 1, include (1) what to try first, (2) what to try next should that prove insufficient, and (3) what to do when success has created the foundation for further work.

DIAGNOSTIC PHASE AND OPENING MODIFICATIONS

Although this paper focuses on what happens *after* the initial diagnostic interviews, a few words on that complex topic are in order (see Nielsen, 2016, for more detail). In early sessions, I obtain a biopsychosocial lay of the land that includes an assessment of the

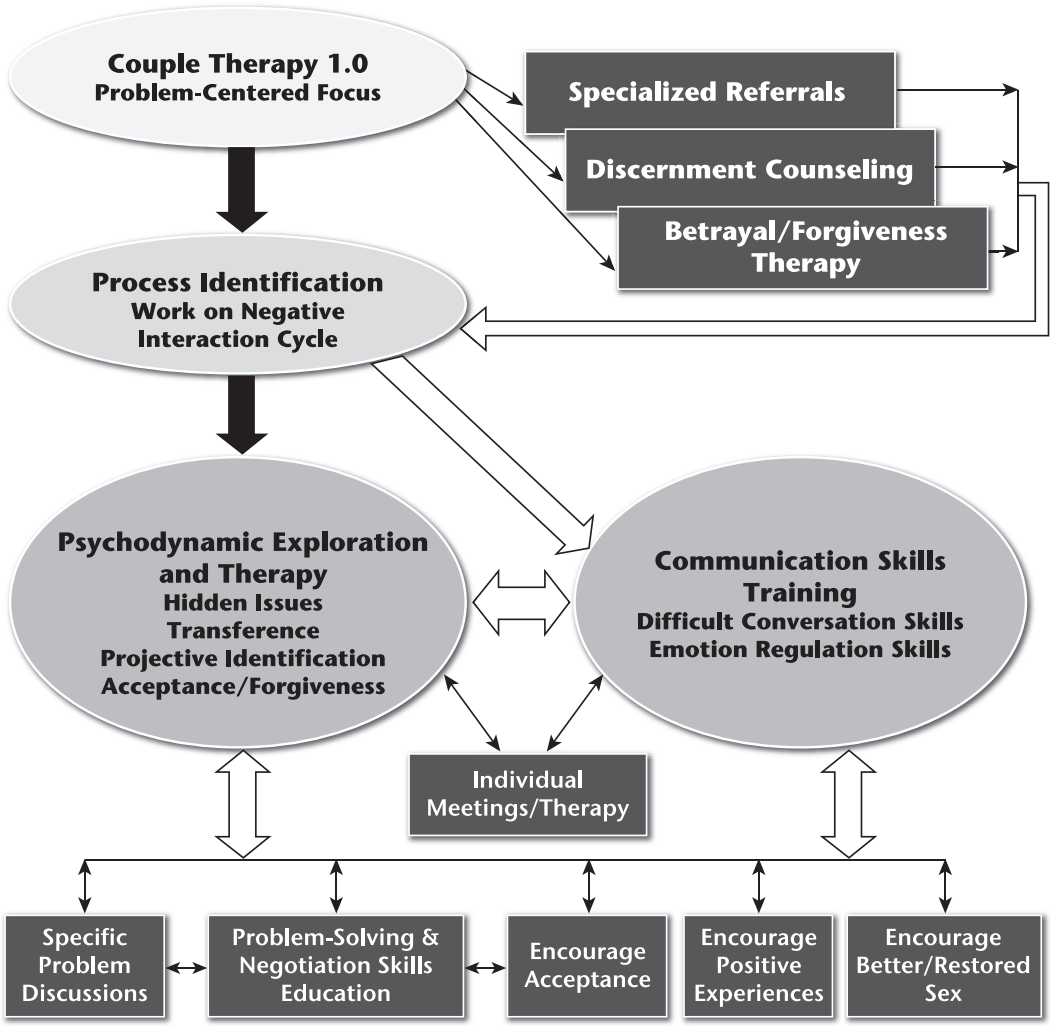

FIGURE 1. Sequencing Couple Therapy Interventions. In general, interventions flow from top to bottom and then horizontally, as indicated, with the ovals representing the earlier and more important options. Rectangles at the top represent a rapid alteration of the conjoint format. Those at the bottom represent therapeutic foci made possible by earlier interventions. The exception is the rectangle of individual therapy or individual meetings with the couple therapist, which may be a necessary or concurrent step supporting the entire enterprise.

