THIRD EDITION

Gerald R. Weeks and Stephen T. Fife

Couples in TREATMENT

Techniques and Approaches for Effective Practice

COUPLES IN TREATMENT

This third edition of *Couples in Treatment* helps readers conceptualize and treat couples from multiple perspectives and with a multitude of techniques. The authors do not advocate any single approach to couple therapy and instead present basic principles and techniques with wide-ranging applicability and the power to invite change, making this the most useful text on integrative, systemic couple therapy.

Throughout the book the authors consider the individual, couple, and intergenerational systems of any case. Gerald Weeks' Intersystem Model, a comprehensive, integrative, and contextual meta-framework, can be superimposed over existing therapy approaches. It emphasizes principles of therapy and can facilitate assessing, conceptualizing couples' problems, and providing helpful interventions. Couple therapists are encouraged to utilize the principles in this book to enhance their therapeutic process and fit their approach to the client, rather than force the client to fit their theory.

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Selected works by Gerald R. Weeks

Focused Genograms: Intergenerational Assessment of Individuals, Couples, and Families by Rita DeMaria, Gerald R. Weeks, and Larry Hof (Routledge, 1999).
New edition available June 2014.

Systemic Sex Therapy edited by Katherine M. Hertlein, Gerald R. Weeks, and Nancy Gambescia (Routledge, 2009).
New edition available February 2015.

A Clinician's Guide to Systemic Sex Therapy by Katherine M. Hertlein, Gerald R. Weeks, and Shelley K. Sendak (Routledge, 2009).
New edition available February 2016.

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To Nancy Love
— GW

To April Fife
— SF

We are grateful for their enduring love and support

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ABOUT THE AUTHORS

Figure 0.1 Gerald R. Weeks, Ph.D., ABPP

Dr. Weeks is a Professor in a COAMFTE-Accredited program in Marriage and Family Therapy at the University of Nevada–Las Vegas and also in private practice. He is an Approved Supervisor, and Clinical Fellow of the American Association of Marriage and Family Therapy, and is Board-certified by the American Board of Professional Psychology and the American Board of Sexology. He has published 19 professional textbooks (8 in couple therapy) in the fields of psychotherapy, sex, couple/marital, and family therapy.

Dr. Weeks won the Outstanding Contribution to Marriage and Family Therapy in 2009 from the American Association of Marriage and Family Therapy, and was named the 2010 Family Psychologist of the Year. Among his most popular texts are: *Paradoxical Psychotherapy* (with Lou L'Abate), *Focused Genograms* (with DeMaria and Hof), *If Only I Had Known: Avoiding Common Mistakes in Couple Therapy* (with Odell and Methven), and *Systemic Sex Therapy* (with Hertlein and Gambescia). Several of his books are available in multiple translations. Dr. Weeks lectures nationally and internationally on the topics of sex and couple/marital therapy.

Dr. Fife is an Associate Professor in a COAMFTE-Accredited program in Marriage and Family Therapy at the University of Nevada–Las Vegas and also in private practice. He is a Clinical Fellow of the American Association of Marriage and Family Therapy, and member of the National Council on Family Relations. He has published and presented his research nationally and internationally on couple therapy, therapeutic change processes, and the foundations of effective clinical practice. His research has been published in several of the leading couple and family therapy journals. He also lectures extensively in the community on topics related to couple and family relationships. He is happily married and is the father of two sons.

Figure 0.2 Stephen T. Fife, Ph.D.

PREFACE

We are pleased to be able to publish the third revision of our text. It was originally written as a professional book, but is widely used in marriage and family therapy programs. The new edition presents the latest developments in the field of couple therapy, but maintains the same basic structure and goals of the previous volumes.

The purpose of this book is to present the concepts regarding the therapeutic process with couples and many of the techniques, methods, and strategies needed by the couple therapist. In several previous volumes, and Weeks (1989) and Weeks and Hof (1987, 1994, and 1995) presented a theoretical approach to couple therapy and provided an overview of the structure and process of treatment primarily through case studies. The current book presents the next step, which is that of providing the "how to" of couple therapy. In this book, we discuss the process of couple therapy, treatment approaches, treatment of some specific relationship problems, and how to properly implement the techniques with couples. Unlike other books on couple therapy which emphasize theory, our text is written by academic clinicians for the clinician who is seeking practical and effective applications, and for students taking a course in couple therapy

The book is divided into two sections. Part I provides the reader with an understanding of how to conceptualize cases from a systems perspective using a metatheoretical model developed by the senior author called the Intersystem Approach. This provides a framework for the clinician to systematically and theoretically integrate various approaches to dealing with couples. There are also several chapters devoted to the process of couple therapy. Most books on therapy will mention process, but none that we have seen offers so much on therapeutic process. A new and exciting addition to Part I is on the common factors in couple therapy. This chapter helps to balance the book between common factors in couple therapy. Part II of the book is a mix of how to treat several of the most common couple problems and how to apply different theories or approaches to couples, such as the application of cognitive therapy to couples. We also guide the reader through the effective implementation of interventions with couples. A clinician may know of a technique, but if the technique is not properly implemented it will be ineffective.

The authors selected scientific information from the field that had clear and effective clinical application and combined that with extensive clinical experience with couples. The senior author has conservatively provided over 30,000 hours of couple therapy and supervised hundreds of cases of couple therapy. The junior author has

also been practicing therapy and supervising graduate students for over 10 years, specializing in couple therapy. The skills and interventions described in this book are practical, straightforward, and foundational for couple work. Advanced skills, unorthodox techniques, and techniques with limited applicability have been purposely excluded. For this reason, the text is ideal for therapists who are beginning to work with couples and as a review volume for the seasoned couple therapist or for the therapist providing supervision. We believe this book has several unique features:

- It is grounded in the Intersystem Approach to therapy.
- It offers clear guidelines for assessment and conceptualization of couple problems.
- It offers practical suggestions for dealing with process issues.
- Approaches and techniques for resolving particular problems are discussed with an emphasis on implementation.
- New techniques are offered to deal with couple problems.
- It discusses common factors associated with positive outcomes in couple therapy, regardless of the specific model used by the therapist.
- The principles and interventions are applicable to diverse clients, recognizing that each couple is different and the therapy must be tailored to the client rather than forcing the client into a particular theoretical framework.

Another unique feature of this book is the emphasis on couples' growth and not just problem resolution. Many couple therapists assume that by eliminating problems they will enhance the intimacy of the couple. Our approach is to focus on both goals simultaneously—problem resolution with enhanced intimacy. To our knowledge, this volume is the only text that focuses on both. By adding the growth-oriented or intimacy enhancement dimension to couple therapy, the process is enriched for both the therapist and the couple.

