CHAPTER 7

Process and Cure in Couples Therapy

An intersubjective approach to couples treatment is by no means limited to any one modality, although empathic/introspective listening remains its core. The intersubjective approach emphasizes “practical reasoning” (Orange, Atwood and Stolorow, 1997) over any specific technique: “each analytic intersubjective field will develop its own process and change its own procedures as needed” (p. 24). An intersubjectively informed couples therapy will not proceed toward a specific set of goals, nor will it necessarily employ any specific techniques such as mirroring exercises, dialogues, directives or homework, though none of these is proscribed. The commitment is to investigate the meaning and effect of the therapist’s activities, to identify which of those activities facilitate an enhanced sense of relationship satisfaction.

It is particularly important to investigate therapists’ actions that create a sense of blame or shame, because these often trigger a shift back toward defensive relationship configurations. Ironically, this can take place in communication models, where the partners are instructed to use “I” statements instead of blaming. Interrupting a statement to encourage a different sentence construction can feel to some patients as a discounting of what they are trying to say. Many otherwise useful approaches to couples therapy suffer from unexamined assumptions that fail to take into consideration the unique and differing responses the couple or either of the partners may have.
to the therapist’s interpretations, suggestions or even innocuous comments. One important corollary to the freedom from specific technique in the intersubjective approach is that the therapist need not know what is right for a couple at any particular time. Indeed, relieved of the burden to know, the therapist is better able to listen and try and make sense of the aspirations and disappointments of the particular couple, with an eye for discovering how he can enter the existing system in a helpful way.

Similarly, a contextualist view of couples therapy limits any notion of cure or success to what is created by the particular intersubjective triad at a particular moment in time. The therapist’s assumptions about the couple’s developmental level, invariant organizing activity or narcissistic vulnerability are an important part of the context in which a decision about the course of couples treatment is made. But these factors must remain one consideration among many. Although the therapist may hope for a fundamental or characterological change, couples may want a briefer, more focused treatment. Again, the systemic nature of couples treatment makes it impossible to predict at what point the system will shift and how stable the new organization will be. A disagreement between the partners or between the couple and the therapist as to when to terminate treatment may be an opportunity to express new health in the relationship in the form of increased ability to tolerate differing subjective views. Conversely, the context of societal, familial or personal expectations of what is “right” in a relationship may be part of the couple’s problem.

FOCUS AREAS

With these general thoughts in mind, let us turn to a more particular description of the process and goals of intersubjective couple therapy. We will discuss six general areas for the therapist to focus on—not a set of rigid procedures that take place in order, but themes that can be woven into the ongoing treatment:

- creating trust,
- fostering the capacity for introspection,
- making system interpretations,
- strengthening the holding environment,
- directly creating development-enhancing experiences,
- strengthening attachment.
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Creating Trust. The approach described in Chapter 6, whereby the therapist begins with a careful examination of each partner’s subjective experience, goes a long way toward establishing trust. The message, conveyed both explicitly and implicitly, is that no one is to blame here, we are just trying to understand what has happened in this relationship.

Beyond that, trust is created by careful exploration of each partner’s experience of the therapist. Sometimes that can entail a review/recognition of where some failure on the part of the therapist threatened his bond with one or the other member of a couple. In such instances, the reparative process actually gives birth to trust of a greater magnitude than what was lost.

For example, in a session near the beginning of treatment, the husband, Max, poignantly described the level of abandonment he’d felt growing up with an alcoholic mother. When he reported that, after a life-threatening motorcycle accident landed him in the hospital for a month, his parents barely phoned him. I observed, “In light of all this, it must be extraordinarily painful when your wife isn’t there for you.” His wife, Andrea, seized on the story, claiming that it explained his constant criticism of her for not being more present in the relationship.

Max came into the next session very subdued. I sought to understand his affect in terms not only of what had happened in the relationship but also of the patient/therapist transference. After some discussion of the previous week’s session, I understood that I had neglected to protect Max from Andrea’s blame, and that Max experienced that oversight as a profound selfobj ect failure. I had completely missed the way Andrea’s comment retraumatized him. The interchange in the preceding session repeated the childhood situation in which Max’s father did not intervene to protect him from the effects of his mother’s alcoholism. Once the issues were uncovered, Max expressed renewed hope in the therapy. Incidents like this one, recurring throughout the course of therapy, are the building blocks of trust.