couple's ability to work both with each other and with me. *Sometimes, the typical conjoint format must be modified (upgraded) immediately*:

- *If there is serious psychopathology, depression, substance abuse, or extensive intimate partner violence, make appropriate referrals for specialized treatment, which may run concurrently with the couple therapy.*
- *If divorce seems imminent because one partner is only tenuously committed to the marriage, propose "discernment counseling" (Doherty, Harris, & Wilde, 2016), including meeting separately with each partner.*
- *If betrayal of trust is central at the outset, begin with a conjoint therapy tailored toward crisis intervention, exploration of the offense, and discussion of possible forgiveness and reconciliation (see Discussion).*

COUPLE THERAPY 1.0 TO THE FORK IN THE ROAD

Aside from the situations just mentioned, I begin with the conjoint format of Couple Therapy 1.0, allowing the couple to discuss and attempt to resolve their presenting problem(s) while offering some basic assistance and maintaining a neutral stance. If this proves inadequate, I focus on identifying the steps in the interpersonal process as mentioned above.

THE FORK IN THE ROAD

After identifying the behavioral steps in the couple's negative interaction cycle (e.g., a pursuer–distancer cycle), therapists of different persuasions take different paths. Behaviorally inspired therapists will choose to label specific problems in communication and teach better strategies. Psychoanalytically informed therapists, emotion/emotionally focused couple therapists, and others who favor a more experiential approach will focus on the psychodynamic issues that lie below the surface of most so-called "communication problems."

After reviewing many studies of this choice point, Sprenkle et al. (2009) concluded that "therapists do better offering insight-oriented procedures to clients who are more self-reflective, introspective, and introverted. Conversely, therapists should offer skill-building and symptom-focused methods to clients who are more impulsive and aggressive" (p. 52). Other research recommends insight-oriented approaches when wives complain about insufficient closeness (Roddy, Nowlan, Doss, & Christensen, 2016) and behavioral approaches, in general, for men (Friedlander et al., 2006), creating a potential juggling act for therapists. Other authors note that cultural norms may inhibit examination of family-of-origin issues (Boyd-Franklin, 2003; Falicov, 2014). Most basically, research shows that therapist flexibility and adaptation to client feedback and intermediate outcomes are essential (Duncan & Miller, 2000).

I employ a pragmatic approach tailored to each client's personality style and receptivity. For reasons to be presented shortly, I usually begin with a psychodynamic, uncovering approach, centered on exposing the underlying issues that power the couple's negative interaction cycle. Should that prove ineffective, I shift quickly (even in the first session) to teaching rules for safe dialog and techniques for emotion regulation.

I teach communication skills more extensively and more systematically in two (sometimes overlapping) situations: with concrete thinkers who are deficient in psychological-mindedness and with emotionally volatile couples. Most such couples seem grateful for this early shift to relationship education. Particularly with high-intensity couples who lack psychological-mindedness, uncovering deeper anxieties—say, about commitment or respect—may be inflammatory. Teaching such couples how to talk more safely will often enable them to access deeper concerns *later* in therapy.

