THE ROLE OF ATTACHMENT IN A TIME-LIMITED MARITAL THERAPY:
IMPLICATIONS FOR PRACTICE AND TREATMENT

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STATEMENT OF SOURCES

This thesis contains no material published elsewhere or extracted in whole or in part from a thesis by which I have qualified for or been awarded another degree or diploma.

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Coral Brown
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ABSTRACT

The present study investigates the role of attachment in a time-limited marital therapy. The study explores Brief Contextual Modular Psychotherapy (BCMT). This approach to practice provides a model that integrates principles and techniques from the major psychotherapies. BCMT can be distinguished from other brief therapies by its theoretical integration, its six-session time limit, its specific clinical focus, and its techniques for dealing with dissatisfaction and distress.

The therapy sets out practice modules—six-session treatment plans—for a diverse range of presenting issues such as the anxiety disorders, depression, trauma, loss and grief, marriage and the phobias. BCMT emphasises the collaboration of the therapist and the client. A community-based psychological counselling centre has practised BCMT for over ten years, applying it in cases of wide diversity and maladjustment. Prior to this research, a comprehensive analysis of the theory underlying the BCMT model or the theory of change it endorses had not been carried out.

The study provides a detailed description of the conceptual and treatment elements of the marital module developed in the treatment manual for BCMT. The study explores how the construct of attachment provides an organising framework or metaperspective for theory construction and therapeutic intervention in the clinical application of this time-limited marital therapy. To achieve this objective, one de-facto and four married couples participated in the time-limited therapy. They completed a questionnaire on adult attachment and also a self-report questionnaire to assess the effectiveness of the therapy. Narrative analysis was used to assess the praxis or the experience of participating in the therapy.

The results show that the integrated model provided a treatment method for differing expressions of marital disturbance and psychopathology. Three of the five couples and eight of the ten participants reported positive treatment outcomes. The research sample included the paraphilias, a major depressive episode with postpartum psychosis, the narcissistic borderline syndrome and childhood sexual abuse. The study supports the association between the role of adult attachment styles and intrapsychic responses in conflicted intimate relationships.

From the point of view of clinical applications of attachment theory, the research highlights how theoretical ideas can be integrated, specific clinical methods can be incorporated and certain treatment perspectives can be derived from one another. Several implications for the treatment process flow from this integration. The integration of attachment theory in BCMT
demonstrates how the therapeutic process progressed through three separate yet interrelated stages: past, present and future. In addition, it led to the identification of three stage-related mourning processes associated with the time-limited therapeutic process: protest, despair and detachment.

From a clinical perspective, the research finds that the theoretical and treatment model does not need to be restricted to marital therapy. The findings suggest that the integrated model could be applied across a wide range of presenting issues. By defining the theory of personality and psychopathology and the therapeutic change processes associated with it, the integration of attachment theory results in BCMT taking its place in the literature as a theory of psychotherapy.
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CHAPTER 1

Background to the Thesis and Research Design

Overview

This thesis examines the role of attachment in a time-limited marital therapy. The therapy studied is Brief Contextual Modular Psychotherapy (BCMT) (Macnab, 1991). The purpose of the study is to provide a coherent framework for the conceptualisation and treatment of differing expressions of marital psychopathology and disturbance. The aim is to demonstrate how the construct of attachment represents an integrating concept in the clinical application of a time-limited marital therapy (Lindegger & Barry, 1999).

In this chapter the professional and historical contexts in which BCMT has evolved are described. Given too are a description of the contribution of the brief dynamic psychotherapies, the introduction of treatment manuals to clinical training and practice and the way that contemporary approaches to marital practice are conducted. The background to the research follows, along with the formulation of the research questions and the description of the methodology.
This thesis examines the role of attachment in a time-limited marital therapy. The therapy studied here is Brief Contextual Modular Psychotherapy (BCMT) (Macnab, 1991). This time-limited approach to practice provides a model that integrates principles and techniques from the major psychotherapies. BCMT is distinguishable from other brief therapies by its theoretical integration, its six-session time limit, its specific clinical focus, and its techniques for dealing with different systems of dissatisfaction and distress. BCMT provides the therapist with a modular, sequential application of interventions and with explicit criteria for movement from one stage of treatment to the next. Bringing resources relevant to the client’s explorative and experiential situation and needs, the therapy follows a stage-related developmental framework.

BCMT details a clear statement of the operations that the therapist will perform. It emphasises the contextual collaboration of the therapist and the client. The therapy sets out practice modules — six-session treatment plans — for a diverse range of presenting issues such as the anxiety disorders, depression, trauma, loss and grief, marriage and the phobias. A community-based psychological counselling centre has practised BCMT for over ten years, applying it in cases of wide diversity, morbidity and maladjustment. Since 1991, two volumes detailing the application of BCMT for the treatment of trauma have been published (Macnab, 2000a; 2000b).

Contemporary therapy paradigms like BCMT highlight how theoretical ideas can be integrated, specific clinical methods incorporated and how certain treatment perspectives can be derived from one another. Parallels can be found between psychotherapy integration and contemporary marital therapies. One of the major contributions to the clinical practice literature is the ability of marital therapies to integrate radically different theoretical models. Some of these theories and therapeutic interventions were once perceived as incompatible. This integration has resulted in couples, marital and family therapies undergoing radical changes in theory and practice in the past four decades (Lindegger & Barry, 1999).

The aim of the thesis is to provide a detailed description of the conceptual and treatment elements of the marital module developed in the treatment manual for BCMT. The purpose of the present study is to demonstrate how the construct of attachment provides an organising framework or metaperspective for theory construction and therapeutic intervention in the clinical application of this time-limited marital therapy (Lindegger & Barry, 1999). The study
is designed to create a coherent framework for the model, to explain the links between the aetiology of conflicted relationships and the role of attachment in the treatment process and to provide research into its effectiveness.

The Professional and Historical Context

Parallels are to be found between the practice of contemporary marital therapies and the emergence of the brief psychotherapies. A number of factors have contributed to the increased acceptance and practice of the brief therapies. Among the most influential are the integration of psychotherapeutic theories, growing empirical support for the effectiveness of the approach, the changing psychosocial context and the increased use of treatment manuals in clinical practice and training. The influence of the brief therapies covers a wide spectrum of syndromes and presenting issues. These range from work with drug dependence, to major depression and to the personality disorders. Brief psychotherapy has thus become a dominant treatment paradigm in clinical practice (Messer & Warren, 1995).

The Shift to Shorter Methods of Treatment

As early as 1919 Freud foresaw the possibility that psychoanalytic techniques would not be adequate for the demands placed upon mental health practitioners (Small, 1971). Freud warned that the task might be to adapt the technique to new conditions. At the same time, Small (1971) noted, Freud voiced his scepticism about brief approaches to psychotherapy. Later in his career he is said to have renounced the approach altogether.

According to Davanloo (1990) one of the consequences of the introduction of the technique of free association into psychoanalysis was “transference neurosis, regression, dependence on the therapist, endless over-determination, and analysis interminable” (p. 2). This resulted in psychoanalysts of the day, such as Alexander and French (1946), expressing their concern about the increased longevity of psychoanalytic treatment. Ferenczi (1980/1926) recommended the increased use of activity by the therapist in psychoanalysis. Rank (1978/1936) highlighted the role of the patient’s will, asserting that present life events deserved relatively more attention rather than the patient’s childhood. He also stressed the role of separation anxiety in the therapeutic process, and the importance of setting a termination.
Contemporary Approaches to Brief Psychotherapy

Alexander and French (1946) published one of the first texts to describe the basic principles of shorter and more efficient means of psychotherapy. Their basic premise was that in the therapeutic relationship re-enactment of past conflictual relationships, ‘a corrective emotional experience’ for the patient was possible. Not only could earlier traumatic experiences be overcome within the more favourable circumstances of the therapeutic relationship, Alexander and French contended that it was possible to extend this corrective experience to everyday life (Crits-Cristoph & Barber, 1991). Malan and Osimo (1992) suggested that Alexander and French’s claim that their approach was a modification of classical psychoanalysis, rather than a method of brief psychotherapy based on psychoanalytic principles, meant that brief psychotherapy came under critical evaluation.

Significant contributions to the way brief psychotherapy might be practised have since been published. Among the earliest and most influential models are the brief intensive psychotherapy of Malan (1979), the short-term dynamic psychotherapy of Davanloo (1978), the short-term anxiety-provoking psychotherapy of Sifneos (1972) and the time-limited dynamic psychotherapy of Mann (1973). Theorists examining the developments in brief therapy (Budman, 1992; Svartberg, 1993; Crits Cristoph & Barber, 1991 and Bloom, 1992) detailed what they perceived as the common attributes of the brief dynamic approaches. Budman (1992) cites these elements as: the therapeutic use of time, the provision of a treatment focus, the high levels of activity by the therapist and the application of specific therapeutic interventions.

Another common element in the brief psychodynamic psychotherapies is the claim that they operate within the framework of transference. Therapists attempt to “clarify and interpret patterns of impulse-anxiety-defense by linking past, present, and transferential relationships” (Grand et al., 1985, p. 22) in what is claimed to be an affectively meaningful way. Messer and Warren (1995) suggested that the basic models of brief psychodynamic therapy can be grouped under three major headings: the drive/structural model of psychoanalytic theory and therapy, the object relational and interpersonal approaches and the integrative and eclectic models.

Greenberg and Mitchell (1983) noted the divide within the psychoanalytic tradition that places clinical primacy on drives and theories that view object relations as clinically central. The ‘intersystemic conflict’ model of mind that relies on traditional psychoanalysis and ego psychology is best exemplified in the brief psychotherapy models of Malan (1979), Davanloo
(1978) and Sifneos (1972). By contrast, the relational models rely on “some notion of primary, original, and independent structures of mind that provide for the mental representation of self, others, and relating” (Messer & Warren, 1995, p. 188). The relational model is found in the brief psychotherapies of Luborsky (1984), Horowitz (1986), Weiss and Sampson (1986) and Strupp and Binder (1984). The integration of the constructs of drive, ego, object relations and self-experience is found in the brief psychotherapeutic practice model of Mann (1973) and other eclectic approaches such as Bellak (1978).

The Psychosocial Context

The influence of brief psychotherapy models and treatment paradigms is not simply due to the growing acceptance of the method. The advent of brief psychotherapy reflects changing social, political and economic environments in the late part of the twentieth century (Messer & Warren, 1995). Radical developments and innovations in health care delivery, place increased pressure on the profession for case accountability and the demonstration of best practice (Kupers, 1988). This is a direct result of the increasing demand on practitioners to meet the requirements of health maintenance organisations and other third party payers. Mental health practitioners must be more pragmatic, resourceful, cost effective, and must practise more clinically relevant treatment paradigms (Cummings, 1991; Talmon, 1990; Budman & Gurman, 1988).

Since the early 1960s formalised treatment planning has gradually become a vital aspect of mental health services (Jongsma & Peterson, 1999). To satisfy this sociocultural shift in the delivery of psychotherapeutic services, O’Leary, Heyman and Jongsma (1998) noted how treatment plans must provide specific problem definitions, specify interventions, detail individual client goals and provide measurable treatment outcomes. In addition, health maintenance organisations and insurance companies have become more involved in the practice of managed care. They restrict clients to a specific number of sessions and mandate practitioners to work within what is perceived by many as a crisis interventionist model (Budman, 1981).

The demand for more relevant psychotherapy practice is also grounded in greater consumer awareness. Health service consumers are more knowledgeable of their legal rights. Further, they have greater awareness of psychological disorders such as depression, anxiety disorders, stress, substance abuse and the schizophrenias (Kupers, 1988). The many forms of available treatment and the increased use of psychiatric medication mean that people expect a diagnosis. They expect a treatment method, based on empirical evidence, that it is the most
effective for their condition. They expect that the recommended treatment method has behind it persuasive evidence for beneficial outcomes (Beck & Haag, 1992).

Research into the Effectiveness of the Brief Psychotherapies

Advantages and Disadvantages of Brief Psychotherapy

Since the early 1960s, support for the efficacy of the brief psychotherapies has increased (Bloom, 1992). In spite of these findings, the advantages and disadvantages of the approach continue to come under scrutiny. One of the major sources of criticism is from psychotherapists working in the traditional analytic situation who are loath to assign much credence to the approach. Small (1971) wrote of how such criticisms may have relatively more to do with the attribution of prestige associated with being a psychoanalyst, or to the perceived status of working in long-term psychotherapy.

The continuing debate about the theoretical nature and effectiveness of the brief psychotherapies resulted in what Malan and Osimo (1992) described as two opposite and incompatible viewpoints: the ‘conservative’ and the ‘radical’. In the conservative view, brief psychotherapy was deemed as palliative and appropriate for mild conditions of recent onset. In the radical view, far-reaching dynamic changes are considered possible even in certain patients with relatively deep-seated and long-standing disturbances (Malan & Osimo, 1992, p. 12). The controversy resulted in the brief psychotherapies being deemed as palliative, appropriate for mild conditions of recent onset and with successful outcomes dependent upon careful patient selection. People with personality disorders, past histories of substance abuse or psychosis were thus excluded automatically from brief psychotherapy treatment (Malan, 1979).

Another criticism is that careful patient selection means that brief therapy works best with responsive and highly motivated patients with an underlying simplicity of psychodynamic conflict. This argument rests on the premise that patients are required to identify a focal problem or define a circumscribed chief complaint and to engage quickly in treatment. Hence, the practice is indicative of ego strength, reality testing, tolerance of frustration and capacity for delaying gratification. Brief psychotherapies are also accused of excluding such variables as socio-political pressures and the psychosocial context (Cade & O’Hanlon, 1993).

Concerns have been raised about (what are claimed to be) covert and manipulative techniques and also about the abuse of power by therapists in directing outcomes (Cade & O’Hanlon, 1993). Also raised is the tendency to ignore the role and importance of time as an integral
part of treatment (Bloom, 1992). Such criticism rests on the contention that the brief approaches to therapy do not provide a theoretical rationale for the brevity of treatment, nor do they specify the way the time limitation enhances the therapeutic process (Messer & Warren, 1995). Yet, the deliberate use of time as a therapeutic technique is a principal feature of the brief psychotherapies (Smyrnios, Kirkby, Smyrnios, & Picone, 1987).

Treatment Effectiveness

In spite of these critiques, the validity of the treatment method, its theory of change and the contribution of the various models to the clinical practice literature have been documented (Svartberg, 1993). A major research focus has been the identification of those dimensions that are relevant and significant to the process itself (Grand et al., 1985, p. 8). Research into the effectiveness of the brief psychotherapies has focused on the difficulties associated with the problems of quantification and of obtaining ratings that are meaningful, uncontaminated and statistically testable.

The main areas of research have been process studies, predictive studies and single case studies. By the use of process research paradigms, and the exploration of more complex dynamics, the briefer psychotherapies have enabled researchers to examine specific variables and their relation to process and outcome. Svartberg (1993) observed that short-term psychotherapy approaches differ along the dimensions of time use, therapeutic focus, therapist style and activity, patient selection criteria and relationship factors. In another meta-analysis Crits-Cristoph (1991) concluded that relative to waiting list conditions brief psychodynamic therapy was effective, but demonstrated only slight superiority to non-psychiatric treatments.

The Contributions of Treatment Manuals

The Contribution of Treatment Manuals to Psychotherapeutic Practice

Parallels exist between the evolution of the brief psychotherapies and the increased use of treatment manuals in clinical practice and training. A number of conventional psychodynamic sources and texts inform the content and format of treatment manuals. Among the most notable is the work of Menninger (1958) that set out to teach the theory of psychoanalytic technique. Since the publication of the early texts, the emphasis has been on more comprehensive descriptions of psychotherapeutic treatment modalities (Butler & Binder, 1987). Treatment manuals have historically described the theory and method underpinning the model, illustrated by case studies and clinical transcripts.
From a psychodynamic perspective, treatment manuals were never intended to offer a new psychotherapeutic system. Some treatment manuals incorporate the ideas and concepts of other early writers on technique. More recently, treatment manuals have been devised for specific presenting issues, such as anxiety (Beck & Emery, 1986), depression (Beck et al. 1979) and personality disorders, (Klerman et al. 1984; Kernberg & Clarkin, 1994). By detailing specific therapeutic procedures, as well as specific change processes, greater possibilities are achieved for comparison and replication in research, and for treatment and outcome studies.

*The Contribution of Treatment Manuals to Clinical Training*

Australian psychotherapists comprise a core group of professionals with training and backgrounds in psychiatry, psychology, social work, and other helping disciplines (Brown, 1994). Once used to refer specifically to the analytic therapies developed from Freud, the term psychotherapist is now widely used and misused. Miller (1979) wrote of the narcissistic disturbance, which predisposes psychotherapists to their profession and results in them being used, if not abused, by people with intense narcissistic needs. Despite this stereotype, there is empirical evidence (Luborsky, 1971) and much intuitive reason to suggest that the psychotherapists who are most effective are mentally healthy, highly skilled and able to resolve their own personal problems (Kottler, 1991).

Christie (1995) noted the difficulties of providing high quality psychotherapeutic services in a profession whose definition remains obscure, has no legal status and has poor public accountability. He cites a Finnish study (Pylkkänen, 1989) as evidence that the most effective way to assess the quality of service delivery is to assure the quality of training. The research identified three components as the required standards for highly specialised levels of training: systematic theoretical training, psychotherapeutic treatment of patients under regular supervision and sufficient experience of personal psychotherapy. Traditional approaches to training, consisting of a didactic curriculum, supervision of actual cases, practica, and internships, have since been questioned (Butler, 1993).

Teyber (1997) observed that one of the major factors contributing to the therapists’ uncertainties and anxieties has its origins in the lack of a clear explanation of the theoretical underpinning of the therapist’s view of personality and psychopathology. Treatment manuals have addressed a number of these practice and training concerns. Before the introduction of manuals, the conventional wisdom in psychotherapy training was that increased clinical experience brought increased effectiveness. Moras (1993) concluded that the clearer the
information received by a trainee, the more quickly he or she can begin to use it to direct their thoughts, perceptions, behaviour and treatment interventions.

The training required in practising the approach.

There are varying opinions regarding the appropriate nature of training for the practice of brief psychotherapy. The need to gain an early focus, to quickly identify the relevant behaviours, and to understand mental processes have resulted in the brief therapies being considered best practised by very experienced psychotherapists. Kinston and Bentovim (1981) advocated that brief psychotherapies should not be conducted by beginning psychotherapists. Budman (1981) pointed out that it is doubtful that therapists can be effective in brief therapy simply because they have undertaken training in other therapies. Mann (1981) observed that previous experience, preferably in long-term psychotherapy and a personal psychoanalysis, are important prerequisites for the brief therapist.

The ability of trainee therapists to successfully conduct brief psychotherapy is supported in the research literature. This refutes the notion that it is only the seasoned therapist who can practise it effectively. Malan and Osimo (1992) evaluated the long-term outcome of 24 brief psychotherapies conducted by trainee psychotherapists at the Tavistock Clinic. By the use of purely interpretative techniques, these clinicians demonstrated that they could achieve therapeutic effects with certain patients who had long-standing and relatively severe disturbances.

In Malan and Osimo’s (1992) research complete beginners, under experienced supervision, treated patients who were not selected nearly as carefully with regard to suitability for therapy. The same types of successful therapeutic outcomes were reported. Quantitatively, Malan and his clinical researchers reported that the treatment outcomes of their long-term follow-up research were not ‘more than moderate’. Qualitatively, they concluded that their brief approach to therapy carried out by trainee psychotherapists with carefully selected patients can not only be extremely effective, but very worthwhile (p. 325).

Marital Therapy

One of the major issues facing couples in contemporary Western societies is the confusion associated with the multitude of images of love and marriage. This is reflected in the increasing number of couples seeking counselling and marital therapy. It is found in the growing dissatisfaction with methods of treatment that are without a clear plan and that lack reasonable estimates of the time and costs involved.
The Psychosocial Context

There is growing evidence that the speed and stresses of contemporary societies place excessive demands on human relationships (Singer, 1993). People increasingly find themselves in a social milieu, which devalues commitment and perceives relationships as temporary (Singer, 1993). The failure of modern relationships to meet the individual’s needs, goals and expectations for themselves and their partners has particular relevance for the practice of marital therapy. Such a postmodern phenomenon reflects an expectation and a desire to unite love and marriage throughout life (Livingston, 1996). Hartin (1990) described how “The pursuit of personal gratification has become paramount in marriage, which is now viewed by large numbers of people as a conditional contract” (p. 36).

The pursuit of personal gratification has resulted in an increased desire for individuals to have their needs for coherence, intimacy and meaning met within marriage, the family and with others (Wiinamaki & Ferguson, 1998). Yet marriage has become less predictable and secure as life expectancy has increased and the social purpose of marriage has changed (Hartin, 1990). Halford (2000) documented that current evidence suggests that 40 to 45 per cent of Australian marriages will end in divorce. The ever-changing shift in personal needs, social values, high divorce rates and the increasing incidence of re-marriage led Solomon (1989) to term the current psychosocial context in which marital therapy is practised the ‘age of confusion’.

The Evolution of Marital Therapy

Among the early texts to offer clinicians a set of explanatory concepts for the evaluation and treatment of marital conflict within an intrapsychic/object relations context are the works of Dicks (1967), Skynner (1976), Sager (1976), and Martin (1976). The psychodynamic approach to marital therapy was driven by an intrapsychic frame of reference that sought to explain the source of marital dysfunction in the intrapsychic conflicts and deficits of individual members which required intensive individual therapy to facilitate resolution of these conflicts and the enhancement of the marital relationship (Lindegger & Barry, 1999, p. 268).

While these therapies had a substantial impact on the conceptualisation and practice of marital therapy, the emergence of family therapy, which operated from within a systems perspective, greatly influenced the development of the brief marital therapies. In the systemic model, no longer was the emphasis on the individual within the marital interaction, but instead the emphasis became assessment, understanding and modification of the couple’s interactional patterns. This development resulted in theorists such as Jackson (1957) and Weakland, Fisch,
Watzlawick, and Bodin (1974) introducing a new conceptualisation for working with couples and families.

These theorists emphasised the role of social, cultural and environmental factors in the development of normal and pathological personality development. Concepts such as boundaries, collusions, homeostasis, sub-systems and communication patterns became part of the accepted method to intervene in the couple system (Lindegger & Barry, 1999). At the same time, the marital and family therapists were able to demonstrate clearly that the strategic interventions associated with the systems approach could change pathogenic relationship patterns within much shorter periods. Weakland et al. (1974), for example, limited treatment to ten sessions.

*The Integration of Theoretical Models in Marital Therapy*

Parallel to these developments, in understanding and treating couples relationships, were the empirical contributions from social psychologists and personality researchers to the understanding of relationships (Feeney, 1998; Feeney & Noller, 1990; 1996). Most notable are the contributions of practitioners and theorists who have integrated treatment paradigms and theories of practice (Lindegger & Barry, 1999). Psychotherapy integration highlights the way contemporary therapy paradigms synthesise ideas, incorporate specific clinical methods and derive certain perspectives from one another.

A review of the practice literature revealed numerous marital psychotherapies, which integrate the psychodynamic, strategic and the cognitive–behavioural therapies in theoretically and clinically meaningful frameworks. Among the most significant is the understanding of the way relationships are informed and shaped by cognitive processes (Weiss & Jacobson, 1981; Feldman, 1979; Gurman, 1981). Marital therapies that most cogently reflect the shift to a more effective and theoretically coherent integration are: object relations therapy (Cashdan, 1988), family systems and object relations (Slipp, 1993; Solomon, 1989), dynamic assessment (Hiebert, Gillespie and Stahmann, 1993), integrative (Nichols 1988), contextual (Boszormenyi-Nagy & Krasner, 1986) and focal family therapy (Kinston & Bentovim, 1981).

Other marital theorists (Bader & Pearson, 1988; Gilbert & Shmukler, 1996; Sharpe 1997) appropriate the developmental stages of childhood to conceptualise and treat marital dysfunction. Central to these treatment models is the assumption that in conflicted intimate relationships reconstructions of relationships, not unlike those of a parent and child, take
place. These theorists use the stages of early childhood development outlined by Mahler, Pine and Bergman (1975), *symbiotic, differentiation, practicing* and *rapprochement*, to provide an organising framework for marital therapy. Mahler et al.’s developmental phases and sub-phases viewed ‘separation–individuation’ as the fundamental process through which both object constancy and a coherent sense of self are developed (Bader & Pearson, 1988).

*The Introduction of Attachment Theory in Marital Therapy*

*The concept of attachment.*

Attachment theory developed out of the object relations tradition in psychoanalysis. Bowlby (1988) moved the psychodynamic focus away from impulses, drives and defence mechanisms towards event theory and information processing (Masiello, 2000). Bowlby (1988) showed how attachment theory draws on “concepts from evolution theory, ethology, control theory, and cognitive psychology” (p. 120). Such an ethological reformulation resulted in a “psychoanalytic metapsychology in ways compatible with modern biology and psychology and in conformity with the commonly accepted criteria of natural science” (Bowlby, 1988, p. 120).

A major purpose of Bowlby’s work was to describe and demonstrate how children become emotionally attached to their primary caregivers and become emotionally distressed when they are separated from them (Hazan & Shaver, 1987). Bowlby was one of the major theorists to suggest that the drive for attachment to others is as significant a class of behaviour as feeding and sexual behaviour. He recognised that attachment to a preferred person develops strongly within the first year of life.

In most cultures, usually the mother is available to nurture and attend to the needs of a baby. If attachment occurs normally, the baby will have a bond with a preferred person who provides them with a secure base (Clulow & Mattinson, 1989). Ainsworth (1989) found that the attachment process between children and their caregiver influences the affectional bonds that individuals develop with others throughout their lifespan. Attachment theorists (Ainsworth, 1989; Hazan & Shaver, 1987) demonstrated how early child–parent bonds not only influence the child’s capacity to master important developmental tasks, they influence the individual’s interpersonal relations, particularly in their intimate relationships (Masiello, 2000).

*The role of attachment in adult relationships.*
A central tenet of attachment theory is the notion that “features and functions of attachment relationships are essentially the same ‘from the cradle to the grave’ ” (Hazan & Shaver, 1992, p. 92). The association between intimate relationships and adult attachment is well supported in the research literature. Hazan and Shaver (1987, 1990) explored the conceptualisation of romantic love as an attachment process; Crowell and Treboux, (1999) studied the role of childhood attachment representations in marriage; and Feeney (1998) researched the role of relationship-centred anxiety.

Since intimate relationships rely both on the presence and absence of an attachment figure, any consideration of the dynamics of relationships must examine the role of loss. Research supporting the relationship between attachment loss and marital distress was reported by Weiss (1975), and on marital separation by Hazan and Shaver (1992). The relationship between severed attachment bonds and marital distress also finds support in empirical research carried out by Hoffman (2000). A study by Strahan (1995) confirms the links between the quality of early parental bonding and the impact on levels of depression in adulthood. Parkes (1972) studied the life-span implications of the loss of close relationships and the processes associated with adult bereavement.

**The role of attachment theory in psychotherapy.**

Attachment theory not only provides a framework for describing the processes by which affectional bonds are forged and broken, it also provides a framework for understanding unconscious processes aroused in psychotherapy. Della Selva (1993) described how the model provided the “most accurate theoretical framework within which to understand those patients who are suffering from anxiety, depression, and emotional detachment” (p. 205). Fish and Dudas (1999) highlighted the relevance of attachment theory for the narratives told in psychotherapy. Masiello (2000) detailed how adult attachment styles would predict an individual’s intrapsychic responses in conflicted relationships.

At the same time, little empirical work has been reported that examines how working models of attachment affect process and outcome (Masiello, 2000). This may be due to the complexity inherent in research into the process and outcome of psychodynamic treatment (Luborsky & Schimek, 1964; Luborsky, 1984). An alternative explanation may be the reluctance on the part of practising psychotherapists to adopt the scientist–practitioner model.

**The Purpose of the Work**
American *Consumer Reports* (1995, November) confirm the complexities associated with the practice of marital therapy (Seligman, 1995). Not only did these reports document how couples report dissatisfaction with their experience of marital therapy, they concluded that marital therapy has poor acceptance, high relapse rates, and provides the least satisfaction for psychotherapy consumers. Negative therapeutic reactions such as low acceptance rates and high drop out rates place additional pressures on the profession for reliable and valid treatment paradigms.

To assess such issues, Dunn and Schwebel (1995) reviewed the findings of 15 methodologically rigorous marital therapy outcomes reported in 19 journals. This meta-analysis of marital therapy research reviews outcome studies published between 1980 and 1993. It investigates the efficacy of behavioural marital therapy (BMT), cognitive-behavioural marital therapy (CBMT) and insight-oriented marital therapy (IOMT). All therapies were found to be more effective in bringing about change in spouses’ behaviour than having no treatment at all. Dunn and Schwebel (1995) concluded that IOMT was more effective than the other methods; and it was more effective, they said, in bringing about change in spouses’ general relationship assessment. This research also concluded that CBMT induced significant cognitive change post therapy.

*The Practice of Brief Contextual Modular Psychotherapy*

The practice context.

Within the Australian context, a search of the psychotherapeutic literature found only three brief psychotherapies for treating marital and familial discord. Morawetz and Walker (1984), Macnab (1991), and Smyrnios et al. (1987) published these. As stated previously, BCMT is a time-limited practice approach that integrates principles and techniques from the major psychotherapies. BCMT provides the therapist with a modular, sequential application of interventions, with explicit criteria for movement from one stage of treatment to the next. For each expression of psychopathology or contextual dysfunction, the therapy follows a developmental framework bringing resources relevant to the client’s explorative and experiential situation and needs. It details a clear statement of the operations the therapist will perform. It emphasises the contextual collaboration of the therapist and the client.

BCMT is distinguishable from other brief therapies by its theoretical integration, its six-session time limit, its specific clinical focus and its techniques for different systems of dissatisfaction and distress. A community-based psychological counselling centre has practised the therapy for over ten years and has applied it in cases of wide diversity, morbidity
and maladjustment. In the therapy are set out practice modules, which are six-session treatment plans for a diverse range of presenting issues such as the anxiety disorders, depression, trauma, loss and grief, marriage and the phobias. Since 1991, two volumes detailing the application of BCMT for the treatment of trauma have been published (Macnab, 2000a, 2000b).

The Theory Underpinning the Model

The BCMT model adheres to the principle of time by relating the individual’s experience of their inner and outer reality to the categories of time, space and causality (Macnab, 1965). By recognising the unconscious meaning and experience of time in the development of the personality, the therapist pays close attention to it (Molnos, 1995). Its theoretical underpinnings in interpersonal, coping and existential psychology focus on four areas of exploration:

1) The biological world of the body; the way people live in their world; their rigidities and flexibilities; their constraints and freedom. This is sometimes referred to by the German word Umwelt.

2) The world of others – the interpersonal world; the social skills and deficits; the intimacy needs and frustrations. This is called Mitwelt.

3) The private world of the self – self-esteem; the experience and management of frustrations and gratification; the inner world of fantasy and dreaming; the sense of satisfaction and dissatisfaction (Eigenwelt).

4) The world of ideas and values; the creation of purpose and meaning; discovering directions and establishing connections with aspects of the environment and with ideals, concerns and symbols which draw them to a higher consciousness, awareness and responsiveness (Uberwelt) (Macnab, 1991, p. 15).

The therapeutic model serves to turn the clients’ attention away from the individual’s loss of connectedness: turning away from others; and, toward the necessity to explore a number of existential issues: being with others (Macnab, 1965). Conceptualisation of psychopathology as a search for increased interpersonal connectedness highlights the existential and primary anxieties associated with the adoption of an alternative world-view. The time-limited treatment model creates the context for therapeutic work in which the individual has the opportunity to move from “a reactive symptomatic posture and anxiety to a pro-active concern and planning for the next phase of his/her life, health and well-being” (Macnab, 1991, p. 5).
Research into the Effectiveness of the Model

BCMT presents the individuals and couples who participate in it with an opportunity for the establishment of better and more fulfilling relationships (Macnab, 1991). In recent years, a body of unpublished clinical data is available from the observations of the therapists who practise the approach. Considerable support for the effectiveness of the therapy in general, and the marital module in particular, comes from the experience of people in group training programs, from clinical supervision of trainees and from the self-report of people who have participated in the therapy.

Although support for the effectiveness of BCMT exists, at present the method has a number of limitations. The model provides neither a detailed description of its underlying theoretical principles, nor the way in which the different theories of therapy have been integrated to create the conceptual framework and treatment process. The treatment manual does not provide a deep or concise coverage of the clinical theories and psychoanalytic systems of pathology informing the therapy. Instead, the therapists applying the method rely on the structure and standardised interventions detailed in the treatment manual to inform their therapeutic practice.

The Research Project

This research attempts to identify the therapeutic processes that occur in the therapy and to translate them into a coherent conceptual framework. It is proposed that the identification of these processes provides information for therapists to understand more clearly the aetiology of the couple’s conflicted interpersonal patterns and to treat them more effectively. An aim of this research is to provide a detailed description of the conceptual and treatment elements of the marital module developed in the treatment manual for BCMT.

To develop the philosophy and principles missing in the original marital therapy, the thesis will provide: conceptualisation, technique and process. In this way the study provides an understanding of the way couples in conflicted relationships respond to and vary in their experience of the marital therapy. The contribution of the model to the clinical literature will be demonstrated, through a study of the treatment process and its outcomes, for five couples following their participation in the brief marital therapy.

The aim of the thesis is to investigate the integration of attachment theory in the marital module of BCMT (Macnab, 1991). The study is designed (a) to articulate the theory of personality and psychopathology underpinning the marital therapy, (b) to describe the theory
of change the model endorses, and (c) to assess the effectiveness of the therapy. From the review of the literature of interpersonal, object relations, attachment theory and contemporary marital therapies, the fundamental research question is stated as follows:

**Fundamental Research Question:**

That the integration of attachment theory would provide an organising framework or metaperspective for theory construction and therapeutic intervention in the clinical application of the marital therapy described in BCMT (Macnab, 1991).

The following four research questions were derived from the fundamental research question.

**Research Question 1.**

That the highly structured therapeutic approach, the specific clinical foci and detailed treatment interventions for each of the six sessions provide a clinical framework for the effective treatment of marital psychopathology and dissatisfaction as demonstrated by self-report.

**Research Question 2.**

That adult attachment styles influence the partners’ interpersonal relations with others, and affect their intrapsychic responses in conflicted intimate relationships as demonstrated by self-report.

**Research Question 3.**

That the therapeutic change processes elicited by the time-limited therapy can be likened to Bowlby’s (1961) stages of mourning: protest, despair and detachment, as demonstrated by narrative analysis.
Research Question 4.

That changes to each partner’s inner working models of self, other and context occur as a result of participating in the time-limited marital therapy, as demonstrated by self-report and narrative analysis.

The Research Design

To determine whether the model provides a coherent framework for the treatment of marital dissatisfaction, five couples presenting for relationship therapy at a community-based psychological treatment and training centre are studied. With each couple, the investigator conducted the six-session time-limited marital psychotherapy described in Chapters 5, 6 and 7.

Method

Couples presenting for marital therapy at a community-based counselling centre, or who had volunteered to participate in a marital therapy training program advertised in the local media, were the participants in the study. To determine the participants’ beliefs about the effectiveness of the therapy, the couples participated in the six sessions of therapy. They agreed to have the therapy observed, to have written transcripts of the sessions made, to have audiotapes made of the sessions and to complete a questionnaire at the beginning and the end of therapy. To determine the intrapsychic processes elicited by the interventions and procedures of the therapy, two assessment measures were administered and verbatim clinical transcripts were made.

Pre-therapy Assessment

To understand the way the attachment process between a caregiver and child influences the affectional bonds with others throughout the life-span, at the commencement of the first session of the therapy the couple were asked to complete the Adult Attachment Styles Questionnaire developed by Hazan and Shaver (1987), which appears as Appendix B.

Assessment

To determine the interrelationships between each partner’s intrapsychic processes, interpersonal patterns and inner working models, clinical transcripts of the sessions were taken by an independent observer in the therapy sessions; and, audiotapes were made of each session.
Post-therapy Assessment

To determine whether any changes occurred in the participants’ perceptions of self, other and context, the self-report questionnaire, which appears as Appendix A, was completed by each partner following the completion of the sixth session of the therapy.

The Structure of the Thesis

The thesis is in four parts. These are:

1) conceptualisation;
2) technique;
3) the therapeutic process; and
4) the research findings and conclusion.

In the next chapter the theory informing the personality and psychopathology of the model is described. This is followed by a description of the theory of change that the model endorses. Next the theory and techniques of the therapy and a description of the interventions applied in the therapy are given. The three chapters following thereafter are devoted to a detailed description of the therapeutic process associated with the six sessions and the treatment plan related to them. This is followed by a description of the research, together with a discussion of the findings. Finally, the implications for treatment and practice that follow from the research reported in this thesis are suggested. The contributions to knowledge in the field are summarised in the concluding chapter of the thesis.
CHAPTER 2

The Theory Underlying the Model of Personality and Psychopathology

Overview

This chapter details how the integration of different theoretical models or paradigms of intervention can complement one another and work together in a synergistic way. It describes how constructs from object relations, interpersonal, and attachment theories provide a framework for treating conflicted intimate relationships. It is proposed that this theoretical integration provides an organising framework, or metaperspective, for marital practice and creates a stronger framework than any particular theory. Mahler et al.’s (1975) stages of childhood development, normal autism, normal symbiosis and separation-individuation and the translation of these object relations concepts for the diagnosis and treatment of differing expressions of marital psychopathology and disturbance are outlined.
The Theory Underlying the Model of Personality and Psychopathology

Marital therapy is concerned with creating change, finding a greater sense of self-efficacy and increasing relationship satisfaction. Extensive debate exists about the most appropriate influences, methods, traditions and interventions to achieve effective outcomes (Richards, 2001). Lindegger and Barry (1999) noted that the future of contemporary marital practice rests on the integration of apparently contradictory and incompatible paradigms of intervention. In the model of marital therapy described here, it is proposed that the integration of contemporary psychoanalytic theory and attachment theory results in an alternative paradigm for the treatment of marital conflict.

This metatheory does not limit marital therapy to the new insights and new understandings associated with a ‘corrective emotional experience’ (Alexander & French, 1946). Instead, it directs the therapeutic attention toward the couple’s “interpersonal behaviours, maladaptive schemata, interactional expectations and relationship patterns” (Eagle, 1999, p. 138). The therapeutic process centres upon an exploration of the relationship between the partners’ unconscious internal object relations and their inability to alter these inner representations in the face of their current experience (Ogden, 1983). And in particular, it directs the psychotherapeutic focus to the ways in which the partners repeat and maintain these cyclical, self-perpetuating, and pathological transactions. The way this metatheory enables the therapist to conceptualise the couples’ dynamics, to understand marital problems and to diagnose the developmental stage of the relational conflict follows.

The Evolution of Contemporary Psychoanalysis

The Object Relations Tradition in Psychoanalysis

One of the major contributions of contemporary psychoanalytic theory has been the shift in the conceptualisation of the unconscious from a repository of repressed instinctual wishes to a structure comprising representations of self, and object (other), and the interactions between the two (Eagle, 1999). The development of the concept of internal object relations can be traced through the work of Freud (1926), Abraham (1924), Klein (1950), Fairbairn (1952), Winnicott (1965), and Bion (1967). Freud originally used the term object in discussions of instinctual drives and in the context of mother-child relations (St. Clair, 1996).

In psychoanalytic theory the use of the term ‘object’ for ‘person’ indicates that the drives seek objects for gratification (Messer & Warren, 1995). Object is a technical term that means, “that
with which a subject relates” (St. Clair, 1996, p. xi). “In combination with relations, object refers to interpersonal relations and suggests the inner residues of past relationships that shape an individual’s current interactions with people” (St. Clair, 1996, p. 1).

By contrast to Freudian drive theory, from the object as the aim of an instinct, in object relations theory the shift is to the individual as object seeking; in other words, the shift is from instincts to relations, from the biological to the social. At the same time, the object to which the infant relates is both an object in the external world, the m-(other) and an object in the internal world. Internal object relations are influenced by instinctual demands and the care from the m-(other) in the external world or ‘environmental provision’ (Winnicott, 1965) and ‘container’ (Bion, 1967). Ogden (1983) makes a distinction that by diverting attention from the unconscious, object relations theory is in fact fundamentally a theory of unconscious internal object relations in dynamic interplay with current interpersonal experience (p. 227).

There are significant theoretical differences among the major object relations theorists. Irrespective of the differing viewpoints, however, there is a development of a central line of thought in object relations theory (Ogden, 1983). This is found in Klein’s (1950) contribution of the idea of internalised representations of self and object, and the mechanisms infants use to deal with intense anxieties, archaic urges, and fears. It can be found in Fairbairn’s (1952) model of object relations. This emphasised how humans inherently seek relationships with others. Further, in the existential psychiatry of Winnicott (1965) the emphasis is placed on maturational experiences in the development of the child, and the delicate balance that exists between the environment and the formation of the self (St. Clair, 1996).

Ogden (1983) suggested that object relations theories are often erroneously thought of as exclusively interpersonal theories. For example, Ryle (1997) noted how the object relations model of Kernberg (1976) “is concerned largely with internal relations between these ‘objects’ (which are the bearers of instinctual forces) and paying little attention to the actual relations between the individual and others, either as formative influences in the past or as expressing and maintaining pathology in the present” (p.44). Self psychology (Kohut, 1971) also offered a major challenge to psychoanalytic orthodoxy. Kohut’s object relations theory places the self firmly at the centre of the psychotherapeutic endeavour (St. Clair, 1996). Unlike Kernberg, Kohut regarded empathic failure as central to an understanding of childhood development and the importance of childhood trauma (Ryle, 1997).

Along with Klein (1950), Winnicott (1965), and Bion (1967), Mahler et al. (1975) integrated traditional instinct theory with object relations theory. This resulted in providing an
intrapsychic understanding of human development. Mahler et al. (1975) referred to the psychological birth of the infant as two complementary developments *separation-individuation*. Separation is described as the child’s emergence from symbiotic fusion with the mother, while individuation consists of those achievements marking the child’s assumption of his or her own characteristics (Mahler et al., 1975).

Empirical research into the infant’s internal representations (Stern, 1985) has since refuted some concepts associated with Mahler et al.’s (1975) model, in particular the notion of symbiosis. Stern (1985) found the young infant to be socially responsive from birth onwards. That is, from the very beginning of life the child has the ability to distinguish between self and m-(other).

*The Interpersonal Tradition in Psychoanalysis*

The acknowledgement of the intrapsychic, interpersonal and cultural influences in object relations theory has resulted in what is known as the interpersonal tradition in psychoanalysis. Interpersonal theory has its origins in the theories of Sullivan (1953), Fromm (1991), Horney (1950), and Erikson (1965/1951). A major contribution of Sullivan was his observation that all individuals are embedded in an interpersonal matrix (Mitchell & Black, 1995). Sullivan (1953) viewed anxiety as the most disruptive force in interpersonal relationships.

Central to the Sullvanian model is the notion of the ‘self-system’, or the way individuals invent illusions to dispel their anxieties. As he believed human beings to be essentially social by nature, Sullivan (1953) observed how infants develop a self-system to avoid or minimise anxiety. The continuous and active function of this set of processes is to steer experience selectively in the direction of the known: when anxiety is low the self-system fades into the background; when it is high, the self-system dominates (Mitchell & Black, 1995, p. 70).

The shift in emphasis from intrapsychic phantasy to the external world helps to explain how individuals contain within their psyches more selves than those with which a rationalist version of human nature can hope to deal (Roazen, 1987). By organising, integrating and synthesising acceptable experiences, those which are forbidden by significant others are no longer part of awareness, or part of the self. This experience could be likened to a dissociative state, where there is a sense of being, but not being (Mitchell & Black, 1995). Sullivan (1953) called this experience the ‘parataxis’. That is, the way individuals operate “through multiple self-organisations that are keyed in to experience of the other(s) with whom they find themselves ‘interacting’ ”(Mitchell & Black, 1995, p. 84).
Emphasis on the interpersonal–cultural in the development of the self highlights the centrality of interpersonal relations in everyday life. This revision emphasises the contextual interaction of subjectivities, their reciprocity and their mutual influence in the development and experience of the self. The main terrain in which this relational ego, or self, is envisioned is that of personal life, of friends, colleagues and relations (Zaretsky, 1998).

Consistent with the Sullivanian notion of the ‘parataxis’, nobody encounters others in life through pristine eyes (Chrzanoski, 1979). Instead, every person carries within them a wealth of interpersonal possibilities taken from past experiences with significant others and subsequent developmental experiences (Gilbert & Shmukler, 1996). Such a metatheory provides a conceptual framework for understanding how individuals mould particular and idiosyncratic ways of perceiving self and other(s). That is, there is an ongoing reciprocity between other people and the social context in defining a sense of self (Mitchell & Black, 1995).

These experiences organise personality in decisive ways (Kwawer, 1981). Personality is not considered to reside solely within the person. Instead, it unfolds as a result of the individual’s interactions and relationships with others and in the broader cultural context. It follows that personality development rests on the ability of the individual to manage the interplay between relatedness and autonomy (Eagle, 1999).

Based on these processes, Blatt (1995) defined the development of the personality as reliant upon: the occurrence of satisfying interpersonal relationships and on a well-differentiated sense of self. Blatt (1995) suggested that the dimensions of relatedness–self-definition, autonomy–affiliation and attachment–separateness constitute developmental themes that occur throughout the lifespan. In this interpersonal definition, the personality is perceived to evolve through the complex interaction of:

(a) an anaclitic relatedness line involving the development of the capacity to establish increasingly mature and mutually satisfying interpersonal relationships and (b) an introjective or self-definitional line involving the development of a consolidated realistic, essentially positive, differentiated and integrated self-identity (Blatt, 1995, p. 1012).

The association between personality dimensions and relationship patterns resulted in Blatt (1995) proposing two interpersonal psychopathologies, the anaclitic and the introjective:

*Anaclitic psychopathologies:* in which patients are primarily pre-occupied with issues of interpersonal relatedness, from more infantile dependent attachments to more mature relationships. Anaclitic disorders involve exaggerated and
distorted preoccupations with interpersonal relations – with issues of trust, caring, dependability, intimacy and sexuality at the expense of the development of the sense of self. Not only do these anaclitic disorders share a preoccupation with interpersonal relatedness ranging from a desire to be close and cared for to concerns about sexual intimacy, but they also all involve the use of avoidant defenses ranging from withdrawal and denial to repression to cope with psychological conflict and stress.

*Introjective psychopathologies:* include disorders in which primary concerns with establishing and maintaining a viable sense of self range from establishing a basic sense of separateness, to a preoccupation with autonomy and control, to more complex internalized issues of self-worth. These patients primarily use counteractive defenses (e.g., projection, rationalization, intellectualization, doing and undoing, reaction formation and overcompensation) (p. 1013).

An understanding of the differences in interactional styles, and the attachment processes that pervade and direct them, is helpful in having the couple overcome their misunderstandings. For example, partners who have experienced developmental failures in childhood or early adulthood may become dependent on each other for their self-esteem. Some may continue to be susceptible to influence from their families; others may have suffered significant early losses, such as separation, the death of a parent, sibling, or caregiver.

**The Role of Attachment Theory in Psychoanalysis**

Attachment theory evolved out of the object relations tradition, particularly the milieu of the British middle group (Cortina, 2001). To account for clinical observations, Bowlby turned to modern biology, in particular ethology and the theory of evolution to construct a new metapsychology (Bacciagaluppi, 1989). Whilst Bowlby (1988) perceived attachment theory as developing out of the object relations tradition, it has struggled to take its place as a distinct psychoanalytic model.

Bacciagaluppi (1989) suggested that this is a result of attachment theory’s effort to place psychoanalytic data within an extra psychoanalytic framework. As psychoanalysis has continued to evolve, Bacciagaluppi argued that the integration of the interpersonal–cultural approach within psychoanalysis and attachment theory, results in a new paradigm for psychoanalysis. Attachment theory reveals a discontinuity in human evolution whereby present society may not satisfy basic human needs (Bacciagaluppi, 1989). Support for the evolution of a new paradigm can be found in the observation of Eagle (2001) that contemporary psychoanalysis and attachment theory share certain basic assumptions and conclusions; and this results in attachment theory becoming “in part at least, a ‘mirror of contemporary psychoanalysis’ ” (p.123).
A central theme in interpersonal theory and attachment theory is that human development can only be understood in a relational context (Cortina, 2001). Both these theories “assign a pivotal role to felt security, severe anxiety and fear in the formation of interpersonal patterns” (Cortina, 2001, p.). While Sullivan (1953) concentrated on the defensive organisation of the self-system, attachment theory originated from Bowlby’s clinical observations of young infants housed in residential nurseries. Bowlby (1960) observed the reactions of small children to separation from their mothers. These observations resulted in the delineation of three distinct phases of separation reactions, each with its own distinct and identifiable experiences and phases: protest, despair and detachment.

Upon realising the mother has left, children in the protest phase cry loudly, appear acutely distressed and watch attentively for any sign of her return. In the phase of despair, which follows the protest phase, the child’s preoccupation with the mother continues. The child increasingly becomes withdrawn, exhibits signs of helplessness and appears to enter a state of mourning (Hazan & Shaver, 1992).

In the final phase of detachment, the child appears to enter a state of recovery. While the child rejects the care offered by others, they smile and look normal. However, on the mother’s return, the child becomes remote, and apathetic and typical strong attachment behaviour is absent. The longer the period of separation, the more unfamiliar the environment, the more frequent the change of caregivers, the greater is the trauma of separation (Hazan & Shaver, 1992; Della Selva, 1993).

Besides the ethological framework, in his account of internal object relations Bowlby placed a strong emphasis on cognitive processes. He described them as inner representations. According to Bowlby (1988), these internal working models generally represent relatively accurate accounts of actual interactions between the child and the caregiver.

In the event that a child cannot fulfil its need to establish emotional links to primary caregivers because of neglect, abuse, rejection or inconsistent parenting, a psychological dilemma exists. How is the child to cope with this dilemma? What adaptations must the child make to survive emotionally (Teyber, 1997)? To explain this process, Bowlby (1988) described how by its very nature, memory of self-representations becomes selective. Such experience leads to the construction of faulty mental representations, or internal working models, of self and other.
These attachment processes become a template, which then becomes “imposed on all relationships distorting the child’s perception to fit the template, and shaping reactions to the object, as if to follow the primary attachment pattern” (Blizard & Bluhm, 1994, p. 384). Bowlby (1988) called the models or schemas that mediate any threats to the continuity or quality of the relational interaction ‘tolerably accurate reflections’ of actual experience. People come to relationships with a set of interactional expectations that influence their behaviour (Eagle, 1999). While these patterns or inner working models can be revised as the individual develops and has different life experiences, they tend to operate consistently, automatically and outside conscious awareness (Lindegger & Barry, 1999).

Although early mother and child interactions directly affect emotional development, Bowlby (1988) acknowledged that family dynamics are not the only factor in the development of the personality. Real failures of the environment also play a part. This observation is found in his concept of the ‘secure base’. As children explore further, and encounter different people and new situations, a secure base becomes increasingly important in assisting them to cope.

Bowlby’s clinical trials showed how a securely attached child, who develops a basic trust in people, has the capacity to draw on his or her relational attachment blueprint and apply it to relationships later in life. As these childhood experiences exert their effects in later life, attachment theory emphasises the

full cycle of relationships – their formation, maintenance, and dissolution – and the defining features of an attachment relationship include reactions to both the presence and absence of an attachment figure (Hazan & Shaver, 1992, p. 90).

Because of attachment theory’s strong emphasis on interpersonal relations, family dynamics and cognitive mechanisms, the method has become associated with a wide research base. The observation supported in the literature is that the lack of consistent care, nurture or support leads to the development of distorted inner working models or mental representations of self and other (Blizard & Bluhm, 1994; Blatt, 1995). Other studies demonstrate the intergenerational transmission of attachment patterns associated with insecure attachment (Bretherton, 1986).

The connection between adult relationships and adjustment has been documented (Collins & Read, 1990; Feeney & Noller, 1990; Hazan & Shaver, 1992; Weiss, 1982). Feeney (1988) reported a direct association between relationship satisfaction and stability of attachment style, or the individual’s general way of thinking and responding in close relationships. The
way love might be conceptualised as an attachment process has been researched (Hazan & Shaver, 1987). And the influence of attachment styles on romantic relationships has been studied (Simpson, 1990).

Empirical support for the continuity of attachments beyond infancy adds plausibility to the notion that the conflict in intimate relationship reflects the partners’ attachment history and psychosocial context. The significance of the model of Ainsworth, Blehar, Waters and Wall (1978) for marital therapy is found in three distinct groups of attachment styles. Ainsworth et al. (1978) delineated these styles of attachment as: secure, anxious/avoidant, and anxious/ambivalent (the last two both regarded as insecure attachment styles) (Lindegger & Barry, 1999, p. 272). Hazan and Shaver (1987) noted that infants in the “anxious/ambivalent category frequently exhibit the behaviours Bowlby called protest; and the avoidant infants frequently exhibit the behaviours he called detachment” (p. 512).

Bowlby (1988) demonstrated how the experience of secure childhood attachment enabled individuals to interact more effectively with others, as well as to achieve a degree of autonomy in their lives. By contrast, the experience of anxious childhood attachment results in greater difficulty in establishing interpersonal relationships and a higher degree of dependency upon others for a sense of well-being. Blatt (1995) described the dichotomy between anxious and avoidant adults as dependent and compulsively self-reliant individuals. In Blatt’s (1995) model the dependent personality has “intense and chronic fears of being abandoned and experiences deep longings to be loved, cared for, nurtured and protected” (p. 1009). Any separation or loss from others results in considerable fear and apprehension. People with a dependent personality may resort to primitive means such as denial, or a desperate search for substitutes to enable them to cope. By contrast, the self-reliant individual “is characterized by self-criticism and feelings of unworthiness, inferiority, failure and guilt” (Blatt, 1995, p. 1009). These individuals engage in harsh self-scrutiny, chronic fears of disapproval, criticism and rejection. This results in strivings for achievement and perfection that can lead to them becoming highly competitive (Blatt, 1995).

The Theoretical Concepts Informing the Model

Many theories and paradigms have informed the practice of marital therapy, but no single discipline has been able to claim it (Shaw, 2001). This has resulted in marital therapy struggling to find its rightful place as a psychotherapy. While the concepts of object relations theory have contributed to the conceptualisation of marital therapy, the way attachment...
processes might be adapted to the practice of marital therapy has not been so widely embraced. In this model the integration of object relations, interpersonal, and attachment theory results in an alternative treatment paradigm for relational conflict.

*The Application of Object Relations Concepts*

From an object relational perspective, couples are increasingly perceived “as complex systems in which projective-identificatory interactions are prevalently observable” (Kissen, 1996, p. 55). Because of the need to conceptualise the couple’s dynamics and interpersonal processes, the defences of projection and projective identification and transference and countertransference have assumed a major role in marital therapy (Cashdan, 1988; Dicks, 1967; Kissen, 1996; Slipp, 1993). The concepts of projection and projective identification are particularly helpful theoretical and technical interventions for working with couples as well as individuals (Kissen, 1996).

Couples use projection and projective identification to negotiate the anxieties associated with the issues of intimacy, power and autonomy (Kissen, 1996). Projection is used widely and is understood in a variety of ways. Freud assigned to projection a fairly strict meaning: “it always appears as a defence, as the attribution to another (person or thing) of qualities, feelings or wishes that the subject repudiates or refuses to recognize in himself” (Laplanche & Pontalis, 1988, p. 352). What is projected is what is ‘hated’ or ‘bad’. Freud illustrated projection at work in ‘projected jealousy’. He used an example whereby the subject fends off his desire to be unfaithful by imputing jealousy to his spouse: in this way he turns his attention away from his own unconscious and redirects it on to the unconscious of the other person, so gaining a great insight regarding the other person while falling into just as great a misapprehension regarding himself (Laplanche & Pontalis, 1988, p. 351).

The concept of projective identification has also evolved as an important concept for understanding how couples utilise each other for communicative purposes and to reduce anxiety defensively (Kissen, 1996). Projective identification involves, in addition, the mechanism by which the subject inserts the self “in whole or in part - into the object in order to harm, possess, or control it” (Laplanche & Pontalis, 1988, p. 356). In marital therapy, Dicks (1967) described how projective identification helps to explain the intrapsychic and interpersonal mechanisms of object relating and defence that are assigned to another person (the spouse or the therapist), who becomes induced to behave, or respond, in an emotionally circumscribed fashion. By externalising those feelings that are unacceptable, anxiety is dealt with as if it were a situation apart from the self, usually in the partner.
From a contemporary treatment perspective, in addition to the couple’s defences, the therapist’s transference and countertransference also play an important role in effective treatment and outcome. In classical psychoanalysis, transference is defined as ‘transference during treatment’. There, “infantile proto-types re-emerge and are experienced with a strong sense of urgency” (Laplanche & Pontalis, 1988, p. 455).