Fostering Self-Reflection. The capacity for self-reflection enables the patient to “recognize the patterns inherent in the mobilization of old, constricting organizing principles and their relational foundation” (Trop, 1994, p. 150). However, there is often resistance by one or both of the partners to this kind of self-reflection; they may fear that the material will be used against them, as in the case of Max and Andrea; the exploration may lead to walled-off areas of painful childhood experience; or the couple may feel that the therapist’s job is simply to fix the relationship rather than examine their psyches.
Educating the couple about the ubiquitous influence of transference and unconscious organizing principles can go a long way toward lowering the resistance. Relationships make us all crazy. The point of looking at your own part in creating or sustaining a relationship problem is to discover the one place you have some control.

There are two areas in which increased self-awareness is enormously helpful to the course of therapy: awareness of the part that each partner’s own organizing principles play in his or her experience of the relationship; and an awareness of the way these organizing principles and the actions they engender affect the outcome of the relationship.

Many patients inherently resist interpretations that emphasize the unconscious factors that influence their perceptions. To these patients, such interpretations sound like accusations that they are paranoid or crazy. It is therefore incumbent on the therapist to focus not on the objectivity of a particular partner’s observations (who said what, who did what) but on the meaning that they hold for the patient and on the effect they engender. I sometimes explain to couples that the mind makes these meanings by matching current events to previous patterns, and that one common source for the matching patterns is childhood experience.

Kohut’s (1984) conception of therapy occurring in two phases, understanding and explaining, is useful in fostering each partner’s self-reflection. In the first phase, the therapist tries to understand the way each partner feels about the relationship and how these feelings are influenced by their histories. This is best accomplished through the empathic/introspective exploration discussed in Chapter 6.

Once each partner develops an understanding that his or her experiences of the other partner are highly subjective, and are likely to be influenced by unconsciously held beliefs and expectations, the therapist can begin to explain that the attitudes and reactions that derive from those beliefs and expectations have a powerful effect on the other partner. Invariant organizing principles function like self-fulfilling prophecies, producing the very reactions the person most dreads. The hypervigilant partner who fears abandonment drives a spouse away; the partner who passive-aggressively resists intrusion creates a partner who is so lonely that she is constantly after him.

Partners’ levels of readiness to address developmental issues often coincide or parallel each other (Dicks, 1967; Siegel, 1992; Solomon, 1989). When one partner begins to work on childhood-derived organizing principles and analogous issues arise for the other, the therapist should recognize a cue to
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intervene, to frame the situation as an opportunity for each partner to sup-

port the other in breaking a personal cycle.

For example, one couple entered treatment after the wife’s career necessi-
tated a relocation. The husband was outwardly supportive and pleased for

his wife, but as his own career suffered in the relocation, he grew withdrawn

and bitter. In the course of treatment, the husband began to feel that his wife,

a beautiful and highly competent woman, was indifferent to his sad, de-

pleted affect states. Furthermore, the patient came to see a strong similarity

between her lack of responsiveness and that of his prim, devoutly religious

and rather depressed mother, who was outwardly very different.

This correspondence led to the unfolding of a subjective world in which

the patient’s attempts to be nice and compliant in relationships masked a

chronic state of despair and anger that anyone would ever meet his needs,

and more profoundly, a pathological belief that he was worthless and would

never amount to anything.

The therapist interpreted the husband’s reactive depression in the con-
text of the relocation and the wife’s preoccupation with her career as an op-
portunity for him to test the validity of those organizing principles: “As a

child, you knew no other way to engage your mother except to be nice and

compliant. The challenge in your marriage is to find an affirmative way to

get your wife to be more tuned in to your needs and feelings, attuned to

you.” The husband was able to see that his core sense of his own worth-

lessness led him to withdraw when he was disappointed, defensively push

his wife away and foreclose any possibility of attunement by hiding his

ture needs and feelings. As he explored these issues in therapy, his behav-

or and feelings began to make sense to his wife, who was able to move

closer and offer him, by her quiet presence in the sessions, an attuned re-

sponse to his emerging affect states.