PSYCHODYNAMIC INTERVENTIONS

- *Focus on underlying issues, personal meanings, transferences, resistances, projective identification, and acceptance.*

The principal reason to focus here first—before teaching fair-fighting skills—is because asking people to control themselves when they want to voice their deep distress may feel unnecessarily constricting to them and could jeopardize establishing an early therapeutic alliance. While virtually all couples can benefit from instruction in the optimal ways to

handle "difficult conversations" (Stone, Patton, & Heen, 2010), many will converse collaboratively soon after the therapist helps them address their underlying concerns. For instance, one couple I treated had been fighting endlessly over whether the husband should work harder on his career. This surface disagreement became accessible to discussion soon after I helped them see that the road to compromise was blocked by the emotional issues connected with both the content and the process of their disagreement: the husband feeling shamed and controlled, the wife feeling powerless to avoid reliving the economic hardships of her childhood. In situations like this, uncovering therapy can move things along rapidly, whereas teaching skills like empathic listening may feel like stalling and can actually increase anxiety if clients feel that their complaints remain unaddressed.

The initial goal of the psychodynamic approach is to reduce defensiveness and blame via "reframing" and "making a short story long" as we explore personal meanings and allergic reactions stirred by surface conflicts. Transference hopes and fears, intrapsychic conflicts, and idiographic sensitivities are explored with the goal of elucidating what powers the counterproductive behaviors of the negative interaction cycle. In all cases, therapists can point out that less-than-perfect behavior is common when people face their negative transference expectations or believe that their central needs are not being met (Leone, 2008; Shaddock, 2000).

Once we uncover and reframe an issue in one partner, the other will often become more understanding. When this does *not* happen, the therapist can work to help him or her respond more sympathetically by uncovering issues that stand in the way.

The next step after the initial exploration of hidden issues (Markman et al., 2001) depends on the psychodynamics and content uncovered: Work on projective identification, families of origin, forgiveness, and acceptance usually evolves organically as specific hidden issues emerge in an increasingly safe setting.

Projective identification is a powerful conceptual tool for couple therapists. It is an interpersonal defense that moves beyond misidentifying others (transference) to inducing them to play roles in some interpersonal drama. It allows projecting partners to locate unacceptable parts of themselves in their partners or to use them to work out unfinished issues from their past (Catherall, 1992; Nielsen, 2017). In either form, it interferes with couple intimacy and problem solving.

As advocated by others (Pinsof et al., 2011; Wachtel, 2017), when I am uncovering and working with psychodynamic issues (meanings, hopes, fears, defenses), my preference is to focus on the here-and-now couple process before exploring historical origins. This is because hearing a negative transference labeled by the therapist ("Perhaps you fear asking for things from your wife because you believe she will become critical of you like your mother?"), is less effective than encouraging clients to test out their (transference) fears in the present—here, a fear of making requests. If clients achieve better results than they expected, the historical explanation is interesting and may help them remember and make sense of their undue fear, but it pales in comparison to the therapeutic impact of their corrective experience. This here-and-now preference also makes it less likely that the spouse will pile on with, "See, I've always said you act like I'm your mother!"

That said, not all psychodynamic work occurs *during* examination of the couple's process. As it turns out, *unpacking the interpersonal process is often the royal road to discovering the individual intrapsychic problems that haunt a marriage*, and serves as the starting point for what I term episodes of "witnessed individual psychotherapy." Here, I proceed as I would in an individual psychodynamic therapy, with the added benefit that partners get to observe and learn more about one another's deepest concerns, sometimes adding their own insights.

• *Work on forgiveness and acceptance.*

With some couples, such as those who begin therapy reeling from a recently exposed affair, issues concerning forgiveness and reconciliation arise from the start, and therapy often begins as crisis intervention. That is why I have diagrammed "Betrayal/Forgiveness Therapy" in Figure 1 as a separate (challenging) form of therapy evolving rapidly out of the limitations of Couple Therapy 1.0. When the presenting problem involves betrayal, we need to focus on the immediate crisis, including the meaning of the betrayal, the loss of trust, possible apologies, and the need to control unacceptable behavior (e.g., Spring, 2004). Once things have settled down—and assuming the partners elect to continue their relationship—work can proceed in the usual manner, focusing on negative cycles, psychodynamics, and skill deficits, and progressing to discussions of the specific issues that may have led to the violation of trust. For other couples, specialized forgiveness work will occur later in treatment, when it becomes safe or relevant to bring up a long-past betrayal.