Chapter Overview

Chapter 1, Couple Therapy and the Intersystem Approach, begins with an overview and history of couple therapy as a unique treatment modality. The primary focus of the chapter is to introduce readers to a comprehensive approach for the treatment of couples called the Intersystem Approach. The Intersystem Approach is meta-theory that is broadly applicable across different therapy approaches and provides an overarching framework to guide therapists in their work with couples. This framework emphasizes three interactive systems or subsystems that must be simultaneously considered when working with couples: the individual, the couple, and the intergenerational. The model provides guidance to therapists as they undertake assessment, conceptualization, and intervention with couples.

Chapter 2, Assessment, Case Formulation, and Avoiding Common Mistakes, describes the comprehensive assessment and case formulation of the couple using the Intersystem Approach. This assessment enables the clinician to formulate a multileveled treatment plan. The chapter also discusses some of the common mistakes made during the evaluation phase and provides suggestions for avoiding these pitfalls.

Chapter 3, Orienting Couples to Therapy, discusses principles that will enhance the ability of a couple to use the therapeutic process effectively. General topic areas include expectations and myths; boundary issues such as lateness, fees, and missed appointments; and instruction on how to help a couple take responsibility for their growth.

Chapter 4, Systemic Conceptualization and Treatment, emphasizes the importance of approaching the conceptualization and treatment of couples from a systemic perspective. The chapter contrasts linear thinking and interventions with a systemic perspective. The difficulties many beginning therapists have in learning to think systemically are elaborated through the descriptions of a number of systemic interventions.

Chapter 5, Keeping Therapy Balanced, covers the importance of balance in systemic therapies. Several techniques for a balanced approach with individual partners in dyadic therapy are discussed. The topics addressed include client understanding of balance, inclusive language, intensity and balance, and seating arrangement to promote balance. The chapter concludes with understanding psychopharmacology and balance, determining whether balance has been established, and loss of balance as an important area for personal insight.

Chapter 6, Moving from Content to Process, covers the challenges of learning to listen to the content of a client communication while understanding and being sensitive to the process. Content and process are defined and contrasted. Methods of understanding the process of a therapeutic session are enumerated.

Chapter 7, Building and Managing Intensity, orients the reader to skills of building appropriate intensity within a therapeutic session. The chapter presents various approaches to building intensity and emotional expression, as well as learning to manage them with couples. The use of images and analogies, a description of specific interventions to raise emotion, use of repetition, and the importance of focusing on primary themes and material are the main topic areas.

Chapter 8, Systemic Therapy with Individual Clients, discusses the use of systemic intervention when counseling an individual member of a marital dyad or committed relationship. Issues of balance, empathy, self-responsibility, and the development of personal power are emphasized.

Chapter 9, Common Factors of Change in Couple Therapy, addresses one of the most significant developments in couple therapy in the 21st century: the theory and research on common factors associated with change and positive therapy outcomes. Following a brief history of common factors debate and research, prominent common factors research and models are reviewed. The chapter concludes with a discussion of common factors unique to couple therapy and practical application of common factors in treatment.

Chapter 10, Enhancing Intimacy in Relationships, provides a growth-orientated model for the clinician based on a clinically useful theory of love. This chapter shows that many couple problems can be traced to the partners having underlying fears of intimacy. Techniques to enhance intimacy are suggested for the couple who want to move beyond a problem-focused therapy and the underlying fears of intimacy which generate many problems.

Chapter 11, Reframing, covers one of the most common of all therapeutic techniques used with couples. Reframing is a technique used to change the meaning

of symptomatic behavior from negative to positive and to change the couple from seeing their problem as individual to one of relationship. This technique appears simple but is very difficult to correctly implement. It is also necessary to reframe problems in a way that is congruent with the couple's belief system in order to lay the groundwork for the implementation of other approaches or techniques with couples.

Chapter 12, Communication Techniques, reviews common communication problems that couples bring to therapy and offers practical guidelines for working with couples to address these problems and learn to communicate more effectively. A general framework is used to teach couples different levels of communication, and specific techniques are reviewed. The authors also elucidate some of the implicit assumptions that facilitate couple communication.

Chapter 13, Conflict Resolution, addresses the issues of conflict as inevitable in all relationships and gives therapists guidance for constructively working with conflict in couple therapy sessions. This chapter examines anger and its underlying emotional components, and the meaning and function of anger in relationships. A model for conflict resolution is proposed that addresses conflict at the individual, couple, and intergenerational levels. The model helps therapists address the couple's feelings, attitudes, and motivations associated with anger before moving to the problem-solving stage of the conflict resolution model.

Chapter 14, Cognitive Techniques and Interventions, reviews an area of couple therapy that is often ignored by therapists: how and what partners think. The chapter reviews the application of cognitive models in couple therapy, with an emphasis on common cognitive distortions as they apply to couples. A systemic model for using cognitive therapy is described.

Chapter 15, Techniques of Relationship Contracting, focuses on several methods of contracting that couples may use to help collaborate to make behavioral changes in their relationship. General principles for creating, implementing, and maintaining contracts are discussed.

Chapter 16, Working with Emotions, follows the cognitive and behavioral chapters with a discussion of how to work with clients' feelings in couple therapy. The authors describe models and techniques to help the couple identify and express emotions. Guidelines are also given for therapists to effectively manage feelings in the session.

Chapter 17, Homework: Extending Techniques from the Office to Home, covers the subject of giving homework to couples in treatment. Many of the techniques in the book may be extended beyond the therapy hour to practice at home. This chapter discusses how to give homework, identifies the structural elements of a homework assignment, and offers suggestions to increase compliance with doing homework.

Chapter 18, Treating Infidelity, grew from students' and colleagues' requests for help in dealing with extramarital affairs. Affairs are among the most difficult and complex moral, ethical, and therapeutic challenges a therapist and couple will face. The primary focus of this chapter is to discuss assessment and treatment. We offer an integrative, structured framework and emphasize the latest research on forgiveness as one of the key components to recovering from an affair. However, forgiveness alone without the other components having been successfully completed is not likely to work.

Chapter 19, Working with Highly Reactive Couples, deals specifically with the therapeutic challenges related to highly reactive, narcissistically wounded couples. These couples are very difficult to work with and often fail to respond to traditional approaches to couple therapy. The dynamics of such couples are described and a step-by-step process is laid out for their treatment.

Chapter 20, Solidifying Change and Maintaining Progress, is directed toward helping couples sustain the changes they have made and prepare for the conclusion of therapy. Topics include encouraging clients to take responsibility for their progress and future success, tapering sessions, continuing relationship enrichment, preventing relapse, and addressing setbacks.

ACKNOWLEDGMENTS

In the early 1980s, Mr. Bernie Mazel, then President of Brunner/Mazel Publishers, asked if I (G.W.) would be interested in writing a book on couple therapy. He was familiar with the fact that I had been teaching one of only a few year-long courses in couple therapy, which was widely acclaimed.