The Other-Centered Listening Stance. One way the therapist can build

self-reflection is to offer interpretations based on his own experience of the

partners. Fosshage (1997) describes two basic listening stances in psycho-

analysis—the subject-centered and the other-centered, in which the analyst

“can experience the patient from the vantage point of the other person (in

this case the analyst).” In couples therapy, there are two potential “other”

perspectives to listen from, the therapist’s and the other partner’s. Each

partner has most likely already made it abundantly clear what it is like to re-

late to the other. This is why it is so crucial for the therapist to provide a

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late to the other. This is why it is so crucial for the therapist to provide a

counterbalancing, subject-centered, empathic vantage point. The therapist
who shares his own experience of relating to one of the partners prematurely will be perceived as taking sides.

There comes a point in most couples treatments, however, when the therapist needs to help one of the partners reflect on the reactions, intended or not, he engenders from his partner. The therapist can either share his own subjective responses or interpose his understanding of why the partner responded as she did (e.g., "I’m beginning to understand why you feel misunderstood. I have the feeling that you are really expressing your concern and understanding, but he thinks you are trying to tell him what to think"). Of course the risk here is that the therapist can appear to be offering some objective truth and thereby undo all that he did to develop an atmosphere that values each partner’s subjectivity, or to be taking one partner’s side over the other’s. It is often necessary to take this risk, however (albeit with a commitment to explore and repair any disjunction caused) because other-centered interpretations are often the only way to interrupt a patient’s self-defeating behavior.

A husband’s complaints about his wife’s remoteness, for example, were highly inflammatory to the wife, who maintained that she was always present and wanting more intimacy. Even when the husband was able to say, “But you always seem so contained and competent, I wonder whether you need me at all,” the wife replied that she did not experience herself that way at all, and felt that she always conveyed her needs to her husband. After the discussion continued in the same vein for a while, the therapist joined in and told the wife that he had sometimes wondered what she needed from him as well.

The wife slumped completely, clearly feeling ganged up on. The therapist moved quickly to reassure her that he did understand her real need for help, but did not understand why she somehow was not communicating her need at a visceral level. What ensued was an exploration of how the patient’s father, with whom she shared a love of books and music, had been her main support in childhood; she had learned to engage him by being bright and interested in the world; she “just assumed” he knew about her difficulties with her angry and critical mother, and was consciously offering her a place of refuge. Her unconscious assumption was that others also intrinsically understood (and were not particularly interested in) the devastated world beneath her brightness. Now her husband (and her therapist) also knew this shattered, lonely part of her experience, and were able to show her that revealing it could be a door to intimacy.
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Making System Interpretations. Addressing interpretations to the rela-
tionship itself rather than to one of the partners is an effective way to lower
blame and engage the partners in collaboration. The focus shifts off each
other and onto the relationship, which is seen as a living, feeling entity. Most
couples have a sense that there is something distinct about “us” that is more
than the sum of their individual selves. And most couples have a sense that
they are often swept up by the relationship into behaving a certain way,
whether they intend to or not.

It is important to make system interpretations that connect to the affective
life of the couple. Interpretations that make the system seem mechanical
only serve to reinforce the sense of alienation between the partners’ inner
world of hopes and sadness and the frustrations of daily relationship life.
Cybernetic thinking rooted in general systems theory and family therapy
can, however accurate it may be descriptively, magnify a couple’s feeling of
deadness, both in the way the therapist thinks and in the way he conveys his
view to the couple. For these reasons a metaphor of the “relationship self” is
useful in imagining the system as a living, personal entity.

The collective, intersubjective entity that we are calling a relationship self
can itself be better evoked by metaphor than in abstract language. The poet
Denise Levertov (“The Ache of Marriage,” 1964) describes partners who
“look for communion/and are turned away” but who nonetheless keep
searching for “some joy/not to be known outside it.” The poet conceives of
their disappointment and longing as a vessel in which they float “Two by
two in the ark of/the ache of it.”

