Ann Vernon *Editor*

Cognitive and Rational-Emotive Behavior Therapy with Couples

Theory and Practice

Cognitive and Rational-Emotive Behavior Therapy with Couples

Ann Vernon
Editor

Cognitive and Rational-Emotive Behavior Therapy with Couples

Theory and Practice

Editor
Ann Vernon
University of Northern Iowa
Cedar Falls, IA, USA

ISBN 978-1-4614-5136-5 ISBN 978-1-4614-5137-2 (eBook)
DOI 10.1007/978-1-4614-5137-2
Springer New York Heidelberg Dordrecht London

Library of Congress Control Number: 2012950046

© Springer Science+Business Media New York 2012
This work is subject to copyright. All rights are reserved by the Publisher, whether the whole or part of the material is concerned, specifically the rights of translation, reprinting, reuse of illustrations, recitation, broadcasting, reproduction on microfilms or in any other physical way, and transmission or information storage and retrieval, electronic adaptation, computer software, or by similar or dissimilar methodology now known or hereafter developed. Exempted from this legal reservation are brief excerpts in connection with reviews or scholarly analysis or material supplied specifically for the purpose of being entered and executed on a computer system, for exclusive use by the purchaser of the work. Duplication of this publication or parts thereof is permitted only under the provisions of the Copyright Law of the Publisher's location, in its current version, and permission for use must always be obtained from Springer. Permissions for use may be obtained through RightsLink at the Copyright Clearance Center. Violations are liable to prosecution under the respective Copyright Law.
The use of general descriptive names, registered names, trademarks, service marks, etc. in this publication does not imply, even in the absence of a specific statement, that such names are exempt from the relevant protective laws and regulations and therefore free for general use.
While the advice and information in this book are believed to be true and accurate at the date of publication, neither the authors nor the editors nor the publisher can accept any legal responsibility for any errors or omissions that may be made. The publisher makes no warranty, express or implied, with respect to the material contained herein.

Printed on acid-free paper

Springer is part of Springer Science+Business Media (www.springer.com)

Preface

Cognitive and Rational–Emotive Behavior Therapy with Couples: *Theory and Practice* is a book that is intended for practitioners working with couples, including marriage and family therapists, psychologists and psychiatrists, mental health counselors, relationship coaches, and social workers. As the reader will note in the first chapter, counseling couples can be very challenging for a number of reasons, and practitioners should find that this publication is a comprehensive guide to working with couples who present in therapy with a variety of issues. Students doing master's or doctoral-level coursework should also find this to be a very useful resource, in particular because they will enter the professional field with a "toolbox" of techniques that will enhance their work with couples.

This book is unique in that most of the authors are, or have been, clinicians as well as scholars. As such, not only they are better able to address their topic from a review of current or relevant literature and research, but they can also focus on the practical application of concepts by providing readers with pertinent case studies that illustrate the principles of theory as well as practice. Practitioners working with couples need such examples in order to most effectively direct their work with this client population.

A significant feature of this book is that it addresses topics relevant to couples across the life span, as well as challenging issues that couples may have to contend with in the course of their relationship. Chapter 1 is an introduction to couples counseling from a cognitive and rational–emotive behavior perspective, which is the theoretical foundation of this publication. This chapter highlights the main tenets of the Cognitive Behavioral Therapy and Rational–Emotive Behavior Therapy as well as the major contributions of Albert Ellis and Aaron Beck, both pioneers in the field of CBT with regard to counseling couples. Chapter 1 also touches briefly on several "third wave" cognitive behavioral approaches, including Mindfulness, which is discussed in detail in Chapter. 2.

The third chapter provides readers with an explanation of marital myths and other self-defeating behaviors that sabotage couple relationships, with practical interventions practitioners can use to help couples overcome these negative beliefs and practices. The next five chapters address specific problems that many couples

present with: dealing with relationship ambivalence, anger and conflict, stress and adversity, intimacy and sexuality, and betrayal and affairs. These chapters all contain case studies and practical application of concepts as well as specific interventions to help couples deal with these issues that may be quite complex and challenging.

Chapters 9–13 focus on specific issues that can present major challenges in some couple relationships. Chapter 9 deals with same-sex couples, which is especially relevant given President Obama recent endorsement of gay marriage. Chapter 10 discusses how to deal with cultural and religious differences, another important topic given the religious and cultural diversity in this country, as well as other countries throughout the world. In each of these chapters, challenges unique to these populations are addressed, as well as strategies for dealing with problems that arise over the course of the relationship. The next chapter focuses on problems that develop when addiction impacts a couple's relationship, and Chapters 12 and 13 both deal with difficult issues that arise when a spouse or child has a chronic physical or mental illness, or when a partner is diagnosed with a terminal illness. Each of these three chapters provides a review of the current literature with an emphasis on the role of distorted cognitions in contributing to the problems couples experience when faced with these issues. Case studies and practical interventions will help practitioners in their work with couples presenting with these serious problems.

Chapters 14 and 15 deal specifically with issues facing couples at different phases of the adult life cycle: the challenges of parenting and grandparenting, as well as dealing with aging. The authors address various dimensions of these topics, and through case study illustrations, present practical ways that practitioners can intervene with couples facing problems during these distinct phases of the life cycle.

Because all of the authors have emphasized practical application of theory to practice, this book should enhance readers' understanding of each of the topics covered in this book from a cognitive behavioral perspective. In addition, they should have numerous cognitive, emotive, and behavioral interventions to employ when working with couples. Students doing masters or doctoral-level coursework will enter the field with a "toolbox" of techniques to enhance their work with couples.

Cedar Falls, IA, USA Ann Vernon

About the Editor

Ann Vernon, Ph.D., Sc.D., RLPC, is President of the Albert Ellis Board of Trustees, a Diplomate of the Albert Ellis Institute, a member of the International Training Standards and Review Committee of the AEI, a member of the Board of Consulting Advisors for the *Journal of Rational–Emotive Cognitive-Behavior Therapy*, and former Director of the Midwest Center for REBT. In addition, she was selected by the American Psychological Association to do a counseling video demonstration entitled *Rational Emotive Behavior Therapy Over Time: Psychotherapy in Six Sessions*. Dr. Vernon is recognized as an international expert in applications of RE&CBT with children and adolescents and has written numerous books, chapters, and articles about counseling this population, including *Thinking, Feeling, Behaving: An Emotional Education Curriculum, What Works When with Children and Adolescents: A Handbook of Individual Counseling Techniques, The Passport Program, and More What Works When with Children and Adolescents*. She is also the editor of *Counseling Children and Adolescents*, a textbook that is used throughout the country and in other parts of the world in many counselor education programs. Dr. Vernon is Professor Emerita, University of Northern Iowa, where she served as Coordinator of the School and Mental Health Counseling programs for many years. In addition to her university appointment, Dr. Vernon was in private practice, working with children and adolescents, as well as couples and women presenting with anxiety, depression, and eating disorders. She currently conducts RE&CBT training programs in Romania at the University of Oradea, the RINO Mental Health Center in Amsterdam, and throughout Australia for Cognitive-Behaviour Therapy Australia. For many years she has been an active presenter in the United States, Canada, and South America, offering workshops on a variety of topics related to counseling children and adolescents.

About the Authors

James McMahon, PsyD., Ph.D., Th.D., Sc.D, founded and has served as President of MATES Foundation, a nonprofit voluntary organization that provides training throughout the world concerning couples education, counseling, and research for 20 years. He has served on various committees and as faculty, supervisor, and trustee of the Albert Ellis Institute and now is its oldest living Life Member. Dr. McMahon is an officer of the International Institute on Mental Health, Professor of the State University of Oradea, Romania, and Visiting Professor of Pastoral Interventions, BBU, Cluj, Romania. He has written extensively on couples and marriage issues and has authored texts and journal articles on clinical, couples, and pastoral counseling interventions. He is currently a member of three journal editorial boards. Dr. McMahon, a Diplomate of the Albert Ellis Institute who holds four earned doctorates plus the Doctor *Honoris Causa* for service to students and psychology, has strong interests in coaching, mental health networks, forensics, and building secular and religiously sponsored service communities.

Candice Siu Woo, Ph.D., is a Psychology Fellow at the Albert Ellis Institute. She received her Ph.D. in clinical psychology from St. John's University and her M.A. in psychology from Teacher's College, Columbia University. Candice obtained her B.Sc. in psychology from University College London, UK. Her research and clinical interests are in the area of trauma and child maltreatment. In her dissertation, she examined the role of meaning-making in young adults' psychological adjustment to trauma and studied children's perceptions of child maltreatment in her master's thesis.

Monica O'Kelly, Ph.D., is Director of Cognitive Behaviour Therapy Australia and Director of the Australian Institute for Rational Emotive Behaviour Therapy. She is an Adjunct Senior Lecturer in the School of Psychology and Psychiatry at Monash University. Dr. O'Kelly was trained in REBT at the Albert Ellis Institute in New York and is a Diplomate and Associate Fellow of the Institute. She has also completed the Extramural Training Program at the Beck Institute in Philadelphia. Dr. O'Kelly is a Fellow of the Academy of Cognitive Therapy and has published many

articles in the area of CBT. In addition to working in private practice, she presents training courses in CBT throughout Australia, New Zealand, and Asia.

James Collard, DPsych, is a practitioner, lecturer, and research supervisor. He has completed extensive training in CBT, both from a traditional perspective of Beck's Cognitive Therapy and Ellis' Rational–Emotive Behavior Therapy, and in the "new wave" forms of CBT, including ACT, mindfulness and Meta-Cognitive Therapy. Dr. Collard works in private practice in Melbourne, Australia for Cognitive Behavoiur Therapy Australia (CBT Australia). In his practice he provides clinical services to children and adults, including couples and families. He assists with running training courses on CBT provided across Australia by CBT Australia. Dr. Collard also currently holds the position of lecturer at the Cairnmillar Institute in Melbourne, where he provides training in CBT and is a research supervisor for Master's-level students.

Richard Dowling, **M.A., LPC,** is founder and owner of The Thought Exchange, LLC: Center for Personal Achievement. He is an adjunct instructor at Montclair State University and a certified supervisor of the Albert Ellis Institute. He is a founding board member of S.M.A.R.T. Recovery Self-Help Network (Self-Management and Recovery Training), based largely on REBT/CBT principles, and he assisted with the development of SMART Recovery's Four-Point Program. Rich Dowling has delivered numerous presentations on REBT/SMART Recovery to professional groups and the general public over the past 20 years. He is also founder and president of *Books Behind Bars and Beyond*, a not-for- profit organization providing REBT/CBT-based self-help books to individuals incarcerated in correctional and related facilities.

Siobhan Evarts, Ph.D., is a licensed clinical psychologist in New York and Connecticut, assistant professor of psychology at Albertus Magnus College, the educational assessment supervisor of Prep for Prep in New York City, and a supervisory fellow at the Albert Ellis Institute. Dr. Evarts has presented scientific research and published articles on a variety of subjects, including anger, anxiety, alcohol use and cue exposure, and cocaine craving/cue reactivity. Dr. Evarts has been certified in Mediation Skills Training with a focus on custody and visitation in divorce by the Hofstra University School of Law. She has given professional trainings to mental health clinicians addressing the theory and therapeutic use of RE&CBT and psychiatric diagnostic interviewing, as well seminars and workshops for the public on topics such as tolerating frustration and managing difficult kids. Dr. Evarts has held a position as a clinical psychologist at the Albert Ellis Institute where she treated clients with relationship conflicts, mood disorders, anger and aggression, addictions, and women's issues.

Vanessa Woods, M.A., is a clinical social worker in the Integrated Forensic Psychiatry Program at the Royal Ottawa Mental Health Centre in Ottawa, Canada with clinical responsibilities for individuals with dysfunctional anger, among other issues. She provides counseling for individuals, couples, and families and also facilitates an anger management group. She received her Master of Social Work from

McGill University and is an Albert Ellis Institute (AEI) Accredited Supervisor in Rational–Emotive Behavior Therapy. She is also an associate staff member of the Centre for Rational and Cognitive Therapies and has conducted training programs in REBT. Her research interests include gender and anger/aggression, as well as the impact of anger and aggression upon family members and loved ones.

Andrew E. Slaby, **Ph.D., M.D., M.P.H.**, received his M.D. from Columbia University's College of Physicians and Surgeons and his M.P.H. and Ph.D. from Yale University. As both a psychiatrist and epidemiologist, Dr. Slaby has authored, coauthored, or edited over 25 books and over 100 articles, chapters, and book reviews, with an emphasis on crisis intervention and managing stress. Dr. Slaby has held numerous positions over the years, including: Director of the Primary Care-Emergency Psychiatric Service at the Yale-New Haven Hospital, Professor of Psychiatry at Brown University, and Psychiatrist-in-Chief of the Rhode Island Hospital. Currently he is Professor of Psychiatry at New York University and New York Medical College and in private practice in New Jersey and in New York City. Dr. Slaby is on the Board of the Samaritans of Rhode Island, the Albert Ellis Board of Trustees, and the National Board of the American Foundation of Suicide Prevention. He won the Janssen Award for outstanding contributions to the field of Emergency Psychiatry (1996) and is listed in *Best Doctors in America*.