Inspired by Mr. Mazel's suggestion, I and a colleague wrote the first edition of *Couples in Treatment: Techniques and Approaches for Effective Practice*. Writing this volume led us to appreciate how much our students have taught us about what is usable, and often used, by the beginning therapist. This third edition was written by myself and Stephen Fife, a new co-author who is an authority in the field of couple therapy. We not only teach and have our own practices, but also supervise students, and it is still the case that our students help us recognize what the beginning couple therapist needs to learn in the long trek to becoming an effective therapist.

After the publication of our first edition, Taylor & Francis bought Brunner/Mazel publishers. Marta Moldvai has been our constant supporter and Editor at Routledge. She and George Zimmar, Publisher, informed us that the book was selling well, was being used in training programs, and should be updated. We want to thank her for her excellent editorial work, patience, and help in moving this writing project along.

We want to thank several research assistants who tirelessly tracked down references for us and proofread the book from a student's perspective. Rebecca Nemecek, Justin Smith, Lauren McCoy, and Tamara Marsar did much of the heavy lifting in this regard. Additional assistance was provided by Austin Ellis, Tod Young, Lindsey Lee, Kathy Disney-Fairchild, Sarah Steelman, Heather Hoshiko, and Luisa Martinez-Cruz.

Part I

BASIC PRINCIPLES AND PROCESSES OF COUPLE THERAPY

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1

COUPLE THERAPY AND THE INTERSYSTEM APPROACH

Although marital and couple relationships received a modest degree of clinical focus during the first half of the 20th century, they emerged as a unique focus of treatment in the later part of the 20th century with the advancement of system theory and its application to psychotherapy. The development of systemic theories and therapies represented a major paradigmatic shift in psychotherapy. These therapeutic approaches represented a shift away from the individualistic and intrapsychic theories developed and employed by Freud and the psychoanalytic/dynamic therapists, as well as many cognitive–behavioral and humanistic models of psychotherapy. The systemic theories all share the concept of the individual-as-part-of-a-system, and they focus on interpersonal variables and relationship dynamics.

The past 40 years have been the "systems era" in the history of psychotherapy. In this short period of time, eight major schools have developed, which Kaslow (1981) grouped under the following headings: (a) psychodynamic–psychoanalytic; (b) Bowenian; (c) relational or contextual; (d) experiential; (e) structural; (f) communication–interaction; (g) strategic–systemic; and (h) behavioral. An additional school represents the most recent development in couple therapy and can be broadly classified as postmodern–constructivist, although not all systems thinkers agree that postmodern–constructivist approaches are systemic (Minuchin, 1998).

These schools of thought all share some basic assumptions about the systemic nature of dysfunction and treatment, but they are clearly different in content. In fact, these schools of therapy were originally presented as if each was to be used exclusively, without "cross-fertilization" from others (Gurman & Kniskern, 1981a). However, most practitioners of systemic therapy and others who are not systems oriented do not operate from such a purist basis. They recognize the implicit need to fit the theories to their clients rather than fitting the client to a single theoretical approach. Thus, integrative approaches have become more common among therapists addressing systemic issues.

This clinical need for integration has led to a new effort within the systems approaches. The latest development, one which spans approximately the last 30 years, is toward the integration of individually and interpersonally oriented theories and the integration of the various systemic approaches. A number of books and papers have been published advocating the synthesis or integration of various theories. Many of these texts have moved thinking within the field towards developing models demonstrating how different, sometimes apparently mutually exclusive, theories and

therapies can be combined. For example, Kaslow (1981) published one of the earliest papers advocating an integrative approach to family therapy, in which practitioners can draw "selectively and eclectically" from various theories.

Duhl and Duhl (1981) presented one of the first clinically integrated models that they called "integrative family therapy." They looked at all the levels of the system, for example, developmental level, individual processes, and transactional patterns. Their approach was focused primarily on how the therapist thinks and intervenes, and was less concerned with theoretical discussion regarding how theories could be integrated. Berman, Lief, and Williams (1981) also published a chapter in which they discussed how several theories could be integrated therapeutically. In this paper, they presented a coherent way of combining contract theory, object-relations theory, multigenerational theory, systems theory, and behavioral analysis all within a developmental and therapeutic model.

In addition, a number of other articles and books have appeared which address the issue of integration in systems therapy. These include: Hatcher (1978) on blending Gestalt and family therapy; Abroms (1981) on the interface between medical psychiatry and family therapy; Stanton (1981) on how to integrate the structural and strategic school; Green and Kolevzon (1982) on convergence and divergence in family therapy; Levant (1984) on a classification scheme for different theories; Lebow (1984) on the advantages of integrative approaches; a series of articles on the integration of structural–strategic therapy edited by Fraser (1984); Doherty, Colangelo, Green, and Hoffman (1985) on ways of reconceptualizing structure and distance in integration; Wachtel and Wachtel (1986) on designing intervention strategies based on family dynamics in individual therapy; Weeks and Hof (1987) and Hertlein, Weeks, and Gambesica (2008) on integrating sex therapy and marital therapy; and Weeks (1989a, 1989b) on integrating individual, couple, and intergenerational approaches. Additionally Case and Robinson (1990) and Snyder and Balderrama-Durbin (2012) both present excellent reviews of efforts at integration in couple and family therapy.

In revising our text, we were disappointed that more efforts toward integration in couple therapy have not taken place since our original publication of *Couples in Treatment* in 1992. With a majority of couple therapists utilizing integrative or eclectic methods (Lebow, 2003), it is surprising that there have not been more formalized attempts at developing integrative approaches to couple therapy. Nevertheless, some of the notable efforts include: Christensen, Jacobson, and Babcock (1995); Jacobson and Christensen (1996); Lawrence, Eldridge, Christensen, and Jacobson (1999); Clark-Stager (1999); Gurman (1992); Dattilio and Padesky (1990), and Dattilio (2010). The majority of the new efforts toward integration involve behavioral approaches and stress cognitive/behavioral-systems integration. The major work to come out of this effort, *Integrative Couple Therapy: Promoting Acceptance and Change* (Jacobson & Christensen, 1996), is an acceptable book on couple therapy, but does little to advance any systematic effort toward integration. They stress what we call an eclectic, rather than integrative, approach. Similar to many efforts at integration, Jacobson and Christensen's model lacks a coherent theory that ties foundational concepts and methods together; thus it is an approach based on technical eclecticism rather than being truly integrative.