The therapist must foster a sense of his own intersubjective relatedness to
the relationship self, and then convey it to each partner. Interpretations
such as “I can feel the disappointment in this relationship” help express the
therapist’s involvement. One key to the therapist’s ability to develop this
kind of relatedness is for him to be aware of the way he holds his own rela-
tionship. In Levertov’s idiom, the therapist who can feel both the sadness of
being turned away from communion and the persistence of longing—des-
epite all disappointment—for the joy that he knows can be found only in in-
timate relationships can connect to the inner life of his patients’
relationship, however hidden it is behind silence, recrimination and dead-
ening repetition.

The therapist’s sense of openness and connection to that inner life is very
powerful for the couple. It is conveyed nonverbally as well as through in-
terpretations that reflect the mix of affects in the relationship, as in a com-
ment like “I can see the way this relationship struggles to keep something positive alive, despite all the anger.”

Interpretations that challenge the organization of the relationship self to allow more development-enhancing experiences can be powerful inducements to change. The case of Laura and Andy is illustrative.

Laura, who had been in individual treatment for five years, requested some couples sessions when her relationship with Andy began to flounder. Andy had recently taken to becoming bitterly critical of something Laura did, accusing her of being dishonest or intentionally hurtful. Laura would begin by defending herself, but she would end by being desperate, calling Andy every hour and begging him to forgive her, not to leave. The power of Laura’s reaction would, in turn, lead Andy to conclude that her need was overwhelming and that they should indeed break up.

Andy’s shifts from being loving and supportive one minute to being irrationally critical the next repeated Laura’s childhood experience with a bipolar mother. Laura’s desperate response to Andy’s criticism was organized by a self-state overwhelmed by fears of abandonment and by an underlying belief that there was something fatally unlovable about her. Seeing the couple together might interrupt this enactment long enough to help Laura, through her individual treatment, develop a less archaically organized reaction to Andy’s criticism. But, in order to be effective, it would be vital to develop a sense of empathic connection to the relationship itself, rather than just to Laura’s retraumatizing experience of Andy.

Given the ferocity of the couple’s fights as well as the intensity of their reconciliations, it was difficult not to view the relationship in terms of a primitively organized, pathological system. But at the heart of the relationship was an ongoing struggle to contain the overpowering affects that both their closeness (sexual and intellectual) and their mutually triggered defensive reactions were engendering.

The cycle of reconciliation, conflict and breakup was an attempt, however clumsy, on the part of the relationship to be at once elastic enough to expand and hold the full range of affects being produced and strong enough to contain them without breaking. Identifying their collective struggle to contain those intense affects was itself a powerful interpretation: it helped vitiate the belief that one or both of them were crazy or hopelessly defective.

The therapy focused on searching for ways to achieve the containment without the repetitive drama. In order to prevent a sense of failure from developing, the couple was also told that they would need those enactments
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Strengthening the Holding Environment. One specific type of systemic interven
tion involves strengthening the capacity of the relationship to withstand
a number of kinds of stress. Various theorists (Scharf and Scharf, Solomon,
Seigel) have applied Winnicott’s (1965) notion of the holding environment
to couples. Both Seigel and Solomon emphasize the therapist’s empathic listen-
ing as the key component of the holding environment.

In addition to strengthening each partner’s individual capacity to contain
reactivity and resist letting intense emotional experience trigger a repetitive-
themed organization of the relationship, the therapist can work on the car-
ying capacity of the system as a whole. This enhancement can be presented
as a collective task with a comment such as, “Even though you have a lot of
anger that needs to be expressed, it should not be allowed to overpower the
relationship, because then it will become unsafe and neither of you will get
heard.”

The therapist can help the couple monitor together the carrying capacity
in the relationship by creating rules such as prohibiting physical expressions
of anger or ensuring a time-out whenever one person feels overwhelmed. If
the couple gets close to exceeding the limit, they have not failed; rather, the
marriage needs regulation. If they are unable to maintain safety, they need to
take a time-out, seek outside help from friends and family and/or increase
the frequency of therapy sessions. The goal is to create collectively a rela-
tionship that can contain rather than amplify disturbing affects.