Mary Russell, M.S., is a school psychology doctoral candidate at St. John's University and is currently a New York State certified school psychologist. She is also pursuing a predoctoral Fellowship at the Albert Ellis Institute where she works as a therapist with children and adolescents, parents, adults, and couples. In addition to her clinical work, she is actively involved in research and has presented at conferences including the Association for Behavioral and Cognitive Therapies, the Society for Research in Child Development, and the International Neuropsychological Society.

Mike Abrams, Ph.D., MBA, has been a practicing clinician for more than 25 years specializing in helping people with acute affective, personality, and sexual disorders. He is a Diplomate of the American Board of Professional Psychology with a specialty in Cognitive Behavior and Rational–Emotive Behavior Therapy. He is the coauthor of numerous works with Dr. Albert Ellis, including three books—one of which was Dr. Ellis's only college textbook. In addition, Dr. Abrams has produced various other psychology publications and is currently completing a textbook on human sexuality. He is a fellow and supervisor of the Albert Ellis Institute and is a fellow of the American Board of Cognitive and Behavior Psychology. He is on the graduate psychology faculty of both New York University and William Paterson University. Dr. Abrams has received commendations from the New Jersey governor, the Hudson County executive, and the Jersey City mayor for his volunteer work. His commitment to pro-bono service includes his being among the first psychologists to volunteer to help people with AIDS in the early 1980s.

David Stoop, Ph.D., is a licensed clinical psychologist in the State of California. He received his Master's in Theology from Fuller Theological Seminary and his

Ph.D. from the University of Southern California. He is the founder and director of The Center for Family Therapy in Newport Beach, California, where he has a counseling practice. He is the cohost of the national New Life Live radio program and is the author of 30 books, including *You Are What You Think.*

Paul Martin, B.A., is a psychologist who has been specializing in the area of sexual and gender diversity for over 25 years. He was voted as one of Australia's 25 Most Influential Gays and Lesbians in 2007 and 2010. Paul has appeared in several documentaries, written chapters for five books, and writes for and is regularly featured in mainstream and LGBTI media. He is a lecturer at Griffith University for Organizational Psychology Masters students, lectures for the University of Queensland School of Medicine on HIV and mental health, is the Director and Principal Psychologist of Centre for Human Potential in Brisbane, and the Political Liaison Officer for the Queensland Branch of the Australian Psychological Society. Dr. Martin develops and runs training programs for general practitioners, psychiatrists, psychologists, counselors, and social workers regarding same-sex attraction and gender diversity. He facilitates programs and consults with organizations to enable employees and managers to understand LGBTI populations in the workplace. He is actively engaged in lobbying for marriage equality in Australia.

Leonor Lega, Ph.D., is a Professor of Psychology at Saint Peter's College in New Jersey, a postdoctoral fellow of the Albert Ellis Institute, and an REBT International Supervisor in Latin America, Europe, and Australia. She is a cofounder of A.E.I. Colombia, Honorary First President of the Asociacion de Terapia Racional Emotiva Conductual, ATREC, in Spain, and author (with Albert Ellis) of several publications for professionals and the general public in Spanish, Portuguese, and Italian, including: *REBT in the New Millenium: A Cross-Cultural Approach*, and the textbook for REBT training in Spanish: *Teoria y Practica de la Terapia Racional Emotivo–Conductual.* She is the coauthor of *Albert Ellis: An Authorized Biography* and *50 Years of REBT*. Dr. Lega conducts trainings on REBT/CBT in Spain, Colombia, and Costa Rica.

Steve A. Johnson, Ph.D., Sc.D., is the founder of the Connecticut Center for RE/CBT, a therapist at the Center for Cognitive Therapy in Avon, Connecticut, and at the New England Center for Cognitive Behavior Therapy and Psychiatry in Glastonbury, CT. He is a Fellow, approved supervisor, and Diplomate of the Albert Ellis Institute. He is also an adjunct professor of psychology and Muslim studies at Columbia International University. His expertise is in addressing religious and spiritual issues as well as cross-cultural issues in therapy.

F. Michler Bishop, Ph.D., is Director of Alcohol and Substance Abuse Services at the Albert Ellis Institute in New York City, where he worked closely with Dr. Ellis in running groups and workshops. He is author of *Managing Addictions: Cognitive, Emotive and Behavioral Techniques* and, more recently, the chapter on alcohol abuse in the *Handbook of Assessment, Conceptualization, and Treatment*. Dr. Bishop is past president of the Division of Addictions of the New York State Psychological Association and the Addictive Behaviors Special Interest Group of

the Association for Behavioral and Cognitive Therapies. As national vice president of SMART Recovery® for over 20 years, he was instrumental in the development of SMART Recovery's Four-Point Program and SMART Recovery Therapy. He has conducted numerous workshops on Rational Emotive Behavior Therapy (REBT) and SMART Recovery in the United States and overseas, most recently in Ankara, Turkey, and Abeokuta, Nigeria. He has worked at the Albert Ellis Institute for over 20 years.

Mark D. Terjesen, Ph.D., is Associate Professor of Psychology at St. John's University and program director of the School Psychology (PsyD and MS) programs. He earned his Ph.D. in Clinical and School Psychology from Hofstra University. Dr. Terjesen has studied, published, and presented at a number of national and international conferences on topics that include matters related to REBT, the assessment and treatment of ADHD, professional school psychology issues, as well as cultural concerns. Dr. Terjesen has trained many professionals internationally in the use of cognitive behavioral practices with children and families. Dr. Terjesen has served as President of the School Division of the New York State Psychological Association (NYSPA) on three different occasions and also served as the President of the Trainers of School Psychologists (TSP), the largest national training organization for school psychology faculty members.

Robyn E. Kurasaki, PsyD., is a practicing school psychologist and an adjunct professor at Queens College in Flushing, New York. She completed a 2-year fellowship at the Albert Ellis Institute and holds a supervisory certificate in Rational–Emotive Behavior Therapy. Dr. Kurasaki has published and presented at a number of national and international conferences on REBT and clinical applications when working with children and parents in a school setting. She is actively involved in the leadership of the international division (52) of the American Psychological Association. Dr. Kurasaki's research interests include the application of Rational Emotive Behavior Therapy and social-emotional curriculums for school-aged children and their parents.

Kristene A. Doyle, Ph.D. Sc.D., is the Director of the Albert Ellis Institute (AEI), as well as Director of Clinical Services and a licensed Staff Psychologist at AEI. During her 14-year tenure at AEI, Dr. Doyle has held various leadership roles including Associate Executive Director, Training and Development Coordinator, and Director of Child and Family Services. She is also a Diplomate in Rational Emotive & Cognitive-Behavior Therapy (RE & CBT) and serves on the Diplomate Board. In addition to training and supervising AEI's fellows and staff therapists, Dr. Doyle has conducted numerous workshops and professional trainings throughout the world. In addition to her work at AEI, Dr. Doyle is appointed as Adjunct Associate Professor at St. John's University as well as external examiner for the MSc in Rational Emotive Behaviour Therapy at Goldsmiths, University of London. Dr. Doyle has published numerous book chapters and articles on applications of RE&CBT to various populations.

Dom DiMattia, Ed.D., is Professor Emeritus, The University of Bridgreport and former Executive Director of the Albert Ellis Institute. Dr. DiMattia, a Diplomate of the Albert Ellis Institute, is the originator of Rational Effectiveness Training, the application of RE-CBT to corporate and organizational training. He has published several books, chapters, and journal articles on RE&CBT topics and currently conducts intensive training programs in REBT and CBT with children and adolescents in Australia, spending 4 months a year there for the past 9 years. During his professional career he conducted hundreds of workshops in the United States, Australia, The Netherlands, Romania, Spain, Mexico, Columbia, Peru, and United Arab Emirates.

Michael Hickey, Ph.D. is Director of the Center for Psychological Evaluation and a licensed clinical psychologist at the Albert Ellis Institute (AEI). Dr. Hickey is a certified supervisor for AEI and has trained numerous students and mental health professionals in the method and application of Rational Emotive and Cognitive Behavior Therapy (RE&CBT). He has also conducted several public and professional workshops at AEI on a variety of topics ranging from eating and body image issues to empirically supported cognitive-behavioral treatment techniques. His clinical and research interests include the etiology and treatment of anxiety disorders, BDD, and other obsessive–compulsive spectrum disorders. He has published his work in scientific journals including the International Journal of Cognitive Therapy and has also presented his research at conventions of the American Psychological Association (APA) and the International Obsessive–Compulsive Disorder Foundation (IOCDF). Dr. Hickey has represented AEI on New York's PIX 11 Morning News, discussing how to overcome social anxiety.

Margaret (Peggy) Swarbrick, Ph.D. OTR, CPRP, is the Director of the Collaborative Support Programs of New Jersey Institute for Wellness and Recovery Initiatives. Additionally, she is a part-time assistant faculty in the Department of Psychiatric Rehabilitation and Counseling Professions at the University of Medicine and Dentistry of New Jersey School of Health Related Professions. Dr. Swarbrick worked many years as an occupational therapist in a variety of settings developing health promotion and wellness-focused services. She has 29 articles in peer-reviewed literature, 10 book chapters, and has contributed to over 18 other publications and manuscripts. She has presented nationally and internationally on the topics of wellness, employment, and peer-delivered service models. She earned a doctorate in Occupational Therapy from New York University and completed a postdoctoral fellowship in Advanced Training and Research, National Institute on Disability and Rehabilitation Research.

Acknowledgments

I would like to thank the 22 authors who contributed their time and expertise to the development of this book, which is intended for practitioners who work with couples. I also appreciate the Springer staff for their assistance in the editing and production of this publication, which should be of value to marriage and family therapists, mental health counselors, psychologists and psychiatrists, as well as students taking marriage and family coursework. A special thanks also to the authors' families for supporting their endeavors to contribute to the field of couples counseling from a cognitive behavioral perspective.

Contents

1 **Introduction to Counseling Couples** 1
James McMahon and Candice Siu Woo

2 **Using Mindfulness with Couples: Theory and Practice** 17
Monica O'Kelly and James Collard

3 **Helping Couples Dispel Myths and Self-Defeating Beliefs and Behaviors that Sabotage Relationships and Marriage** 33
Ann Vernon

4 **Helping Couples Deal with Relationship Ambivalence** 49
Richard Dowling, Siobhan O'Leary Evarts, and Ann Vernon

5 **Helping Couples Deal with Anger and Conflict** 65
Vanessa Woods

6 **Helping Couples Deal with Stress and Adversity** 81
Mary Russell and Andrew E. Slaby

7 **Helping Couples Deal with Intimacy and Sexuality** 97
Mike Abrams

8 **Helping Couples Deal with Betrayal and Affairs** 117
David Stoop

9 **Counseling Same-Sex Couples: Dispelling Myths and Understanding the Unique Challenges** 133
Paul Martin

10 **Helping Couples Deal with Cultural and Religious Diversity** 149
Leonor Lega and Steve A. Johnson

11 **Helping Couples Deal with Addictions** 169
F. Michler Bishop

12 Helping Couples Deal with Chronic Medical or Mental Illness of a Partner or Child 191
Robyn E. Kurasaki and Mark D. Terjesen

13 Helping Couples Deal with Terminal Illness 211
Kristene A. Doyle

14 Helping Couples Deal with Parenting and Grandparenting 225
Ann Vernon and Dom DiMattia

15 Helping Couples Deal with Aging 243
Michael Hickey, James McMahon, and Margaret Swarbrick

Name Index 263

Subject Index 271

Contributors

Mike Abrams New York University, New York, NY, USA
William Paterson University, Wayne, NJ, USA

F. Michler Bishop Director of Alcohol and Substance Abuse Services, Albert Ellis Institute, New York, NY, USA

James Collard Cognitive Behaviour Therapy Australia, Melbourne, Australia
Cairnmillar Institute, Melbourne, Australia

Dom DiMattia The Univeristy of Bridgeport, Bridgeport, CT, USA
The University of Northern Iowa, Tucson, AZ, USA

Richard Dowling The Thought Exchange, LLC Center for Personal Achievement, Morristown, NJ, USA

Kristene A. Doyle Director, Albert Ellis Institute, New York, NY, USA

Siobhan O'Leary Evarts Albertus Magnus College, New Haven, CT, USA

Michael Hickey Albert Ellis Institute, New York, NY, USA

Steve A. Johnson Center for Cognitive Therapy, Avon, CT, USA
Center for Cognitive Behavior Therapy and Psychiatry, Glastonbury, CT, USA