In 2000, Johnson and Lebow published an article in which they considered whether couple therapy had "come of age" (Johnson & Lebow, 2000, p. 23; see also Gurman & Jacobson, 1995). Although marital therapy began formally in the 1950s and has received consistent, yet sparse, attention since that time, we question whether it has truly "come of age." There are relatively few texts on marital/couple therapy when compared to the number of books devoted to individual therapy and family therapy. Most training programs offer one course in marital/couple therapy even though they are called marriage/couple and family therapy programs. Clinicians and some faculty still believe anyone trained in family therapy can automatically do couple therapy. The fact is, these two approaches require different skill sets, although they share many of the same basic assumptions about the systemic nature of relationships. Our experience in training literally hundreds of therapists is that family therapists know relatively little about couple therapy.

Although the past decade has brought some improvements, the field of couple therapy has been overlooked and underfunded by governmental bodies such as NIMH. Couple therapy simply is not viewed as fundable research, which has meant university faculty struggle to investigate important questions about couple therapy. Thus, empirical studies historically have been scattered, and those that are conducted are often done with little or no funding or with small university grants, have small sample sizes, and are sometimes poorly designed.

Nevertheless, over the past two decades the field of marital/couple therapy endeavored to establish a foundation of empirical support for the effectiveness of treatment. These efforts resulted in an ever-growing body of research that has helped solidify several conclusions related to treatment effectiveness. First, couple therapy is effective. A meta-analytic review of effectiveness research revealed that those receiving couple therapy are better off than 84% of those not receiving treatment (Shadish & Baldwin, 2002). Second, the effectiveness of treatment is generally consistent, regardless of the treatment approach being used (Sprenkle & Blow, 2004a, 2004b). Part of the effort to improve the empirical support for couple therapy included efforts to determine which model(s) was most effective. However, results indicate there is not one couple therapy approach that is superior to the others. Because of these findings, some have postulated that there are certain curative factors related to successful treatment outcomes that are independent of theory or the treatment model being used (Asay & Lambert, 1999; Davis, Lebow, & Sprenkle, 2012). Chapter 9 discusses in more detail common factors of change in couple therapy.

Given the lack of funding for empirical research and a lack of scientific rigor in its early days, the field of couple therapy has attracted its share of self-proclaimed experts, many of whom are really expert self-promoters. Some of the more charismatic figures have managed to capture the attention of many of the newer, more naive members of our field. As an example, in the Johnson and Lebow (2000) article some of these figures are mentioned without due criticism of their work. The clinician who is unfamiliar with this field might assume a John Gottman and a John Gray are of equal significance and value to our field. In addition, both fields of marital therapy and family therapy are highly political. Certain groups are "in" and others are "out," depending on the source. In particular, the Johnson and Lebow article mentioned above, which purports to be a comprehensive review of the field, does not mention

the several volumes the current authors and others have produced, in spite of the fact that the senior author has published more professional texts on couple therapy than anyone in the U.S.

The therapist who is new to this field is urged to have a critical attitude and maintain a healthy degree of scientific skepticism, objectivity, and scholarship. Unfortunately these values are underemphasized in master's-level training programs, partly due to the fact that clinical practice tends to run ahead of empirical validation, and faculty do not stress the connection between research and practice. The clinician must learn to balance his or her clinical experience with sound theoretical arguments and empirically based research.

The Intersystem Model

There are a variety of formalized therapy approaches that therapists can choose from in their work with couples. These approaches generally align with one of the eight schools identified by Kaslow (1981). Nevertheless, the purpose of this book is not to review these models; this has been effectively done by others (for overviews of the various couple and family therapy models, see Goldenberg & Goldenberg, 2012; Gurman, 2008; Nichols, 2012; Sexton, Weeks, & Robbins, 2003). Rather, our intent is to present fundamental principles related to couple therapy in order to help the reader conceptualize and treat the couple from multiple perspectives and with a multitude of techniques. We do not advocate any single approach to couple therapy. The therapy should be crafted for the couple *and* their problem(s). Techniques can be sequenced and blended in order to tackle different problems and problems at different depths. The principles and techniques described in this volume are not advanced or complex. They are basic with wide-ranging applicability and power to invite change.

The model we present to guide therapists in their work with couples is known as the Intersystem Model. It is a comprehensive, integrative, and contextual model, originally conceived by Gerald Weeks and published in 1977 in a paper on dialectics in psychotherapy. This early article did not present the model in its current form but was the genesis of intersystemic thinking based on dialectics. The model was first presented in the 1989 edited book *Treating Couples: The Intersystem Model of the Marriage Council of Philadelphia* (Weeks, 1989a). The theory was further developed by Weeks in 1994 in *The Marital-Relationship Therapy Casebook: Theory and Application of the Intersystem Model* (Weeks & Hof, 1994; see also Weeks & Cross, 2004).

The Intersystem Model is not a specific approach to couple therapy. Rather it is a meta-model or meta-theory that provides an overarching framework to guide therapists in their work with couples. A meta-model, or meta-framework, can be superimposed over existing therapy approaches to help therapists know what to focus on and why (Fife, Whiting, Bradford, & Davis, 2013). The Intersystem Model, as a meta-framework, emphasizes principles of therapy, rather than specific theories or techniques. It is broadly applicable across different therapy approaches and helps facilitate the integration of different ideas, interventions, and theories. Its application can enrich the theoretical depth and therapeutic versatility of a clinician's work with couples.

According to the Intersystem Model, whenever a couple is being treated, three systems or subsystems must be simultaneously considered: the individual, the couple, and the intergenerational. Most other approaches to marital and family therapy focus only on one or two of these systems, whereas we have found a comprehensive approach requires focus on all three. The model increases the therapist's awareness of these different systems in terms of assessment, conceptualizing couples' problems, and providing helpful interventions. It also highlights the interactive nature of the three systems (see Figure 1.1). One system cannot be adequately understood without considering the influence of the others.

The need for this model stems from the limitations arising from two dominant forces in psychotherapy: individual philosophy and the natural sciences. An individualistic worldview makes up the philosophical foundation for most of the therapy models available to clinicians. Furthermore, the natural sciences promote a linear view of events (i.e., A causes B) and approach the natural world from a reductionist stance (trying to reduce complex phenomena to their smallest components). These two perspectives make it difficult to understand and treat relationship partners as an interlocking system. In contrast to traditional psychological theory, the Intersystem Model is grounded in a systemic perspective that accounts for the interconnected nature of couple relationships while simultaneously recognizing that couples are inherently made up of individuals and are also connected to other social systems (Weeks, 1994). As a meta-model, it can also provide a framework for therapists as they integrate various approaches in their work with clients.

The Individual System

Perhaps our most striking departure from other systems approaches is our recognition of the couple as a system consisting of two individuals. Other systems approaches have for the most part been anti-individual and anti-diagnostic in the traditional sense. Unfortunately, systems thinkers have been so intent on separating or differentiating themselves from individual psychotherapy that they have totally discarded the value of seeing the individual *as* an individual, as well as an important part of the couple system. In our approach to couple therapy, the individual's coping mechanisms, defense mechanisms, life cycles, ethnicity, intrapsychic dynamics, and individual psychopathology are assessed and treated within the context of the relationship, rather than denying that individuals exist in such contexts. We also recognize and draw upon the individual strengths and abilities that partners bring to therapy in order to facilitate progress toward the relationships goals they have for treatment.