Since Freud’s time, the term transference has taken on very broad definitions. A common one is the way clients transfer aspects of their past relationships to the present relationship with the therapist (St. Clair, 1996). As psychoanalytic treatment has come to be understood as a relationship, increased attention has been paid to the unconscious reactions invoked in the therapist by the patient’s transference (Laplanche & Pontalis, 1988). Messer and Warren (1995) described countertransference as the acquisition of interpersonal empathy.

Questions have been raised about the use of transference and countertransference in brief dynamic therapy. A dynamic interactional process like transference and countertransference is strongly influenced by the inner representations assigned by the couple (Schaeffer, 1998, p. 8). In this marital therapy, countertransference is regarded as a particularly valuable source of information about the couple’s subjectivities, object relations and transference reactions (Wachtel, 1977).

Countertransference reactions provide the therapist with clues about what cannot be said in words (Solomon, 1989). Sometimes erotic feelings such as passionate attachment and intense emotion in the countertransference can signal intense primitive, unthought and unthinkable affect. Even though therapists recognise the need to maintain therapeutic neutrality, at the same time they need to be aware that their own feelings are part of the therapeutic relationship (Solomon, 1989). Sharpe (1981) argued that an understanding of both the therapist’s and the couple’s transferential, developmental and attachment processes are crucial, if the marital therapist is to devise appropriate therapeutic interventions.

The relationship between the couple’s inner representations and cognitive processes and current experience suggests specific interventions and techniques. In this marital therapy the transference and transference reactions between the partners is a sustained focus of attention. That is, the therapist’s mood, feelings, fantasies, and stray thoughts inform the process of every session. Such a level of emotional involvement results in therapists being constantly confronted with their own countertransference responses (Gilbert & Shmukler, 1996).
The integration of attachment theory highlights how the transference to the partner and to the therapist will be patterned after relationships with primary care givers (Blizard & Bluhm, 1994, p. 388). The parallel between attachment processes and therapy has been acknowledged in the literature (Bowlby, 1988; Pistole, 1989). When working with attachment issues, one of the goals of the therapy is to focus on transference and the defences associated with the denial of feelings of anger, despair and longing. As transference is a form of resistance, the therapist uses this information to address each partner’s current reality and to undertake a meaningful exploration of original traumas involving early attachments (Della Selva, 1993). This process is used to help the couple develop more effective attachment systems, to feel more secure in their relationship and to explore alternative modes of operation (Lindegger & Barry, 1999).

The Theory Underlying the Model of Psychopathology

The question of what constitutes psychopathology is a key consideration in any psychotherapy (Messer & Warren, 1995). Central to the model of psychopathology underpinning the time-limited marital therapy proposed here are the unconscious processes aroused by loss of relationships in which one has close emotional ties. This loss can be real or perceived. While Bowlby’s (1973) metatheory of attachment and loss gives rise to a different model of personality functioning, his emphasis on the phenomenon of separation anxiety gives rise to a different model of psychopathology and its treatment.

Bowlby believed separation anxiety to be the fundamental form of anxiety and the principal source of future psychopathology. He also emphasised that separation anxiety is accompanied by anger (Bacciagaluppi, 1989). A model of psychopathology based on the dynamic of separation–individuation and attachment–loss highlights the conscious and unconscious processes that occur as each partner attempts to establish and maintain a close emotional bond. As relationships are continually being constituted and dissolved, such a process involves the losses associated with giving up some aspect of the self, other and world view (Hazan & Shaver, 1992).

As the partners in intimate relationships become emotionally involved with each other, attachment processes not unlike those between mother and infant start to evolve. Solomon (1989) described this dynamic process as the establishment of a ‘mutual self’ or ‘joint personality’ (p. 27). Given the stability and durability of a couple’s attachment styles, each partner’s inner working models play a major role in the formation of the new couple system. 
In this model, three factors are important in the conceptualisation of marital psychopathology: separation anxiety, the interpersonal defences against loss, and the psychosocial context.

**Separation Anxiety**

Not until his later writings, did Freud address the anxiety that arises from loss, the threat of loss, or the defensive processes evoked by intense anxiety (Bowlby, 1973). The antecedent for a model of psychopathology based on loss can be found in Freud’s paper on *Mourning and Melancholia* (1917). In this paper Freud focused on identification as “the means by which one not only remembers, but in part emotionally replaces, a lost external object with an aspect of oneself that has been modelled after the lost internal object” (Ogden, 1983, p. 228). In describing melancholia, Freud (1917) wrote:

> Thus the shadow of the object fell upon the ego, and the latter could henceforth be judged by a special agency, as though it were an object, the forsaken object. In this way an object-loss was transformed into an ego loss and the conflict between the ego and the loved person into a cleavage between the critical activity of the ego and the ego as altered by identification (S.E. 14, p. 249).

According to Bowlby (1974), because of Freud’s emphasis on defence, mourning and separation anxiety, the psychopathological significance of separation anxiety was over looked in the psychoanalytic literature. It was not until the end of Freud’s career that he accorded separation and loss its central place in what was to be his final theory of anxiety. In 1926 in *Inhibitions, Symptoms and Anxiety*, Freud wrote that “missing someone who is loved and longed for represented the key to an understanding of anxiety” (cited in Bowlby, 1973, p. 27). By acknowledging the role of separation anxiety, Freud recognised that “anxiety is the reaction to the danger of losing the object, the pain of mourning the reaction to the actual loss of object, and a defence a mode of dealing with anxiety and pain” (Bowlby, 1973, p. 29).

Bowlby (1973) observed that while missing someone who is loved and longed for represents one key to an understanding of anxiety, it is not the only one. Fear and anxiety can become aroused in many kinds of situations (p. 30). Bowlby’s contribution to the psychoanalytic understanding of psychopathology can be found in his observation that each of the three main phases in the young child’s response to separation is related to one or another of the central issues of psychoanalytic theory:

> Thus the phase of protest is found to raise the problem of separation anxiety; despair that of grief and mourning; detachment that of defence. These three types of response – separation anxiety, grief and mourning, and defence – are
phases of a single process and that only when they are treated as such is their true significance grasped (Bowlby, 1973, p. 27).

The anxieties associated with losing some aspect of the self and the defences employed against loss in intimate relationships are found in the process of falling in love. This falling in love stage reactivates the most primitive form of object relationships (Dicks, 1967). While an awareness of separateness of self and other is present, as the partners are flushed with idealisation, they will totally, or partially, ignore any differences between them.

According to Dicks (1967), idealisation represents the major defence mechanism in marital relationships. Idealisation represents the ego’s repression of the sadistic, or hate, aspect of ambivalence towards the love objects leaving only the good aspect of the object conscious. Idealisation allows the individual to experience pure love and leads to the phrase: love is blind. It becomes the reality testing that follows the honeymoon period that activates the return of the repressed (Dicks, 1967).

The sense of separation and loss in intimate relationships highlights the need to consider that relationship dissatisfaction may not be solely due to feeling unloved but rather, to an overwhelming sense of not feeling valued by self, other or society. Treurinet (1989) confirmed the difficulties associated with the making and giving of value. In this explanation, relational conflict not only involves a splitting of the ego, it involves ‘disavowal’ and ‘depersonalisation’. Drawing on the concepts of Winnicott (1965) of the capacity to be alone and the development of the capacity for concern, Treurinet (1989) defined the experience of feeling valued as follows:

To value, then has both a knowing and a feeling aspect. Valuing is different from loving…. To give value, or valuing, resembles to ‘give meaning’ but it is not the same…the capacity to be alone and the capacity for concern are part of giving value. It has to do with giving something a personal quality, an ‘ego quality’…. What we do value or like, however, is someone, a person, who is willing to face the truth, which makes him or her reliable (pp. 399-400).

From this contention, it follows that a model of marital psychopathology based on loss might need to consider the experience of not feeling emotionally held in adulthood: the notion of environmental provision (Winnicott, 1965) or the notion of container/contained (Bion, 1967).

Jossellson (1993) provided another explanation of this phenomenon as neither ‘cognitively realistic nor emotionally intelligent’, but rather existing between ‘fantasy and reality’ (p. 34). According to Jossellson (1992), “it is the juxtaposition of knowing and not knowing that gives
our need to be held its distinctive cast. Yet as soon as we know surely that we are not held, we seek other ground” (p. 34).

The Interpersonal Defences Against Loss

Much has been written in the psychoanalytic literature about formulations of love and its vicissitudes, in particular the choice of a love object (person). Chessick (2000) described how falling in love carried with it the imago of childhood love objects. According to Laplanche and Pontalis (1988), Freud conceptualised two basic types of love-object choice: the narcissistic and the anaclitic. The narcissistic choice operates on the assumption that the object represents some aspect of the self.

Freud described how a person might love “what they themselves are; what they were; what they would like to be; and someone who was once part of themselves” (Laplanche & Pontalis, 1988, p. 259). In contradistinction, the anaclitic choice is based on the model of parental figures: “the woman who feeds them; the man who protects them; and the succession of substitutes who take their place” (Laplanche & Pontalis, 1988, p. 33). Freud’s explanation of the phenomenon of falling in love as an experience of finding again incestuous parental objects has been extended in the psychoanalytic literature (Chessick, 2000). Kernberg (1974) observed how the ability to fall and remain in love is based on the achievement of two separate yet related developmental milestones. The first requires the establishment of a full object relationship, or the ability of partners to love each other as separate individuals. The second milestone includes an accurate perception of the beloved incorporating the integration of personal goals, ambitions and sexual needs. According to Kernberg (1976) mature love involves the experience of leaving behind the real objects of childhood. A true love relationship includes idealisation, tenderness and a special form of identification:

A mature selection of the person one loves and with whom one wants to live one’s life involves mature ideals, value judgments, and goals, which, added on to the satisfaction of the needs for love and intimacy give a broader meaning to life. It may be questioned whether the term ‘idealization’ still applies here; but, insofar as a person is selected who corresponds to an ideal to be striven for, there is an element of transcendence in such selection, a commitment that comes naturally because it is the commitment to the type of life that the relationship with that person represents (Kernberg, 1976, pp. 221-2).

In marital therapy, the unconscious factors involved in mate selection have centred around who chooses whom and why (Sharpe, 1981). The existence of a collusive complementary meshing of internalised object relations has resulted in the observation that like marries like
(Dicks, 1967). This is defined by Sharpe (1981) as the “developmental levels of self and object differentiation” and, second in regard to a level “of self-esteem which is largely contingent upon the level of identity formation” (p. 83).

A variety of conscious and unconscious defences are used for the purpose of avoiding the anxiety involved in emotional closeness and in its loss. Defences consist of affective, interpersonal and cognitive strategies employed to keep anxiety-provoking affect out of awareness (Della Selva, 1993). Kohut (1977) wrote of the mourning processes that occur when the ‘selfobject’ or narcissistic line of development becomes traumatised.

Bowlby (1973) described how it is common in clinical work to find people whose problems spring from the tendency to respond towards their attachment figure with a turbulent combination of intense possessiveness, intense anxiety, and intense anger.

An incident of separation or rejection arouses a person’s hostility and leads to hostile thoughts and acts; while hostile thoughts and acts directed towards his attachment figure greatly increase his fear of being further rejected or even of losing his loved figure altogether (p. 254).

Kohut (1977) emphasised the growth and development of the self through a matrix of self–self-object relationships over the lifespan. In this perspective, the selfobject “is a person who is so significant to another’s functioning that he/she (that is, the selfobject) is experienced as part of the other’s self” (Pollack, 1990, p. 318). When developmental failures occur, the individual’s ability to form significant relationships, without being overwhelmed by the guilt aroused by the feelings associated with relational connectedness, becomes impaired. One mechanism for avoiding anxiety is to enter love relationships with people who display a similar air of self-sufficiency, as a means of dealing with their own anxiety (Pollack, 1990).

Another common mechanism was described by Dujovne (1990). She noted how individuals who were given love narcissistically, or by parents who were depressed or unconnected, were prematurely encouraged to become independent. Others who have experienced developmental failures may believe that they had a happy childhood, thus defending themselves against loss and depression (Dujovne, 1990). Similarly, Pollack (1990) used the term ‘defensive autonomy’ to describe the unconscious processes used to defend against feelings of engulfment. Such individuals are often experienced as being ‘cold and uncaring’ by those around them, while they may consider themselves to be autonomous, or ‘rigidly independent’ (Pollack, 1990, p. 318).
Couple relationships occur within a broad social and cultural context. Yet many marital therapies fail to take into consideration these contextual variables or the part they play in the ability of the couple to form and maintain close emotional bonds. As a result, criticism has been levelled against the practice of psychotherapy. First is the assumption in traditional models of psychotherapy that individuals exist in a certain and expected cultural environment; and second is the supposition that people have the opportunity to adapt and adjust (Mack, 1994). Instead of acknowledging the destructive imperatives of economic, political and social systems, Schnitzer (1993) suggested that the practice of psychotherapy has failed to raise questions about the social context.

The current psychosocial context highlights the increasing difficulty to form intimate relationships when neither self, other, or society appears expected or reliable. Parental, social and media influences, sexual stereotypes and expectations can promote relationship satisfaction, or can serve to undermine relationship functioning (Halford, 2000). Such experiences highlight the inability of contemporary Western society to provide the couple with a secure base (Bowlby, 1988).

Postmodernist culture is not simply an outer frame, which surrounds the couple. It is more powerful and is deeper than that. The diversity of cultural assumptions and beliefs places ever-increasing needs for intimate partners to affirm their values, to find answers to what makes life worth living and to embrace what confers meaning in their lives (Taylor, 1989). The ability of the cultural context to undermine relationships was documented by Mitchell and Black (1995). Contextualism is defined as a way of thinking about self, mind, and other, consistently with the themes that characterise postmodernism:

Contextualism results in a decentring of the singular self, the dispersal of subjectivity, and the emphasis on the contextualization of experience. Meaning is to be found not in the rational and objective, but in the interpersonal transactions of the here and now. Each relational configuration yields two ways of being in the world; each actual relationship may contain multiple self-organisations; and there may be many such relationships (Mitchell & Black, 1995, p. 111).

The effects of these depersonalising forces on relationship satisfaction and stability can be found in the observation of Fromm (1991) of the individual’s continuing search for approval and recognition. Fromm defined this loss of personal identity as contextual compromise.
Solomon (1989) wrote of how in intimate relationships, narcissistically vulnerable individuals desperately wish “to be involved in relationships but have expectations of giving and getting that almost invariably lead to disappointment for themselves and their partners” (p. xii). When the very fabric of social and physical existence continues to be threatened, it results in the partners (and therapists) being forced to address existential matters, or what Erikson (1965/1951) called ‘ultimate concerns’. These concerns include basic values such as choice, life, death, responsibility and the nature of spirituality or God and so forth (Mack, 1994, pp. 180-181). Frosh (1991) noted that the inability to give of oneself derives from the experience that there appears to be nothing to give.

Whilst defining what constitutes better adjustment in intimate relationships is a matter of some controversy, substantial differences in expectations and beliefs about relationships can be a significant source of conflict (Halford, 2000). Important differences between how men and women function in intimate relationships and the satisfaction they gain from them have been reported. Halford (2000) found that relative to men, women are more likely to report dissatisfaction with lack of emotional closeness, to be more emotionally expressive when discussing relationship issues, to experience greater conflict between work and family roles and to be more likely to initiate divorce. Self-disclosure was also believed to be an important part of intimacy for women; men were more likely to experience shared activity as intimacy (Halford, 2000, p. 21).

One consequence of these differences has resulted in intimacy and identity taking on the characteristics of diametrically opposed concepts (Pollack, 1990). Feminist writers have attempted to define and explain these characteristics. Gilligan (1982) and Chodorow (1978) argued that female identity formation occurs through the integration and identification of an ongoing affiliative relationship with the mother.

Hence the formation of a female self is accomplished by an ongoing attachment. While for boys, to be masculine means to be different from the mother; there must be a clear-cut separation both intrapsychically and interpersonally from her. As a result, “men’s gender identity and sense of self will continue to be threatened by intimacy; whereas women will tend to experience threats to the self in the areas of individuation and/or autonomy” (Pollack, 1990, p. 317). Carpenter and Treacher (1989) proposed that it is wrong to blame men for holding women back by being too dependent on them (while paradoxically denying that dependence).
Understanding the developmental context of an intimate relationship and the interactions and defences that evolve plays a central role in diagnosis and treatment (Sharpe, 1981). The notion that relationships progress through developmental stages is central to the conceptualisation of this time-limited marital therapy. Clulow and Mattinson (1989) described these developmental stages as the establishment of a committed relationship, the transition to parenthood, the middle years and the adjustment to children leaving home. Significant events such as illness, unemployment, retirement, and death of parents also have the potential to increase or decrease relationship satisfaction. Halford (2000) noted how relationship problems are more likely to develop during periods of high rates of change and stressful events.

From a treatment perspective, Sharpe (1981; 1997), and later Bader and Pearson (1988), observed that couples’ relationships evolve through stages that resemble early childhood development. These clinicians appropriated Mahler et al.’s (1975) developmental model of the psychological birth of the human infant, normal autism, normal symbiosis and separation–individuation, to marital therapy. In this model, the intrapsychic separation–individuation process was divided into four sub-phases: “differentiation, practicing, rapprochement, and on the way to libidinal object constancy” (Mahler et al., 1975, pp. 39-40).

During these developmental phases, considerable overlapping occurs and no one phase is completely replaced by another (St. Clair, 1996). In addition, Mahler et al. (1975) detailed the two developmental tracks of separation–individuation as follows:

    One is the track of individuation, the evolution of intrapsychic autonomy, perception, memory, cognition, reality testing; the other is the intrapsychic developmental track of separation that runs along differentiation, distancing, boundary formation, and disengagement from mother (p. 63).

In marital therapy Mahler et al.’s (1975) model has been used to describe how couples with deficits in interpersonal communication ascribe blame for relationship problems to negative characteristics of their spouse, while repeating outmoded intrapsychic and interpersonal coping strategies. To resolve their issues they will continue to use those schemas that may previously have been important, but that no longer meet the couple’s current relational needs or expectations (Sharpe, 1997).

Sharpe (1997) described how conflicted couples experience specific impasses or themes that progress along a developmental continuum. In Sharpe’s model, four basic couples were formulated:
the symbiotic couple;
the oppositional couple;
the gender competitive couple, and
the Oedipal couple.

In Bader and Pearson’s (1988) model, five stages were formulated:

symbiosis;
differentiation;
practicing;
rapprochement, and
mutual interdependence.

_A developmental approach to relational psychopathology._

Because these stages enable the therapist to conceptualise the couple’s level of self and object differentiation and the couple’s level of self-esteem, the importance of these stages for marital therapy requires closer examination. The relationship between the models of Sharpe (1997) and Bader and Pearson (1988) and the role they play in the theory underpinning the model of personality and psychopathology in this marital therapy are now considered. A discussion of the specific developmental themes, and the conflicts and defences that reflect the couple’s most prominent mode of object relating follows.

_The symbiotic stage (The Symbiotic Couple)._  
Symbiosis denotes the first stage in the intrapsychic process of separation–individuation where, in the end, the infant achieves a sense of separateness from the mother. Mahler et al. (1975) defined symbiosis “as an intrapsychic rather than a behavioural condition” (p. 8). This developmental milestone represents the child’s movement to an increased awareness that the mother exists as a separate gratifier of needs. Mahler et al. (1975) described the symbiotic phase as one of the ‘basic building blocks’ of emotional attachment. Like Bowlby, Mahler et al. (1975) observed that the establishment of a sense of separateness from, and relation to, a world of reality, reverberates throughout the life cycle. It is never finished; it remains always active; new phases of the life cycle see new derivatives of the earliest processes still at work (p. 3).

The significant feature of the symbiosis stage of Mahler et al. (1975) for marital therapy is a state of merger (Dicks, 1967).
In the initial stage of the transition to being a couple, Sharpe (1997) noted how if couples remain symbiotically entwined, they will be unable to integrate the most fundamental relational capacity to have trust in the self and in their world-view. But as the partners start to develop a growing awareness of separateness, their symbiotic wishes for merger inevitably become frustrated. Each partner’s ability to tolerate and preserve separate thoughts, wishes and emotions begins to dominate.

This experience may be due to extreme and unrealistic expectations about their relationship and their partner. Others may have deficits in their self-esteem or sense of self. They may struggle to adapt and may cope by exhibiting an extreme form of mutual dependance. Such a lack of inner resources, results in the slightest disagreement being experienced as disregard or rejection (Bockhus, 1993).

According to Bader and Pearson (1988), partners who remain in symbiotic enmeshment present with two possible forms of dysfunction: “as enmeshment characterised by merger, avoidance of conflict and minimization of differences; or as hostile–dependent, which is dominated by anger and conflict” (p. 10). The symbiotic couple provide starkly polarised and split internal worlds.

The hostile–blaming type can leave the therapist feeling unintegrated, disorientated, and uncertain. The therapist may feel repelled by the couple’s internal confusion and chaos. The transference induction toward the therapist may be that the therapist becomes the “omnipotent, all giving, all-wise, constantly available mother who will be able to meet all the couple’s needs” (Sharpe, 1997, p. 45). By contrast, the symbiotic or pseudo–mutual couple, who have split off and displaced all the bad representations into a third party, do not feel initially so invaded or assaulted by any eruption of hostility. In couples with this presentation, the initial countertransference induction becomes: “we will take care of you, make you feel special, if you take care of us and save our relationship” (Sharpe, 1997, p. 48).

There are two major predictors of relationship dissatisfaction in this stage. The first predictor is the partners’ capacity to balance individuality and mutuality in their interaction. Partners who have not mastered the task of interpersonal closeness become anxious at entering into agreements and obligations. The second predictor is that partners who have not mastered the task of individuation become anxious at the prospect of differences and separateness (Gilbert & Shmukler, 1996, p. 60).
This results in poor affect regulation (high neuroticism) and in the “inability to respond constructively to negative feelings such as anger, sadness or frustration” (Halford, 2000, p. 60). Negative expectations and communication deficits make such an impact that the partners remain locked in endless rounds of mutually inflicted pain. Couples in this relational stage become “too terrified to end the relationship and not mature enough to end the battles” (Bader & Pearson, 1988, p. 10).

Working with couples in this developmental stage requires the therapist to gain an understanding of the pain and anger associated with each partner’s separation anxiety, particularly the internalised object representations associated with maintaining secure emotional ties. Couples who have been in a long-term symbiotic enmeshed relationship may present with a symptomatic child or with depression in one partner. Because of the primary defences of distancing and hostility, and the primitive behaviour that results, the therapist needs to provide the hostile–dependent couple with structure and containment (Bader & Pearson, 1988).

The differentiation stage (The Oppositional Couple).

The association between relationship satisfaction and childhood development can be found in Mahler et al.’s (1975) phase of differentiation. This refers to the process whereby the child starts to separate and assert his or her autonomy, while at the same time still relying on the mother’s presence. Bader and Pearson (1988) described this phase as

- a developing aggressive drive, including the need to experience developing functions and abilities; the increasing interest in the external world, with the father acting as the bridge into that world and stimulating the child’s interest in it; and the mother’s ability to allow separation and to become supportive of the separation-individuation process at a phase-appropriate time (p.100).

The behavioural, cognitive and affective characteristics of couples in this stage evolve over issues of dependence and independence. Conflicts are likely to arise as couples seek to re-establish their own personal limits or boundaries within the relationship. As the romantic fantasy of the symbiotic stage starts to fade, differences between the partners start to emerge. For couples with poor communication skills, unrealistic expectations and inflexible coping patterns, aggression is likely to surface. By contrast, couples with more effective coping patterns will be able to support each other in the separation process. This results in a mutative experience where earlier internal working models of self, other and context are reworked (Bader & Pearson, 1988).
For some couples, this developmental stage highlights the partners’ unresolved issues or anxieties around separation or abandonment. One partner may live in constant fear of abandonment, while the other feels constrained by the demands of his or her partner to remain emotionally bound to him or her (Gilbert & Shmukler, 1996). Collusive splitting, or the defences aroused by the dependence–independence conflict, usually occurs in the form of one partner becoming increasingly frustrated and disappointed. Negative experiences such as these may result in the disappointed partner becoming dependent. They may become needy and in pursuit of the other partner who, on the surface at least, appears to be more independent. Given that certain aspects of the couple’s expectations are not likely to be met, one partner typically acts as the critical controlling demanding parent, whereas the other acts out the role of the irresponsible child or teenager (Gilbert & Shmukler, 1996).

Couples with acute and chronic patterns of emotional expression such as these present with feelings of loss, grief and betrayal (Bader & Pearson, 1988). Unless both partners differentiate from their families of origin, they will not be able to establish themselves as a couple in their own right. Instead, they are likely to repeat dysfunctional family patterns. Given the low level of emotional and relational satisfaction in this stage, in therapy emphasis is placed on the need for both partners to articulate clearly their feelings so that they can achieve a greater sense of self-reliance. In other words they must accept each other’s need for exploration, without feeling rejected or hostile.

Sharpe (1997) found that the highly conflicted emotional milieu associated with this developmental stage could leave the therapist feeling that they are oscillating between two polarities. On the one hand they may feel they are being dominated, taken-over, told what do or criticised. Alternatively, they find themselves forced into battles for control and domination. Since the process of differentiation is associated with high levels of emotional conflict, fear (or anxiety) both in the partners and in the relationship, the therapist needs to feel comfortable with allowing the conflict to surface (Sharp, 1997).

*The practising stage (The Gender Competitive Couple).*

In the practicing sub-phase, Mahler et al. (1975) described how “the smoothly separating and individuating toddler finds narcissistic solace for the minimal threats of object loss – which probably each new step of progressive development entails” (p. 71). The child increasingly ventures away from the mother, becomes absorbed in its own activities returning periodically for emotional or physical ‘refuelling’. Children who are better able to separate from the
mother without straining their resources are also more able to separate out and differentiate their self-representation (St.Clair, 1996).

To understand more clearly this period of development, Mahler et al. quoted Kierkegaard (1846, p. 85).

He supports himself by the arms that do not hold him and constantly strives towards the refuge in his mother’s embrace, little suspecting that in the very same moment that he is emphasizing his need of her, he is proving that he can do without her, because he is walking alone (cited in Mahler et al., 1975, p. 73).

In object relations terms the issues of fusion and engulfment predominate the couple’s interaction in this stage (Bader & Pearson, 1988). As one or both partners seek greater autonomy, they begin to assert their individuality. For example, they may seek a greater input in bringing up children or in pursing their own careers.

One of the outcomes of these relatedness–autonomy strivings is that the partners become less attuned to each other. Partners will tend to spend less time together, and become less willing to do so; they have difficulty consolidating their gains, or building new or shared interests (Bader & Pearson, 1988). The greater the fear of engulfment, the less satisfying the relationship and the more negative the partners become.

Characteristic of couples during this stage is the drive to maintain attachment while maintaining a sense of separation. The issues associated with establishing a separate, yet integrated, relational identity can be encapsulated in the common presenting issue: lack of communication. Since one partner seeks to establish a separate sense of self, the primary treatment goal for couples in this stage is to balance both sets of needs. In this way, participation in the therapeutic alliance can reduce their defensiveness, and create a safer climate and increase self-understanding (Bader & Pearson, 1988).

Sharpe (1997) called partners in this stage of development the ‘gender competitive couple’. By contrast to couples in the symbiotic or differentiation phases, couples do not usually exhibit the extremes of marital boundary problems in the practicing stage. Because of their pervasive need for admiration and competition, they have usually attained a more individuated sense of self and more stable object constancy (Bader & Pearson, 1988). Whilst these couples initially appear more likeable and engaging, they continually require their narcissistic needs for admiration and confirmation to be affirmed.
From a transference perspective, Sharpe (1997) stressed how these partners will typically arouse feelings of insecurity or inferiority in the therapist. In addition, they will need to prove their competence to therapists and will attempt to be admired by them. Sharpe (1997) noted that while a couple’s behaviours that invoke these reactions in the therapist are hard to pinpoint, the partners would project their shared insecurities and competitiveness in the transference by certain subtle and not so subtle putdowns. Because of the marked competition between the couple, Gilbert and Shmukler (1996) observed that in this stage, treatment focuses more on the process of the conflicts, rather than their content.

The rapprochement stage (The Oedipal Couple).

In the rapprochement phase of Mahler et al.’s model, the young child learns to alternate between experiences of increased intimacy and increased independence. The achievement of individuality begins to develop and with it “an increased capacity to tolerate the delay of gratification and to endure separation” (p. 116). While the child requires the mother to be emotionally available, they need to be comforted only at specific times.

For the child to obtain optimal senses of self and functioning, he or she requires the mother’s continuing emotional support (Bader & Pearson, 1988). At the same time, the father of the child begins to play a more central role in his or her development. The successful completion of this stage of the child’s psychological development involves the ability to form and carry internal images, remembrances and relational expectations, even when the object is absent (Bader & Pearson, 1988).

Sharpe (1997) described couples in this developmental stage, as the ‘Oedipal couple’. Couples who successfully negotiate this stage will have resolved their earlier issues around emotional closeness, fears of abandonment, or the discomfort associated with feeling engulfed. According to Gilbert and Shmukler (1996), as partners negotiate the ability to be attached yet remain independent, they present for therapy as more adult and more able. These couples constantly engage in self–other internalisations that complement and enhance each other’s respective identities. This results in a greater sense of security and mutuality, and creates the potential for increased self-development (Gilbert & Shmukler, 1996).

Conversely, couples with remaining psychological, emotional or situational vulnerabilities present with resentments that have built up over the years. In the Oedipal couple, one partner may feel left behind, or left out. These feelings may be due to their weak ego identity, negative attributions, or real failures of the environment such as a history of psychological
disorder, histories of depression, alcohol or substance abuse (Halford, 2000). Alternatively, these feelings may be due to the absence of one partner because of career pressures, a preoccupation with other interests, or over involvement with children.

A major and distinguishing strength of these couples is their capacity to experience feelings of love and hate toward their partners, without resorting to splitting (Sharpe, 1997). This apparent endurance is because they have stopped projecting their inadequacies, or blaming their spouse for everything that is wrong. Such a presentation can evoke an idealising countertransference in the therapist: they become the therapist’s favourite couple, or children, with the therapist in the role of the ‘doting parent’ (Sharpe, 1997). Given the poor conflict management and communication skills likely to be involved in this presentation, the therapeutic task becomes one of bringing the couple back together in a new way (Gilbert & Shmukler, 1996). Such an intervention involves having both partners recognise the other as a separate individual whose wishes do not always coincide with their own.

Mutual interdependence.

Couples who have reached this stage in their intimate relationship enter what Bader and Pearson (1988) described as a ‘phase of constancy’. In developmental terms, this stage has its antecedents in the child’s ability to attain a degree of object constancy and the consolidation of individuality (Mahler et al., 1975 p. 109). Pollack (1990) summarised the achievement of this developmental stage as the necessity to gain a balance between the “capacity to remain related and connected to significant others”, and the capacity of the partners to “develop a sense of self-focused interest and achievement” (p 319).

The achievement of a mature loving relationship is expressed in something that Mahler et al. (1975) observed:

In the state of object constancy, the love object will not be rejected or exchanged for another if it can no longer provide satisfactions; and in that state, the object is still longed for, and not rejected (hated) as unsatisfactory simply because it is absent (p. 110).

An understanding of attachment processes, interpersonal anxieties and the stages of childhood and disturbed adult relationship development, all combine to represent an integrating concept as described by Lindegger and Barry (1999). The way the integration of these concepts from object relations, attachment, interpersonal, object relations theories as they apply in this model of marital therapy, is set out in Table 2.1.
Table 2.1

*The Integration of Concepts from Object Relations, Interpersonal and Attachment Theories*

<table>
<thead>
<tr>
<th>Attachment Processes:</th>
<th>Interpersonal Anxieties:</th>
<th>Stages of Childhood Development:</th>
<th>Stages of Disturbed Adult Relationships:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bowlby</td>
<td>Blatt</td>
<td>Mahler</td>
<td>Sharpe</td>
</tr>
<tr>
<td>Protest</td>
<td>Trust</td>
<td>Symbiosis</td>
<td>The Symbiotic Couple</td>
</tr>
<tr>
<td>Separation Anxiety</td>
<td>Caring</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dependability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Despair</td>
<td>Intimacy</td>
<td>Differentiating</td>
<td>The Oppositional Couple</td>
</tr>
<tr>
<td>Grief &amp; Mourning</td>
<td>Sexuality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Detachment Defence</td>
<td>Autonomy and Control</td>
<td>Practicing</td>
<td>The Gender Competitive Couple</td>
</tr>
<tr>
<td></td>
<td>Self Worth</td>
<td>Rapprochement</td>
<td>The Oedipal Couple</td>
</tr>
</tbody>
</table>

Sources: Bowlby (1961); Blatt (1995); Mahler et al. (1975); Sharpe (1997)

In this chapter the theoretical concepts underlying the model of personality and psychopathology were reviewed. It was demonstrated how the integration of attachment theory provided an alternative conceptual framework for the treatment of differing expressions of marital psychopathology and disturbance. In the next chapter the way these theoretical constructs interact with the time limitation and the structured therapeutic focus of the treatment to create therapeutic change are discussed. The ways the praxis or the experience of participating in the therapy can be explained by reference to the concept of the phases of mourning – protest, despair and detachment (Bowlby, 1961) – are described.
CHAPTER 3

The Theory of Change the Model Endorses

Overview

Interpersonal theory and attachment theory have much in common, particularly in regard to the role of anxiety and fear in regulating interpersonal relations. This chapter provides an understanding of the way attachment, as an integrating factor in the marital therapy, gives rise to a different view of the role of separation anxiety in conflicted interpersonal relationships. The introduction of the construct of attachment also provides an alternative view of the therapeutic process and the intrapsychic and interpersonal processes that flow from it. It results in an understanding of therapeutic change as three separate yet related mourning processes. The first phase of mourning is one of protest, the second is one of despair, and the third is one of detachment (Bowlby, 1961). Such an understanding of the praxis provides a framework for the therapist within which to better conceptualise individual attachment styles, to gain a new perspective on the internal working models of the partners, to direct interventions and to evoke therapeutic change.
The Theory of Change the Model Endorses

The introduction of attachment theory in the conceptual framework of this time-limited marital therapy gives rise to a different view of the role of separation anxiety in conflicted interpersonal relationships. A metatheory of internal object relations in dynamic interplay with current interpersonal experience helps to explain how each partner’s relational need has its roots in their earliest experiences, which in turn become bound up with their deepest and unconscious feelings (Klein, 1993, p. xv). At the same time, the model privileges the psychosocial and other real failures of the environment.

Such an integrated metatheory emphasises how each partner has been shaped by, and inevitably becomes embedded within, a matrix of relationships, struggling both to maintain ties to others and also to differentiate from them. Hence, the partners’ feelings of inequality, powerlessness and helplessness assume relevance in treatment and process. To focus on the couple’s interpersonal processes without the context of their past and present relationships would remove them and their dysfunction from a context that would provide enhanced understanding of the couple (Mitchell & Black, 1995).

In clinical practice, partners who have experienced developmental failures can retain a “pathological degree of depression, which remains encapsulated within the personality without the signs typically associated with clinical depression” (Dujovne, 1990, p. 476). It is not until the individual is once again threatened with reattachment to a love object (partner or therapist), that this paradoxical sadness begins to reappear (Dujovne, 1990). As processes akin to mourning become activated in psychotherapy, it is difficult for the therapist to differentiate between grief reactions and depressive disorders. Della Selva (1995) used the term ‘facilitating grief’ to describe the therapeutic work required to access previously inaccessible feelings, memories, or ideas.

Pistole (1994) demonstrated how in intimate relationships attachment theory helps the therapist to organise behaviour and feelings in a way that matches such experience. The theory provides, an effective working model to intervene and change the partners’ awareness of self and other. Attachment theory is therapeutically useful since the working model provides both cognitive and affective points for intervening and changing awareness of self and partner. Therapeutic work on the various components of the client’s working model can facilitate change in dyadic struggles (Pistole, 1994, pp. 52-53).
The integration of attachment theory gives rise to a different view of the therapeutic process and the intrapsychic and interpersonal processes that flow from it. An understanding of the couple’s object relations constellation provides the therapist with a framework to conceptualise individual attachment styles, to gain a new perspective on the internal working models of the partners, to direct interventions and to evoke therapeutic change. A description of the therapeutic change process that flows from this conceptualisation follows.

The Praxis

Although psychotherapy is effective for a wide variety of conditions, research has largely failed to isolate conclusively the specific mechanisms that produce positive therapeutic outcomes. Instead, what works for whom and under what circumstances continue to attract debate (Larner, 2001). Richards (2001) conducted a review of the published meta-analyses to identify the differences and effectiveness of psychotherapeutic interventions, techniques and treatment outcomes. Richards concluded that irrespective of the method adopted, people who receive some treatment are better off than those who receive none.

By contrast, Andrews’ (2001) research into the most effective therapeutic mechanisms led him to identify three predictors of therapeutic change. These mechanisms are therapist variables, therapeutic systems and the therapeutic alliance. Andrews (2001) concluded that there is “convincing evidence for conceptualising psychotherapy as a reciprocal influence process that includes therapist variables and specific intervention systems within the context of a therapeutic alliance” (p. 107).

The problem of defining the process of therapeutic change in psychotherapy, as distinct from defining the content to be changed, continues to concern the profession (Held, 1991). Bradbury (2000) observed that “despite some advances, these processes are not easily studied, and a comprehensive understanding of them is not yet to hand” (p. 965). Crowell and Treboux (1999) suggested that the test of a theory depends on the possibility of assessing its theoretical constructs. Held (1991) argued that without processes to implement change, purported systems of psychotherapy are nothing more than theories of personality and psychopathology. Hence, while content predetermined by a theory of personality and psychopathology may or may not be desirable, a specified change process is necessary to qualify a theory as a theory of psychotherapy (p. 207).
Ultimately the goal of therapy is to achieve change. The process of therapeutic change requires an understanding of both what is said and what is done. Eisold (2000) in discussing the psychoanalytic praxis identified three parts:

(1) The task of identifying the unknown, that which needs to become known, the area or location of work, (2) The role of anxiety as the guardian, so to speak, of that which is being kept unknown, (3) The creation of the mental reflective space required for its emergence (p. 62).

Levenson (2001) suggested that the act, the praxis – “the inquiry, association, dreams, fantasies, and the reiteration of those themes in the behavioural field of patient and therapist, in the office and as it extends into their private worlds – is the cure!” (p. 250). In this model three specific yet related mechanisms contribute to the praxis or the experience of participating in the therapeutic process. In this therapy the following factors combine to bring about change – the time limitation, the structured clinical focus of each session, and the therapeutic alliance.

The Psychological Processes Aroused by the Experience of Separation and Loss

The integration of attachment therapy results in an alternative understanding of the therapeutic praxis. The concept of psychotherapy as a developmental process that passes through a series of three stages usually defined as beginning, middle and termination, is not new (Horowitz, 1990; Mann, 1973; Molnos, 1995; Usher, 1993). Although stage theories have been questioned, Thomas and Siller (1999) noted that the idea of an unfolding sequence of unvarying process retains much appeal for appreciating the temporal nature of object loss. The practice of time-limited therapy touches upon many old feelings and important memories that become focused upon and worked through (Molnos, 1995). Mann (1973) wrote of the therapeutic value of a time limit to treatment and assigned a central role to the issues of loss, which are brought to the fore by a set limitation of time.

Bowlby (1961) wrote of the intimate relationship between separation anxiety, grief and mourning. Bowlby described how the experience of mourning applies equally to infants, young children over six months and adults. “At all ages, we now see, the first phase of mourning is one of Protest, the second one of Despair, and third one of Detachment” (Bowlby, 1961, p.338). These three types of response “are phases of a single process and that when treated as such each illumines the other” (Bowlby, 1960, p. 91).

Given the appropriation of Bowlby’s stages of mourning to explain the therapeutic change process, the following definition of mourning, grief and depression, will be adopted:
‘Mourning’ will be used to denote the psychological processes that are set in train by the loss of a loved object and that commonly lead to the relinquishing of the object. ‘Grief’ will denote the sequence of subjective states that follows loss and accompany mourning. ‘Depression’ is used to describe an affect that, it is held, is as integral to psychic life as is anxiety (Bowlby, 1961, p. 318).

The process of change being suggested here is that during the first stage of treatment, the time limit keeps the couple present focused, containing the couple’s separation anxiety, and creating a sense of hopefulness. During the second stage of the therapy in which the couple become past focused, the couple’s growing disappointment in the process turns to despair as they realise that neither the therapist nor their partner can take away the pain associated with their present and past emotional losses. During the third stage of the therapy that keeps the couple future focused, an experience of detachment occurs. The couple’s capacity to adapt to the disappointments, anger and sadness associated with the past are confronted as issues of self-differentiation are focused upon.

The reciprocal influences of these mechanisms, together with the exploration of each partner’s interpersonal relations, family dynamics and cognitive processes, result in a stage-related praxis. As each successive stage of the therapy unfolds, the therapeutic reconstruction, revision, integration and abstraction associated with object loss and the subjective states associated with it, become open to interpretation. From a psychoanalytic standpoint, the process of mourning includes affective, cognitive and behavioural components (Buechler, 2000).

The Stages of the Therapy (Protest – Despair – Detachment)

In the initial stage of the therapy, where the emotional reactions of separation anxiety predominate, the mourning processes aroused in the couple by the therapeutic process are associated with protest. These emotions can be related to retaliation and rebellion and include direct and indirect methods of externalised anger and aggressiveness. These defensive behaviours serve a twofold purpose. First, they provide a way whereby one or both partners make further despairing attempts to gain their partner’s attention. Second, this behaviour provides a defensive escape for the individual and the couple, as they wrestle with the denial (real and unconscious) of the losses and changes in the relationship.

In the second stage of the therapeutic process the couple begin to experience feelings associated with the mourning process of despair. These feelings are due to the realisation that neither the partner nor the therapist appears able to meet the partners’ emotional needs. Here
the partners’ internalised anger is likely to surface, with depression the predominant emotional reaction.

The third and final stage in the evolutionary process involves the couple in the mourning processes associated with *detachment*, thus allowing for a reintegration or reorganisation of the self to take place. The activation of these mourning processes involves the partners in three grief reactions: grief over the perceived loss of a love object, grief over loss of the old self, and grief over the loss of potential (Magnavita, 1997).

It would be wrong to suppose that there are no differences in determining the course of the change. These three modes of experience are not just stages in the couple’s development, where one mode is transformed into the next, thereby resulting in a more advanced relationship. Instead, these predominant modes of interpersonal experience can exist side by side and may continue to organise and disorganise the relationship. In discussing a phase-specific model of mourning, Horowitz (1990) observed that “no one person must necessarily follow the order presented or even experience all of the phases” (p. 301). Personality style, current conflicts, the developmental level of the personality and the social context, all affect the modes of experience (Horowitz, 1990).

In this marital therapy, an understanding of the immediate impact of object loss and the influence of the effects on development of earlier and subsequent object loss, provides a developmental clinical framework (Thomas & Siller, 1999). Much psychotherapy, and models not explicitly directed toward the resolution of grief, is concerned with undoing the denied loss experienced throughout life (Della Selva, 1993). According to Thomas and Siller, the ability to help people adjust to object loss and the resolution of the mourning process are among the most important conditions for clinical success. Successful treatment outcomes also involve the processes of accepting the “new reality”, and focussing on forward-moving goals, and their emotional investment.

To understand the processes of mourning that become aroused by the praxis, a discussion of the progression of change follows in the next subsection about the role of time.

The clinical focus of each session, the phases of the therapy and the treatment focus are shown in Table 3.1.
Table 3.1

The Structured Treatment Focus

<table>
<thead>
<tr>
<th>Session</th>
<th>Clinical Focus</th>
<th>Treatment Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Present Focus</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One</td>
<td>Separation Anxiety</td>
<td>Defensive Restructuring</td>
</tr>
<tr>
<td>Two</td>
<td>Interpersonal Processes</td>
<td>Defensive Restructuring</td>
</tr>
<tr>
<td><strong>Past Focus</strong></td>
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<td></td>
</tr>
<tr>
<td>Three</td>
<td>Unconscious Influences</td>
<td>Cognitive Restructuring</td>
</tr>
<tr>
<td>Four</td>
<td>Inner Working Models</td>
<td>Cognitive Restructuring</td>
</tr>
<tr>
<td><strong>Future Focus</strong></td>
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<td></td>
</tr>
<tr>
<td>Five</td>
<td>Intersubjectivity</td>
<td>Affective Restructuring</td>
</tr>
<tr>
<td>Six</td>
<td>Existential Anxieties</td>
<td>Affective Restructuring</td>
</tr>
</tbody>
</table>

The Role of Time in the Change Process

The recognition of time as a contributing factor in the treatment of psychoneurotic disorders has been acknowledged (Osimo, 1991). As psychoanalysts developed their ability to treat neurotic disorders, so too did the length of treatment expand and anything less than a few hours per week over several years was considered inadequate (Kalpin, 1993). As changing social and health contexts have altered the way psychotherapy is practised, the issue of time has assumed greater importance. Molnos (1995) has argued that the universal pull toward longer rather than shorter therapy is the consequence of the concept of time itself.

The Role of Time in the Development of the Personality

The relationship between time and death is a recurrent theme in the history and philosophy of science. Many authors treat time as a mental construction that operates as an important existential variable (van Bragt & Hesselink, 1993). The perception of time influences the way people experience and appreciate self and others (van Bragt & Hesselink, 1993). Heidegger (1964) wrote that the only reason for individuals to perceive time is because they know that they have to die.
Boss (1979) in discussing the existential foundations of medicine and psychology noted how human beings are in some form of permanent relationship with time. Although they have been familiar with time from their beginnings, Boss (1979) observed that individuals seldom pay particular attention to time, or their relationship with it (p. 93). Mann (1973) made the distinction between ‘categorical time’ (adult time) and ‘existential time’ (child time).

Categorical time relates to the time of the clock and the calendar. It is the recognition of the limits of time and the ultimate separation that death brings. Existential time incorporates the special paradise of the child, a timeless paradise where time seems infinite and the future is forever beyond reach (Mann, 1973). To explain the parallels between conceptions of time and conceptions of change, Mann (1973) cautioned that most people presenting for therapy are in existential time. That is, they will avoid making decisions or refuse to take responsibility for themselves.

Bowlby (1960) observed children’s emotional reactions to temporary deprivations; and these demonstrated the effect of time on a child’s emotional development. In the development of the personality, Lachmann (2000) observed, “the sense of self is constructed and integrated along an axis of time” (p. 52). Molnos (1995) wrote how the two stay closely linked in later life and affect the perception and handling of real time. According to Molnos (1995) the fear of losses, separations, endings and ultimately the fear of death, account for the individual’s escape into feelings of timelessness.

The Limitation of Time in Therapeutic Practice

The compression of time affects therapeutic outcome, the pace of the therapy and the rate of change (van Bragt & Hesselink, 1993). Kalpin (1993) suggested that the existence of a known time limit is a significant factor in bringing about therapeutic results. Molnos (1995) observed that by manipulating the sense of time it is possible to catalyse a meaningful sense of time in the therapeutic alliance and to interact with the patient at greater depth (1995, p. 36). In Lachmann’s (2000) perspective, it is time itself that represents the vehicle for therapeutic action. Lachmann (2000) described the construction of themes that organise the treatment experience thus:

Time relationships, past, present, and future, are brought together. The past appears in the present in a new context, the new context revises the past, provides a new experience in the present, and more varied expectations of the future. As in early development, in psychoanalytic treatment the sense of time, temporal continuity, is interactively constructed (p. 39).
The experience of the compression of time creates the potential for past experiences of the self to be revived in the present. Larner (2001) noted the inter-relationships of the factors of meaning, language, culture, spirituality and relationship. In the context of marital therapy, the compression of time creates expectations that have the potential to mend the past. Messer and Warren (1995) viewed the existential aspect of this therapeutic experience as the need “to work toward facing up to the past in order to gain some mastery over the present and, in this way, to be freer to shape their future” (p. 204).

The Role of Time in the Brief Therapeutic Approaches

Over the past forty years, psychodynamically oriented therapists have developed various forms of brief therapy. Magnavita (1993) documented how the clinical and research data on short-term models of treatment support their effectiveness and the depth of change possible, within certain time constraints. However, the specific number of sessions required for effective treatment differs across the various models of treatment.

The time limit for Malan’s (1979) brief focal psychotherapy ranges between 20 to 40 sessions. Davanloo’s (1978) short-term anxiety provoking psychotherapy ranges between 20 to 30 sessions. Molnos (1995) made the observation that a therapy of 40 sessions or fewer can be called brief. Crits-Christoph and Barber (1991) found that good treatment results are documented in many cases with treatments of 20 sessions or less.

Even though the issue of time is central to all approaches of brief therapy, the subjective and objective meaning of time in the change process is not always clear. Messer and Warren (1995) made the point that much brief psychotherapy does not offer a theoretical rationale for the brevity of treatment or for the way the time limitation enhances the therapeutic process. The first exception to describe the time limit as a fundamental aspect of the method was Time-Limited Psychotherapy (Mann, 1973). In Mann’s model there is an unvarying constant of 12 sessions, whatever the presenting issue.

Mann (1973) provided a detailed description of the effectiveness of time as a therapeutic mechanism. He demonstrated how much of the therapeutic gain in brief dynamic therapy could be associated with the unconscious meaning of time in the development of the personality. Coherent with the view that the limitation of time represents an important change factor, Mann (1973) observed how a time-limited treatment format consists of three phases.

Osimo (1991), in discussing Mann’s phases, described how in the first phase the time limitation encourages feelings of omnipotence, creates an atmosphere of togetherness and
establishes positive transference feelings. In the second phase of treatment the patient’s sense of time gradually emerges. The final or termination phase activates issues associated with the forthcoming separation from the therapist and the losses and separations that have occurred in the past. Change is considered to occur as the therapist becomes internalised as a less ambivalent and less guilt-ridden object, thus making separation a genuine maturational event.

The Role of Time as an Agent of Change in this Marital Therapy

All analytic therapies, whether brief or longer term, are designed to help the individual explore and tolerate the emotional ambivalence aroused by wanting to be separate and yet remain attached (Molnos, 1995). Buchholz and Sorter (2000) noted how the developmental lines of attachment and separateness, or engagement and disengagement are inextricably related. Both are necessary and each augments the other. The experience of intimate attachment involves the partners in a process of loss. According to Mann (1981), each separation requires a giving up of someone or something.

Participation in this time-limited therapy requires the couple to work within a finite period. The manipulation of time as a meaningful agent of change increases the couple’s awareness of time and intensifies the therapeutic process (Molnos, 1995). It is proposed that by imposing a termination date at the outset, a parallel process is created. That is, the agreement by the couple to a time-limited contract allows the couple to address unexpressed concerns or anxieties, about their object loss, the relationship, and the future to be addressed.

This process results in a known, but unknown, acknowledgement by the therapist and the couple that therapy is finite, just as life is finite. The time-limited process challenges the partners’ unconscious to confront the anxiety and sadness that the threat of loss brings (Messer & Warren, 1995, p.178). The compression of time for therapeutic gain confronts the partners’ existential and primary anxieties as they search for increased interpersonal connectedness (Macnab, 1965). Concurrently, the compression of time confronts the couple with the need to address the issues and common dilemmas that lower their own and their partner’s self-esteem (Macnab, 1991).

The unconscious processes aroused by the compression of time set in motion a compelling need for the partners to seek, rediscover and symbolically reclaim aspects of self and other (Horowitz, 1990). To achieve this objective the clinical focus systematically addresses the partners’ present experience, past history and future directions. This existential focus serves to turn the couple’s attention away from their loss of connectedness (turning away from others),
toward the necessity to explore their relationship more fully with each other (being with others) (Macnab, 1965).

*The Processes Aroused by the Limitation of Time*

The mutative processes aroused by the compression of time extend the focus of the treatment to take into account the present context. Gurman (1981) found that in marital therapy, couples need to integrate what has gone before in their lives, to create for themselves a more accepting emotional environment and to tolerate separateness in one another. The time-limited therapeutic process encourages the partners to believe that change, re-orientation and improvement might be within their immediate grasp (Macnab, 1991).

These mutative processes have their parallel in Winnicott’s (1956) observation of the need in the infant to be emotionally and physically held by the mother. In Winnicott’s (1956) view, an appropriate holding environment provided by the ‘good enough’ mother facilitates psychic development. Such an experience allows a time-span in which the child learns to cope with his or her anxieties and to move toward a more differentiated object-related state. Ginot (2001) noted that the concept of the holding environment is based on Winnicott’s clinical observations of the need for the analyst to provide important parental functions that have been absent or grossly distorted.

At the same time, the process of the therapy may introduce iatrogenic affects (Molonos, 1995). The compression of time can intensify each partner’s anxieties about separation, loss, and the fears aroused by the conscious strivings to sustain a loving relationship. Solomon (1989) found that as couples become involved in therapy, they experience a number of affective, emotional, and feeling experiences that threaten their self-cohesion. She noted how archaic affects and defences begin to emerge as the couple are confronted with new challenges and new dangers.

In this model the time limitation addresses the couple’s heightened anxiety by providing a holding environment that creates the potential for the couple to experience loss in a healthier fashion. The evolutionary process aroused by the therapeutic experience allows the couple to “conjure the past into the present and work through it in the here-and-now” (Molonos, 1995, p. 66). Kupers (1988) described how self-actualisation, personal development and the achievement of independence, need not provoke anxiety and conflict. Instead, healthy reactions to loss and change entail a gradual emotional reorganisation and a refocusing of one’s attachment feelings (Karen, 1994).
The Phase Specific Therapeutic Process

The origins of a stage theory of adjustment to loss can be found in Freud’s (1917) discussion of the emotions that normally accompany mourning and trauma. In *Mourning and Melancholia* (1917), Freud presented a clear and consistent theory of mourning as the need to detach those feelings and attachments from the lost object. Freud described the process of mourning as a process of adjusting to loss by gradually shifting cathexis from the lost object onto new available objects. Freud (1917) wrote: “Mourning is regularly the reaction to the loss of a loved person, or to the loss of some abstraction which has taken the place of one, such as a fatherland, liberty, an ideal, and so on” (p. 153).

Freud distinguished between the process of mourning in which there is nothing unconscious about the loss, and melancholia, which is related to an unconscious loss of a love-object. About melancholia, Freud (1917) wrote:

> The object has not perhaps actually died, but has become lost as an object of love (e.g. the case of a deserted bride). In yet other cases one feels justified in concluding that a loss of the kind has been experienced, but one cannot see clearly what has been lost, and may the more readily suppose that the patient too cannot consciously perceive what it is he has lost. This, indeed, might be so even when the patient was aware of the loss, giving rise to the melancholia, that is, when he knows whom he has lost but not what it is he has lost in them (p. 155).

In *Processes of Mourning* (1961) Bowlby defined three phases of mourning and the adaptive processes associated with them thus. Phase one: Urge to recover lost object and Phases Two and Three: Disorganisation and reorganisation. In his earlier work *Grief and Mourning in Infancy and Early Childhood*, Bowlby (1960) presented evidence that the response to loss in children was substantially the same as when the older child or adult loses a loved figure (Bowlby, 1961, p. 317).

These clinical observations led Bowlby (1961) to provide an alternative conceptual framework to explain the underlying dynamics of love, grief and loneliness. Bowlby (1980) described the intense emotions that become aroused in the formation, maintenance, disruption and renewal of intimate relationships, particularly the anxiety and anger associated with separation. He characterised this process as follows:

> The formation of a bond is described as falling in love, maintaining a bond as loving someone, and losing a partner as grieving over someone. Similarly, threat of loss arouses anxiety and actual loss gives rise to sorrow; while each of these situations is likely to arouse anger (p. 40).
**The Processes of Mourning in the Therapeutic Process**

Much of the psychoanalytic literature on object loss focuses on the treatment of bereavement. Psychological stage theories of adjustment to loss describe variations in affect as the mourning process progresses. Many writers have contributed to the contemporary understanding of the psychological processes associated with mourning. Following Freud (1917), subsequent models of bereavement have differentiated specific phases of mourning and the psychological processes associated with grief (Bowlby, 1961; Horowitz, 1990; Lindemann, 1979; Kubler-Ross, 1969; Pollock, 1961; Thomas & Siller, 1999; Macnab, 1989).

Psychoanalytic theories of mourning have identified the emotional reactions associated with pathological mourning, as well as the psychological processes that enable individuals to respond to loss in a healthy manner. A review of the clinical and empirical literature led Baker (2001) to the following contemporary psychoanalytic conceptualisation of mourning: “Mourning is seen as a process of inner transformation that affects both the images of the self and of the object in the mourner’s inner world” (p. 55).