For most couples, work on *acceptance* will almost always come later, after attempts at problem solving and compromise have shown their limitations (Jacobson & Christensen, 1998), which is why this psychodynamically informed module is shown as a rectangle of its own at the bottom of Figure 1. Work on acceptance is important because research shows that many couple problems are "perpetual" and unlikely to change (Gottman & Levenson, 1999). To some extent, acceptance is a background theme for all therapeutic interventions, as we work to help clients learn to live with their less-than-perfect partners *and* their less-than-perfect selves. (Working on self-acceptance also reduces projective identification, because clients who can accept negative aspects of themselves no longer need to locate or induce them in their partners.)

• *Aim for more than conflict resolution.*

When using psychodynamic interventions, *we seek not only to reduce conflict and enable productive problem solving, but to facilitate empathy, intimacy, self-esteem, and love.* Among other things, couples learn to trust each other with more honest self-disclosure, and to balance the existential conflict between meeting their needs and meeting those of their partner. These more far-reaching goals may explain the more enduring and intensifying benefits found in some follow-up studies of couple therapy emphasizing psychodynamics (Johnson & Greenberg, 1985; Snyder & Mitchell, 2008).

• *Pay attention to countertransferences.*

Throughout couple therapy and independent of intervention category, therapists must monitor their emotional reactions to clients, their countertransferences. During psychodynamic work, this facilitates guesses about the role relationships and expectations in play (Tansey & Burke, 1989). To assess these, I imagine what it might be like to be married to each of the partners, and ask myself whether I would experience the same sorts of frustrations and disappointments they are describing. If it seems likely that I would, I feel more confident that those problems are worthy of attention. If I see different problems not yet mentioned, I may wonder why a spouse is so complacent. If I am not much bothered by the problems mentioned, I am more likely to wonder whether the complaining spouse is having allergic reactions. All of these musings depend on my having a working knowledge of my own personal biases, emotional allergies, and current concerns.

I pay particular attention to negative countertransferences. Noticing a reflexive inclination to side against an obviously offensive partner often leads to my coming to that

person's aid. This stems partly from systems thinking: A whining, annoying, or stridently defensive spouse is often the one holding the fewest cards, having the least power, and therefore acting the most symptomatically. In couple therapy, the squeaky wheel is often the partner who is not getting needed psychological grease. When I find a client particularly repellant, I consider the possibility that he or she is not doing a good enough job representing his or her position or needs. If I can reframe, uncover, or give coherent voice to the client's concerns, this often improves the repellant behavior, the marriage, and the therapeutic alliance.

BEHAVIORAL/EDUCATIONAL INTERVENTIONS

- *Teach communication and emotion regulation skills.*

Early in treatment, I give clients handouts and recommended readings that discuss skillful communication (e.g., Markman et al., 2001). The readings help develop a shared vocabulary of dos and don'ts for difficult conversations, presenting the material more systematically and in greater depth than makes sense in therapy sessions. I then offer individualized relationship training, as necessary: communication skills when we encounter recurring maladaptive ways of speaking and listening, emotion regulation skills when emotion tolerance is repeatedly exceeded, and problem-solving and negotiation skills when we discuss specific concrete conflicts (see Nielsen, 2016).

As indicated by the horizontal arrows in Figure 1, I regularly toggle between psychodynamic work and skills education. When couples fail to follow recommended communication rules, I explore their internal psychological obstacles. And when they *do* successfully follow the rules, we often uncover previously hidden issues and witness corrective experiences (Segraves, 1982). For instance, in one typical pursuer–distancer couple, the sheepish husband who perennially feared displeasing his wife was overjoyed to see how sticking to the role of active listener almost guaranteed him success with her. Both spouses also had corrective experiences after the wife followed the rule that the speaker keep remarks to a manageable duration. That allowed this timid man to experience his wife as less overwhelming, and allowed her to experience him as more responsive (in contrast to her negative expectation, which had powered her off-putting pursuit).