The Couple System

Obviously, the couple's interactional system must also be assessed and treated, because a couple is more than the sum of its parts. Couples develop spoken and unspoken contracts, communication styles, patterns of dealing with or avoiding conflict, and so on, and the interactional system is usually the first experience a therapist has with a couple. As a system, a couple's interactions are circular, with each partner influencing and being influenced by the other. This system is always present and the easiest to

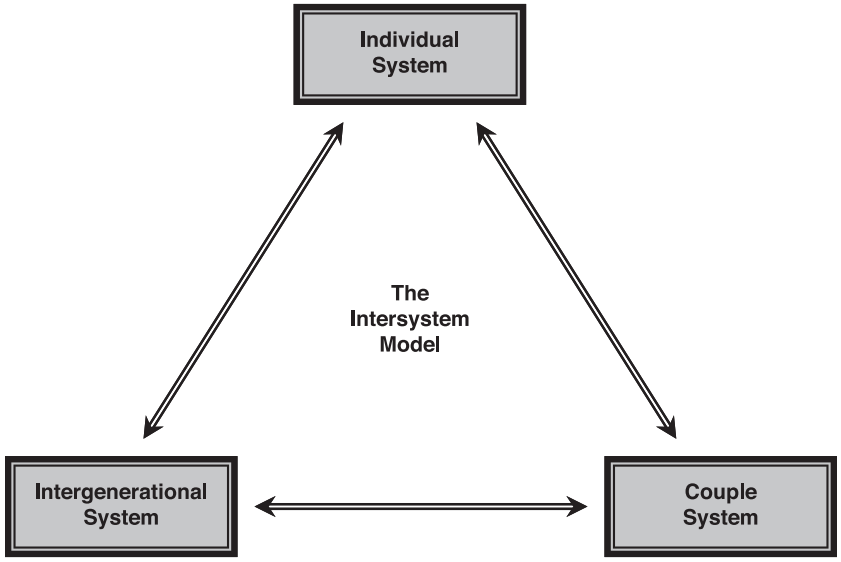

Figure 1.1 The Intersystem Model
Source: Adapted from Weeks (1994).

observe. Relationship dissatisfaction and dysfunction often are the couple's stated reasons for seeking treatment, so naturally couple therapy will focus on clients' problematic interpersonal processes. Although couples often present in therapy with a very problem-saturated view of their relationships, the couple therapist recognizes that each couple will have certain relationship strengths and resources (although perhaps dormant) that can be identified and incorporated into the treatment process.

The Intergenerational System

Many couple therapists focus their assessment and treatment of couples exclusively on the couple system, overlooking the importance of the intergenerational system. Each member of the couple has a unique history rooted in his or her family of origin. They draw upon experiences, expectations, roles, and behaviors from their parents to guide them in their own marriage or committed relationship. These experiences, historical and present, influence the current relationship. In many cases, couples recreate unresolved issues with their own parents or previous relationships using their partner or children as a substitute. Consequently, intergenerational influences are often hidden until an exploratory process uncovers them. Neglecting the intergenerational context of couples also means that therapists and couples may miss out on the family of origin influences that are positive, as well as resources and traditions from which clients can draw to improve their relationship.

Clinical Application and Therapeutic Principles

As a meta-framework, the Intersystem Model transcends specific couple therapy models. It is a model or meta-theory that views therapy as a theoretically integrative process. Thus, it does not offer specific prescriptions in terms of theories, techniques, or methods to use with clients. Non-integrative approaches each have their own set of defined techniques consistent with the theory. Our meta-theory recognizes that therapy is not a one-size-fits-all enterprise, and what works for one couple may not work for another. Therefore, therapists must be flexible in their methods and responsive to their clients. The principles of the overarching model help the therapist tailor therapy to the couple, rather than forcing clients to adapt to the therapist's model (Weeks & Cross, 2004).

The Intersystem Model helps clinicians think of multiple levels of clients/treatment concurrently: the individual, couple, and intergenerational systems. It provides a framework for clinicians as they make decisions related to assessment, case conceptualization, and treatment. For example, it guides therapists during assessment to focus on vital individual, relationship, and intergenerational issues that may be contributing to the couple's problems. Likewise, it helps facilitate treatment planning and interventions that focus on each of the three interrelated systems.

Weeks (1994; Weeks & Cross, 2004) argues that to be truly integrative, a model must (a) include both foundational and integrational constructs, and (b) retain the fundamental aspects of the combined theories while seeking to achieve an integrative balance that is clinically useful for therapists. As a truly integrative and contextual theory, the Intersystem Model contains the *foundational* and *integrational* constructs necessary to combine individual, interpersonal, and intergenerational theories of treatment. Foundational constructs are the underlying philosophical assumptions upon which a theory rests. The foundational construct for the model is dialectic meta-theory (Weeks, 1977, 1986), which is grounded in the thinking of Riegel (1976) and Basseches (1980). Integrational constructs include the concepts or principles that are used to integrate disparate phenomena. The integrational constructs of the Intersystem Model pertinent to this volume are based on Strong and Claiborn's (1982) model of social interaction. In particular, Strong and Claiborn's model includes six integrative principles: three interpersonal/interactional (congruence, interdependence, and attributions) and three intrapsychic (definition, interpretation, and prediction). Presenting the complex theoretical formulation of the model is beyond the scope of this book. Interested readers are referred to Weeks' earlier work (1977, 1986, 1994, Weeks & Cross, 2004), in which he thoroughly articulates the foundational and integrational aspects of the model. Nevertheless, there are some important principles of application within the model that the therapist should keep in mind in their work with couples.

Therapeutic Relationship

An important foundation for successful couple therapy is a strong therapeutic relationship between the therapist and the client(s). This begins with the process of joining. The clinician should be friendly, attentive, empathetic, respectful, supportive, and non-judgmental. Clients often fear that the therapist will be disapproving of

them. However, the therapist's overarching attitude is one of acceptance of each partner. Joining with clients also includes learning what their expectations are for therapy and developing an approach that is a good fit with them. The clinician works to remain balanced and join with both partners and to provide interventions that are congruent with the couple's expectations and needs.

As the therapist successfully joins with clients and presents a congruent and coherent plan for treatment, clients will come to trust the therapist and have confidence that by working together their needs will be met and their goals will be achieved. The therapeutic relationship must be attended to throughout the course of treatment. Therapy does not always proceed smoothly, and it is common for small ruptures in the therapeutic relationship to occur. Clinicians must be quick to recognize and seek to repair them, lest clients become disillusioned with therapy and/or the therapist.