**The Process and Experience of Object Loss**

The psychodynamic treatment strategies intended to facilitate the psychological processes associated with object loss in marriage have not been so clearly explained. Models of psychological loss have used developmental perspectives and different terminology to explain the process and experience of object loss: denial, anger, bargaining, depression and acceptance (Kubler-Ross, 1969); outcry, denial, intrusion, working through, completion (Horowitz, 1990); shock, grief, pain, reaction to separation, beginning of object decathexis (Pollock, 1961); somatic distress, preoccupation guilt, anger and hostility and restlessness (Lindemann, 1979); numbing, yearning and searching accompanied by periods of sobbing and angry outbursts, despair and disorganisation and reorganisation (Bowlby, 1961).

Other psychoanalytic theories have been used to explain the transformative aspects of schemas in object loss. Baker (2001) pointed out how in the Kleinian model, reparation refers to the positive changes in the psyche that result from gaining a better ability to appreciate other people and other experiences in life. Thomas and Siller (1999) described the concept of ‘the work of mourning’ as the need for the person to absorb object loss and to reconstitute their self-image. From a reparative perspective, the internal separation–individuation process requires certain aspects of the self to undergo a process of adjustment, acceptance and adaptation (Thomas & Siller, 1999).
Psychoanalytic treatment strategies intended to facilitate, re-create or re-establish the mourning process do so

by the transference, analysis of defenses against mourning, re-grief therapy and linking objects or by creating a situation where the treatment process itself sets in motion the need to seek out and discover and symbolically reclaim the lost object (Thomas & Siller, 1999, p. 191).

An examination of the clinical literature shows few attempts to conceptualise the processes of grief and mourning aroused by the practice of marital therapy. In this model, the limitation of time arouses previously unacknowledged or unknown feelings in the partners concerning the lost objects of self and other. The process involves the couple in confronting those aspects of the self that keep them, “angry, hostile, aggressive, non-feeling and unempathetic and fearful of closeness and indeed unable to love in a mature way” (Foehrenbach & Lane, 1994, p. 40). Another way of perceiving the process is by having the couple gain a balanced relationship between their inner and outer objects (Baker, 2001). Baker summarised the end result of mourning as the ego becoming free from its former attachments and ready to attach to a new object. In this case, a different view of the self, the partner and the relationship emerges.

The Process of Working Through

In Dujovne’s (1990) view, a major task of psychotherapy with people who fend off love and pleasurable affect requires a return through the skipped phases of ‘protest’ and ‘despair’. The therapeutic process involves, “going through all the previously repressed sadness, rage, hopelessness and wishes for love” (p. 478). Foehrenbach and Lane (1994) argued that the process of inner transformation involves the working through of the interpersonal defences associated with barriers to love and the completion of the developmental stages left unfinished in childhood. This experience can be likened to a ‘working through’ process in which the partners’ schemas of self and other come into line with the demands of reality and their current situation (Horowitz, 1990).

Sullivan’s (1953) interpersonal theory and Bowlby’s (1960) attachment theory both emphasised that experiences with primary caregivers are carried forward in development as emotional–cognitive mental schemas (Cortina, 2001). These internalisations serve as templates that inform expectations, interpretation of events, interfere with new self-experience and inhibit the development of new ways of being (Hirsch & Roth, 1995). Sullivan (1953) and Bowlby (1988) emphasised different mechanisms by which these mental schemas are carried forward in development; “both acknowledge the importance of an exclusive attachment that ‘this person is special’ ” (Cortina, 2001, p. 197).
Horowitz (1990) noted that the term ‘working model’ applies to a transient schema that is based on immediate perceptions of external reality. Schemas have the potential to both organise and distort perception. Fonagy (1998) suggested that the internal working models in highly dysfunctional adult attachment relationships “may be the inevitable consequence of early attachment relationships that jeopardize the emergence of psychological functions essential for normal, intimate, interpersonal relationships” (p. 152).

The Three Stages of the Therapy

The mourning processes aroused by the time limitation in this model serve an evolutionary purpose. By passage through the stages of the therapy, the potential is created for the couple to make new commitments to each other and to accept new personal roles. This process involves an unconscious change in mental structures of meanings about the self, other and context (Horowitz, 1990).

The psychological processes aroused by the praxis of this therapy create the potential for the partners to become aware that traumatic events from the past can be integrated if not repaired (Kaplan, Sadock & Grebb, 1994). Such an experience has the potential to create an environment for the partners to participate in what Levenson (1995) stressed were the hallmarks of the brief psychodynamic therapies — new understanding and new experience. Gurman (1981) noted that in marital therapy this requires the achievement of “two clinically interrelated, yet conceptually separable goals: more accurate interpersonal perception, and more whole self-experiencing” (p. 433).

A description of the overall progression of change through the stages of the therapy follows.

Stage One—Protest

*The Desire for Merger*

A basic assumption underpinning stage one of the therapy is that the desire for merger with an exclusive other is a normative process that occurs throughout the lifespan (Alperin, 2001). Ainsworth’s (1989) discussion of attachments beyond infancy confirmed how positive affectional bonds inspire trust and provide a ‘secure base’ from which individuals gain confidence. The experience of merger, continuing contact, the sharing of experiences and the giving of affection provide comfort and a sense of security.
Charles (1999) described the promise of love or the continuing search for relief and understanding as the greatest of lures. The fantasy that one might be transformed or healed through the love of some perfect other is what Bollas (1987) called the search for the transformative other. The search for a transformative object requires a shift from an external search to an internal one, that is, to a loving internalised representation of a ‘good enough’ object, thus increasing the individual’s capacity for greater self-reflection and understanding. The sometimes desperate search for the unattainable external transformative object has with it painfully regressive yearnings for transformation from outside (Charles, 1999).

Alperin (2001) recorded how the desire for intimacy has its origin in Mahler et al.’s (1975) symbiotic period. Subsequent contributions to the understanding of psychological processes by researchers of infant behaviour such as Stern (1985) found that this period can be characterised by moments of merger, rather than a permanent state of merger. According to Alperin (2001), because of the affective centrality and lasting significance of these moments of merger, the desire to return to a benevolent sense of oneness is not only universal, it remains eternal. The experience of merger requires the individual to tolerate momentary losses of self and the sensations that blur the distinction between self and other.

The normal wish for comfort and the feeling of pleasure that merger brings can be a source of intense anxiety. In discussing the barriers to intimacy, Alperin (2001) suggested that there are a number of anxieties that make problems with intimacy universal. Included in these barriers are intrapsychic conflicts such as fear of fusion, fear of object loss, paranoid–schizoid and sexual anxieties. The more pathological the anxiety, the more primitive the corresponding defences (Alperin, 2001).

The concept of merger helps to explain how the couple’s presenting issues represent both a form of communication and an increasingly sophisticated response for the partners’ presence and attention (Bowlby, 1980). In conflicted intimate relationships the partners’ distress becomes heightened, as they become increasingly aware that their partner is no longer emotionally available to them. For partners with less permeable ego boundaries, there is the intense emotion associated with loss, separateness and the fear of abandonment.

**Loss of the Love Object**

The first phase of the mourning process is associated with a searching for the lost object. In psychoanalytic models of mourning, this period is associated with the phase of denial (Horowitz, 1990); feelings of internal loss, (Pollock, 1961); separation anxiety (Bowlby,
1961) adjustment (Thomas & Siller, 1999) and anxiety of lost coherence and emptiness (Macnab, 2000a). Various defences are used to reduce emotional flooding, emotional numbing and to reduce the alarm reactions that characterise the early phase of mourning. Bowlby (1961) found that “repeated disappointment, weeping, anger, accusation and ingratitude are all features of the first stage of mourning. They are to be understood as expressions of the urge to recover the lost object” (p. 334). Macnab (1989) wrote how some losses leave people, numb, depressed and with no fantasy about the future.

As in death, the loss of the object of love is responded to at first with denial. Bowlby (1961) described how the individual’s thoughts, feelings and behaviours are organised to achieve reunion. Weeping and anger are considered the major methods of trying to recover the lost object. These behaviours have their origin, Bowlby (1961) pointed out, because of their earlier ability to gain attention, comfort and the return of the loved (m)other.

According to Dujovne (1990) people who have experienced developmental failures use hostility, anger or aggression as a barrier to the giving and receiving of love. Foehrenbach and Lane (1994) found how hostility could act as a defensive manoeuvre, both within the therapeutic setting and in the external world. According to these authors,

there are both direct (more open) and indirect (more covert) forces operating within the patient that oppose the process of growth. The fending off of love and of pleasurable affects, perhaps even the ability to feel anything positive at all is frequently a predominant behaviour (p. 25).

Looked at in this way, the disappointment, anger and hostility evident in marital conflict can be explained in attachment terms by describing how the threat of loss reduces the couple’s sense of safety. ‘Outcry’ is the term Horowitz (1990) used to describe the strong feelings associated with the immediate response to object loss. Horowitz (1990) wrote that while the purpose of these defences is to ward off pain, they are usually unconscious and the person may not know what it is that is being warded off.

Stage Two—Despair

The emotions aroused in the second stage of the therapeutic process can be likened to the feelings of disappointment when hope for reunion with the love object starts to fade. As the hope for a better relationship engendered by the first two sessions begins to diminish, feelings of disillusionment and disappointment with the process begin to predominate. Once the partners begin to realise that the relationship cannot be recovered in the way that one or both people hoped for, a form of emotional despair emerges. Another explanation for this reaction
could be the growing recognition that their partner appears resistant, unwilling, or unable to change.

The Experience of Depressive Affect

Bowlby (1960) described the emotional distancing that takes place in children when the intense activity involved in attempting to be reunited with an attachment figure is unsuccessful. Passivity, withdrawal, and obvious sadness were found to be common emotional experiences characteristic of children left alone for extended periods (Hazan & Shaver, 1989). Such a conceptualisation leads to a consideration of depression as the affect most likely to be experienced in this stage of the therapy.

Bowlby (1961) observed that the depressive phase of mourning is probably no different from depression in other situations:

It is a view of depression which sees it, like separation anxiety, as an inescapable aspect of life and in that sense as normal. Looked at in this way the behavioural processes going with depression can be seen to have an adaptive function; whilst the painfulness of mourning and other forms of depression becomes more comprehensible. Since the patterns of behaviour which have grown up in interaction with the lost object or goal have ceased to be appropriate, were they to persist they would be maladaptive: only if they are broken down is it possible for new ones, adapted to new objects, to be built up (p. 335).

In adulthood, depressive behaviour is likely to emerge when an attachment bond is severed, or when affective needs are unacknowledged or misinterpreted. Beach, Sandeen and O’Leary (1990) found that marital discord was both a cause and a correlate of depression. As a result of their research, these authors concluded that there is strong evidence to indicate that a discordant marriage leads to an increase in depressive symptomatology. If the wife sees the relationship as unsatisfactory for instance, the likelihood of her being depressed was found to be as high as 50 percent. A person in a discordant relationship appeared to be 25 times more likely to be depressed.

Chronic and acute depressive episodes were also found to be true for husbands and wives. These researchers found that the initiator of the separation is likely to experience the loss far sooner and more gradually and to be less distressed than the abandoned partner. These findings support Levenson’s (1995) observation that the meaning of a person’s loss becomes intimately tied to the meaning of the destroyed relationship and the part they perceive they played in its destruction.
Identification with Members of the Family of Origin

During stage two, the therapeutic process focuses upon the repetition associated with perpetuating what Hirsch and Roth (1995) described as the familiar and familial. This refers to those aspects of the self that have always defined one’s basic sense of identity (Hirsch & Roth, 1995, p. 272). As many of these configurations remain unarticulated or dissociated, they become associated with a wide variety of affective experience.

Among the most salient are those feelings associated with the loss, pain, vulnerability and anxieties associated with disapproval from primary caregivers. As the child’s cognitive-emotional development unfolds, other emotions such as shame, humiliation, pride, jealousy and envy have a powerful regulatory effect on his or her attachment processes (Hirsch & Roth, 1995). To access the repetition of this experience, the therapeutic discourse shifts to the past and focuses on the partners’ representation of it.

Embedded in the partners’ internalised templates are identifications with parents, siblings and other significant people. The role of these identifications is to preserve loving attachments to them, while continuing to maintain a stable sense of self. Paradoxically, the most persistent identifications may reflect the most painful and troublesome attachments, as the individual strives to preserve the connections to primary caregivers and maintain what was once perceived as love (Hirsch & Roth, 1995).

Grief Over the Loss of the Old Self

The complex attachment feelings aroused in this stage are perceived as activating the grief associated with the loss of the old self. The partners become acutely aware that experiences, such as loss, illness, death, divorce, and separation from important attachment figures and contexts, represent a core trauma in their development (Magnavita, 1997). For some, there is the grief and guilt associated with moving beyond their families; for others, mourning processes involved in confronting their own and their partner’s limitations will become activated by the process.

These mourning processes become intensified as the partners realise that significant opportunities have been missed because of their particular experiences and histories (Magnavita, 1997). Bringing the couple’s attention to the abandonment, abuse, or neglect associated with their earlier developmental failures confronts the partners with the need to deal with the ambivalence toward their earliest objects of desire. Bollas (1987) described this process as discovering the unthought known.
Some partners who have seen their mother or father as all bad, or idealised them as all good, will now have an increased understanding and an acceptance of the faults of these figures. Magnavita (1997) stressed the pain people experience when they realise that these earliest experiences helped determine their choice of love object, influenced their career decisions, where they live, their relationships with their children, and their life choices.

Stage Three—Detachment

During stage three of the therapeutic process the clinical focus makes a strategic shift from past expressions of the self to the identification of future and possible selves (Macnab, 1991). A shift from a reactive symptomatology to a more proactive view of change takes place. The structured therapeutic process turns the couple from introspection, toward prospection, as the partners’ ability to establish more emotionally mature relationships and adopt alternative ways of being in the world come under consideration.

The Process of Reorganisation

Of significance in this stage are the mourning processes activated by the previous two sessions. By structuring the clinical focus on the present, the past and now the future, the time-limited process begins to compel the couple to define their problems differently, to relate to one another differently, and to conceive of change differently. The mourning processes aroused by this experience can be likened to Bowlby’s phase of detachment.

Bowlby (1960) described how children responded to prolonged separation by an active and seemingly defensive disregard for and avoidance of the mother. In this discussion of the processes of mourning, Bowlby (1961) described how Disorganisation and Reorganisation predominate at this time. Bowlby (1961) wrote of how in phase three of the mourning process, the person’s capacity first to tolerate the disorganisation associated with object loss, and the subsequent ability to undertake a process of reorganisation towards a new object, represents a valuable adaptive process.

Other models of mourning have described the experience expected during this phase as acceptance (Kubler-Ross, 1969; Thomas & Siller, 1999); completion (Horowitz, 1990); restlessness (Lindemann, 1979), and as the beginning of object decathexis (Pollock, 1961). An adaptive response to object loss in this stage of the therapy requires the partners to gain the capacity to experience the depression associated with the destruction of some part of the personality. It requires the partners to reorganise themselves towards a new object or goal (Bowlby, 1961).
Grief Over Loss of Potential

This aspect of the therapeutic process involves each partner in giving up some feature of the self, the relationship, and each person’s world-view (Hazan & Shaver, 1992). As such, intersubjectivity has particular implications for stage three of the therapy. The process of intersubjectivity has become a major focus of interest among psychoanalysts and psychologists (Mitchell, 1993). Frie and Reis (2001) defined intersubjectivity as, “the interaction between two subjects: myself and another person, or self and other” (p. 297). Whereas the work of analysis is an understanding of the nature of interaction between the analyst and analysand, here the intersubjectivities and interpersonal exchanges of the partners become the focus of attention.

During stage three of the therapy the couple will be encouraged to get in touch with the questions of loneliness, finitude, anxiety, and the meaning of life. This experience is achieved by the therapist directing the focus of the therapy away from the past toward the future. An exploration of the couple’s deepest longings and yearnings comes to the forefront of the clinical inquiry. This intersubjective exchange requires the partners to hear their own and their partner’s deeper goals, desires, longings, illusions and disappointments (Macnab, 1991).

Such a mutative process allows for each partner’s capacity for relational connectedness and self-sufficiency to become available to interpretation. The therapeutic discourse presents the couple with an opportunity to consolidate a new and more empathic understanding of their own and their partner’s memories, yearnings and desires. To initiate this intersubjective discourse the following questions are addressed to the unconscious:

    Deep down what am I really looking for? Deep down, what is my inner voice telling me to be? Deep down, am I going about things in a way to get what deep down I really want, and to be what deep down I believe I can (Macnab, 1991, p. 72).

This intersubjective exchange involves the couple in a process of mutual recognition. According to Frie and Reis (2001), a course of action such as this involves the individual in a process of mutual recognition that the “self and other always exist in a relationship of dependency, desire, and control, which is resolved only by means of mutual recognition” (p. 303). Another understanding of this intersubjective process is the relationship between “one partner’s own consciousness of self and another person’s consciousness of self” (Frie & Reis, 2001, p. 302). The intersubjective system that exists between the couple and the narrative or
language used to speak their experience into being becomes the focus of therapeutic attention. At the same time, there is the recognition that each integration creates a new dynamic tension (Frie & Reis, 2001, p. 314).

The Process of Integration

The grief sustained over the loss of the potential self can be explained by Mitchell’s (1993) observation that no version of the self is ever fully present at any instant. Instead, a single life is composed of many selves. According to Mitchell (1993), whether it is the individual self, the relationship self, the idealised, denigrated, or the observing self, these selves are continually changing and being transformed.

From within this frame of reference, the self represents the sum of the individual’s subjective organisation of meanings, which in turn become a symbolic way of thinking, feeling and reacting. The process could be likened to Winnicott’s (1971) concept of ‘transitional phenomena’. Winnicott described how one of the outcomes of the child’s use of the ‘transitional object’— in this case the therapeutic experience — was to create an alternative or ‘potential relationship’.

Kahn (1986) noted that for individuals to assume responsibility for some control over their self-image and destiny they need to know that someone has really understood the depth of their dependency and has grasped the pain of the early deprivations that generated it. It also requires the recognition of persisting, unintegrated and distressing memories. Kahn (1986) observed that in an existential encounter of this nature, all the individual’s significant past relationships, all of his or her most basic hopes and fears are there in focus. According to Magnavita (1997), grief over the injury that has been sustained to the self is often the deepest layer of grief.

Mann (1991) suggested that a satisfactory termination in psychotherapy is one in which the patient leaves treatment feeling sad. Sadness in place of depression allows for separation without self-injury. In a successful treatment outcome, ambivalence that previously had always led to feelings of anger, depression or self-derogation can be replaced by more positive feelings about the self.

At the same time, the treatment process itself might heighten the potential for one or both partners to regress to a state of emotional ‘protest’. The realisation that the therapy is coming to a close confronts both partners with the need to give up impossible longings for endless nurture or restitution. While the presenting issues may have abated, improved or disappeared,
the ‘new self’ or ‘new relationship’ may not live up to the partners’ hopes, or expectations (Beach, et al. 1990).

In this chapter the mourning processes aroused in the partners by the time limitation were discussed. By passage through the stages of the therapy, the potential for the couple to make new commitments to each other and to accept new personal roles was highlighted. In the next chapter, the implications of the socio-political context for the practice of marital therapy and the impact it has on the personal and professional development of the clinicians who practise it are discussed. So too, the principles and techniques required for bringing about change in the partners’ mental structures of meanings about self, other and context are reviewed. The way the integration of attachment theory provides defensive, cognitive and affective points for intervening and changing the partner’s awareness of self, other and relationship are discussed also.
CHAPTER 4

The Psychodynamic Principles and Techniques Informing the Therapeutic Model

Overview

This chapter describes how the integration of attachment theory in BCMT results in an alternative approach for the treatment of conflicted intimate relationships. To achieve this objective, the psychodynamic principles central to the treatment will be defined, operational definitions of the interventions given, and more precise information about the practice of the therapy provided. The way the integration of attachment theory in the conceptual framework results in a psychodynamic formulation described as the Central Relationship Theme (CRT) will be detailed. Consideration will be given to the way the transformation of the couple’s conflicted interpersonal and intrapsychic schemas can be modified by the systematic restructuring of the defences followed by the cognitions and lastly the affect. The way this conceptual framework enables the therapist to treat the couple more effectively, contain their own anxieties and improve their sense of personal and professional efficacy will be discussed.
Attachment theory has a great deal in common with the principles of other psychoanalytic models that regard conflicts as arising within interpersonal relationships. Like other relational theories, attachment theory is concerned with both the intrapsychic and interpersonal world and the social context in which a person’s experience is embedded. Bowlby’s concepts of bonding and attachment have had a major impact on the understanding of human development. Clinical evidence now supports the notion that notwithstanding an insensitive primary caregiver and developmental failures in the child’s upbringing, children can subsequently encounter an empathic and well attached other with whom normal reflexive functioning may be established (Fonagy, 1998, p.159).

Grotstein (1990) described the introduction of attachment theory as a paradigmatic revolution in psychoanalytic theory. Bowlby, for example, acknowledged the links between the concept of inner working models and their application in the brief psychodynamic therapies. In particular, the similarities between the centrality of attachment in human development in the brief psychotherapies of Mann (1973), Strupp and Binder (1984), and Horowitz, Marmar, Krupnick, Wilner, Kaltreider and Wallerstein (1984) (Bowlby, 1988, p.140).

More recently, attachment theory has increasingly been associated with a number of individual, marital and family therapies (see Byng-Hall, 1995; Fonagy, 1998; Pistole, 1994). Attachment theory enables the marital therapist to conceptualise how partners in conflicted relationships access their feelings, defend themselves against their anxiety and maximise the opportunities of their psychosocial environment. Of particular relevance is the way that such a conceptualisation enables the partners to recognise that their inner working models of self and of other, derived from the past, may not be appropriate in the present and future (Bowlby, 1980).

The integration of attachment theory in BCMT results in an alternative conceptual framework or metaperspective for the treatment of conflicted intimate relationships. To understand more fully the implications of the integration of attachment theory for the practice of BCMT, a discussion of the psychosocial factors influencing the practice of marital therapy, the evolution of brief psychodynamic therapies, and the principles and techniques informing the stage-related therapeutic process follows.
From tentative beginnings in 1947, the Australian marriage guidance movement developed along similar lines to that in Britain. It relied on volunteers, received most support from churches and promoted client-centred listening skills as its preferred technique (Fox & Miller, 2000). Marital therapy in Australia received increased professional recognition and status through the introduction of The Family Law Act in 1975. Since the mid 1970s the role of marital therapy has become devalued; and, government funding for marriage counselling remains tenuous (Shaw, 2001).

At the present time there has been an increased demand for marital therapy where about half of all first marriages are projected to end in permanent separation or divorce (Halford, 2000). Assisting couples to separate, to finish dangerous relationships or to divorce is not a valued process. One reason for this phenomenon is the tension that exists between changing social values and the demand on practitioners for the demonstration of best practice. Another, is that the anxieties aroused by the practice of marital therapy have resulted in individual psychotherapists disregarding the specialist requirements for treating relationship conflict (Shaw, 2001). Gurman (1981) provided a further explanation for this phenomenon

As difficult as it is to avoid unconsciously colluding with the patient in individual treatment, it may be more difficult to do so in marital therapy, because it is nearly impossible for most marital therapists not to encounter, in their own current intimate relationships, the painful issues involved in the relationships of patient couples, and because the therapist’s level of activity does not allow a great deal of time and opportunity for in-process self-reflection (p. 441).

Parallels exist between the evolution of marital therapy, the increased practice of brief psychodynamic therapy and recent changes in the social, political and economic context. Throughout the 1990s there was a growing incidence of third-party payers in the delivery of mental health care. With the advent of managed care, health maintenance organisations have controlled service delivery and attempted to reduce costs (Atkins & Christensen, 2001). As insurance companies and governments have become increasingly involved in service delivery, there has been a growing demand for evidence-based care from psychologists and other health professionals (Larner, 2001). Evidence-based health care requires clinicians to be accountable for the safety, efficacy, appropriateness and cost-effectiveness of their treatment models (Higgs & Hunt, 1999).
In the Australian context a large percentage of people with mental health issues do not seek treatment. More often than not, the treatment provided is made by general practitioners, nurses, and social workers, rather than by psychologists and psychiatrists (Richards, 2001). In the United States of America where there is a growing trend towards therapy being provided by low-cost therapists, the debate has shifted from accountability, to the suitability of people to practise (Richards, 2001). In a climate of clinical accountability, the issues of training and qualifications have aroused similar debate in Australia (Andrews, 2001; Larner, 2001; Orlinsky, Botermans, & Ronnestad, 2001; Richards, 2001).

**Suitability for Practice**

A great deal has been written on the subject of the therapist’s role and function in the therapeutic process (Strupp & Binder, 1984). Within the psychotherapeutic literature there is no disharmony in Herron’s (1988) observation that if psychotherapy can be perceived as a personal learning experience, then the practice of it ought to be of practical value and a similar learning experience for psychotherapists themselves. In the practice of psychotherapy the potential is created for therapists to become clearer about their own boundaries, more able to understand who they are, where they are going and what they value. Not only do therapists need to be less constrained, to increase professional competence they need to be able to experience a range of affect in their relationships with others (Herron, 1988).

One of the distinguishing features of the practice of psychotherapy is the ability of the therapist to become deeply involved with the private selves of others (Ehrlich, 2001). Davies (1980) wrote of how work plays an important role in a person’s sense of agency. He argued that work could be therapeutic and self-therapeutic when it is:

> Assimilated into the identity or into the self by introjection…. This is because the work or task out there which has become part of the self can be worked on, attacked, struggled with, improved, corrected in a way that the person cannot do directly with their own inner self… inner problems can be projected out into the world as outer problems where he/she can then work with them far more easily with less anxiety, less repression, than they could by direct introspection (pp. 9-10).

**The Effect on the Therapist of the Practice of Marital Therapy**

A distinguishing feature of marital therapy is the constant exposure to the dynamic tension between the partners’ benign and malignant passions (Fromm, 1991). While each clinical presentation is unique, one uniting factor is the couples’ high level of hostility and ambivalence (Solomon, 1989). A couple’s attempt to resolve the selfhood and meaning
dilemma and the selfhood and cultural participation conflict can be extremely confronting for
the marital therapist.

Some therapists choose not to practise marital therapy, find it too difficult, or do not wish to
jeopardise their own intimate relationships (Shaw, 2001). The therapeutic process can
recreate earlier pain or panic at having to share the same parent with siblings. It may arouse
inner conflicts about the birth of their own siblings or of the birth of the therapist’s own
children. The anxiety aroused in the therapist by the high levels of conflict helps to explain
why many therapists refuse to acknowledge the worth of marital therapy, or are reluctant to
practise it (Broderick, 1982).

Along with the heightened sensitivities required to participate in the process, there is also a
need for the marital therapist to remain open to self-reflection, self-scrutiny and to become an
observer of their own interpersonal needs and anxieties. Sharpe (1997) observed that the
triangular format of couples’ therapy exerts a powerful and regressive force in the stimulation
of competition and rivalry for a parent’s love, thus reactivating Oedipal issues. By becoming
the third party in the partner’s dynamic, this therapeutic configuration can be challenging and
sometimes problematic for the marital therapist.

The partners’ defensive, manipulative and sometimes threatening behaviours can undermine
the therapists’ effectiveness and the competence of their work. Shaw (2001) observed that the
greatest anxieties facing marital therapists include the ability to contain their own anxieties, to
reduce the couple’s tension to a bearable level and to stay within the couple frame. Eisold
(2000) described how the frame requires the therapist to develop a reflective space. There, the
couple develop the capacity to think, feel and experience what has previously not been
available for thought.

Solomon (1997) noted that if the marital therapist remains unwilling to become a participant
in the couple’s emotional turbulence, the therapy remains superficial. By talking more,
interrupting more, as well as assigning homework tasks, the marital therapist becomes more
open to self-disclosure (Gurman, 1981). Gurman noted how participation in this dynamic
process actively forces the therapist to address overtly and actively any evidence of negative
transference reactions.

The high levels of hostility associated with marital therapy led Nichols (1989) to record how
negative outcomes are far more likely to occur when little structure or guidance is given.
Cashdan (1988) found that premature termination is likely to occur if the marital therapist is
unable to contain the conflict in the early stages of therapy. Papp (1982) observed that the therapist’s confidence in the application of the treatment method directly influences the rate of change. Marital therapists not only have to believe that their treatment methods are conceptually sound, they must be convinced that the basic principles they practise lead to therapeutic change (Cashdan, 1988).

The Practice of Brief Therapies

The suitability of people to practise psychotherapy has attracted similar debate about who is best qualified to practise the brief therapies. Brief therapy has been perceived by brief-psychodynamic therapists such as Mann (1973), as not suitable for the beginning therapist because of its intensity and rapidity. This is because of the need to gain an early focus, to quickly identify relevant behaviours and to understand mental processes (Kinston & Benvotim, 1981). In Mann’s (1973) view, time-limited therapy calls for high levels of activity, flexibility and spontaneity in the therapist. Concerns have also been raised about the ability of therapists to conduct effective brief therapy, simply on the basis that they have undertaken training in other therapies (Budman, 1981).

Another associated concern is the recognition that brief practice is more demanding and often more difficult for the therapist than time-unlimited therapy (Bloom, 1992). Mann (1981) argued that previous experience, preferably in long-term psychotherapy, and a personal psychoanalysis were necessary prerequisites for the brief dynamic therapist. Similar concerns have been raised about the continuing psychological losses experienced by the therapist in the practice of brief therapy.

In discussing the continuing loss of clients, Buechler (2000) observed how therapeutic training does little to prepare therapists for it; their training often leaves them ill-equipped to deal with the losses associated with the practice of brief therapy. The experience of repeated psychological losses has been associated with considerable personal distress and discomfort for the therapist (Bloom, 1992). Levenson (1995) emphasised that because of their issues with termination, inexperienced brief therapists may find patients’ desires not to finish difficult to confront. In contrast, with an explicit ending date, other therapists may need to become aware of or confront their own resistances to the termination.

Accreditation and Training

The economic, technological and political imperatives to define how and what works in individual and marital therapy have had significant implications for accreditation, training and
practice. Until recently counselling and psychotherapy were poorly defined, poorly regulated and inadequately underpinned by tertiary courses. Psychotherapy has been regarded as either an activity accompanying, or extending from other disciplines such as psychology, psychiatry, medicine or social work. In the past counsellors and psychotherapists have not been organised into discrete professions, with minimum competencies or defined standards of practice.

To ensure high standards and responsible practice, a national organisation of 40 different counselling and psychotherapy associations, the Psychotherapy and Counselling Federation of Australia (PACFA), was formed in November 1998. PACFA provides a voice to the public and the government for the diverse but compatible helping professions, whose members call themselves either counsellors or psychotherapists. In addition, all the member associations have accepted education and training standards and an ethical principles guide.

This shift to codified practice and training reflects the increasing demand for evidence-based practice (Higgs & Hunt, 1999). Larner (2001) argued that this political discourse increasingly constrains psychologists to a strict positivistic scientific-practitioner model. Larner’s (2001) investigation into clinical training led him to conclude that what is required is a clinical-practitioner model of therapy that addresses issues of context, personal meaning and effective change. Given the increased demands on the practitioner for specific treatment criteria and for evidence of the effectiveness of the method, there is growing empirical support for the use of treatment manuals in skills acquisition and training (Orlinsky et al., 2001).

A well-specified manual details the constructs that are central to the treatment, provides operational definitions of recommended interventions and gives the therapist, clinical supervisor, or trainee more precise information about the treatment plan (Moras, 1993). The clearer the information received, the more quickly the therapist can begin to use it to direct their thoughts, perceptions, behaviour and treatment interventions (Moras, 1993, p. 583). Against this socio-political background, a description of the psychodynamic principles informing this marital therapy follows.

The Psychodynamic Principles Informing the Model

The therapeutic goal in traditional psychoanalysis is to make the unconscious conscious, particularly the unconscious defences against forbidden impulses and wishes (Shapiro, 2000). This process is achieved through a controlled regression. In contemporary analytic psychotherapy, Molnos (1995) described the essence of the process as the creation of a
special space in which the past can reappear in the here-and-now, a space in
which past emotional conflicts are re-lived and understood with clarity, and in
which new solutions to old problems are found (p. 26).

The time-limited model of marital therapy described here can be distinguished from other
brief marital therapies through the formulation of a psychodynamic focus for each session.
As the structured approach to treatment proceeds, each distinct clinical focus results in a
dynamic process. The clearly articulated and planned treatment strategy for each session acts
as a clinical heuristic in its own right (Butler & Binder, 1987). This clinical heuristic

involves the creation of a narrative that describes cyclic, maladaptive patterns
in a consistent and coherent manner. The narrative idea is based on the
assumption that the primary psychological mode of construing life experience
is narration: the telling of a story to oneself and others (Spence, 1982) (cited in

In summary, the objective of this marital therapy is to transform the couple’s schemas, so that
they gain a fuller experience of their feelings about the past and its effects on the present
(Della Selva, 1993). From this metaperspective, the essential principles informing the
therapeutic process can be defined as follows:

(1) Since people shape each other’s personalities, couples therapy can lead to
individual change; and, (2) behavioural change can change the inner schemata
of both one’s self and one’s partner that constitute the perceptual templates of
central importance in marriage and other close, committed relationships

To bring about change in the partners’ mental structures of meanings about the self, other and
context, the treatment is informed by two major psychodynamic concepts. The therapeutic
process involves making meaningful links between: (1) the central issue (Mann, 1981) and
the cyclical maladaptive pattern (Butler & Binder, 1987) and (2) the triangle of insight/the
triangle of person (Menninger & Holzman, 1958; Malan, 1979; Malan & Osimo, 1992). The
way the integration of attachment theory with these psychodynamic concepts provides
complementary points of entry for therapeutic interventions (Lindegger & Barry, 1999) in the
stage-related process is now described.

The Psychodynamic Formulation

A distinguishing feature of the brief therapies has been the identification of one core issue, or
a selected problem area that becomes the emphasis of selective attention. The identification
of a psychodynamic formulation allows the therapist to bypass patient defences, control
anxiety, facilitate a working alliance and develop positive transference (Mann, 1973).
According to Magnavita (1997), the integration of a therapeutic focus, a time limit and a psychoanalytic framework represents a major advance in the field of psychotherapy.

This has resulted in the use of focality, time limits and a circumscribed set of technical modifications becoming synonymous with brief practice. The work of many contemporary theorists of brief dynamic therapy reflects this advancement. Various names have been used to describe the psychodynamic formulations associated with brief practice: the core conflictual relationship theme (Luborsky, 1984); role-relationship models (Horowitz, 1988); unresolved Oedipal conflicts (Sifneos, 1979); focal issue (Malan, 1979); plan formulation method (Weiss, 1993); the central issue (Mann, 1973) and the cyclical maladaptive pattern (Strupp & Binder, 1984).

In marital therapy the expression of a psychodynamic formulation has not been so clearly articulated. Instead, its effectiveness has relied on the therapist’s ability to conceptualise the couple’s issues within a particular therapeutic paradigm. For example, object relations (Cashdan, 1988; Slipp, 1993); psychodynamic (Scharff, 1995) and self-psychology (Solomon, 1989). The psychodynamic principles informing the psychodynamic formulation in this therapy follow.

The Conceptualisation of The Central Relationship Theme

In this marital therapy the conceptualisation of the intrapsychic and interpersonal processes contributing to the marital psychopathology can be described as the Central Relationship Theme (CRT). The CRT provides a clinical heuristic for understanding the way each partner systematically elicits, organises, contributes to and sustains their maladaptive interpersonal patterns. The psychodynamic formulation elucidates how the partners’ core interpersonal schemas create an interactive process, which comes to represent the ‘relational identity’ or ‘personality’ (Solomon, 1989). The term ‘central’ is not intended in a purely psychodynamic sense. Instead, it reflects the couple’s subjectivity, recognises the couple’s real issues and is in the context of present time (Osimo, 1991, p. 37).

The CRT can be set out for the couple as part of the therapeutic verbal discourse, or alternatively be provided in written form. The identification of the CRT speaks to past emotional losses and separations (Mann, 1973). The formulation of this psychodynamic focus seeks to explain how the partners’ enhance and maintain their self-cohesion. Such a psychodynamic focus allows the couple to gain a greater awareness of their own and their partner’s interpersonal processes (new understanding). At the same time the secure base,
provided by the time limitation and the therapeutic alliance, allows them to gain a different perception of the issues confronting the relationship (new experience) (Levenson, 1995).

To achieve this treatment objective, the therapist pays close attention to each partner’s subjective world. Solomon (1989) wrote of how in marital therapy significant interventions take place at the intersection where self and object meet. In particular, the therapist attempts to identify each partner’s active role in perpetuating the conflicted relational pattern. According to Macnab (1991), such a psychodynamic formulation allows the therapist to examine “the processes and psychopathology that provoke and sustain the problem…. [until the] “reactive, anxious, symptomatic posture is replaced by a proactive concern for the next phase of his/her life, health and well being” (p. 13).

The Formulation of the Central Issue

The formulation of the central relationship theme requires the therapist to create a therapeutic narrative. The couple’s presenting issues are linked to important interpersonal themes, thereby connecting their emotional reactions to childhood, current situation and the therapeutic situation (Menninger & Holzman, 1978; Strupp & Binder, 1984). To create such a narrative, the CRT draws on Mann’s (1973) conceptualisation of the ‘central issue’.

The central issue includes time, affects and the image of the self. It is linked with the various affects that are attached to the particular patient’s time line or history (Mann, 1981, p. 33). Mann (1981) wrote of how the effectiveness of this prescriptive narrative rests on its ability to communicate a distinct message. It requires an empathic acknowledgement of a persistent negative self-image or lowered self-esteem and the emotional pain and distress involved.

The formulation of the central issue involves the therapist in an understanding of the ego’s adaptive role in keeping the pain out of one’s mind and out of others’ sight. The central issue acknowledges “that a painfully hidden part of the self—something which the patient has never fully allowed him or herself to know, and which has always been a source of pain—has been brought to light in a most empathic and non-threatening manner” (Mann, 1981, p. 35). Messer and Warren (1995) documented how the first part of the statement points to the role of the ego in disguising and managing this pain.

According to Mann (1981), because this statement is couched in empathic terms, it is meant to bypass defences, rather than confront them in a way that might arouse anger or defensiveness. Because the central issue “does not speak to the conflict with significant others” it “does not give rise to automatic defense mechanisms” (Mann, 1981, p. 35). The statement of a central
issue has the potential to soothe a partner’s damaged self, allay anxiety, and promote a working alliance and positive transference (Messer & Warren, 1995).

**The Conceptualisation of the Partners’ Interpersonal Processes**

The second psychodynamic principle informing the CRT is the recognition of the partners’ interpersonal processes. Butler and Binder (1987) described four categories of interpersonal processes that comprise a psychodynamic formulation they described as the Cyclical Maladaptive Pattern (CMP). In Butler and Binder’s (1987) model the identification of the CMP enables the therapist to describe the narrative that creates a ‘vicious cycle’ in the individual’s current life. The aim of this clinical formulation is to uncover, “a central or salient pattern of interpersonal roles in which patients unconsciously cast themselves and others, and of the resulting maladaptive interaction sequences, self defeating expectations, and negative self appraisals” (Butler & Binder, 1987, p. 219).

The narratives of the constructions of feeling, perceiving, wishing and anticipating become translated into predictable interpersonal transactions. The process of working through them requires the therapist to identify the CMP’s, “as they evolve in the therapeutic relationship [and] helping the patient to understand, rather than act out the problematic interpersonal scenarios” (Butler & Binder, 1987, p. 221). They described these four categories as follows: Acts of self; Expectations of others’ reactions; Acts of others toward self; Acts of self toward self (introject) (Butler and Binder, 1987).

*Acts of self.*

Acts of self refer to actions of self towards other people. Included are private and public actions (such as feeling affectionate as well as displaying affection). Acts of self vary in the degree to which they are accessible to awareness. They can be public and overt or private and internal (Binder & Strupp, 1991). Of therapeutic concern is what the individual actually does to, for, with, without and in spite of another person.

*Expectations of others’ reactions.*

This category assumes that others’ actions are systematically misinterpreted through the narrative. Thus the perceptions of these actions influence what is expected of them. Expectations of others’ reactions are imagined reactions of others to one’s own actions and may be conscious, preconscious or unconscious.

*Acts of others toward self.*

These are others’ observed acts viewed as occurring specifically in relation to the act of self. One partner tends to misconstrue the interpersonal meanings of
the other’s actions in a way that confirms their own wished for or feared expectations. These are often actions of others which appear to be evoked by the individual’s own actions. Like the acts of self, these acts may be public or private.

Acts of self toward self (Introject).

This category refers to how one treats oneself, for example, self-controlling, self-punishing, self-congratulatory, and self-destroying. These actions should be articulated in specific relation to the other elements of the categories; acts of self, expectations of others, and acts of others (Butler & Binder, 1987, pp. 219-221).

The Integration of Attachment Theory in the Conceptual Framework

The introduction of attachment theory into the CRT enables the therapist to clarify the links between each partner’s individual experience and the interpersonal patterns they perpetually act and re-enact with each other. Sullivan (1953) and Bowlby (1961) assumed that the infant’s interactions with primary caregivers result in the formulation of emotional-cognitive mental schemas: “personifications” in Sullivan’s model, “internal working models” in Bowlby’s (Cortina, 2001). Bowlby’s and Sullivan’s concepts of self and other are considered strongly influenced by subsequent and current experience and remain open to change throughout the life cycle. But as Cortina (2001) noted, if negative environmental experiences in childhood and adolescence are not changed, the individual’s inner working models become increasingly rigid and difficult to change.

Fonagy (1998) suggested that the greater the ability to regulate affect, the greater the sense of ownership in all types of inner experience and in self-understanding. In particular, the ability of the individual to cope with the anxiety associated with expressing, or experiencing, blocked or unmet childhood needs. The way interpersonal and attachment theory complement each other to provide an understanding of the role of anxiety and fear, hostility and rage, and disillusionment and failure in regulating interpersonal relationships follows.

Adult Attachment Styles

A number of measures of adult attachment have been developed against criteria of interpersonal functioning in intimate relationships (Ainsworth, 1989; Collins & Read, 1994; Feeney & Noller, 1990; Hazan & Shaver, 1987). Of particular relevance to conceptualisation of the psychodynamic formulation in this marital therapy is the four-part classification of adult attachment styles. With the secure attachment style, the individuals’ working models are organised around the expectation that attachment figures will be reliable, available and responsive. For insecure attachment, the opposite will apply. The anticipation (and fear) of
loss, results in working models organised around the expectation that attachment figures may not be available or responsive (anticipation of loss) (Hazan & Shaver, 1992).

In discussing the way individuals seek comfort and security under conditions of stress, Fonagy (1998) spoke of the activation of the four individual attachment systems. Secure adults are expected to be more self-confident, trusting and comfortable with closeness, whereas avoidant or dismissive adults are expected to deny distressing aspects of interpersonal situations, reject offers of assistance and assert their independence aggressively. Preoccupied attachment results in the adult becoming clinging, dependent, jealous and anxious about relationships; such people are likely to exhibit confusion about relationships. The disorganised attachment style is associated with social inhibition, lack of assertiveness and strong combinations of avoidance and preoccupied traits (Fonagy, 1998, p. 150).

Hazan and Shaver (1992) noted that insecurely attached infants experience more rejection from their primary care givers and are more likely to be rejected by their peers as preschoolers. While as adults, they are more prone to experience relationship losses and are more likely to have shorter-lived romantic relationships. They have been found to be less competent in providing care to their partners and have a higher rate of divorce (see Feeney, 1998; 2002; Gallo & Smith, 2001).

**The Formulation of Acts of Self**

Similarities exist between adult attachment styles and Horney’s (1950) conceptualisation of interpersonal processes. From an interpersonal perspective, Horney (1950) stressed three major ways people act towards themselves and others by the use of fixed interpersonal coping styles or defensive adaptations: ‘moving toward’, ‘moving away’ or ‘moving against’. These emotional templates, usually acquired in the context of a problematic family of origin, result in the individual failing to assert their own wishes.

Some individuals learn to gratify indirectly the need for approval. They reduce their anxiety by constantly moving toward and pleasing others. Moving toward others is an attempt to earn approval and decrease the threat of rejection by being accommodating and pleasing others. In the context of disturbed intimate relationships, moving toward is regarded as a positive coping style and is best described as moving alongside. Other people learn to cope with their anxiety, by becoming resistant or by using aggression; hence the terminology moving against. They cope through seeking to control themselves and others, often approaching relationships with
the attitude that they must win what they deserve, usually in a demanding and aggressive way (Teyber, 1997).

In direct contrast, people who use the coping strategy of moving away learn that the best way to defend against their unmet needs is to withdraw and physically avoid others (Teyber, 1997). For example, a woman who has constantly tried to please her authoritarian and emotionally absent father, persistently and unknowingly continues this maladaptive pattern with her husband. She moves away from him by remaining quiet, not expressing her unhappiness, or letting him know of her emotional needs.

The relationship between adult attachment styles and Horney’s (1950) interpersonal processes can be seen as follows:

Secure/autonomous individuals appear to value attachment; they are able to integrate memories, maintain objectivity regarding favourable and unfavourable experiences \([\text{moving towards/alongside}]\).

Insecure/dismissing individuals deny and denigrate, devalue or idealise past and current attachments. In other words, they tend to normalise adverse experiences \([\text{moving away}]\).

Preoccupied individuals are overwhelmed and excessively passive or inappropriately angry and may show fearful preoccupation with attachment-related events \([\text{moving against}]\).

The fourth category of unresolved or disorganised individuals with respect to loss or trauma will be assigned (in addition) to one of the three major categories to transcripts that include significant dysfluencies or lapses of reasoning in connection with such an experience (Fonagy, 1998, p. 151).

The integration of adult attachment styles, interpersonal processes and internal working models, or inferred representations of self and others, can be seen in Table 4.1 overleaf.

*The Formulation of Expectations of the Partner’s Reactions*

To conceptualise this aspect of the couple’s CRT, the therapist pays close attention to the way each partner uses selective attention to interpret and misinterpret their partner’s, others’, and the therapist’s actions toward them. One of the predominant patterns in conflicted relationships is the predisposition of each partner to assume knowledge of how the other thinks, feels or behaves. Solomon (1989) noted how partners would not overtly state to each other much information significant to the relationship. Instead, they act upon conscious and unconscious material that is not verbalised by either.
Table 4.1

Attachment Style, Interpersonal Processes, and Inferred Representations of Self and Others

<table>
<thead>
<tr>
<th>Attachment Style</th>
<th>Interpersonal Coping Style</th>
<th>Internal Working Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secure / Autonomous</td>
<td>Moving towards [alongside]</td>
<td>Self - worthy of care/others reliable</td>
</tr>
<tr>
<td>Insecure / Dismissing</td>
<td>Moving away</td>
<td>Ineffective or weak in eliciting care/others inconsistent</td>
</tr>
<tr>
<td>Insecure / Preoccupied</td>
<td>Moving against</td>
<td>Self - unlovable/others rejecting</td>
</tr>
<tr>
<td>[Insecure / Disorganised]</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sources: Cortina, 2001; Fonagy, 1998; Horney, 1950.

Commonly known as ‘mind-reading’, the partner’s rigid self-perception sets in train predictable and imagined reactions by their partner towards them. Such expectations about the other’s actions are systematically misinterpreted according to a preconceived set of expectations. This inner narrative virtually accounts for the actions of others. Each partner “projects onto the other positive and negative fantasies that may have little to do with that person’s true motivations” (Solomon, 1989, p. 28).

Included in this category are the individual’s wishes, fears and fantasies with respect to his or her partner’s reactions. Expectations about others’ reactions often take a form such as, “If I tell him how I feel, I imagine that he will reject me.” Or, “If I speak up for what I want, she will laugh at me” (Messer & Warren 1995, pp. 131-132.). The rigidity of these inner working models of self and other tend to elicit the very behaviour in the partner that is most painful to them. Thus their inner working models confirm their original expectations (Messer & Warren, 1995).

The Formulation of Acts of Others Toward Self

This aspect of the couple’s CRT builds on the previous formulation. It highlights the need for the therapist to gain an expanded understanding of the unconscious expectations each partner brings to the relationship. Throughout the therapeutic process, continuous attempts will be made to clarify what information is perceived and interpreted as being uncomfortable, angry, bored and disappointed. “It is the selective attention involved in what is perceived and the
particular interpretation (or misinterpretation) of others’ actions that reflects the patient’s preconceived sets for construing social reality” (Butler & Binder, 1987, p. 220).

Gurman (1981) referred to this aspect of the couple’s conflicted interpersonal processes as ‘relational rules’.

It is assumed that marital conflict arises when the “rules” of an intimate relationship that are central to each partner’s sense of self are in some way violated. These relational “rules” include both the conscious and unconscious expectations of, and anxieties about, intimate relating that are brought to the marriage by each partner…. In this, it is assumed that people generally strive to maintain a relatively consistent sense of self and a relatively consistent perception of those to whom they are intimately connected (p. 187).

In conflicted relationships, these expectations or relational rules operate unconsciously and automatically. Typically, they will be expressed in stereotypic form (Solomon, 1989). Where ineffective attempts to exchange important emotional needs within the relationship are not met, such dysfunctional patterns become exacerbated. For example, “When I asked him for more money he refused to speak to me” (Messer & Warren, 1995, pp. 131-132). Rather than being perceived as a reasonable response to an unwarranted demand, such a response is regarded as a validation of this woman’s negative expectations (Messer & Warren, 1995).

The Formulation of Acts of Self Toward Self (Introject)

The formulation of the partner’s acts of self toward the self rests on the psychoanalytic concept of introjection. In Klein’s model of object relations, she sought to describe, “the phantasised comings and goings of ‘good’ and ‘bad’ objects (introjection, projection, reintroduction)” (Laplanche & Pontalis, 1988, p. 229). It is by the process of introjection that individuals create a complex inner world. The concept of introjection helps to explain how a person’s inner world consists of good, bad, and idealised internal objects affectively relating to each other, the self and the external world (Solomon, 1997).

Each partner’s internalisations include images of the parental relationship as well as identifications with both mother and father (Messer & Warren, 1995). These models of the self, or introjections, become so deeply entrenched in experience, that they simply become accepted as valid reflections of everyone’s shared experience. For example, one partner may self-punish with verbal self-recrimination about his or her unworthiness to have a happy relationship.

In addition, couples continually strive to establish themselves as a ‘marital pair’ (Solomon, 1989). In so doing, they recreate aspects of their separate inner worlds, and their early
relationship with their parents. “Together, they recapitulate earlier relationships with their parents. Together, they recapitulate earlier conflictual experiences” (Solomon, 1989, p. 28). The internalisation of their earliest experiences results in the partners seeing themselves as, “I’m loving and lovable”, or “I’m a nuisance and unwelcome here” (Messer & Warren, 1995, pp. 131-132).

**The Statement of the CRT**

The statement of the CRT conveys to the couple that while their present difficulties are painful, they have most likely been experienced already at other times in their lives. The identification of the CRT communicates an inherent understanding of the couple’s rule-governed problematic behaviour. Gurman (1981) wrote of the importance of the acquisition of new information that allows a restructuring of both self-perceptions and perceptions of the partner to evolve. As a consequence, the identification of this issue conveys the message that the therapist is willing to understand, to help, and to use his or her knowledge to alleviate the pain (Osimo, 1991, p. 39).

The formulation of the CRT has three schematic elements: a fixed opening, a positive statement of the clients’ strivings or achievements and an empathic description of the partners’ inner working models (Omer, 1993). An illustration of a CRT for a couple called “Michelle & Steven” might be as follows:

**T: Michelle:** You are the type of person who appears devoted to the care of your children and your partner. But in spite of your best efforts to provide love for the people in your life, you feel exhausted, neglected and taken for granted [central issue].

Since the beginning of your relationship with Steven you have felt anxious about his commitment to you [expectations of other’s reactions]. You cope by distancing yourself from him both emotionally and physically [acts of self]. You express a desire to have open communication and in spite of your best efforts, you continually disagree on issues that remain unresolved [acts of others toward self]. You feel that you are empathetic toward him, but feel that he does not respond in this way toward you [acts of self toward self (introject)].

**T: Steven:** You are the type of person who feels committed to the welfare of your family and the state of your relationship with Michelle. In spite of your struggles to
resolve the issues in your marriage, you feel powerless and frustrated with Michelle’s inability to let go of the past [central issue].

You continue to feel frustrated in your relationship with Michelle [acts of self toward self]. In spite of still loving her, the relationship is demanding and leaves you constantly seeking solutions [acts of others toward self]. You feel Michelle is not meeting your physical needs and this leaves you feeling empty [expectations of others]. Michelle’s constant threats to leave increase your anxiety and highlight your frustration at not being able to do something, just as when you were a child [acts of self toward self (introject)].

The Psychodynamic Techniques Informing the Model

The third psychodynamic principle informing the therapy draws on the concepts of the Triangle of Conflict and the Triangle of Person (Menninger & Holzman, 1958; Malan, 1979). Freud originally conceptualised the three key concepts involved in intrapsychic conflict as the formal operations (defences) designed to avoid anxiety-provoking (anxiety) or painful ideas and affects or feelings (impulse/feelings) (Della Selva, 1996).

Menninger (1958) extended this tripartite concept, by introducing what he described as the ‘triangle of insight’. Menninger described the three key concepts in this second triangle as other, transference and parent. In their elaboration of the understanding and teaching of the psychoanalytic method, Menninger and Holzman (1973) defined insight as the, “simultaneous identification of characteristic patterns of behaviour patterns in childhood, contemporary situations and the analytic situation” (p.152). In doing so, they stressed the central importance of the interpersonal context in which intrapsychic conflict finds its expression.

The Triangle of Person

In his model of Brief Focal Psychotherapy, Malan (1979) expanded upon the basic constructs of psychoanalytic technique and proposed that both the triangle of conflict and the triangle of insight were essentially both triangles of insight. This led Malan (1979) to propose that ‘the triangle of person’ was a much better term (p. 80).

In Malan’s model wherever possible a, “simple dynamic hypothesis is made of the patients’ central problem” (Osimo, 1991, p. 42). The focal issue includes feelings associated with
termination and with previous losses, separations, unsatisfactory relationships and unresolved mourning. The focal issue also addresses the patient’s inner strength.

Therapeutic work is centred on the two therapeutic triangles and is highly active. Osimo (1991) defined this level of therapist activity as not missing an opportunity to deepen the therapeutic relationship. To achieve this therapeutic objective, the therapist directs the patient’s attention towards the relevant material or chosen focus, while clarifying and interpreting as often and as thoroughly as possible. Osimo (1991) observed how all these issues contribute to psychotherapeutic planning, time limits and the treatment technique adopted.

*The Triangle of Conflict*

The triangle of conflict (see Figure 4.1) refers to one of the cornerstones of psychodynamic theory. That is, that the neuroses arise from defences against feelings or impulses that are made intolerable by the anxiety, guilt or pain with which they are associated. Hence, they become unconscious or ‘hidden’ (Malan & Osimo, 1992). Like Molnos (1995), Malan noted how the goal of dynamic therapy aims to reach beneath the defence and anxiety to the hidden feeling. This process enables the therapist to trace the feelings in the present back to the past, usually to the parents (Malan, 1979, p. 80).

Molnos (1995) noted that the concept of the triangle of conflict takes cognisance of the individual’s original conflict that needs to be revived in the present. This concept enables the therapist to conceptualise and address the conflict related to important persons in the patient’s current life, and the present relationship with the therapist. In her discussion of the triangle of conflict, Molnos noted how in individual therapy the relationship between the patient and the therapist threatens the patient because of its immediacy (Molnos, 1995, p. 37).

![Figure 4.1. The Triangle of Conflict](image-url)
The triangle of conflict is related to the triangle of person “by an almost universal empirical observation in dynamic psychotherapy, namely that the intolerable feelings were originally experienced in relation to family members in the distant past” (Malan & Osimo, 1992, p. 34). Once again there is a repetition if these feelings are perceived in relation to people in the patient’s current (or recent past) life. And as a consequence, these early feelings will be directed toward the therapist (transference) during the course of therapy (Malan & Osimo, 1992).

![Figure 4.2. The Triangle of Person](image-url)

The relationship between the triangle of conflict and the triangle of person suggests that Malan’s (1979) model incorporates psychoanalytic concepts within an interpersonal model. In other words, the patient’s problems are interpersonal in nature. Intrapsychic conflict (D A and H I/F), originating in childhood, manifests itself in maladaptive behaviour patterns that are repeated in current interpersonal relationships. This results in the following formulation.

These are the O/P link, where feelings directed towards Other are derived from those directed towards Parent; the O/T link, where some kind of similar feelings are directed towards Other and Therapist; and the T/P link, where Transference feelings are derived from feelings about Parents (Malan, 1979, p. 80).

According to Malan and Osimo (1992) the therapist’s skill consists of being able to recognise, “which elements of which triangle to include in an interpretation at any given moment” (1992, p. 34). This interpretation can also be described, “as asking a question of the unconscious”: i.e. “What is it you are afraid of?” (Malan, 1979, p. 81). In the context of this time-limited approach to practice, it is important to note Malan’s observation that the triangle of person
can be represented by a *triangle of time*: “‘Other’ corresponding to current, or recent past; Transference to here-and-now; and Parent to distant past” (1979, p. 80). See Figure 4.2.