Robyn E. Kurasaki St. John's University, Queens, NY, USA

Leonor Lega Saint Peter's College, New York, NJ, USA

Paul Martin Australia Centre for Human Potential, Brisbane, QLD, Australia

James McMahon State University of Oradea, Oradea, Romania
Abert Ellis Institute, New York, NY, USA

Monica O'Kelly Cognitive Behaviour Therapy Australia, Melbourne, Australia

Australian Institute for Rational Emotive Behaviour Therapy, Melbourne, Australia

School of Psychology and Psychiatry, Monash University, Melbourne, Australia

Mary Russell St. John's University, New York, NY, USA

Andrew E. Slaby New York University and New York Medical College, New York, NY, USA

David Stoop The Center for Family Therapy, Newport Beach, CA, USA

Margaret Swarbrick Collaborative Support Programs, New Jersey Institute for Wellness and Recovery Initiatives, Freehold, NJ, USA

Mark D. Terjesen, Ph.D. St. John's University, Queens, NY, USA

Ann Vernon University of Northern Iowa, Cedar Falls, IA, USA

Albert Ellis Institute, New York, NY, USA

Candice Siu Woo Albert Ellis Institute, New York, NY, USA

Vanessa Woods Integrated Forensic Psychiatry Program, Royal Ottawa Mental Health Centre, Ottawa, ON, Canada

Chapter 1
Introduction to Counseling Couples

James McMahon and Candice Siu Woo

In a recent New York Times article entitled *Does Couples Therapy Work?* (March 2, 2012), Weil cited Richard Simon, editor of *The Psychotherapy Networker,* who noted that couples therapy is extremely challenging for therapists. Why is this so? For one, it is difficult to work on a couple's relationship when the conflicts have not been addressed and, over time, one or both members of the couple become emotionally disengaged from the relationship. Another challenge is that doing couples work is rather like walking a tightrope because each individual wants the therapist to take his or her side, which is a precarious position to be in. Another difficulty is that one partner might be having an affair, but that may not be revealed to the therapist, so efforts to work on the couple's relationship are compromised because one partner has a secret lover and is already half way out the door, so to speak. Furthermore, therapists working with couples sometimes feel as if they are referees, trying to get both partners to "play by the rules"—listening instead of yelling, working with facts versus accusations, and so forth.

The purpose of this chapter is to provide an overview of some cognitive behavioral theories that can address these challenges namely, Rational Emotive Behavior Therapy (REBT), Cognitive Therapy (CT), and Mindfulness-based approaches to couples therapy, highlighting their similarities and differences. Given that the divorce rate in United States remains high and is increasing significantly for couples in their 50s and 60s (Montgomery, 2012), it behooves practitioners to find effective approaches to working with couples. This is particularly relevant because despite the prevalence of divorce, the reality is that the remarriage rate for divorced persons,

J. McMahon, PsyD., Ph.D., Th.D., Sc.D (✉)
University of Oradea, Oradea, Romania

Abert Ellis Institute, New York, NY, USA
e-mail: bjpsymac@comcast.net

C.S. Woo, Ph.D
Albert Ellis Institute, New York, NY, USA
e-mail: candicesiu@gmail.com

A. Vernon (ed.), *Cognitive and Rational-Emotive Behavior Therapy with Couples: Theory and Practice*, DOI 10.1007/978-1-4614-5137-2_1,
© Springer Science+Business Media New York 2012

as well as widows and widowers, is quite high (Centers for Disease Control and Prevention, 2009), at least in the United States. This leads one to conclude that in this country, as well as in many others throughout the world, we are still a couple-oriented society. For many people, being part of a couple is preferable to living as a single person, although recent research on divorce among baby boomer couples suggests that a high percentage (66%) would prefer divorce to an unhappy marriage. This was not the prevalent opinion of younger Americans, however. And while being coupled may still be the preference for many couples, there are numerous challenges that result in conflict and would be amenable to couple counseling interventions.

Cognitive Behavioral Therapy: An Overview

As O'Kelly (2010) noted, Cognitive Behavior Therapy is an umbrella term that encompasses several therapies that share a common premise, which is that cognitions, not the environment or situations, trigger emotional and behavioral reactions. According to O'Kelly, Cognitive Behavior Therapy is "like a river" with many tributaries (p. 10), including classical and operant conditioning and learning theory, among other influences. She also noted that the growth of cognitive theory and therapy was referred to as the cognitive revolution, which began in part as dissatisfaction with the behavioral stimulus–response model increased, as well as the realization that other psychological theories were inadequate. Thus, during the 1950s and 1960s, Albert Ellis and Aaron T. Beck were at the forefront of the movement to revolutionize the field of psychotherapy. While there is little evidence that these two men collaborated regarding the development of their theories, according to O'Kelly (2010), they were in solid agreement about the significant role of cognitions in relationship to emotional disturbance.

"It has been difficult to determine when the two behavioural and cognitive tributaries combined to form the major cognitive behavior therapy river that they are today" (O'Kelly, 2010, p. 14), but it appears that Beck used the term cognitive behavior therapy in 1970, during which time Cognitive Therapy and Behavior Therapy were just beginning to make their presence known. Consequently, it was natural to combine the two terms, although according to O'Kelly's research, the term was not used as frequently as were the terms Cognitive Therapy, REBT, or Behavior Therapy until the late 1990s. Now, it appears that the term Cognitive Behavior Therapy is used more commonly than Cognitive Therapy or REBT, as reflected in the establishment of the World Congress of Behavioral and Cognitive Therapies and the professional publication called the Journal of Rational Emotive & Cognitive Behavior Therapy (Springer), which recognizes CBT as the umbrella term representing both theories, as well as others (O'Kelly, 2010): Multimodal Therapy (Lazarus), Self-Instruction Training (Meichenbaum), Dialectic Behavior Therapy (Linehan), Constructivism (Mahoney), Schema Focused Therapy (Young), Mindfulness (Kabat-Zinn), and Acceptance and Commitment Therapy (Hayes).

Cognitive-Based Theoretical Models of Couples Counseling

Experienced therapists would likely concur that when working with couples, it is not at all uncommon for one member of the partnership to be less motivated to participate in therapy than the other. Therefore, approaches that stress the involvement of both members of a couple, while salient, are not exclusive in cognitive behavioral theoretical approaches that emphasize individual as well as conjoint therapy whenever possible and desirable. Two widely known cognitive theories can be applied effectively with couples are REBT and Cognitive Therapy. More recently, Acceptance and Commitment Theory (ACT) and other Mindfulness-based therapies have been added to the mix.

Rational-Emotive Behavior Therapy

Albert Ellis, known as the grandfather of Cognitive Behavior Therapy and the father and founder of REBT (McMahon & Vernon, 2010), began his career as a sex, marital, and family counselor in the 1940s (Ellis & Dryden, 1997). His interest in sex and relationship issues dated back to the 1930s, when he read voraciously on the subject and began to offer help on these issues to anyone who would ask him for it—especially friends and relatives. He developed a program called LAMP, which was an acronym for *Love and Marriage Program,* but no publication or anything of significance resulted from it.

After he was awarded a doctorate in psychology from Teachers College, Columbia University, in 1947, Ellis maintained his substantial interest in sexology. While working at the sex offender program in New Jersey, he befriended Alfred Kinsey and later, Werdel Pomeroy, both noted sexologists. Ellis anticipated some innovations in the field, as well as research findings concerning amative issues (Ellis & Abarbanel, 1967). Specifically, he anticipated the idea of working directly with couples concerning matters of frigidity and erectile dysfunction. He proposed that if each person in the dyad was willing to become vulnerable and practice sexually prescribed behavior techniques, they would be capable of helping each other as a couple and individually to become sexually fulfilled.

Ellis' interest in couple relationships resulted in several publications, including *How to Live with a Neurotic* (1957), a "cookbook" intended for lay readers as well as professionals. There, Ellis described the term *neurotic* as stupid behavior by people who were not stupid. In this work he also radically departed from individual and couples psychoanalytic theory, proposing that it was not repressed memory that was associated with negative emotions such as depression and anxiety. He argued for false beliefs as the basis for these neurotic behaviors that could be disputed and changed to help achieve rationally based thinking, feeling, and behaving (McMahon & Vernon, 2010). Ellis proposed that by disputing a couple's irrational inferences

(i.e., conclusions reached from circumstantial rather than concrete evidence) about each other, he could help them change their irrational and maladaptive inferences and beliefs in order to develop cognitive flexibility, increased empathy, and, ultimately, acceptance of each other. In turn, the primary goal of couples therapy was to create an "us-" or "we-" focused relationship, as well as for couples to develop acceptance of the other person—that is, accepting him or her while not necessarily accepting his or her behavior.

Ellis went on to publish *The Art and Science of Love* (1960) and *Creative Marriage* (Ellis & Harper, 1961). This last book pioneered the role of cognition and behavior in working therapeutically with couples among all cognitive behavioral therapy approaches. Ellis and Harper (1961) argued that individuals often hold irrational and unrealistic expectations about a partner or the relationship. Specifically, individuals make irrational and unrealistic generalizations when partners and the relationship do not live up to their expectations or *demands*. In turn, these cognitions lead to negative emotions and maladaptive behaviors toward one's partner. Based on this theory, traditional REBT strategies can be applied to assist couples with relationship dissatisfaction.

For more than 25 years, Ellis was concerned with relationship issues specific to partners who lived together as well as those who were married. In *How to Live with a Neurotic* (1957), he proposed that if therapists were successful in changing one person's neurotic patterns, the effects probably would generalize and impact the couple and their relationship positively. The basic theory, intervention, and research regarding individuals and couples resulted 7 years later in the publication of Ellis's then magnum opus, *Reason and Emotion in Psychotherapy: A Comprehensive Method of Treating Human Disturbance* (1962).

At the end of the 1980s, Ellis, along with colleagues Joyce Sichel, Ray Yeager, Dominic DiMattia, and Ray DiGiuseppe (1989), published *Rational-Emotive Couples Therapy*, delineating the differences between couples therapy using REBT and other approaches such as systems theory, and behavior therapy. The unique feature of couple therapy using REBT was the emphasis on identifying and modifying irrational beliefs a couple held about each other. The goal was to unconditionally accept the partner while admitting that s/he had flaws in order to promote well-being among couples.

Cognitive Therapy

Cognitive Therapy is most closely associated with its founder and champion, Aaron T. Beck, M.D. While Beck served as the president of a psychoanalytic association, he began to examine cases of depression that he had treated, refuting the psychoanalytic theory that depression primarily and causally was anger directed against oneself. Instead, Beck proposed that depression seemed to consist of hopelessness (e.g., "there is no future for me"), helplessness (e.g., "not even God can help me"), and worthlessness (e.g., "I have no value as a person"). Distortions, then, included

generalization from the one to the many, a classical error in thinking often referred to as “all or nothing” or black and white thinking (Burns, 1980).

Beck then turned his attention to couples, discovering that they exhibited the same sorts of cognitive distortions as did his anxious and depressed clients. He claimed that in treating a substantial number of people who were in distressed marriages, it was very common for the troublesome relationship to result in depression and anxiety in one of the partners (Beck, 1988). Furthermore, he found that these clients tended to “fixate on what was wrong with their marriages and disregard—or blind themselves to—what was good” (Beck, 1988, p. 1). Indeed, Beck maintained that when conflicts occurred, couples blamed each other instead of looking at the issue as a problem to be solved. Consequently, the problems escalated and one or both partners began doubting the viability of the relationship.

Beck’s main contribution was that couple distress was associated with cognitive distortions that led to conflict (Beck, 1988). He proposed a cognitive therapy methodology to help couples avoid attributing cognitive distortions to partners and to the relationship, thereby improving communication. In 1988 he published *Love is Never Enough*, a practical book about how couples could resolve conflicts and enhance their relationship through cognitive therapy. In this publication, Beck debunked the myth that love alone is enough to sustain a relationship, and described cognitive principles which he proposed could help partners deal with unrealistic expectations, self-defeating attitudes, and illogical conclusions.

Cognitive Therapy with couples is similar to REBT in that it hypothesizes that couples and individuals hold cognitive distortions, as well as a tendency to emphasize negative aspects of the relationship or of the partner’s character or behavior, thereby overlooking positive attributes. The goal of CBT is to challenge these distortions that most likely contribute to relationship conflict or negative feelings such as unhappiness or anger. Beck further argued that couples benefitted from being educated about the dynamics of marriage and that it was possible to help couples in troublesome relationships by “correcting their misinterpretations, untying the knots that twisted their communication, and tuning up their abilities to see and hear their partners’ signals accurately” (Beck, 1988, p. 7).

