

CHAPTER 15

Building Intimacy Bridges

From the Marriage Checkup to Integrative Behavioral Couple Therapy

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When I (MIM) met Nick and Eve for the first time, I could not have foreseen the amount of time I would end up spending with them. They had come to the Center for Couples and Family Research to receive a marriage checkup (MC) (Córdova, 2009). We had just begun seeing couples in the MC study; a trial of a brief marital health intervention, developed by the second author (JVC) and funded by the National Institute of Child Health and Human Development. Eve and Nick entered the MC interview room with pleasant smiles and friendly small talk. They were a middle-class, Caucasian couple in their mid-40s, excited to get a “checkup” on their relationship after more than a decade of marriage. Nick worked full-time in engineering, while Eve worked part-time in the catering business. Eve had seen our ad in the newspaper and brought the idea of getting an MC to Nick, who, as I would soon find out, tended to go along with what she suggested.

Nick and Eve’s story is about intimacy—how it develops, how it can be undermined by corrosive relationship patterns, and how it can be repaired. We follow the journey taken by Eve and Nick as they moved through a prevention intervention—a marital-health checkup—into a longer-term, acceptance-based couple therapy.

THE MC

The MC (Córdova et al., 2005; Córdova, Warren, & Gee, 2001; Gee, Scott, Castellani, & Córdova, 2002) was developed as a two-session assessment and feedback marital health intervention utilizing techniques from both motivational interviewing (Miller & Rollnick, 2002) and integrative behavioral couple therapy (IBCT; Christensen et al., 2004; Jacobson & Christensen, 1996). Couples begin the MC by completing a battery of questionnaires assessing a wide range of relationship health domains, followed by an in-person, conjoint assessment session designed to celebrate their strengths as well as to identify and examine their most significant areas of concern. The MC was designed to be a resource for couples who do not typically utilize psychotherapeutic services for their relationship. Although premarital services are widely available for engaged couples, as are tertiary interventions for highly distressed couples, there are few resources available for couples in between the newly married and severely distressed. Such couples may not be ready to seek a full course of therapy but could potentially benefit from a short-term, early intervention capable of detecting and arresting risk factors for marital ill health or deterioration that might not otherwise be addressed. The primary objective of the MC is to provide nonstigmatizing, preventive care to promote marital health, like physical exams do for physical health. Eve and Nick's demographics and assessment scores indicated they could be precisely the type of couple who would benefit from the MC. On the one hand, they both reported being highly committed to their relationship. For example, Eve, an attractive brunette who wore silver glasses, expressed that she believed "this is who I'm meant to be with for the rest of my life." At the same time, their relationship satisfaction scores were predominantly in the moderately distressed range and their intimacy scores were in the low-average range, indicating growing dissatisfaction in the marriage and diminishing intimacy. And yet they were not involved in any type of couple treatment.

Preventive intervention programs for couples are often viewed as being quite distinct from and different from remedial interventions such as psychotherapy and are undoubtedly in short supply.

Question: What commonalities do you see between preventive and remedial couple interventions, as gleaned from this chapter or other experiences or exposures you have had? Are there elements of any preventive couple programs with which you are familiar that can be incorporated into couple therapy practice?

I was eagerly anticipating meeting Nick and Eve for the first time, as they were one of the first couples to enter the new MC study. Given the short-term

nature of the MC, it is particularly important to quickly establish rapport with both partners. MC therapists are meant to be consultants to the spouses, encouraging and assisting them in their goals for their relationship. During the MC assessment session, MC consultants are primarily doing just that—assessing—by listening carefully, paraphrasing, and empathizing with each couple member in order to develop a therapeutic alliance. Forming rapport with Eve was relatively easy, given her energetic and talkative nature. Nick, however, a conservative-looking, attractive man with salt-and-pepper hair, presented as more introverted and tentative. Although he cooperatively answered questions when asked, I felt uneasy about his responses, sensing that perhaps there was more to the story than he was saying.

The Oral History Interview

Following completion of the initial battery of questionnaires, the MC assessment session begins with the Oral History Interview (OHI; Buehlman, Gottman, & Katz, 1992) to (1) help the couple acclimate to the session, (2) assess the quality of their courtship narrative, and (3) orient them toward some of the positive qualities of their relationship. After brief introductions, I asked Nick and Eve, “Tell me how the two of you met and got together . . . what were your first impressions of each other?” And then, “Tell me how you decided to get married . . . of all the people in the world, what led you to decide that this was the person you wanted to marry?”

Eve and Nick’s romance began about 15 years earlier when Nick’s mother, who knew Eve from the gym, invited Eve over to their house for dinner. Eve recalled that when Nick entered the room, she immediately thought “Wow, he’s cute,” and hoped that he would ask her out. Nick also found Eve very attractive and was struck by her professional demeanor. After a few months, Nick finally asked Eve to dinner, and after more than a year of dating, Nick proposed. Nick described their decision to get married as an “intangible” and a “comfort.” Eve recalled feeling very certain. They joked that they were also both huge baseball fans. Nick liked that his mother approved of him being with Eve, too. While reminiscing about their courtship, Eve and Nick smiled brightly, as they clearly enjoyed bringing these warm, intimate memories into the room.

The Therapeutic Interview: Strengths

The subsequent therapeutic interview began with Eve and Nick exploring what they considered to be their greatest strengths as a couple, using a list of strengths as a guide. Nick discussed their capacity for forgiveness and tolerance, explaining the most painful time in their marriage was not being able to have children. At the time this had been devastating for them, but he felt they had worked

through it together and came out stronger for it. Eve agreed that they “don’t hold grudges” and that their ability to adapt to those changes early in the marriage had brought them closer. I noted that forgiveness is rarely selected as a couple’s greatest strength, but kept that to myself for now. Eve believed their most prominent strength was making their marriage a high priority. She expressed being keenly aware that relationships need maintenance to remain healthy and described her efforts to keep the lines of communication open with Nick. Eve said that communicating had consistently been very important to her throughout their relationship, expressing her belief that if they retreated to their separate corners they would “never find their way back.”