Choice and Responsibility

An important part of the therapy process involves the therapist helping create a context in which change can occur. Therapists create this context by building a strong therapeutic relationship, helping clients feel they have choice in their decisions, and helping them accept responsibility for change. If therapists take over responsibility for change or get caught in clients' efforts to recruit them to one of their sides, then one or both partners may not perceive choice or responsibility and may reject the interventions the therapist offers.

Strong and Claiborn (1982) argue that change can either be forced or spontaneous. Weeks (1994) points out that when clients change because they are forced to (or feel that they are being forced), they often attribute change to someone or something outside themselves. "They experience themselves as *doing* something different, but not as *being* different" (p. 13, italics added). The effect may be that clients see change as being external to themselves, rather than something for which they are responsible, which may have a negative effect on whether the changes will last. Nevertheless, when a therapist creates an appropriate context for change, spontaneous compliance is more likely to occur, and clients are more likely to accept responsibility for change. For example, rather than using language such as "You should . . .," the couple therapist might engage clients in a collaborative process by saying, "Let's think together about what the two of you need to do . . ." Clients who accept responsibility for change will likely engage in the work necessary to reach their goals for therapy and sustain the progress they make in treatment. Furthermore, they are more apt to attribute successful outcomes to their own efforts rather than the therapist's efforts, outside forces, or luck.

A systemic approach also invites clients to accept responsibility, not only for their participation in relationship problems but also their role in resolving them. A systemic approach assumes circular, rather than linear, causality. Clients stuck in a linear view of problems blame their partner for the relationships problems, which leaves them believing that the other is the one that needs to change. In the end, such a perspective is disempowering, leaving the client with little choice and little motivation to change. However, as the therapist helps a couple see the circular nature of their struggles, individual partners can see that they are linked together in circular patterns (Weeks, 1994). For example, one partner may withdraw in response to the other's intense

efforts to engage him or her. The withdrawing leads to further efforts to connect, which may lead to more withdrawing. Each one's behavior invites the other in a circular, mutually perpetuating manner. Couples who learn the connection between their behaviors may come to accept more responsibility for change and ultimately the outcome of treatment.

Control

Closely related to choice and responsibility is the principle of control. Clients often view their problems as involuntary and uncontrollable. Part of the process of therapy is to help clients experience newfound control over what was seen as uncontrollable, volition over the involuntary, and mindfulness over mindless or automatic behavior (Weeks, 1994). Paradoxically, therapists help create a context for this kind of change by taking control of the process while not appearing to take control. As Weeks and Cross (2004) explain, "The process of therapy requires that the therapist be in control of the process. This is accomplished paradoxically by giving control back to the client in order to effect change. In this way, the client simultaneously learns self-control and self-reliance" (p. 60).

Therapists deliberately attribute change to the couple's efforts and help them embrace responsibility for and take ownership of change. As clients work through their struggles, they learn that their symptoms and behaviors—once thought to be beyond their control—are voluntary and controllable. When they experience change that arises from their own efforts, couples begin to attribute change and successful outcomes to themselves. As a couple's sense of control grows, so also will their confidence in their ability to maintain and build upon the changes they've made in therapy.

Context

Symptoms are best understood within the context in which they occur (Weeks, 1994). The individual, couple, and intergenerational systems are each part of the couples' relationship context, and each needs to be considered when assessing, conceptualizing, and treating couples. Clients bring complex problems to therapy, and the therapist must attend to the individual context, the interpersonal context, and the intergenerational context of the issues. The Intersystem Model provides a framework for understanding couples issues and then designing treatment that best meets their needs. Before applying interventions, therapists would be wise to thoroughly consider the multiple systems and contexts of their clients.

Integrating the Individual, Couple, and Intergenerational Systems

Marital/couple therapists constantly face the decision of which of the three systems they should focus on in treatment. Historically, couple therapists have seen these systems as discrete, and treatment has tended to focus on the individual/intrapsychic context of the couple (essentially individual therapy with each partner), on the here-and-now interactions of the couple (the interpersonal system/context), or on the

family histories of clients (intergenerational system/context) (Weeks, 1994). Therapists may feel overwhelmed by the thought of attending to all three systems simultaneously, and working on each one separately may seem less complicated. However, the Intersystem Model helps the therapist better fit treatment to the couple by providing a framework for integration that recognizes the complex nature and wholeness of individuals, couples, and families.

Each of the three systems relates to and interacts with the others in a dynamic way. A couple is made up of two separate individuals, each with his or her own internal processes (individual), who form a relationship system that transcends their individual selves (couple), and who bring with them family histories that influence both of the above (intergenerational). The three systems exert reciprocal influence on each other, and a systemic therapist recognizes that a change in one part of a system effects a change in the whole system. "Without considering all three systems and using them therapeutically, change would likely not be long-lasting" (Weeks & Cross, 2004, p. 64).

Integration is also facilitated by viewing clients through a systemic lens and helping couples come to understand the interpersonal nature and the variable contexts of their struggles. In fact, the first task of couple therapy is to view the couple as a system and to help the couple see themselves in this manner. Couples should come to see their behavior as reciprocal and interlocking.

Conclusion

Couple therapy is a highly dynamic and rewarding endeavor. There are multiple systems to which a therapist must attend, and the complex nature of couples' problems can be overwhelming. Doherty (2002) suggested that couple therapy is the most difficult form of therapy. He also suggested that most therapists are not very good at it. Yet there is a great need for well-trained, competent couple therapists. The purpose of this book is to illustrate fundamental principles of couple therapy. In this chapter we provided an overview and history of couple therapy and its distinction from individual psychotherapy. We also discussed the notion of integration and presented our integrative Intersystem Model. In the chapters that follow, we present more on the practice of couple therapy including assessment and basic principles, processes, and techniques of treatment. We conceptualize therapy in terms of process, rather than outcome, and couple therapists are encouraged to utilize these principles and techniques to enhance the therapeutic process and fit their approach to the clients, rather than forcing the clients to fit their theory.

2

ASSESSMENT, CASE FORMULATION, AND AVOIDING COMMON MISTAKES

In order to use the techniques presented in this book effectively, it is necessary to conduct an assessment of the couple and develop a formulation of the case. The assessment phase consists of the initial interview and may include up to four or five more sessions. This chapter will not focus on the details of how to conduct an initial session because this aspect of treatment has been adequately covered elsewhere (see Haley, 1976; Heller, 1987; Patterson, Williams, Edwards, Chamow, & Grauf-Grounds, 2009; Weber, McKeever, & McDaniel, 1985; Young & Long, 1998). Heller is a colleague of ours, and thus her article is especially representative of our approach. Instead, our focus will be on how to conduct a thorough assessment and case formulation. The chapter will also include ideas regarding common mistakes made by therapists. If these mistakes are made early on, especially during the assessment phase, therapy may be abruptly ended by the couple.