REBT and CT for Individuals and Couples

Ellis first called his theory Rational Therapy, but he yielded to criticism that the term sounded more rationalistic or off-putting than was the case. He changed it to Rational-Emotive Therapy and later, recognizing the importance of the behavioral component, called it REBT in 1992 (Ellis, 1994). While many of the interventions in REBT and CT are similar, it could be argued that REBT is a top-down philosophy of psychotherapy and couples counseling grounded in *unconditional self-acceptance*, whereas CT is a bottom-up, exploratory method using Socratic dialogue in service of empiricism. In fact, both REBT and CT proceed similarly. However, CT does not address the philosophical issue of human worth, which is a foundation of

REBT—that each human being is worthy despite our fallibility (Neenan & Dryden, 2011). Further, REBT and CT differ in the *level* of cognitive distortion that is first disputed. For example, when individuals or couples present with distorted inferences such as "I will end up alone" or "I will not be able to survive this," CT therapists tend to focus on exploring and illuminating the empirical foundation of these inferences, which are called automatic thoughts in CT: "Where is the evidence you will end up alone or not be able to survive?" On the other hand, REBT therapists would address *irrational beliefs* (demands and evaluations) that may have contributed to irrationally based inferences for self and couple, challenging beliefs such as "How is being alone so horrible and awful?" or "How can you be worthless just because you cannot save your relationship?" These beliefs may underlie the above-mentioned inferences.

Further, Ellis argued for *unconditional acceptance of others* (UOA) and flexibility rather than absolutism (such as *must, should,* and *awful* statements), irrespective of the other person's behaviors. Beck, however, proposed flexibility in thinking but emphasized the validity of one's inferences about others rather than unconditionally accepting others. For example, when an individual complains about his or her partner's messy habits, Ellis would suggest that the individual accept the partner as a worthy human being with messy habits, whereas Beck would ask the individual to examine the truthfulness of his or her inference: "Is your partner *always* messy?" "Does your partner *never* do anything right?"

More recently, couples work within Cognitive Therapy has been influenced by Dattilio (2005), and Dattilio and Padesky (1990), who suggested that traditional directive strategies for modifying individuals' maladaptive schemas about their partners and the relationship may be overly linear. Specifically, directly challenging individuals' schemas may overlook the interactional patterns of couple communication or established roles between couples as proposed by systemic theories of couples therapy (Dattilio, 2005). In turn, modifications to traditional CT have been suggested to increase therapists' awareness of a couple's interaction patterns, as well as the therapist's role when employing interventions. Similarly, Baucom and Epstein (1990), contributed to the understanding and use of CT with couples through recognizing cognitive distortions and subsequent behavioral interactions that may create difficulties within a couple. In other words, they also focused on the transactional nature of couple's therapy in addition to traditional linear cognitive and behavioral factors that lead to relationship dissatisfaction or other negative outcomes.

Epstein, Baucom, and Rankin (1993) outlined a number of cognitive factors common in relationship disturbance: (1) selective attention—overemphasizing the negative aspects of a partner and overlooking the positives; (2) attribution—attributing negative behaviors to the partner's negative intent or personality traits; (3) expectancies—low expectancy of changes in the relationship or the couple; and (4) assumptions and standards—a discrepancy between the actual relationship and one's perceived standard of a relationship. Further, they discussed negative behaviors following the above-mentioned cognitive schemas that may lead to or exacerbate the relationship conflict. Finally, they offered couples concrete strategies for

recognizing cognitions and behavioral patterns that may lead to disagreement for different phases of conflict, such as before, during and the aftermath of the relationship conflict.

From an REBT perspective, despite its pioneering role in the development of couples therapy, the primary focus has been on disputing irrational beliefs that underlie relationship dissatisfaction, or maladaptive behaviors toward one's partner. The REBT therapist's main goal is to help each individual within the couple relationship to replace irrational beliefs with more flexible, rational beliefs in order to increase relationship satisfaction. For example, therapists would target irrationalities that interfered with *other-acceptance*, which is an important concept in that it helps each individual accept the other partner as a human being with unbounded worth, albeit with flaws and mistakes. REBT therapists would place little emphasis on the transactional nature of a couple's interaction. DiGiuseppe (1986) suggested incorporating systemic approaches to couples therapy by addressing how each partner's irrational beliefs and behaviors may initiate conflict within the couple.

Acceptance and Commitment Therapy with Individuals and Couples

ACT has been described by Steven Hayes (Hayes & Smith, 2005) as being part of the third wave of behavior therapy (behavior interventions and cognitive behavior interventions being the first two). This third wave of CBT interventions proposed alternative ways of dealing with maladaptive cognitions; instead of directly challenging or changing these cognitions, individuals are encouraged to adopt strategies such as mindfulness, acceptance, and cognitive defusion (Teasdale, 2003). Based on the theory that much of human learning and cognition is based on the interrelated functions of language and context, ACT proposes that psychopathology also stems from an overly rigid reliance on verbal processes or contextual rules (i.e., cognitive fusion; Hayes, Luoma, Bond, Masuda, & Lilis, 2006). Thus, cognitive flexibility in the service of leading a life in accordance with one's values is the overarching therapeutic goal of ACT. Specifically, one distinct departure of ACT from RE&CBT is the treatment of *distorted cognitions* or *inferences.* Rather than disputing or challenging these distortions, ACT proposed that individuals simply acknowledge the presence of these thoughts, accept them as thoughts one possesses, and avoid placing judgment or value on the validity of the thoughts. However, ACT is similar to RE&CBT in that it also focuses on behavioral change. It assists individuals and couples in identifying their values, and establishing steps toward cultivating these values (e.g., political, religious, economic, social, and theoretical values). According to Hayes et al. (2006), there are six core processes of ACT, of which the first four constitute mindfulness processes, and the final two, commitment and behavior change. The mindfulness processes are the following: (1) acceptance—being aware of and accepting cognitive processes or thoughts without attempting to change the content or form; (2) cognitive defusion—strategies for relating with cognitive

processes without changing their content, such as repeating the thoughts until only the sound remains, or watching the thoughts spelled out in words dispassionately; (3) being present—engaging with psychological or environmental events without passing judgment, such as observing the color of leaves or the temperature of the air; and (4) self as context—acceptance of self as a transcendent context rather than positive or negative labels and evaluations. The commitment processes are the following: (5) values—clarification of values in different life domains and (6) committed action—behavior changes. See Chap. 2 for a more thorough description of the first four processes related to mindfulness, with specific application with couples.

With regard to working with couples, there has yet to be research on the systematic application of ACT to couples. However, some researchers have made preliminary suggestions about how to implement ACT principles and strategies to help couples cope with stressors associated with relationship distress or dissatisfaction in conjoint therapy (Carson, Carson, Gil, & Baucom, 2006; Peterson, Elfert, Feingold, & Davidson, 2009). Specifically, couples are taught to use cognitive defusion to accept without changing negative cognitions relating to one's partner and the relationship. Mindfulness and acceptance techniques are recommended to help individuals recognize their reactions that may perpetuate negative interactions between the couple. Individuals are then asked to use the commitment and behavior strategies to try and foster a more satisfying relationship according to their relationship values, in spite of interfering cognitions. Peterson and colleagues (2008) provided evidence from a single case-study design that ACT may be effective in both increasing marital satisfaction and in reducing personal or interpersonal distress in couples. Thus, ACT seems to be applicable to couples therapy in conjoint sessions, using a format similar to RE&CBT. The major difference appears to be the ways in which individuals cope with maladaptive cognitions relating to their partners and the relationship.

Mindfulness-Based Stress Reduction for Couples

Mindfulness-Based Stress Reduction (MBSR) is also part of the third wave of behavioral therapy, pioneered by Kabat-Zinn in the 1980s (Kabat-Zinn, 1994) to help individuals with medical and psychological difficulties. Similar to ACT, Mindfulness emphasizes attending to the present purposefully, without judgment, and without changing the content or form of the experience of cognitions (Kabat-Zinn, 2009). Mindfulness is applied in a similar way to help people cope with maladaptive cognitions such that individuals are dissuaded from directly challenging or changing negative thoughts, as one would in RE&CBT. MBRS assists distressed couples by increasing their individual abilities to cope with stress in life and stress related to their relationship. Techniques may include breathing exercises or body scans or walking meditations which primarily attempt to increase one's awareness of the present moment and to adopt an open, noncritical attitude (Kabat-Zinn, 2009). In terms of working with non-distressed couples to enrich their relationship, MBRS has specific techniques which are outlined in the O'Kelly and Collard chapter of this book.

Couples Education

In view of the lack of success of couples therapy to head off divorce, several organizations have been established in the United States to promote marital longevity and to decrease divorce rates through providing education and strategies for couples to stay together. Although only one of these programs is specifically based on cognitive principles, the concept of couples' education has merit, and the authors of this chapter recommend that cognitive-based education programs be developed to help couples improve their relationships.

Marriage Savers

Marriage Savers is a nonprofessional mentor program for couples which works through houses of worship, and there are now organized groups in over 200 American cities (McManus & McManus, 2008). Mentor couples are trained to meet with couples in all stages of the relationship, including engaged or premarriage couples, to provide information and encouragement about staying in a marriage. Specifically, Marriage Savers stresses four principles for premarriage intervention: (1) that the individuals agree not to live together even if they had previously lived together; (2) that they agree to take a marriage survey; (3) that they agree to meet with a mentor couple to review survey results; and (4) that the mentor couples have both marriage longevity and quality (i.e., enjoy being married). Further, mentors do not characterize themselves as experts; instead, they reflect what is said to them, listen carefully, tie together what has been said previously, and ask couples if what they are doing is helping them to meet stay-together goals.

Results from the first group of over 20 diverse houses of worship in Modesto, California, in the late 1980s showed that the divorce rate dropped from 5 of 10 new marriages to 2 of 10 new marriages. Those data were studied and the model has been replicated in over 200 North American cities with some showing similarly high results compared to the national divorce rate as studied by the Barna Group (the Christian evangelical equivalent of Gallup). The key to Marriage Savers success, a vibrant ongoing program, seems to be the role of mentor couples as interventionists (http://www.marriagesavers.org/sitems/Resources/index.htm). A larger and more recent study evaluating the long-term effectiveness of strengthening marriages within houses of worship using a similar model evidenced a slight decrease in divorce rate among 122 sites (Birch, Weed, & Olsen, 2004). It was interesting to note that during the process of reviewing the results of standardized assessments measuring couples' strengths and areas of growth on the Focus Pre-Marriage Inventory (Madison, 2008), the ReFocus Marriage Enrichment Inventory (Madison, 2008), or the Prepare-Enrich Inventory (Olson, Larson, & Olson, 2009) 10% of the couples ended their relationship—perhaps to spare themselves the misery of a divorce or general unhappiness later (McManus & McManus, 2008). Marriage Savers uses these assessments to help couples clarify and reduce the differences in values in order to facilitate communication.

Smart Marriages

Smart Marriages is an umbrella organization for marriage education founded by Diane Sollee (www.smartmarriages.com). It sponsored annual national meetings for about 10 years and presented featured workshops on topics such as dealing with divorce, planning for first and second marriages, dealing with affairs, recovering from the death of a spouse, or planning a great date, among other topics. Based on empirical evidence, Smart Marriages offers skills and information to couples to maintain a relationship, including information on couples communication patterns and conflict management (Smart Marriages, 2011). As part of Smart Marriages, marriage and couples educators are trained to offer skills-based courses in accessible locations, such as community centers, congregations, or military bases. The courses provide information on the benefits of marriage, commonly experienced stages and challenges in marriage, and skills and behaviors for maintaining a healthy relationship. It now offers course work for people living together, either in premarriage, post-marriage, or exploratory relationships.

MATES Foundation

One of the chapter writers (McMahon) founded a nonprofit organization in 1992 called MATES Foundation, an acronym for Marriage Assistance through Educational Seminars. The goal of the organization was to work through other organizations such as nonprofit mental health agencies, welfare boards, churches, and hospitals to provide an alternative to counseling with individuals or couples. MATES uses educational principles to enhance relationships. It also incorporates RE&CBT principles, especially related to helping couples get past discomfort anxiety and lack of *unconditional acceptance* of partners. The program also helps couples identify the positive attributes of the relationship and what attracted them to the relationship in the first place. The goal is to teach couples how to "calm the waters" by *unconditionally accepting* the partner as a fallible individual who makes mistakes. Further, couples receive guidance about how to set realistic goals and identify what factors block these goals, how to increase their self-awareness, how to identify what works for them, and how to plan time together without interference. In addition, MATES incorporates ideas from Gottman (as described in the following section), Stosny (2006; i.e., identifying the core values of the couple), and O'Hanlon and Harley (1995; i.e., solution-focused approaches such as how to set goals rather than ruminating about what the couple or the partner is not able to achieve or provide). Participants are also directed to a wealth of resources such as those available on the Smart Marriages Web site. This approach also emphasizes the importance of spending quality time together as a couple without interruption and also among other married couples, as in the concept of *birds of a feather flock together* (Lyngstad, 2011; McMahon & McManus, 2004).