The Therapeutic Interview: Areas of Concern

The most important part of the MC assessment session focuses on the couple’s areas of concern. This interview aims to accomplish both assessment and intervention by unpacking the couple’s most significant problems in a way that fosters intimacy, acceptance, and collaboration. On the one hand, the interview is pure assessment; we simply want to know what the two biggest issues are and how they manifest in their relationship. On the other hand, the interview is designed to give both us and them a deeper understanding of those problems. This interview is not designed to solve the issues; it is designed to get *under* the issues. The goal is to foster understanding of the issues’ “softer” emotional content, why these issues are understandable points of contention between the couple, and how they have may have come to feel stuck in the same trap. This should ultimately elicit a greater sense of shared compassionate understanding in place of what is usually experienced as embattled defensiveness. The following are the three main techniques, rooted in IBCT, that an MC therapist can utilize during the therapeutic interview:

1. *Kick-starting intimacy: Uncovering soft emotions.* Soft emotions refer to those emotional expressions that tend to elicit empathy, compassion, and wanting to move closer to one’s partner (e.g., sadness, loneliness, worry, fear, love, affection, liking). In contrast, hard emotions refer to those emotional expressions that tend to elicit withdrawal or counterattack from a partner (e.g., anger, indignation, blame, criticism, contempt). Encouraging partners to express and respond to the more vulnerable emotional content builds intimacy bridges between them. Theoretically, intimacy emerges from interactions in which one partner engages in vulnerable behavior and the other partner reinforces that vulnerable expression (Córdova & Scott, 2001), often through expressions of empathy.

As behavior therapists, Morrill and Córdova naturally present here a brief definition of “intimacy” in the language of learning theory. The language of “reinforce-

ment,” “punishment,” “stimulus control,” “functional analysis,” and so forth, is probably quite foreign to many therapists, even “aversive” (a behavioral concept!) to others.

Question: Assuming you have some familiarity with the core concepts of learning theory (and perhaps behavior therapy in general, as well), what do you find to be the advantages and disadvantages, strengths and limitations, of calling upon these principles of human behavior in your clinical work, specifically in understanding problematic couple interactions and formulating plans for therapeutic intervention?

2. *Building mutual acceptance: Discovering understandable reasons and identifying themes/patterns.* The process of building greater mutual acceptance involves helping partners develop a more thorough understanding of each other and of the central dynamic between them. In almost every case, there are perfectly understandable reasons for the way each partner contributes to their mutual issues. Often those understandable reasons have historical origins. We want to know what in this person’s history set the stage for this particular vulnerability. If we can talk about the couples problem as an understandable pattern or theme, then the partners are in a better position to gain a more empathic perspective of their own and their partner’s role in the recurrent theme. Building a sense of greater mutual understanding leads to greater acceptance, which in turn fosters an emotional context more conducive to intimacy and collaboration.

3. *Building a collaborative set: Mutual traps, same page, “it-ifying”.* The goal here is to frame the issue as a *shared* problem that emerges from common and understandable differences between the partners, and for which neither one of them is to blame. We often talk about these mutually emerging points of friction as “naturally occurring flaws in the fabric” of their relationship. Jacobson and Christensen (1996) describe “unified detachment” toward the problem as a detached, descriptive view of the problem that both partners share. In the MC, we call this technique “it-ifying,” objectifying the problem as a separate entity from either partner that they can work together to resolve. We even at times suggest imagining the problem sitting in a third chair, confronting both partners simultaneously. There is empirical evidence that couples who talk about their problems as a shared “it,” rather than engage in their problems in a spirit of blame, are more satisfied following a course of couple therapy (Córdova, Jacobson, & Christensen, 1998).

The concept of “itify”ing” relational problems for clinical purposes is not unique to IBCT. For example, it [sic] also figures prominently in social constructionist approaches to couple therapy, such as narrative therapy (see Dickerson & Crocket, Chapter 8, this volume) that have very different conceptual origins.

Question: Compare the manner in which, for example, IBCT therapists “it-ify” problems with how narrative therapists “externalize” problems. How are they different or similar procedurally? In intent? Do you think IBCT and narrative therapists would agree with each other about when and how to use these interventions?

When initially asked about the difficulties in their relationship, Eve and Nick described two major areas of concern: communication and sex. Eve lamented that she always initiated conversations with Nick, never the other way around. Nick described feeling hesitant to express himself to Eve, as well as being puzzled by Eve’s desire to discuss what he saw as insignificant matters. I could empathize with Nick’s concerns, as I also sensed Eve’s potential to be intimidating and verbose. On the other hand, I also understood Eve’s desire for more engagement from Nick, as I also found myself wishing he would be more forthcoming. Nick and Eve explained how their communication difficulties affected their sexual relationship, admitting that they did not talk about their sex life. Eve complained that Nick did not initiate sex frequently enough and was not “experienced” enough to meet her needs. Eve was also concerned that their history of trying to conceive children had taken a toll on their sexual relationship. Clearly, something was interfering with their intimacy in terms of both their ability to communicate openly with each other and their satisfaction with their sex lives.