Particularly in the beginning stages of treatment, the therapist’s office
can serve as a symbol of the holding environment. Couples can interrupt
disturbing or escalating interactions with the hope that they will be able to be
expressed and contained in the office. The therapist can say to the couple,
“Try to work it out at home, but if you can’t, leave off and bring it in here.”
Ultimately, the office becomes internalized as the capacity to contain differing subjectivities and painful affects in the same room, and by extension, in the same house and in the relationship itself.

It is also true that couples who have been traumatized might be “gun-shy” and need encouragement to push the limits to see if the holding environment can contain their disappointments. This is especially true when the sexual relationship has broken down. I sometimes suggest to a couple that they try and have “bad,” perfunctory sex to see if the relationship can withstand the disappointing experience. Such couples often find that they have misread the relationship’s capacity to tolerate intense affects. Surviving the disappointment emboldens them to try again.

**Directly Creating Development-Enhancing Experiences.** Most of the approaches described in this book are nondirective. The goal of enhancing the capacity of each partner to tolerate inevitable selfobject failures while remaining open to intimacy and growth is achieved through creating an intersubjective field characterized by empathy, containment and a spirit of exploration. When one partner is silently witnessing the other’s interaction with the therapist, the listening partner becomes part of the collective good will in the room and the therapist’s mode of listening serves as a model for future interactions. There are times, however, when the therapist will intervene to directly facilitate a development-enhancing selfobject experience or to block a potential selfobject failure.

As to the latter, it is vital that the therapist’s office represents for each partner a place of sanctuary and hope. Accordingly, it is almost always appropriate for the therapist to interrupt escalating conflicts and redirect both partners’ angry expressions to him. Similarly, the therapist will supplant one partner’s incomplete or distorted response with his own understanding (e.g., “I can see how you would see it that way, but I noticed something else in what she was saying”).

Another important intervention is to highlight both partners’ emerging capacities to provide development-enhancing selfobject experiences. Comments such as, “Did you take in the way he was really listening this time?” or “She’s trying to fulfill your request to be more positive there,” both mirror the achievement of the provider and help interrupt the defensive resistance of the receiver.

In terms of a more direct approach, I will describe three interventions that I have found useful: creating mirroring experiences, enlisting the partners to
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sponsor each other’s growth and encouraging self-assertion. It is very im-

portant that any resistance to these interventions be met with tolerance and

understanding, and that the therapist—although at times quite forceful in

initiating a certain type of interaction—not become too attached to a specific

outcome. It is useful to remind yourself that no matter how “right” you

think you are, yours is only one of three subjectivities in the room.

Creating Mirroring Experiences. The therapist can intervene to directly

create moments of mutual regulation and attunement in a session. Partners

are directed to sit facing each other, to try and clear their minds of precon-

ceptions and to take in what the other partner is verbally and nonverbally

expressing: she’s really afraid of you, he’s saying how lonely he’s been feel-

ing. The therapist coaches each partner to come up with an accurate picture.

The therapist slows the usual back-and-forth communication down and en-
courages each partner to listen.

Exercises like this that foster reflective listening are a common stock of

most couples therapists (cf. Hendrix, 1990; Wile, 1988). Most commonly they

direct one partner to repeat in his own words what the other has just told

him. This can provide a vital mirroring selfobject experience. However, rote

repetition of content by one partner can create an experience of mirroring

failure—the listener gets all the words right but completely misses the affect

behind them. When this happens, the therapist needs to interpret that affect

explicitly and have the mirroring partner try again. The therapist should be

careful to minimize and defuse blame or shame with a comment like, “All of

us have trouble listening to others rather than just hearing what we have

come to expect or defending ourselves.” As a step beyond merely getting it

right, partners can be encouraged to provide a self-delineating experience

for each other by acknowledging, without judgment, the other’s perceptions

and feelings.