*The Integration of the Triangles*

Malan and Osimo (1992) investigated the effectiveness of 24 brief dynamic therapy cases of less than 40 sessions. In their review of the techniques of the model, these authors conceded that if the triangles are kept separate, it is not easy to grasp the relationship between them. Malan and Osimo acknowledged Molnos’s (1995) thesis that there are three triangles of conflict, one in relation to each of the corners of the triangle of person, thus making four triangles in all.

Molnos’s (1995) model provided a further development of the two triangles, in particular a different notation of anxiety. In Molnos’s (1995) model the patient’s true feelings are, “symbolised by an X, the independent unknown variable at the start of the therapy” (p. 36). Represented diagrammatically, “the large triangle represents the triangle of person, and in each corner there is a small triangle representing the conflict in relation to each of the three categories of person, current, transference, and past” (Malan & Osimo, 1992, p. 35).

![Diagram of Malan’s Integrated Model](image)

Molnos (1995) proposed that the formulation of four triangles acts as a visual guide for the process of brief dynamic therapy.
Four general principles apply in regard to this integrated model:

1) The therapist chooses the area suggested as currently most important by the patient’s material, aiming to clarify the triangle of conflict in this area, and starting with the defence D.

2) In interpreting the hidden feeling X, it is very important to make clear the defences that are being used against it.

3) If possible, A, the anxiety should be interpreted at the same time; but often the nature of A may be self-evident (for example, a fear of experiencing the pain of grief); alternatively it may be unknown, and therefore will not be mentioned.

4) Only when the triangle of conflict has been clarified in one area is the link made to another area.

In addition:

For therapeutic effects to be permanent, usually both a cognitive and an affective element must be present. In other words, the patient must both experience X and understand the nature of the defences, in relation to C and P (Malan & Osimo, 1992, p. 36).

The way these psychodynamic principles are systematically applied in this marital therapy follows.

The Stage-Specific Therapeutic Techniques

The treatment techniques explicated in this model assume that the couple’s relational identity can be modified by the logical and systematic application of three restructuring methods: defensive, cognitive and affective restructuring (Magnavita, 1997). Davanloo (1988) wrote how the term ‘restructuring’ refers to shifting the relationships between the components of the triangle of conflict: defences, anxiety and feelings/impulses. Kalpin (1993) noted that restructuring involves cognitive and affective components, which in turn result in changes to the type of defences used and the way anxiety manifests itself.

Magnavita (1997) stated that in its most simplistic sense these restructuring methods could be defined by the following questions:

Defensive restructuring: “What are you doing right now?”

What is going on between you and me – in the interpersonal field – and of you and others, that interferes with your relationships, goals and so on? Further, what does this indicate about intrapsychic functions.

Cognitive restructuring: “What are you thinking right now?”
That is, what is going on in your head right now that is influencing how you are behaving, feeling and perceiving? It pinpoints the cognitive apparatus and how that apparatus is schematically organized.

Affective restructuring: “How are you feeling?”

It attempts to uncover the affect and its links to current problems. This entails activation of the affective schemas that are usually well protected (p. 18).

*Stage One—Defensive Restructuring*

The focus of stage one of the therapy is on present meanings, the present experience and present directions (Macnab, 1991). In sessions one and two the therapist begins with an exploration of the couple’s defences against intimacy. Within this perspective, the couple’s dysfunctional behaviour can be perceived as an interpersonal process enacted with each other as they attempt to embrace their basic needs for attachment and closeness, without compromising their need for autonomy (Della Selva, 1996). These interpersonal processes and behaviours represent a means of defending themselves against past and further loss (Molnos, 1995, p. 50).

![Figure 4.4. Stage One Defensive Restructuring – Sessions One and Two](image-url)
The Reconstruction of Interpersonal and Interactional Defences

In the first stage of the therapy, the conflict is contained by the empathic assault on the couple’s defensive system. Interpersonal and interactional defences consist of the cognitive, emotional and interpersonal strategies employed by each partner to keep their anxiety-provoking thoughts and feelings out of awareness. Problematic and repetitive patterns of interaction are regarded as goal directed, representing both a means of minimising the anxiety associated with the need for attachment and an attempt to regulate the interactions of their partner (Della Selva, 1993).

Whether there is a general or specific relational disturbance, defensive restructuring has significant implications for the therapeutic process. According to Malan and Osimo (1992), the importance of defensive restructuring lies in dealing with the material most important to the patient. Curtis (1992) observed that when the self-system becomes threatened, the person is able to respond cognitively, affectively or behaviourally in an attempt to problem-solve. In this way, they attempt to preserve their self-representation system by remaining unaware and ruminating, becoming behaviourally inhibited and by ignoring the treatment.

Solomon (1989), in her discussion of the anxiety aroused by the real or perceived withdrawal of love, observed how the couple’s defences could be exhibited in one of two major ways: either by high degrees of relational activity or by passivity. Osimo (1991) also pointed to the centrality of the defences in psychotherapeutic practice. These range from an obsessional definition such as vagueness, distancing, silence, intellectualisation and the regressive defences in the form of unconscious resistance.

Reconstruction of the defences has a number of flow-on effects. It allows the therapist to make contact with each partner at a deeper emotional level. It plays an important part in the establishment of the working alliance. It increases each partner’s awareness of his or her defensive patterns. It enables each partner to perceive his or her conflicted behaviour as a means of self-protection. By systematically pointing to the role of these self-defeating patterns, the therapist attempts to have the partners recognise that the patterns are outmoded and to substitute more adaptive patterns of behaviour (Magnavita, 1997).

Transference Reactions

In this model, transference to the therapist is not considered solely the result of misplaced interpersonal perceptions. Instead, they reflect “the individual’s idiosyncratic ways of construing what the therapist is doing – and the therapist is never doing ‘nothing’, even when
he is being silent or reflecting back a question instead of answering it” (Gurman, 1981, p. 440). Ehrlich (2001) described the phenomenon of resonance between the individual and the therapist as highly relevant in both treatment and outcome. He also noted that little is known of the elaboration of how the therapist becomes conscious on a moment-to-moment basis of his or her inner response to what clients are saying or doing (p. 284).

Unlike individual therapy, where the defensive processes are associated with the therapist, in therapy with couples the defensive processes are not the sole focus of attention. Transference reactions provide important information about each partner’s “feelings, perceptions, misperceptions, and attributions of intent, motivation and loyalties concerning specific therapist interventions” (Gurman, 1981, p. 440). Instead, the transference reaction between the couple becomes an additional focus.

Sullivan (1953) spoke of parataxic distortions. This intrapsychic process predisposes the partners to systematically misperceive and organise perceptions of their intimate other in characteristic ways. Dicks (1967) described how this process enables the partners to deny the reality of ambivalent hate or anger. Instead, they attribute to their partners all those bad feelings that they must not own themselves. Alternatively, they make their partners all good and exalted, while taking on themselves all the guilt and the badness.

**Narcissistic Vulnerability**

In addition, a narcissistic vulnerability is created or exists in conflicted intimate relationships and it requires a defensive structure to protect it. Some defences are recognised as the acting-out or acting-in behaviours. These defences become activated when the partners’ real or internal experiences become more than their protective barrier or self-system can handle. Acting out may take the form of over-work, extra marital affairs, complaining, fighting, sexual dysfunction, overeating or substance abuse. Other individuals may express their anxieties as a form of ‘acting in’, with depression, illness, lack of motivation or direction being among the most common forms of expression (Solomon, 1989).

Molnos (1995) described acting out as a hidden manifestation of destructive anger, which is not experienced as anger or any feeling, but it is acted out instead. Similarly, Molnos referred to acting in as the repressed, unrecognised fury. The expression of these defences against self-encroachment can also be manifest in psychosomatic symptoms, accident proneness, suicidal ideation and other unconscious acts of self-sabotage whether at work or in relationships.
This behaviour reflects the inevitable conflict of an inner self, oriented overwhelmingly toward enhancing and fulfilling two sets of powerful emotions ‘bonding’ and ‘dominating’ (Douglas, 1984). The presence of these behaviours in conflicted relationships represents each partner’s struggle for (a) self protection, (b) defence of the marital myth, or (c) to keep one’s world-view in a stable state. Those who cannot find love, intimacy and sex commonly become ‘power hungry’ and ‘aggressive’, or they become helpless, powerless and depressed and search for substitute satisfactions.

By contrast, people who cannot successfully dominate become submissive and are commonly very dependent in their loving, intimate and sexual relations (Douglas, 1984, p.86). This results in their partner’s actions or inactions being considered as bad. The partners are perceived as mean, selfish, inconsiderate or deceitful. Alternatively, one partner may label the other as emotionally disturbed, hysterical, compulsive, dependent or afraid of intimacy (Jacobson & Christensen, 1996). Under consideration, is the need for the couple to negotiate a number of implicit needs and tasks: how to connect, yet not merge; how to respond, yet not be absorbed; how to detach, but not withdraw.

Stage Two—Cognitive Restructuring

A strategic shift in the clinical focus, from the defences to the cognitions, takes place in the third and fourth sessions of the therapy. From its emphasis on the present in the previous two sessions, now the focus turns to the past. The structured clinical focus in stage two of the therapy confronts each partner with the need to become aware of the way they have been driven by unacknowledged or previously unknown developmental histories or regressed defensive patterns (Macnab, 1991).
The Reconstruction of the Partners’ Internalised Schemas

Cognitive restructuring requires an in-depth exploration of the partners’ internalised schemas, templates and inner-representations (Magnavita, 1997). Beck (1998) emphasised how the goal of cognitive restructuring involves the identification, evaluation and response to a person’s dysfunctional thoughts and beliefs. The goal of this technique is to have the partner recognise that it is not the situation that directly causes their reaction. But rather, their interpretation of situations influence how they feel emotionally and how they act and react.

Cognitive restructuring addresses the rigid, global, negative beliefs the couple have about themselves, their world and other people that stem from childhood. The contemporary threat or deprivation may be a realistic contemporary phenomenon that arouses both unconscious and confused conscious material. Using this technique, the therapist helps the couple to understand more fully their situation and that his or her perception of the other might not be entirely accurate. Beck (1998) suggested that the process of the reconstruction of the cognitions helps the individual to see that given his or her respective developmental histories, it is natural for them to have integrated negative experiences. Or alternatively, it shows how they have failed to acknowledge the role of positive data (p. 189).

The therapist uses cognitive restructuring to examine the way each partner’s schema shapes the construction of the self and contributes to the negative events between them, and with
other people in their worlds. As each new wave of defences against intimacy and closeness emerge, the therapist attempts to separate the partners’ emotions from the underlying problems (Macnab, 1991). Whereas, previously the couple’s problems had appeared outside their control, by the use of more appropriate coping and problem-solving skills the couple’s ability to differentiate the problems from their affective loading increases.

The use of this technique challenges the couple to adopt more effective methods for dealing with their thoughts, feelings and fantasies. Successfully executed, the separation of the problem from its affective loading results in a form of cognitive acceptance (Macnab, 1991). Participation in such a strategic and structured focus has the potential to enhance the couple’s affective regulation and tolerance. By increasing their capacity for having a collaborative relationship and their tolerance to discuss and to confront material that is often disturbing, the process produces a form of psychological mindedness (Beck, 1998).

The Deconstruction of the Relational Narrative

The use of cognitive restructuring techniques reflects the growing view of psychotherapy as a re-narration of the client’s life story. From a contemporary interpersonal point of view, Hirsch and Roth (1995) noted that participants in psychotherapy negotiate a mutually constructed understanding of the entanglement of their history and interactions. The construing of life experiences through telling a story to oneself and others represents a major revisionist movement within psychoanalytic theory and practice (Schafer, 1992; Spence, 1982). This mutually constructed understanding represents a storyline in Schafer’s (1992) view, or narrative in Spence’s (1982) view, that makes sense to the couple and the therapist.

In this meta-perspective, stories are representative of the constraints and guidelines that render lives comprehensible. Harvey, Weber and Orbuch (1990) found that stories represent a major way in which individuals attempt to understand themselves. From a therapeutic perspective, Schnitzer (1993) described the task of narrative deconstruction as an examination of the uncharted region of the unimagined, non-verbalised, unexpressed and censored, which may not be communicated. Implicit in the retelling of a family story is a prioritizing of what can or should be said. In addition, the process represents what the speaker chooses to leave unsaid (pp. 454-5).

To achieve this objective the therapist works from the position that what is being heard are not ‘truths’ but ‘renditions’. Spence (1982) called this process ‘historical truth’ and ‘narrative truth’. In listening for what is unsaid, the therapist can distinguish between the censored and the not-yet-expressed. In particular the therapist can distinguish how memory
and expectation inform the present. That is, the process requires active listening on the part of the therapist for the gaps, distortions, reifications, identifications, idealisations and narcissistic investments that the individuals present in the narrative (Schnitzer, 1993).

Such a therapeutic focus means that each partner’s narrative can be perceived as a chronicle that moves across time from the beginning, through the middle, to an ending (Schnitzer, 1993). Schnitzer (1993) observed it is important for the therapist to perceive the ‘story metaphor’ as a personal rendition, whose meanings are dynamic across time and are a reflection of the interpersonal and cultural context in which they are expressed. To more fully understand this process Penn (2001) referred to the role metaphors play in the production of new meaning; “metaphors do something different” (p. 45).

Stage Three—Affective Restructuring

As the couple’s attention becomes directed toward the future, the last two sessions act as the beacon ahead. By first restructuring the defences and then the cognitions, in the final stage of the therapy the treatment focus shifts to the affect. By bringing past, present and now future together, a form of turning in on the self takes place.

The sequential restructuring of the defences, the cognitions and now the affect challenges each partner to address the person they might become. It raises the question of how they might live (Macnab, 1991). The concept of an alternative self implies the idea of an ‘observing ego’, more mature forms of relating and the incorporation of a more benign introject (Messer & Warren, 1995). To achieve this treatment objective the therapeutic discourse focuses on the different expressions of the self.
The Examination of Self Organising Processes

The technique of affective restructuring enables the therapist to demonstrate to the couple how with time, a new experience of self, other and context might be formed. The process of affective restructuring highlights the way in which the choices the couple make influences their own and their partner’s self-esteem and self-efficacy. The expression of primary emotion brings to consciousness the realities, fantasies, anxieties and cognitive confusion associated with existential choice. Teyber (1997) stressed that the emotions likely to be aroused in this stage will be the fear, sadness and grief associated with the shame and guilt about the failure to live up to one’s desired self-image.

In her discussion of self-organising processes, anxiety and change, Curtis (1992) suggested that a new paradigm of self-organising processes has emerged from social, cognitive and clinical psychology. She argued that this new paradigm demonstrates how much information is not integrated into consciousness when self-representations become threatened. Therefore attention and memory are selective by their very nature “anxiety occurs in three situations — when the preservation of self, self-representations, or a positive sense of well-being are threatened” (Curtis, 1992, p. 295).

As each partner’s emotions become heightened and his or her self-awareness increases, links and associations to the past occur and further derepression of memories and connections can
be expected (Magnavita, 1997). Past experiences will be seen as belonging to a self that has been disposed of, altered in some way, or as being without importance for the present (Weiss, 1975). Such an existential experience confronts the couple with the need to increase their motivation and to move toward an increased capacity for intimacy (Magnavita, 1997). The self-organising processes aroused by the process of affective restructuring can be likened to a very particular form of self–other biography or the development of empathy for self and other.

The Creation of Empathy for Self and Other

Kohut (1977) saw narcissism as the soil from which higher forms of narcissism, such as creativity, humour, and the acceptance of mortality spring. Further, he proposed that human aggression was not an innate instinct, but rather a disintegration product of a non-responsive environment (White & Weiner, 1986). The mere presence of empathy, according to Kohut, whether in a clinical setting or in human life in general has a beneficial effect.

For Kohut (1977), creation of what he described as a ‘selfobject milieu’ provides a context in which a person feels listened to by another seemingly sensitive human being who seeks to understand who we are and explain us to ourselves. Little (1985) described biography, or the finding of the self in others, as one of the most widely shared human concerns. In Little’s thesis, in a good part of each ordinary day, there is not simply either society or the individual. People strive to determine who they are and to discover themselves in the other.

In effect, the social and the individual are the same thing. Instead of being shaped by external, social or historical influences, individuals become authors of their own destiny. By highlighting the importance of the social context, this psychosocial construction of identity requires a distinguishing individual pattern of experience. Building on Sartre, Little (1985) called this thrust for affiliation ‘projects’. For Little the question is: “Which biography?” And: “Who will we become?”

Carpenter and Treacher (1989) referred to the intensity of the feelings aroused by this process as being due to the intensity of human relationships and the emotional bonds that give life meaning. According to White and Weiner (1986), empathy for self and other is one of the most crucial emotional experiences for psychological survival and human growth. In the present context, the ability of the individuals to develop empathy for his or her partner remains pivotal to the therapeutic process. Winnicott (1971) described the mutuality of two people being found and created by each other as the “potential space”, an intermediate area free of objective perception where two people can imagine together.
In this chapter a description of the psychodynamic principles informing the time-limited treatment model have been provided. The constructs that are central to the treatment were defined, operational definitions of the interventions were given, and more precise information about the practice of the therapy provided. A detailed description of the psychodynamic principles was considered not only to treat the couple more effectively, it creates the ability for the therapist to contain their own anxieties, and to improve their sense of personal and professional efficacy. The way these principles are translated into technique will be the focus of discussion in the next chapter. There, a treatment plan for stage one of the therapy will be described, and the clinical format and the specific techniques required for therapeutic change will be detailed.
CHAPTER 5

The Therapeutic Process Stage One

Overview

This chapter will begin the discussion of the therapeutic process for treating different expressions of marital psychopathology and disturbance. Consistent with the concept of the praxis as a process of mourning, these chapters will describe how as the therapy progresses protest turns to despair, disappointment begins to mount, hopes of reunion fade and feelings of sadness and depression set in (Bowlby, 1961). In stage one of the therapy being discussed here, it is assumed that the partners will not readily relinquish the love object and will cling to it with considerable tenacity. This results in many therapists failing to engage couples because of their inability to contain the partners’ heightened anxieties and the feelings of hostility and fear associated with abandonment. In this chapter, the psychodynamic formulations, psychotherapeutic processes, and interventions required to contain each partner’s anxiety, and to establish an empathic therapeutic alliance and create a sense of realistic hope will be discussed.
Stage One – Defensive Restructuring

Psychoanalysis has provided valuable insight into the role of passion, its sources in early childhood experiences, its role in relationships and its contributions to imagination and creativity (Brown, 1994). Fromm (1991) wrote that grand passion is to be found in the dynamic tension between the archaic, irrational, regressive ‘malignant’ passions and the ‘benign’ passions for love. Just as contemporary psychotherapy has moved away from the drive–conflict model, there has been a corresponding shift in the focus of treatment from conflict resolution to self-realisation (Summers, 2000). Kwawer (1991) observed that psychotherapy represents “an inner confrontation with malignant passions, ultimately in the service of strengthening of life instincts” (p. 617).

In contrast to the view of marital distress as having uniformly negative effects, it is proposed here that one of the outcomes of the therapeutic process is the potential for higher levels of emotional maturity (separation-individuation). Alperin (2001) asserted that a successful separation–individuation process, including the establishment of secure boundaries between self and object, and the formation of a separate self-identity are prerequisites for the capacity for intimacy. The intent of this conceptualisation is to perceive the psychological processes aroused by the experience of separation–individuation, not only as a process of detachment from the love object, but as a process of transformation (Baker, 2001).

The Stage-Related Process—Protest

In stage one the psychological processes aroused by the disruption to intimate relationships are perceived as variants on the states of mind that are common after stressful life events. These include periods of outcry, denial, searching for the lost object, emotional numbing and warding off implications (Horowitz, 1988). Parkes (1971) used the term psychosocial transition to describe the positive and negative emotions associated with major life events such as marital disruption. Cordova, Cunningham, Carlson and Andrykowski (2001) referred to the concept of psychosocial transition as being consistent with existential theory. The experience of separation, loss or estrangement confronts the partners with their mortality. Such an experience can lead to re-evaluations of life goals and their priorities, greater investments in personal resources, in relationships and in spirituality.

This psychodynamic formulation has as its focus the partner’s feelings of pain, hopelessness and helplessness that become aroused by the real or anticipated loss of a love object (Bowlby,
1961). Consistent with the concept of the praxis as a process of mourning, it is assumed that as the therapy progresses protest will turn to despair, disappointment will begin to mount, hopes of reunion will fade and feelings of sadness and depression will set in (Bowlby, 1961). In the first two sessions, it is assumed that partners in conflicted relationships will not readily relinquish the love object and will cling to it with considerable tenacity.

This psychodynamic formulation helps to explain the painful affects such as rage, despair and devaluation that are common experiences of people presenting for marital therapy. Bowlby (1961) noted a sequence of processes, which emerge when for any reason a person loses a loved object as:

the intimate relationships of grief and separation anxiety, the urge to recover the lost object that is dominant throughout the first phase of mourning, the weeping and the aggressive acts that are a part of it, and the roles of disorganization and subsequent reorganization that are the main processes occurring in the second and third phases (p. 338).

Following separation or death, the person finds themself in disequilibrium, bewildered and unable to believe what has happened or grateful that the suffering is over. At first there is a strong tendency to continue to act as though the lost partner were still present. However, coupled with the incredulity of loss goes a strenuous effort to recover the lost object or to find a new and better object (Bowlby, 1960). In discussing anxiety, Bowlby wrote that some measure of separation anxiety is the inevitable counterpart of a love relationship. Bowlby (1960) wrote that

just as unconscious hostility directed towards the loved object increases expectant anxiety, so does expectant anxiety, especially in regard to whether or not one is loved, increases hostility….Further and more important is that, because the hostility is directed towards the loved object, it is often repressed and, being repressed, tends to generate further anxiety (pp. 108-109).

Looked at in this way the partners’ heightened levels of anxiety and hostility at presentation, are easier to understand. Bowlby (1961) observed how death of a love object is rare compared to the many separations encountered throughout life. He wrote

Almost every separation has a happy ending, and often a small or large dash of aggression will assist this outcome. It may assist too in ensuring that it will not be repeated…. It is in its function of ensuring that separation will not be repeated, perhaps, that we can see most clearly the adaptive function of aggression when it is directed against the loved object itself (pp. 333-334).

The urge to recover the lost love object, results in the assumption that in the first two sessions of the therapy the partners’ relational issues will evoke memories of earlier separations and
the painful affect—grief, rage, devaluation of the love object—associated with earlier losses (Strupp & Binder, 1984). A second assumption is that many people enter psychotherapy because they have been unable to resolve earlier traumas or losses. This conceptualisation results in the couple’s issues being perceived as representative of unresolved dependency on earlier lost objects with whom they have unfinished business (Strupp & Binder, 1984).

Bowlby (1961) advanced that unfavourable personality development can be attributed to prolonged unsatisfactory responses to loss. Such an experience can dispose the individual to respond similarly to all subsequent losses. Fonagy (1998) proposed that highly dysfunctional adult attachment strategies represent the inevitable consequence of disrupted early attachment relationships. In Fonagy’s view, disruption in early attachment can jeopardise psychological functioning to such an extent that it becomes difficult to maintain normal, intimate, interpersonal relationships.

Transformation of Inner Working Models

Consistent with the psychoanalytic understanding of normal and pathological mourning, a distinction is needed between a normal response to separation and loss and its pathological intensification. In normal grief reactions, the pangs of anger are modulated and individuals do not remain in intense or prolonged rageful states. In pathological grief reactions, the rage is more intense and lasts a lot longer in some. In others they can become neurotically helpless, needy or irresponsible (Horowitz, 1988).

Horowitz (1988) described the psychological experiences involved in a traumatising experience, such as the threat of real or perceived abandonment, as follows:

In intense states of fearful worry, often associated with pangs of utter despair or moments of giving up on life, the person may act according to schemas in which the self is weaker, more defective, and less capable than is actually the case. This person may have suffered intense separation anxiety in childhood or adolescence whenever separated from a nurturing caregiver. Now they feel not only loss, but as if suffering an abandonment beyond their ability to tolerate (p. 69).

In this perspective, mourning requires both a relinquishing and a learning process. “During mourning, one abandons certain schemas and learns new ones” (Horowitz, 1988, p. 64). Horowitz (1988) wrote that any loss results in a disruption of self-organisation and requires the revision of the individual’s schemas. One of the results of the mourning associated with the inner transformation of images of self, other and relationship involves a revision of schemas that are prototypical of other types of stress-induced change (Horowitz, 1988).
The conceptualisation of the therapeutic process as the transformation of the partners’ inner working models involves the therapist in a breaking down of the partners’ emotional reactions associated with loss. Della Selva (1996) observed that the activation of mourning processes in the therapeutic setting compels the individual to face the impact of their past losses and the effects these have had on their life. As the partners start to work through their loss, the ability of the therapist to restore their self-organisation and schemas to an acceptable accord with reality increases (Horowitz, 1988).

The experience of intersubjective holding created by the time-limitation provides opportunities for the partners to engage in interpersonal, cognitive and affective processes previously not available to them. This process enables the partners to discuss the problems that are most distressing, recurrent and remediable (Beck, 1998). Talking, thinking and participating in the therapeutic process may elicit reappraisal and integration of the experience of loss. Baker (2001) described such a transformed inner relationship as not being identical to the previous object relationships.

Building on the work of Horowitz (1990) in this therapy, the overall progression of schematic change as the partners participate in the therapy can be schematised as shown in Figure 5.1. Cordova et al. (2001) noted how cognitive processing models such as the one being proposed in Figure 5.1 hold that distressing experiences “disconfirm assumptions about the self, the world and, the future” (p. 177). Conceptualising the therapeutic process schematically, allows the therapist to recognise recurrent themes, dysfunctional reactions and to identify the partners’ core beliefs and assumptions (Beck, 1998). The greater the ability of the individual to develop new assumptions, skills and coping mechanisms, the greater the opportunity for positive existential and interpersonal growth.
A wide body of research supports the view that marital distress is grounded in attachment problems (see Davila & Bradbury, 2001). Davila and Bradbury (2001) challenged the belief that people stay in unhappy marriages because of moral, cultural, social, economic or religious beliefs. Instead, they found that compared with either spouses in happy marriages or people who have divorced, spouses in stable but unhappy marriages showed the highest levels of attachment insecurity, both initially and over time. Penn (2001) used the term ‘relational trauma’ to describe the physical stress, isolation and feelings of helplessness associated with unhappy marriages.

In the first session of the therapy there is an acknowledgement of the partners’ unresolved issues. As described in detail in chapter four at pages 92-95, the defences that are obstacles to resolving them form the basis for treatment planning. Session one is based on the assumption that the partners will not readily relinquish the love object and will cling to it with considerable tenacity. The partners are considered as unconsciously wishing “to reinstate the earlier relationship, perpetuate it, and/or bring it to a more satisfactory resolution” (Strupp & Binder, 1984, p. 260).

Horowitz (1997) suggested that an important factor in the formulation for psychotherapy is the question of what can change. Thus:
Modifications can be made to dysfunctional beliefs about how the development of the self is due to excessive fear or inappropriate despair. Past memories and fantasies can be reappraised, areas of confusion clarified, contradictions integrated and conflict resolved and incomplete mourning completed (p. 1).

**Treatment Planning**

**Assessment of the extent of the marital conflict.**

For the therapist, the first session of the therapy involves a number of assessment tasks. These involve the therapist’s assessment of the extent of the conflict, while also making a preliminary diagnosis of the partners’ interpersonal processes and attachment styles. In the assessment phase of the session, a major question confronting the therapist is, “What keeps this couple in such a (destructive) relationship?” (Hartin, 1977).

Papp (1982) described how couples seldom have a clear picture of what the problem is between them. Because relationships are complex and the partners are often polarised “the basic conflict is usually buried under a morass of irrelevant details, accusations, projections, denials, defensiveness, and vague statements such as, ‘We don’t communicate’ ” (Papp, 1982, p. 357). Papp (1982) highlighted the need for the therapist to listen carefully to the manifest content of the conflict, as well as seeking the underlying tensions. While the presenting issue may reflect the partners’ inner confusion, it may also reflect insufficient coping mechanisms, inadequate parenting skills and other failures of the environment.

In discussing this paradox, Slipp (1993) noted that:

> while their original articulation of their issues reflect a grasp of certain facets of their relationship, the couple will know far more than they are able to say. In voicing their concerns, they will know things, however intuitively, that they are unable to comprehend in words (p. 183).

Couples may consciously withhold important information, while unconsciously employing a wide range of regressive defences. While the couple may be acutely aware of the self-destructive and damaging consequences of their behaviour, genuine dialogue is frequently absent. Each person’s self esteem (ego identity) is felt to be dependent upon the behaviour of his or her partner.

Signs of the defensive process may include conflicted topics, unintegrated memories, dissociated views of identity and thwarted ambitions (Della Selva, 1996). Strupp and Binder (1984) noted how defensive operations serve a self-protective function by shielding the person (however ineffectively) from the experience of painful affects, such as anxiety. This
affect may include, “a dreaded state of feeling empty, sour and depressed or an anxious state of fear of loss of contact” (Della Selva, 1996, p. 102).

Assessment of the partners’ patterns of responses to abandonment.

The psychological processes being described here can be illustrated by reference to the responses that Ainsworth et al. (1978) and her colleagues observed in the strange situation. In the laboratory situation Ainsworth et al. observed infants of one to one-and-a-half years, who were temporarily separated from their caregivers. The infants were exposed to two brief separations from their caregiver, once for three minutes and once for six minutes. The way the caregiver and child greet each other on reunion reveals the reciprocal strategies of caregiving and careseeking under stress. Four behavioural strategies were observed in the infants: ‘secure’; ‘insecure – anxious-resistant’; ‘insecure-ambivalent’ and ‘disorganised-unresolved’ (Ainsworth, et al, 1978).

Byng-Hall (1995) noted that the children in Ainsworth’s study were also observed for many hours at home. Congruent patterns of interaction were found, thus giving validity to the observation that the typical scenarios evoked in the strange situation can be used to illustrate important aspects of attachment relationships. Appropriating and applying the concept of secure and insecure attachment in the context of this marital therapy can be seen in Table 5.1.

Table 5.1

Patterns of Response to Abandonment by the Partner

Secure Attachment Pattern

Upon reunion
1. Immediately seeks and maintains contact
2. Are happy to see partner
3. Contact is effective in terminating distress
4. Able to return to relationship

Anxious-Resistance Attachment Pattern

Upon reunion
1. Mix contact seeking with contact resisting
2. May continue attention seeking behaviours
3. Are not able to focus on relationship
4. May show striking passivity / depression
Table 5.1 continued

Anxious-Avoidance Attachment Pattern

Upon reunion
1. Active avoidance (turning way, looking away, moving away, ignoring)
2. May mix avoidance with proximity
3. Avoidance becomes more extreme
4. Seek solace in other activities or people

Source: Adapted from Cortina, 2001.

Treatment Objectives

To understand more clearly each partner’s attachment processes, the major treatment objective of the first session is to reduce the relational conflict and to clarify the partners’ interpersonal defences. The following outline serves as a conceptual framework for organising the material emerging during the session, as well as in guiding the therapist toward the relevant topic areas (Strupp & Binder, 1984). Strupp and Binder (1984) noted that in the process of assessment the therapist should take note of the following matters:

1) In what period(s) of the patient’s life and in which kinds of relationships is there evidence of difficulties reflecting the current problems that led the patient to seek treatment?

2) In surveying the patient’s interpersonal relationships over the course of his or her life, note the qualities of relations and interactions with (a) peers; (b) authority figures; (c) those perceived in subordinate roles; (d) others of the same sex as the patient and (e) others of the opposite sex.

3) In surveying the patient’s interpersonal history and current relationships, note evidence of conflicts around (a) anger, aggression, and assertiveness; (b) passivity and dependency; (c) interdependence and intimacy, (including separation/autonomy struggles); (d) affectionate, tender, loving feelings and yearnings; (e) playfulness and spontaneity; (f) sexual impulses and feelings and (g) pleasure and enjoyment versus constriction of impulses and feelings and/or dysphoria (p. 62).

Obstacles to Engagement

Central to the conceptualisation of the assessment phase is a consideration of the obstacles to therapeutic engagement. Although the therapist assumes responsibility for the pace and direction of the therapy from the outset, in the initial evaluation the therapist does not comment directly on the defences. Book (1998) documented that the therapist’s ability to maintain vital defences offsets regression and protects the patient against injuries to his or her self-esteem or self-worth.
In session one there is an expectation of high levels of ambivalence by each partner toward
the therapist and the process. The traditional psychoanalytic view portrays ambivalence as
“the simultaneous existence of contradictory tendencies, attitudes or feelings in the
relationship to a single object—especially the coexistence of love and hate” (Laplanche &
Pontalis, 1988). In this perspective, ambivalence is exhibited in certain pathological
conditions and in certain states of mind such as in jealousy and in mourning. It also implies,
that ambivalence will also be found in healthy relationships.

While paying attention to the role of ambivalence in their conceptualisation, the therapist
strives to validate the couple’s maladaptive interactional patterns by interpreting them as
stressed the importance of keeping the clients focused on the present to overcome their
anxieties about each other and the process. This experience provides them with a sense of
security, while allowing them to grapple with the issues over which they have some control.

Horowitz (1988) noted how ambivalence denotes the desire to approach or avoid another
person, while at the same time experiencing both attraction and repulsion, love and hate, care
giving and destructive aims. Unlike the traditional psychoanalytic definition of ambivalence,
Horowitz (1988) asserted that ambivalence is not pathological but a common human
condition. “Those who love want love in return, and are frustrated if they do not get all they
desire” (Horowitz, 1988, p. 71).

Resistance.

Just as there are many potential ways to define conceptually and clinically the role of
ambivalence in the therapeutic process, the formulation of the partners’ resistance to the
process presents similar complexities. According to Laplanche and Pontalis (1988) resistance
is one of the relatively few strictly process constructs in psychoanalytic treatment. The term
resistance “is given to everything in the words and action of the analysand that obstructs his
gaining access to his unconscious” (p. 394).

Contemporary approaches to practice provide an alternative view of the role of resistance in
the therapeutic process. From an interpersonal perspective, Bromberg (1995) defined
resistance “as not simply an avoidance of insight or a fear of change, but as a dialectic
between preservation and change—a basic need to reserve the continuity of self-experience in
the process of growth by minimizing the threat of potential traumatization” (p.174). Such a definition suggests resistance can instil meaning, while creating a sense of belonging.

Strupp and Binder (1984) provided the following interpersonal perspective of resistance as an obstacle to therapeutic progress:

We view resistances not as the mere expression of oppositional psychic functions but rather, from the patient’s viewpoint, as unconsciously derived personal actions aimed at maintaining a sense of security and avoiding some form of danger, and directed by unconsciously held convictions about oneself and others. We conceptualize resistance as patterns of construing experience as modes of behaviour based on those subjective views (p. 181).

Similarly in Existential–Humanistic models, resistance is not viewed as being confined to therapy, or as being solely directed toward the therapist. Instead, resistance is regarded as resistance to self-exploration. Resistance is perceived as part of a “self-and-world construct system” a set of coping resources (Yalom & Bugental, 1997, p. 125).

Yalom and Bugental (1997) also noted that to bring about change in psychotherapy, the therapist must see, feel and experience the client’s patterns of resistance.

We help them become aware of these self-defeating patterns by calling the client’s attention to them as they are being enacted in the consultation room. At first gently but with increasing force we need to repeat these interventions (p. 126)

*The Therapeutic Process*

*The therapeutic alliance.*

A strong therapeutic alliance is central to most schools of psychotherapy. Yalom and Bugental (1997) noted that a therapeutic alliance based on the foundation of empathy and therapeutic presence allows for in-depth exploration. An empathic therapeutic alliance creates security and allows the therapist’s comments or behaviours to be perceived as coming from a foundation of support and caring. In this model, the therapist attempts to achieve this objective by: (1) gaining positive entry to the couple’s world; (2) creating an empathic holding environment, and by (3) exiting the session by establishing a collaborative working relationship (Macnab, 1991).

*Gaining Positive Entry to the Couple’s World*

Entry to the couple’s world takes place from the moment the therapist makes first contact in the waiting room (Macnab, 1991). As this often occurs when the couple are in crisis, their
anxieties are likely to be heightened. This means that they are more likely to be highly defended or more dysfunctional than they would be at other times.

The first step in the process requires the stabilisation of the emotions of the couple; any surrounding biological or social circumstances related to the presenting issues become paramount (Horowitz, 1997). This requires an assessment of the issues and circumstances that are likely to have direct links to the couple’s level of interpersonal functioning. At the same time, the therapist is aware of the need to empathically affirm both sides in the interpersonal dispute. Teyber (1997) wrote of how:

Their primary task is to resist the couple’s eliciting manoeuvres and keep from taking sides by participating in the good guy/bad guy, overadequate/inadequate, healthy/neurotic, or other polarizations that the couple presents. When couple counselling fails, one member of the couple usually stops treatment because she or he accurately perceives that the therapist has taken sides in the marital conflict (p. 256).

By taking control of the process at the outset, and addressing each person by name, the therapist attempts to avoid recurring accusations or recriminations about partiality. Della Selva (1996) noted that taking control from the outset clearly and efficiently communicates that the aim of the therapy is the resolution of problems. Salzberger-Wittenberg (1988) wrote of the need to create immediately the potential for the couple to understand, and eventually to integrate, the painful situation in which they find themselves.

Creating an empathic holding environment.

Throughout the marital therapy, a number of key therapeutic techniques are used to reduce the couple’s uncertainty and the anxiety associated with an unfamiliar and potentially threatening setting (Levenson, Butler, & Beitman, 1997). Cashdan (1988) observed that in marital therapy, empathic reflection is not only an important means of engaging the couple, it prepares them for what lies ahead. Empathic reflection allows the therapist to consider how and why adaptive change might occur and to formulate what interventions might be necessary (Horowitz, 1997).

Like most clinical aspects related to intersubjectivity, the meaning and relevance of empathy to clinical work continues to attract debate (Ginot, 2001). Many definitions and descriptions of empathy have been offered. Bolognini (2001) provided the following:

Empathy is a condition of conscious and preconscious contact characterized by separateness, complexity and articulation—a wide perceptual spectrum including every color in the emotional palette, from the lightest to the darkest—
and above all, it incorporates progressive, shared, and deep contact with the complementarity of the object, including the other’s defensive and split-off parts, no less than the other’s ego-syntonic subjectivity (p. 453).

In the marital context, Salzberger-Wittenberg (1988) described empathy as the therapist’s ability to put him or herself into each partner’s world. It involves imaginatively using one’s mind, as if it could be inside the other person’s. Because it involves feeling, empathy requires that the therapist project a part of himself or herself into the couple. At the same time, it involves the therapist becoming sensitive to the echoes and vibrations set off by another’s projections. Empathy requires the therapist to be reliable, attentive and sympathetically responsive to the couple and their presenting issues (Salzberger-Wittenberg, 1988).

Salzberger-Wittenberg (1988) noted how the empathic process makes it safe for the partners to express their grievances and hostilities, without feeling the relationship is bound to break up. The experience of empathy results in both partners being given the space to be heard, while having their respective positions valued. In this environment, the partners’ unconscious and frightening feelings can be contained, explored and redirected. The adoption of an active, dynamic, yet empathic intervention establishes a set of expectations about the possibility for change.

Exploration of the Presenting Issues

From the outset of the session, the therapist demonstrates the highly structured, intensely focused and directive nature of the therapy (Papp, 1982). By a careful process of experiencing the mood, of listening and of observing the couple’s reactions, the therapist commences the session by addressing the partner who appears most anxious to begin the session. The therapeutic discourse with the imaginary couple ‘Steven’ and ‘Michelle’, might be as follows:

T:  Steven, tell me what is happening in your relationship that has led you to seek the assistance of someone like me?

S:  We have a lot of problems in the marriage at present. Michelle is unable to cope with the children, and our communication has broken down.

Next, aware of the need to engage both people in the process of the session the therapist turns to hear the other partner’s perception of the issues and their involvement in them. At this early stage, it is important for the therapist to understand, hold and contain the partners’ mental pain. From this perspective, the therapeutic experience functions as a container for multiple levels of reality.
Ginot (2001) asserted that Winnicott’s concept of intersubjective holding in the therapeutic environment is seen “as inextricably connected to the feeling of being understood and experienced by the other within the intersubjective matrix” (p. 420). Modell (1990) wrote of how such an experience in the therapeutic setting makes it possible for memories to be remodelled by current experiences. For example, helping a couple recognise the unique, unconscious and invariant principles that organise their own experience and that of their partner.

Bader and Pearson (1988) documented how the technique of empathic statements provides a clarifying description of some inner state, promotes a feeling of self-acceptance and increases affect tolerance. Empathic statements create the potential to shift the therapeutic dialogue from the factual to the emotional. The use of this intervention keeps the partners focused in the present, and addresses the metacommunication in the partners’ remarks.

The use of empathic techniques by the therapist communicates to the partners that their feelings are acknowledged and that their pain is appreciated. Cashdan (1988) described the technique as emotional linking. Cashdan (1988) provided the following example to illustrate the importance of emotional linking in the early stages of therapy: “It makes you happy when you talk about… You seem upset whenever the subject of… comes up. You’re really annoyed at…” (p. 88).

Supportive and expressive techniques.

In commenting on the intervention models in psychoanalysis and psychotherapy, Wallerstein and de Witt (1997) made a distinction between the supportive and expressive techniques of “expressive (interpretive, insight-aiming, uncovering). … [versus] supportive (ego-maintaining, suppressive)” (p. 129). Book (1998) defined these techniques as follows:

Supportive activities are those that allow the patient to feel safe enough in the therapeutic arena to tolerate the anxiety associated with uncovering painful, repressed material. Expressive activities, such as empathic comments, clarifications, confrontations, and interpretations, encourage the patient, once he or she feels safe, to become aware of and express previously disavowed material (p. 18).

Levenson et al. (1997) also documented how the use of ‘expressive activities’ by the therapist can be anxiety provoking. Yalom and Bugental (1997) noted that the use of supportive techniques in psychotherapy is sometimes seen as antithetical to real growth or depth work. Hence:
Rather than limiting the scope of the therapeutic exploration, support helps to provide the safety and container which make the work possible. Within a strong framework of support, the therapist is freer to nudge, push, and confront clients toward facing the areas in their lives of deepest concern (p. 119).

To be effective, this technique requires the couple to be actively involved, to be co-operative and to have at least a minimal level of trust in the therapist. The appropriateness of supportive techniques in the process of this marital therapy is the emphasis on current circumstances, symptom amelioration, skills acquisition and the improvement of self-esteem.

**Diagnosis of the Partners’ Levels of Emotional Development**

Once the therapist has gained a preliminary understanding of the partners’ interpersonal processes, he or she then attempts to make a determination of the pervasiveness of the partners’ neurotic and characterological problems. While the first session is about gathering a great deal of information in a brief time, it is also about diagnosis (Strupp & Binder, 1984). The therapist’s goal is to obtain a clear recognition of the partners’ needs, anxieties, fears and limitations (Penn, 2001).

**The role of countertransference in conceptualisation and treatment.**

Throughout the process of the session the therapist must be alert constantly to the affective reactions evoked by the couple’s maladaptive modes of relating (Strupp & Binder, 1984). Although perspectives on therapeutic action differ among theoretical schools, generally the importance of the therapist’s emotional reaction in psychotherapy is considered essential to the therapeutic process (Ehrlich, 2001). It requires the therapist to monitor closely his or her own inner experience. The potential to create new possibilities for the couple means that any stray thoughts or free associations aroused by the therapeutic experience become central to the process.

Horowitz (1997) described how the therapist might facilitate a person’s efforts to change in two important ways. “Therapists are sometimes relatively passive (carefully listening) and at other times relatively active (speaking)” (p. 5). These activities involve the therapist in the process of ‘free-floating attention’ and ‘focused attention’ (Horowitz, 1997). The technique of free-floating attention involves the therapist in the observation of the couple, the therapeutic process and the consequences of the couple’s interaction with each other.

Focused attention involves the therapist in the consideration of the couple’s maladaptive phenomena. Both of these techniques involve attention to more than what is being said; the
therapist must watch carefully for the other partner’s reactions. Also with these techniques, the therapist has to pay close attention to his or her own emotional and imaginative responses.

Such subjective information provides important clues about what the partners omit, their level of defensive functioning, recurrent interpersonal themes and each partner’s sense of agency (Book, 1998). Sharpe (1997) observed that if critical countertransference communication is ignored, it could have an inhibiting effect and interfere with the spontaneous reaction and receptivity of the therapist. Levenson et al. (1997) noted, negative counter-transference “can threaten the therapeutic alliance, and the therapist must be alert to its emergence” (p. 20).

Assessment of the Couple’s Developmental Context

Once the therapist has gained a preliminary determination of the factors contributing to the relational dissatisfaction, each person’s coping strategies come under consideration. As the partners are confronted with the need to reflect on the issues in the relationship, the therapist’s task is to demonstrate how their relationship might operate differently. This phase of the session is characterised by the ability of the therapist to conceptualise the interpersonal conflict with the partners’ past experiences, losses, and separations.

At the forefront of the therapist’s thinking sits the diagnostic question of: ‘Why Did Jack Marry Jill?’ (Hartin, 1977). As the diagnostic inquiry proceeds a clinical picture begins to emerge. In Silverman’s (2001) view the conceptualisation of maladaptive attachment processes allows the therapist to focus on the significant features as they emerge in the clinical setting.

Information gathering.

The process of information gathering involves the therapist in obtaining detailed information about the relational identity, how it was formed and how it has evolved. Cashdan (1988) noted the importance of information gathering as central to the therapeutic process. The acquisition of historical information helps to structure the session and is non-threatening for those who may be nervous at being in therapy for the first time (Baucom & Epstein, 1990).

Information gathering enables the marital therapist to listen to the unconscious wishes, needs and desires that are being transferred or projected onto the partner (Kinston & Benvotim, 1981). Baucom and Epstein (1990) noted that by demonstrating interest in the minute details of the relationship, information gathering moves the couple beyond the presenting issues. Bolognini (2001) asserted that the sharing of past experiences plays an important part in the therapeutic process and is a precursor to empathy.
At the same time the therapist is cognisant that this information is constantly modified to become consonant with enduring affective themes. Throughout the process, the couple’s memories of personally relevant events are considered subject to a variety of reconstructions (Strupp & Binder, 1984). Penn (2001) described the need for the therapist to pay close attention to conversation, language, metaphor and voice in the construction of experience, events and of the self.

**Conceptualisation of the Couple’s Level of Development**

The couple’s beliefs and meaning systems about self and other are integral to the therapist’s understanding of the partners’ psychological and attachment processes. Questions about the couple’s relational history with each other evoke the partners’ fantasies, illusions and desires about intimate relationships. Penn (2001) noted that talk of desire evokes an abiding sense of self. “If you ask about desire, what often follows is a statement of engagement with life” (p. 45).

As the partners describe their experiences, the therapist pays close attention to the narrative (Levenson et al., 1997). The need to bond will be influenced by a number of transferential, infantile wishes and social and cultural factors. The partners’ responses provide the therapist with important clues about the couple’s level of emotional maturity when they first met. In some cases, one partner may have developed, matured, or changed, while in others, both partners may have become blocked, or have even regressed to an earlier stage of development than when they first met (Solomon, 1989).

Such a conceptualisation enables the therapist to assess the couple’s present developmental context—symbiotic, differentiating, practicing or rapprochement (Bader & Pearson, 1988). According to Bader and Pearson (1988), it takes an average of between six months and two years for couples to define a relational identity as a couple. Bader and Pearson (1988) suggested that most couples have typically begun to evolve from the symbiotic stage within this timeframe. If such a developmental shift has not taken place, they are likely to be found still in the enmeshed, or hostile-dependent, configurations. Couples with a longer relational history might be expected to have moved into one of the more advanced stages of object relating.

**Obtaining a Developmental History**

Structured developmental questioning has a number of core elements: initial encounter and relationship development, marriage/commitment, relationship and personal difficulties
(Hiebert et al., 1993). The process of obtaining the developmental context of the couple’s relational issues is illustrated by the work of Baucom and Epstein (1990), Hiebert et al. (1993) and Bader and Pearson (1988). Ordering questions developmentally enables the therapist to pinpoint those phases that have been mastered by each partner and those which signal an impasse. An explanation of each of these elements follows.

*Initial encounter and relationship development.*

The selection of a partner is based on a complex, conscious, confused and unconscious mutual signalling system (Nichols, 1988). Nichols described this system as the capability for jointly working through unresolved conflicts or splits in one’s personality. At the same time, this mutual signalling system contains the paradoxical message that such conflicts will not be worked through with that person.

In some relationships, people choose partners whom they consider to be inferior, thus relieving them of the anxiety about being the superior person; others choose a partner whose qualities they feel, or sense, will be complementary (Sager, 1994). In pathological relationships an unconscious bargain is struck. Each partner perceives the other as providing an unconscious promise that old problems will be worked through (Nichols, 1988).

Papp (1982) noted that the complementary interaction of couples has best been described as “one partner emotionally detached, the other craving affection; rivalry between the partners for aggressive dominance; one partner helpless, the other ostensibly strong, but in reality seeking the dependent role” (p. 453). Fishbane (1998) elaborated on the concept of complementary interaction by describing the patterns of relating as “pursuing/distancing, over functioning/under functioning, and rational/emotional” (p. 46).

*Marriage/commitment.*

Partners in conflicted relationships will be largely unaware of the anxieties aroused by making a final commitment to another person. Throughout the therapy there is the “tacit assumption that final commitment to a partner whether in marriage or an intimate relationship, is a desirable end” (Malan & Osimo, 1992, p. 252). In discussing the issues associated with commitment, Malan and Osimo (1992) defined the anxieties associated with commitment as “further loss; loss of independence; fear of being controlled; fear of engulfment; attachment to parents; anxieties aroused by repeating the parents’ marriage” (p. 253).

Individuals use a variety of conscious and unconscious mechanisms for avoiding commitment, and for avoiding “the even wider variety of anxieties that these mechanisms
expressed” (Malan & Osimo, 1992, p. 252). Although the mechanisms individuals adopt vary, they can be classified into two broad categories: deliberate avoidance of commitment and forming relations in which final commitment is impossible. Examples include short-lived relationships, avoiding having children, attachment to much older partners and superficial relationships (Malan & Osimo, 1992, p. 252).

Relationship and personal difficulties.

Next, the therapist seeks to uncover the beginning of the relationship difficulties. This line of questioning allows the partners to express disillusionment associated with the loss of the initial idealised fantasy. It also allows the therapist to hear the partners’ disillusionment about their relationship and more. Bader and Pearson (1988) asserted the importance of this question, and that “when successfully mastered, the first disillusionment usually propels partners into a phase of separation/individuation” (p. 32).

In addition, the response to this inquiry enables the therapist to understand more fully the couple’s potential to move toward more mature levels of intimate relationships; alternatively, the couple’s answers highlight their inability to negotiate the transition to another relational stage. In cases where the partners are unable to resolve their initial disillusionment with each other, their responses to this question help the therapist to clarify in his or her mind, the interpersonal processes and maladaptive patterns at work (Solomon, 1989).

The conceptualisation of the couple’s developmental stage and inferred representation of the partner can be seen in Table 5.2. The partners’ characteristic representations are perceived as stemming from their often shared attempts to rework the conflicts and themes from a particularly early childhood phase in the development of self and object relations (Sharpe, 1997). Even though a couple may present for treatment most prominently displaying one object relations mode, Sharpe (1997) noted “progression and regression in the course of therapy, and in life, move the couple forward and backward on the developmental continuum” (p. 43).
Table 5.2

Developmental Stage of Relationship, and Inferred Representation of Self and Partner

<table>
<thead>
<tr>
<th>Developmental Stage of Relationship</th>
<th>Inferred Representation of Self and Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symbiotic – Symbiotic (Enmeshed)</td>
<td>We are one.</td>
</tr>
<tr>
<td>Symbiotic - Symbiotic (Hostile - Dependent)</td>
<td>I can’t live with you and I can’t live without you.</td>
</tr>
<tr>
<td>Symbiotic – Differentiating</td>
<td>I’ll change if you change.</td>
</tr>
<tr>
<td>Differentiating – Differentiating</td>
<td>Don’t leave me.</td>
</tr>
<tr>
<td>Symbiotic – Practicing</td>
<td>Leave me alone.</td>
</tr>
<tr>
<td>Practicing – Practicing</td>
<td>I want to be me.</td>
</tr>
<tr>
<td>Practicing – Rapprochement</td>
<td>One foot in, one foot out.</td>
</tr>
<tr>
<td>Rapprochement – Rapprochement</td>
<td>Homeward bound</td>
</tr>
</tbody>
</table>


Termination of the Session

Once the issues in the relationship have been explored, the couple’s strengths validated, their desire to participate in the therapy affirmed then the process of termination begins. Termination is an important and distinct phase in the therapeutic process. The way this occurs has the potential to confirm or undo the interventions that have been put in place in the session (Book, 1998).

Although the couple agree to, and consciously understand the six-session time limit, the process of termination of each session arouses anxiety (Macnab, 1991). Because of the emotional reactions aroused by the focus of the session, termination presents the couple with another opportunity to face feelings around loss (Strupp & Binder, 1984). Strupp and Binder (1984) advocated that following any therapeutic interview there should be a feeling that the person has benefited from the session, in spite of the unpleasant feelings aroused.

Statement of the central relationship theme.

The establishment of the time-limited contract commences the termination phase of the first session. Structuring the therapeutic contract to motivate the partners to begin therapy requires skill and sensitivity (Bader & Pearson, 1988). In developing the therapeutic contract, the therapist undertakes a series of separate yet interdependent tasks. During the contract phase
the therapist informs the couple about how the therapy will be conducted, how long it will last and the part that they might play in it (Book, 1998).

To achieve this objective the therapist formulates the central relationship theme described in chapter four at page 78. The first task requires the therapist to involve the couple in gaining an appreciation of the way their individual projective identifications affect others (Cashdan, 1988). This will be achieved by providing them with an understanding of the processes occurring between them. The aim of this intervention is to provide them with a preliminary insight into the psychodynamic makeup of their personalities. This involves the partners in becoming more aware of the contribution they make to the marital discord. As an illustration, the therapist might make the following interpretation:

T: Do you notice the strong need you both have to feel good about yourselves and your relationship? I wonder whether your current issues are a means of protecting yourself from the disappointment and hurt you feel when your needs are not being met...

The second task requires the therapist to state the central issue (Mann, 1973). In doing so the therapist attempts to organise the items of information that have emerged from the couple’s narrative. At the same time, the therapist pays close attention to each partner’s response as the tentative formulation is made. For example the central issue for the imaginary couple ‘Steven’ and ‘Michelle’ would be as follows:

T: You are the type of couple who in spite of your best attempts to meet each other’s needs, no matter what you do, nothing seems to change...

Once the therapist states the central issue, they pause to allow its impact to take hold.

The third task requires the therapist to reaffirm the collaborative nature of the therapeutic process. The therapist describes what a realistic outcome might be. Setting explicit goals is of central importance in brief therapies such as the one described here (Levenson, et al., 1997). According to Book (1998) the process of detailing the therapist’s and the clients’ tasks during therapy is associated with better outcomes than when no explanation is given.

To achieve this objective the therapist will be clear about the boundaries of the therapeutic contract. Yalom and Bugental (1997) noted that the therapeutic contract serves as a container that makes it safe for client and therapist to engage each other. The aim of this technique is to
have the couple and the therapist become as “fully and authentically as possible in their respective roles” (p. 122).

**Statement of the therapeutic contract.**

The therapist’s ability to make a meaningful statement about the structure, advantages and potential outcome of the therapy, plays a major part in gaining the couple’s participation and commitment. The agreement to the time limitation permits the couple to have a sense of control over the process; it reduces the anxieties and uncertainties about the therapeutic process and keeps them focused (Book, 1998). To commence the contractual process, the therapist summarises the six sessions of therapy as follows.

T: In this first session we have become aware of the way in which your anxieties become aroused when you perceive your needs, goals and expectations are not being met. But rather than solving your problems, these repetitive patterns of thinking, feeling and behaving contribute to your ongoing problems and difficulties.

In the second session, the focus will shift to a deeper examination of the way in which your frustrations and disappointments contribute to your difficulties. The potential will be created for you to become more aware of the strategies you both use to keep your anxiety-provoking thoughts and feelings from awareness. As part of this process you will come to discover that in the same way as you have learned these maladaptive patterns, you can also unlearn them.

In the third session, we will explore the influences from your past, the way quite unbeknown to both of you that childhood patterns are being repeated in the present. We will see how you have internalised these past experiences and influences in such a way as to assume a driving, yet unrecognised, power over your way of being in the world. In this way, you will learn new ways of understanding the influences from your families of origin.