During the therapeutic interview, I began to flesh out these concerns by delving into each of their histories. Nick was the youngest of four children and recalled that he was never asked for his opinion in family decisions, nor did he remember having confrontations or emotional conversations with his parents or older siblings. Nick described his mother as easygoing, affectionate, and kind, although when she became overwhelmed she would lock herself in the bathroom and no one dared approach her. Nick’s father, who had died when Nick was a young adult, had been a benign alcoholic who was emotionally distant from Nick. Nick recalled that he was never given much responsibility during his upbringing, and that his identity in the family was the “easygoing kid who would go along with anything.” He also expressed regrets going back to his teenage years about being too passive at different points in his life, such as with his first girlfriend, who broke up with him. He later learned she had ended their relationship out of frustration that he had never made sexual advances toward her. Although he had the opportunity to talk to her about that soon after, he avoided the topic, and had regretted it ever since. Decades later, he still wished he had brought it up to her, and even still remembered her phone number.

Eve was the oldest of three siblings and was parentified from a very young age, both by caring for her younger siblings and by serving as her mother's confidante. She recalled that her father was also an alcoholic for most of her childhood, and that her mother was extremely cold, critical, and aggressive. Eve described that in her house, growing up was like "a war zone," and she was constantly in "survival mode." She tried to be the "perfect child" in order to avoid being abused. Both of her parents were still alive, and as an adult she continued living in close geographical proximity to them, allowing them to remain uncomfortably intertwined in her life.

I deliberately drew out these memories from Nick and Eve in front of each other, as much for the benefit of the listening partner as for my own understanding. Often when the listening partner hears their spouse describe their painful past experiences, they develop greater compassion for the understandable reasons behind their partner's current thoughts, feelings, and reactions. This new perspective forges intimacy bridges by emphasizing each partner's vulnerability while removing the blame from the other partner. It is sometimes possible to literally witness the other partner softening while their spouse speaks, as the partner is being guided by the structure to listen deeply to these stories, perhaps for the first time.

Nick and Eve's upbringings also allowed us to create greater "unified detachment" toward a possible central theme in their relationship. As the oldest, parentified child, Eve brought into her relationship with Nick a long history of dominance and control. The unloving, chaotic, and violent environment in her family of origin created a vulnerability to hypervigilance and anxiety in her relationship with Nick. As a result, Eve was easily panicked by anything that even remotely threatened her sense of security; she would respond to these triggers by aggressively asserting control over the relationship and Nick's behavior. This control showed up in issues ranging from how Nick should "correctly" do the dishes, to what she expected from him in bed, to decisions he made at work. Nick, on the other hand, had learned in his family that "going along to get along" was the way to be loved and accepted. As the youngest child, he was discouraged from asserting his own identity and felt less competent than his older siblings. There was almost no open conflict in Nick's house, giving him little experience with handling tense interpersonal situations. Although he reported having some of his emotional needs met by his affectionate mother, he also learned to avoid her when she was emotionally dysregulated. His father was withdrawn and disengaged. This all culminated in Nick's propensity as an adult to avoid conflicts and confrontations. He would go to great lengths to avoid arguments with Eve, even if it meant criticizing or degrading himself. Furthermore, he did not seem to have a solid sense of his own opinions or desires even when asked about them. Each of their histories clearly prepared them to make

room for each other: Eve expected to control and direct, and Nick expected to be controlled and directed.

The Feedback Session

The information gathered during the MC assessment session is consolidated into a feedback report that is presented to the couple at the feedback session 2 weeks later. Based on motivational interviewing (Miller & Rollnick, 2002), the goal of the feedback session is to provide the partners with objective information about their strengths and concerns in order to motivate them to care for their marital health. The MC therapist acts as an unbiased collaborator during the feedback session, helping the couple meet their relationship goals. First, the couple's strengths are highlighted to reinforce their sense of self-efficacy for the healthy marital behaviors they are already practicing. Then their concerns are reviewed in light of what we have learned about soft emotions, understandable reasons, and common themes. Finally, a menu of options is provided, offering several ways the couple might begin to address those concerns if they choose to do so.

For Eve and Nick, the feedback report noted they were not currently highly distressed in their relationship and had many strengths to draw from. However, there were some warning signs that a pattern was developing between them that was interfering with their ongoing intimacy, particularly in the areas of communication and sex. We analyzed how this dynamic affected their communication in the feedback report:

“It is possible that Nick and Eve learned to communicate differently while they were growing up, and these naturally occurring differences created a pattern in their relationship that leaves them both feeling discouraged and alone. Eve may have learned to pursue communication aggressively as the most effective way of maintaining stability and safety. Nick, on the other hand, may have learned to withdraw from conflict and accommodate others in order to maintain stability and safety. As each pursues the same goal, they both get increasingly stuck in the resulting trap this creates. To the degree that Eve and Nick recognize this pattern when it is happening, they will be in a much better position to respond wisely to the situation at hand. Alternatively, if this dynamic runs unabated, it is likely to continue to create conflict and mounting tension in the relationship.”

Eve and Nick were experiencing a version of the “demand–withdraw” theme, one of the most common themes discussed in couples literature (Jacobson & Christensen, 1996). In this pattern, one partner takes on a critical, demanding

role and the other takes on an avoidant, uncommunicative, withdrawn role. We provided three options for Nick and Eve's struggle with communication, including (1) taking note of the demand–withdraw pattern, naming it, and working toward acceptance of the underlying naturally occurring differences; (2) scheduling time to communicate; and (3) blocking off small amounts of time at the beginning and end of each day to check in with each other (John Gottman's Love Maps; Gottman & Silver, 1999).

We offered similar suggestions in the feedback report for the difficulties in their sexual relationship, including reading a self-help book, communicating about their sexual relationship, and pursuing longer-term couple therapy. For the latter, we wrote:

“If you find yourselves getting stuck in your own efforts to resolve this issue, seeing a qualified couple or sex therapist could be beneficial. The research literature consistently suggests that therapy with someone who has had specific training in couple/sex therapy improves the odds that couples will move back into the maritally satisfied range and maintain those improvements over time. No treatment is guaranteed to work for everyone, but our best evidence suggests that couples who have become caught in discomforting patterns, but who have not deteriorated to the point of severe distress, have a high likelihood of benefiting greatly from a course of marital therapy.”