Enlisting the Partners to Sponsor Each Other’s Growth At a certain point in

the treatment, the relationship will oscillate between development-enhancing

and repetitive attractor states. The therapist can, in a sense, deputize each

partner to be an advocate for the other’s growth, and, in turn, an advocate

for a developmentally themed relationship. One partner can encourage the

expression of walled-off or disavowed affects, or the assertion of boundaries

or limits. This can be doubly beneficial: one partner receives permission to

try new modes of being; the “coaching” partner gets to be experienced as the

longed-for parent who encourages, rather than thwarts, development. If one

of the partners had a parent who only selectively or conditionally encour-
aged her or his development, the “coaching” partner’s provision of support for actions that appear to go against his interests can have a profound effect. Ultimately the two partners can be empowered to alter the system, both by regulating their own repetitively themed reactivity and by coaching their partner with comments like “You don’t have to go there.” Supplying this kind of encouragement can be a developmental step for the coaching partner as well. In one instance, a rather immature and narcissistic husband was able to advocate for his wife, who had been abused as a child, to be more assertive of her needs for safety around sex, urging her to ask for time-out when she became anxious. He was simultaneously differentiating himself from her abusive father and learning that he could be admired for being generative.

Encouraging Self-Assertion. Along with advocating for the other, each partner needs encouragement to advocate for the kind of relationship he or she wants. In some instances, the therapist will stop a nonproductive process and invite a partner to try and change it, with a comment like, “Let’s see if you can get her to understand what you’re trying to say;” or “Tell him what it feels like when he does that.”

The capacity for self-assertion is grounded in a conviction that one’s thoughts, needs and feelings are valid. Therefore, the provision of a self-delineating selfobject experience, at first by the therapist and then by the other partner, is a vital precursor.

Another obstacle to self-assertion is the fear of retaliation. This fear can be a product both of unconscious organizing principles and of experience in the relationship. In either case, partners need a safe place to try to confront that fear. In the case of Beth and Richard, which we have been referring to throughout the book, Richard, for all of his demands for admiration, was really very unskilled at setting boundaries or protecting himself from Beth’s angry denunciations. As you may recall, Richard was himself a victim of his father’s verbal abuse. At first, Richard, in the name of repairing the injury of the affair, felt that he had to not respond to Beth’s angry tirades. At one point in the therapy we worked directly on Richard’s setting limits with Beth. He was encouraged to communicate both how her attacks made him feel and his need for her to stop treating him that way. Richard’s ability to assert his needs was actually helpful to Beth; she experienced him as able to contain her anger, and she intuitively knew that if he was able to be more directly assertive he would be less likely to get his needs met by acting out.
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*Strengthening Attachment.* In some cases where attachment between partners is weak or inconsistent, it is possible for a therapist to make interventions designed to repair or strengthen the attachment. Recalling the work of Beebe and McCorrie (1996) described in Chapter 5, we note that attachment is a subjective experience that emerges from a dyadic system. Although, as the authors point out, there is a considerable amount of research supporting the profound influence that childhood attachment patterns have on the experience of adult love, this influence is not invariable, nor is it unidirectional. One partner's history of insecure or chaotic attachment (Ainsworth et al., 1978) can indeed be a factor in the emergence of a similar adult attachment that can negatively affect the other partner's ability to feel secure. But a partner with a childhood history of secure attachment can help create a new sense of refuge and freedom in a partner who has a history of less secure or chaotic attachment.

Of particular importance to the couples therapist is the potential for creating attachment-enhancing experiences in the treatment context that can transform the partners' representations. Again we note that the influence between the interpersonal and intrapsychic is reciprocal. Remembering Beebe and Lachman's (1994) three principles of salience, the therapist can attempt to alter the experience of attachment of one or both partners by facilitating moments of heightened emotional intensity, helping to create a regular and expected pattern of relating, and seeing to it that emotional disruptions are repaired.

As mentioned earlier, one disengaged couple was encouraged to try "bad sex." The idea was that emotional intensity of one sort or another would begin to alter the subjective sense of the relationship tie as weak or nonexistent. The narcissistically vulnerable husband reported that he was really into lovemaking until the wife made a joke, which spoiled everything. The therapist spent time exploring the different affects that had taken place in the sexual encounter: arousal, anxiety, humor, disappointment, anger; then explained that relationships were a stew made up of all of these intense feelings, not just safe or pleasurable ones.