Marriage Counseling Revisited

John Gottman, a clinical psychologist who cofounded the Relationship Research Institute at the University of Washington, proposed an entirely different approach toward working with marriage as a system. About 25 years ago he established the "Love Lab" at the University of Washington in Seattle. Today, Gottman has his own institute where he has tracked over 600 couples for more than 20 years. His work has stimulated research and, in addition to popular books on best-seller lists, he has written a text on marriage statistical data (Gottman, Murray, Swanson, Tyson, & Swanson, 2005). Most recently, the Gottman Institute has been offering webinar presentations, which draw large number of interested professionals in various stages of training and credentialing.

In addition to clinical textbooks, Gottman's work has focused on describing his sound couples house (metaphor for a relationship with a basement, floors, and attic), and on repair bids, a concept for repairing a relationship, such as giving the person a cup of coffee or a hug even during an argument (see table below). In line with the sound couples house, foundational issues include knowing a great deal about the other person (best friend in childhood, favorite movies, color of eyes, shoe size, for example), respecting the person, turning toward the person, repair bids, not killing the other person's dreams, and creating a reality called marriage or long-term, happy, and productive relationship by being coupled. Interventions are based upon data collected from couples observed in the Love Lab, tallying information from observations of these couples, interviews, outcome of the relationship, and formulations for applications. Gottman's research has allowed him to predict within 15 min, from the beginning of an interview, which couples would divorce, and his predictions reach 94% accuracy (Gottman & Silver, 1999). Longevity data also demonstrate that the interventions he proposes head off divorce at about the same levels as Marriage Savers—the latter uses ideographic couples as their own baseline approach compared to Gottman's nomothetics. Some salient factors from Gottman's work that predict success for couples include those listed in the table below (Gottman & De Claire, 2001):

Managing the four Horsemen:			
Criticism	Contempt	Defensiveness	Stonewalling
Turning toward			
Facing the other spouse even during disagreement			
Learning that couples generally agree only about 32% of the time:			
Learning how to emphasize agreements by negotiating the other 68% of the time on a case-by-case basis if possible			
One spouse not killing a disagreement dream and letting it be aired from time to time			
Good relationships see repair bids:			
Spontaneous touches, giving coffee, helping, overcoming by doing, kiss or hug without sexual intent			
22:1-for every negative behavior there are in a good relationship 22 positive: even on a bad day the repair bid rate is positive 5:1			
Shared meaning can be those intimacies (what I will tell you and nobody else):			
Favorite meals	Favorite places	Important dates that only the couple know	Rising above self to create an "us"

McMahon and Viterito (2007) described the overlap between REBT concepts and Gottman's 4 Horsemen: criticism, contempt, defensiveness, and stonewalling. According to McMahon and Viterito (2007), criticism was blame of self or another, contempt was trying to devalue or generalize the negative worth of self or another person, defensiveness involved irrationalities that confused who a person was with what she or he did, and stonewalling was described as avoidant behavior. These authors posited that the most serious of these as a predictor of divorce was contempt because it meant much more than lack of fondness and admiration: it was the basis for treating a spouse with disgust and derision, as if he or she was nonexistent.

The Present Status of RE&CBT with Couples

Several past and current chapters and articles from the RE&CBT and related literature describe how couples can enhance their quality of life together (Beck, 1988, 2011; Carson et al., 2004; Ellis & Dryden, 1997; Gottman et al., 2005). One might infer that improving quality of life leads to happiness that may result in increased marital or couple satisfaction through increased flexibility and acceptance of one's partner or relationship while decreasing misunderstanding through disputing irrational beliefs. However, the authors of this chapter are unaware of any serious studies that contradict the findings of Jacobson and Addis as cited by Gottman (Gottman & Gottman, 2006), who showed that 2 years after intensive twice-weekly couples therapy, only 11–14% of the treated couples remained married. With that in mind, plus quality of life issues, the role of RE&CBT interventions in couple's therapy can be very powerful. We suggest that serious efforts be undertaken to examine Gottman's theory, findings, and strategies within the architecture of RE&CBT in order to learn where RE&CBT can strengthen its own couples theory and intervention or amalgamate it with Gottman's effective strategies. For example, RE&CBT could develop a training program for mentor couples in a look-alike program or within the Marriage Savers model, working with a broader clientele which might include people living together for a long term, as well as gay couples. And, if divorce or relationship dissolution is the most appropriate option for a couple, they could be better able to learn to manage that outcome rationally without anger and retaliation by utilizing RE&CBT principles, as well as ACT and Mindfulness interventions.

Conclusion

It appears that REBT, CT, ACT, and MBRS each offers important theoretical and clinical insight into relationship discontent and possible repair or improvement, through strategies for managing couples' distorted cognitions about their partners and the relationship. More specifically, CT couples counseling involves challenging

maladaptive cognitions about each other and the relationship. In a similar but distinct way, REBT approaches couples therapy by helping individuals unconditionally accept their partners and the relationship as worthy, although flawed in varying degrees.

According to the third wave behavior therapies, ACT proposes an acceptance-based strategy for relating to negative cognitions about one's partner or the relationship and suggests behavioral interventions that result in improving an intimate relationship in accordance with one's relationship values. MBRS approaches couples therapy by assisting couples to accept and not place judgments on the negative conditions about one's partner and the relationship, as well as negative cognitions about daily life. While these theoretical frameworks appear to have minimal impact on couples' tendency to head off divorce (Gottman & Gottman, 2006), they may provide targeted and powerful ways to improve quality of life and happiness. Therefore, research on the effectiveness of incorporating RE&CBT couples counseling seems reasonable given the effectiveness of these approaches in reducing stress, anxiety, and depression which obviously impacts relationships. Using CT, REBT, ACT, and MBRS with couple peers (mentors who are happy and enjoy life together) would seem to be another possibility for an amalgamation of marriage counseling and marriage education.

References

Baucom, D. H., & Epstein, N. (1990). *Cognitive-behavioral marital therapy*. New York: Brunner/Mazel.

Beck, A. T. (1988). *Love is never enough*. New York: Harper & Row.

Beck, J. S. (2011). *Cognitive behavior therapy: Basics and beyond*. New York: The Guilford Press.

Burns, D. D. (1980). *Feeling good: The new mood therapy*. New York: Avon Books.

Birch, P. J., Weed, S. E., & Olsen, J. (2004). Assessing the impact of community marriage policies on county divorce rates. *Family Relations, 53*, 495–503.

Carson, J. W., Carson, K. M., Gil, K. M., & Baucom, D. H. (2004). Mindfulness-based relationship enhancement. *Behavior Therapy, 35*, 471–494.

Centers for Disease Control and Prevention (2009). *National Marriage and Divorce Rate Trends.* Retrieved from http://www.cdc.gov/nchs/nvss/marriage_divorce_tables.htm

Dattilio, F. M. (2005). The critical component of cognitive restructuring in couples therapy: A case study. *Australian and New Zealand Journal of Family Therapy, 26*, 73–78.

Dattilio, F. M., & Padesky, C. A. (1990). *Cognitive therapy with couples*. Sarasota, FL: Professional Resource Exchange.

DiGiuseppe, R. (1986). A rational-emotive theory of marital dysfunction and marital therapy. *Journal of Rational-Emotive Therapy, 4*, 22–37.

Ellis, A. (1957). *How to live with a neurotic*. Oxford, England: Crown Publishers.

Ellis, A. (1962). *Reason and emotion in psychotherapy: A comprehensive method of treating human disturbances*. New York: Lyle Stuart Co.

Ellis, A. (1994). *Reason and emotion in psychotherapy, revised and updated*. Seacaucus, NJ: Carol Publishing Group.

Ellis, A., & Abarbanel, A. (1967). *The encyclopedia of sexual behavior*. New York: Hawthorn.

Ellis, A., & Dryden, W. (1997). *The practice of rational emotive behavior therapy*. New York: Springer Publication Company.

Ellis, A., & Harper, R. A. (1961). *Creative marriage*. New York: Lyle Stuart Co.

Ellis, A., Sichelm, J. L., Yeager, R. J., DiMattia, D. J., & DiGiuseppe, R. (1989). *Rational- emotive couples therapy*. Elmsford, NY: Pergamon Press.

Epstein, N., Baucom, D. H., & Rankin, L. A. (1993). Treatment of marital conflict: A cognitive-behavioral approach. *Clinical Psychology Review, 13*, 45–57.

Gottman, J. M., Murray, J. D., Swanson, C., Tyson, R., & Swanson, K. R. (2005). *The mathematics of marriage*. Boston: The MIT Press.

Gottman, J. M., & De Claire, J. (2001). *The relationship cure*. New York: Three Rivers Press.

Gottman, J. M., & Gottman, J. S. (2006). *Ten lessons to transform your marriage: America's love lab experts share their strategies for strengthening your relationship*. New York: Three Rivers Press.

Gottman, J. M., & Silver, N. (1999). *The seven principles for making marriage work*. New York: Three Rivers Press.

Hayes, S. C., & Smith, S. (2005). *Get out of your mind and into your life: The new acceptance and commitment therapy*. Oakland, CA: Raincoast Books.

Hayes, S. C., Luoma, J. B., Bond, F. W., Masuda, A., & Lilis, J. (2006). Acceptance and commitment therapy: Model, processes, and outcome. *Behaviour Therapy, 44*, 1–25.

Kabat-Zinn, J. (1994). *Wherever you go, there you are*. New York: Hyperion.

Kabat-Zinn, J. (2009). Full catastrophe living: Using the wisdom of your body and mind to face stress, pain, and illness (15th anniversary ed.) (15th ed.). New York, NY US: Delta Trade Paperback/Bantam Dell.

Lyngstad, T. H. (2011). Does community context have an important impact on divorce risk? A fixed-effects study of twenty Norwegian first-marriage cohorts. *European Journal of Population, 27*, 57–77. doi:10.1007/s10680-010-9226-6.

Madison, L. (2008). *Foccus Inc. USA*. Retrieved from http://www.foccusinc.com/contact.aspx

McMahon, J., & McManus, M. (2004). The Marriage Savers Movement. *Christian Counseling Today, 12*, 66–69.

McMahon, J., & Vernon, A. (2010). *Albert Ellis—Evolution of a revolution*. Fort Lee, NJ: Barricade Books, Inc.

McMahon, J., & Viterito, J. (2007). LAMP unto our feet: The light of Albert Ellis shines in the work of John Gottman. In E. Velten (Ed.), *Under the influence: Reflections of Albert Ellis in the work of others* (pp. 97–110). Tucson, AZ: Sea Sharp Press.

McManus, M., & McManus, H. (2008). *Living together: Myths, risks, & answers*. New York: Howard Books.

Montgomery, R. *Generation EX: Boomer couples are divorcing at a record rate*. Retrieved March 31, 2012. www.kansascity.com

Neenan, M., & Dryden, W. (2011). *Rational Emotive Behaviour Therapy in a nutshell* (2nd ed.). London: Sage.

O'Hanlon, W., & Harley, W. F. (1995). *Love is a verb: Stop analyzing your relationship and start making it great*. New York: Norton.

O'Kelly, M. (2010). *CBT in action: A practitioner's toolkit*. Melbourne, AU: CBT Australia.

Olson, D. H., Larson, P. J., & Olson, A. K. (2009). *PREPARE/ENRICH program: customized version*. Minneapolis, MN: Life Innovations, Inc.

Peterson, B. D., Elfert, G. H., Feingold, T., & Davidson, S. (2009). Using acceptance and commitment therapy to treat distressed couples: A case study with two couples. *Cognitive and Behavioral Practice, 16*, 430–442.

Smart Marriages. (2011). Retrieved December 4, 2011 from: http://www.smartmarriages.com/diane.sollee.html

Stosny, S. (2006). *Love without hurt: Turn your resentful, angry or emotionally abusive relationship into a compassionate, loving one*. New York: Free Press.

Teasdale, J.T. (2003). Mindfulness and the third wave of cognitive-behavioural therapies. Paper presented at the *European Association for behavioural and cognitive therapies annual congress*, Prague, Czech Republic.

Weil, E. (2012). Does couples therapy work? Retrieved from http://www.nytimes.com/2012/03/04/fashion/couples-therapists-confront-the-stresses-of-their-field.html?_r=1&adxnnl=1&pagewanted=all&adxnnlx=1334687636-mBIyDLjWjHryzTWFTBDFnQ

Chapter 2
Using Mindfulness with Couples: Theory and Practice

Monica O'Kelly and James Collard

As a concept, mindfulness is common to a range of Eastern and Western religions and philosophical traditions. It is a mode of being that appears central to the human experience, as it is fundamentally rooted in conscious attention and awareness (Brown, Ryan, & Creswell, 2007). The influence of mindfulness on the practice of psychology in recent years, however, has been predominantly influenced by Buddhist traditions. In this form it has experienced increasing interest over the past 30 years, due largely to the efforts of Jon Kabat-Zinn who pioneered a Mindfulness-Based Stress Reduction (MBSR) program for medical and psychological patients in the early 1980s (Kabat-Zinn, 2009).