Nick and Eve were quite receptive to the feedback, continuing their generally cooperative manner throughout the MC. At the end of the feedback session, they expressed some interest in the option of pursuing couple therapy. Nonetheless, as is so often the case, it was not long until Nick and Eve fell into the busyness of their day-to-day lives, relegating therapy to the back of their minds until it was forgotten altogether.

BOOSTER MC, 1 YEAR LATER

A year later, it was time for Eve and Nick's booster MC (BMC). I was planning to call them to schedule the appointment when I received a voicemail from Eve. “Hi,” she said, “I think it's been a year and we're supposed to come back in.” I smiled; of course Eve was on top of it. I was also pleased that they were looking forward to coming back in. As part of the MC study, BMCs are provided yearly to the couples as an annual marital health check-up, similar to an annual physical check-up. The BMC is meant to check back in on any “ailments” from the prior year and to assess any new warning signs of ill health. For couples who have taken action over the past year and who have improved or stabilized, the BMC is

their chance to celebrate their improvements and solidify their gains. For couples who have not taken any steps to address the concerns in their relationship, who have continued to deteriorate, or who have experienced new issues over the year, the BMC uses motivational interviewing to address the barriers that prevented them from taking action and to develop a new or expanded menu of actions they could take. Furthermore, marital research has consistently revealed that relapse is not uncommon after a couple intervention, resulting in an emerging suspicion that regular boosters may be necessary for lasting marital health.

I was looking forward to the opportunity to follow-up with Eve and Nick, as the MC study was moving along steadily a year later. I was not prepared for what happened. After a few niceties, Eve dove in.

"I'm in this alone," she said passionately, shaking more and more as she spoke, her voice rising. "He's not an equal partner; he's never been an equal partner. I just kind of reached the point, I'm frustrated, I almost don't care any more. He doesn't talk, and the sex issue is still there, and I'm tired. This has probably been the year of the greatest change in my life. I don't think he grasps how severe the change has been. I don't have anything left for the marriage. We've had sex twice in the last 2 months, and that's not acceptable to me. There were people in my family I had to step away from on a permanent basis because they were so poisonous for me. And it has been very difficult. He put his job in jeopardy for 6 months and didn't tell me anything about it. I know life is not always certain, but in that one moment he told me he shattered every sense of security I had. That he could be that irresponsible is flabbergasting to me. I've reached my limit. I just can't live the way I've been living anymore."

Eve was almost crying by the end; her overwhelming negative affect had momentarily stunned me to silence. Nick was simply nodding along. I was not sure which surprised me more: how harshly Eve could criticize Nick as if he were not there, how easily Nick absorbed the onslaught without defending himself, or how differently they were presenting from last year. Their relationship had obviously taken a sharp turn for the worse over the last year, significantly increasing their distress and decreasing their commitment to each other. Indeed, their scores at the 1-year point, as compared to the previous year, supported this deterioration. Almost all of the subscales from the Marital Satisfaction Inventory—Revised (MSI; Snyder & Aikman, 1999) declined from moderately distressed to highly distressed for both Nick and Eve. This included worse overall distress, less satisfaction with the quality of their emotional communication, more difficulties with problem solving, greater tension around the amount and quality of their time together, and less satisfaction with their sexual relationship. Furthermore, Nick's intimacy scores, as measured by the Intimate Safety Questionnaire (ISQ; Córdova & Blair, 2007), reflected diminishing closeness, and both Eve and

Nick's commitment had markedly decreased on the Commitment Inventory (CI; Stanley & Markman, 1992).

Although the BMC assessment interview revealed that their two major areas of concern were still communication and sex, circumstances in the lives had polarized Eve and Nick's differences, worsening their distress. Throughout the booster MC session it became increasingly clear that their pursue-withdraw pattern was enveloping more and more areas of their relationship, leaving them both feeling strikingly less secure in their marriage. Longer-term therapy, again offered as one of the menu of options in the BMC feedback report, now seemed even more imperative to address the growing, insidiously unbalanced nature of their relationship. This troubling dynamic, only modestly visible a year ago, was now reaching a breaking point, with Eve pushing ever more relentlessly and Nick retreating even further. Eve and Nick also recognized how close their relationship was to suffering irreparable damage, and by the end of the BMC expressed determination to begin longer-term therapy. The MC had served as the catalyst we hoped for—without the easily accessible MC intervention, Eve and Nick may have never considered therapeutic services, leaving them alone to face what was rapidly becoming an overwhelming situation. Still, taking this on in longer-term therapy would prove to be quite a challenge.

INTEGRATIVE BEHAVIORAL COUPLE THERAPY

When Nick and Eve called the university couple clinic 2 months later, their case was coincidentally assigned to me, as I was also a therapist in the clinic. Our clinic provides longer-term IBCT for distressed couples in the community. I experienced several competing feelings when I learned that I could be Eve and Nick's therapist. On the one hand, I believed Nick and Eve would greatly benefit from IBCT and were appropriate for this treatment modality. On the other, I was concerned by the glimpse I had received in the BMC sessions of the pervasive and powerful nature of the struggle in their relationship. I checked in with them by phone, and we decided to schedule our first of what was ultimately 24 sessions of IBCT together. My job now was to determine whether and how IBCT could help Eve and Nick.