Our ideas for assessment and case formulation stem directly from the Intersystem Model, which was presented in Chapter 1. We advocate an assessment approach that is comprehensive, multidimensional, and multilayered, which will allow for comprehensive, multidimensional, and multilayered treatment. A case formulation is a method of summarizing the data provided by the clients into a theoretically consistent framework that includes the couple dynamics and a treatment plan based on those dynamics and the goals of therapy. Many case formulations in couple therapy are based on a single theory, which means the couple may be conceptualized and treated within narrow parameters. This fact exists because many practitioners tend to adhere to just one model of intervention. As we have indicated, the field is becoming more theoretically and technically integrated.

However, rather than being haphazard in combining ideas and interventions, we encourage clinicians to be knowledgeable and thoughtful in their integration of theories and techniques in their work with couples. Good therapists not only know *what* to do, they also can articulate *why* they decide to use certain interventions. In other words, good therapists have a sound theoretical rationale to support the interventions they use. The Intersystem Model is one framework that can facilitate thoughtful integration by couple therapists.

Before describing how to develop this type of case formulation, we would like to give the reader some guidelines on how to get started with the assessment phase of treatment. These guidelines are framed in terms of don'ts and do's, and are designed to help the clinician avoid some of the common mistakes which are made with couples.

Common Mistakes Made in the Assessment Phase

Assessment in couple therapy is a process that continues throughout the course of treatment. The therapist constantly monitors the couple for change and progress, as well as for newly emerging problems or setbacks. Because of this, assessment and treatment often overlap when doing couple work. Nevertheless, the initial assessment or evaluation phase is critical for the success of therapy and usually requires two to four meetings. During these meetings the therapist's task is to join with the couple, collect information needed to develop a case formulation, and avoid mistakes that would disrupt development of a therapeutic relationship. The first two of these tasks have been discussed widely in the literature. However, with the exception of Haley (1976) and Doherty (2002), little attention has been given to describing the typical mistakes a couple therapist might make that can abruptly end treatment. The purpose of this section is to list some of the don'ts and do's which are so important during this phase. Many of these ideas apply throughout treatment, but the importance of adhering to these guidelines is greater during the first few sessions than later sessions, as the joining process is still taking place and the therapeutic relationship is still forming. However, once the therapist has established a good therapeutic relationship with a couple, a mistake has less potential to result in premature termination, as couples are more likely to be forgiving and discuss mistakes openly with the therapist. Although we call this list don'ts and do's, the reader should view them as useful guidelines and not as dogma. The reader who is interested in an in-depth study of common mistakes made in couple therapy and how to avoid them may wish to read our book focused specifically on this topic (Weeks, Odell, & Methven, 2005).

Don'ts and Do's

1. *Don't take sides.* Therapists should remain balanced in their attention to each partner. It is easy to get seduced into taking one partner's side, especially when that partner's pathology or contribution to the problem is not as clearly evident. However, the therapist must keep a systemic perspective. Otherwise, one partner may feel sided against and decide not to return, and the accusing partner has his or her linear view of the situation reinforced. Systemic assessment requires therapists to recognize the interconnected aspects of couples and pay attention to the interpersonal dynamics of the clients. The therapist should shift back and forth trying to understand each partner's perspective. The way the therapist uses language during this phase is important. The therapist needs to utilize reflective listening and use phrases such as "It is your perception, belief, opinion, idea, thinking, feeling," and so on. For example, in response to a client complaining that his or her partner is controlling, the therapist might say, "It is your perception that your wife is controlling," rather than "Your wife controls much of your behavior." The latter statement implies that the therapist

agrees with the validity of the statement being made, while potentially disregarding the perspective of the other partner. Utilizing a systemic approach in assessment will set the stage for systemic intervention later on, which empowers couples to work together to bring about desired changes, rather than expecting change just in one's partner.

2. *Don't intervene too quickly.* Clients may come to the first session in crisis with an urgent desire or expectation to see changes right away in the relationship (or in their partner). One or both partners may see treatment as a last resort (i.e., "If this doesn't work then we are getting a divorce"), and they place a lot of weight on the first session or two. In response to the clients' anxiety and sense of urgency, the therapist may feel obligated to start changing the system before understanding it. Premature intervention may destabilize the couple in such a way that it is too threatening for them. It is best to go slowly and intervene in ways that appear safe or nonthreatening to the couple.

The primary task is to join and collect information early on in treatment. The couple can be told that change is a process and that the first few sessions will be to conduct the evaluation and then to develop a treatment plan with their collaboration. The assessment phase is also a good time to educate couples that change is going to require effort on their part, both during the sessions and in between sessions, and that therapy is designed to give them tools that, if applied, can help them manage their current and future problems.

3. *Don't answer questions from the couple until ready.* In some cases, a question from a partner is designed to show how the other person is wrong, at fault, sick, or crazy. Questions from each partner need to be viewed with caution and skepticism. For example, a client might ask, "How would you feel if your partner said that to you?" "Do you think it is a good idea for me to stay in this relationship?" "Do you think that is what a husband should say to his wife?" The therapist needs to quickly assess whether the question has a hidden purpose or is designed to get the therapist to take sides. Therapists may respond to problematic questions by saying they don't know the answer yet or by deflecting the question, asking the questioner what she or he thinks, and getting the partner to offer an opinion. Legitimate questions about the therapeutic process, such as how long a session lasts, should be answered openly and honestly.

4. *Don't assume you understand the real problem.* It can be enticing for a therapist to start interventions early on to show the couple that she or he can help, but without a thorough understanding of the problem useful solutions cannot be developed. Therapists should avoid the tendency to quickly assume an understanding of couples' problems, even if they have worked with clients who have had similar complaints or presenting problems. Prematurely foreclosing on assessment may leave the clinician with an incomplete understanding of the couple's problems and goals. Therapists must treat each couple as unique and conduct a thorough assessment and case formulation so they can tailor treatment accordingly. The real problem may not be highlighted or even mentioned during the initial session or for many sessions. The real problem may be too threatening to mention, such as partner violence or an

addiction, or the couple may too ashamed or embarrassed to mention it, such as in the case of a sexual problem. Clients may be testing the therapist and need to feel they have joined before revealing the nature of the real problem. When clients are avoiding the real problem they will present minor problems or vague problems such as "communication."

5. *Don't proceed until the problem(s) and goal(s) have been clarified.* Couples usually present with a number of different problems. In the initial session it is useful to get an overview and then come back to discuss the specific problems in greater depth. Part of the process is deciding which problems to work on first, whether the stated problem is the real problem, and whether the partners desire the same resolution of the problem. The couple needs to be clear on the goals for treatment. This includes identifying goals in terms of desired outcomes for their relationship. Couples often define goals in terms of what they do not want (e.g., "We don't want to fight any more," or "I don't want us to keep neglecting our relationship"). Therapists should help clients articulate their goals in terms of positive or desired outcomes (e.g., "We want to learn to communicate our feelings and solve problems in more constructive ways," or "I would like us to make nourishing our relationship a priority").