In another case, a couple who were only attached through intense feelings and who chaotically alternated between honeymoon intensity and breaking up were specifically advised to create routines. They agreed to go the grocery store together once a week to shop for their respective apartments and to develop a schedule for staying with each other on particular nights. These routines helped mediate against the reactive pull of their emotional upsets.
While the repair of disruptions is the stock in trade of most couples therapy, couples for whom disjunctions or conflict threaten a weak sense of attachment may require further exploration, even beyond the usual working through. An infant whose sense of urgency and distress was not adequately regulated will likely develop an avoidant attachment, with an emphasis on self-regulation. As an adult he will be prone to retreat from conflict or intensity. The therapist may need to come back to a successful resolution of a conflict, no matter how trivial, again and again, to point out the couple’s growing capacity to rebound from disappointment. The therapist holds out the potential for repair with her optimism and calm in the face of the couple’s turmoil, and this gradually becomes assimilated into a new schema of attachment.

Sexual intimacy, with its close resemblance to caregiver/child interactions, is rife with attachment meanings. In one couple, the husband reported that, though they loved each other dearly and had been married for ten years, he believed the relationship could end at any moment. Underneath this belief was a profound pessimism at the depth of their attachment—a pessimism rooted, it turned out, in the wife’s reluctance to initiate sex. This experience echoed his understimulated experience with his depressed mother in infancy, an experience that had been assimilated into a profound sense of insecurity. In fact, the wife had long since given up initiating sex because he was so often critical and angry. Because sex had become such a loaded issue for the couple, the therapist chose to work in the area of non-sexual physical intimacy. The wife was instructed to just place her hand on his head or back from time to time, and the husband was asked not to react, but to come in to treatment and report his various responses to her touching. Eventually, the couple was able to develop a rapport or nonverbal “grammar” of touches, which gave them a way of dealing with the problem of the husband’s insecurity.

CURE IN COUPLES THERAPY

If, as Thelen and Smith (1994) emphasize, development has no fixed endpoint, then our notion of what constitutes cure in couples therapy must remain open as well. Nonetheless, couples therapy needs to be informed by some sense of direction. This direction has usually been theory-driven. A brief survey of the psychoanalytic notions of health in relationships reveals that they grow more out of their implicit assumptions than out of pragmatic considerations. From an
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an intersubjective perspective, these theories are ways for the therapist to organize his own experience of the relationship. They will also inevitably affect the three-person intersubjective field of the treatment.

Kernberg (1974) emphasizes the need for drive neutralization and psychosexual development and identifies three hallmarks of mature love: the integration of aggression and bisexuality into the heterosexual relationship; the transformation of "pregenital strivings and conflicts" into mature object relations characterized by tenderness, concern and gratitude; and a sense of moral commitment to the partner created by healthy superego development. Object-relations- oriented therapists emphasize the lessening of projective identification: "The main therapeutic task is, as always, the reintegrating of the feared, denied and split-off aspects of the relationship" (Scharf and Scharf, 1987, p. 153).

Kohut (1971) emphasized transmuting internalizations, in which the self-object provision of the caretakers is structuralized and internalized as part of the self. This internalized structure leads not to autonomy but merely to a reliance on more mature selfobjects throughout the lifespan. Although he never described these mature selfobjects in detail, he indicated (1984) that they would come from a wide variety of sources and include the use of symbols and identifications as well as interpersonal experiences. Following Kohut, Wolf (1988) describes marriage as a phase in which "Spouses are used by each other for a variety of selfobject functions" (p. 59). Wolf emphasizes two functions in particular, that one spouse allows the other to regress in the other's presence without fear of merger, and that spouses use intimate contact with the other's experience as a mode of expanding the boundaries of their selves. In true self psychological fashion, Wolf has here uncovered the positive developmental aspect of relationship configurations that might be otherwise be labeled as pathology: regression and living vicariously.

In terms of couples therapy, Solomon (1989) emphasizes the achievement of narcissistic equilibrium, in which the relationship functions to stabilize each partner's narcissistic vulnerability. Livingston's (1995) goal is to get "the marital venture back on track so that it can once again function as a powerful source of developmentally needed experience and, thus, a mutually reparative process and the [vehicle for the] revitalization of two lives" (p. 430).

Trop (1994) stresses increasing the couple's awareness of the contribution of each partner's invariant organizing principles to the dynamics and outcome of the relationship.
Contextualists view individual development and marital development as reciprocal and mutually reinforcing. As evidenced in the preceding example of the husband who himself matured when he supported his wife's asserting her needs around her sexual anxiety, individual developments are potentially growth-enhancing for both members of a couple.