Getting into It: How IBCT Can Help

IBCT evolved from traditional behavioral couple therapy when Jacobson and Christensen (1996) began interpreting the accumulating evidence that an exclusive emphasis on change left many couples unimproved. The search for more effective methods to treat these more challenging couples eventually led Jacob-

son and Christensen to suggest that the way to improve these relationships may be to facilitate greater acceptance of issues that at first glance seem irreconcilable. IBCT highlights a couple's natural differences and how their interactions have caused these variations to evolve into problematic patterns.

Some would argue not that “their interactions have caused these differences to evolve into problematic patterns,” but that the partners' differences (personality style, vulnerabilities, values, etc.) have caused the problematic interactions (which then both continue in a recursive loop).

Question: These two points of view see different causal pathways in recurrent couple conflict. Which perspective seems more compelling to you? Does it really matter, or are we better served clinically by remembering the classic family systems idea that “the system is its own best explanation,” that is, that cause and effect are difficult to disentangle, that the best way to “explain” problematic behavior is to look at what keeps it going now, not its origins or history?

The idea behind IBCT is that (1) all couples have naturally occurring and perpetual issues, and (2) precisely in those places where we find our greatest challenges, we all long to be accepted by our partners. This acceptance is at the root of intimacy and security. Three primary techniques are used when conducting IBCT: (1) unified detachment (developing an objective, detached understanding of the couple's troublesome relationship patterns; (2) empathic joining (sharing of vulnerable feelings to create intimacy); and (3) tolerance (helping couples better cope with the discomfort elicited by their partner's behaviors, by appreciating the positive aspects of their differences, engaging in more effective self-care, etc.) (Doss, Mitchell, & De la Garza-Mercer, 2007). As partners come to embrace their differences more wholeheartedly, what change might be needed often flows relatively easily.

Eve and Nick's shared narrative when they began therapy was that *Nick* did not take an active enough role in their household and financial responsibilities, was not communicative, and did not initiate enough sexual interaction. They both stated that their goal in therapy was to change Nick so these areas could improve.

It is not uncommon for therapists to see couples who (seem to) agree that one of them “is” the problem in their relationship, that if only he or she would change in particular ways, all would be well. This shared (linear, one-sided) perception/ attribution can pose a major obstacle to change from the therapist's perspective, in that couple therapists are always aiming for much more dyadic, relational, inter-actional formulations of couple problems and couple interventions.

Question: Think of at least three different ways to understand why a given couple might “agree” that one of them “is” the problem between them. How would these different understandings lead to different therapeutic strategies or interventions?

Clearly, Nick and Eve’s ability to collaborate toward negotiated change was significantly compromised by this lopsided dynamic, and they were experiencing a large degree of emotional polarization between them. The IBCT treatment plan, therefore, would need to focus first on developing greater mutual acceptance and intimacy to create a more shared collaborative set. Only then would we be able to successfully incorporate behavioral techniques to improve their communication, sexual relationship, and reciprocity skills. Whether Nick and Eve would have the willingness and endurance to tolerate this counterintuitive approach was the question.

The Theme

An obvious starting place for acceptance work with Eve and Nick was to focus on their destabilizing theme, which stood out clearly in the therapy room. The theme is an important part of the formulation in IBCT, in addition to the polarization process and mutual trap to encourage unified detachment. The IBCT theme explains how couples turn differences into problems; simply put, each partner’s role in the theme pushes the other partner into a more extreme version of their own role and so they polarize and become stuck. Once couples become more aware of recurring patterns and their consequences, blindly engaging in these patterns becomes more difficult, and their disagreements should become less destructive (Jacobson & Christensen, 1996).

Formulation work presents at least two distinct challenges. The first challenge is to develop a theme in collaboration with the couple that fits their particular dynamic. We often start with an “off-the-rack” theme, such as demand–withdraw, and over the course of several sessions gradually tailor that theme to the specific couple. Uncovering a couple’s unique theme often involves a lot of dead-ends and false starts, but as the customized theme eventually emerges, the couple should resonate more with it and become more attuned to it in the moment. This speaks to the second challenge of formulation work, which is that it often takes repeated presentations of the theme before the couple can begin to see it for themselves. Much like a fish in water, couples’ themes are often such a pervasive part of their environment that they simply cannot easily detect it unless it is brought to their attention.

In Nick and Eve’s case, I initially considered several possible themes to capture the distinct dynamic that was impeding their intimacy: demand–withdraw, control–responsibility, parent–child, aggressive–passive, responsible–

irresponsible, work–play, powerful–impotent, mature–immature, worried–carefree. I was cognizant of the potentially offensive or emasculating implications of some of these labels, a real risk as I tried to maintain rapport with both of them in the early stages of therapy. My goal was to identify a theme that was palatable to both Eve and Nick while still accurately reflecting their powerful imbalance.

After the IBCT initial conjoint intake and individual assessment interviews with each of them, I began describing the theme in the fourth IBCT session, the feedback session:

“The two of you clearly have a conflict over how active your roles are in taking care of household and financial responsibilities, and how you spend your free time, and in your sexual relationship. I see these problems as reflecting a more general struggle about mutuality in your relationship. It’s also of note that your disagreements follow a certain storyline, a narrative, that the two of you created and you both seem to believe. The storyline goes something like Eve is making responsible decisions and taking care of things while Nick is trying to learn but is failing. And as you both described, the origins of your respective roles are clearly understandable from your childhoods, with you, Nick, being the youngest, easy-going child who was often directed and felt incompetent at times, and Eve, with you being the oldest, parentified child who was responsible for everyone else. However, this ‘student–teacher’ dynamic may be getting you stuck, because although you have fallen into an agreement about the reason for your unhappiness, neither of you are actually satisfied with the result. Instead, you each feel more distant from each other.”