As mentioned before, the timing of teaching skills is critical: too soon, and the therapist may fail to connect with the couple's pain; too late, and the couple may be deprived of powerful tools that can arrest their persistent negative cycles. Sometimes, I offer educational structuring right out of the gate. When teaching communication skills, I begin by emphasizing restraint from speakers ("*not* doing what comes naturally") and curiosity and empathy from listeners.

For most clients, following "communication rules" feels awkward and artificial, so it can help to remind clients of other beneficial procedures that initially feel unnatural: a medical team using a presurgery checklist, a PTA meeting adhering to Robert's Rules. While some therapists have argued that skills training is pointless because clients already know how they "should" behave but cannot perform that way under pressure, research (e.g., Baucom et al., 2008; Roddy et al., 2016) and clinical experience demonstrate that many people benefit.

With volatile clients, I explain how to initiate and manage timeouts and how to downregulate intense emotions, as per Linehan (1993) and Atkinson (2005). And, to lower the intensity of conjoint sessions, I sometimes supplement them with individual sessions. Psychoactive medication can also help.

REMAINING INTERVENTION CATEGORIES

Problem-Solving Interventions

• *Work toward resolving specific tangible problems.*

Once we have a workable interpersonal process, we can target concrete areas of couple conflict. All along, couples will have been discussing *some* specific issues that have elicited conflict and hard feelings, even as we have been focusing on their maladaptive process, their underlying psychodynamics, and their communication skills. But it is only now, after we have cleared away some of the structural constraints to productive problem solving, that couples will make headway in settling their more thorny and chronic disagreements. As we do so, we will almost always uncover additional *specific topic-related* underlying issues (psychodynamics) that will require attention and facilitate conflict resolution.

• *Suggest relevant self-help readings.*

In this phase of treatment, couples often benefit from self-help readings pertaining to the topics they are discussing (step-parenting, financial planning, caring for an aging parent).

• *Teach problem-solving and negotiation techniques.*

Sometimes, it helps to teach problem-solving and negotiation skills over and above rules for talking to each other safely, such as brainstorming and systematic problem assessment, as per Markman et al. (2001) and Fisher, Ury, and Patton (2011). Clients can then continue to access these resources after treatment ends.

Success in achieving practical and equitable solutions takes the heat out of pathological dancing and is strongly correlated with future marital happiness (Roddy et al., 2016). While work to improve process must often come first, resolution of highly distressing problems (e.g., managing an ex-spouse in a new stepfamily) may ultimately be what couples remember as most beneficial.

Concurrent Interventions

The following interventions are theoretically separable from ones aimed at improving negative interaction cycles or practical problem solving, and can run concurrently with them.

• *Encourage positive interactions*.

Beginning as soon as I believe there is a reasonable chance of success, I encourage date nights and other pleasurable activities, occasions explicitly designed to be free from conflict and stress. I help couples brainstorm and work with them to identify and reduce impediments, including the responsibilities (childrearing, work) and activities (solo recreation) that many chronically distressed partners focus on as alternatives to marital satisfactions. Although this idea is familiar to behavioral couple therapists, it is a valuable upgrade for therapists who might otherwise attend only to interpersonal process or who were trained to be nondirective.

• *Work to restore sexual intimacy.*

Sexual problems are extremely common in the general population (Laumann, Paik, & Rosen, 1999) and are almost universal in couples who present for couple therapy. Except

for couples whose leading complaint concerns sex, most couples will choose to put this topic on hold until later in their work, as they assume, often correctly, that their lack of sex is secondary to their negative feelings toward each other.

It might seem logical that sexual encounters would resume spontaneously after overt conflict declines and cordial feelings return, but this is often not the case. For such couples, physical and sexual contact is often the final frontier requiring our help, something insufficiently addressed in many couple treatments that assume that this area of life will take care of itself (Gurman & Fraenkel, 2002; McCarthy & Thestrup, 2008).