You will be looking in the fourth session at how your sense of power becomes undermined by faulty perceptions and expectations about yourselves, other people, each other and your situation. You will look at alternative strategies to separate your problems from their emotional loadings. In the fifth session we will make a transition to a deeper examination of your beliefs and values. You will both be encouraged to
find out what it is you are really looking for, or what your life’s future directions might be, as you become more aware of your thoughts, wishes and desires.

In the sixth session a consensus will be reached about the way your relationship might proceed in the light of the new experience and understanding you have gained in therapy. If further therapy is indicated, the issues, objectives, and focus will then be discussed (Macnab, 1991).

Book (1998) pointed out that the specific preparation of patients for treatment represents an important factor in the outcome of therapy. Any concerns, questions or issues of the couple will be dealt with at this point. After exploring any issues raised by them, the therapist reaffirms the six-week time limitation and clearly communicates the date of the final session. The contractual process concludes by the therapist gaining a commitment from the couple to engage in the therapeutic contract. The cost, the agreed appointment time for the weekly sessions and the length of the sessions are then agreed.

*Homework tasks.*

In the final stage of termination, the therapist provides the couple with a number of homework tasks. Papp (1982) described the therapist’s ability to give homework tasks as requiring great skill. She suggested, that “if the task is not aimed at changing the basic contradiction in the relationship”, in this case the sense of hopelessness, “it will be ‘superficial’ and will reap superficial results” (p. 352).

Gurman (1992) documented how the rapid introduction of a novel set of thoughts, interpretations and or tasks consolidates any gains made in the therapeutic process. This is particularly so if these out-of-session tasks reflect the themes identified in the session. In the context of the first session, the provision of homework tasks involves the therapist in a four-step process.

**Step One**

The therapist asks both partners to refrain from making any decisions about the relationship while the problems and possibilities confronting them are being explored in the six weeks of therapy.
Step Two

The couple are requested not to involve any members of their families, friends, or extended networks, by discussing with them what is happening in the therapy.

Step Three

The therapist asks both partners to reflect on what they have learned about themselves and the relationship in the session. In the light of what they have learned, they are then asked to consider what their needs, goals and expectations might be for themselves and their relationship.

Step Four

The partners are requested to observe their inner anxieties. The therapist encourages the couple to become aware of their anxiety without becoming overwhelmed by it, thus making a link to the next session.

The formulation of homework tasks such as these gives the couple, a greater sense of control in what might have been previously perceived as a hopeless situation (Greenberg & Johnson, 1986). In addition, the purpose of these interventions is to have each partner separate their anxiety from that of the partner, who is typically regarded as having the problem. At the same time the therapist attempts to have the partners recognise their contributions to the conflict (Macnab, 1991).

Finally, the therapist puts one strategic intervention (homework task) in place. The couple will be asked to refrain from speaking to each other about the content of the session for the next twenty-four hours. This intervention is used to contain any issues or emotions that might get out of control. The couple will be asked also, to emphasise any positive encounters they have during the forthcoming week (Macnab, 1991). A corollary to this intervention may be suggested also. If one partner does not wish to speak about the issues raised, the other partner will be asked to respect their wish and wait until the next session.

Alternatively, if one partner feels the need to speak and the other does not, then they are asked to listen to what the other person has to say without comment or without becoming emotionally engaged. In conclusion, the therapist provides a strong, empathic reaffirmation of the partners and their participation in the process. By bidding the couple a positive farewell, the therapist establishes an environment of hope and creates an existential linkage to future sessions (Macnab, 1991).
Session Two—Clinical Focus Separation Anxiety

Whereas in the first session the focus of attention was on each partner’s interpersonal coping mechanisms, now the therapeutic discourse seeks to further uncover the anxieties underpinning the relational dissatisfaction. Such a clinical focus enables the couple’s interpersonal transactions to be formulated as an attempt to preserve self, other, and relationship. These interpersonal transactions are perceived as a means of minimising the anxiety associated with the need for attachment, and an attempt to regulate the interactions of their partner (Bowlby, 1961).

Treatment Planning

The principal treatment goal of the second session is to create for the couple awareness and an empathic understanding of the core anxieties underlying their negative emotional and behavioural responses. The treatment objective of anxiety reduction requires the therapist to help each partner to recognise his or her points of anxiety arousal, anxiety about loss of attachment, security, satisfaction, meaning and world view. In effect, it requires them to understand their use of projection and projective identification (Cashdan, 1988).

Implementation of these interventions puts in place a process by which the couple are confronted with the need to deal with their fears, expectations and habitual relational patterns in new and more adaptive ways. The techniques of anxiety management, problem solving and defensive restructuring will be used to achieve this objective. The primary therapeutic task becomes an exploration of the dominant anxieties disrupting each partner’s feeling, functioning, and fantasy regarding their future together and apart (Macnab, 1991).

Cashdan (1988) has suggested that one of the reasons couples return to therapy in spite of their misgivings is that at a much deeper and unacknowledged level, the anticipation of again being held by the therapist prevails. Mitchell and Black (1995) provided another explanation for this phenomenon. Namely, that people have a secret hope that the therapist will speak frankly with them about who they are, the way they affect others, and what goes wrong between them and others.

To achieve this objective the therapist builds on the preliminary diagnosis and clinical observations about the couple’s emotional, developmental and social context. Once again, while the initial framework of the problem as the couple see it provides clues to the depths beneath the symptoms, as the session evolves these deeper dimensions will be disclosed. The role of the therapist is to have the couple inter-connect with aspects not previously perceived.
in the original problem definition (Bockhus, 1993, p. 187). For example, an explanation of the couple’s current issues as being representative of each partner’s capacity for handling difference.

*Re-engagement with the couple.*

Major shifts in the partners’ levels of affect, their vulnerability, sensitivity, and their resistance to participating in the process will be anticipated between the first and second sessions (Jacobson & Christensen, 1996). A number of factors can contribute to the partners’ altered mood states. The couple’s ambivalence may have been heightened through the previous session, for example, what the therapist might have said, or not said.

One partner may experience a sense of relief at being engaged in the therapeutic process. The other may continue to have misgivings about the therapy, the experience, or the outcome (Jacobson & Christensen, 1996). Della Selva (1996) noted that therapists could become so focused on defences and symptoms that they fail to acknowledge or respond to the changes in the patient. She observed that any doubts the therapist has about change could slow the pace of therapy and the growth process.

Against this background, the therapist commences the session by reaffirming the couple and their participation in the therapy. A reassessment of the couple’s level of affect, motivation, and current experiences of each other, in the light of the therapeutic contract will then be made. At the same time, any visible signs of regression in the couple since the first session will be closely monitored.

Once more the therapist contains any potential conflict by taking control at the outset. The therapist begins by recalling the major presenting issues. A number of focused questions assist in this objective. For example, by enquiring whether:

1) anything has happened in the intervening days to change the partners’ perception of these issues [mastery];

2) either partner perceives their situation differently in the light of what occurred since their engagement in the therapy [the holding environment];

3) they managed the experience of not speaking about their issues for at least twenty-four hours or longer [containment], and whether

4) the couple have been able to recognise and monitor their reactions, tensions and concerns when they perceived that their needs, goals and expectations were not met [coping strategies] (Macnab, 1991).
A therapeutic communication, might be:

T: I know that what both of you are trying to describe is very complicated and not easy for someone who isn’t actually living in it to understand… Last week I felt we gained a better understanding of your concerns and made a good beginning.

T: Michelle, last week we made progress in identifying the issues confronting you at this time. We also identified a number of patterns of behaviour that you and Steven would like to change. Tell me what concerns you consider are the most pressing today?

Interpretation of the couple’s repetitive interactional patterns.

Curtis (1992) noted that as anxiety precedes anger, clinical wisdom has always been that anxiety distorts perception resulting in two major responses: one is by drawing attention to the threatening material (hyper vigilance or sensitisation); the other is avoidance (repression). From this perspective, the couple’s resistance to change may be perceived as due to an actual experience (normal or explicit anxiety) or as a threat to the self (implicit or neurotic anxiety) (Curtis, 1992). Explicit or normal anxiety has three characteristics, which the therapist keeps at the forefront of his or her thinking:

1) it is proportionate to the objective threat in the situation being confronted;
2) it does not involve repression; and whether
3) it can be used creatively to identify and confront the conditions bringing it about.

In the case of neurotic anxiety they need to address whether:

1) it is disproportionate to the objective threat;
2) it involves repression; and
3) it is destructive rather than constructive (Nelson-Jones, 1995, p. 139).

By continuously bringing each partner’s attention to the role of anxiety in their relationship, the therapist attempts to help the couple recognise the situations that precipitate conflict and their mutual involvement in it. At the same time, the therapist pays close attention to:

1) the types and intensity of the emotions the spouses experience about their partner and the relationship;
2) the deficits that partners have in recognising the nature of their emotions and the factors which elicit and maintain them;

3) any skill deficits, emotions or cognitions which interfere with spouses’ expressions of emotions within their awareness; and

4) the types of emotions, which impede the relationship functioning constructively (Baucom & Epstein, 1990, p. 124).

As the therapeutic dialogue proceeds, the therapist listens attentively. This is to ensure that they gain a clear picture of each partner’s compulsion to repeat negative interpersonal patterns. Once the partners have been heard and their fears and issues confronted, the therapist makes the transition to anxiety and its management. A number of interventions are used to achieve this objective.

*Clarification and interpretation.*

Interpretation is reflected in the comments the therapist makes that tie together the patient’s attitude and behaviour toward significant others from the past, with his or her attitudes and behaviours toward people in the present, including the therapist (Book, 1998). Interpretations and confrontation, according to Nichols (1988), can mark the beginning of an alternative inner world. Nichols (1988) wrote how the therapist can either:

(1) interpret the unconscious fears that bring about such defensive reactions, and (2) confront straightforwardly the misperceptions of marital partners and help them to discover behaviours in each other that they had not previously perceived, thus providing a corrective perceptual experience (1988, p. 66).

Horowitz (1997) described clarification and interpretation of the connections between external events and inner meaning as one of the most important therapeutic techniques. The therapist attempts to link current external anxiety to pathogenic beliefs and contradictions. Clarification is used to summarise, paraphrase and organise the partners’ statements without elaboration or interference (Levenson et al., 1997).

The partners’ responses to this process give the therapist some indication of their current ego-adaptive capacity and guide the therapeutic process. The basic assumption being that the partners’ “fear or defense makes sense in terms of what has transpired in past relationships, although it is no longer necessary or adaptive in many current relationships” (Teyber, 1997, p. 141). The process of anxiety management encourages the partners not to coerce or otherwise draw the marital partner into patterns of interactions based on unresolved interactions and relationships from the past.
An illustration of the process by which the therapist links the defences (D) to the anxiety (A) that arises in response to the partners’ hidden impulses/feelings (I/F) might be as follows:

Steven: Michelle continually puts the children before me. She doesn’t seem to appreciate how much I contribute to the family. I just don’t seem to be able to get through to her. I get a little (D) annoyed (I/F).

T: And how do you respond when Steven reacts like this Michelle?

Michelle: I become overwhelmed, roll my eyes (D)... then I usually become furious(I/F) shout, threaten to leave, and tell him he will never see his children again.

T: Steven, how do you feel (I/F) toward Michelle when this occurs?

Steven: I usually feel threatened (A), get the sulks and refuse to speak to her (D).

T: So, in face of your annoyance (I/F) with Michelle you become withdrawn.

T: Steven, I wonder if you withdraw from Michelle when she doesn’t respond warmly to you (defence linked with projection) and you get anxious and angry when she becomes withdrawn? (anxiety and impulse in the projection).

T: Michelle, what would Steven have to do to make you respond warmly toward him (cognitive/affective link)?

Having examined the triad of feeling/defence/anxiety, the therapist attempts to bring together the dissociated parts of each partner’s self, so that they can relate to one another, free from object relations distortions. The aim of this intervention is to identify the significant projective identifications and distortions operative in the relationship. An illustration of this technique would be as follows:

T: Michelle, I notice that when you get anxious about Steven’s inability to communicate, you respond in an angry and helpless way. I wonder if it is Steven you are angry with, or whether it is your own feelings of frustration at not being acknowledged by him for who you are and what you do?
T: Steven, I wonder if your avoidance of commitment to Michelle, and the children, might be your way of trying not to be controlled, as you seem to have been in your past? Perhaps this fear of being controlled might also explain why you withdraw from Michelle...

Coping and self-management strategies.

In addition to insight, one of the basic assumptions underpinning the second session is that the most durable clinical change occurs when couples learn alternative interpersonal skills. The major skill acquisition in this session requires the partners to recognise their points of anxiety arousal. This will be achieved by having them monitor their faulty method of self-management and by educating them about how to intervene, before their anxiety gets out of control. Breaking their repetitive patterns of hostility and destructiveness increases the couple’s conscious choice of appropriate levels of self-expression, and creates the potential for them to gain a greater sense of self-entitlement (Macnab, 1991).

A number of interventions are used to hasten this outcome. The intervention of behaviour exchange requires each partner to focus on the aspects of their own behaviour that they would like to change, as opposed to that of their partner. An extension of this technique is to have one partner tell the therapist the behaviours they believe their partner would most like them to change to increase their satisfaction in the relationship.

In addition to identifying the partners’ faulty and repetitive patterns toward each other, if time permits, in vivo rehearsal of these behaviours could be carried out in the session. Alternatively, the therapist might encourage the couple to pay attention to the impact of their own and their partner’s behaviour over the next week. They would be asked to reflect upon their feelings about themselves, and the relationship, which result.

Other couples may benefit most from communication training. Guerin, Fay, Burden, and Kauto (1987) noted the need for couples to exchange information and discuss their thoughts and feelings. In particular, emotionally charged issues or topics that provoke intense emotional reactions. Communication training involves teaching each partner listening and expressive skills. Bringing the partners’ attention to the value of active listening, and the use of open questions, reflection and paraphrasing are some of the most appropriate skills (Cashdan, 1998). In addition, the use of assertiveness skills might also be stressed. The partners might be encouraged to express themselves as follows for example:
M: Steven, I feel really good about your contribution to the children and me this week, but when you spend so much time in your study at night, I feel unloved and unappreciated. But I recognise I need to tell you what I want and what I am feeling. I would prefer an hour together after the children go to bed, even if it is watching television.

**Cognitive restructuring.**

Cognitive restructuring encourages previously repressed material to emerge, be expressed, observed, resolved, understood and reconstructed (Book, 1998). In the marital context, Macnab (1991) described this therapeutic technique as asking each partner to separate his or her emotional problem solving, from their anxiety-based problem solving. To achieve this objective the couple will be encouraged to distinguish between problem definition and problem solution, and between emotional and rational appraisals. Problem definition requires emotional expression and validation, without generating solutions. Whereas problem solution involves both partners suggesting solutions, which would involve changes in their own behaviour first.

Modifying characteristic interactional themes involves the couple in gaining a greater understanding of their partner’s needs and concerns. By hearing their partner’s anxieties about separation and abandonment, the couple are encouraged to differentiate their own needs, thoughts, feelings, wishes and desires from those of their partner (Macnab, 1991). Such a mutative process enables each to gain a greater understanding of their partner’s cognitions and attributions.

Introducing the couple to effective cognitive appraisal skills can set the groundwork for the re-establishment of trust. Effectively carried out, it prepares the way for collaborative problem solving and creates the potential to build intimacy and sensitivity. In this way the couple are encouraged to take responsibility for their repetitive and self-defeating relationship patterns, and to intervene in their conflicted and maladaptive relational cycles. Such a process creates the potential for both partners to become agents in their own healing (Macnab, 1991).

**Cross-dyadic questioning.**

Another technique used throughout the therapy, and in this part of the process in particular, is the use of cross-dyadic questioning (Hiebert et al., 1993). This technique requires the therapist to ask each person to explain their perception of their partner’s understanding of the
psychological processes occurring between them, such as their partner’s fantasies, feelings or functioning. For example:

T: What do you think that Steven is trying to achieve by behaving in this way?

T: What do you feel might motivate Michelle to continue along this pathway?

By the use of this technique both are given the opportunity to gain additional understanding about their partner’s underlying emotional experience, or what it is that might be bothering them. Successfully implemented, this therapeutic interaction can lead the couple to a new experience of each other. It also creates a preparedness to view their own and their partner’s actions, with more acceptance and compassion.

**Termination of the Session**

During termination the therapist is alert to changes in the partner’s mood, attitude and behaviour. Book (1998) emphasised how during the termination phase the therapist can offer a final opportunity to confront the need for change. Talmon (1990) conceptualised readiness to change as a “state of immediate preparedness and willingness in which various conditions are near a threshold and can, with recognition and skilful facilitation, be assisted and potentiated into actuality” (pp. 36-37).

In concluding the second session the therapist can expect growing feelings of disappointment to emerge about the failure of the partners, the therapist and the therapy (Della Selva, 1996). With this in mind, the therapist attempts to increase the individual’s self-esteem and self-efficacy. The couple will be encouraged to examine how they habitually become involved (albeit unconsciously) in patterns of hostility and destructiveness (Macnab, 1991).

**Homework tasks.**

In conclusion, the therapist has the couple engage in a “paradoxical ritual” (Papp, 1982, p. 360). The partners are encouraged to focus their attention on the origins of their faulty relational patterns. Before the next session they are asked to give consideration to the origins of their anxiety and conflict:

T: I am struck by how you have both been prepared to look at the effect that you have on each other and the way you both appear driven to repeat patterns that previously
appeared out of your control. In the next session we will look at your earlier experiences and influences.

Before next week take some time to pause and reflect upon the way in which your earliest role models dealt with their own anxieties. How did they deal with their frustrations and hostilities? I would like you both to pause and consider how you might be repeating some of these patterns. Please take some time to think about the people who have been most important in your life (Macnab, 1991).

This induction involves the following task. To consolidate the progress and facilitate any insights or gains made in the session, once again the couple will be asked to avoid speaking about any issues raised in the session for the next twenty-four hours. In addition to containing the general concerns about loss, this homework task helps the couple to contain their anxiety.

The therapist reminds the partners not to become concerned about where the therapy might be heading, or what the outcome might be. The couple will again be asked to avoid wondering or worrying about the relationship, but rather to just be in it (Macnab, 1991). In this way, the therapist creates a therapeutic bridge to the third session where unconscious influences from the past are examined, the cognitive processes informing the couple’s working models are challenged and the continuing transformation of their inner working models is carried out.

This chapter examined the conceptual and treatment interventions required to contain the anxiety of couples presenting for marital therapy. The heightened anxieties and feelings of despair associated with separation and abandonment were highlighted. The chapter detailed how the partners’ relational issues evoke memories of earlier separations and the painful affect associated with them. A description of the overall progression of schematic change for the therapy was provided together with the examples of the process of defensive restructuring. In the next chapter the way the therapist attempts to understand how memory and expectation impact on the presenting issues assumes importance. The way the next stage of the therapy involves the therapist in a determination of the unconscious influences provoking and sustaining the conflict will be considered.
I know what I think, but words in the head are like voices under water. They are distorted. Hearing the words as they hit the surface is sensitive work.

Jeanette Winterson - Oranges Are Not The Only Fruit

Overview

In this chapter the way the formation, development and intergenerational patterns influence relationships will be discussed. The treatment strategies for the third and fourth sessions highlight how the partners’ internal working models might be restructured to function in regulating reality as well as in creating reality. The way the couple’s deeply held cultural assumptions about class, religion, race, education or gender influence relationships will be discussed. The way individuals become so embedded in their families that their assumptions and values go largely unnoticed until such time as something happens like births, deaths, illness or conflict is also reviewed (Jossellson, 1993). The chapter will highlight how at times of psychosocial transition such as major life events, individuals become more aware of the importance of past experiences and the influences they have in everyday life.
Stage Two – Cognitive Restructuring

The second stage of the therapy concerns the couple and the therapist in a rediscovery of the memories, affects and cognitive schemas associated with the couple’s earliest interactions and experiences. As described earlier in chapter four at pages 95-98, whereas the first two sessions emphasised ‘present issues and concerns’, now the therapist shifts the therapeutic discourse to the ‘unconscious influences from the past’. Ryle (1982) suggested that even if therapy cannot change many aspects of a person’s nature, it could help them to change how they understand themselves in relationship with others and the choices open to them.

To achieve these objectives, the therapist attempts to demonstrate to the partners how they might have a choice between a more accurate and fuller experience and a muted, denied or distorted experience (Ryle, 1982). In stage two the unconscious processes associated with the partners’ inability to recover their relationship, in the way one or both want it, begin to predominate. Consistent with the concept of the praxis as a process of mourning, feelings of disillusionment will emerge. Protest turns to despair, disappointment begins to mount, hopes of reunion fade and feelings of sadness and depression set in (Bowlby, 1961).

The Stage-Related Process - Despair

The Making and Breaking of Affectional Bonds

Attachment theory provides a conceptual frame of reference within which to describe the experience of sadness and despair associated with this stage. Central to the conceptualisation of stage two is Bowlby’s (1988) observation that a person’s emotional life is influenced by the state of the relationships they have with others. At the core of attachment theory is the notion that basic parent-child bond, peer bonds and bonds established with others, together with real life experiences, continue to exert their effects in later life.

Ainsworth (1989) made a distinction between an ‘affectional bond’ and an ‘attachment’. An attachment is an affectional bond, and hence an attachment figure is never interchangeable with or replaceable by another, even though there may be others to whom one is also attached (Ainsworth, 1989, p. 711). In attachment as in affectional bonds, there is a need to maintain proximity; it provides the necessary emotional security from which to explore the world (Bowlby, 1988).

Attachment theory thus provides a framework that is conducive to the persistence of attachments after loss (Baker, 2001). Bowlby (1988) wrote: “whilst separation is the usual
response to a threat or some other risk of loss, mourning is the usual response to a loss after it has occurred” (p. 31). The parallel between the experience of mourning and the unavailability of an attachment figure has been documented (Weiss, 1975; Hazan & Shaver, 1992; Weber, 1992). Unlike the experience of loss associated with bereaved adults, in conflicted intimate relationships the lost attachment figure is potentially recoverable.

Unlike bereavement, continuing contact with the love object requires a reworking of many of the issues associated with present and past losses. This process can result in an increased sense of sadness, despair and depression (Baker, 2001). According to Hazan and Shaver (1992) the experience of close relationship loss, results in the kind of anxiety that characterises attachment-system activation. They described this process as “alternating between wanting to separate from the partner and panicking at the thought of losing the relationship” (p. 98).

The anxiety aroused by the disruption to a partner’s attachment bond evokes distinct feelings and behaviours. Emotional isolation was the term used by Weiss (1973) to describe the feelings experienced in the absence of an attachment relationship. Hazan and Shaver (1992) noted that the loneliness associated with the “absence of an attachment figure is like protest without an object” (p. 103). Hence the growing sense of despair when the partners reach the mid-point of the therapy and begin to realise that the love object cannot be altered, changed or recovered in the way they had hoped for.

**The experience of disappointment.**

Bowlby (1961) described the feelings of depression being attributed to this stage of the therapy, as an affect that all healthy individuals experience in certain situations. In contrast to the more complex aspects of depressive illness, some of the characteristics of the healthy type of depression were characterised by Bowlby (1961) as follows:

So long as there is active interchange between ourselves and the external world, either in thought or action, our subjective experience is not one of depression: hope, fear, anger, satisfaction, frustration, or any combination of these may be experienced. It is when interchange has ceased that depression occurs. Often this is due to disappointment and the relinquishing of a goal; sometimes, and more surprisingly, to the goal having been successfully reached and so relegated to the past; on occasion it may be due to other and less obvious reasons. No matter what the cause, however, until such time as new patterns of interchange have become organized towards a new object or goal we experience restlessness or apathy, with concurrent anxiety and depression (p. 335).
In stage two of the therapy, parallels can be drawn between Schafer’s concept of disappointedness and Bowlby’s concept of healthy depression. Bowlby (1961) took the view that it is the experience of continuing and repeated disappointments that leads to despair. Schafer (1999) wrote that the widespread affective experience of disappointment has not received the analytic attention it deserves.

Making a distinction between disappointment and disappointedness, Schafer (1999) observed that feelings of disappointment have their antecedent in the role of idealisation in desire. Schafer (1999) described disappointment as an inevitable, painful and often traumatic experience in almost every phase of life.

Many patients who develop fixed, hardened attitudes of disappointment have suffered prolonged, severe deprivation and pain in their early object relationships. The deprivation and pain might have been inflicted by violence and extreme poverty; however, they might just as well have been inflicted by the strain trauma of continuous neglect or abuse of emotional needs stemming from parental inhibition, depression, psychosis, physical illness or harsh child-rearing practices that presumably favoured total self-reliance and self-control but produced the opposite results. Alternatively, this disappointedness might be the consequence of a steady diet of humiliation ostensibly designed to make sure that one never brings shame on the family; in this regard, the key phrase tends to be ‘knowing one’s place’ (p. 1095).

This experience results in hidden pockets of profound disappointment “that can insidiously limit or halt significant aspects of a person’s development” (Schafer, 1999, p. 1093). For some, it becomes a defensive organisation erected against exposing the self to feelings of disappointedness or showing it at all. While for others, disappointedness becomes more than a fixed attitude it can “become a goal in life, even a career” (Schafer, 1999, p. 1093).

*The psychosocial expectations of love and relationships.*

Feelings of disappointment are not solely related to the partner or the therapeutic process; they reflect the cultural context in which the relationship is embedded. Noller (1996) advocated that love is, at least in part, socially constructed. In seeking to define love, Noller observed that the beliefs and expectations the culture has about love affect an individual’s experience and interpretation of it.

People in Western societies are socialised to perceive love and romance as not only important, but as an essential component of intimate relationships (Orbuch, Veroff, & Holmberg, 1993). Noller (1996) emphasised the negative implications for family life of these beliefs, particularly the suggestion that “love is blind, external, and uncontrollable” (p. 97).
Expectations such as these led Kahn (1986) to observe that marriage represents an institution of modernity that people are neither able “to do with or without” (p. 15).

Such a cultural context, confronting the partners in conflicted intimate relationships with the need to make allowances for their own and their partner’s differences. To have the partners move beyond the societal and emotional expectations of marriage, requires them to accept each other’s differences and to acknowledge their own and their partner’s anxieties and insecurities. Schafer (1999) wrote of how “people feel disappointed when experience fails to be in line with strong wishes or confident expectations” (p. 1094).

Blatt (1995) discussed the destructiveness of perfectionism and the implications such an experience has for the treatment of depression. His clinical research led him to conclude that the combination of self-oriented and socially prescribed perfectionism, the sense of profound personal failure and the belief that one has failed to meet the high standards and expectations of the people who matter most (both contemporary figures and especially conscious and unconscious identifications with harsh, judgmental figures from the past), can create a marked vulnerability to experiences of failure and the sense that one has nowhere to turn. The resulting feelings of helplessness, hopelessness, and utter despair can lead to clinical depression and suicide (p. 1008).

The experience of a secure emotional base.

The importance of a secure emotional base, or the experience that an individual has somewhere to turn, has assumed a central position in the marital and family therapies (Byng-Hall, 1995; Lindegger & Barry, 1999). Byng-Hall (1995) defined a secure base as “a family that provides a reliable network of attachment relationships in which all members of whatever age are able to feel sufficiently secure to explore” (p. 46). In contradistinction, various family situations have been found to undermine the individual’s feelings of security. Common family situations that lead to insecurity can be seen in Table 6.1 on the following page.

In the context of family therapy Byng-Hall (1995) noted that if a person is able to make sense of their childhood and recognise the motives behind each person’s behaviour, they are more likely feel securely attached. From the perspective of marital therapy Pistole (1994) observed that by gaining an understanding of their familial attachment history the partners gain some objectivity about their own and their partner’s behaviour. Exploration and contrast of familial and current attachment issues may stimulate an integration process and result in change in the client’s sensitivity and responsiveness to the adult partner’s attachment needs (p. 154).
Fear of losing, or actual loss of an attachment figure: The effect of loss and separation on children has been studied extensively (Bowlby, 1980).

Attachment figure is captured: Another member of the family may ‘capture’ the attachment figure.

Turning to an inappropriate attachment figure: When an appropriate attachment figure is unavailable, an individual may turn to an inappropriate member of the family.

Conflict within relationships: The most striking example of a conflict that undermines security is that of abuse, whereby the attachment figure becomes the source of danger as well as being the person to whom the child would naturally turn for protection.

Expectation of repetition of losses similar to those encountered in previous generations: When children reach the same age at which their parents suffered major traumas, parents may start to behave as if it is about to happen again in this generation.


In the context of marital therapy, partners with an avoidant or self-reliant attachment style are “likely to perceive a relationship as satisfying to the extent that it allows for a safe distance between the partners, whereas partners with an anxious-ambivalent attachment style are more likely to need a relationship with greater dependency, closeness and even enmeshment” (Lindegger & Barry, 1999, p. 277). Bowlby (1988) found that both anxiously attached and compulsively self-reliant individuals have a predisposition to depression. Blatt (1995) defined two intense and basic wishes in depression as: “to be passively gratified by the dominant other” and “to be reassured of one’s own worth, and to be free of the burden of guilt” (p. 1009).

Session Three—Clinical Focus Unconscious Influences

Many of the brief psychodynamic therapies make use of explicitly cognitive language (Messer & Warren, 1995). Contemporary integrated treatment modalities can be found in the Cognitive Analytic Therapy (CAT) developed by Ryle (1982; 1997), which integrates personal construct psychology with object relations theory. Other brief psychotherapies, such as that of Weiss and Sampson (1986) use the concept of ‘pathogenic beliefs’. Gassner (2001) described pathogenic beliefs and expectations “as distressing constructions of reality, usually
unconscious, that link frightening outcomes to the pursuit of normal developmental goals” (p. 93).

Other brief psychotherapeutic models (such as that of Horowitz, 1997) draw “directly on contemporary cognitive theory and relies heavily on schematic representations that appear to have their origins in cognitive and information-processing approaches to psychology” (Messer & Warren, 1995, p. 116). Schematic representations organise perception, and are combined to form scripts that organise action in the world concerned with ‘self-evaluation and self-judgement’ (Ryle, 1982). Rather than highlighting emotional catharsis, an individual’s view of self and other is regarded as the result of cognitive distortions based on errors in thinking. This demonstrates the compatibility of cognitive theory and terminology and clinical object relations theories (Messer & Warren, 1995).

There has also been a growing practice of integrating aspects of narrative therapy with psychodynamic theory, psycholinguistics and/or cognitive science (Rennie, 1994). Acknowledging the role of narrative process in psychotherapy, Omer (1993b) likened the therapeutic activity of re-narrating personal stories as embodied in the concept of the life-sketch. The life-sketch represents a compressed psychobiography that is centred upon a symptomatic complaint in the life journey (Omer, 1993b, p. 668).

Parallels can be drawn between therapy as an alternative psychobiography and the development of brief psychotherapy, in particular, the conceptualisation of a psychodynamic formulation. Such a psychodynamic formulation can be found in the central issue of Mann (1973), the central maladaptive pattern of Strupp and Binder (1984) and the life sketch of Omer (1993b). In the brief and time-limited approaches, psychodynamic formulations such as these serve

as a guiding beacon, evoking memories and experiences of striving and frustration. The very time-limit is a constant reminder of the boundless/bounded polarity: the coming separation at once activates and checks the craving for closeness (Omer, 1993b, p. 669).

The identification of the partners’ inner working model.

The antecedent for the brief integrated psychodynamic framework adopted here can be found in interpersonal and attachment theory (Bacciagaluppi, 1989). Sullivan (1953) and Bowlby (1960) both assumed that early childhood experiences are carried forward in development as emotional-cognitive mental schemas: ‘internal working models’ in Bowlby’s view, ‘personifications’ in Sullivan’s (cited in Cortina, 2001). In his discussion of the similarities
between these insights, Cortina (2001) observed how early childhood interactions become represented mentally and serve the purpose of selectively excluding intense fear and anxiety from further conscious processing.

Cortina (2001) described how Sullivan and Bowlby emphasised the different ways these mechanisms are taken forward in development.

Bowlby and attachment researchers focus on the different expectations and implicit beliefs children develop according to the nature, responsiveness and availability, of attachment figures. These expectations and beliefs are strongly influenced by experience. Sullivan emphasizes the disruptive effect of mild, and particularly severe anxiety on restricting the field of interpersonal awareness (p. 199).

These personal schemas or ‘inner working models’ inform a person’s expectations of self and other and guide them in their future social interactions (Bowlby, 1988). For a person’s inner working models to remain adaptive, they need to remain open and be able to be modified in the face of new experiences (Strahan, 1995). Dysfunctional assumptions, inaccurate appraisals of situations and deficient behaviour repertoires can result in extremely negative views of the self, other people and world-view (Beck, 1998). Unlike other cognitive schemas, internal working models often become resistant to change. New information is assimilated into existing structures rather than the structures themselves being modified to accommodate new experience.

**Treatment Planning**

_The connection between current concerns and past experiences._

The overall aim of the therapist in the third session is to establish a secure base in which both partners are given the opportunity to gain a new understanding of their relationship problems. It requires them to explore how past losses influence their present action. The uncovering of early life experience helps the couple to understand what they do and to acknowledge the choices that they make (Kahn, 1986).

This process assists in helping the partners lessen their projections, become aware of displacement, splitting and other defensive manoeuvres. Bowlby (1961) wrote:

Since the patterns of behaviour which have grown up in interaction with the lost object or goal have ceased to be appropriate, were they to persist, they would be maladaptive: only if they are broken down is it possible for new ones, adapted to new objects, to be built up (p. 335).
Bowlby (1988) suggested that the role of the therapist is to provide the conditions in which people can explore the representational models of their attachment figures. This creates an opportunity for individuals to reappraise and restructure them “in the light of the new understanding he acquires and the new experiences he has in the therapeutic relationship” (p. 138). This leads to a re-evaluation of past experiences, a revision of inner working models, and improved interpersonal relations in the here and now (Bowlby, 1991). The complexities associated with changing the schemas of partners in conflicted relationships have been documented. Gurman (1981) observed how poorly differentiated partners are likely to adhere rigidly to their interpersonal schemata making it more likely that they will see their partners in terms of past relationships or past marital experiences, rather than real contemporary people.

Looked at in this way the discourse of the session rests on the ability of the therapist to have the partners face their feelings of disorganisation and depression. As the process unfolds, it requires the couple to reassess past emotional losses and their growing feelings of disappointment about the relationship and the therapy. Consequently, the partners’ existing defensive organisation is likely to be clung to and the anxieties associated with reorganisation will be fought off (Bowlby, 1961). To break down this defensive organisation, each partner’s interpersonal configurations, inter-generational patterns and familial loyalties come under consideration (Gerson, Hoffman, Sauls, & Ulrici, 1993). The therapeutic discourse centres upon an exploration of the unconscious influences sustaining the conflict, prohibiting the partner’s emotional maturation, and the social affirmations and negations in which they find their expression (Macnab, 1991).

**Unconscious influences and the narrative of self.**

As each partner’s narrative of self, other and context unfolds, the therapist attempts to connect the couple’s defensive coping strategies to their sequestered feelings and blocked interpersonal needs. The concept of development of the narrative self as dependent upon some aspect of disrupted development poses a question for the therapist (Meares, 1995). What represents the correct story? Meares (1995) emphasised the importance of this question thus:

> It has a major therapeutic implication, which is that the person telling his or her own story to a psychotherapist for the first time is, in some way, telling the wrong story. If this is so which is the right one? The implied therapeutic task is to help in the creation of a narrative that is truly a manifestation of self (p. 541).

This conceptual framework requires the therapist to embark on a search through each partner’s remembered history for a narrative point of origin. Phenomenological work such as
this means that the therapist attends to the experience behind the behaviour and seeks to understand “the structures of human being-in-the world” (Keen, 2001, p. 39). Weber (1992) defined this approach as follows:

A ‘phenomenon’ is literally an ‘appearance’, a subjective experience from the descriptive perspective of the experience. In practical terms, phenomena—the appearances of things—are to be contrasted with the things themselves (1992, p.180).

The complexities associated with understanding the layers of meaning expressed in the context of the therapeutic narrative were addressed by Meares (1995), in noting that the

Self as the stream of consciousness is not, in ordinary experience, a narrative. Words that might accompany it can never quite capture the experience. These words are not the stream itself, but manifestations of it. What has been called the ‘narrative of self’ reflects something of it, but is not self itself. A principal characteristic of this narrative is its form, which shows, to a degree, the dynamic movements of a particular kind of mental activity that underpins it (p. 546).

Meares remarked that the development of memory is not one of factual and emotional episodes, but rather a memory system or a form of knowledge. Meares (1995) wrote of how memories become reactivated by the circumstances of later life. These circumstances can be contextual or external triggers. Affective memories can also become aroused by the therapeutic situation. In circumstances where the self is threatened, the positive affect of well-being is replaced by a negative emotional state. Memories can be impinged upon by negative affects associated with an unknown repetition in the present, of past anxiety (Macnab, 1991).

Content and process are not the only focus in the retelling of a story. The therapist must also be aware of the increased contact with feelings that storytelling requires (Levenson, 1995). Once the partners become engaged in storytelling, it can lead to a number of effects: catharsis, silent self-reflection and frequent contact with inner disturbance, whether intended or not (Rennie, 1994). Rennie (1994) distinguished three main effects of storytelling as a therapeutic experience: first, it provided emotional relief, second, it stimulated contact with inner disturbance and finally, it served as a medium for productive thinking carried out privately (p. 239).

Accordingly, the “activity of telling a story is often more powerful than its representation in dialogue would suggest” (Rennie, 1994, p. 234). The creation of a story involves “meaning, coherence and involves feeling, desire and will” (p. 241). Accordingly, the therapist must pay close attention to the emotions aroused in each person. Schafer (1994) wrote of how emotions
are “inherently more primitive, ambiguous, and fluid than words in sentences, which organize and establish a record” (p. 514).

Such a phenomenological approach not only requires the therapist to uncover the essence of what is being said and heard about the self, it requires them to uncover the essence of the making of the affectional bond also. It does so with certain questions in mind:


Keen (2001) described how this treatment objective would be achieved by the use of intentional listening. In contradistinction to selective listening, intentional listening “is listening in depth, to the depth, which is both ‘behind’ the surface and yet directly in it as well” (p. 40).

Unconscious influences and the narrative of the relational conflict.

Every person who separates from a long-standing relationship develops an account to explain what went wrong (Weiss, 1975). Weber (1992) described an account as a “story-like narrative or explanation of one’s experience, such as in a personal relationship, emphasizing the characters and events that have marked its course” (p. 178). This account becomes a story that focuses on significant events or themes and allocates the blame for the break down of the relationship. Subsumed within such accounts are stories about first meetings, significant shared history, moments of conflict and the successful or unsuccessful attempts to cope with moments of conflict

Like Weiss, Weber explored the process of account making as a response to stress or trauma, especially relationship conflict or loss. Weber and her colleagues (Harvey et al., 1990) adapted the stress-response sequence of Horowitz (1986) [traumatic event, outcry, denial, intrusion, working through, completion and identity change] to describe the phenomenology of account making. The stages of loss and the accounts associated with them can be seen in Table 6.2 on the following page.

In this model Harvey et al. (1990) suggested that failure to engage in account making incurs a number of negative consequences. These include failure to work through loss, failure to complete the mourning process and failure to integrate the experience into a sense of self. These experiences can lead to psychosomatic illnesses, higher levels of stress, inappropriate
and fixed maladaptive response patterns, and prolonged levels of grief and anxiety (Weber, 1992).

Table 6.2

The Phenomenology of Account Making in Response to Stress or Trauma Associated With Relationship Conflict or Loss

<table>
<thead>
<tr>
<th></th>
<th>Phenomenology</th>
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<tbody>
<tr>
<td>1</td>
<td><strong>Traumatic event</strong>: involving shock (feeling overwhelmed, numb)</td>
</tr>
<tr>
<td>2</td>
<td><strong>Outcry</strong>: involving emotional expression (panic, exhaustion, despair, hopelessness)</td>
</tr>
<tr>
<td>3</td>
<td><strong>Denial</strong>: early stage of account making, possibly involving escapism (avoidance, isolation)</td>
</tr>
<tr>
<td>4</td>
<td><strong>Intrusion</strong>: continued or initial account making, with flooded states (distraction, obsessive review)</td>
</tr>
<tr>
<td>5</td>
<td><strong>Working through</strong>: intensified account making, confiding with close others</td>
</tr>
<tr>
<td>6</td>
<td><strong>Completion</strong>: completion of the ‘story’, acceptance, possession of coping skills</td>
</tr>
<tr>
<td>7</td>
<td><strong>Identity change</strong>: behavioural expectations formulated in line with the account</td>
</tr>
</tbody>
</table>


Therapeutic Planning

One of the major challenges facing the therapist in stage two rests on his or her ability to focus on each partner’s core beliefs, individual schemas and hypothetical structures of the mind. Cognitive behavioural therapy shares many attributes and displays an intrinsic compatibility of theory and terminology with clinical object relational theories, such as interpersonal and attachment theory (Cortina, 2001). All three theories emphasise the development of cognitive conceptualisation, active evaluation of the person’s cognitions and a collaborative therapeutic alliance (Beck, 1998). Hendrick (1992) pointed out how cognitive behavioural therapy “places the locus of emotional problems and dysfunction in the individuals’ cognitions (self-defeating thoughts, catastrophising)” (p. 38). It allocates “power for improving these dysfunctions to changing the individual’s behaviours (for example, self-monitoring, cognitive restructuring, skills training)” (p. 38).

The treatment objectives of the third session are based on the premise that storytelling is more than an aid to the process of therapy; it is integral to the process itself (Rennie, 1994). The therapist makes use of the therapeutic alliance to demonstrate how the couple’s narratives limit their self-efficacy and prevent them from having their emotional needs met. Bowlby
(1988) held that by inspiring trust and providing a secure base, the therapist assumes the role of an attachment figure. Such a therapeutic relationship enables the partners “to explore and reassess their working models of attachment figures and of themselves” (Ainsworth, 1989, p. 711).

The therapist utilises this relationship to uncover the essence of what is being said, to reconstruct the partners’ narratives of self, other and context, and to assist the partners develop a new self-image (Omer, 1993b). By the use of intentional listening, the therapist assists the couple to develop new responses to old stimuli and arrive at a new construction of reality. Attempting to change the partners’ perceptions of their families requires the couple (and the therapist) to gain a greater appreciation of their own and their partner’s past and their anxieties and vulnerabilities. In particular, each partner’s ability for flexibility and adaptability, which intimate relationships demand, comes under consideration.

**The Therapeutic Process**

**The therapeutic review.**

The therapist commences the third session by undertaking a review of the couple’s experience of the previous session. To contain the partners’ anxiety and growing feelings of disappointment and despair, any issues raised or expressed concerns will be heard but not necessarily pursued. Instead, the therapist makes an immediate transition to the focus of the session. An opening statement might be as follows:

T: Steven, from what you are saying it appears that in spite of your best efforts, you continue to respond to Michelle in a way that finds you far from getting what you want. What do you think drives you to repeat these patterns that fail? What might be behind this form of helplessness, where did you learn it? Where might it have come from? (Macnab, 1991).

Next, the therapist makes a shift to the connections between the partners’ unconscious influences and their effect on the present relationship.

**Identification of the family life-sketch.**

On the surface, the therapist’s inquiry into the history and developmental context of the partners’ families of origin appears to be a process of factual information gathering. But as the narrative unfolds, the therapist will be acutely aware that partners are often reluctant to speak frankly or openly about their parents, especially in front of their partners (Satran, 1991).
Partners with a fragile sense of ego identity will hear any comments or remarks about their family as criticism and a subjective threat to the self.

This is often a painful and difficult process. It requires the partners to consider possibilities, ideas and feelings about their parents that they have regarded as unimaginable and unthinkable. In doing so, the person may be “moved by strong emotions and urges to action, some directed toward his parents and some towards the therapist, and many of which he finds frightening and/or alien and unacceptable” (Bowlby, 1988, p. 139).

Emotionally charged issues need to be handled with care or they may lead to denial or rejection by the partners (Gerson, et al., 1993). Other impediments may contribute to the partners’ understanding of their parents as individuals with their own anxieties, affections needs, disappointments and frustrations. Satran (1991) wrote how most people hold relatively simplistic views and varying degrees of empathy or appreciation of their parents’ personalities. Characters and experiences of the parents are often poorly defined. One parent may be seen carefully and with sensitivity, whereas the other parent is experienced opaquely, or as a stranger (Satran, 1991).

In framing their inquiry the therapist keeps in mind the sometimes mythological image or remembrance of the family and the idealisation of its members. To defend against these feelings, the partners may set up idealised memories of their past to contrast their current feelings of disappointment and emotional isolation (Schafer, 1999). Schafer contended that by idealising the past, a person might sustain a sense of hope and reflect on his or her efforts to correct past omissions. “More often, however, analysis suggests that idealised memories are being used defensively to justify intense disappointment in the present” (Schafer, 1999, pp. 1098-1099).

Against this conceptual background the therapist listens intently for what is remembered, forgotten, or denied. What is it from the past that makes one or both people unwilling to continue to act as a love object for the other? As the process unfolds, the therapist assists the couple to understand the chronic fears associated with “pleasure, change, and development” as well as “their preferred ways of coping with these fears” (Schafer, 1974, p. 505).

If the therapist experiences resistance, or feels the partners are blocking, he or she makes use of dyadic questioning. This involves asking one partner a question about the other, which the therapist recognises would be likely to raise that partner’s anxiety and increase resistance. For example the therapist might say:
T: There is probably some connection between Steven’s past and what is happening in your relationship right now. Michelle, what do you think this connection might be?

*The genogram.*

The time limitation and the structured nature of the therapy require the therapist to start collecting data from the very first contact. Now the therapist’s observations and hypotheses about the partners’ core beliefs and recurrent interpersonal reactions become subject to a more detailed assessment (Beck, 1998). To understand more fully how the unconscious influences from the family of origin contribute to the present conflict, the next step in the process requires the therapist to undertake a detailed genogram. The genogram provides a diagrammatic representation of the family and represents one of the quickest ways for the therapist to learn about family alliances and intergenerational patterns (Nichols, 1988).

Genograms provide the basic data from which the therapist assesses the premorbid state of the family. McGoldrick and Gerson (1985) described how the genogram provides the therapist with both a cognitive and affective map. This conceptual tool highlights the way the couple’s current problems represent the symptomatic expression of emotional patterns over multiple generations within the family (Pinsof, 1995). It enables the therapist to gain a sense of timing in historical and affective development, and the predominant social, cultural, emotional and role expectations.

Guerin et al. (1987) noted that marriage is a joining of two family systems. Recorded in the genogram are the members of the immediate and extended families, as well as significant people who have lived with or played a major role in the family’s life and the premorbid state of the family (McGoldrick & Gerson, 1985). This includes the premorbid states of the families and the number and severity of individual dysfunctions, and the conflicts in those systems. Vital emotional, interactional, historical and demographic information can be gained from a schematic representation of the couple’s family of origin and procreation.

Carefully executed, this document provides a graphic representation that includes the subsystems involved. Patterns of familial triangulation, complementary and symmetrically reciprocal relationships, and broader socio-cultural context, all become highlighted (McGoldrick & Gerson, 1985). The genogram becomes a valuable part of the professional reporting requirements and plays a pivotal role in clinical supervision, in peer review and in case accountability.
Patterns of individual and familial experiences, such as accidents, illness, difficulty in bodily functions, or other somatic problems, all inform the therapeutic record. Laplanche and Pontalis (1988) noted that

From its beginnings the Freudian theory of neurosis is inseparable from the notion that illness is brought on and maintained by virtue of the satisfaction it affords the subject. …In a general sense, ‘gain from illness’ covers all direct or indirect satisfaction that a patient draws from his condition (p. 182).

This process involves the therapist in a determination of the ways in which each partner’s basic need for secure relational ties were met as children. The importance of a secure base for achieving higher levels of emotional maturity was emphasised by Bowlby (1961) and Ainsworth and Bowlby (1991). Even though individuals in relationships have established a sexual pair bond, Ainsworth (1989) found that attachment or affectional bonds to parents do not disappear.

Another source of information is the stories each partner tells about their siblings, particularly the ability of the siblings to maintain their relationships and to succeed in life. This inquiry is based on the premise that children who function best in adulthood and marriage are those who have established some sense of separateness from the family of origin (Byng-Hall, 1995). Geographical distance can provide a clue, but of even more importance is the degree to which other members of the family have left home ‘psychologically’ (Heibert et al., 1993).

Assessment of multigenerational patterns.

In addition to understanding the developmental context that shapes each partner’s subjective worldview, the therapist listens for multi-generational patterns. Jossellson (1993) described how families provide their members with the myths and fables about themselves that connect them with the past. It is from these stories that they obtain a sense of belonging. By interpreting their lives in the same terms as those who have come before them and passing on stories to the next generation, individuals ensure a continuity of existence that outlasts them (Jossellson, 1993).

Laing (1969) described families as an ongoing play, with each generation projecting onto the next a heritage composed of projections and inductions. Similarly, Bollas (1992) proposed an outline for a theory of ‘generational consciousness’. The term generational consciousness refers to how with the passing of time and the process of reflection, three generations reach an agreed ‘general signature’. Each generation and each family, for example, select particular
general objects, persons, events and things that have particular meaning for the identity of that generation (Bollas, 1992, p. 259).

The therapist’s inquiry has as its concern the basic familial themes of work and general roles, patterns of decision-making and power plays. Expressions of love, intimacy and sexuality, distancing and closeness will be heard. The retelling of the family history, includes how the family identity was forged, how any changes in its values were made.

From within an object relations perspective these developmental considerations inform the therapist about the couple’s fears, anxieties and other affects (Kahn, 1986). This matrix of historical experiences “creates the disposition to act, motivating the individual to repeat and repeat patterns and action, often compulsively, usually unconsciously” (Kahn, 1986, p. 16). Nichols (1988) stated how family myths act as a series of unchallenged beliefs, which are shared by family members and serve as family defences (we were not an affectionate family); or alternatively act as an individual defence (therefore I am not an affectionate person).

*The inverted parent-child relationship.*

Once the therapist has grasped the nature and origins of the partners’ developmental contexts, next an attempt will be made to assess the misleading messages from the parents that have resulted in the partners thinking, feeling and acting in the way that they do (Bowlby, 1988). This inquiry rests on one of the cornerstones of attachment theory, the concept of the inverted parent-child relationship (Bacciagaluppi, 1989). Bacciagaluppi (1989) considered this concept to be at the core of psychopathology and defined it as follows:

Parents who have suffered from a twofold frustration of basic needs cannot, in turn, satisfy these needs in their children. They cannot satisfy their children’s initial attachment needs, and they will later tend to prevent them from achieving autonomy. On the contrary, they more or less covertly seek to satisfy their own needs by eliciting parental behaviour in the children (p. 316).

Boszormenyi-Nagy and Spark (1984) employed the term ‘parentified’ to describe the children who experienced an inverted parent-child relationship. Parentified children grow up to feel overly responsible for others. Miller (1981) described how parentified children become particularly attuned and sensitive to their parents’ needs and assume the role of their emotional caregiver. As a consequence they become afraid of depending on others, or feel guilty about having their own needs met.

Individuals who are unable to get their nascent needs met fear that if they were to express their real feelings, it might result in an emotional standoff. They fear that they may be
rejected, or that their relationships may end explosively (Solomon, 1989). Teyber (1997) suggested that 50 percent of all people who present for psychotherapy have been parentified in their family backgrounds.

Assessment of the Couple’s Object Deployment

To understand more fully the partners’ object relations and attachment experiences, the therapist seeks to understand the rules that the family established to govern emotional expression (Bockhus, 1993). Parents give out certain cues or models of interaction about how families act, which are consciously and unconsciously imitated or rejected by their children. As a result, how the couple’s parents balanced the recurring issues of mutuality and individuality significantly affect their children’s mastery of this crucial task (Bockhus, 1993).

Parents who hide their emotions and life stories can impede the development of empathy in their children. Such an experience can block the child’s potential to develop empathy in his or her adult relationships. By contrast, a parent who tells all about his or her life may burden and generate too much feeling and empathic identification in the child (Satran, 1991).

Alternatively, parents raising children in a one-parent family may reveal too much to their children and adopt or use them as their confidants (Satran, 1991). Where a psychological split existed between the parents one of the children may be chosen as a surrogate spouse. If this has been the case, even though they marry someone else, difficulties often arise for them in maintaining an effective marriage (Slipp, 1993). Conversely, in families where the parental relationship was firm and healthy, the potential exists for the creation of a greater sense of independence and self-esteem.

Identification of patterns of triangulation.

The formation of an attachment bond requires the partners to shift their primary emotional attachment from their parents to their partner. “Most adults continue a meaningful association with their parents, regardless of the fact that the parents penetrate fewer aspects of their lives than they did before” (Ainsworth, 1989, p. 710). The significance of the concept of relationship triangles and the emotional processes that occur within them has been central to the treatment of marital and family therapy (Guerin, et al., 1987).

In the midst of problems around primacy of attachment, significant conflicts can arise between the partners and their immediate and extended family. When the relationship becomes threatened, couples bring in a third party to counteract their anxiety (Solomon, 1989). Guerin et al. (1987) identified the most common triangles in marital therapy as:
extramarital affairs, social network triangles within the multigenerational family, in-law triangles, extended family triangles, triangles with children and step-family triangles (p. 83).

In her discussion of triangulation, Solomon (1989) defined the process as an understood but unstated collusion between anxious or damaged partners. “Through formation of covert alliances, the triangle saves the marriage partners, who are unable to tolerate the anxiety caused by their own internal or external difficulties” (p. 30). For example, as each child is born, parents whose relationship is unstable draw the child into a new triangle. Alternatively, two children in a family will form alliances to protect themselves against powerful parents. This collusive process can perpetuate the familial pathology and predispose children to the same problems as their parents (Solomon, 1989).

**Termination of the Session**

*Homework tasks.*

To bring meaningful insight and sustainable behavioural change in the coming week and to commence termination of the session, the therapist introduces a specific homework intervention. The therapist utilises the couple’s heightened level of awareness to make the therapeutic transition to the fourth session. Both partners are requested to become reflective about themselves as agents of change and healing (Macnab, 1991). To achieve this objective, a statement such as the following brings the session to a close.

T: Steven and Michelle, in the light of what you have learned about yourself and your families today, before the next session I would like you both to pause and take some time to reflect on the person you might now become? How might you live in the present, if you were free from the emotions, patterns and influences from your past?

**Session Four—Clinical Focus Inner Working Models**

In the context of stage two the partners’ feelings of despair can be attributed to more than disappointedness in their partner. Despair reflects the partners’ growing disappointment in the therapeutic process as it reaches its mid-point. In the fourth session, the therapist will encounter growing feelings of sadness as the parties confront the inevitability of change. For some partners this experience could be described as a special case of depression. Like separation anxiety it is seen “as an inescapable aspect of life and in that sense is normal” (Bowlby, 1961, p. 335). While for others with more complex developmental failures, feelings associated with the process of chronic mourning might start to appear.
Hazan and Shaver (1992) defined chronic mourning as “essentially persistent protest accompanied by feelings of anxiety and anger or an inability to overcome depression and despair” (p. 101). Another perspective on the feelings likely to be encountered in the fourth session can be found in Blatt’s (1995) differentiation between two types of depression, anaclitic (or dependent) and introjective (or self-critical) depression. Based on the assumption of depression as a manifestation of disturbed object ties, it follows that one of the objectives of treatment is to modify those representations (Messer & Warren, 1995).

Treatment Planning

Whereas in the third session the therapist focused upon having the couple make contact with the origins of their anxiety, now the therapeutic discourse turns to having the couple manage the beliefs associated with the conflict. Whereby previously the therapist assisted the couple to learn more about the impact of ‘unconscious influences’ on their feelings and behaviours, now the prescription for change aims at reversing each partner’s ‘self-defeating repetitious patterns’ (Papp, 1982).

The ability of the therapist to move the couple toward a more satisfying relationship does not rely so much on the therapist’s understanding of whether the relationship will become stable/satisfactory, unstable/unsatisfactory or stable/unsatisfactory (Macnab, 1991). Instead, it involves the therapist having the couple contain their anxieties and projections. Pivotal to such a ‘new experience’ becomes the therapist’s ability to modify the couple’s representation of self and other. Or in other words, the therapist must help the couple perceive how they might

function as projective and transferential objects for each other; (ii) how their sense of self depends on this interpersonal object deployment and; (iii) the way in which the changes needed to occur in the relationship threaten their individual and interpersonal object relations (Pinsof, 1995, p. 43).

Identification of the partners’ internal working models.