As I described the theme in terms of a teacher–student dynamic, I emphasized that both of these roles were reasonable attempts to benefit the relationship. The mutual trap they were stuck in was not either of their faults, but rather was an understandable result of this dynamic between them. My summary also introduced their lack of collaborative set, a significant roadblock to the intimacy they desired. When I asked them whether they wanted to commit to the first 10 sessions of IBCT, explaining that therapy often feels worse before it gets better, they readily agreed, stating they were willing to do whatever it took to improve their relationship. Time would tell if that was indeed the case.

Early IBCT: Grappling with the Theme

Eve and Nick came in to our fifth IBCT session (the first session after the assessment and feedback process) looking upbeat and positive. I had assigned them the

homework of noticing the teacher–student dynamic as it came up over the week and bringing in examples. In IBCCT we do not necessarily expect couples to do the homework in exactly the way it is assigned, but instead recognize that how partners grapple with the task will give us important information about their relationship process. Nick and Eve proved this point. When I asked about the homework, Eve took out a list of instances over the week when Nick had acted as “the student”—not completing household chores and not expressing tender emotions to her. Nick also meekly mumbled about an instance when he had been upset by Eve’s lecturing, although he felt it was own his fault. Not surprisingly, their responses to the homework indicated that they were not yet noticing both of their roles in the student–teacher dynamic as I intended, but were instead continuing to enact it. Thwarted here, I decided to try another approach: drawing attention to their dynamic as it occurred in the therapy session.

Various out-of-session “homework assignments,” structure-challenging tasks, and so forth, are common in couple therapy and are extremely valuable. Still, it may be that the ultimate power of couple (and family) therapy may lie in the simple fact that in couple therapy, the therapist has direct access to the problem in its (more) natural environment, facilitating not only change, but also generalization of change to life outside the consultation room.

Question: Besides simply having both partners in a distressing relationship in the office rather than working with either of them separately, what are some ways couple therapists can intervene to improve the chances that changes that take place during therapy sessions will carry over into “real life,” and maybe even expand in real life?

I only had to wait a few minutes for the opportunity to arise. It came while Eve was talking to Nick about his lack of tenderness toward her.

EVE: *(to Nick)* You never tell me how you feel about me. I believe you love me, but I have no idea what you really feel about me. *(to therapist)* He never really tells me his emotions. He doesn’t tell me how he feels about me in his life.

NICK: There’s an inadequacy I feel about how to respond.

THERAPIST: It’s clear that you both want to feel loved. And it’s interesting because I’m noticing a little bit of the dynamic right here.

Eve’s statements had the flavor of a teacher–parent conference, in which she was informing me of Nick’s failures in the third person. Nick, on the other hand, was avoiding conflict by criticizing himself and addressing me instead of

Eve. Fortuitously, another opportunity to point out the theme arose in the same conversation:

EVE: There's not enough tenderness between us. He has no concept of expressing tenderness. It's something I've been saying to him for a long time.

THERAPIST: It sounds like you're feeling a deep craving for something you didn't get as a child. And I guess my question is: Is there a lot of intimacy between a teacher and a student?

EVE: (*pause*) Probably not. (*to Nick*) I don't want to be your teacher.

Hope ran through me, as Eve's statement was the first indication of her recognition that her own teacher role was also negatively affecting the relationship, as was Nick's student role. At the end of the session, I reassigned them the homework of noticing the student–teacher dynamic over the week and clarified that they should also be watching for their *own* role in the dynamic, not just for complaints they have about their partner's role. Tempering my optimism, however, was my growing apprehension about Eve and Nick's reaction when they would begin to fully grasp the meaning of the teacher–student theme. Their established narrative to this point did not involve Eve nor any dynamic they were both contributing to. Acknowledging the theme could potentially shake up their established relationship balance, destabilizing them and the therapy. Indeed, when they came back in for the sixth session, the tension was mounting.

EVE: (*to Nick*) See, this is the problem: You're still operating as if you were a kid. I resent saying this has to be done, and then you resent when I say it. You need to be an equal partner. If you don't like my systems, great, but you're not doing anything to help. It's like a parent–child thing.

THERAPIST: Much of what you are saying seems to fit into this dynamic. These patterns tend to have a life of their own, with both people contributing equally. Although it's not a theme that either of you wants or likes, there is something that perpetuates it, probably coming from the roles each of you have played for a long time.

EVE: I would think after all these years he should be ashamed when he says, 'I don't know how this house runs.' Decisions should be made jointly, but they're not because he doesn't know to do the bills, how much is due each month.

THERAPIST: Nick, what feelings are coming up for you?

NICK: I feel incompetent, childish. I can't do these basic things that I know other people are doing. I don't consider myself lazy or a playboy, but my energy

level at home is not good. I don't see work first, I see what can I get out of first.

THERAPIST: It sounds like you feel guilty. Like something's wrong with you.

NICK: I have resentment toward my family. I wasn't made to do anything. Maybe my childhood should have been more structured.

Their habitual scapegoating of Nick, again reflecting their lack of collaborative set, was remarkably stubborn and difficult to shift. Nick was still unaware of his role in the dynamic, but was instead automatically playing the role of a meek student in therapy. Eve was beginning to grasp the meaning of the theme, but her natural impulse was to fall back on "teaching" Nick how not to play the part of student. The problem was that as Nick made himself a more stumbling student, Eve became a more domineering teacher, and vice versa, leaving them both frustrated and resentful. The following opportunity to point out Nick's role in real time arose in our eighth session.

THERAPIST: Nick, you started out saying that you've mistreated Eve for many years.

NICK: Well, taken advantage of—mistreated sounds bad, more taken for granted.

THERAPIST: Here's the thing about those statements: It feels like those statements are when you become the "student" in here. It's a comfortable place you go to. This seems like an example of when it comes up for you.