While clients come to trust their partners to fight fair, many will remain reluctant to trust them with their strong, literally naked, desires for love and affection. As a result, I have found it helpful to think of myself as a ballroom dance instructor of frightened middle schoolers, the instructor who declares that it is now time to choose a partner and master the anxieties of dancing together. I begin slowly, encouraging the couple to hold hands, to hug, and to engage in sensate focus exercises, as needed, prior to erotic contact. Along the way, we may encounter specific sexual problems that need skillful, individualized attention. Consulting the relevant literature (e.g., Levine, Risen, & Althof, 2010; McCarthy & Thestrup, 2008) is helpful here. I designate this an upgrade because to address sexual problems successfully, therapists must be both proactive "dance instructors" and informed experts on what works beyond basic couple therapy.

SOME ADDITIONAL GUIDELINES

Repetition and Nonlinearity

Although the decision tree I have presented appears fairly linear, actual therapy is far more circular, chaotic, and repetitive; important changes take time and practice before they sink in. Clients rarely understand this. They expect that their partners will change after being told to, and are surprised when therapy takes so much time and patience. When progress is slow, we must help them replace their dispirited "Here we go again!" with a more hopeful "OK, so things are heating up again. What have I learned that can make this better for both of us?"

Direction versus Nondirection

Throughout treatment, therapists should be alert to tradeoffs between being directive and providing a safe, nondirective space for client initiative (Fraenkel, 2009), between having a plan for the next step and going with the flow. Therapists without a plan may become lost and fail to recognize landmarks they have passed before, whereas therapists with *too* much of an agenda may miss improvisational opportunities that emerge from the give-and-take of the moment. As in so many areas of life, balance optimizes success.

We return to our prototypical couple to illustrate some of these issues.

THE INTIMIDATOR AND THE NOVELIST: A PROTOTYPICAL CASE

Recall that this couple came to therapy stuck in the zero-sum problem of deciding whether to move away from Chicago. In our first meeting, both Tom and Jennifer described the negative cycle that emerged whenever they tried to discuss this conflict. When I encouraged them to talk to each other rather than to me, I got to observe it directly. And when I attempted to mediate a discussion of the pros and cons of moving, their negative cycle impeded my efforts. As often happens, this attempt at bare-bones Couple Therapy 1.0 proved insufficient. We did, however, now have a handle on a working diagnosis, as their description, their unaided process in the room, and their

imperviousness to straightforward assistance all pointed to their negative interaction cycle as the culprit needing attention.

A business school graduate after ending his professional sports career, Tom was very competitive. He interfaced with his wife—and the world—in a dogged, excessively logical manner, but his detailed charts showing the advantages of moving had no effect on Jennifer. Her reluctance—not only to move, but even to *discuss* moving—remained mysterious, especially since they both knew that Tom was growing increasingly depressed since the job opportunities he sought and the recreational activities he loved were unavailable locally.

The couple had met in college, where both were active in sports, and had bonded over this common interest and other shared values. Jennifer had been attracted to Tom's self-assurance, but resisted when he pressured her against her wishes to meet his needs. This was true in the bedroom, as well; although she had initially enjoyed sex with him, she had lost interest, feeling he imposed on her when she was not in the mood. Her rejection only added to Tom's frustration and feelings of inadequacy. Both his depression and his insistence that they move intensified. Clearly, the same negative interaction cycle was interfering with this other important area of their marriage. This was another reason, distinct from our inability to solve their presenting problem, to shift our focus to the pathological dance itself in order to address multiple problems simultaneously.

"Tom," I began, "to the extent that you forcefully and repeatedly try to influence Jennifer with what you believe is impeccable logic, Jennifer feels increasingly dominated and withdraws still more into her angry, confused state of mind. When she retreats and refuses to participate in this crucial discussion, you feel unimportant, anxious, and out of control. As a result, you redouble your efforts to force her to talk, and around you go."