The general view of the session is that each partner’s inner working models create a sense of coherence by selectively focusing on events and experiences and interpreting them idiosyncratically. This conceptualisation requires that the therapist identify the partners’ habitual attachment processes and to assist them to work through their cognitions, “automatic thoughts, intermediate beliefs (attitudes/rules/assumptions) and core beliefs/schemas” (Shean, 2001, p. 159). From this vantage point, the focus of the session rests on the interpretation of the inner working models informing the couple’s narrative and helps to facilitate the establishment of an alternative meaning to their situation (Rennie, 1994).
On the basis of these developmental and clinical considerations, the therapist attempts to expand his or her understanding of the situations that leave the partners feeling anxious, depressed or unfulfilled. In their discussion of the role of affect in couples therapy Greenberg and Johnson (1980) observed:

The experience and expression of emotion by partners in couples therapy promotes a number of different kinds of cognitive change. One partner’s view of the other’s predominant affect experience provides a framework within which new attributions about the other’s thoughts and feelings are made. The expression of new affective experience in one’s spouse creates a reorganization of the other’s perceptual framework (p. 6).

To achieve this perceptual reorganisation, the therapist attempts to cast the couple’s cognitions into a new and more flexible form that renders them accessible to change (Papp, 1982). The complexities of this task were highlighted by Beck (1998) who listed some of the schemas common in people who have suffered acute trauma or low level, but chronic, traumatic experiences as children (see Table 6.3 overleaf).

Identification of the partners’ cyclical maladaptive patterns (see chapter four at pages 80-81).

Cognitive restructuring involves the couple and the therapist in a partnership wherein they search for actions and reactions according to a preconceived set of wishes, fears and fantasies [Expectations of Other’s Reactions]. Close attention will be given to the way in which each partner uses habitually selective attention to interpret and misinterpret their partner’s and other people’s actions toward them [Acts of Others Toward Self] (Butler & Binder, 1987). Once these interpersonal and interactional patterns have been identified, the aim is to explain to the partners how they might be modified and changed.

Strupp and Binder (1984) described the capacity for mature relationships as the ability to relate to others as separate individuals. By disconfirming the negative images the couple have of each other, the therapist encourages them to move beyond their perceptions of their partner as unloving, ungiving or malevolent. Solomon (1989) noted how in marital therapy couples would inevitably be confronted with the need to allow new information about themselves and their partner into awareness.

The therapist endeavours to have the couple see how these actions and perceptions contribute to the way they treat themselves, and the effect this has on their self-efficacy [Acts of Self Toward Self (Introject)] (Butler & Binder, 1987). Throughout the process, for each partner’s perceptual patterns to be broadened and enhanced, the therapist attempts to increase the
couple’s awareness of their participation in the cycle of reinforcement (Gilbert & Shmukler, 1996).

Table 6.3

The schemas common in people who have suffered acute trauma or low level but chronic traumatic experiences as children.

<table>
<thead>
<tr>
<th>Core beliefs of personality disorder patients</th>
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<tr>
<td>Helpless</td>
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<tr>
<td>Inadequate</td>
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<tr>
<td>Powerless</td>
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<tr>
<td>Trapped</td>
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<tr>
<td>Inferior</td>
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<tr>
<td>Ineffective</td>
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<tr>
<td>Incompetent</td>
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<tr>
<td>Weak</td>
</tr>
<tr>
<td>Vulnerable</td>
</tr>
<tr>
<td>Failure</td>
</tr>
<tr>
<td>Defective (Doesn’t Measure Up)</td>
</tr>
<tr>
<td>Not Good Enough (Doesn’t Measure Up)</td>
</tr>
<tr>
<td>Loser (Achievement-Wise)</td>
</tr>
<tr>
<td>Needy</td>
</tr>
<tr>
<td>Out of Control</td>
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</tbody>
</table>


Worrell (1999) pointed out how a person’s sedimented beliefs serve to maintain a solid sense of self. Any change in the partners’ perceptions of the self, Worrell (1999) suggested, has implications for the change in the partners’ constructions of the self both in and outside the relationship. What the therapist is asking the partners to do in the session is to take greater responsibility for the psychodynamic make-up of their personality (Kaplan, Sadock, & Grebb, 1994).

Such a mutative process provides the couple with an opportunity to relate to each other in more authentic ways and to take increased responsibility for their own choices (Teyber, 1997). The aim is to get the partners prepared to ask the question of the unconscious: “who will I be if I change in this or that direction” (Worrell, 1999, p. 13). At the same time the
therapist needs to be constantly aware that challenges to these constructs are likely to be met with resistance.

**The Therapeutic Process**

**The therapeutic review.**

Prior to the commencement of the fourth session, the therapist pauses to consider a number of important issues that assist in the treatment planning: What are the couple’s current assets? What have they let go? What are the continuing blocks, disputes and disappointments? How can the couple be assisted to speak more openly about painful emotions, the continuing situations or experiences that evoke guilt, shame or resentment? How might the individuals become more aware of the ability to clarify and express his or her emotional needs, wishes, and expectations more clearly? (Macnab, 1991).

**Free associative questioning.**

The session commences by encouraging both partners to listen to their inner voice (Macnab, 1991). The aim of this intervention is to increase each partner’s awareness and to then engage in further self-reflection. To achieve this objective the therapist makes use of two free-associative questions (Macnab 1991). First the therapist asks each person:

T: Tell me what’s on your mind?

Once any issues aroused by this question have been processed they ask a second, strategic question to the unconscious:

T: Have you taken the opportunity to daydream about the person you would like to be if you were free from the influences of your past?

In listening to the couple’s responses, Stern (1985) suggested that “as new behaviours and capacities emerge, they are reorganised to form organising subjective perspectives on self and other” (p. 26). Interventions such as these create the potential for the couple to “define their problems differently, relate to one another differently and conceive of change differently” (Papp, 1982, p. 351).

**Descriptive clarifications.**

In attempting to increase genuine modes of expression, the therapist now attempts to determine the patterns and conflicts latent in the narrative that make them memorable to the
couple (Luborsky & Mark, 1991). Further entry to the couple’s narrative will be facilitated by what Worrell (1999) calls ‘descriptive clarifications’. This is a therapeutic method whereby given statements are explored in terms of their implied beliefs, values and meanings.

Of clinical significance is the way implicit expectations embedded in the couple’s narrative organise the relationship in ways which are self-defeating, rather than self-fulfilling (Baker, 1991). The act of clarifying faulty assumptions presents the partners with an immediate challenge. Such questioning creates the opportunity for the couple to expect more authentic emotional connections. According to Teyber (1997), “It also frees them to take the necessary steps for enduring changes in their coping styles, behaviour and expectations of themselves and others” (p. 147).

The therapist’s clarifications to the partners are put in such a way as to stimulate empathy for self and other. A typical descriptive clarification might be:

T: I can hear how much your inability to be heard continues to upset you and how frustrated you both become. It seems that when your needs are not met, it is as if you both become driven by an inner voice that works against, rather than for you. I now want us to look more closely at this… To see how we might change it.

Or alternatively:

T: Do you notice how disappointed you become with each other when you believe you are not treated in the way that you would like to be? I wonder if we might now explore how these expectations keep you from getting what you want?

Facilitative and investigative techniques.

The point of emphasis in cognitive restructuring is the importance of the partners developing their own continuing investigation of their relationship and their life. Schafer (1974) described the value of talking to patients pedagogically and personally in the interest of facilitating investigation and understanding. Although Schafer acknowledged that these techniques can lead to intellectualisation rather than emotional expression, he stressed how in brief psychotherapy the therapist combines “non-directiveness and activity, curiosity, laissez faire and forcefulness, neutrality and emotionality” (Schafer, 1974, p. 503). Some examples of talking to the partners personally and as their educator follow:
Acts of Self

T: Michelle, I wonder if you see how your mistrust of men might be getting in the way of making a success of your relationship?

T: Steven, do you notice that your need to be loved and accepted stops you from creating appropriate boundaries in your relationship with Michelle, your mother and some of the people at work.

Acts of Others

T: Michelle, I am wondering if your strong belief that people will reject you, leads you to behave in such inappropriate ways?

T: Steven, from what I have seen and heard of your relationship, there’s probably some connection between Michelle and your feelings of insecurity.

Expectations of Others

T: Michelle, you appear to be acting towards Steven, as if he were treating you like your father. I am wondering what that might be about?

T: Steven, I keep hearing you compare Michelle with some model in your head of how women should treat you? I wonder if this is why she often feels criticised by you?

The Process of Termination

Therapeutic review

Termination requires the therapist to illustrate to the couple how the four sessions of the therapy have been integrated in such a way as to help them to proceed differently in the relationship and the future. For example, the therapist might say:

T: Today we have again been looking at your patterns of feeling, thinking, wishing and acting. We have worked hard to find out how we might change a number of your expectations, demands and compulsions.

We have been trying to see how we might increase the possibilities for a better sense of self, and a better relationship for you both. We have looked at how you imagine
other people will react to you, and how disappointed you become when they do not appear to behave as you expect.

Next week we want to make a shift to changing your beliefs about yourself and others further. Before we do this, it might help if I tell you again about your interaction with me.

T: Michelle, I understand how hurt you feel in all this, but I often experience you as so needy. An experience like that is bound to be upsetting.

T: Steven, I know that one part of you wants so desperately to make this work, but I often feel as if I am in competition with you for Michelle’s attention. I wonder if there is some connection between your guardedness with me and your general mistrust of people.

Homework tasks

Once again the dysfunctional aspects of the partners’ narrative and cognitions are tested in mutually agreed homework assignments. The importance of cognitive restructuring in homework tasks has been emphasised by Shean (2001). Each partner will be encouraged to “identify their cognitive distortions, examine evidence for and against these distortions and generate more adaptive alternative interpretations or attributions” (Shean, 2001, p. 159). For example,

T: Over the coming week it would be helpful if you could again pause to hear how you perceive situations. Listen to what you tell yourself before you speak or act; ask yourself how you might respond in a different way…

Finally, the therapist closes the session by introducing a homework task that makes a therapeutic link to the existential focus of the fifth session.

T: It would be therapeutic if over the coming week you both paused to say: ‘I am accepted’. Try it. Listen to your inner voice. Notice the difference. During the week, I want you also to pause and consider a number of questions: What type of person would you now like to become? How might you look at your problems differently…? How might you perceive one another differently…? In the light of the insights,
understanding and changes you have made as a result of the therapy, how will you shape your experience and interactions with others? (Macnab, 1991)

According to Papp (1982) a ‘paradoxical ritual’ of this kind, tests the marital system, as well as the partners’ dedication to change. In the present context, this intervention highlights that the therapy will soon be ending. In addition, the intervention alerts the couple to the existential focus of the next session – the recognition that the therapy, like life, is limited and is drawing to a close.

In the next chapter is a description of how the therapist extends their understanding of the relational dynamic by focusing on the partners’ subjective experience. Such a therapeutic focus enables the couple to understand more clearly how their sense of power and agency becomes undermined by entanglement of memory, by the narrative associated with memory narrative and by the emotional investments associated with it. The existential focus of stage three creates the potential for the couple to promote a positive new experience of self, other, and relationship. In the next chapter the way the therapist processes, reflects and interprets the interpersonal schemas expressed in the relational space is described.
A definition of the self takes precedence in the last stage of the therapy. A shift in focus, from ‘self’ as ‘object’ to ‘self as subject’, takes place in this third stage. The focus of the therapy turns from the cognitions to the affect. From its concern with the anxieties around abandonment and the despair of leaving behind outmoded core beliefs, the therapeutic project becomes the way the partners might relate more effectively in the future. A number of factors contribute to this existential experience. The focus of stage three creates the potential for the partners to undertake an inner transformation of self, partner and relationship. The therapeutic discourse stresses relatedness, socialisation, self-expression and the issues of self-esteem. The intent is to conceptualise the final stage of the therapy as one where detachment from the old relationship to an integration of the self as a sustaining inner presence takes place.
Stage Three – Affective Restructuring

A redefinition of the self takes precedence in the last stage of the therapy. As described in chapter four at pages 98-100, the focus of the therapy turns to the affect. Whereas previously the issues of: ‘Where am I’? and ‘Where do I come from’? were relevant, now the questions being addressed to the unconscious become: ‘Where am I going’? ‘Who will I become’? A number of factors that each emerge from the other coalesce to contribute to this existential experience. Such a therapeutic experience results in each partner “speaking-into-being” (Worrell, 1999), a recontextualised view of the self.

By privileging the couple’s subjective experience of being-in-the-world in this way, the couple are encouraged to reconstruct a different view of the self and of the self in relationship with others. Hence the process of this stage presents the partners with an opportunity to recognise their partner in a different context, as a person, rather than in a role such as husband, partner, father or wife. Buber (1970) called this the I-Thou, or I-You relationship, as distinct from the I-It relationship.

The Stage-Related Process—Detachment

Existential Anxiety

Buber’s concept of I-Thou rests on the most primitive perception of all: “the capacity of the mother and child to know each other’s affective states, which antedates the acquisition of language” (Bacciagaluppi, 1989, p. 313). The intersubjective experience of session five, engages the couple in an acknowledgement of a reworking of the reciprocal role they have played with each other. Stage three of the therapy rests on the assumption that once the partners experience an empathic response, they will feel affirmed for that which they are. Buber (1970) described this concept as “imagining the real”. This is a form of deeply knowing the other's existence and participating with the other where he or she is (Jossellson, 1993).

The essence of this existential focus is the authenticity in human experience. Macnab (1965) wrote of the importance of such an experience as follows:

Authenticity is achieved when man turns towards the future with resolve (and particularly as far as his death is concerned). It is achieved when he accepts his guilt and thus resolves to be his past; it is achieved when he turns away from his falseness and accepts his past into his present, and from this projects
himself into the future. Personal Being (Dasein) is always ahead of itself (1965, p. 143).

The basis for this conceptualisation rests on one of the cornerstones of the humanistic theories about the nature of the self. That is, the belief in human potential and in the capacity for self-actualisation (Maslow, 1970). In stage three the potential for the couple to move toward a higher order of relating and a deeper awareness of their own ‘being-in-the-world’ is created. It involves the therapist bringing past and future into the present. Or in other words, this process requires the therapist to have the couple look forward and backward simultaneously (Norcross, 1992).

By directing the therapeutic focus toward the future, the couple discover more about their personal possibilities. The potential is created for each partner to uncover more of their deeper natures and lay bare more of their own aliveness (Bugental, 1976). Bugental (1976) described the existential issues aroused by such an experience as follows:

To know (in the deepest sense of knowing) what could be is to be enlivened to what is. To know how one might be fully alive is to be discontent with what is plastic and partial in the way one is now alive. To recognize the fullness that awaits one is to be hungry for richer living (p. 296).

**The Goal of Mourning**

In the psychoanalytic literature the goal of mourning has been regarded as the detachment of libidinal ties from the love object (Baker, 2001). In *Mourning and Melancholia* Freud (1917) described how “when the work of mourning is completed the ego becomes free and uninhibited again” (p. 154). Freud showed that there is a gradation between normal mourning, pathological forms of mourning and, lastly, melancholia (Laplanche & Pontalis, 1988). Laplanche and Pontalis (1988) stated that “in pathological mourning the conflict of ambivalence has come to the fore; with melancholia, a further step has been taken: the ego identifies with the lost object” (p. 486).

This perspective implies that healthy mourning represents an intrapsychic process “whereby the subject gradually manages to detach himself from this object” (Laplanche & Pontalis, 1988, p. 485). Freud (1917) also observed that the state of the relationship the person had with the deceased would determine whether normal or pathological mourning occurred. He wrote:

Just as the work of grief, by declaring the object to be dead and offering the ego the benefit of continuing to live impels the ego to give up the object, so each single conflict of ambivalence, by disparaging the object, denigrating it, even as it were by slaying it, loosens the fixation of the libido to it. It is possible, therefore for the process in the Ucs to come to an end, whether it be
that the fury has spent itself or that the object is abandoned as no longer of value (p. 169).

Horowitz (1990) noted that the greater the ambivalence in a relationship, the more likely it is that the individual will experience “intense and turbulent affects and more extensive and regressive defenses” (p. 301). Conversely, people with greater ego strength and resilience are considered to adapt more readily to changed circumstances. In working with people who have suffered loss, Horowitz (1990) stated that “the more ambivalence and conflict found in the themes for review, the harder it will be to reach the conclusions that complete the mourning process” (p. 316).

The Process of Detachment

The existential focus of stage three creates the therapeutic space for the partners to undertake an inner transformation of self, partner and relationship. In the present context, this perspective results in detachment being defined “as a process of inner transformation of both self and object images” (Baker, 2001, p. 56). The intent is to conceptualise the final stage of the therapy as one where detachment takes place from the old relationship, to an alternative relationship where the self acts as a sustaining inner presence.

In reviewing the clinical and empirical literature on the current status of the phenomenon of mourning, Baker (2001) concluded that a reconceptualisation of the intrapsychic processes could be made. Baker found evidence that questions the detachment aspect of Freud’s concept of the work of mourning. Bowlby (1980) and others have found that in healthy mourning individuals maintained internal representations of others after the death. This led Baker (2001) to observe that:

Mourning is seen as a process of inner transformation that affects both the images of the self and of the object in the mourner’s inner world. It involves not the breaking of an object tie, but the transformation of that attachment into a sustaining internal presence, which operates as an ongoing component in the individual’s internal world (p. 55).

The transformation of a lost attachment bond into a sustaining internal presence has particular implications for the final stage of the therapy. According to Horowitz (1990) the term working model “is based heavily on immediate perceptions of external reality, although schemas organize (and potentially distort) that perception” (p. 306). In Horowitz’s model a schema of a role-relationship is less situationally dependent and becomes activated by inner wishes.
Thus we may infer that the mind unconsciously compares the working role-relationship model and the enduring role-relationship model. If they do not match, intense emotions may arise, serving to motivate either plans for correcting the mismatch or defensive avoidance to reduce recognition of it (Horowitz, 1990, p. 306)

Transformation of the partners’ object relationships “requires an internal separation–individuation process in which certain aspects of the self are no longer tied to the object image” (Baker, 2001, p. 68). The transformed relationship with the partner is not identical to the previously existing object relationship. Instead, the process of detachment requires a continuing re-evaluation of aspects of the self and also that of the partner. A second characteristic of the process involves the partners in a “sorting-out process in which certain aspects of the self are assigned to the self and some to the other” (Baker, 2001, p. 69). A third characteristic is the identity-maintaining aspects of the process by having the partners decrease their feelings of loneliness, but also to sort out their own thoughts and to define their own wishes, needs, and feelings. They are using the internal relationship to define and maintain their sense of self-identity (Baker, 2001, p. 69).

*The Process of Transformation*

The psychological processes aroused by this inner transformation have a parallel in the concept of healthy mourning. A first dimension of a healthy response to mourning requires the individual to move from a preoccupation with images of the deceased to being able to access memories of them as required. A second dimension relates to the ability of the mourner to acquire a realistic representation of the deceased. This process requires a realistic mixture of positive and negative perceptions: “neither exclusively positive (idealized) or exclusively negative (devalued)” (Baker, 2001, p. 67). A third dimension involves the internal relationship remaining open and adaptive to change, while retaining its core characteristics (Baker, 2001).

This perspective implies, that it is wrong to think of the self in isolation. Rather the self is considered to exist in an intersubjective relational field (Worrell, 1999). Worrell (1999) discussed the experience of the self as not being inherently substantial or fixed. This implies the possibility of ‘non-being’. Worrell (1999) defined the Existential-Phenomenological viewpoint as follows:

Existential-Phenomenological psychotherapy has as its philosophical bedrock the relational concepts of ‘Intentionality’ and ‘Intersubjectivity’. Its basic
proposition is that all mental activity, affect and behavior is relationally constituted (p. 12).

Just as the transformation of the partners’ schemas implies the development of new self and object representations, other factors are considered to enhance and hinder this objective. As the observer and the observed are both relationally defined, in such a confrontation there is the potential for the self to be experienced as ‘no-thing’. This experience “can be a deeply disturbing one, as it may be experienced as a threat to being itself” (Worrell, 1999, p. 13).

As the process of the session evolves, the partners are confronted with the plasticity of the self-as-process. Mahoney (1991) defined the self not so much as an explicitly articulated set of beliefs, but as an abstract and open set of organising principles:

The essence of this perspective is that the self is a complex and dynamic metaphor for the unique and spontaneous self-organizing processes that are each person in his or her step-by-step, moment-to-moment becoming. In this view, who and how one becomes are expressions of deeply ingrained patterns of activity that are fundamentally emotional and minimally explicit (p. 224).

This perspective helps to explain how the partners develop implicit theories about themselves. The self can be both the subject and object of what is known. Located within the self are the conclusions drawn from lifetime experiences, and the perceived and real responses from earliest carers, who provided the foundation of self-awareness long before the individual was aware of the self (Ryle, 1982).

Meanings of situations and events are understood and the selection and evaluation of lower-order aims and actions all occur through reference to this overall cognitive structure. The ‘observing self’ evaluates the effectiveness of individual performance and the meaning and outcomes of behaviour. The ‘ideal self’ reflects how the individual feels as a result of the mismatch between the real self and the ideal self, or the difference between a person’s perceptions of the self and how they would like the self to be perceived by others (Ryle, 1982).

**The Paradox of Relatedness and Autonomy**

The existential discourse of an alternative view of self highlights each partner’s need to address one of life’s fundamental dilemmas. It confronts them with the dynamic balance between the universal need to be engaged in relationships with others and the achievement of an autonomous identity (Eagle, 1998). As discussed more fully in chapter two at pages 24-25, like Blatt (1995), Eagle (1998) noted that the ability to balance relatedness and autonomy is a critical factor in personality development.
Grey (1991) wrote that there are two ways of understanding the relationship between ‘relatedness and autonomy’. First, these concepts can be seen as complementary capacities that each person develops as they attempt to achieve a sense of wholeness and a desire to live in more satisfying connection with others. Alternatively, relatedness and autonomy can be conceptualised as “polar alternatives in unresolvable opposition to each other…[in which] the achievement of one goal entails a sacrifice of the other” (Grey, 1991, p. 663).

To more fully understand this concept, reference can be made to Winnicott’s notion of transitional phenomena. Winnicott (1955) described the earliest transitional experience of the child as subjective omnipotence, by which he meant the way they experience themselves as all-powerful and all-knowing, the centre of all being. The child believes it is his or her own wish that creates the object of desire. But ultimately the child (and the adult) needs to come to the acute realisation that the desired object is a separate and distinct object over which they have no control. In attachment theory this is known as ‘attachment and exploration’ (Bowlby, 1980), in object relations theory as ‘symbiosis and separation-individuation’ (Mahler et al., 1975) and in interpersonal theory as ‘relatedness and self-definition’ and ‘attachment and separateness’ (Blatt, 1995).

The concept of the individual’s desire for merger confronts the therapist with the need to perceive the couple's dissatisfaction as being aroused by complex feelings. In particular, the recurring experience that something is missing in their lives: that more is needed of the sustaining object of which one (the partner) continues to deprive the other (Mann & Goldman, 1982). According to Mann and Goldman (1982), the wish to merge with another, but also the absolute necessity of learning to tolerate separation and loss without undue damage to one's feelings about the self, represents one of the major private dilemmas in therapy and in life (p. 29).

In attempting to enrich their inner attachments, the partners will be confronted with the need for each to perceive the other as a separate person, rather than for the gratification they afford the self (Scharff, 1995). From this perspective, the most prominent model of mature relatedness “requires two (or more) autonomous selves committed to each other's growth, and related to each other in mutual care, acceptance, empathy and undefensive openness” (Grey, 1991, p. 663). Highlighting the paradox of being related yet separate, Young-Eisendrath (2000) wrote that the ability of the individual to gain insight and understanding about hidden desires and emotional habits are the first steps toward autonomy.
Central to the practice of existential-phenomenological psychotherapy is the concept of “encounter” (Worrell, 1999). In therapy-as-encounter there is an assumption that the therapist attempts to clarify the couple’s manner of being-in-the world. In the context of stage three, such a process provides the partners with an opportunity to develop a more realistic and affirming self-concept (Teyber, 1997). It confronts them with the possibility of claiming the psychological permission necessary to put their emotional needs before those of their partner, children, family or anyone else. In existential terms the interpersonal relationship is seen not only as the basis of all human interaction, but a sine qua non of living (Strasser & Strasser, 1997).

The therapeutic focus of this stage requires the partners to engage in an existential encounter of a different kind. It confronts them with the need to embrace more authentic ways of relating. Such a therapeutic moment represents the search for what Bugental (1976) described as an existential identity. He wrote how this experience gives promise for a new resolution to old problems and the ability to recognise, though in changed ways, new and deeper hope for their lives, while seeing the possibilities for a new relational experience.

In the context of stage three, the therapist encourages the partners to become authors of their own relationship and to be thoughtful about the ‘between’ in their lives together (Fishbane, 1998). Kohut (1977) stressed the importance of a mirroring other (or selfobject), as someone who confirms the individual for who they are, and as a psychological necessity of life. When those parts of the self are not adequately mirrored, they are frequently split off from the personality, kept secret or private, or repressed altogether. Greenberg and Johnson (1986) emphasised the need for the partners to “encounter each other in the session in a new way and participate in the corrective emotional experience of an I-Thou relationship” (p. 38).

An existential encounter of this kind has the potential to bring the couple to an experience that had not previously been part of their interpersonal field. In doing so, it facilitates a change in the nature of their encounter with each other and the context in which it is expressed. As a consequence, the therapeutic process gives promise of a new resolution to old problems (Gilbert & Shmukler, 1996).

Winnicott (1955) wrote of how the establishment of the holding environment being described here creates a ‘transitional phenomenon’ from past historical, experiential, emotional, and
dysfunctional experiences. Winnicott highlighted how individuals attribute their own particular meaning to objects and phenomena. Neither internal to the self (fantasy), nor external (reality), this paradoxical space is an intermediate or illusory space where, like infants, each partner has the potential to create and manipulate their own unique contribution to being.

May (1992) spoke of this ‘I-am’ experience as characterising what it means for a person to be aware of his or her own being. Like Fromm’s (1991) concept of benign passions, and Kohut’s (1977) concept of narcissism, this potential space is the place of adult creativity, culture and the arts. By being open and direct and not afraid to speak frankly of their hopelessness, the existential encounter has the potential to engender a sense of hope (Kwawer, 1991).

Against this background, the therapist aims to have the couple establish an environment wherein they can be free to confront their own and their partner’s existential anxieties. To the extent that the couple, and the therapist, gain an awareness of their inner being, an alternative biography for self, other, and relationship becomes possible. In essence, the therapist attempts to increase each partner's motivation to move toward an increased capacity for intimacy (Magnavita, 1997) through a more secure sense of their own identity and autonomy.

Resistance to the Therapeutic Focus

A view of the self as an open set of organising principles has implications for the conduct of the last two sessions. It requires the therapist to take cognisance of the intense and potentially negative affect that is likely to be aroused by the detachment process. Consistent with the concept of change in inner representations, there is a need for the couple to realise that the relationship as it was is finished. Looked at in this way, the existential focus of the third stage represents a threat to the self that will inevitably result in resistance.

Within an existential-phenomenological perspective, Worrell (1999) defined resistance as representing an expression of the client’s “current manner of constructing self and other as well as expressive of the avoidance of ontological anxiety” (p. 13). Or, in other words, the anxiety associated with the threat to being itself. Similarly, Foehenrach and Lane (1994) wrote of how there are both “direct (more open) and indirect (more covert) forces operating” within people that oppose the process of therapeutic change in therapy (p. 23).

Some of the resistances preventing change in the present context might be the use of aggression as a barrier to love (Foehenrach & Lane, 1994), irrational and unrealistic cognitions (Mahoney, 1991) and repression from awareness of internal attachments (Baker,
2001). Alternatively, these phenomena can be seen as reflecting limits in the partners’ current capacities or psychological development, or they may involve important opportunities for learning (Mahoney, 1991). Rather than perceiving resistance as an impediment to therapeutic change that must be overcome, Mahoney argued that the therapist should work with it rather than against it. Mahoney (1991) took the view that resistance “reflects natural self-protective processes that guard systematic integrity and resist rapid or substantial core change” (p. 243).

From an attachment perspective, secure attachment has been linked to more constructive relationship behaviours, including better problem solving skills, the ability to compromise during conflict and more flexible patterns of disclosure (Feeney, 2002). Feeney noted that there is now strong research evidence to suggest that secure attachment is linked to higher relationship quality. In this research Feeney (2002) found that in insecure attachment there is a greater reactivity to recent spouse behaviour, as well as the tendency for insecure spouses to report more spousal negativity.

In marital therapy, it is possible that the working schemas of one partner may become more open to change, just as the subjective experience of the other partner remains the same. In this outcome new efforts to re-engage the partner can be expected (Horowitz, 1990). With these factors in mind, the attachment style, personality, current conflicts and developmental level of the personality all inform the therapist’s understanding of the process. Combining Ainsworth’s (1978) attachment styles and Horowitz’s (1990) model of mourning, potential detachment patterns can be seen in Table 7.1.

Table 7.1

<table>
<thead>
<tr>
<th>Secure and Insecure Attachment Patterns</th>
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<tr>
<td>Attachment Style</td>
</tr>
<tr>
<td>Secure</td>
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<tr>
<td>Insecure</td>
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<tr>
<td>Avoidant</td>
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<td>Ambivalent</td>
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</table>
| Disorganised type | Unable to exhibit an adult type of mourning |}

Sources: Ainsworth (1978); Horowitz (1990).
Awareness of Therapist’s Anxiety About Termination

Just as the role of resistance in the client acts as an impediment to change, there is also the need to understand how the therapist might impede the detachment process. Reviewing the different contributions to the understanding of resistance Worrell (1999) highlighted the need to perceive the role of the therapist’s own resistance. “The therapist viewing the client as ‘resisting’ may be alternatively viewed as an expression of the therapist’s resistance to ‘being with’ the client” (p. 10).

Mann (1981) wrote of two factors that influence the therapist’s anxiety about termination as being “the personal feelings and responses to separations, and the need of many therapists to encourage patients’ dependence upon them” (p. 41). As stage three involves having the couple come to terms with the issues of disappointedness and despair:

It is at this point that countertransference reactions will press toward a reluctance to fully face the termination process or even toward actions which will serve to continue the treatment and not bring it to its agreed-upon end (Mann, 1981, pp. 41-42).

From this perspective then, at no other stage is the therapist more likely to confront his or her own anxieties about their own being. The existential focus of the third and final stage confronts them with their own issues of separation and loss. As the process involves distorted aspects of the partner’s self-image, such a process highlights whether the therapists have mastered their own anxieties. Satran (1991) described such anxieties as due to the normal denial of eventual death, and the inability to perceive the self as not being alive and in the world, or for that matter the perception of the world existing without them.

Consistent with this understanding of resistance is the view that participation in the intimate process of marital therapy may arouse anxieties about the therapist’s own mature autonomy or identity. According to Omer (1993b)

The therapist’s work has traditionally been viewed as resting on two foundations: knowledge (theoretical, empirical, and clinical), and interpersonal skills (empathy, clinical acuity, and the ability to relate). Selection and training have always been oriented toward these two features, combining scholastic achievements and knowledge, with interpersonal characteristics (p. 672).

The supposition that therapists possess a more developed sense of self was highlighted by Pollack (1990). This is assumed to manifest itself in the creation of ego boundaries, limits, differentiation and individuated functioning. In addition, it supposes that the therapist has developed the necessary affiliative skills to engage successfully in the therapeutic process.
(Pollack, 1990). But even with highly developed affiliative skills, this may not be enough for some therapists to overcome their feelings of envy, existential longings and anxieties. Participation in such an intimate process as marital therapy can result in empathic failure, acting-out and a negative treatment outcome.

Session Five—Clinical Focus Existential Anxieties

The existential focus of stage three emphasises confrontation, the will to change and the courage to be different. This results in the last two sessions bringing to the therapeutic discourse the uniqueness of the self, the development of new object-relationships and a richer inner world. Each partner's deeper desires, longings, illusions and disappointments come under consideration (Macnab, 1991). The therapeutic focus involves the therapist in a conceptualisation of the way an alternative view of self, partner and relationship, might unfold. This turning in on the self was described in chapter four at pages 98-100.

The existential focus of session five is predicated on the assumption that as the partners begin to understand more fully their object deployment, further feelings associated with previous losses become activated. This therapeutic focus requires both partners to hear and confront what they know, but are unaware that they do know. In other words, it requires that they gain an increased awareness of ‘what they have known all along’ (Levenson, 2001). Bollas (1987) described this experience as the discovery of the ‘unthought known’. In practical terms, by providing the couple with choices that were previously unthought of or unknown, the likelihood that they will remain at their task becomes enhanced.

The process of inner transformation requires the therapist to work in two contrasting temporal perspectives (Norcross, 1992). As historians they must “evaluate the past in order to alter perceptions and actions in the present,” as futurists “they study the future in order to alter perceptions and actions in the present” (Norcross, 1992, p. 3). This involves a consideration of the couple's self-identity, deepest fantasies, existential loneliness and factual relationship woundings.

Greenberg and Johnson (1986) wrote that to bring about change in the definition of a relationship the therapist must access previously unattended to and unacknowledged affect. The intersubjective exchange of session five requires the therapist and the couple to explore the emotions associated with merger and detachment. What the therapist is asking the unconscious of the individual is not to make the choice between relatedness and autonomy,
but to adopt a different pattern of positioning the self in relation to their partner, and to a broad range of human possibilities (Macnab, 1991).

Consistent with the general theory of intersubjectivity it is assumed that such a discourse creates the potential for each person to become more aware of his or her emotional vulnerability. Much can be gained in the movement from the experience of the partner as the cause of emotional pain and frustration (Mitchell & Black, 1995). In effect, the process requires the partners to gain greater respect for their own as well as their partner’s emotional struggle.

As session five unfolds, the therapist attempts to have the couple clarify the choices attached to their manner of being-in-the-world (Worrell, 1999). Once again, the therapist attempts to have the partners understand the pressures and anxieties that prevent them from doing so. Rather than adhering to the belief that both their self-image and self-esteem are dependent upon being admired and accepted by others, both partners will be encouraged to take responsibility for their own lives.

There are two outcomes of this sorting-out process. First there is an awareness that both self and other struggle with the same existential issues and concerns. And second, there is an acknowledgment by the partners, that rather than acting as if they are self-confident, loving, and all the other things a competent adult is supposed to be, “in some sense this is a fiction” (Douglas, 1984, p. 87).

Treatment Planning

Although the therapy is entering the final stage, the therapist continues to accept responsibility for setting up the necessary conditions for control of the process. In their discussion of termination in brief marital therapy, Gilbert and Shumkler (1996) observed that the therapist must take the initiative, contain the process and set in place a process of creative disengagement for couples. Any feelings of guilt about the inability to change, being let down by their partner, the therapist, or the process all need to be contained.

The treatment review.

Stage three begins with a reassessment of the therapeutic progress. Every couple has a unique developmental pattern, and every therapy will combine periods of progression and regression. In partners with higher levels of ambivalence, more pervasive levels of confusion, hostility or depression are likely to be present (Horowitz, 1990). This results in the therapist being aware
that one partner may be more able psychologically than the other to confront the future and its meaning.

This provides the basis for a broader conceptualisation for the treatment of object loss. Gilbert and Shmukler (1996) defined a number of specific tasks facing the therapist at this time.

Are there observable indicators of change, both within the sessions and outside of these (as reported by the partners)? Have the partners gained an awareness of the process underlying their communication failures – of the cycle of reinforcement that perpetuates their non-problem-solving behaviour? Has the experience of new options within the sessions been generalized to situations outside the sessions? (p. 140).

Positive and negative treatment reactions.

In cases where the therapeutic process has provided the couple with ‘new understanding’, session five will find them becoming more introspective and reflective. Such an experience will result in them being more open to the “internal separation–individuation process in which certain aspects of the self are no longer tied to the object image” (Baker, 2001, p. 68). They are likely to be reflective about the future of their new and potentially reparative relationship, its direction and shape and their role in it (Clarkson, 1994).

At the same time, as internal object relationships are complex, even in positive therapeutic reactions the therapist will be aware of resistance to the process. Magnavita (1997) warned of how the achievement of greater intimacy leads to increased anxiety. When pressure is placed on the partners to reveal their innermost thoughts, feelings and fantasies, the therapist can expect their level of anxiety to increase rapidly.

In negative treatment reactions one or both of the partners may exhibit ambivalence, deny any change or refuse to acknowledge the significant problems in the relationship (Bader & Pearson, 1988). Bader and Pearson (1988) observed that concentrating primarily on a future focus when one partner is unable or unwilling to move forward could reinforce the dysfunctional dynamic in the relationship. Such a future focus can lead to feelings of being overwhelmed or increasingly distressed.

Irrespective of the ambivalence toward the process, the therapist does not confront the partners’ negative reactions directly. Instead, the therapist continues to empathically acknowledge each partner's fears, disappointments and feelings of despair. Paradoxically, by
staying with the process and ignoring any resistance, the therapist acts as if change is inevitable.

The Therapeutic Process

The existential encounter.

The therapist commences the session by gaining immediate entry into the couple’s experience. This entry is facilitated by the therapist encouraging the partners to take time to consider, and also to listen, to their own and their partner’s deepest needs (Macnab 1991). Worrell (1999) described this process as the need for the therapist to be in the relationship with the couple for the purpose of clarifying the lived experience of each partner’s “manner of being-in-the-world” (p. 13).

Strasser and Strasser (1997) noted how the purpose of interventions such as this is to promote an examination of the meaning of freedom and life choices. In essence, the therapist encourages the partners to separate their self-disclosure and self-differentiation from their concealed and obfuscated past powerful influences. This existential position assumes that the couples have choices in the creation of the self “and that there are always many possibilities available to choose from” (Strasser & Strasser, 1997, p. 115).

To achieve this objective, the therapist asks a number of ‘imagining-the-self’ questions of the partners’ unconscious. To increase the partners’ awareness of the existential issues of loneliness, finitude and the meaning of life, the therapist makes a simple yet profound existential enquiry of the unconscious (Macnab, 1991). This free associative technique allows the partners to formulate more clearly their life-directions and commitments. The therapist first asks one partner then the other:

T: Today, I want you to ask yourself: Deep down, what am I really looking for? Deep down, what is my inner voice telling me to be? Deep down, am I going about things in a way to get what deep down I really want, and to be what deep down I believe I can be? (Macnab, 1991, p. 72).

Once they have worked with the issues aroused by the process the therapist then makes use of cross-dyadic questioning. The aim of this intervention is to enable the partners to exchange “each other’s deeper goals, desires, longing, illusions, disappointments” (Macnab, 1991, p. 72). In the case of Steven and Michelle for example, the therapist might say:
T: Do you think that is what Michelle, deep down, really wants? Do you think that if, deep down, that is what she really wants, that she is, deep down, acting in a way that will help her get it?

T: Do you think that is what Steven, deep down, really wants? Do you think that if, deep down, that is what he really wants, he is, deep down, acting in a way that will help him get it? (Macnab, 1991, p. 72).

The next intervention involves the therapist in a further determination of the partners’ interpersonal and existential choices. The act of clarifying their beliefs and values challenges the couple to take responsibility for the way they interpret their experience and that of others. In doing so, Worrell (1999) noted how the “possibility (inevitability) of further choice is presented along with the experience of anxiety that this provokes” (p. 13).

In endeavouring to continue the process of encounter and clarification, the therapist brings two further questions to the therapeutic dialogue: How will the couple live? What will be of ultimate importance to them? (Macnab, 1991). It is by the use of these questions that the therapist attempts to create a situation in which the partners are more likely to listen to each other in a new and more empathic way. Greenberg and Johnson (1986) discussed:

how the expression of newly synthesized emotions to one’s spouse has the potential to communicate new powerful interpersonal messages, which on an analogic level changes the way the relationship is defined and also facilitates the growth of intimacy (p. 7).

Making the partners emotionally accessible to the other’s vulnerability in this way not only raises their existential anxiety, it can highlight their sense of enjoyment and excellence also. To assist the partners to respond more sensitively and attentively to each other, the therapist may bring about further de-repression of significant memories and associations (Davanloo, 1990). There are several different outcomes of this process.

First it allows for the free expression of any feelings of rage, guilt or grief associated with the frustration or neglect of each partner’s deepest longings, yearnings, and desires. Second, it attempts to have the partners modulate their innermost feelings about their past, present and future relationships. And third, it helps them to see that some part of those feelings is not entirely determined by the realities of the present situation. Salzberger-Wittenberg (1988) summarised the purpose of such a process as having the couple come to a deeper understanding of the preciousness of their partner's and their own time of life.


The Process of Termination

Once the therapist works with any uncertainties or issues raised by the existential encounter, the link to the sixth and final session of the therapy will be made. As stated, it is expected that the realisation that the therapy is coming to an end will raise the partners’ anxiety about separation and loss. This can have the effect of evoking strong emotions, such as the fear of rejection, anger, sadness and grief (Strasser & Strasser, 1997).

In doing so, the therapist again presents the couple with the opportunity to gain a different and alternative sense of self. To achieve this objective, the couple will be asked to spend some time over the next week being reflective and contemplative about the self, their relationship, and their supportive influences. What would the partners need to help sustain the vitality of the relationship and better ways of relating? (Macnab, 1991).

Homework task.

To consolidate the insights made in the session, the couple will be asked to set aside ten minutes to engage in another ‘imagining-the-self’ experience. This involves the couple considering two of the basic endeavours in existential psychotherapy— the creation of an alternative self-construct and an increased sense of self-esteem (Strasser & Strasser, 1997). As the partners’ self-construct is intricately entwined with their value system, this process involves them in a consideration of the passing of time and of life-processes. The therapist might say:

T: Between this and the next session, set aside ten minutes to sit quietly. Let the deeper things, the good strong things of your inner, deeper self be there. Do not do anything. Simply let them be there. Accept them. Let them accept you. Listen to them telling you to accept yourself. Do that again, for ten minutes, three days later (Macnab, 1991, pp. 72-3).

Alternatively, where the therapist perceives the couple as having ongoing issues or personal difficulties, they might say:

T: Next time we will bring our experiences in these sessions together to see where we will go after the sixth session; whether there has been a sufficient restructuring, or whether it will be desirable to go on further with one of the forms of therapy I have opened to you (Macnab, 1991, p.73).
Session Six—Clinical Focus Recontextualised Selves

The role of termination in psychotherapy and psychoanalysis is well recognised (Usher, 1993). From a psychodynamic perspective, the experience of termination has traditionally centred upon a number of indicators. In individual psychodynamic therapy Usher (1993) documented these factors as:

Symptomatic improvement; improved capacity to work and love; a more comprehensive appreciation of what underlies one's symptoms and conflicts; a greater tolerance for anxiety and depression, and also for pleasure; an improved sense of autonomy; and the ability to use newfound insights to adaptively alter day-to-day functioning (p. 99).

Other authors have been less specific in their description of termination. Laplanche and Pontalis (1988) documented how the good and bad aspects of the therapy become introjected. Rather than the experience going away, there is the potential for a turning around upon the subject’s own self. Bringing people to a new ending is the way Malan (1979) described the goal of termination in psychotherapy. Finally, Menninger (1958) observed that rather than being the old self, the potential is created to acquire an enlarged, an improved, or indeed a new self.

However, the debate about termination in psychotherapy continues. A review of the literature on termination in brief psychotherapy led Pinkerton and Rockwell (1990) to conclude that either a major or a minimal emphasis is placed on termination. Small (1971) took the view that termination becomes less problematic in the brief therapies where there is a contract concerning a specific number of sessions, or a date set for termination. In Small’s view, this results in the patient making a flight into ill health less likely. Lamb (1988) also suggested that the imposition of an imposed time frame serves as an important catalyst for client exploration, risk-taking and action.

In time-limited psychotherapy like that being described here, sensitivity to the idea of termination influences the therapeutic process from its inception to its conclusion. Like the time-limited psychotherapy of Mann (1973), by setting a termination date at the outset the ambiguity about time and the inevitability of separation permeate the process. In the present therapy, termination is considered to evoke further memories and emotional reactions associated with previous losses (Strupp & Binder, 1984).
The therapeutic process of detachment reflects the dilemma of wanting to be an individual (self) and wanting to be connected (other). This involves a giving up of impossible longings for endless nurturance or restitution (Della Selva, 1996). In this the last session, feelings associated with the loss of the holding environment will predominate. The therapist can expect to find high degrees of resistance, as a result. This could lead to the partners re-experiencing feelings of abandonment (protest) or increased depressive symptomatology (despair) (Bowlby, 1960). It could also take the form of a re-emergence of increased levels of conflict and the denial of acknowledged gains.

Having the partners understand the meaning and function of their behaviours and interpersonal schemas, both people will be acutely aware that intimacy requires a proactive as well as a reactive approach to loving and living. Gilbert and Shmukler (1996) noted that in ending, it is important to look at the future contracts and what plans people have for sustaining in times to come the new behaviours and the changes that may be made. This involves anticipating what situations might provoke old solutions and suggesting alternative options to avoid anxiety-provoking scenarios.

The process of affective restructuring.

In session six the therapist attempts to access any previously unattended to and unacknowledged affect (Greenberg & Mitchell, 1983). The process of affective restructuring was described in detail in chapter four at pages 98-100. Greenberg and Johnson (1986) summarised the experience as the evocation of primary emotional responses. These authors argued that self-disclosure by the partners in marital therapy can play a major role in increasing intimacy.

Not only does the experiential focus of the session mean that the couple become more open to greater levels of empathy. Such an experience results in the partners becoming more aware of theirs and their partner's deepest needs, while increasing their levels of self-efficacy and self-esteem. “The process of accessing previously acknowledged emotionally-laden aspects of the self tends to make the self-definition process explicit…. [This involves] both partners in a growth process together which enables them to empathise with each other in a new way” (Greenberg & Johnson, 1986, pp. 7-8).
The Therapeutic Process

The last session of the therapy is conducted in three parts. First is the ‘therapeutic review’, the second is the ‘existential inquiry’ and the third is the ‘therapeutic farewell’.

Step One

The therapeutic review.

The first step takes the form of a review of the focus, process and outcomes of the previous sessions. Magnavita (1997) noted that review and summarisation of the therapy provides a powerful communication. He observed how the therapeutic review highlights the work that has been accomplished. In the marital context, it involves engaging the couple in the process, so that they do not lose sight of the larger perspective, especially on how they have progressed.

To achieve this objective the therapist provides a summary of the therapeutic contract, the couple’s achievements, the ability of each partner to perceive him or herself differently and to sustain any changes made. The therapeutic review takes the following format:

T: We have now had five sessions together. You have worked hard, covered considerable ground, and achieved much. Now it is time to pause and review what we have done. In the first session we looked at your goals and expectations for the relationship. We also considered your emotional needs. We considered your feelings about yourself, your situation and your family. We worked through the fantasies about yourself and your partner and your behaviour toward each other and how this resulted in neither of you getting your needs met.

Next, we looked at the ways in which you both handle your anxieties and the effect this has for you. By examining your families in Session Three, we found how the influences and ghosts from your past found you repeating patterns, without you being fully aware of it. You gained insight into the way you have both colluded with each other, repeated patterns from the past in the present and learned to lessen their limiting and negative influences.

Your perceptions about yourself and each other were the focus of Session Four. Here you learned how to shift your perceptions of yourself and your partner. Last week, I asked you to pause and look more deeply at your most intimate longings, wishes and
desires. I asked you whether you were getting what you want, and whether you were
going about getting it in the right way.

We now have a greater understanding of who you and your partner really are. We
have come a long way. Today, you are more open than ever before to hear what has
been happening to you as a person and as a couple. We now need to pause and
consider how you might proceed as a result of our time together.

*The review of the therapy by the partners.*

Having completed the therapeutic review, the therapist invites the couple to comment on how
they perceive themselves and their situation as a result of their participation in the therapy. It
is proposed that this process of encounter and clarification challenges the partners to consider
their own and their partner’s self-construct. It encourages them to explore the beliefs, values
and meanings that inform their sense of ‘Who I need to be’ (Worrell, 1999).

Having gained entry into the partners’ experience of being-in-the-world (Worrell, 1999), next
the therapist asks them to clarify any unstated assumptions about who they are and where they
might be heading.

  T: I would now like you to again pause and tell me how you perceive yourself, how
you might be, given your greater understanding of yourself and the current state of
your relationship.

If one or both partners have difficulty with this inquiry as an alternative way of hearing their
unconscious wishes and desires, a different question might be used. For example:

  T: Tell me what you perceive as being the important turning points for you during our
time together.

As the process unfolds, the therapist identifies the behaviours, resources and skills necessary
for the couple to maintain alternative coping strategies and changed perceptual patterns.
Rennie (1994) observed that the therapist must pay attention to this inner experience including
the thoughts, feelings and images being expressed in speaking the self-into-being. The
couple’s narrative alerts the therapist to the partners’ ability to anticipate situations that might
provoke old solutions, while helping them to find strategies for alternative outcomes.
Step Two

The existential inquiry.

Step two involves the therapist in a further shift in the therapeutic process. This intervention engages the couple in an analysis of their future and possible selves.

T: I want you both to take some time to reflect for a few moments. How might you proceed to enhance your self-esteem and self-confidence? How might you meet the challenges of living your life more fully?

Each person is then asked to take time to pause and consider how he or she might express their transformed sense of self, in the context of their relationships, families and extended world. Issues of marital expressivity, self-actualisation and self-satisfaction, have the potential to unfold. The existential inquiry and response might take the following format:

T: I wonder whether you are fully in touch with your own resources and potential. Is this where you want to be in your self, in your relationship and in your family at this moment? Take your time; I want you to consider what is really important to you at this stage of your life.

Returning to the example of the couple Steven and Michelle, the response from the partners for a positive therapeutic outcome might be as follows:

S: I feel much better about myself, than I did six weeks ago. I can now see that I am more like my father than I had ever dreamt. I have been trying hard not to tell Michelle what to do. And I am not taking the children over when I think she is not coping. This appears to be working well. I can see more clearly how Michelle struggles with her anxiety and she becomes frustrated with herself. I can see that it is not always with me. I can also see how difficult it must be for her when I am away at work for so much of the time.

T: And Michelle, what about you, how in touch are you with yourself and your own resources?

M: Now the possibility has arisen for me to go back to part-time work, I feel much better about myself. I need to work for me. Somehow it feels as if I have been given permission in the therapy. But it is hard. Steven is helping me a lot more with the
children and I find this helps me to cope better with them. But I can see now I still need a lot of support and it is appropriate and important for me to seek help, particularly with all of my family so far away. What I have learned is that you have to put yourself first. That has been a great revelation to me.

Of utmost importance in the termination stage, is the language of the therapist. What they actually say contributes greatly to the process of healing and change. The therapist must tread a delicate balance between confronting difficult truths and feared inclinations, while trying not to damage the couple’s increased self-esteem, and without arousing further distress (Wachtel, 1993). The therapist would then paraphrase each partner’s response, keeping in mind the importance of therapeutic communication.

T: Steven, from what you are saying you seem to be taking a more positive view of yourself and your contribution to the relationship. All that is excellent. By recognising that you do not have to take such tight control to keep your family together appears to be working for you. You also seem to be saying that you do not have to take responsibility for Michelle’s happiness, which you find liberating. All this has increased your confidence about the future of the relationship.

According to Satran (1991) the development of self-empathy, or the ability to feel comfortable with different versions of the self is what is truly mutative in psychotherapy. By participating in a ‘corrective emotional experience’ (Alexander & French, 1946) the partners recognise the need to feel empathy toward the self and to integrate the negative aspects of his or her past experiences. Creation of an empathic self has implications after termination for couples who have had a reparative experience and for those who remain conflicted at termination.

By way of contrast, in a negative treatment outcome, the therapist might say:

T: Michelle, last week I was left with the feeling that you felt nobody loved you. This must be deeply hurtful. I found myself wondering whether you are trying to demand that Steven love you… yet even when he says he does, nothing seems to convince you that this is true.

M: I have been trying to get the love I want for years. But I don’t seem to be able to get it. In this case I refuse to take the blame, he has to take some too.
T: I can see that you must be feeling terribly disappointed. You have been very successful in everything you have done in your life, but the one stumbling block appears to be your intimate relationships. Yet as we look at the origins of this, we recognise that you did not come from a very secure base. You can both see now how this is extremely important. I hope you can see that when Steven does show you he loves you, you find some behaviour, bring up an issue, or some other person to distance yourself from the hurt. All this results in you feeling insecure again.

T: Steven, last week you were again reflecting on your relationship with your mother. For the first time in your life, you saw the need to distance yourself from her emotionally, not just physically. I wonder if this is your way of showing yourself and Michelle that you are now going to go about your life differently.

S: This is the first time in my life that I have looked closely at my family, particularly my mother. As a result of therapy I am beginning to perceive her and my life differently. From all that has happened I am not sure if it is too late for Michelle and me. Being in love with Michelle has been a very different experience.

T: I wonder if something new is happening between you. It sounds as if there was no one in your families to hear either of you. But now you are both beginning to see yourselves and your relationship more realistically. This is very encouraging.

The next part of the process involves the couple in an existential encounter. Irrespective of whether the couple appear to have resolved the major presenting issues, or whether conflict still exists, the therapist attempts to engage the couple in further levels of introspection. What decisions need to be made about their relationship? How might they cope with the skills and resources learned in the therapy? What plans might be put in place to integrate the insights and gains made? The treatment objective is to help the couple to recognise the need to work through or gain resolution of their difficulties, rather than re-enact their intrapsychic and interpersonal conflicts.

T: Michelle, can you again pause and tell us both what you need. First let us hear from you and secondly from Steven. Take your time.

M: I want Steven to stop thinking of me as sick. I want him to see that my tiredness, yelling at the children, our quarrelling and my depression is normal for a working
mother with three young children. And I want him to understand that this will pass. I also want him to see that my work is also worthwhile, and to continue to help me or if not, pay for someone to help.

T: Steven, now it is over to you. Can you tell us both what decisions you want to put in place?

S: I want what is best for the children and Michelle, but I also want a pleasant home, where I am treated with respect and for the contribution that I make. That would make an enormous difference for me.

T: Steven did you hear Michelle? She wants to feel valued by you and her contribution to the relationship. At a deeper level I believe she doesn’t want to feel rejected by you, as she was by her biological parents. If she does things differently, she wants to be appreciated for her efforts. Michelle, what Steven wants from you seems much like what you want from him: a home where you both feel less anxious and more secure. If you were able to do this for each other it would make both of you feel better and increase your self worth.

Step Three

The therapeutic farewell.

The third step of the termination process requires the therapist to make a final yet strategic therapeutic shift. The focus now moves to the way the couple’s participation in the therapeutic process might act as a transitional experience. Couples who have worked through their issues in the six-week time limitation will have been effectively renegotiating their relationship throughout the therapy.

In cases where further treatment is indicated individually or as a couple, the issues, objectives and the theoretical focus the therapy might take will be formulated. In some cases consensus may be reached; in others, when it is agreed that continuation will result in on-going conflict and dissatisfaction, the relationship will be considered to have irretrievably broken down.

In a negative treatment outcome, the discussion would centre upon the way in which the couple might separate with as little emotional disruption and destructiveness and as much dignity as possible. Time frames can be worked out, and interventions put in place to
minimise the damage to the couple’s families of origin and procreation, their social relationships and their extended networks.

Some couples may be referred to mediation to help them deal with the legal issues involved in marriage dissolution. Others may be encouraged to continue with ongoing therapy, for themselves, or for other family members who may be affected. A bridging statement such as the one that follows might be used.

T: In view of what you are both saying, perhaps we need to look at how we might now proceed from here…

Because of the developmental issues and the continuing challenges facing people in intimate relationships, the couple are encouraged to return to therapy if they confront other difficulties, or believe further work is appropriate. Alternatively, this outcome might help to resolve the issues relevant to the developmental and relational context obtaining at the time (Gurman, 1981). Rather than seeing a return to therapy as a failure, the couple are encouraged to see further work as an important adjunct to the initial therapy and their commitment to the relationship. In essence, they are encouraged to see the process of therapy not as a once-only occurrence. Instead, it is considered as an experience, which can be repeated across the life span (Cummings, 1991).

Irrespective of the treatment outcome, the therapist ends with a positive farewell. The farewell plays a vital role in the therapeutic process. The way the therapist conveys their expectations about the therapeutic gains exerts a powerful influence on the outcome. With this concept in mind an example of a farewell statement might be:

T: You have both come a long way in six weeks and we have achieved much. You both need to take great encouragement from that. You can now see more clearly how difficult it is to make relationships work and that you are not alone. You have been working harder than many who want to make their relationship a worthwhile experience.