The practice of mindfulness, as described by Kabat-Zinn (1994), is "paying attention in a particular way: on purpose, in the present moment, and non-judgementally" (p. 4). As suggested by this description, mindfulness relies on an awareness of the present moment and an open, noncritical attitude. In attempting to facilitate the transition of mindfulness into the practice of empirical studies of psychology and medicine, Shapiro and Carlson (2009) recently posited three fundamental components of mindfulness practice: *intention*, *attention*, and *attitude*. For *intention*, it is important that one is clear about their reasons for practicing mindfulness and that such reasons are based upon functional values. Consequently, motivation and pragmatic goals are of importance. *Attention* involves the direct observation

M. O'Kelly, Ph.D. (✉)
Cognitive Behaviour Therapy Australia, Melbourne, Australia

Australian Institute for Rational Emotive Behaviour Therapy, Melbourne, Australia

School of Psychology and Psychiatry, Monash University, Melbourne, Australia
e-mail: mokc@starnet.com.au

J. Collard, D.Psych.
Cognitive Behaviour Therapy Australia, Melbourne, Australia

Cairnmillar Institute, Melbourne, Australia
e-mail: jjcol01@hotmail.com

A. Vernon (ed.), *Cognitive and Rational-Emotive Behavior Therapy with Couples: Theory and Practice*, DOI 10.1007/978-1-4614-5137-2_2,
© Springer Science+Business Media New York 2012

of each moment and what happens in it. As noted by others (Barnes, Brown, Krusemark, Campbell, & Rogge, 2007; Brown et al., 2007), this is for both internal and external occurrences and has a present focus that encompasses the ability to disengage from thoughts about the past and the future. *Attitude* refers to how the individual pays attention. It is critical that mindfulness is practiced with an "open-hearted compassionate" quality featuring nonjudgmental acceptance for all that is brought into awareness.

The mindful way of being is therefore suggested to reduce one's tendency to respond on automatic processes in which one's sensations, perceptions, actions, and emotions, and those of others, pass by without conscious awareness (Langer, 2009). Such automatic processes have otherwise been labeled mindlessness (Brown & Ryan, 2003).

Another key feature of mindful living includes a flexibility of awareness and attention (Brown et al., 2007). This flexibility of attention is voluntary and fluid, enabling one to move out of particular states of mind to gain a larger perspective on situations, while also allowing one to focus in on situational details. Mindfulness also stresses an empirical stance towards reality (Brown et al., 2007). It seeks an objective observational perspective that helps one to gather all information about the experience of each moment.

Unsurprisingly, the benefits of mindfulness have been suggested to help enhance the quality of life in general and romantic relationships. For example, Kabat-Zinn (2009) theorized that mindfulness leads people to approach stressful events as a challenge, rather than as a threat, which would ameliorate the impact of stress upon relationships. It has further been suggested that mindfulness may promote a greater connectedness and closeness in relationships. Research investigating these claims has been initially promising, but is still quite new.

Cultivating Mindfulness

The ability to be mindful, as stated previously, is an inherent capacity of all humans. Its development is thought to be influenced by genetics and environmental factors, as reviewed by Brown and colleagues (2007). The influence of environmental factors can have either a positive or negative impact on the development of one's capacity to act mindfully, depending on the nature of the event. Similarly, it is thought that the capacity for mindfulness can be enhanced through training, just like any other skill. Simply put, mindfulness reflects the individual's skill at staying present in the moment and maintaining a nonjudgemental awareness of internal and external events.

Cultivating mindfulness involves practicing intentional attending to the present with an open, accepting and discerning attitude. Exercises to practice mindfulness can be categorized into formal and informal types (Shapiro & Carlson, 2009). While the recent interest in mindfulness emerged from the study of Buddhist traditions, the practice of mindfulness is not based on any particular religious or spiritual beliefs. Instead, it is cultivated by purposefully paying attention to things we ordinarily

never give a moment's thought to (Kabat-Zinn, 2009). As Kabat-Zinn (2009) stated, "Mindfulness is basically just a particular way of paying attention. It is a way of looking deeply into oneself in the spirit of self-inquiry and self-understanding. For this reason it can be learned and practiced (p. 12)."

Formal exercises designed to help practice mindfulness, and perhaps the best known, are meditative exercises. These include sitting meditation, body scan meditation, and walking meditation. The practice of such meditations can be relatively brief, but they can also be practiced in a more intensive manner for extended durations. This is often the case in retreats where mindful meditative exercises can be practiced for hours or even days.

The informal practice of mindfulness involves the application of mindfulness skills in everyday life. It is practicing and maintaining a mindful state of being, such as being open, accepting, attentive, and nonjudgmental, relative to whatever one is doing. For example, people can practice mindful eating, mindful driving, or even mindful reading. Shapiro and Carlson (2009) suggested that this informal practice helps generalize to everyday life the skill for mindfulness that is developed through formal practice.

It has been shown that mindfulness practitioners score higher in terms of trait mindfulness, as measured by the *Mindfulness Attention and Awareness Scale* (MAAS; Brown & Ryan, 2003). This provides support for the notion that mindfulness can be developed through deliberate behavior. However, while the benefits of practicing mindfulness, particularly as detailed by MBSR have now been well established according to Baer (2003), Brown and colleagues (2007), Grossman, Niemann, Schmidt, and Walach (2004), the direct mechanisms that lead to these benefits are not well understood. Nor do we know the optimal ways for cultivating mindfulness. Baer (2003) has suggested that mindfulness interventions could work through a number of mechanisms including exposure, cognitive change/restructuring (especially at a metacognitive level), self-management for coping with stressors, and through activation of the relaxation response.

Treatments utilizing formal practice of mindfulness have been conducted in many forms. In its original form MBSR was designed as an 8-week program (Kabat-Zinn, 2009). Others, however, have developed alternative meditative programs for developing mindfulness of longer durations. For instance, Tanner et al. (2009) designed a 3-month Transcendental Meditation program. From this they reported that participants demonstrated significant increases in mindfulness over the period of the program, as compared to a waitlist control. Whether individuals require such periods of training is questionable, however, as others have demonstrated that individuals can demonstrate increasing treatment effects from mindfulness programs even after treatment has been discontinued (Shapiro, Oman, Thoresen, Plante, & Flinders, 2008). Furthermore, it has recently been shown that a number of meditative practices, influenced by both Eastern and Western traditions can help to cultivate mindfulness (Shapiro et al., 2008).

Similarly, it is unclear as to what degree individuals need to practice mindfulness-based meditations to achieve benefit. While some research has indicated that there may be a dose response (Carson, Carson, Gil, & Baucom, 2004), others have found that the there is no relationship between the amount of formal practice and

reported levels of mindfulness (Brown & Ryan, 2003). Moreover, mindfulness has been integrated into a number of other psychological treatment programs, such as Dialectical Behavior Therapy (DBT) (Linehan, 1993), Mindfulness-Based Cognitive Therapy (MCT) (Segal, Williams, & Teasdale, 2002), Acceptance and Commitment Therapy (ACT) (Hayes, Strosahl, & Wilson, 1999), and Metacognitive Therapy (Wells, 2009). In a number of these mindfulness is not necessarily taught through meditation. For example, in both DBT and Metacognitive Therapy, mindfulness is instead taught as a variety of skills.

Benefits of Mindfulness for the Individual

While the mechanisms for change induced by mindfulness are not yet well understood (Carmody, Baer, Lykins, & Olendzki, 2009; Chiesa & Serretti, 2009), research over the past few decades have consistently supported its use in enhancing psychological well-being for individuals. These benefits have been observed for a range of populations including medical patients and those with psychological disorders, in addition to nonclinical populations. Mindfulness has been associated with improvements in a range of psychological constructs, both in terms of reducing negative and enhancing positive functioning.

There have now been a number of meta-analytic reviews demonstrating the effectiveness of mindfulness for reducing psychological stress, particularly in the forms of depression and anxiety (Baer, 2003; Bohlmeijer, Prenger, Taal, & Cuijpers, 2010; Grossman et al., 2004; Hofmann, Sawyer, Witt, & Oh, 2010). In general, these reviews have found moderate effect sizes for pre- and post-intervention measures of depression and anxiety symptoms. For example, Grossman et al. (2004) both found through meta-analytic studies that mindfulness interventions resulted in average effect sizes of approximately 0.5 across a range of physical and psychological conditions. The reported effect sizes in these studies ranged between 0.30 and 0.92. For Axis I psychological disorders the reported effect sizes have often been stronger (Baer, 2003; Hofmann et al., 2010). An exception to this was a review conducted by Bohlmeijer et al. (2010) who found the average effect sizes to be weaker when restricting their sample to more tightly controlled studies. For instance, mindfulness interventions for anxiety were found to have an average effect size of 0.24 and for depression an average effect size of 0.26. Their research was restricted to benefits of mindfulness to individuals with chronic medical diseases, however. It may also have been influenced by a ceiling effect whereby participant's room for improvement may have been limited by low pretest reports of depression and anxiety. Effect sizes for changes to specific anxiety and depressive symptomatology have not generally been studied to date.

Furthermore, mindfulness has been found to have a negative relationship to aggressive behavior. In research conducted by Heppner and colleagues (2008) it was found that individuals who demonstrated a higher disposition for mindfulness self-reported lower levels of aggression and hostile attribution styles. They also

found that in an experimental setting those who went through a mindful induction (mindful eating, exercise) reported lower levels of aggression when given rejection feedback, as compared to those who did not receive the mindfulness intervention.

The proposed mechanisms for changes arising from cultivating mindfulness are still largely based on qualitative reports at this point in time. However, in several studies, other constructs related to psychological stress have been demonstrated to have an inverse relationship to mindfulness. For example, Brown et al. (2007) found that mindfulness was negatively associated with neuroticism and with negative affect. It has also been associated with reduced engagement in ruminative thinking processes (Chiesa & Serretti, 2009). On a neurological level, an fMRI study conducted by Creswell, Way, Eisenberger, and Lieberman (2007) found that higher levels of mindfulness have been associated with greater activity in the prefrontal cortex and reduced bilateral amygdala activity. This is possibly a result of cognitive reappraisal resulting from mindfulness and is consistent with previous research which has shown that such patterns of neurological functioning are associated with better emotional regulation (Ochsner, Bunge, Gross, & Gabrieli, 2002).

In addition to ameliorating detrimental influences to psychological health, mindfulness has been suggested to enhance positive aspects of mental health. For instance, Brown and Ryan (2003) found that mindfulness could enhance positive affect, independent from its influence on reducing negative affect, and that it is positively related to extroversion and autonomy in day-to-day activities. They also found that mindfulness, volitional regulation of behavior, and hedonic experience were interconnected. Adding to these findings, Chiesa and Serretti (2009) have shown that mindfulness promotes empathy and self-compassion.

Benefits of Mindfulness for Couples

There has been limited research focusing on the application of mindfulness to relationships. Mindfulness and the exercises designed to promote it have typically been individual activities, yet recent advances have explored the impact of this individual activity on the intimate relationship between a couple. In addition, more interactive meditative practices have been developed.

Relationships that stand the test of time need to deal with stressors that invariably occur across the lifespan of a relationship. However, stress has not been as widely studied as other factors that contribute to relationship dissatisfaction (Carson, Carson, Gil, & Baucom, 2006). Given that a meta-analysis of 115 longitudinal studies clearly showed that a couples' ability to cope with stress enhanced the relationship (Karney & Bradbury, 1995), this is an area that is worthy of attention. For some time, researchers in the field have been suggesting that enhancing the emotional functioning and stress management of individuals in a relationship is advantageous in the belief that healthy individual functioning is important for successful relationships (Halford, Sanders, & Behrens, 1994). This knowledge has been the impetus for the use of mindfulness with couples to enhance their individual and relationship well-being.

Empirical Support

Research studies that explore the relationship between mindfulness and relationship measures fall into two categories: those that consider mindfulness as a personality trait which measure mindfulness at a set point in time and those that study change as a result of mindfulness-based intervention programs. Results from both approaches indicate a positive relationship between mindfulness measures and measures of relationship satisfaction.

Mindfulness as a Personality Trait

Studies exploring the relationship between trait mindfulness and relationship satisfaction have largely focused on the psychological functioning of individuals and couples who are not presenting with relationship problems. In a study investigating the relationship between mindfulness and marital satisfaction, the results indicated a stronger relationship between mindfulness and marital satisfaction than for other variables (Burpee & Langer, 2005).