My first goal here was to *interrupt* the negative process by labeling its steps and showing how they led to their standoff and escalating unhappiness. I also wanted to validate each partner's emotional reasons for continuing to dance as they did, by offering empathic explanations, sometimes directly ("Tom, it's hard for you to remain calm when your career and self-respect are blocked by Jennifer's reluctance to engage these issues.") and sometimes indirectly, representing one to the other ("Tom, I think what Jennifer would like to tell you, if she could be more direct and less afraid of hurting your feelings, is that when you get all worked up and insistent, it makes her feel like you're not interested in *her* needs. This makes her angry, and then, feeling uncomfortable with her anger, she shuts down.").

This combination of labeling the steps in their vicious cycle and providing empathy—a melding of systemic and psychodynamic approaches—almost immediately helped to slow them down and give them hope. It also cleared a space where we could further explore the underlying issues that both powered the cycle and were concealed by it. Specifically, as I continued to validate Tom's frustration at Jennifer's indecisiveness, and to block the guilt-inducing/controlling tactics he was using to deal with it, he became more patient, and we were able to uncover the reasons for her hesitation.

As the mood lightened, we found an amusing and telling image for an aspect of their dance: It turned out that, in sports, both of them had been known for "intimidating" their opponents. Significantly, this had been the *sole* area of Jennifer's life where she had allowed herself to be satisfyingly aggressive. Her anger was otherwise channeled indirectly, through characters in her novels who stood up to authority figures. I worked to help her express, overtly, the resentment she felt at being pushed around by Tom, now labeled "The Intimidator." In the process, she began to reflect on the origins of her difficulty expressing her needs. We learned of a career-ending sports injury and how she believed that she had allowed others, including her domineering father, to bully her into the surgery that made things worse. We also uncovered considerable internal conflictedness

about her parents, who lived nearby, and about their expectations that she remain in the area to assist with family responsibilities.

Calling Tom "The Intimidator" might seem like a put-down, but he actually liked the title, which reminded him of times when he had felt strong and capable, so that he accepted being ribbed for being too dominating in his marriage. Further, reminding Jennifer of *her* past glories as an "intimidator" energized her to find a more assertive voice.

To help them experience a more balanced form of communicating, I taught them some speaking and listening skills, which helped Tom restrain himself and encouraged Jennifer to speak in ways that Tom could hear. Tom proved to be particularly coachable (he had, after all, been a professional athlete). He became almost a co-therapist, drawing Jennifer out about her family and her wish to never again go along blindly with plans proposed by others.

Tom's more patient and empathic presence made it possible for Jennifer to hear him as he spoke movingly of his fears of being like other professional athletes who ran through their earnings, of his shame at being unemployed, and of his lifelong love of the outdoor sports he could not pursue in Chicago. The difference was that now Jennifer, as she "softened," could hear him and be moved by his pleas to relocate. More fundamentally, they experienced moments of real intimacy and connection in my office, and their sex life picked up at home (unlike many couples who require special attention to resuscitate sexual contact).

As their interpersonal process improved, they became a team working together to solve their external problems. On their own, they decided in favor of the relocation Tom favored, and, equally important, they worked together to deal with the resulting fallout from making a choice contrary to Jennifer's parents' wishes.

It may appear that Jennifer "resolved" her marital conflict by simply resorting to her old pattern of capitulation, but I do not believe that is what happened. What we discovered was that the major obstacle to her acceding to Tom's wish was her semiconscious guilt over displeasing her parents. Unearthing this problem, coming to accept that she could not please everyone, and choosing marital happiness (her own, as well as Tom's) over fulfilling her parents' wishes that she care for her disabled brother allowed her to settle her disagreement with Tom and agree to move.

After solving the specific problem that had brought them to therapy, and using a problem-solving template I had taught them, Tom and Jennifer became better at managing other conflicts (e.g., which new house to buy), demonstrating that they were prepared to handle future episodes of conflict. Their depressed mood lifted, and their pleasure in their shared life was palpable, then and a year later, when they returned for a follow-up visit.