Nick paused, looking straight at me, and then said, "OK." Like something clicked.

Getting Worse before Getting Better

Despite these early moments of recognition of the theme, as is often the case, it was a "two steps forward, one step back" process with Nick and Eve. There were several weeks when I began to feel like a broken record, and wondered how this repetition was affecting them. I would note instances of the pattern for several sessions with little response, then for a session or two they would notice it themselves, then not again. Nick came to several sessions saying something like, "We're failures," and they would subsequently describe problematic interactions that fit perfectly into their student-teacher theme, or they would enact their roles quite clearly in session, with little insight into their process. So, we would discuss the theme again, and then again. However, this focus on the theme also continued to destabilize them, especially Eve. They had spent more than 15

years relying on this dynamic to protect each of their deepest vulnerabilities: Nick acted as a student so that he could safely avoid conflict, and Eve played the role of a teacher so that she could control her lifelong anxiety. Recognizing this pattern as problematic was understandably threatening for each of them. I worried that the building pressure could rupture our therapeutic relationship.

In our eighth session, when we were again discussing the theme, Eve neared a breaking point. “I surrender,” she said with hopelessness and anger in her voice. “I have no fight left. I don’t know what to do or say.” Recognizing the dynamic in the relationship was pushing Eve into an untenable dilemma. She was becoming sensitized to her tendency to teach Nick, and at the same time she continued to feel compelled to *do something*, without knowing what to do. Nick at the same time displayed hopelessness about altering his student role, once saying, “If it was something that I knew more about than she, like fixing cars, then I could be the teacher.” I momentarily halted the session to regroup, and checked in about whether they were willing to continue the painful work of addressing their pattern. Although they expressed commitment to continue, I remained concerned about their increasing desperation. I also feared losing rapport with them and especially with Eve, still the decision maker in the relationship, which would likely jeopardize our work. Spontaneously, an idea came to me from the tolerance strategies in IBCT. I wondered if it would be more effective if we shifted our focus away from “recognizing their roles,” reframing it instead as “taking care of themselves.” Promoting greater self-care is a technique that IBCT uses to increase tolerance of the other partner’s painful behavior. Despite Nick and Eve’s allegiance to their respective roles, Eve clearly also wanted relief from the burden of controlling everything so tightly. Similarly, one of Nick’s lifelong wishes for himself was to have a greater sense of agency. When we began exploring this, Eve described that taking care of herself would mean not worrying so much about every detail of the housework, spending time reading her favorite books, going out to dinner with friends, or just relaxing in front of the television. Nick explained that taking care of himself would involve “being vocal about how I feel. I usually just go along with what she wants, but there will be times when I don’t want to do what she’s suggested, and I could let her know.” Not only was this what they wanted for themselves, this was what they wanted from each other! Furthermore, these self-care actions were outside of their teacher–student pattern. I commented in a session soon after: “Eve, it feels like for you taking care of yourself would be trying to let go of control of things, even when you get triggered and feel very nervous. For you, Nick, taking care of yourself is expressing yourself and not hiding how you really feel or what you really think. If each of you take care of yourselves in those ways, that would not be the student–teacher dynamic. That would be something different.”

Toward Acceptance

Nick and Eve came in to our tenth session after the holidays with a lighter step than I had seen in several sessions. Nick was recounting his family's holiday gatherings when the conversation quickly turned to his relationship with Eve:

NICK: My mother did the best she could, because my father was sickly. My father didn't know how to show he loved me. I think I have some of that, too. (*looking at Eve*) I love you, but I don't know how to show it.

EVE: Yeah, I know you love me, but not in the ways that I would like to feel it or see it. I think I could be better toward you too. Because your mother never hugged, hardly ever said she loved you. Do you feel it from me or no? I could be better.

NICK: It could be better. It's a fault we both share, the same fault.

I was so moved by the couple's empathic joining and unified detachment occurring in front of me, and how markedly different this was from previous sessions, I could barely contain my enthusiasm.

THERAPIST: This is a huge step toward what we're trying to do! You can empathize about your problems in an objective way, and may even be able to use those problems to be closer, though that seems counterintuitive.

NICK: A shared problem.

EVE: I can kind of see what you're saying. I've never heard him say that before, I never realized we do have that shared problem.

It appeared that Eve and Nick's new focus on taking care of themselves was facilitating their ability to discuss their relationship difficulties together in a much more intimate and collaborative way.

Even given this progress for Nick and Eve, we needed to take it a step further. In the true spirit of acceptance, the goal was not just to notice their pattern, but also to work toward increased acceptance of each other's roles in the theme. Although partners can limit the damage themes do, and even use them as intimacy bridges, themes do not usually completely disappear. Nick and Eve would probably always be vulnerable to falling into their respective roles of teacher or student, but noticing it when it happens with humor and compassion would be much healthier and more loving than blaming themselves or each other. Nick's propensity to go along with others was something that was deeply ingrained, and really was a positive attribute of who he was. Similarly, Eve's intense emo-

tions were not likely to go away and were part of her uniquely passionate personality. IBCT's tolerance technique of "highlighting positive features of negative behaviors" was useful here. I asked Eve to imagine what would happen if she was married to another "teacher" and Nick to imagine if he was married to another "student." Both of them laughed as they recognized that double doses of either of their personalities would be a disaster, and discussed how their spouse's differences did indeed complement themselves and benefit the relationship.

True to the theory, after integrating the acceptance work over many weeks, Eve and Nick reported that although their arguments continued to occur, they became shorter and less destructive. In our twentieth session, Nick's job again unexpectedly transitioned him to another shift under uncertain circumstances. Although Eve reported she still "freaked out" as she would have previously, she did not withdraw from Nick this time, and they were still able to enjoy a date they had preplanned. In a later session, they reported noticing and naming their pattern in real time when it started happening, which immediately deescalated it. The student–teacher theme appeared to be loosening its powerful grip.