6. *Don't proceed until both partners have made a commitment to therapy.* Clients may come to the first session confused and uncertain about whether or not they want to stay in the relationship. It may be premature at the beginning of therapy to ask clients for a commitment to the relationship; however, before moving forward with treatment, therapists should confirm each partner's commitment to therapy. Doherty (2007) suggests this means that clients take divorce/separation off the table and agree to a course of treatment over a defined period of time where they both agree to put forth a united effort to build the relationship with the help of the therapist.

To obtain a commitment to therapy it may be helpful to discuss with clients how they would feel if they were able to work out the problems and what they would be willing to do to obtain the desired joy, peace, or happiness (whatever they want out of therapy). Once they have obtained a clear view of what they want, the therapist can discuss how long they are willing to work in therapy and try the solutions they discover in order to see if they can bring about the desired changes. At this point the therapist might want to reiterate that change is a process and that progress is best achieved through sustained effort over time.

7. *Don't assume that partners will perceive the problem in the same way.* Part of the reason the couple is coming to treatment is because they see things differently. The therapist should communicate this idea to the couple and not push for a similarity of perception or definition or even goals. At this stage, it is useful to normalize differences, stating that it will take time to work through these issues. When the therapist communicates this attitude, she/he is giving them permission to express their differences.

8. *Don't discuss problems abstractly and nonconcretely.* Couples will sometimes begin therapy stating their difficulties in abstract, nonspecific, nonbehavioral language (e.g., "We have communication problems"). This type of language does not lead to

any understanding of the problem, particularly the sequence of behaviors involved in their reciprocal interactions. The therapist can quickly move from the abstract to the concrete by asking who, what, when, and how questions. Therapists can also begin to emphasize the systemic nature of relationship problems by asking circular questions. For example, "When your wife is upset, how do you respond?" By focusing the couple to begin thinking in circular ways, they will usually see what the therapist needs and alter their description of the problems. In other words, while doing the assessment the therapist is beginning to teach them to view their problems as circular or interlocking patterns of behavior, which can be accomplished by asking the questions in certain ways and in a certain sequence. For example, after asking one partner about their behavior the therapist may quickly turn to the other partner to ask how they typically react and the reaction that is elicited in the partner.

9. *Don't discount problems, even small problems.* When partners come in together they are sometimes reluctant to discuss complaints openly, honestly, and with the intensity they actually feel about the problem. This tendency results in problems being understated or minimized. Some clients may do this to test whether or not therapy is safe for them or to see if their concerns will be validated. If the therapist allows small complaints to have validity it may help clients to open up about deeper issues. Although a problem may not seem significant to the therapist, she or he might ask the client how it is important to them. If clients feel the problem impacts them or their relationship, ignoring it has the potential to make them hesitant to open up and explore other possibly "bigger" concerns.

In some cases, the real problem is not brought up at all in the initial session because of the level of sensitivity, embarrassment, or shame associated with it. The therapist must read between the lines or listen with a "third ear" to what is being presented and go back to those problems at a later time, once the therapeutic relationship is established. Problems that are often understated include alcohol and drug abuse, emotional/verbal abuse, physical violence, financial issues, and sexual difficulties. Couple therapists should routinely ask about these issues as part of assessment to create space for these conversations. If the clinician brings these issues up as part of the assessment the clients may be willing to open up about it sooner rather than later. Nevertheless, the therapist should remain aware that partners may not be forthcoming at the beginning of treatment about these sensitive issues.

Additionally, the therapist could inadvertently fall into collusion with one partner by agreeing that the other partner's problem is not that distressing. For example, a wife may complain that her husband is not attentive enough. The husband may then discount her statement by giving numerous examples of being attentive. If the therapist summarily dismisses her complaint because of what the husband said, then she or he has colluded with him. In order to effectively join, the therapist must take each partner seriously.

10. *Don't allow differences to escalate.* Couples often come to treatment when they are unable to resolve their differences. In all probability they have struggled with these differences for some time and with some emotional intensity at home. During the assessment phase, the therapist does not want these differences to escalate. She or he wants to understand them and for each partner to feel heard and understood.

Additionally, therapists need to show clients that the therapy office is a safe place where differences and problems can be discussed openly without being attacked or mistreated. To do this a therapist should set boundaries and intervene quickly when interactions become too heated. The therapist can also normalize this type of situation, letting the clients know that all couples have differences and these do not necessarily mean the partners cannot get along or are incompatible. When the level of emotional intensity begins to escalate, the therapist can ask cognitively oriented questions (e.g., who, where, what, how) or shift to another topic, stating that it is clear the partners are very much at odds on the issue at hand and that it will be discussed later. Therapists who fail to appropriately manage the escalation of differences risk alienating clients and undermining their trust.

11. *Don't allow emotion to take charge of the session.* One or both partners may become emotionally distressed to the point of controlling the session. The therapist's task is to manage affect. In later sessions, the therapist may want to intensify and escalate affect. However, in order for the couple to feel safe and secure with the therapist early on, they must know the therapist is not frightened by their emotions and is able to keep emotional exchanges under control. In some relationships, one partner is controlled by the emotions of the other. If the therapist allows this process to be repeated, the controlled partner will not see how therapy can be helpful. Techniques to control affect are discussed later in Chapter 16, Working with Emotions.

12. *Don't unbalance the system.* This guideline has two meanings. The first was discussed above in terms of not intervening until the therapist understands the problem(s), goal(s), and consequences of change. The second meaning deals with siding with one partner or accepting one partner's definition of the problem over the other's. Although it may be useful to conduct separate interviews during the evaluation phase, one of the greatest risks is that of appearing to be or actually siding with one partner. Each partner may be very convincing about the pathology in the other. The therapist should reserve judgment, stay balanced, and keep a systemic perspective, especially at the beginning of treatment. Later in treatment it may be therapeutic to temporarily align with one or both partners to help the couple develop better balance and a stronger partnership.

13. *Don't make premature interpretations.* One of the fundamental techniques in psychotherapy is interpretation. In individual therapy, early and/or premature interpretations are often forgiven, overlooked, or constructively challenged. However, when an interpretation is made about one partner in the context of couple therapy, the therapist may be seen as blaming or siding with one partner against the other. It is best to contain an interpretation until enough information has been gathered to feel confident of its validity—and only after the joining process has been completed. The safest interpretations early in the treatment process are systemic (e.g., "The two of you appear to . . ." or "It seems when one of you does . . ., the other of you does . . .").

14. *Don't get hooked on the past.* When couples begin treatment, it is easy for them to begin rehashing the past all over again. The therapist may see the 50th