In place of an end state of health for relationship development or a notion of cure in couples treatment, couples therapy can be evaluated and measured by the degree of progress the couple is making toward any of the following four goals.

1. **The relationship will be characterized, at least some of the time, by a renewed sense of hope.** Couples treatment mobilizes long-submerged selfobject needs. It also exposes longstanding feelings of loss and hurt—both in the relationship and from each partner’s family of origin. Hope, as opposed to actual fulfillment, is what allows couples to continue to engage, despite disappointments. Hope, according to Mitchell (1993), is “seeking a psychological space in which genuine desire may become possible, in which the self can find a ‘new beginning’” (p. 206).

   The coping skills that partners need in relationships—a sense of personal agency, the capacity to tolerate painful affects, the ability to communicate—are all enhanced by an intersubjective field characterized by a sense of hope. In couples without hope, these skills, even if present, will atrophy. In order for hope to prevail in a relationship, the underlying beliefs that support hopelessness—that oneself or one’s partner is defective, for example, or that one’s needs are invalid—must lose their grip. An intersubjective field characterized by hope allows couples to occupy a middle ground between the need for perfectly attuned responsiveness and the defensive reactions engendered by its absence.

2. **There will be an increased acknowledgment and acceptance of the partners’ differing subjectivities, as well as a growing conviction that these differences need not threaten the relationship tie.** Tolerance of difference is essential in a relationship. It is the source of novelty and aliveness. In order for partners to be curious instead of furious about differences, the capacity to stay rooted in one’s own thoughts and feelings must be established. This is of course the sine qua non of a healthy sense of self. Developing this capacity, even as a transient phenomenon in couples treatment, can signify a new level of self-development. Pathological
self-organization is based on the fear of repetition of trauma. The fear of difference is ultimately either a fear of annihilation—I will be overwhelmed and taken over by your differences—or a fear of abandonment—if you are different, we will not have any connection. Couples therapy provides the moment-by-moment possibility of the discounting of these pathological beliefs.

3. There will be an increased capacity to tolerate and process disturbing affects. The capacity to tolerate and integrate affects is central to intersubjectivity theory’s view of mental health. The overall goal in couples therapy is to shift the quality of the relationship from a source of disturbance to a source of soothing. The silence, bickering or rage that characterizes unhappy relationships signals failures to contain disturbing affects. Understanding, tolerating and modulating—rather than perfectly integrating—them are appropriate objectives. The emphasis on affects—rather than representations as in object relations models—underlines the process aspect of relationships. The goal is not the “autonomy” offered by stable and realistic representations of self and other but the ability to process and recover from times when partners feel bad about themselves or see each other as hateful and destructive.

4. The relationship system will support each partner’s development. If we view relationships as developmental systems, then we must pay close attention to the fate of each partner’s emergent aspirations and achievements within the marriage. The concretized roles, rules and identities that characterize stuck relationships must become more flexible if these emergent developments are not to be stillborn. In one couple, a famous musician began canceling concerts to spend more time with his family and the wife, a talented woman in her own right, began to reclaim the career she gave up to raise her children. This goal is akin to Bowen’s (1978) concept of differentiation, but with a significant difference. Rather than seeing the goal for the relationship as tolerating increased differentiation, each partner’s growth is inextricably linked to the relationship system. From a systems perspective, the achievement of this goal is not necessarily enhanced by the therapist’s commitment to fairness and stability. A knowledge of systems theory will allow the therapist to view a period of chaos, perhaps precipitated by the individual growth of one of the partners, as a potentially positive harbinger of a more development-enhancing relationship system.
At the heart of these four goals is intersubjectivity theory's challenge to the Cartesian dialectic between self and other. Remembering Beebe and McCrorie's (1996) metaphor, healthy relationships improvise like jazz music on the twin "riffs" of self and mutual regulation. Whether one partner is rising to new heights of individuation or the two are "playing" in close harmony, the goal of couples therapy is to help the couple find a relationship form that allows for both collaboration and improvisation.