TRADITIONAL BEHAVIORAL COUPLE THERAPY TECHNIQUES

As the theme work continued to increase Eve and Nick's acceptance, intimacy, and collaboration, this opened up the opportunity to introduce traditional behavioral techniques to directly target their initial complaints of communication and sex. We began with general communication training after I gave them each an instructional chapter to read at home. The method for communication training built directly on the efforts that Nick and Eve had already been making in relation to the student–teacher dynamic, requiring Nick to express himself openly and Eve to listen attentively in order to paraphrase accurately. It also constrained Eve's statements to a reasonably brief duration so that Nick could paraphrase her and forced Nick to listen openly instead of presumptively. It leveled the playing field, making each of them alternately and flexibly play the roles of speaker and listener. Nick and Eve first practiced this communication skill in therapy to discuss a relatively safe topic—their bathroom renovation—and later to discuss a much more emotionally loaded subject—their sexual relationship. During the latter, Nick opened up for the first time about how the years of trying to become pregnant had impacted his enjoyment of their sexual relationship, to which Eve responded with relief and appreciation for his honesty. These mutual conversations allowed them to behaviorally enact the growing intimacy between them, and several times later in therapy they requested to use the technique again to discuss various topics.

Soon after, I introduced a prototypical behavior exchange (BE) task, as illustrated by Jacobson and Christensen (1996). While Nick and Eve had made progress toward better self-care, their need to take better care of each other remained. The BE task began with each of them making a list of actions they could do to increase marital satisfaction in the other. Eve listed that she could “be more physically affectionate, by touching and hugging,” and “allow Nick to decide how he cooks or cleans up without criticizing.” Nick said he could clean the bathroom, initiate conversations with Eve about their retirement plan, and hold her while they were watching movies. They were then each assigned to independently and privately pick one or two relatively simple actions from their own list that they could do each week and notice how it affected their spouse. I checked in on this homework each following session, as Nick and Eve customized the assignment to work optimally for them. It was important to Nick that his caring behaviors were originating from his own autonomous intent. Initiating these acts moved Nick out of the “wait and see” stance into a more active role in his relationship with Eve. On the other hand, it was initially challenging for Eve to feel comfortable doing things for Nick, as it reminded her of being taken advantage of as a child. We explored whether caring for Nick could also paradoxically serve as self-care, and indeed she experienced evidence of this reciprocity in their improved sexual relationship. These were precisely the actions that Nick and Eve longed for from each other when they initially presented for therapy, and they both clearly appreciated the improved quality of their relationship.

TERMINATION, UPS, AND DOWNS

As the summer neared, so did the end of our second round of ten therapy sessions, and we prepared to terminate our work together.

Available data suggest that about three-quarters of the courses of couple therapy last fewer than 20 sessions, and that, on average, couple therapy lasts about 8 to 12 sessions. Interestingly, while behavior therapy, including behavioral couple therapy, is often seen as being very brief, both the behavioral cases in this casebook lasted well over two dozen sessions.

Question: On average, how long does your work with couples last? What seem to be the main factors that affect the length of therapy with couples?

I noticed how fond I had grown of this couple, over almost 2 years and 28 sessions, and how difficult it was going to be to say goodbye. Although my

goal had been to address the major areas that appeared to be hindering Nick and Eve's intimacy, additional issues still came to mind that we could have discussed, although I recognized the inevitability of that unfinished feeling. I was impressed by the risks they had taken during our work, how vulnerable they had made themselves, and how tenaciously determined they had turned out to be to improve their relationship. I expressed my admiration and gratitude concerning their efforts in therapy. They also graciously shared their appreciation. Eve said I "had gotten her to give up control more than she ever had before." Nick pinpointed the theme work as most beneficial for him, and I was pleased this had facilitated his developing assertiveness. I wondered, however, whether Eve's statements reflected her desire to be the "perfect client" in therapy, just as she had to be the "perfect child" in her family of origin. And was Nick trying to be a "good student" by telling me all he had learned? Still, their marital distress scores had improved over the course of therapy, such that they were much more satisfied in their relationship than they had been at their Booster MC. More tellingly, perhaps, the issues that they had been struggling with overtly—sex and communication—had by their own report begun to improve considerably. However, given that relapse is such a common concern for couples like Nick and Eve, they may ultimately be ideal candidates for regular annual checkups to monitor and maintain their relationship gains.

In our second-to-last session, Nick and Eve anxiously asked what they would do if they needed more assistance after we finished therapy. Although the university clinic would be closed for the summer and I was ending my time as a therapist in the clinic, I assured them they could call the MC lab at any time for a referral to a couple therapist in the community. I also anticipated that highs and lows likely still lay ahead for Eve and Nick, predicting that the upcoming weeks were likely to resemble the fluctuations of the last couple of years. I hoped they were adequately prepared for these potential relapses, especially if circumstances in their lives again became more stressful.

Indeed, Eve and Nick's relationship still experienced ups and downs right through the last session. To my delight during the final session, Nick confidently summarized, "We can't force each other to be the same as each other, but we both are happier in the relationship if we're each working toward our individual goals." However, also in our last meeting, Nick and Eve told a story from the day before when Nick had planned to buy a "kiddie" ice cream cone, but changed his mind and got a small instead. Eve became very upset and lectured him about his problems with cholesterol; Nick ultimately agreed he should have gotten the kiddie cone. Oh, yes, the student–teacher theme lived on. Our hope now was that they could continue to build on the intimacy they had gained from the MC and IBCT to move toward the type of relationship they desired, theme and all.

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