T: I too have learned a lot from my time with you. I want you to know that whatever the reason or issue, if at any point in the future, one or both of you decide to return to therapy, this demonstrates your increasing ability to take responsibility for your self… But for now… farewell…
In this chapter the ability of the therapist to bring the treatment to completion has been described. The final stage of the therapy, creates the opportunity for the partners to undergo an inner transformation from a lost attachment bond with the partner, to a sustaining internal presence. The process of the therapy was considered to help each partner recognise in the other a different perspective. Rather than seeing their partner as husband, partner, father or wife, instead it provides them with an opportunity to see them as struggling with the same issues as him or herself. In the next chapter the application of the principles and techniques of the therapy described in this and previous chapters will be demonstrated. The therapies of five couples presenting at a community-based psychological centre will be detailed. A discussion of the application of the treatment methods and the outcomes achieved will form the focus of the research.
This study examined the role of attachment in a time-limited marital therapy that integrated concepts from interpersonal, object relations and attachment theories. An aim was to determine whether the model provided a coherent framework for the treatment of differing expressions of marital psychopathology and disturbance. To achieve this objective, one de facto and four married couples participated in the time-limited therapy. They completed the Adult Attachment Styles Questionnaire (Hazan & Shaver, 1987) and a self-report questionnaire to assess the effectiveness of the therapy. Narrative analysis was used to determine whether the praxis or the experience of being in the therapy could be explained by reference to Bowlby’s (1961) concept of the phases of mourning. Included in the treatment sample were the paraphilias, a major depressive episode with postpartum psychosis, the narcissistic borderline syndrome and childhood sexual abuse. Three of the five couples and eight of the ten participants reported positive treatment outcomes. The research found the model provided an effective treatment method for differing expressions of marital disturbance and psychopathology.
Couples, marital and family therapies have undergone radical changes in theory and practice in the past four decades (Lindegger & Barry, 1999). In recent times attachment theory has emerged as a dominant paradigm in both the theory and practice of marital therapy (Lindegger & Barry, 1999). A growing body of research into adult attachment supports this paradigm shift. Research has focused on such predictors as attachment insecurity and marital satisfaction (Davila & Bradbury, 2001), attachment processes in the choice of love object (Hazan & Shaver, 1987), disagreement between partner’s attachment representations (Crowell & Treboux, 1999) and the relevance of attachment and adult narratives in psychotherapy (Fish & Dudas, 1999).

Parallel to these developments in the practice of contemporary marital therapy has been an evolution of brief approaches to psychotherapeutic practice. This has resulted in brief psychotherapy becoming the dominant treatment paradigm in clinical practice (Messer & Warren, 1995). A number of factors have contributed to this. Among the most influential have been the integration of psychotherapeutic theories, growing empirical support for the method’s effectiveness, changes in health service delivery and the increased use of treatment manuals in clinical practice and training.

Although there is growing evidence supporting the proposition that brief psychotherapy is generally beneficial, questions remain concerning negative effects, dropout rates and which therapies are the most effective for treating particular presenting issues (Najavits & Strupp, 1994). Following a review of an article in the American Consumer Reports, November, 1995, Seligman (1995), concluded that patients benefited very substantially from psychotherapy, that long-term treatment did considerably better than short-term treatment, and that psychotherapy alone did not differ in effectiveness from medication plus psychotherapy (p. 965).

As a result of a supplementary statistical analysis of the American Consumer Reports (1994) survey of 180,000 readers about psychotherapy and drugs, Seligman (1995) concluded no specific modality of psychotherapy did better than any other for any disorder; psychologists, psychiatrists, and social workers did not differ in their effectiveness as treaters; and all did better than marriage counselors and long-term family doctoring (p. 965).
The traditional research methods used to find out whether psychotherapy works have been efficacy studies and effectiveness studies. Traditional efficacy studies involve contrasting a particular form of therapy with a comparison group under controlled conditions. Patients are placed by randomisation into the structure suitable for the requirements of a specific treatment manual, that is into fixed-duration treatment environments or into control groups. This research approach has proved to be particularly expensive and time consuming. In spite of these factors, because of the empirical validation involved, efficacy studies have come to represent the ‘gold standard’ of psychotherapeutic research (Seligman, 1995).

Psychotherapy as practised in the field has variable duration, uses self-correcting techniques, is aimed at improving quality of life as well as symptom relief, treats patients who are not randomly assigned and who present with multiple problems. As a result, the factors that most clearly characterise psychotherapeutic practice are underestimated, or missed altogether, when studied under the highly controlled conditions of the efficacy study. This led Seligman to conclude that treatment effectiveness cannot be empirically validated. Instead, it requires a different assessment method. According to Seligman (1995), “The efficacy study is the wrong method for empirically validating psychotherapy as it is actually done, because it omits too many crucial elements of what is done in the field” (p. 966).

Research into the Experience of Participating in Psychotherapy

Examining the factors that produce change during psychotherapy has resulted in similar controversy. To understand therapeutic change, researchers have focused primarily upon generating hypotheses about the use of the transference, and obtained their data from clinical case studies, rather than from scientific testability (Maisello, 2000). With the advent of the brief dynamic therapies, systematic efforts have been undertaken to study psychodynamic constructs such as core conflictual relationship patterns (Luborsky & Schimek, 1964; Luborsky, 1984; Maisello, 2000).

Others, such as Levenson (2001) have long argued that it is the praxis or the experience of being in the therapy that is therapeutic, rather than any particular construct. Or as Levenson (2001) put it:

Because our goal is to effect change in our patients, it behoves us to attend to how people learn and change, the relationship of what is said to what is done, of experience to conceptualisation of experience (p. 251).

The concept of the praxis as being essentially therapeutic raises questions about the role of the therapist in effective treatment outcomes. This has resulted in the therapeutic alliance gaining
increased attention as a predictor of outcome in psychotherapy (Krupnick et al., 1994). For example, the Krupnick et al. (1994) study of the role of the therapist and the clinical outcome in the treatment of depression found a significant association between the therapeutic alliance and the treatment outcome, and between interpersonal therapy, cognitive–behavioural therapy and medication and therapy.

Of significance in the present context was the Krupnick et al. (1994) finding that in interpersonal psychotherapy, the therapeutic alliance assumed greater importance than in cognitive behavioural therapy. This research found that “differing treatments, with their differing tasks and goals may require or assume different bonds” (Krupnick et al., 1994, p. 33). From the perspective of attachment theory, Byng-Hall (1995) wrote of the need for the therapist to establish a secure base, while exploring the beliefs contributing to the individual’s sense of insecurity. In therapeutic terms, the secure base includes two main functions. These are protection, which requires identification of dangers and conflict in the family, and exploration that includes understanding distance conflicts and exploring how past losses or experiences influence present actions (Byng-Hall, 1995, pp. 54-55).

Narrative Analysis

More recently the effectiveness of what it means to participate in psychotherapy has focused upon narrative, or story telling, becoming a dominant paradigm. Kirkman (2002) noted that while narrative is essentially interdisciplinary, from a psychological perspective it represents a ‘root metaphor’ in psychology. This paradigm shift has resulted in narrative theory becoming of increasing interest to psychoanalysts, psychologists, personality theorists and cognitive scientists in their studies of the individual’s internal processes (see Mears, 1995; Rennie, 1994, Spence, 1982; Schafer, 1992). According to Kirkman (2002), “narrative theory is invaluable to those psychologists who want both to retain the complexity of the individual lives they study and also to investigate multiple interactions among individuals and cultures” (p. 36).

Wigren (1994) described how narrative organises affect, creates identity and achieves social connection. Accordingly, narratives serve three vital psychological functions.

First, narratives both provide and contain the understandings that permit the use of past experience in understanding, predicting, and responding to future experience. Second, narratives are an essential part of the fabric of social exchange: people relate to each other, validate each other, indeed construct each other by sharing stories. Third, narratives are the language in which connections between thoughts and feelings are made (p. 416).
The concept of therapy as re-narration has also been increasingly regarded as an important therapeutic technique in psychotherapy and in family and systems therapy. In marital therapy, narrative principles provide a theoretical framework for identifying the couple’s patterns of interaction, for ascertaining their levels of anxiety and for determining the focus of psychotherapeutic attention (Wigren, 1994).

Lindegger and Barry (1999) suggested that the concept of attachment itself acts as a narrative. Main (1996) described the construct of narrative coherence as the ability both to provide a clear account of one’s childhood and to re-experience some of the emotions as the account is given. In addition, narrative coherence requires a capacity to have empathy for one’s parents and to have insight into the difficulties that the individual may have contributed to his or her family of origin. This construct led Lindegger and Barry (1999) to observe that “narrative construction is at least partially, and most probably quite powerfully, a function of the attachment patterns or narratives constructed in adult emotional relationships or family of pro-creation” (p. 281).

Research into the Effectiveness of the Brief Psychotherapies

Parallel to these developments in understanding the role of narrative in psychotherapeutic practice, the efficacy of brief therapy continues to attract attention. A major source of criticism has come from psychotherapists working in the traditional analytic situation, who are loath to assign much credence to the approach. Small (1971) noted that such criticisms might have more to do with the attribution of prestige and the status of working in long-term reconstructive psychotherapy.

Another criticism has been that careful patient selection results in brief therapy achieving better results with responsive and highly motivated patients with an underlying simplicity of psychodynamics. This argument rests on the premise that patients are required to identify a focal problem or define a circumscribed chief complaint and to engage quickly in treatment. Brief psychotherapies have been accused of excluding such variables as socio-political pressures and the psychosocial context (Cade & O’Hanlon, 1993).

Concerns have also been raised about what are considered covert and manipulative techniques and the abuse of power by therapists in directing outcomes. The tendency to ignore the role and importance of time as an integral part of treatment has been raised also (Bloom, 1992). This criticism rests on the contention that the brief therapies do not provide a theoretical
rationale for the brevity of treatment, nor do they specify the way that the time limitation enhances the therapeutic process (Messer & Warren, 1995).

In spite of these concerns, validity for the treatment method, its theory of change and the contributions of the various models to the clinical practice literature have been documented (Svartberg, 1993). A major research focus has been the identification of those dimensions that are relevant and significant to the process (Grand, et al. 1985). The main areas of research have been process studies, predictive studies and single case studies.

By the use of process research paradigms, and the exploration of more complex dynamics, the briefer psychotherapies have enabled researchers to examine specific variables and their relationship to process and outcome. Svartberg (1993) observed that short-term psychotherapy approaches differ along the dimensions of time use, therapeutic focus, therapist style and activity, patient selection criteria and relationship factors; and, there is evidence that differences are sustained when tested empirically. A meta-analysis of brief therapies conducted by Crits-Cristoph (1992) concluded

brief dynamic therapy demonstrated large effects relative to waiting list conditions but only slight superiority to non-psychiatric treatments. Its effects were about equal to those of other psychotherapies and medication (p. 151).

Research into the Effectiveness of Marital Therapy

While consensus has emerged that psychotherapy is on average effective, questions concerning the treatment of partners in distressed relationships remain. The observation of Seligman (1995) that consumers considered marital therapy as being least effective supports Shaw’s (2001) opinion. This is that treating distressed couples is a complex and often demanding task, especially as conflicted couples can be impulsive, destructive and difficult to contain. This has also resulted in an ongoing search for what interventions and treatment methods are most effective (Shaw, 2001).

Shedding further light on this phenomenon, Baucom and Hoffman (1995) observed that there is “a reluctance among many marital therapists to evaluate the effectiveness of their procedures” (p. 597.) Until more recently, this resulted in little research into the effectiveness of the systems, psychodynamic, cognitive and experiential approaches to marital therapy. As a consequence, few conclusions can be drawn concerning the relative effectiveness of these approaches (Baucom & Hoffman, 1995).
The reluctance to evaluate the effectiveness of marital therapy may be due to clinicians in applied settings having neither the desire nor the means to conduct treatment–outcome research (Baucom & Hoffman, 1995). Alternatively, it may have to do with a rejection in academia of the case study method. In turn this may be because of the vague and unclear way in which some such studies have been conducted and presented in the literature. Hartin’s (1981) review of the effectiveness of marital therapy led him to conclude that the relatively underdeveloped state of research is due to the fact that marriage counselling is a field dominated by practitioners, not researchers.

More recently, the review of Bradbury et al. (2000) of research from the period 1981 to 1998 into the nature and determinants of marital satisfaction resulted in a different conclusion. These authors found that key conceptual and empirical advances have been made. At the same time they called for “more large-scale longitudinal research that links marital processes with socio-cultural contexts” (p. 964).

Research in the 1990s appeared to support these concerns, while at the same time indicating that a lot more is now known about problems in close personal relationships and the theories and methodologies used to treat them. In his review of the research on marriage and the family in the United States of America over the period 1991–1998, Milardo (2000) summarised the predominant research methods as follows:

One issue of the journal from each year of publication (1991-1998) was randomly selected, yielding a sample of 163 articles (excluding ‘feedback items’). And, for those interested in the minutiae: 60% of first authors were female; 28% of articles were single-authored; 89% used interview or survey methods, typically with large samples; 10% were based on the National Survey of Families and Households and 5% on the National Longitudinal Study of Youth; 4% were based solely on qualitative methods (a proportion that is increasing); 2% represented theory or review (a surprisingly low percentage and one that surely needs to increase; 3% were based on observation research, and none on experimental designs) (p. 874).

Research into the Association between Adult Attachment Styles and Marital Satisfaction

One of the major contributions to the practice of marital therapy has been attachment theory. This addresses the questions about how the experiences of relationships early in life influence working models of relationships and subsequent interpersonal functioning (Bradbury et al., 2000). Whereas research into interpersonal and intrapsychic processes has been shown to influence relationships with others, researchers on attachment have examined the influence of early relations with caregivers on adult relationships (Maisello, 2000). Simpson and Rholes
(1998) noted that research undertaken in the 1990s indicated that no single area of research has attracted more interest than the application of attachment theory to adult relationships.

Early research focused on the infant–caregiver interaction. Later, a substantial body of theoretical and empirical evidence emerged to support the importance of attachment in an adult context (Feeney & Noller, 1996). Evidence suggests that children who are not securely attached are less likely to feel secure in intimate relationships as adults, despite wishing to do so (Maisello, 2000). Other aspects of research on adult attachment have included the association between attachment, romantic love, affect regulation and relationship quality (Orbuch, 1992).

The effects of early child–parent bonds and their influence on the individual’s capacity to establish intimate relationships can be explained by reference to Ainsworth et al.’s. (1978) typology: the secure, avoidant and anxious–ambivalent attachment styles. Gallo and Smith (2001) noted that the two dimensions of avoidance and anxiety underlie most measurements of attachment.

According to this typology, Ainsworth’s avoidant attachment type captures both those individuals who are ‘dismissing’ of attachment (i.e., low anxiety and high avoidance) and those who are ‘fearful’ of attachment (i.e., high anxiety and high avoidance). Secure attachment describes individuals with low avoidance and anxiety, and ‘preoccupied’ attachment (i.e., anxious–ambivalent attachment) captures those with low avoidance and high anxiety (p. 264).

Although the predictors of relationship satisfaction are complex, secure adults are considered more able to deal with closeness, have higher levels of self-esteem and are more trusting. Adults with insecure avoidant attachment styles are characterised by aggressive attempts to assert their independence, and by denial of interpersonal distress. Adults with insecure anxious attachment styles are characterised by jealousy, anxiety about their relationships, confusion and high levels of dependence (Fonagy, 1998).

In addition, attachment research has demonstrated the association between attachment style, marital interaction and relationship satisfaction. Insecure attachment has been found to have a negative affect on marital satisfaction between spouses. Gallo and Smith (2001) found that individuals with insecurely attached partners reported lower levels of marital satisfaction; secure attachment styles are generally associated with better marital adjustment.

From an interactional perspective, Feeney (2002) found that the relationship between spouse behaviour, marital satisfaction and attachment style was:
moderated, but not mediated by reported spouse behavior. Specifically, insecure individual’s evaluations of their relationships were more reactive to recent spouse behavior, an effect that was especially marked for fearful participants and for those in longer-term marriages (p. 39).

Examining the association between attachment style and marital functioning, Gallo and Smith (2001) concluded that partner’s attachment style acted as a predictor of marital functioning, with insecure/anxious attachment being a stronger predictor of marital adjustment than insecure/avoidant attachment. Consistent with this research, Feeney (1998) observed that people with secure attachment styles are less likely to respond to separation with feelings of anxiety.

Feeney (1998) found that people with different attachment styles behave differently in stressful situations, use different coping strategies and respond to physical separation differently. She concluded: “There seems little doubt that relationship conflict is a salient issue for those individuals who are highly anxious about their relationships, particularly when questions of distance separation are at stake” (p. 215). The overall pattern of results supports the view that “security exerts pervasive effects on perceptions of the relationship across a range of variables and conflict situations” (p. 214).

Reviewing the attachment research literature, Simpson and Rholes (1998) concluded that in the clinical applications of attachment theory, little research has been reported that examines how working models of attachment affect process and outcome (Masiello, 2000). In their discussion of this phenomenon, Simpson and Rholes (1998) observed that the following research questions remain unanswered.

For example, how is greater security produced in therapy? What are the specific processes, stages, or steps through which an individual must navigate to become more secure? How does ‘earned’ security (i.e., security that is achieved after insecurity has been successfully overcome) differ from ‘continuous’ security? More specifically, how do the adult relationships of individuals classified as earned secure differ from those of individuals who have been secure their entire lives? When major life difficulties arise, are earned secure individuals more capable of fending off and constructively dealing with experiences that would lead most people—including perhaps continuously secure individuals—toward insecurity? (p. 17).

The Present Study

The aim of the present study was to investigate the integration of attachment theory in the marital module of BCMT (Macnab, 1991). The study was designed (a) to articulate the theory of personality and psychopathology underpinning the marital therapy, (b) to describe the
theory of change the model endorses and (c) to assess the effectiveness of the therapy. One of the purposes was to identify the treatment interventions and techniques that lead to therapeutic change. The first criterion used for assessing the effectiveness of the therapy was the number of couples reporting positive treatment outcomes. A second criterion for assessing the effectiveness of the therapy was the number of individuals reporting positive treatment outcomes. A third criterion for assessing the effectiveness of the therapy was the participants’ ability to articulate their needs, thoughts and desires.

The Research Questions

The present study was designed to provide a coherent framework for practising the marital module of BCMT (Macnab, 1991). The aim of the research was to explain some of the links between attachment processes and the aetiology of conflicted intimate relationships. The study examined how this time-limited therapeutic approach brings together observation, theory and method into an integrated treatment model, which takes into account the conceptualisation of the condition and the therapy.

It was proposed that a greater understanding of the couple’s interpersonal processes would enable the therapist to treat more effectively couples in conflicted intimate relationships. To understand the treatment implications of this focus it was predicted that different kinds of adult attachment styles would arouse different kinds of interpersonal patterns in conflicted intimate relationships (Maisello, 2000). From the review of the literature of interpersonal, object relations, attachment theory and contemporary marital therapies, the fundamental research question was stated as follows:

Fundamental Research Question:

That the integration of attachment theory would provide an organising framework or metaperspective for theory construction and therapeutic intervention in the clinical application of the marital therapy described in BCMT (Macnab, 1991).

The following four research questions were derived from the fundamental research question

Research Question 1.

That the highly structured therapeutic approach, the specific clinical foci and detailed treatment interventions for each of the six sessions, would provide an effective treatment method for differing expressions of marital psychopathology and dissatisfaction as demonstrated by self-report.
Research Question 2.
That adult attachment styles influence the partners’ interpersonal relations with others, and affect their intrapsychic responses in conflicted intimate relationships as demonstrated by self-report.

Research Question 3.
That the therapeutic change processes elicited by the time-limited therapy can be likened to Bowlby’s (1961) stages of mourning: protest, despair, and detachment as demonstrated by narrative analysis.

Research Question 4.
That changes to each partner’s inner working models of self, other and context will occur as a result of participating in the time-limited marital therapy as demonstrated by self-report and narrative analysis.

Method

Participants
The participants were five couples presenting for relationship therapy at a community-based psychological treatment and training centre. The partners ranged in age from 33 to 56 years. The average age for the males was 44 and the females 43. Of the participants, four couples were married and the fifth lived in a de facto relationship. Six of the ten participants had participated in therapy on previous occasions, either as individuals or as couples. No screening of the couples took place prior to commencement of the therapy. The participants were the first five couples who agreed to participate in the study.

It was the first marriage for all of the married participants. The length of marriages ranged from seven to 28 years. Of the de facto couple, each partner had been married previously. This couple had been in a relationship for 10 years and had lived together for the past five years. All of the couples had children, ranging in age from four months to 36 years.

All of the male participants in the sample were in full-time employment. Four men had completed tertiary education. One of them currently worked in the helping professions; the others had careers in commerce, marketing and in sales. The fifth man had trade qualifications. The female participants in the sample had all completed tertiary education and had worked outside the home at some time during the marriage.
At the time of the study, one professional woman was on maternity leave. Another woman had taken time away from her professional career to complete a higher degree. A third woman was at home with her two small children. The other two women worked part-time. One of them worked in an allied health profession and the other worked in administration.

A description of the couples, their psychosocial context and their presenting issues based on the information provided by them follows. All names, backgrounds and distinguishing features of the participants have been changed to maintain confidentiality.

**Couple One.**

‘Sylvia’ age 51 and ‘Stan’ age 54 have been married for 28 years. It is the first marriage for both. Sylvia was three months pregnant when they married. The couple have four adult sons. Two sons, one of whom suffers from schizophrenia, live at home. Sylvia is the elder of two children. Her father died suddenly of a heart attack when she was 10. Stan is an only child. His father left the home when he was four. He and his mother then went to live with her parents. The mothers of both partners are still alive and neither has remarried.

The couple presented for therapy complaining of a long history of chronic dissatisfaction involving emotional and occasional physical abuse. Sylvia reported that seven years into the marriage, she left with the children and lived with another man. This relationship lasted for three weeks. Stan recently left the marriage for nine months. During that time he lived with a much younger woman whom Sylvia knows. Sylvia stated that this experience had a profound effect on her, their children and the relationship. During his absence, Sylvia insisted that Stan transfer the title of the family home to her. He did. Since his return, he reported, he is sleeping in a separate room and paying Sylvia ‘board’.

**Couple Two.**

‘Lucas’ age 39 and ‘Laura’ age 35 have been married for 13 years and met at university 17 years ago. They did not live together prior to their marriage. Lucas has two younger sisters. Laura is the younger of two girls. It is the first marriage for both of them. Lucas works in a sales position, while Laura works at home caring for their two sons, the elder aged four years and the baby of 18 months.
The couple, childless for the first nine years of the marriage, stated that during this time they established themselves in their careers and travelled extensively. They reported that the birth of their first son resulted in an emergency Caesarean section after which Laura and the baby were both extremely ill. The baby continued to have serious respiratory problems for the first year of his life. The birth of the second child, a boy age 18 months at the start of the therapy, was reported as being relatively problem-free.

Lucas recently returned to the marital home after a separation period of a month. During this time he began a sexual relationship with an old friend who was recently divorced from her husband. Laura stated that this experience had devastated her perception of her relationship with Lucas. She reported feeling betrayed, revolted by his behavior and left doubting the veracity of his claim that the relationship was not sexual prior to his separation from Laura. Lucas’s discontent in the marriage is centred upon his sexual and affectional needs not being met. Laura has not regarded sex as a high priority, especially since the births of their two children.

**Couple Three.**

‘Denise’ age 38 and ‘David’ age 40 have been married for 11 years. For both of them it is a first marriage. They presented for therapy describing theirs as a marriage marked by a history of traumatic events. These included moving interstate, losing their home due to financial collapse, retrenchment and Denise’s series of miscarriages. More recently, this included the discovery of David’s fetishism. This involved fondling, and sometimes wearing, Denise’s underwear. The day after she discovered and confronted David’s behaviour, her father died. This discovery of David’s fetish triggered the couple to present for marital therapy. They both wished to understand more fully David’s behaviour and its effect on the marriage.

The couple’s one son aged nine years was born prematurely. They described him as being a ‘difficult child’. After his birth Denise had two miscarriages. She stated that she first perceived David as a very strong and capable businessman who would be a good provider. She reported dreaming that they would have many children, would live in a house with a ‘white picket fence’ and have a happy life. David stated that while initially he had been strongly attracted to Denise, he now perceived her as giving him no love or support.
Couple Four.

‘Kristine’ age 34 and ‘Keith’ age 33 have been married for seven years. They first met when they were 21 and studying at university. Kristine is the third child of four siblings. She worked in a helping profession until six weeks before the couple’s first child was born. This baby girl was four months old at presentation. Keith worked as a paramedic.

Shortly after the birth of the baby, Kristine experienced a major depressive episode marked by a post-partum psychosis. She was hospitalised, treated by a psychiatrist and medicated. Following her discharge from hospital, she attended a depression group for women. She was referred to the community health centre both because of the effects this experience had on the couple’s relationship and a psychologist’s observation that she did not appear to be recovering as quickly as expected. The couple reported that prior to Kristine’s pregnancy they had a happy, normal marriage, based on mutual activities, including sport and other recreational interests.

Couple Five.

‘Catherine’ age 56 and ‘Colin’ age 55 have known one another for over 30 years. They have lived together for the past five years. Catherine’s first marriage lasted for 10 years. She has two adult children from this marriage. Colin was also married previously. He has three adult children from that marriage. Catherine and Colin’s relationship began when they lived in different states. After five years Catherine left her family to live interstate with Colin. More recently, both partners returned to live in Melbourne and pursue their respective careers.

The couple presented for therapy stating that they were concerned about the way their relationship had been deteriorating over the past 15 months. They identified their problems as communication and as being of a sexual nature. Colin described feelings of rejection, pressure to engage in discussions with Catherine and feeling it safer to withdraw from their arguments for fear of being misinterpreted and abandoned. Catherine said she felt rejected because of Colin’s lack of involvement with her. Colin expressed the need for more frequent sex and related his feelings of inadequacy in seducing Catherine. Catherine stated she felt pressured to engage in more sex than she desired, saying that she felt unable to oblige when put under such pressure.
Procedure

Prior to the commencement of the therapy, all five couples agreed to participate in the six sessions and to have the therapy observed by one other person. They also agreed to have written transcripts of the sessions made and for audiotapes of the sessions to be recorded. They agreed to complete two questionnaires - The Adult Attachment Styles Questionnaire (Hazan & Shaver, 1987) and a Self-Report Questionnaire designed by the principal investigator. In addition, each participant signed a consent form approved by the Ethics Committee of the Australian Catholic University.

The researcher, a registered psychologist and a member of The Australian Psychological Society, conducted the therapeutic sessions. Before the first session the partners were again advised of, and agreed to, the confidentiality of the sessions. Of 50 minutes duration, these weekly sessions were conducted for six consecutive weeks. No fees were paid. The independent observers, who took transcripts during the sessions, were drawn from the staff of the community health service, or were internists there.

The observers did not play an active role in the therapy. Instead, the transcripts were undertaken as a back-up in case of tape failure and to ensure that an accurate representation between transcript and tape recording was made. Except in cases of illness or scheduling, the same observer participated throughout the six weeks of the therapy.

The fact that six of the ten participants had some previous therapeutic treatment could be seen as a confounding variable in the study. In addition, the fact that the researcher is also the therapist is well recognised as a confounding factor in the subjective assessment of effectiveness of therapy. For example, it is likely to exacerbate the likelihood of responses being strongly influenced by factors such as social desirability.

Measures

Pre-therapy assessment – Adult Attachment Styles Questionnaire

To gather evidence on the way attachment processes influence affectional bonds with others throughout the life span, the couples completed the Adult Attachment Styles Questionnaire (AASQ) (Hazan & Shaver, 1987). The study of Hazan and Shaver (1987) examined the three major patterns of attachment organisation considered to remain continuous across the life-span: “– secure, avoidant, and anxious/ambivalent – and on the notion that continuity of
relationship style is due in part to mental models (Bowlby’s “inner working models”) of self
and social life” (p. 511).

Hazan and Shaver’s (1987) study was predicated on the following assumptions:

(a) relative prevalence of the three attachment styles is roughly the same in
adulthood as in infancy, (b) the three kinds of adults differ predictably in the
way they experience romantic love, and (c) attachment style is related in
theoretically meaningful ways to mental models of self and social
relationships and to relationship experiences with parents (p. 511).

This single-item measure was designed by translating the description of Ainsworth et al.
(1978) of infant–caregiver attachment into terms appropriate to adult attachment. The
questionnaire was based on the assumption that

coscient beliefs about romantic love—concerning, for example, whether it
lasts forever and whether it is easy or difficult to find—are colored by
underlying, and perhaps not fully conscious, mental models. The measure
of attachment history was a simple adjective checklist used to describe childhood
relationships with parents and the parents’ relationship with each other (Hazan

Hazan and Shaver’s (1987) study of adult attachment uses a forced-choice item measure
which requires subjects to choose from a number of themes including trust, dependence and
comfort with closeness. Since the original study, concerns have been raised by Hazan and
Shaver and other researchers about the limitations of the questionnaire, in particular the
reliability of measurement. Feeney and Noller (1990) noted that while the issues of reliability
of attachment measures continue to concern researchers “it is widely acknowledged that even
the simplest attachment measures show consistent associations with relationship variables and
hence must possess a fair degree of reliability and validity” (p. 47).

Although the AASQ has been found to be a reliable and valid measure for the assessment of
adult attachment styles (Masiello, 2000). At the same time, however, since Hazan and Shaver
(1987) first developed the AASQ, they have subsequently modified the questionnaire (see
Hazan & Shaver, 1990). Subsequent research into the dimensions underlying attachment
styles and how best to represent and measure them have been developed (Atkins, 2001).

Other researchers have developed scales that would yield dimensions of variability
responding to the AASQ. For example, Carver (1997) has developed a Measure of Adult
Attachment Qualities (MAQ) that assesses the relationship between personality and adult
attachment. Future research could consider the MAQ or other measures such as the Global
Assessment Scale (GAS) developed by Blatt et al. (1991), or the Adult Attachment Scale
(AAS) developed by Collins and Read (1990) to determine the partners’ object representations and the role they play in treatment and outcome.

In the present context the AASQ was used rather than other measures such as those mentioned above. One other measure considered as relevant was the Adult Attachment Interview (AAI) (George, Kaplan, & Main, 1985). The AAI measures the adult’s memories of childhood relationships with parents together with the current evaluations of these early experiences and on their adult personality.

While the AAI is considered to provide a reliable measure of attachment, administration is time-consuming, training in administration is required, and the administration and interpretation of the measure complex. By contrast, the AASQ is quick to administer, non-intrusive in the clinical setting and provides the clinician with immediate feedback. In the present study the couples were asked to complete the questionnaire at the outset of the first session. Its format is set out in Appendix B.

*Post-therapy assessment—Self-report questionnaire.*

The effectiveness of the therapy was examined at the conclusion of the six weeks through having each partner complete a self-report questionnaire. Hendrick (1992) recorded that self-report measures represent the single most popular data-gathering means in close relationship research. Self-report measures provide individuals with “the widest and most extensive opportunity to observe his or her own behavior and is privy to thoughts, feelings, and desires, that are not publicly expressed” (Costa & McCrae, 1992, p. 31).

The self-report questionnaire was designed to record the individuals’ reported thoughts, feelings and behaviours, together with their perceptions of their partner’s thoughts, feelings and behaviours (Hendrick, 1992). The questionnaire was in two parts. In the first part, an attempt was made to obtain subjective data about the participants’ experiences of being involved in the therapy. The second part was an attempt to obtain subjective data about the participants’ beliefs about the effectiveness of the therapy.

In part one of the questionnaire, the questions were formulated to address *Research Question 4*, that is to determine whether changes to each partner’s inner working models of self, other and context had occurred as a result of participating in the therapy. This was also measured by a second ordering of questions. For example the use of questions such as *Have you become more aware of your self-talk or inner voice, as a result of being in therapy? How has your self-talk or inner voice changed?*
In addition, in part one of the questionnaire, the questions were formulated to examine Research Question 3. That is, whether the change processes elicited by the praxis could be likened to that of a process of mourning. To achieve this objective, the questions were grouped into the three stages of the therapy: present (protest), past (despair) and future (detachment).

In part two of the questionnaire, the questions were formulated to address Research Question 1. That is, to determine the participants’ experience of the time limitation, the specific clinical foci and the detailed treatment interventions for each of the six sessions. The questions were grouped to build on the information gained in part one of the questionnaire about the participants’ experience of the clinical focus of each session: Session 1 – Separation Anxiety; Session 2 Interpersonal Processes; Session 3 Internal Working Models; Session 5 Intersubjectivity; Session 6 Existential Anxiety.

In addition to the responses gained from the Adult Attachment Styles Questionnaire (AASQ), Research Question 2 that adult attachment styles influence the partner’s interpersonal relations with others and affect their intrapsychic responses in conflicted intimate relationships, was informed by two “free associative” questions at the end of part 1 and 2 of the questionnaire. If your relationship as it is now were a drama, movie, or book, what would it be titled? How would it end? If you could think of one word, phrase, or image to sum-up the experience of being in the therapy you have just completed what would it be?

Questions were grouped according to the three stages of the therapy: past, present and future. To assess the wide variety of variables associated with close relational loss, the questions were also grouped to take into account the clinical focus of the sessions: defences, anxiety, unconscious influences, inner working models, existential anxiety and the recontextualised self. And last, the questionnaire was designed to assess the participants’ perceptions of the therapy and its techniques; Stage One, defensive restructuring, Stage Two, cognitive restructuring and Stage Three, affective restructuring (Magnavita, 1997).

Participants were given the questionnaire at the end of the sixth session. The couples were asked to complete it independently and mail it to the principal investigator. All except one man returned the questionnaire. With his agreement, the principal investigator orally administered the questionnaire to him.

Post-therapy assessment—Narrative analysis.
Narrative analysis was used to investigate Research Questions three and four, to understand how the participants make sense of their own lives, how they perceive their partners’ lives and their subjective experience of the therapy. Clinical transcripts and audio tapes were used to understand the unconscious processes aroused by the time limitation of the therapy, the accounts the partners gave about their feelings of separation and loss; and the association between the partners’ attachment styles and their narratives of self, other and context.

The clinical transcripts were read and analysed to discern significant narrative threads for each participant, in order to determine whether the model would provide an effective treatment method for differing expressions of marital psychopathology and dissatisfaction as demonstrated by self-report. Transcripts were reread to identify important strands of information across the corpus of the interviews. The narratives were then analysed in the subcategories of protest, despair and detachment.

**Results**

The findings of the present study support the fundamental research question that the integration of attachment theory would provide an organising framework or metaperspective for theory construction and therapeutic intervention in the clinical application of the marital therapy described in BCMT. To support this finding, a discussion of the results from the four research questions follows. In the Table 8.1 on the following page, some of the key characteristics of the couples are presented. These summary profiles assist in the interpretation of the results in this and the following sections.
### Table 8.1

**Summary Descriptions of the Couples**

<table>
<thead>
<tr>
<th>Participant (age)</th>
<th>Attachment Style</th>
<th>Marital Status</th>
<th>Number and Ages of Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sylvia (51)</td>
<td>Insecure/ Anxious</td>
<td>Married 28 years</td>
<td>Four adult sons</td>
</tr>
<tr>
<td>Stan (54)</td>
<td>Insecure/ Avoidant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laura (35)</td>
<td>Secure</td>
<td>Married 13 years</td>
<td>Two sons, 4 years and 18 months</td>
</tr>
<tr>
<td>Lucas (39)</td>
<td>Secure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denise (38)</td>
<td>Secure</td>
<td>Married 11 years</td>
<td>One son, 9 years</td>
</tr>
<tr>
<td>David (40)</td>
<td>Insecure/ Anxious</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kristine (34)</td>
<td>Secure</td>
<td>Married 7 years</td>
<td>One daughter, 4 months</td>
</tr>
<tr>
<td>Keith (33)</td>
<td>Secure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catherine (56)</td>
<td>Insecure/ Avoidant</td>
<td>De facto 5 years</td>
<td>Two adults, prior marriage</td>
</tr>
<tr>
<td>Colin (55)</td>
<td>Insecure/ Avoidant</td>
<td></td>
<td>Three adults, prior marriage</td>
</tr>
</tbody>
</table>

### Research Question One - The Overall Effectiveness of the Therapy

Research question one investigated whether the highly structured therapeutic approach, the specific clinical foci and detailed treatment interventions for each of the six sessions, would provide a clinical framework for the effective treatment of differing expressions of marital psychopathology and dissatisfaction.

### The Effectiveness of The Therapy

The criterion used for assessing the effectiveness of the therapy was the number of couples reporting positive treatment outcomes. Three of the five couples (60%) reported a positive treatment outcome. Of the other two couples, both were insecurely attached. In one of these two couples the male partner found the therapy effective whereas his partner responded, ‘unchanged’. In the second of these two couples, the male partner reported positive treatment outcome and the female partner responded ‘unsure’. From the perspective of the individuals’ experiences of the therapy eight of the participants (80%) responded that they thought some aspect of the self had changed as a result of the therapy.

The reported effectiveness of the treatment can be seen in the Table 8.2.
Table 8.2

*Attachment Style and the Reported Effectiveness of the Treatment Outcome*

<table>
<thead>
<tr>
<th>Participant</th>
<th>Attachment Style</th>
<th>Perceived Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stan</td>
<td>Insecure/ Avoidant</td>
<td>Effective</td>
</tr>
<tr>
<td>Sylvia</td>
<td>Insecure/ Anxious</td>
<td>Unsure</td>
</tr>
<tr>
<td>Lucas</td>
<td>Secure</td>
<td>Effective</td>
</tr>
<tr>
<td>Laura</td>
<td>Secure</td>
<td>Effective</td>
</tr>
<tr>
<td>David</td>
<td>Secure</td>
<td>Effective</td>
</tr>
<tr>
<td>Denise</td>
<td>Insecure/ Anxious</td>
<td>Effective</td>
</tr>
<tr>
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<td>Secure</td>
<td>Effective</td>
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<td>Kristine</td>
<td>Secure</td>
<td>Effective</td>
</tr>
<tr>
<td>Colin</td>
<td>Insecure/ Avoidant</td>
<td>Effective</td>
</tr>
<tr>
<td>Catherine</td>
<td>Insecure/ Avoidant</td>
<td>Unchanged</td>
</tr>
</tbody>
</table>

Nine of the participants (90%) reported that they thought the long-term effects of participating in the therapy would be positive. Seven people (70%) found the structured approach to the therapy helpful. Similarly, seven participants (70%) reported that they found the time-limitation of six sessions helpful. Some of the themes relating to time and its limitation can be found in the following responses:

Denise: It was helpful in that we knew that we had committed ourselves to a six-week period so we couldn’t throw in the towel at any stage before that!

Catherine: It felt quite containing; almost implicit in the time limitation is that the relationship is ‘curable’.

David: To understand that the therapy had an end-point beyond which we must keep working at achieving a healthy relationship.

In response to the question concerning the structure of the therapy, one female participant remarked that she thought she needed more time.

Sylvia: If I had more time maybe it would have worked – it just seemed too short for what was required.
In response to the question concerning which of the six sessions was most helpful, the data revealed no clear pattern. Answers ranged from the first, to the third, to all the sessions, to unsure. A similar outcome was found in response to the question about which session was the least helpful. In response to this question one female participant was able to identify the session she found the least helpful. She described it as follows:

Sylvia: The fifth session as that was when it appeared to me that it was my personality which had caused all our problems – thus everything I was going through was my fault and that this was all a waste of time as I can’t change who I am, without love and support.

Of the sample, three participants (30%) stated that they found the statement of the treatment plan helpful. With regard to the therapeutic alliance, eight people (80%) responded that they did not find the therapist had taken sides with their partner, six people (60%) had a positive experience of the therapist and three of the participants (30%) did not respond to the question. Examples follow of the responses, to the question: ‘What did your therapist do which you found most helpful? How was it helpful?’

Colin: [The therapist] enabled each of us to express our anxieties, hopes and aspirations.

Laura: At one point when I was very obviously upset and could not see how I could move on in the relationship, the therapist at the end of the session reminded me that we were in the middle of a journey and that we couldn’t get off the road in the middle of the journey; we had to see it through to the end of the road and the six weeks. Thank goodness she did. We are still here together and at that point I really didn’t think that we would be.

Catherine: The therapist created a space that was safe enough for us to speak freely.

In response to the question: ‘What did the therapist say that was least helpful?’ one woman responded:

Kristine: It was not so much what was said but what was not said. Maybe I am not familiar with therapy, but I was looking for more answers from the therapist. We as a couple did most of the talking. On occasions I was a little unsure of where we were heading.
**Stage One Defensive Restructuring – Sessions One and Two**

All of the participants reported that they had their goals and expectations clarified in the first two sessions. Similarly, nine of the participants (90%) responded positively to the question about whether they gained a greater awareness of the role of anxiety in their relationship and the situations that triggered it. In response to the question as to whether they were able to manage their anxiety more effectively, nine people (90%) reported positive responses. Support for the technique of defensive restructuring can be found in the following responses:

- **Kristine:** Use self-talk to try and put situations that cause anxiety into perspective. Have had mixed success.
- **Keith:** Being aware of the doubts it [anxiety] induces and trying to anticipate them.
- **David:** Confident that I can address my fears directly and find solutions that are reflective of my values.

Similarly, when asked whether their current coping strategies for dealing with anxiety differed from the way they managed anxiety prior to the therapy, five participants (50%) said that they did. Three examples of positive responses follow:

- **Kristine:** I was not managing anxiety at all before therapy. My realisation that this was having a negative effect on my relationship with my husband was a catalyst for immediate change.
- **Catherine:** Better able to see that much of what I initially see as criticism is not.
- **David:** Yes. Over a period of time, I lost confidence in my ability to manage my fears and anxiety and stopped dealing honestly with my feelings.

**Stage Two Cognitive Restructuring – Sessions Three and Four**

The importance of restructuring the cognitions associated with the partners’ unconscious influences from their childhood and their effect on the present was confirmed. Seven participants (70%) perceived themselves as having a good or happy childhood. Of the remaining participants three (30%), responded as follows:

- **Catherine:** Sadness, hopelessness and anger. I do not feel close to them.
Stan: I realised I was selfish.

David: Confusion, hurt, lack of real connection.

Three participants (30%) perceived that their view of their family of origin was changed as a result of the therapy. These participants responded as follows:

Laura: That when my parents divorced I had always thought that it didn’t really affect me, but obviously everything leaves a stamp on your perceptions of yourself and of your expectations for your own marriage.

David: An understanding that my upbringing and experiences as a child are fundamental to the person I am today.

Colin: From these [sessions] I understood the intensity of my feelings about very early senses of isolation and coldness and my later abandonment as a teenager. I never knew who my father was. My mother was very critical of all, making me very scared of criticism.

All the respondents reported that they had gained some insight into their repetitive patterns of behaviour from the past. For example

Laura: Repeat our parent’s mistakes also!

Kristine: Negatively from past (i.e. childhood) has coloured the way I have dealt with many aspects of my life.

David: Behaviours become habitual and it requires a fundamental examination of my values and belief system to change this.

By contrast, in response to the question whether their self-talk or inner voice changed as a result of the therapy, six participants (60%) said that it had not. In response to the question as to whether there had been a change in his or her thinking, feeling or behaving, six participants (60%) reported ‘yes’. Among the positive answers were the following:

Kristine: My anxiety levels have dropped markedly and I have been able to enjoy time on my own.
Denise: Trying to feel more positive first, not negative.

Catherine: I’m more aware that withdrawing/arguing are behaviours associated with feelings that may or may not be due to the current events or situation.

Stage Three Affective Restructuring – Sessions Five and Six

The participants’ responses on the self-report questionnaire confirmed the difficulty associated with having couples in conflicted relationships confront their existential anxieties. Two of the ten participants (20%) stated that they felt positive as they entered the last stage of the therapy. The remaining eight participants (80%) reported heightened levels of anxiety. For example:

Keith: Concern about the ongoing effects of my partner’s illness and her contentment as a mother. Concerned that we may not be as close in future.

Laura: At the time I was very hurt by my partner’s inability to tell me the truth and I felt that my life was heading to single parenthood.

In response to the existential inquiry concerning the partners’ ability to articulate where their life might be heading, three participants (30%) replied yes. A similar response was found to the question concerning the partners’ ability to articulate their innermost needs, thoughts and desires. Five participants (50%) reported that they felt able to do so. Seven of the participants (70%) reported that they felt safe to express their innermost needs in front of their partner.

Research Question Two - The Influence of Adult Attachment Styles in Conflicted Intimate Relationships

Research question two investigated whether adult attachment styles would influence the partner’s interpersonal relations with others and would affect their intrapsychic responses in conflicted intimate relationships.

The Participants and Their Reported Attachment Styles

Of the sample, in Table 8.3 on the Adult Attachment Styles Questionnaire, five of the ten participants classified themselves as secure, three classified themselves as insecure/avoidant and the remaining two partners described themselves as insecure/anxious/ambivalent. These findings differ slightly from the average population proportions of infant–mother attachment reported by Hazan and Shaver (1987): 62% secure, 23% avoidant, and 15%
insecure/anxious/ambivalent (p. 514). Others, such as Byng-Hall (1995) have reported a different split: 57%-73% secure, 15%-32% insecure/avoidant, 4%-22% insecure/anxious/ambivalent and 15%-25% disorganised [a fourth classification not used by Hazan and Shaver] (pp. 49-50).

Matching of attachment styles.

On the Adult Attachment Styles Questionnaire in two of the five couples, both classified themselves as secure. In the other relationships, one woman classified herself as secure, while her partner responded as being insecure/anxious. Both partners of one couple classified themselves as insecure/avoidant, while in the remaining couple the man classified himself as insecure avoidant and the woman classified herself as insecure/anxious. See Table 8.3.

Table 8.3

<table>
<thead>
<tr>
<th>Attachment Style</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secure</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Insecure/ Avoidant</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Insecure/ Anxious/Ambivalent</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

Adult Attachment Styles and Couples’ Diagnostic Profile

The stages described by Bader and Pearson (1988) and Sharpe (1997) are distinguishable by specific developmental themes, conflicts and defences that reflect the couple’s most prominent mode of object relating. In addition to assisting the clinician understand the influence of adult attachment styles in conflicted intimate relationships, these themes assist the clinician in diagnosing the couple’s developmental stage. Given the diagnostic criteria listed by Bader and Pearson (1988) and Sharpe (1997) for determining the developmental stages of couples presenting for therapy, the investigator/therapist formulated a diagnosis. No independent measure or attempt to evaluate the inter-rater reliability of this assessment was made. The couples’ diagnostic profile and adult attachment styles can be seen in Table 8.4.
Table 8.4

*Adult Attachment Style and Couples’ Diagnostic Profile*

<table>
<thead>
<tr>
<th>Participant</th>
<th>Attachment Style</th>
<th>Couple Diagnostic Profile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stan</td>
<td>Insecure/ Avoidant</td>
<td>Symbiotic – Hostile-blaming:</td>
</tr>
<tr>
<td>Sylvia</td>
<td>Insecure/ Anxious</td>
<td>Primary Attachment – Basic trust/mistrust Abandonment/merger/engulfment.</td>
</tr>
<tr>
<td>Lucas</td>
<td>Secure</td>
<td>Opposition:</td>
</tr>
<tr>
<td>Laura</td>
<td>Secure</td>
<td>Attachment/Separation-individuation Dependence/independence</td>
</tr>
<tr>
<td>David</td>
<td>Insecure/Anxious</td>
<td>Opposition:</td>
</tr>
<tr>
<td>Denise</td>
<td>Secure</td>
<td>Attachment/Separation-individuation Dependence/independence</td>
</tr>
<tr>
<td>Keith</td>
<td>Secure</td>
<td>Symbiotic – Pseudomutual:</td>
</tr>
<tr>
<td>Kristine</td>
<td>Secure</td>
<td>Primary Attachment – Basic trust/mistrust Abandonment/merger/engulfment</td>
</tr>
<tr>
<td>Colin</td>
<td>Insecure/ Avoidant</td>
<td>Oedipal Competitive:</td>
</tr>
<tr>
<td>Catherine</td>
<td>Insecure/ Avoidant</td>
<td>Oedipal: Positive Oedipal conflict</td>
</tr>
</tbody>
</table>


Research Question Three - Assessment of the Therapeutic Experience as a Process of Mourning

Research question three investigated whether the association between the imminent threat of loss of self, other and relationship would arouse similar intrapsychic responses to those Bowlby (1973) observed in children separated from their caregivers—protest, despair and detachment.

The Stage of Protest

In the first two sessions of the therapy it is assumed that just as small children use protest to gain their parent’s attention, adults in conflicted relationships will use the therapeutic space to protest about the real and perceived threat of abandonment. This will include behaviours aimed at getting their partner’s and the therapist’s (mother’s) attention. In defining this process it is assumed that the couple will not only act out their anxiety, they will construct
accounts to explain their past and present experience. In response to negative life events, such as relational loss and trauma, these accounts include behavioural events, explanations and catharsis (Hendrick, 1992).

To illustrate this process, reference can be made to the narrative that underpins the anxious/avoidant attachment style of Stan and Sylvia. This couple were locked in a marital neurosis marked by helplessness and hostility, which invokes their defensive narcissistic and borderline pathology (Scharff, 1995). Both partners have a very high degree of tolerance for hatred and dysfunction. Such defensive manoeuvres result in a traumatic battle of the past, marked by a demoralising ambivalence and an unformulated desire to protect their adult children.

Bader and Pearson (1988) described couples like Stan and Sylvia who possess the ability to tolerate high levels of anger, conflict and hostility as exhibiting the: ‘I can’t live with you. I can’t live without you’ interaction. “Too terrified to end the relationship, and not mature enough to end the battles, the couple remain locked in endless rounds of mutually inflicted pain” (pp. 9-10). In the first stage of the therapy, Stan’s narrative demonstrates his protest about his ongoing sense of abandonment by his father and now of Sylvia.

Stan: It hasn’t changed much. Nobody takes any pride in the house [him]. When I build something I expect it to last, but that’s a bit hard when there’s a dog shitting all over the carpet that I laid down. I told Sylvia we didn’t have room for another dog. It still goes on today.

Sylvia’s hostility about Stan’s emotional absence (and her father who also left her) is expressed in her narrative of helplessness and hostility:

Sylvia: My needs in this relationship are commitment, reassurance, trust and promise. They are a must. These are the main things I need from Stan – to make a commitment again. He hasn’t made any such commitment yet. I need a reassurance that he’s not going to pack up and run away again. It’s hard when the kids are saying: ‘Dad’s fair enough but we can’t trust him’. My goals for the relationship are to have understanding and support. Stan just doesn’t talk.

David and Denise.

David’s insecure attachment style is acted out in a different way. Kaplan et al., (1994) defined the paraphilia of fetishism as one in which “the sexual focus is on objects (such as shoes,
gloves, pantyhose, and stockings) that are intimately associated with the human body” (p. 676). In contemporary psychoanalytic thinking, “What distinguishes one paraphilia from another is the method chosen by the person (usually male) to cope with the anxiety caused by the threat of (1) castration by the father and (2) separation from the mother” (Kaplan et al. 1994, p. 675).

David’s behaviour is consistent with what Kaplan et al. (1994) observed. This is that the role of the paraphilias is, among others, the disruption of the bonding between two persons. This behaviour allows him emotional contact with his inner disturbance (emotional abandonment by his mother and father) in a safe way. David’s account of his behaviour, given below, gives support to the discussion of Rennie (1994) that narrative “is a way of creating meaning and coherence” (p. 241):

David: [To Denise] You’ve expressed your inability to understand and cope with that [his fetish]. I’ve tried to explain that its not that I’m a sexual monster. I’ve tried to explain the deeper issues that I’ve been dealing with. All you want to say is, ‘Let’s go forward’.

*Keith and Kristine.*

By contrast, the case of Keith and Kristine demonstrated how the relationships of couples with secure attachment styles could be affected by contextual factors such as the birth of the first child. The experience of being a parent profoundly affects and influences adult experience. Until such time as one begins parenting there is little need to deal with, or remember, one’s own experiences of being parented. These issues do not have to be confronted, or reworked (Karen, 1994). According to Bradbury et al. (2000), “Research suggests that children have the paradoxical effect of increasing the stability of marriage, at least when children are relatively young, while decreasing its quality” (p. 969). Karen (1994) also documented how in the first year of life, anxious displays of attachment in the child bring into play, or further into play, disturbed aspects of the parent’s own psychology.

Kristine’s major depressive episode and hospitalisation disrupted the inner representations (beliefs and expectations) about marriage and being parents. According to Kaplan et al., (1994) postpartum psychosis where hallucinations, delusions and thoughts of infanticide may predominate is rare – 1 or 2 in 1,000 deliveries. Negative life events, such as postpartum psychosis, have implications for the father also.
Kaplan et al. (1994) reported a similar mood change in the father during the wife’s pregnancy or after the baby is born. These include: “added responsibility, diminished sexual outlet, decreased attention from his wife, and the belief that the child is a binding force in an unsatisfactory marriage” (p. 36). In stage one of the therapy this couple’s narrative finds them locked within themselves and highly receptive to messages of anger.

Keith: We are not aggressively fighting but I think I am being more critical in my own mind. When we were out, Kristine was quiet and reserved… but I am more critical now. I want her to lighten up and have a good time. Maybe I’m giving bad vibes.

Kristine: I feel judged sometimes. I don’t want to feel under scrutiny all the time, which I now feel all the time. I feel that I have to watch what I say and do, and how I behave.

Colin and Catherine.

The insecure/avoidant attachment style of Colin and Catherine exhibited itself in a more passive but nonetheless persecutory form. As each partner had reduced relational capacity, both were caught in an egocentric dilemma as to who would take responsibility for their diminished empathic ability. While persecutory anxieties and the defences against them are normal, in cases such as Colin and Catherine, once the idealised object fails to live up to ideal expectations, these feelings quickly turn to the opposite.

Salzberger-Wittenberg (1988) wrote of how the pain of disillusionment results in people holding onto the belief that an ideal exists somewhere, or in someone else. Fonagy (1998) described the emotional reactions associated with feelings of insecure attachment as denial, denigration and devaluation, or alternatively, idealisation of past and current attachments that are not supported by specific memories. Feeney (2000) discussed marital interaction and relationship satisfaction describing how partners with insecure attachment styles, such as Colin and Catherine, tend to monitor exchanges and to evaluate their worth according to their partner’s behaviour. In the longer term, this results in both seeing their partner as undependable and untrustworthy. This leads to disenchantment and a strengthening of negative inner working models.

Such a defensive constellation results in these partners needing to improve their capacity for autonomy and to perceive their partner more accurately as a separate person, rather than simply for the gratification they afford the repressed parts of the self (Scharff, 1995).
Catherine and Colin’s experience of each other’s avoidant attachment style results in them feeling unsafe and misunderstood.

Catherine: I recall saying unsafe. That has a meaning I possibly didn’t make clear, in that I can’t say what I recall thinking for fear of hurting Colin. I feel unsafe to just be and let stuff out. I don’t feel physically unsafe. It’s a lack of being ‘who I am’ in an intimate space. Misunderstood is how I really see it. I want to be seen for who and what I really am. I’m probably not good at putting that out. It’s far from rejecting, it’s actually like, ‘I want you to know me and accept me’. When I do say things like, ‘What does that mean?’ ‘How do I feel?’ or, ‘Is this is what I want?’ it gets misinterpreted.

Colin: Mine’s a shade of the same thing. The sense of rejection is when I say something it seems to be the wrong thing to say. I’m of the opinion that it’s better for me to say nothing, because then there’s not the chance of me saying the wrong thing. It’s not necessarily even a conscious thing. It’s also not in my nature to answer to every statement. I’m likely to be silent about things that I don’t have an answer for. Sometimes it seems that the responses indicate that I’ve stuffed up again, so I’m more likely to shut up.

The Stage of Despair

The focus of sessions three and four requires the couple to search through their past to create a narrative that makes sense of their present lives. Consistent with Bowlby (1961), during this stage the couples growing disappointment in the process starts to turn to despair, as they realise that neither the therapist nor their partner can take away the pain associated with their present and past losses. Three of the participants with secure attachment styles spoke of their pain and loss associated with earlier developmental failures.

Take for example Laura’s narrative about the divorce of her parents, their continuing intimate contact, her mother’s religious conversion and her father’s subsequent re-partnering to a ‘fruit-loop’. Also, there are the feelings that became aroused by Lucas’s revelation of prolonged childhood sexual abuse. It also includes his sense of despair upon learning that his sister’s hospitalisation, and near death from a diagnosed psychological condition, were possibly due to the same experience. Another example is Denise’s description of her “stable” and idealised parents, who in late adulthood had been forced to sell their family home to pay their debts.
Stage two of the therapy provided David with the psychological frame to explore his fear of intimacy and feelings of rejection. The process enabled him to confront his considerable anger toward himself and his unacknowledged hostility toward Denise. Session four of the therapy found him mourning the losses associated with his family. Not only did it find him mourning his past, there was recognition that by being self-contained and remaining withdrawn, his passive but hostile behaviour toward Denise was as aggressive as his father’s absence.

David: I think I have a real sense of sadness at the moment and sense of loss in terms of my family. I can see that we haven’t been close for a long time, and just haven’t shared things that parents should share with their children and siblings. I don’t blame them for all that; I understand that I have been part of that loss and lack of communication. Now it just seems sad that we are at this stage of our lives and a period is lost and the reality is that it’s not going to be recoverable.