This case is typical of many successful cases: A couple presents with a specific problem and some level of chronic unhappiness. Their sex life is compromised, and they are growing increasingly estranged from each other. They may be considering divorce. What helps, beyond providing a safe forum for them to talk to each other, is directing early attention to their negative interaction cycle, labeling it, and working to expose its roots, enabling them to feel and act more sympathetically and collaboratively with each other. Teaching communication and problem-solving skills also helps, and improved systemic process exposes previously concealed personal concerns (psychodynamics). Intimacy, problem solving, and overall happiness improve concurrently.

DISCUSSION

I conclude with some remarks comparing my approach to the integrative models proposed by authors I cited earlier, whose work I have built on.

Common Ground

Having studied most of the literature on integration in couple therapy, my foremost conclusion is that we integrative couple therapists are more alike than different. This is encouraging, since it suggests that the countless years of experience of numerous clinicians have yielded convergence on many key elements of therapy integration. In truth, we are most different from some 20th-century therapists who manifested "an almost xenophobic fear and loathing" of integration (Gold & Stricker, 2006, p. 3), and contemporary therapists who still identify with more narrowly defined approaches.

All integrative models strive to interweave attention to interpersonal process and intrapsychic psychology—what I call systemic and psychodynamic approaches—in ways that seem clearly superior to couple therapies of the past that were naively atheoretical or exclusively psychodynamic, behavioral, or systemic. All emphasize the therapeutic alliance and the need to attend to client priorities, cultural norms, and therapeutic preferences, while remaining open to changing course as needed.

Almost all prioritize problematic interaction cycles, although addressing them sometimes takes a back seat to presenting problems (Breunlin and Pinsof). And, while all identify priorities, all agree that the work has (disciplined) improvisational elements, similar to jazz (Pinsof et al.) or painting (Fraenkel), and note that optimal interventions often make simultaneous use of different approaches.

Differences

Regarding teaching communication skills, some place great value on using this option formally, early, and often (Snyder & Mitchell). Others (like me) usually wait a bit. And still others do this only informally, preferring to exert control over process by laying out ground rules (Scheinkman & Wachtel). Most authors have a "home theory" that is discernable as psychodynamic, family systems, or behavioral/educational, which gives their writing a distinctive flavor and accounts for other differences not mentioned here.

Distinctive Features of the Present integration

- The novel use of the metaphor of *Couple Therapy 1.0* as a common foundation for conjoint couple therapy, with *upgrades* as additions, allowing for a nonbranded, incrementally improving couple therapy, possibly termed "comprehensive."
- The (less distinctive) somewhat greater early focus on the pathological interpersonal process, with the (more distinctive) "theoretical integration" (Gold & Stricker, 2006) of applying any of the distinct approaches (systemic, psychodynamic, and behavioral/educational) to couple problems *generally* to improve collaboration *narrowly*.
- Though not elaborated here, greater weight given to projective identification and to contemporary developments in psychoanalytic theory (Nielsen, 2017).
- More explicit acknowledgement of the benefits of toggling between psychodynamic and educational interventions—using psychodynamic exploration to facilitate adherence to communication rules, and using communication rules to facilitate psychodynamic exploration and corrective experiences.
- Greater clarity about additional upgrades/modules *prior to* the conjoint contract (e.g., "discernment counseling"), upgrades *made possible by* improved couple collaboration (e.g., return to problem solving of presenting and intercurrent problems), and *ongoing* interventions (encouraging positive experiences and attending to the sexual relationship).
- No assumption that certain interventions, especially depth psychological ones, should *always* wait until others have failed.
- A less encyclopedic map that is more user-friendly because it is easier to remember.

A Scaffolding for the Future

Just as I have moved on from the Couple Therapy 1.0, I began with to the more comprehensive, integrative model presented here, I anticipate that the field will continue to discover and refine therapeutic options. I hope that this framework will serve as a scaffolding for future integration.

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