Other studies exploring mindfulness in intimate relationships have in general terms conceptualized mindfulness as present-centered awareness. In a study of 33 married couples exploring the relationship between mindfulness, marital quality, and emotional repertoire, an association was found between mindfulness and a measure of marital adjustment (Wachs & Cordova, 2007). Further exploration indicated that the mindfulness scores were negatively correlated with hostile anger expression and positively associated with control of anger and self-soothing. Regression analysis revealed that the relationship between mindfulness and marital adjustment was mediated by the anger reactivity variable. The authors concluded that the trait of mindfulness offers specific benefits in an intimate relationship. In particular the more mindful couples exercise more control over aggressive impulses and keep hostility to a minimum (Wachs & Cordova, 2007).

Similar results were obtained in a study of dating college students (Barnes et al., 2007). Using the MAAS, mindfulness was positively related to measures of relationship satisfaction. They also found positive correlations between mindfulness and self-control and accommodation. The authors claimed support for their hypotheses that mindfulness is related to greater satisfaction in romantic relationships as well as to a greater capacity to manage the stresses that are experienced in an intimate relationship.

In a second part of the study conducted by Barnes and his colleagues (Barnes et al., 2007), the responses of dating college students were measured pre- and post-discussion regarding areas of conflict. Mindfulness was again correlated with romantic satisfaction. In addition, the participants with higher mindfulness reported less severe emotional post-discussion anxiety and anger-hostility. These individuals did, however, go into the conflict discussion with lower anxiety and anger-hostility. Trait mindfulness scores also predicted less negative changes in love and commitment.

As a result, the researchers maintained that those individuals with higher trait mindfulness experienced lower levels of negative emotions and more positive perceptions of their partner and their relationship after a negative exchange. Interestingly, Barnes et al. (2007) stated that the positive impact of mindfulness occurs for the individual's own experience but had no effect on the experience of their partner. This result suggests that relationship satisfaction is subjective and can be independent of the state of the relationship.

In an online-based study, the relationships between hostile conflict, attachment avoidance, attachment anxiety, and mindfulness were explored (Saavedra, Chapman, & Rogge, 2010). This was a large study with over 1,000 respondents. After the initial response, participants completed questionnaires 1, 2, 3, 4, 6, 9, and 12 months later. Follow-up sets of questionnaires were completed by 865 participants. Mindfulness was shown to be positively associated with relationship satisfaction. Furthermore, high levels of mindfulness moderated and reduced the impact of attachment anxiety on relations over time thus buffering the relationship from increased risk of breakup.

In a recent study (Jones, Welton, Oliver, & Thoburn, 2011) the relationship between mindfulness and marital satisfaction was again reported. Jones and her colleagues also explored the role of spousal attachment as the mechanism through which trait mindfulness contributed to greater marital satisfaction. They suggested that the growth of neural circuitry associated with safety, security, and positive affect within the romantic relationship is promoted by mindful atonement to one's partner.

These studies of mindfulness as a trait are a snapshot in time. They are correlational in nature and all clearly show a positive relationship between mindfulness and relationship satisfaction. That these two variables occur together is not unexpected, although the direction of the interaction cannot be ascertained. Without intervention studies we do not know if this trait of personality or behavior patterns simply occur together in a static fashion or whether mindfulness can be taught as a skill and influence the individual's marital satisfaction.

Intervention Studies

Mindfulness-based relationship enhancement has been studied with positive outcomes reported. Carson and his colleagues (Carson et al., 2004) designed an intervention program for non-distressed couples based on the MBSR program of Kabat-Zinn (1982). The authors considered mindfulness not only as a set of meditative exercises but also as a way of being with three salient aspects: first, that mindfulness would lead to relaxation and de-arousal; second, that mindfulness leads to acceptance of an emphasis on one's experience without judging; and third, that the practice of mindfulness exercises has a generalization of effect.

In the study, 44 non-distressed couples were randomly assigned to an intervention group, involving attendance at the Mindfulness-Based Relationship Enhancement group or a wait list control. The group program consisted of 8 weekly

150 min group sessions plus a full day retreat. Measures were taken pre- and posttreatment and at 3 months follow-up. Details of the program are outlined later in this chapter. Homework practice of mindfulness techniques guided by audiotapes was encouraged throughout the program as well as informal mindfulness exercises.

Results indicated superior scores in the mindfulness group posttreatment in comparison to pretreatment. This was the case for the measures of relationship satisfaction, autonomy, relatedness, closeness, acceptance of partner, and relationship distress. The mindfulness treatment group also had superior scores on the relationship satisfaction measure in comparison with the wait-list control group. Furthermore the gains were maintained at the 3 month follow-up. Individuals in the mindfulness treatment group had superior outcomes posttest in comparison with pretest for optimism, spirituality, individual relaxation, and psychological distress. The diary records indicated that couples in the mindfulness groups improved in comparison with the control group in the areas of relationship happiness and relationship stress in the individual areas of stress coping and were more resilient. In fact, greater practice of mindfulness was associated with increased relationship happiness, decreased relationship stress, increased coping efficacy, and decreased overall stress. There was a clear dose-dependent effect. In any 1 day greater levels of mindfulness practice led to greater experience of relationship satisfaction.

In their follow-up study Carson, Carson, Gil, and Baucom (2007) reported on which process of change could account for the improvements in the mindfulness group. They found that the only factor enhancing relationship satisfaction was that participant couples sensed that by attending the mindfulness group they were participating in a self-expanding and exciting activity together. In the context of the study mindfulness was seen as a shared domain with insights, feelings and behavior change shareable with their partner. Relaxation and acceptance were surpassed by the self-expanding nature of the activity.

These studies provide clear evidence that both individual psychological well-being and relationship functioning can benefit from a mindfulness-based relationship enhancement program for relatively well-functioning couples. To date, there is no research reported using mindfulness as the only intervention with distressed couples.

Promising results have, however, been reported in two intervention studies for intimate partner violence by Kazdin, in which mindfulness was one component of treatment (as cited in Rathus, Cavuoto, & Passarelli, 2006). These studies were designed for males and involved a group program over 22 weeks. The program included mindfulness, in addition to skills modules to develop distress tolerance, interpersonal effectiveness, and emotional regulation as in a dialectic behavior therapy program. In both studies, physical, emotional, and verbal abuse reduced from pre- to posttreatment. Decreases in interpersonal difficulties, emotional deregulation, and impulsivity were also reported. In the second study, evidence showed that gains were maintained at 9 month follow-up. Improvements were further confirmed by the participants' partners. These results are promising; however, further research is needed to tease out to what extent mindfulness contributed to the gains made.

Mindfulness Interventions for Couples

It is beyond the scope of this chapter to describe in detail all the mindfulness techniques that can be used with couples. However, examples will be given to illustrate how these techniques can be used in counseling couples.

Interventions for Individual Members of the Couple

As the theory and research have indicted, individuals who demonstrate better levels of psychological functioning have more rewarding relationships. Consequently, many mindfulness techniques can be used with individuals to enhance relationships. The following is an example of such an exercise adapted from Kabat-Zinn (2009, p. 58).

1. Find a comfortable position either lying on your back or sitting. If sitting, keep the spine straight with relaxed shoulders.
2. Close your eyes if comfortable.
3. Focus on your abdomen. Observe it rise when you inhale and lower on the exhale.
4. Ride the waves of your breathing, focusing on your breathing for the full breath in and the full breath out.
5. When you notice your mind wandering off then gently refocus your attention on your abdomen and your breathing.
6. Every time your mind wanders simply bring your attention back to your breathing not matter how many times you mind if drawn to something else.
7. Practice this exercise for 15 min every day whether you feel like it or not. After a week see how it feels to have a meditation practice in your life. See what it is like not having to do anything but be with your breath.

An advanced breathing exercise adapted from Kabat-Zinn (2009, p. 58) is as follows.

1. At different times during the day focus on your breathing, paying attention to the movement of your abdomen as you do so.
2. Tune into your thoughts and feelings, and just observe them without judging or reacting to them.
3. Notice any changes to the way you see things and to your feelings.

Other contemplative techniques include body scans and walking meditations. An adapted example of a walking meditation is provided below (Kabat-Zinn, 2009, p. 116):

1. Decide on a period of time (e.g., 10 min) to focus formally on a walking meditation.
2. Choose a location where you can walk slowly back and forth (Note—it is best to choose a private place to avoid observation and interruptions from others).

3. To maximize your mindfulness focus your attention on one aspect of your walking (e.g., your feet), rather than changing from one part of the body to another.
4. Walk at a slower than normal pace for the selected period of time.
5. You may choose to focus on different aspects of your walking during subsequent walking meditations.

Mindful eating exercises have also been developed, often focused on contemplation of sensations and experiences while eating foods such as chocolate and raisins. The following is adapted from Kabat-Zinn (2009, pp. 27–29).

1. Taking a raisin, focus on it as if you had never seen one before; notice its color and the nature of its surface.
2. Feel the texture of the raisin with your fingers.
3. Be aware of any thoughts about raisins or food in general. Note any thoughts of liking or disliking raisins.
4. Smell the raisin.
5. Bring the raisin to your lips, being aware of the movements of your arm and of any salivation in anticipation of eating the raisin.
6. Place the raisin in your mouth and chew it slowly, experiencing the taste and the textures of the raisin.
7. When ready to swallow, observe the impulse to swallow so that it is experienced consciously.
8. Note any lingering tastes or sensations in the mouth after swallowing the raisin.

Non-meditative skills for practicing mindfulness have also been developed by Linehan (1993). These include:

- Observing: noting one's experiences without reason, judgment or labels. It can include observations of own thoughts and feelings, the actions of another, or even the physical environment.
- Describing: applying verbal labels to the observations, without presuming they are factual or jumping to conclusions.
- Participating: engaging in a task with focused attention, being present in the moment. Such mindful engagement can be practiced with any activity (e.g., driving, eating, running, and communicating).

Descriptions of other mindfulness exercises can be found elsewhere (e.g. Kabat-Zinn, 2009; Segal et al., 2002).

Couple-Focused Interventions

Carson and colleagues (Carson et al., 2004) have been leaders in the adaptation of mindfulness interventions for couples. As stated previously, they developed a program based on MBSR which was designed to enrich the relationships of relatively happy, non-distressed couples. In addition to the individual activities of MBSR they

Table 2.1 Main topics of intervention sessions (Carson et al., 2004, p. 478)

Session 1	Welcome and guidelines, loving-kindness meditation with partner focus, brief personal introductions, introduction to mindfulness, body-scan meditation, homework assignments (body scan and mindfulness of a shared activity)
Session 2	Body-scan meditation, group discussion of practices and homework, introduction to sitting meditation with awareness of breath, homework assignments (body scan plus sitting meditation, and pleasant events calendar including shared activities)
Session 3	Sitting meditation, group discussion of practices and homework with didactic focus on pleasant experiences, individual yoga, homework assignments (alternating body scan with yoga plus meditation, and unpleasant events calendar including shared events)
Session 4	Sitting meditation, group discussion of practices and homework with didactic focus on stress and coping, dyadic eye-gazing exercise and discussion, homework assignments (alternating body scan with yoga plus meditation, and stressful communications calendar including communications with partner)
Session 5	Sitting meditation, taking stock of program half over, group discussion of practices and homework with didactic focus on communication styles, dyadic communication exercise, homework assignments (alternating sitting meditation with yoga, and attention to broader areas of life [e.g., work] that impact relationship, exploration of options for responding with mindfulness under challenging conditions)
Session 6	Partner yoga, sitting meditation, group discussion of practices and homework with didactic focus on broader areas of life (e.g., work) that impact relationships, homework assignments (alternating sitting meditation with yoga, and attention to obstacles and aids to mindfulness)
Full day session	Multiple sitting meditations and walking meditations, individual and partner yoga, mindful movement and touch exercise, dyadic and group discussions
Session 7	Sitting meditation, group discussion of experiences during full day session, discussion of obstacles and aids to mindfulness, loving kindness meditation, mindful touch exercise and discussion, homework assignments (self-directed practice)
Session 8	Partner yoga, sitting meditation, group discussion/review of program focusing on lessons learned, personal and relationship-related changes, and wrap-up

developed a number of couples-focused mindfulness activities. Their program is outlined below (Table 2.1).

The following is an example of the *Loving Kindness Activity* outlined by Carson and colleagues in their program (Carson et al., 2006).

> Partners are asked to recall the days when they first fell in love and decided to be together, and observe whether they could actually feel again in the present moment the sense of discovery, closeness, trust, sweetness, or fun that they had at that time (p. 318).

Interactive mindfulness exercises were also included in the program to encourage collaborative practice between the couple, including a dyadic eye gazing exercise and a mindful touching exercise. The dyadic eye gazing exercise is a two part exercise that is conducted as follows.