…I certainly think I’ve known for some time it hasn’t been with my father. I think he might have, for the last couple of months, had more of a sense of understanding of my mother. It’s probably more a sense of… I feel really sad for her that she’s been harbouring this feeling of isolation that she’s been experiencing. It’s disappointing that it’s come to this, but I’m not sure that in the near future that I can remedy that.

The case of Kristine highlights the need for the therapist to be aware that one of the possible accommodations to trauma is to dissociate from it. Such experiences are split off from awareness, sequestering the traumatic experience inside the self or in the marriage in a nucleus of trauma (Wigren, 1994). This experience can be observed in Kristine’s hostility toward her brother because of his emotional abuse toward her and the failure of her parents to protect her. This trauma may have lain dormant until the birth of her baby. At that time, she became hostile to the ‘baby part’ of herself rejecting her baby and confirming her fears of a hostile world (Salzberger-Wittenberg, 1988).

In cases like this, Scharff (1995) spoke of the need to help the individual and the couple to “mourn their losses and find more gratifying ways to express their love and anger” (p. 188). Keith’s despair at the real and perceived loss of his love object can be found in the following account.

Keith: Of course, and loss of our expectations of how the first few months of how the baby was going to be. That was a huge loss really. And the loss of her [Kristine] during that time.
Keith: Hugely distant. I thought, ‘This is not the girl that I married’, and ‘This is going to be terrible’; it was very odd. We’ve had to reassess the whole way we get on. I thought, ‘Well I’ll get on with work’. I wasn’t sure if I’d ever get her back.

In respect to the depressive phase of mourning, Bowlby (1961) wrote of how the sum of previous disappointments mounts as hopes of reunion with the lost [idealised] object fade. Feelings of despair can be found in Catherine’s account following the fourth session of the therapy. She revealed a pivotal experience that had heightened her awareness of all the emotionally avoidant and absent men in her life.

Catherine: I don’t know if this is relevant, but on the weekend I went to find my grandfather’s gravesite. He was very important to me. Colin and I went to the cemetery where I thought it was, but it was actually in another one. When we eventually found it the thing that shocked me was that my grandfather’s name wasn’t on it, only my grandmother’s name. I rang dad who claimed he didn’t know much about why. I asked him if he would like to put it on now and he said why bother after all this time. That made me very angry.

I’ve been really affected by it. I don’t know what’s happening inside, but I know it’s really hard. I went into a kind of trance really, not really sleeping and not really awake. It feels numb. So that’s why I’m really burnt out. My father never liked any male that I’ve liked.

**The Stage of Detachment**

During the third stage of the therapy, where the couple are kept focused on the future, an experience of emotional detachment from the partner begins to occur. Such an experience involves a heightened awareness of the individual’s and the couple’s capacity to adapt to the disappointments, anger and sadness associated with past disappointments and losses. From a psychoanalytic standpoint, there is an understanding that the mourning processes include cognitive, behavioural and affective components (Buechler, 2000).

The clinical focus of the third stage results in aspects of each partner’s subjective states becoming aroused and more open to interpretation. Since the patterns of behaviour that have grown up with the [lost] partner are no longer appropriate, new and more adaptive interpersonal processes need to be built. The process of emotional detachment can be painful
and it carries with it the risk that a new and more satisfactory relationship may not be achieved (Bowlby, 1961).

Given that the partners’ attachment styles influence their satisfaction in intimate relationships, it follows that the process will heighten the anxieties and increase their insecurities. The analysis of the partners’ narratives found that the process of emotional detachment produced positive and ambivalent responses. This can be found in the following accounts.

**Insecure Attachment Styles**

*Ambivalent detachment accounts.*

Sylvia: I’d like a commitment and I’d like to put my wedding ring back on my finger as a sign of that commitment, or some sort of ceremony to show that.

Catherine: I am trying to describe how I feel. I don’t have an identity in some sort of way. I don’t have these things so I don’t feel the same. I feel different now. I’m asking him to acknowledge these feelings, not saying that I want to divide everything into two. I feel completely wiped by that. I can’t talk about that feeling to him without having an eruption. I’m saying to him, ‘This is how I feel and where I’m coming from’. It seems that I’m the only one to look at it from both sides. He will only acknowledge his own position. It’s always my fault. The differences we talked about can’t be stated or owned.

Colin: I think we both hate it when we fight, it makes us very sad because there’s something very special there and we love each other a lot.

*Positive detachment accounts.*

Stan: As far as I am concerned, history’s history – let’s go forward.

David: I think this is a time, as Denise said, when there is obviously a significant change going on around us, and I think we are feeling our way. I think from the time we’ve spent in this room we both know there is more change to come in terms of who we are individually and who we are as couple. …Absolutely, and I have come to that realisation; there are times when I find that a bit sad almost, of a load to carry, but ultimately I am a believer that you either move on from that or you don’t and I have chosen to move on. And that’s all there is to it…
Secure Attachment Styles

Positive detachment accounts.

Denise: Something like, we were going out, that’s what it was, I was getting dressed and David said, ‘Are you wearing stockings?’ and I said ‘Why are you?’ and we just sort of laughed you know. We do get on very well; we do like each other. David is great company. He really is.

Kristine: I’m enjoying the baby. The relationship is getting back on track so I’m hoping it won’t change too much in that way.

Laura: I feel like we’ve walked through a door and closed it behind us and we need to move on now and plan our future and get the tools on how to go through these times in a better way than we have this time.

Ambivalent Detachment Accounts

Lucas: So you just sit back and let it happen or consider your options. I can’t exist with Laura being in other relationships. …Perhaps [as the result of therapy] we know where the parameters of that bond are now.

Research Question Four - Changes in The Partners’ Inner Working Models

Research question four investigated whether changes to each partner’s inner working models of self, other and context will occur as a result of their participation in the time-limited marital therapy.

Changes in View of Self

In terms of the restructuring of the self, eight people (80%) said that they believed some aspect of the self had changed as a result of therapy. This included such comments as:

Denise: Yes, I think about things more.

David: Yes, an unwillingness to hold back from developing myself into the person that I know I am capable of being.
Laura: I think that I put people on a pedestal and expected them to be perfect, or very close to it. I now know that we are all human and we all make mistakes and that does not make us any worse as people.

Lucas: I am likely to consider my course of action closer.

*Changes in View of Other*

In terms of a different view of their relationship as a result of participating in the therapy, five participants (50%) reported seeing their partners differently. As an extension of this, eight people (80%) said that they saw their relationship in a different way as a result of the therapeutic experience. And further, they considered that their present perceptions of their partner would continue to change. For example,

Kristine: I feel that I am no longer under scrutiny as I was when I was feeling low. We are a little closer now.

Denise: Yes, problems are now bumps in the road to be travelled over rather than baulked at.

David: Yes, more dynamic and dependent upon both of us to achieve the goals that we both yearn for.

Colin: An awareness of our anxieties and a greater ability to avoid/understand/work around our communication barriers.

When asked about the most important insight they gained about their partner during the therapy, the following observations were made.

Laura: That he’s not perfect.

Catherine: He is very different to me – his view of the world and his way of expressing his feelings are foreign to me.

Lucas: Her strength, her love and ability to reason.

Colin: Her fear of dismissal and her feelings of not having anything of her own.
Changes in View of Context

The free associative questions that Bader and Pearson (1988) suggested be administered prior to therapy were: ‘If the relationship as it is now were a drama, movie, or book, what would it be its title? How would it end?’ The responses were as follows.

Kristine: ‘What’s around the next corner’.

Keith. ‘Hopefully’. A great interlude. Back to how it was pre-baby.

Laura: ‘The [family name]: One day at a time’. It wouldn’t end. It would be a multi-generational saga.

Lucas: ‘OK’.


David: ‘False Expectations’. A strong, loving relationship built upon mutual understanding respect and honesty.

Sylvia: ‘Taming of the Shrew’. If I submit it may improve but there’s no guarantees and I’d lose myself again.

Stan: ‘Coronation Street’. It would end up everyone still fighting at the end. No it would be called Sylvania Waters. They were always fighting.

Catherine: Title: No idea. Ending: To be continued.

Colin: We would be moving off into the distance with a hopeful smile.

Discussion

Research Question One

Scores on the self-report questionnaire support research question one, that three of the five couples reported effective treatment outcomes. Beyond this, the data show that greater number of individuals, eight of the ten participants, found the treatment to be beneficial.
These findings have implications for research into whether the couple is the correct unit of study when considering the effectiveness of marital therapy.

Factors Influencing Treatment Outcome

Research into the effectiveness of marital therapy has paid particular attention to the interventions that most effectively modify or enhance couples’ relational quality and the relational system as a whole. Lindegger and Barry (1999) noted that, “little or no attention is paid to the individual and his or her private, let alone unconscious, experience” (p. 278). The findings of the study undertaken here provide preliminary support for the proposition that if an individual member of the couple benefits from therapy, the potential for a flow-on effect to the other partner in the immediate or longer-term future is created.

The study also indicates some gender differences in these participants’ experiences of the therapy. Of interest is the finding that of the five participants who were insecurely attached, all three insecure males reported positive treatment outcomes. On the other hand, the two insecure females described themselves as either unchanged or unsure about the effectiveness of the therapy. This finding suggests that the males with insecure attachment styles found relatively greater benefit from the time limitation and the highly structured nature of the therapy. Contrasting with this, the insecure women in the sample found their participation in the therapy less helpful. The reason for this apparent gender difference is unclear and may warrant further attention.

The Effect of the Time Limitation on Treatment Outcome

The results of the study support the relationship between the time limitation and positive treatment outcomes. While the majority of the participants acknowledged that the time-limitation mattered, none of them were able to articulate clearly which session was the most or least helpful. Similarly, the majority of the partners were unable to articulate clearly the role that time played in their experience of the therapy. This could be partly associated with the role of time in the unconscious. Mann (1973) pointed out time-limited therapy highlights the conflict between timelessness, infinite time, immortality and the omnipotent fantasies of childhood. This can be contrasted with finite time, which is associated with adulthood, reality and with death.

The findings here are consistent with the hypothesis that anxieties about emotional separation and loss become heightened by the process of time-limited therapy (Mann, 1973). Another explanation could be that the partners with insecure attachment styles may sense they have
more work to do to alter their inner working models and that the six sessions has just begun to touch the level of disturbance within them. This observation has some support from the present study. All the participants who experienced the time limitation of the therapy as unhelpful had self-reported his or her attachment styles as insecure. Again, this gives some support to the observation that insecure adults are likely to cling to the construct of ‘child time’ with its timeless, infinite, immortal and omnipotent fantasies (Mann, 1973).

The results also indicate that the structured time limitation is effective in providing a secure base or holding environment for couples with high degrees of conflict, anxiety and chronicity. Not one couple dropped out of therapy. This outcome could be attributed to the skill and experience of the investigator/therapist; she has practised the method for more than ten years.

Alternatively, the positive outcomes reported by the participants could be the result of many processes or mechanisms. For example, these could include the expectation of the clients that change was possible within six sessions. Another explanation could be the unconscious processes aroused by the time limitation itself. No research has been carried out into these factors and this warrants further investigation.

To investigate this finding the design of the study could be re-considered. For example, a comparison group with a longer period of therapeutic intervention would give further support to the findings. Such a research design would allow a more detailed investigation of the interventions and techniques that lead to therapeutic change, and whether the conclusions drawn in the present study can be confirmed. However, the finding does provide preliminary support for anecdotal evidence and clinical observations that inexperienced therapists with minimal or little training in the method have low drop out rates. To date, no research has been carried out into these factors and this too warrants further investigation.

Research Question Two

The findings of the study show a relationship between adult attachment styles and the developmental tasks of marriage. The study supports previous research carried out by Masiello (2000) that attachment styles influence an individual’s interpersonal dealings in their intimate relationships. This research question was based on the concept that the three fundamental attachment styles initially identified by Ainsworth (1978) will influence adult relationships (Hazan & Shaver, 1987). The study supports findings from previous attachment research (e.g. Ainsworth, 1989; Hazan & Shaver, 1987), that early child-parental bonds influence the child’s capacity to master important developmental tasks such as marriage.
The Effect of Adult Attachment Styles on Treatment Outcome

Research findings from another theorist (Feeney, 1998; Feeney, 2000) that attachment styles are predictors of relationship and marital satisfaction also find support from this present study. Here it is confirmed that there is an association between adult attachment styles and their influence on the couple’s responses in conflicted intimate relationships. Of the two couples where each partner reported secure/secure attachment, the presenting issues were contextual. That is, the presenting issues were related to the birth of a first child and a subsequent major depressive episode. In the second case this was in relation to a partner’s affair. Both couples said that prior to these events, they experienced relatively higher levels of functioning, greater intimacy and relationship satisfaction.

Neither of the securely attached couples had previously sought psychological treatment. The other three couples Colin and Catherine - insecure (avoidant) and insecure (avoidant); David and Denise - secure and insecure (anxious); and Stan and Sylvia - insecure (avoidant) and insecure (anxious) had all presented previously for therapy. This had been individually and as couples.

The Correlation Between the Couples Developmental Stage and Adult Attachment Styles

The findings support Sharpe’s (1997) and Bader and Pearson’s (1988) observations that successful treatment of conflicted relationships is assisted by the diagnosis of the couple’s developmental mode of object relations. While most attention in the field of marital therapy has been devoted to the diagnosis of developmental stages or themes, the integration of attachment theory provides an integrating concept in clinical work with couples. Here, the integration of the concept of adult attachment styles suggests a more comprehensive treatment approach to diagnosis for couples therapy.

The findings also confirm previous research that individuals with secure attachment styles are more likely to be higher functioning, have less relational conflict, place greater emphasis on intimacy and possess greater potential to realise marital ideals than insecurely attached adults. While the present study supported secure attachment style as a predictor of increased marital satisfaction, at the same time the study found that contextual factors such as the birth of a first child and extramarital affairs re-arouse separation anxieties that have been sequestered in the personalities of securely attached individuals. For example, childhood sexual abuse and emotional abuse by an older male sibling assumed importance in the therapeutic discourse.
Research Question Three

The narrative analyses provide preliminary evidence to support research question three that the therapeutic change processes elicited by the therapy could be likened to Bowlby’s (1961) stages of mourning - protest, despair and detachment. The findings indicate that the partners’ accounts did not necessarily follow a clear developmental progression. The difficulty in providing clear evidence for this question from the partners’ narratives may be partly due to the factor discussed earlier, that in marital therapy the lost object remains recoverable (Hazan & Shaver, 1992).

Identification of the Process of Mourning

As predicted, narrative analysis indicated that the couples’ accounts contained themes of tension, coherence and meaning. Although issues of sadness, loss and searching for lost love objects in cemeteries pertained, the ability to provide support for the praxis or experience of participating in the therapy as representative of a process of mourning was not clear. The data suggest that the couples gave a variety of meanings to their participation in the therapy. Researchers into close emotional loss have reported similarly (see Hendrick, 1992; Weber, 1992).

Alternatively, these findings may be consistent with Bowlby’s (1961) argument that the experience of loss is not stage-specific. Instead, the findings point to his observation that the unconscious processes associated with mourning close relationship loss are phases of a single process, with each phase informing the others. Again, as no research has been carried out on the role of mourning in the process of this time-limited marital therapy, further research may be helpful in clarifying this.

The Use of Narrative Analysis

The present study highlights the complexities associated with what Seligman (1995) described as doing research and therapy at the same time. The study also highlights the complexities associated with simultaneously being both therapist and investigator. However, the study demonstrates the value of the scientist-practitioner model as representing a meaningful framework for psychological research and in particular for investigating treatment outcomes in psychotherapy.

At the same time, the findings demonstrate the complexities associated with conducting narrative analysis. There needs to be an awareness that the narrative method is associated with
imprecise boundaries between data, method and theory. It simultaneously involves the risk of inference, evidence, or outcomes being dismissed as “anecdotal” (Kirkman, 2002).

In addition, the results support using qualitative research and narrative analysis as valid research methods to understand the practice and treatment outcomes of marital therapy. The findings suggest that narrative analysis as a research method into treatment effectiveness enables the clinical researcher to build an, albeit inductive, interpretation of the praxis.

**Research Question Four**

The contention of research question four, that participation in the therapy would bring about change in the partners’ inner working models can be supported by one of the major findings of the study. All of the participants reported that they had experienced a change in their perception of themselves as a result of the therapy. There is also support from the finding that, to a slightly lesser degree, the participants reported too a change in their perception of their partners.

**The Transformation of Inner Working Models**

The findings suggest that the integration of the triangles of conflict and person with the interventions of defensive, cognitive and affective restructuring provide the marital therapist with an integrative framework for the transformation of the partners’ inner working models. This contention receives support from another finding of the study. All of the participants reported gaining insight to their repetitive behaviours from the past and the effect that this continues to have on their present relationships. But, all of them were unable to articulate clearly where their lives might be heading as a result of the therapy.

This finding was expected, given that the existential nature of this inquiry would inevitably meet with resistance. It should be noted, however, that irrespective of their attachment styles, the holding experience of the time-limited therapy resulted in the majority of participants being able to express their innermost needs, thoughts and desires. In addition, it should be noted that they were able to do this freely in front of their partners.

The results of the research support using the techniques and interventions of this time-limited model both to understand the cognitive-emotional processes by which each partner sets goals or ideals for the relationship, as well as to understand the formation of a new couple system (Lindigegger & Barry, 1999). The findings support the effectiveness of a model for the systematic restructuring of the defences, followed by the cognitions and the affect
(Magnavita, 1997). The positive treatment outcomes suggest that the model of Magnavita (1997) may be extended from the treatment of the individual to the dyad of marital therapy.

Conclusion

The findings of the present study support the fundamental research question that the integration of attachment theory in the time-limited model would provide a coherent framework for the treatment of a broad range of marital issues and distresses. Previous research has not assessed the effectiveness of BCMT nor has it sought to define clearly and systematically the therapy’s conceptual or treatment framework. Here, the research finding is that the model provided an effective treatment method for differing expressions of marital disturbance and psychopathology for the treatment group. In particular, the paraphilias, a major depressive episode with postpartum psychosis, the narcissistic borderline syndrome and childhood sexual abuse.

The present study added a further dimension to attachment and marital research through its evidence that adult attachment styles act as a predictor of treatment effectiveness. The results supported an association between attachment styles as a predictor of the partners’ experience of participating in marital therapy. Perhaps the data is indicating also that the model is particularly appropriate for couples who are more secure in their attachment patterns and that additional therapy may be needed for couples who are insecure.

These findings provide preliminary support for the contention that insecure attachment styles may account for resistance to the therapeutic process, or the disavowal of the gains from it. This provides some support for the view of Feeney (2002) that the inner working models associated with insecure attachment styles sensitise individuals to negativity. Similarly, the finding gives some credence to an opinion of Schafer (1999) that for some, the experience of disappointedness becomes embedded in the personality.

This chapter highlighted the extent to which the methods of the self-report questionnaire and narrative analysis, in combination, provided a valid research method for understanding the meaning that couples attribute to marital therapy. In the next chapter conclusions are drawn from the data to substantiate how this research makes its contribution to the theory and practice of marital therapy. It is shown how the attachment process functions with both intrapsychic and systemic properties to provide a comprehensive theory for understanding and treating conflicted intimate relationships. In addition, it will be shown how the integration of
attachment theory in the model serves as an effective framework for the treatment of marital dissatisfaction.
CHAPTER 9

The Implications of the Research for Practice and Treatment

Overview

The principal aim of this thesis was to demonstrate how a time-limited marital therapy that integrated concepts from interpersonal, object relations, and attachment theories provides a coherent treatment framework for differing expressions of marital psychopathology and dissatisfaction. The research highlights how theoretical ideas can be integrated, specific clinical methods incorporated, and certain treatment perspectives can be derived from one another. By defining the theory of personality and psychopathology underpinning the model, and by specifying the therapeutic change processes associated with it, BCMT is able to take its place in the literature as a theory of psychotherapy. The research findings indicate that the theoretical and treatment model described in the thesis need not be restricted to marital therapy. The findings suggest that the integrated model could be applied across a wide range of presenting issues.
The Implications of the Research for Practice and Treatment

The aim of this thesis was to provide a detailed description of the conceptual and treatment elements of the marital module described in BCMT (Macnab, 1991). Prior to this research a comprehensive analysis of the theory underlying the model, or the theory of change the model endorses, had not been carried out. Little explanation has been given to help the therapist conceptualise the antecedents of the presenting issues or the relational conflict. Instead, the therapist has relied on what is essentially a treatment plan to guide them in the application of the method. Nonetheless, considerable support for the effectiveness of the therapy has been gained from unpublished clinical data and the self-reports of people who have participated in it.

To address these theoretical and clinical issues, a central task of the thesis was to develop the theoretical model for the marital therapy, to articulate the therapeutic change processes and to define the principles of treatment. The ultimate goal of the thesis has been to research the effectiveness of the approach and to evaluate its contribution to contemporary marital therapy. A discussion follows of the way the integration of attachment theory in BCMT resulted in a re-conceptualisation of the treatment model, and a different understanding about the role of the time limitation in the therapeutic change process.

Significance of the Study

The present study demonstrated how a time-limited marital therapy that included concepts from interpersonal, object relations and attachment theories results in an integrated model for treating differing expressions of marital psychopathology and dissatisfaction. The purpose was to create a coherent framework for the model, to explain the role of attachment in the aetiology of conflicted relationships, and to describe the therapeutic processes that result (Held, 1991). There were a number of reasons for examining attachment theory as an integrating factor in the treatment of conflicted intimate relationships.

A significant development in clinical practice has been the ability of contemporary marital therapies to integrate psychotherapeutic theories that were once perceived as incompatible (Lindegger & Barry, 1999). This has resulted in the emergence of marital therapies integrating the psychodynamic, strategic, and the cognitive-behavioural therapies in theoretically and clinically meaningful frameworks. At the same time the contribution of applied practice is essential to the development of the knowledge base of clinical psychology (Hayes, 1981).
example, marital and family therapists have been able to demonstrate how new meanings and perceptions can change pathogenic relationship patterns, within much shorter periods (Weakland et al., 1974).

Attachment Theory as an Integrating Concept

A major reason for the integration of attachment theory in BCMT was the emphasis it places on interpersonal relations, family dynamics and cognitive mechanisms (Bacciagaluppi, 1989). The convergence of attachment theory with the interpersonal theories more readily allows the therapist to conceptualise the relational dynamics, in particular, the identification of the anxieties aroused by the real or perceived abandonment by a [love] object. Such integration enables the therapist to understand more readily the processes of change unique to the therapy (Held, 1991). Such integration results in an “intentional psychology that uses the language of agency and self to describe the development of interpersonal interactions” (Cortina, 2001, p. 193).

This integrated metaperspective has important theoretical and methodological implications for the practice of this time-limited marital therapy. Following Bacciagaluppi (1989) and Lindegger and Barry (1999), the integrated metaperspective resulted in

both a set of empirically testable ideas and a rich base of empirical data, which is absent in some other areas of couple and family therapy (Lindegger & Barry, 1999, p. 287).

The research findings support Lindegger and Barry’s (1999) thesis that the construct of attachment provides an organising framework or metaperspective for theory construction and therapeutic intervention. In the clinical application of the model, this metaperspective allows the therapist to understand more clearly how secure and insecure attachment processes influence the partners’ experience of marital therapy. The high level of treatment effectiveness reported by the participating couples supports this hypothesis.

Attachment Theory as Clinical Heuristic

The research indicates that the integrated treatment model provides the therapist with a clinical heuristic to understand more fully the partners’ maladaptive cognitions and interpersonal conflict. The treatment outcomes suggest that an increased awareness of the partners’ individual attachment styles enables the therapist to gain a richer understanding of their internal working models. Such a clinical heuristic was found to provide a treatment framework that contains principles of practice to follow, and upon which the therapist might rely (Held, 1991).
A number of issues arise in inferring what changes occurred as a result of participating in the marital therapy. The immediacy of the therapeutic change reported by the couples indicates the effectiveness of the therapy for marital cases of wide diversity, morbidity and maladjustment. This conforms with Kazdin’s (1981) observation that:

The degree to which inferences can be drawn about the causal agent in the treatment of a clinical case also depends on the kinds of changes that occur. The immediacy and magnitude of changes contribute to judgments that treatment may have caused the change. Usually, the more immediate the therapeutic changes after the onset of treatment, the stronger a case can be made that treatment was responsible for change (p. 187).

These findings have considerable promise for providing new insights regarding the processes of marital therapy. The research demonstrated how the sequential treatment interventions of defensive, cognitive and affective restructuring in marital therapy results in therapeutic change. In particular it demonstrates, how the partners’ internal organisations or expectations become integrated into cognitive structures that provide the foundation for goal-directed interventions by the therapist. This finding supports Lindegger and Barry’s (1999) observation that in the practice of couples therapy:

Awareness of and attention to these individual attachment styles, and their compatibility between partners, may enable the therapist to find ways of engineering these structural changes in such a way as to accommodate the attachment style of the individual partners and maintain or enhance a secure base between the partners (p. 278).

Theoretical and Treatment Implications

There is convergence between the results reported in the research and the findings of other attachment researchers. A strong association between the function of adult attachment and its role in conflicted intimate relationships was found. The findings provide evidence to confirm Ainsworth and Bowlby (1991) in their emphasis on the importance of early emotional and developmental experiences as the building blocks of emotional relationships. And in addition, the findings support Bowlby’s (1988) emphasis on the role of attachment in the making and breaking of emotional bonds.

The Theory Underlying the Model of Personality and Psychopathology

Many of the themes embedded in the clinical case studies give testimony to Bowlby (1988) and Ainsworth (1989) in their observations that “features and functions of attachment relationships are essentially the same ‘from the cradle to the grave’ ” (Hazan & Shaver, 1992, p. 92). For example, narrative analysis of the clinical transcripts confirmed Hazan and Shaver
(1987, 1990) in their conceptualisation of romantic love as an attachment process. Also confirmed was the influence of childhood attachment representations in marriage, as described by Crowell and Treboux (1999). So too, the role of relationship-centred anxiety in adult attachments as reported by Feeney (1998) was supported in the research.

The findings supported Masiello’s (2000) research that adult attachment styles predict individuals’ intrapsychic responses in conflicted intimate relationships. In particular, they show how the partners “conceptualize love relationships, how they experience their relationships and how their behavior changes in response to stress” (Carver, 1999, p. 866). As a result, the present research goes some way to addressing the observation of Masiello (2000) that further research is required to understand how early patterns of attachment influence an individual’s intimate relationships. The clinical case studies, self-report questionnaires and narrative analysis of the clinical transcripts, support Carver’s (1999) observation that:

Adults whose attachments in childhood were secure will relate securely to their romantic partners (and others); those with avoidant attachments in childhood will be more mistrustful and distant; and those with ambivalent attachments in childhood will display a mixture of clinging closeness and rejection (p. 866).

Another result of the integration of attachment theory was the identification of the treatment interventions and techniques that result in more effective therapeutic change. From the viewpoint of clinical practice, attention to the issues of security, avoidance, and ambivalence were shown as valuable clinical tools. In addition, the conceptualisation of the couple’s dynamics in the treatment of interpersonal conflict proved valuable (Carver, 1999). The treatment outcomes also give support to the research of Dunn and Schwebel (1995) who found that insight-oriented marital therapy was the most effective method for bringing about relationship change.

In keeping with the contextual focus of BCMT, it was not assumed that adult attachment styles would account for all of the relational dysfunction. The presenting issues reflected the contemporary psychosocial context, and the post-modernist themes of meaninglessness, nothingness, emptiness, and emotional isolation (Frosh, 1989; Weiss, 1973). The significant impact on intimate relationships of major life transitions as reported by Halford, (2000) and Parkes (1971) were also reflected in the sample. For example, the impact of contextual issues such as the birth of the first child, the discovery of an affair and other forms of acting out behaviours all played an important role in the marital conflict.
The developmental context of the relationship [symbiotic, practicing, differentiating or rapprochement] and its effect on the couple’s relationship issues also mattered (Bader & Pearson, 1988). The findings suggest that the ability of couples to make the transition to the next stage of their relationship are influenced by their attachment style. For example, in cases where both partners reported insecure attachment, the ability of two of the female partners to move toward higher levels of interpersonal relationship was impaired by their anxious and avoidant attachment styles.

The Therapeutic Change Process

The introduction of attachment as an integrating factor in the conceptual framework of BCMT did more than give rise to a different consideration of the role of anxiety; it suggested an alternative treatment perspective. Previously BCMT had provided the therapist with a modular, sequential application of interventions with explicit criteria for movement from one stage of treatment to the next. The inclusion of attachment theory resulted in a different view of the therapeutic process and the intrapsychic and interpersonal processes associated with it.

The Conceptualisation of the Therapeutic Process as a Process of Mourning

From the point of view of clinical applications of attachment theory, the research carried out here goes some way to providing preliminary answers to the concern of Simpson and Rholes (1998). That is, little research has been carried out that examines how working models of attachment affect therapeutic process and outcome. Held (1991) highlighted the problem of defining the process of therapeutic change in psychotherapy, as distinct from defining the content to be changed. Similarly, Bradbury (2000) observed that “despite some advances, these processes are not easily studied, and a comprehensive understanding of them is not yet to hand” (p. 965).

Several implications for the treatment process flow from the integration of attachment theory in BCMT. As described in chapter three and detailed in Table 3.1 this integration led to a consideration of the therapeutic process as progressing through three separate yet interrelated stages: past, present and future. In addition, it led to the consideration of whether participation in the time-limited marital therapy would activate similar intrapsychic mourning processes to those described by Bowlby (1961) as: protest, despair and detachment. Additionally, the integration suggested that the couple’s unconscious processes could be perceived as moving from feelings associated with separation, to despair and finally to detachment.
A view of marital therapy as a stage-related process that includes a persisting attachment to the love object was found to have several important implications for the conduct of the therapy. A therapeutic change process based on mourning implied a treatment methodology founded on an overall progression of schematic change of the partners’ inner working models. To understand more fully these intrapsychic processes, the developmental model of object loss detailed by Horowitz (1990) proved valuable. This conceptualisation gave rise to an alternative consideration of the transformation of the partners’ object relationships in marital therapy.

The conceptualisation of the therapeutic change process as one of object transformation allowed the therapist to understand more clearly the variations in the partners’ affect as the therapy progressed (Horowitz, 1990). This integrated framework permits an understanding of the process of the therapy not as a detachment process from the [lost] object, but as a process of transformation. Baker (2001) showed how “this process requires an internal separation-individuation process in which certain aspects of the self are no longer tied to the object image” (p. 68). Because these transformations are painful, this integrated framework allows the therapist to engage in more strategic cognitive and interpretative interventions. The high level of effective treatment outcomes reported suggests that this intervention results in less negative reactions than might otherwise have occurred.

Another result of the integration was the creation of a metaperspective that takes into account the partners’ attachment processes as they occur in the three stages of the therapy: past, present and future. It creates the potential for the therapist to empathise with the partners’ need to preserve internal stability, while rebuilding their internal attachment with the [lost] object (Baker, 2001). Further, it involves the therapist in developing and maintaining a positive therapeutic alliance, as a means of containing the high levels of overt and covert hostility at the commencement of the therapy. At the same time, this conceptualisation allows the therapist to understand the partners’ interpersonal defences and to interpret their emotional reactions to the threat of loss and abandonment.

In summary, such an integrated conceptual framework provides the therapist with a stage-related process that enables them to recognise and to anticipate the couple’s anxiety as the therapy progresses. In addition, it provides them with an increased awareness of the partners’ maladaptive cognitions. And finally, it assists the therapist to help the partners establish a sense of mastery over the anxieties contributing to and currently hindering the relationship.
The Treatment Implications of the Psychodynamic Formulation

Helping clients develop an awareness of their core interpersonal patterns in therapy has emerged as an important task for practitioners as well as researchers (Masiello, 2000). As stated, in brief psychotherapeutic practice, these psychodynamic formulations have been well documented and researched. The central issue (Mann, 1974), the core conflictual relationship pattern (Luborsky, 1984), the focal issue (Malan, 1979) and the cyclical maladaptive pattern (Butler & Binder, 1987) are examples.

However, underpinning the conceptualisation of psychodynamic formulations such as these, is the assumption that the therapist has the ability to actively engage in the inductive method. At the same time, there is an assumption that the therapist possesses an advanced level of clinical training and high orders of theoretical knowledge and therapeutic skill. For example, high levels of intellectual and technical complexity are found in the cyclical maladaptive pattern of Butler and Binder (1987), where four discrete yet related elements inform the psychodynamic formulation.

Similar complexities can be found in the assessment procedures associated with the core conflictual relationship themes of Luborsky (1984). Or alternatively, there is the clinical experience required to conceptualise the developmental context of the relationship in Bader and Pearson’s (1988) model. Not only are such processes intellectually demanding and time consuming for the therapist. These formulations can also be particularly difficult for practitioners with little clinical experience and limited understanding of a developmental model of separation–individuation (Mahler et al., 1975).

The research showed how the integration of attachment theory resulted in three separate yet related psychodynamic formulations that inform the treatment process. For example, the conceptualisation of the stage-related praxis as a process of mourning – protest, despair and detachment acts as a simple clinical heuristic in its own right. In addition, the conceptualisation of the partners’ central relationship theme (CRT) assists the therapist in bringing about change in the partners’ object relationships. And finally, the concept of Adult Attachment Styles adds a further dimension to the psychodynamic formulation. The findings of the present study suggest that these three concepts create the potential for the therapist to work more strategically, effectively and efficiently.
The Adult Attachment Styles Questionnaire

One of the significant findings of the study was the use of the Adult Attachment Styles Questionnaire (AASQ) (Hazan & Shaver, 1987) as a diagnostic measure in the clinical situation. The AASQ is a useful, reliable instrument that assesses four attachment styles in a manner consistent with theory and current research (Masiello, 2000). The AASQ is non-intrusive, quick to administer and provides the therapist with a richer understanding of the partners’ conflictual interpersonal patterns. In particular, it provides an overview of the partners’ secure, or insecure–anxious or avoidant attachment styles.

The use of this test here suggests that the administration of the questionnaire prior to the commencement of therapy enabled the marital therapist to understand more clearly the relational conflict in object relations terms. The AASQ provides immediate feedback for the therapist, irrespective of their level of clinical experience. Administered at the commencement of therapy, the information obtained from this assessment creates the potential to enhance the therapist’s clinical focus, to create a clinical heuristic and to achieve more effective treatment outcomes.

The research findings not only suggest that the AASQ might provide an immediate diagnostic tool in the practice of marital therapy. It appears that the measure might have other clinical applications. The results of the research indicate that the reliability and validity of the AASQ as a clinical diagnostic measure merits further research.

The Time Limitation

One of the major criticisms of the brief approaches to therapy rests on the contention that they do not provide a theoretical rationale for the brevity of treatment, nor do they specify the way that the time limitation enhances the therapeutic process (Bloom, 1992; Messer & Warren, 1995; Smyrnios et. al., 1987). Like many contemporary brief psychotherapies the role of time in the therapeutic process of BCMT has not been elaborated fully. One of the noteworthy contributions of the research to clinical practice is the importance the model places on the role of time as integral to the treatment outcome. The results demonstrated that inferences can be drawn between the deliberate use of time and the number of couples reporting positive treatment outcomes.
The role of the time-limitation in the treatment of marital dysfunction.

The basic starting point of the research was to provide an explanation for the role of time in the process and the effectiveness of the model, in particular, the way the partners’ attachment styles become aroused by previous experiences of separation and loss as the therapy progresses (Strupp & Binder, 1984). The integration of attachment theory in the model resulted in a different conceptualisation of time and its role in treatment and outcome. Several implications for the treatment of conflicted intimate relationships flow from this.

The thesis proposed that time itself, its unconscious suspension and the partners’ unconscious experience of it (Molnos, 1995) were principal factors in the therapeutic change process. The basic contention is that the specific limitation of time as an unvarying constant from the beginning of treatment would set in train a series of unconscious dynamic events (Mann, 1973). The research findings provide support for this observation.

The findings also provide support for the observations of Mann (1973) and Molnos (1995) about the denial of time in the unconscious. The participants’ self-reports show that at a conscious level, time appeared of little importance to the couple’s experience of the therapy. This is in contradistinction to the finding that the majority of individuals participating in the time limited therapy found it to be of benefit.

Working within a secure time frame such as the one described here, together with an understanding of the role of time in the therapeutic change process, allays much of the anxiety associated with the practice of couple therapy (Shaw, 2001). Future research into the role of time in the practice of this and other marital therapies has the distinct possibility of contributing to a greater understanding of the change processes associated with the brief psychotherapies. Given the increasing incidence of marital breakdown and the growing demand on the clinician to treat distressed couples, this is an important finding.

The effect of the time limitation on the therapist.

A second factor that may have contributed to the effectiveness of the treatment outcome is the effect of the time-limited process on the therapists who practise the method. The results of the study indicate that inferences can be drawn also between the time limitation and the psychological meaning of time in the therapist’s own unconscious. This finding also attests to the significant role played by the patient – therapist relationship in the psychotherapeutic change process (Harrist, et al., 1991). The findings give credence to Blatt, Wiseman, Prince-Gibson and Gatt (1991) in their observation that the therapeutic relationship acts as
a vehicle through which pathological patterns of separation–individuation may be reworked and ameliorated, so that more adaptive patterns of intersubjective relatedness may be established and consolidated (p. 275).

Just as the treatment plan and time limitation of the therapy acts as a secure base for the couple, it also reduces the therapist’s anxieties about their participation in the process. Such a holding experience for the therapist appears to be associated with more positive outcomes, including the amelioration of psychological symptoms (Harrist, et al, 1991). Support for the current findings can be found also in Molnos’ (1995) discussion of the practice of brief psychodynamic therapy. Molnos (1995) wrote of how the therapist “has to be confident and convinced that it is possible to use the limited time to maximum effect, that good, productive work can be done within the given time limits” (p. 52).

The degree of change reported by the participants in the research supports the observation about the immediacy of therapeutic change as an indicator of treatment effectiveness (Kazdin, 1981). The reported treatment outcomes provide support for the observation that the clearer the information the therapist has about the therapeutic process, the more quickly he or she can begin to direct their thoughts, perceptions and behaviour (Moras, 1993). The findings suggest that the more the therapist understands the role of time in the unconscious of the partners, as well as its role in the process of the therapy, the more effective they are likely to be.

The Contribution of the Treatment Process to Clinical Training

On the basis of the current findings, it appears that becoming an effective clinician may not necessarily be due to personal characteristics. Research into the cognitive, emotional and relational characteristics of master therapists suggests that they have an ability to have more complex schemata and to notice more subtle features than that of neophyte therapists (Jennings & Skovholt, 1999). The present findings indicate that while the therapeutic alliance plays a central role in achieving effective treatment outcomes, two other factors have implications for treatment planning and clinical training.

One factor is the mourning processes aroused by the praxis described earlier. While the research highlights the difficulties associated with gaining direct evidence to support the notion that the mourning-like process was an essential therapeutic mechanism responsible for therapeutic change. The study also demonstrates that the concept of mourning is a useful way of conceptualising the treatment process.
On the basis of the current findings it appears that detailed treatment plans have benefits for clients, therapists and treatment outcomes. The use of a treatment plan in applied clinical practice appears to be beneficial on several other grounds. First, the ability to evaluate treatment is enhanced by increasing feedback to the clinician about the partners’ responses to the treatment. Second, the statement of a clearly defined treatment plan appears to increase the clinical effectiveness of the practitioner. Third, the ability to transfer the knowledge to other cases increases the therapist’s sense of mastery. And finally, the ability to undertake focused clinical supervision is a further benefit.

Implications for Future Research

While clinicians have been influential in the development and practice of the brief therapies, there has been reluctance on their part to adopt the scientist-practitioner model (Kazdin, 1981). One reason for this reluctance is the time constraint involved in administering and scoring psychometric tests in general psychotherapeutic practice. Another reason for the reluctance by practitioners to undertake research is inadequate or cumbersome research tools that are incompatible with clinical realities and assumptions (Hayes, 1981). This has been especially so in marital therapy which is predominated by practitioners, and where couples often present with high levels of conflict (Hartin, 1981). Instead, diagnosis has relied on the clinical interview or observational and structured diagnostic tools such as questionnaires and paper exercises (Bader & Pearson, 1988).

The second factor is the description of a detailed treatment plan. The present study suggests a method for clinicians who are increasingly required to work within an evidence-based framework, to assess treatment outcomes, and to provide supporting evidence of therapeutic change. This does not mean that the current research does not have limitations. The findings raise a number of questions about future research into the effectiveness of the model. Some suggestions for further research follow.

Drawing valid inferences from self-report questionnaires.

The extent to which the present model can be judged as a valid treatment method raises a number of issues about the use of self-report questionnaires. The self-report questionnaire has played a central role in clinical psychology and is one of the most widely used sources of research data. Costa and McCrae (1992) advanced the idea that self-reports provide individuals with the “widest and most extensive opportunity to observe his or her own
behavior and is privy to thoughts, feelings, and desires, that are not publicly expressed” (p. 31).

Although the present results were confirmatory, from a methodological perspective the extent to which inferences can be drawn about treatment effects is influenced by the measurements administered (Kazdin, 1981). In particular, the questions and properties of the self-report questionnaire designed specifically for the study would need to be considered in future research. The questionnaire requires that participants retrospectively think about complex issues happening in each of the six sessions. Reasonable doubt could be cast on the reliability of retrospective reports about specific therapy sessions.

This observation is confirmed by some participants’ responses to the questionnaire, such as “I can’t remember” and “Don’t know”. It could also account for the refusal of one participant to complete the questionnaire. This factor needs to be considered as an important methodological complication in the present study. Future assessment of the psychotherapy’s effectiveness based on retrospective reports would need to take this factor into account.

In addition, the extent to which the present participants may have portrayed themselves, their relationship and the therapeutic experience in a positive light is unknown. The reliance by the investigator on the Adult Attachment Styles Questionnaire (AASQ) as the principal measure for the study of attachment is another factor. Carver (1997), for example, pointed out the AASQ is not the only way “adult attachment can be assessed, and there is some danger in relying too exclusively on a single measure” (p. 866).

**Drawing valid inferences from case studies.**

Another factor that warrants consideration for future research is reliance on the case study method. The case study occupies an important place in clinical work and has played a central role in psychotherapy practice and research. Kazdin (1981) noted the importance of the case study for its heuristic value and for its intensive investigation of individual clients.

Although case studies are widely recognised for their ability to conceptualise clinical issues and treatment strategies, Kazdin (1981) also suggested that case studies “are usually considered to be completely inadequate as a basis for drawing scientifically validated inferences” (p. 191). For example, the case studies reported here demonstrate that the couples participating in the therapy experienced an immediate reduction in the intensity of their relational conflict. However, no treatment follow-up was carried out to determine the continuing effects of the therapy.
Once more, this research highlights the ongoing tension between research, clinical practice and the reluctance, or perhaps inability, of the clinician to formally investigate treatment outcomes. Overall, the findings support the argument that the case study represents a potential source of scientifically useful information for psychotherapeutic practice and clinical research (Kazdin, 1981). Further research is desirable to determine the long-term effects of the restructuring of the partners’ experience of participating in the marital therapy.

**Number and heterogeneity of subjects.**

The size and heterogeneity of the clinical sample studied also has methodological implications for the research findings. Kazdin (1981) noted how the number of subjects influences the conclusions that can be drawn about treatment effects. Obviously, the greater the number of cases the stronger may be the basis for inferring the changes associated with treatment. The question of whether five cases are sufficient validation for a reliable test of the method remains open. A larger research sample, for example, may have produced different outcomes.

Aside from the number of cases, the heterogeneity of the cases also contributes to the inferences that can be drawn about the cause of therapeutic change (Kazdin, 1981). All but one person in the present sample of participants was tertiary educated. Similarly, they were all middle class, middle aged and presently in relationships of more than ten years duration. Bradbury (2000) and Halford (2000) have reported an inverse correlation between relationship satisfaction and length of marriage. Future research may consider the effectiveness of the model for couples presenting for therapy with shorter relationships or from different socio-economic and educational backgrounds.

The present findings suggest an association between the gender differences and positive treatment outcome. These gender differences warrant further investigation. The preliminary association made between secure and insecure attachment as a predictor of treatment effectiveness also merits investigation. Future research might focus on these and other aspects of the therapeutic process.

These dimensions do not necessarily exhaust all of the factors impinging on the conclusions drawn from the research. The degree to which inferences can be drawn about the effectiveness of the therapy needs to consider that the investigator/therapist has more than ten years experience in practising the method. Another variable that could have influenced the outcome was that the majority of the participants had previously participated in therapy. Questions
remain about whether the findings may be capable of being generalised beyond the context of this group. Once more, the present findings demonstrate the difficulty associated with the clinical investigator controlling for such variables (Seligman, 1995).

*Drawing inferences from narrative analysis.*

The research highlights the value of narrative analysis for the assessment of treatment effectiveness in psychotherapeutic practice. The use of qualitative measures enabled an investigation into whether the processes of change that take place during the course of therapy were parallel to those described in Bowlby’s stages of mourning. Narrative analysis of the clinical transcripts found that as the therapy progressed, issues of separation and loss assumed predominance in the therapeutic discourse (Mann, 1973; Strupp & Binder, 1984). Evidence to support the hypothesis of the therapeutic process as one of mourning were found in the discourse of a participant who described the mourning he was feeling about his lack of relationship with his father when he was a child. It was found too in the female participant who with her partner (following session three which focused on unconscious influences) went searching for her grandfather’s grave, and the feelings of disassociation that accompanied this experience.

One of the criticisms that could be leveled against this finding is the risk of looking for evidence to support Bowlby’s framework. This could result in the researcher allowing findings to emerge that may, or may not, fit this framework. Or alternatively, that the researcher may overlook other themes emerging from the narrative, to support the research question.

The narrative analyses found that the extent to which the psychotherapeutic change process can be understood as a process of mourning, warrants even more sophisticated narrative analysis. Evidence to support actual change in the participants working models of self and other can be found in the individuals’ responses on the self-report questionnaire. The participant’s answers provide support for the hypothesis that changes will emerge as a result of specific therapeutic interventions. Conclusions can also be drawn that change in models of self and others occur as a result of participating in the time-limited marital therapy.

At the same time, the present findings do indicate a convergence between self-report questionnaires, the case study and narrative analysis for understanding the individual and their interactions with others. The integration of these three methods extends the clinical investigator’s ability to generate evidence about the bases of personality and attachment.
styles. It is also a reference point for developing and applying interventions and techniques (Kazdin, 1981).

**Conclusion**

This thesis started with the proposal that the construct of attachment would provide an integrating factor in the practice of the marital module detailed in the treatment manual for BCMT. The research found that the integration of interpersonal, object relations and attachment theory resulted in a more concise definition of BCMT. The study found evidence to support the effectiveness of the treatment method, its theory of change and the contribution of the model to the clinical practice literature (Svartberg, 1993).

The research demonstrated how the integration of attachment theory provided a conceptual framework for understanding and treating couple relationships. As well as developing the therapeutic model, the integration of attachment theory led to a greater understanding of the change processes and the stage-related therapeutic process. In terms of clinical practice, it led to the development of specific therapeutic interventions and a greater understanding of the partners’ interpersonal processes. It also increased the therapist’s ability to guide behavioural change and to achieve more effective treatment outcomes.

In view of the research findings, the integration of attachment theory in the practice of this time-limited therapy warrants further consideration at the levels of theory, research, and clinical interventions. The findings suggest that the integration of attachment theory in BCMT need not be restricted to the practice of marital therapy. Instead the therapeutic model could be applied across a wide range of presenting issues.

The research provides a new understanding for the way the marital therapy might be applied and the training of the clinicians who practise it. This suggests that the research findings have implications for the health of individuals, couples and the general community. By defining the theory of personality and psychopathology and the therapeutic change processes associated with it, the integration of attachment theory enables BCMT to take its place in the literature as a theory of psychotherapy.
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Appendix A

The Role of Attachment in a Time Limited Integrated Marital Therapy: Implications for Practice and Treatment

Questionnaire Format

CASE NO:

AGE:

SEX:

INTRODUCTION:

Thank you for participating in this study and for agreeing to complete this questionnaire. In order for us to fully understand your experience of being in the therapy you have just completed, it is important that you take your time. We expect the questionnaire will take approximately one hour to complete.

PART 1

We would like you to think back to the first two sessions of therapy and answer the following questions.

What issues and concerns were addressed?

What emotional needs were clarified?
What goals and expectations were clarified?

What were your feelings when you came to the first session?

What were your feelings when you came to the second session?

Was there a change in your perceptions of the relationship?

What was the change?

What brought about the change?
Did you gain some awareness of the role of anxiety in your relationship and the situations that trigger your anxiety?

If you answered yes, what role do you see anxiety has?

How do you now see yourself as being able to manage your anxiety?

Is this any different to the way you managed your anxiety prior to therapy? If so, in what way do you manage it differently?

What were the major insights about yourself or your partner in the first two sessions?

We would like you to think back to the third and fourth sessions of therapy and answer the following questions.
What were the predominant feelings that you had about your family before coming to therapy?

Was there a change in your perception of your childhood as a result of being in therapy?

What was the change?

What brought about this change?

What feelings became aroused when you were asked to speak about your family?

Was there a change in your perception of your partner’s childhood relationships?
What was the change?

In what way do you now understand how you repeat patterns of behaviour from your past?

Have you become more aware of your self-talk or inner voice, as a result of being in therapy?

How has your self-talk or inner voice changed?

What effect has this change had on your thinking, feeling or behaving?

Do you see yourself differently as a result of being in therapy?
Do you see your partner differently as a result of being in therapy?

Do you see your relationship differently as a result of being in therapy?

In what way do you think changing your perceptions might continue to change your relationship with your partner?

We would like you to think back to the fifth and sixth sessions of the therapy and answer the following questions.

What feelings or reactions became aroused when you were asked to consider your life and where it might be heading?

Were you able to clearly articulate where your life might be heading in session five of the therapy?
Were you able to clearly articulate your inner most needs, thoughts and desires during session five of the therapy?

How safe did you feel expressing your inner most needs, thoughts and desires in front of your partner?

What about now?

Do you believe some aspect of your self has changed as a result of the therapy? If so, in what way has it changed?

What was the most important insight you gained about your partner as a result of being in therapy?

What about other people?
What do you consider the long-term effects of participating in the therapy might be?

What were your predominant feelings when the therapy came to a conclusion?

If your relationship as it is now were a drama, movie, or book, what would it be titled? How would it end?

**PART 2**

Had you had any counselling or therapy prior to undertaking this six-week marital therapy?

Was it as a couple or as an individual?

How did you perceive your previous experience of counselling or therapy as different from the therapy you have just completed?
Did you like the structured approach taken in the six-week therapy?

Was it helpful to have a plan of the therapy? How was it helpful?

Was it useful to know that the therapy had a time limitation? How was it helpful?

Which session did you find the most helpful? Why was it helpful?

Which session did you find the least helpful? Why was it not helpful?

What did your therapist say which you found most helpful? How was it helpful?

What did your therapist do which you found most helpful? How was it helpful?
What did your therapist say which you found the least helpful? How was it not helpful?

What did your therapist do which you found the least helpful? How was it not helpful?

Which interpretation or insight did you find the most helpful? How was it helpful?

Did you feel the therapist favoured your partner at any time and in what way?

If you could think of one word, phrase, or image to sum-up the experience of being in the therapy you have just completed, what would it be?

Research Questionnaire – Appendix A
THE ROLE OF ATTACHMENT IN A TIME LIMITED INTEGRATED MARITAL THERAPY: IMPLICATIONS FOR PRACTICE AND TREATMENT

QUESTIONNAIRE - A

CASE NO:
AGE:
SEX:

WHICH OF THE FOLLOWING BEST DESCRIBES YOUR FEELINGS?

Please tick one of the following:

(a) I find it relatively easy to get close to others and am comfortable depending on them and having them depend on me. I don’t often worry about being abandoned or about someone getting too close to me.

☐

(b) I am somewhat uncomfortable being close to others: I find it difficult to trust them completely, difficult to allow myself to depend on them. I am nervous when anyone gets too close, and often love partners want me to be more intimate than I feel comfortable being.

☐

(c) I find that others are reluctant to get as close as I would like. I often worry that my partner doesn’t really love me or won’t to stay with me. I want to merge completely with another person, and this desire sometimes scares people away.

☐

Appendix C

Ethics Approval from the Human Research Ethics Committee

<table>
<thead>
<tr>
<th>Principal Investigator(s) (if staff):</th>
<th>Prof Barry Fallon</th>
<th>Campus: Patrick</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co Investigator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Researcher(s) (if student(s))</td>
<td>Caro Brown</td>
<td></td>
</tr>
</tbody>
</table>

Ethics clearance for modifications has been approved for the following project: Brief contextual marital therapy

For the period: 22.5.2001 - 1.10.2001

University Research Ethics Committee Register Number: V2000019

subject to the following conditions as stipulated in the National Health and Medical Research Council (NHMRC) Statement on Human Experimentation and Supplementary Notes 1992:

(i) that principal investigators provide reports annually on the form supplied by the Institutional Ethics Committee, on matters including:
   - security of records;
   - compliance with approved consent procedures and documentation;
   - compliance with special conditions, and

(ii) as a condition of approval of the research protocol, require that investigators report immediately anything which might affect ethical acceptability of the protocol, including:
   - adverse effects on participants;
   - proposed changes in the protocol, and/or
   - unforeseen events that might affect continued ethical acceptability of the project.

and subject to clarification of the following to the Human Research Ethics Committee:

A Final Report Form will need to be completed and submitted to the HREC within one month of completion of the project.

An Annual Progress Report Form will need to be completed and submitted to the HREC within one month of the anniversary date of approval.
Please sign, date and return this form (with any additional information or material, if requested by the Committee) to the Administrative Officer (Research) to whom you submitted your application, for approval to be confirmed.

Signed: ____________________________ Date: 29.5.2001
Administrative Officer (Research)

[To be completed by the Principal Investigator, or Student and Supervisor, as appropriate]

We hereby declare that we are aware of the conditions governing research involving human participants as set out in the Human Research Ethics Committee’s Guidelines and Instructions for Researchers/Students and agree to the conditions stated above.

Signed: ____________________________ Date: 8/6/2001
Principal Investigator (if staff) or Supervisor, as appropriate

Signed: ____________________________ Date: 8/6/2001
Researcher (if student)
Appendix D

Letters to the Participants

AUSTRALIAN CATHOLIC UNIVERSITY
Information Letter to the Participants

Title of Project: The Role of Attachment in a Time Limited Integrated Marital Therapy: Implications for Practice and Treatment

Supervisors: Dr. Cecelia Winkelman
            Prof. Barry Fallon

Student Investigator: Coral Brown

Thank you for agreeing to participate in this study. You will be asked to participate in six sessions of marital therapy. Each session will be of approximately 50 minutes. On completion of the therapy you will be asked to complete a questionnaire. The purpose of the study is to determine whether the model of therapy provides a coherent framework for the treatment of marital dissatisfaction.

Complete confidentiality is assured. During the study, independent observers will take case notes and verbatim transcripts of the sessions. To ensure an accurate record of the sessions is made, audio tapes will also be used. All the data from the sessions will be kept secure in the investigator’s locked filing cabinet. Your identity will be protected, both during and after the study. In writing the results for the thesis or for publication, all factual information will be changed to ensure confidentiality. Your participation is voluntary. You are free to withdraw from the study at any time, and withdraw any data supplied without giving a reason, without losing your place in therapy. If you have any queries or concerns, please contact Dr. Cecelia Winkelman on 9953-3112, School of Psychology, Australian Catholic University.

This project has been approved by the University Human Research Ethics Committee, Australian Catholic University. In the event that you have any complaints about the way you have been treated during the research, or a query that the supervisor has not been able to satisfy, you may write to the Chair, University Human Research Ethics Committee, c/- Office of Research, Australian Catholic University, Locked Bag 4115, Fitzroy VIC 3065, Tel: (03) 9953-3154, Fax: (03)9953-3053. Any complaint made will be treated in confidence, investigated fully, and you will be informed of the outcome.

Thank you again for your participation.

Supervisor…………………………………………Student Investigator…………………………
Appendix E

Consent Forms

AUSTRALIAN CATHOLIC UNIVERSITY

Participant’s Statement of Consent

Title of Project: The Role of Attachment in a Time Limited Integrated Marital Therapy: Implications for Practice and Treatment

Supervisors: Dr. Cecelia Winkelman
Prof. Barry Fallon

Student Investigator: Coral Brown

I ………………………….(the participant) have read and understood the information provided in the Information Letter to the Participants and any questions I have asked have been answered to my satisfaction. I agree to participate in this activity, realising that I can withdraw at any time.

I agree that research data collected for the study may be published or provided to other researchers in a form that does not identify me in any way.

Name of Participant: ………………………………………………………………………… (block letters)

Signature: ……………………………………………………………………….. Date: …………………

Please sign both copies, returning one and keeping the other for your records.

Signature of Supervisor: …………………………………………………………………………

Signature of Student Investigator: ……………………………………………………………