> During the first part, partners enter into a brief "facing stress" experiment in which they gaze into one another's eyes without diverting their attention. In many partners this sustained gazing soon elicits a vague sense of discomfort and vulnerability. Rather than react based on these feelings, couples are encouraged to simply take notice of whatever feelings

> and urges come up, while remaining attentive and open to any shifts that occur in their experience. In the second part of the exercise, couples are asked to continue their gaze, while now doing their best to recognize and inwardly welcome a "deep-down goodness" present within their partner and also within themselves. The exercise ends with a group discussion of its implications for learning to remain mindfully nonreactive and receptive to one's partner in the face of stress-inducing circumstances that might otherwise lead to hurtful arguments or withdrawal from one another (Carson et al., 2006, pp. 312–313).

The mindful touching exercise includes each member of the couple giving and receiving a back rub. Either as the giver or the receiver of the back rub, each individual focuses on the sensations, thoughts and feeling arising in response to their involvement in the exercise. Following the back rub the couple discusses the sensations, thoughts and feelings they experienced, and how this could enhance their physical intimacy (Carson et al., 2006). This exercise could be adapted for hand-holding, foot rubs, hugging, and other physical contact.

Like many other programs for couples, mindfulness-based programs have also tended to be developed with guidelines for communication. They attempt to help the couple learn how to mindfully pay attention to how they are communicating with one another. Mindful communication focuses on typical aspects of effective communication such as taking turns, succinct expression, and attentive listening, and also focuses on spontaneously speaking from the heart (Carson et al., 2006). This occurs in the context of the individual remaining mindful, trying to maintain awareness of their present experiences without responding to them in a judgmental manner. It would also likely be enhanced by incorporating the practical mindfulness skills describe by Linehan (1993), such as observing, describing, and participating, with a focus on increasing the effectiveness of communication.

Case Study

Tom (40 years old) and Sarah (38 years old) have been married for 17 years. They have two sons, aged 2 and 5. Tom owns his own construction business and finds this work very stressful. Sarah works in the business office of their company.

Their relationship had been rewarding and satisfying until their second son was born, which coincided with Tom working longer hours. Sarah became depressed and resentful towards Tom, as she considered Tom to be unsupportive. He found it difficult to cope with Sarah's complaints and the demands of two young children. They frequently argued over a range of issues and had difficulty communicating effectively. Physical intimacy between them had also suffered. When they first presented in therapy, they were considering separation.

Therapy commenced with a focus on their individual psychological problems. They were both initially taught mindful breathing exercises which they practiced over the course of several sessions. This technique helped Tom manage his work-related stress more effectively and helped Sarah manage her stress regarding the children and their household. As a result of this intervention, Tom was calmer when he returned home from work at the end of the day, which allowed him to assist more

with duties relating to the children and the household. Sarah appreciated this and noted that she had become more aware of her own emotional reactions to stressors at home and wasn't taking her frustration out on Tom as frequently. She also reported being more organized and effective in her time management.

Mindfulness strategies were then implemented to enhance their communication. This taught them to observe and describe their experiences in an objective manner, with a focus on not reacting to them. Participation skills were directed towards encouraging them to actively attend to what their partner was saying.

They reported that this helped them to communicate more openly and to understand each other better. They were less judgmental and more supportive. They also shared that they were able to effectively resolve conflicts in short period of time due to their improved communication, and arguments had become infrequent.

To increase intimacy, a sensate focus exercise was suggested, to be practiced in a mindful manner. Both Tom and Sarah reported increased relationship and physical intimacy as a result of this intervention. At the end of treatment Tom and Sarah were no longer considering separation. While they still had a number of stressors in their lives, they were dealing with these in a calmer manner and Sarah was no longer feeling depressed. In general, they were both happier within themselves and with each other, were more empathetic towards each other, and were communicating more effectively. They also reported that they were content with the level of physical intimacy expressed in their relationship.

Conclusion

With its integration into psychological therapy over recent decades, mindfulness has been shown to be effective for a range of problems, particularly relating to stress management. Over the past decade attempts have been made to extend mindfulness to interventions for couples. Theoretically this has initial promise, but the research to date is limited. Initial studies regarding the use of mindfulness as an enhancing and preventative strategy for the relationships of well-functioning couples have shown positive outcomes. Mindfulness has also been used as a component of effective treatment for distressed couples. With a foundation based on mindfulness exercises for individuals, work in this area has recently led to the development of couple-focused activities.

References

Baer, R. A. (2003). Mindfulness training as a clinical intervention: A conceptual and empirical review. *Clinical Psychology: Science and Practice, 10*(2), 125–143.

Barnes, S., Brown, K. W., Krusemark, E., Campbell, W. K., & Rogge, R. D. (2007). The role of mindfulness in romantic relationship satisfaction and responses to relationship stress. *Journal of Marital and Family Therapy, 33*(4), 482–500.

Bohlmeijer, E., Prenger, R., Taal, E., & Cuijpers, P. (2010). The effects of mindfulness-based stress reduction therapy on mental health of adults with a chronic medical disease: A meta-analysis. *Journal of Psychosomatic Research, 68*(6), 539–544.

Brown, K. W., & Ryan, R. M. (2003). The benefits of being present: Mindfulness and its role in psychological well-being. *Journal of Personality and Social Psychology, 84*(4), 822–848.

Brown, K. W., Ryan, R. M., & Creswell, J. D. (2007). Mindfulness: Theoretical foundations and evidence for its salutary effects. *Psychological Inquiry, 18*(4), 211–237.

Burpee, L. C., & Langer, E. J. (2005). Mindfulness and marital satisfaction. *Journal of Adult Development, 12*(1), 43–51.

Carmody, J., Baer, R. A., Lykins, E. L. B., & Olendzki, N. (2009). An empirical study of the mechanisms of mindfulness in a mindfulness-based stress reduction program. *Journal of Clinical Psychology, 65*(6), 613–626.

Carson, J. W., Carson, K. M., Gil, K. M., & Baucom, D. H. (2004). Mindfulness-based relationship enhancement. *Behavior Therapy, 35*(3), 471–494.

Carson, J. W., Carson, K. M., Gil, K. M., & Baucom, D. H. (2006). Mindfulness-based relationship enhancement (MBRE) in couples. In R. A. Baer (Ed.), *Mindfulness-based treatment approaches: clinician's guide to evidence base and applications*. San Diego: Academic.

Carson, J. W., Carson, K. M., Gil, K. M., & Baucom, D. H. (2007). Self-expansion as a mediator of relationship improvements in a mindfulness intervention. *Journal of Marital and Family Therapy, 33*(4), 517–528.

Chiesa, A., & Serretti, A. (2009). Mindfulness-based stress reduction for stress management in healthy people: A review and meta-analysis. *Journal of Alternative and Complementary Medicine, 15*(5), 593–600.

Creswell, J. D., Way, B. M., Eisenberger, N. I., & Lieberman, M. D. (2007). Neural correlates of dispositional mindfulness during affect labeling. *Psychosomatic Medicine, 69*(6), 560–565.

Grossman, P., Niemann, L., Schmidt, S., & Walach, H. (2004). Mindfulness-based stress reduction and health benefits: A meta-analysis. *Journal of Psychosomatic Research, 57*(1), 35–43.

Halford, W., Sanders, M. R., & Behrens, B. C. (1994). Self-regulation in behavioral couples' therapy. *Behavior Therapy, 25*(3), 431–452.

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (1999). *Accetpance and commitment therapy: an experiential approach to behavior change*. New York: Guilford Press.

Heppner, W. L., Kernis, M. H., Lakey, C. E., Campbell, W. K., Goldman, B. M., Davis, P. J., et al. (2008). Mindfulness as a means of reducing aggressive behavior: Dispositional and situational evidence. *Aggressive Behavior, 34*(5), 486–496.

Hofmann, S. G., Sawyer, A. T., Witt, A. A., & Oh, D. (2010). The effect of mindfulness-based therapy on anxiety and depression: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 78*(2), 169–183.

Jones, K. C., Welton, S. R., Oliver, T. C., & Thoburn, J. W. (2011). Mindfulness, spousal attachment, and marital satisfaction: A mediated model. *The Family Journal, 19*(4), 357–361.

Kabat-Zinn, J. (1982). An outpatient program in behavioral medicine for chronic pain patients based on the practice of mindfulness meditation: Theoretical considerations and preliminary results. *General Hospital Psychiatry, 4*(1), 33–47.

Kabat-Zinn, J. (1994). *Wherever you go, there you are*. New York: Hyperion.

Kabat-Zinn, J. (2009). *Full catastrophe living: Using the wisdom of your body and mind to face stress, pain, and illness (15th anniversary ed.)* (15th ed.). New York, NY: Delta Trade Paperback/Bantam Dell.

Karney, B. R., & Bradbury, T. N. (1995). The longitudinal course of marital quality and stability: A review of theory methods and research. *Psychological Bulletin, 118*, 3–34.

Langer, E. (2009). Mindfulness versus positive evaluation. In S. J. Lopez & C. R. Snyder (Eds.), *Oxford handbook of positive psychology* (2nd ed., pp. 279–293). New York: Oxford University Press.

Linehan, M. M. (1993). *Skills training for treating borderline personality disorder*. New York: Guilford.

Ochsner, K. N., Bunge, S. A., Gross, J. J., & Gabrieli, J. D. E. (2002). Rethinking feelings: An fMRI study of the cognitive regulation of emotion. *Journal of Cognitive Neuroscience, 14*(8), 1215–1229.

Rathus, J. H., Cavuoto, N., & Passarelli, V. (2006). Dialectical behavior therapy (DBT): A mindfulness-based treatment for intimate partner violence. In R. A. Baer (Ed.), *Mindfulness-based treatment approaches: Clinician's guide to evidence and applications*. San Diego: Academic.

Saavedra, M. C., Chapman, K. E., & Rogge, R. D. (2010). Clarifying links between attachment and relationship quality: Hostile conflict and mindfulness as moderators. *Journal of Family Psychology, 24*(4), 380–390.

Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2002). *Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse*. New York: Guilford Press.

Shapiro, S. L., & Carlson, L. E. (2009). What is mindfulness? In S. L. Shapiro & L. E. Carlson (Eds.), *The art and science of mindfulness: Integrating mindfulness into psychology and the helping professions* (pp. 3–14). Washington, DC: American Psychological Association.

Shapiro, S. L., Oman, D., Thoresen, C. E., Plante, T. G., & Flinders, T. (2008). Cultivating mindfulness: Effects on well-being. *Journal of Clinical Psychology, 64*(7), 840–862.

Tanner, M. A., Travis, F., Gaylord-King, C., Haaga, D. A. F., Grosswald, S., & Schneider, R. H. (2009). The effects of the transcendental mediation program on mindfulness. *Journal of Clinical Psychology, 65*(6), 574–589.

Wachs, K., & Cordova, J. V. (2007). Mindful relating: Exploring mindfulness and emotion repertoires in intimate relationships. *Journal of Marital and Family Therapy, 33*(4), 464–481.

Wells, A. (2009). *Metacognitive therapy for depression and anxiety*. New York: Guilford Press.

Chapter 3
Helping Couples Dispel Myths and Self-Defeating Beliefs and Behaviors that Sabotage Relationships and Marriage

Ann Vernon

The long-anticipated day had finally arrived, signaling the end of months of meticulous planning. As the melodic sounds of the string quartet drifted throughout the room, friends and family members watched the wedding party slowly proceed down the aisle. All eyes turned as the music signaled the entrance of the bride, resplendent in her magnificent gown and escorted by her proud father. As the groom watched the procession, he focused not only on this moment but also on the future. He was excited; he and his soon-to-be spouse had so much in common and they were so much in love. There was no doubt in his mind that they would have a good life together.

These thoughts stayed with him as he and his beloved faithfully promised to love, honor, and respect each other. The exchange of rings signified their official union. They beamed as they joined hands and marched back up the aisle, secure in their love and eagerly anticipating their future as a couple.

Although this scenario naturally varies depending on cultural, financial, familial, personal, and various other factors, the essence of this ceremony is something that many people experience as they officially acknowledge their union as a married couple. Promises are made with the expectation that they will live happily ever after.

But in reality, we know that in the United States, between 40 and 50 % of first marriages end in divorce, 60 % of second marriages don't last, and the divorce rate is even higher for third marriages—73 % (Baker—www.divorcerate.org). As Parrott and Parrott (2006) noted, "For too many couples, marriage has become 'till divorce do us part'" (p. 14). They commented on the irony that most couples prepare more for their wedding than they do for marriage; if the reverse were true, and more energy was spent on formal marriage preparation, the divorce statistics might

A. Vernon (✉)
University of Northern Iowa, Cedar Falls, IA, USA

Albert Ellis Institute, New York, NY, USA
e-mail: ann.vernon@yahoo.com

A. Vernon (ed.), *Cognitive and Rational-Emotive Behavior Therapy with Couples: Theory and Practice*, DOI 10.1007/978-1-4614-5137-2_3,
© Springer Science+Business Media New York 2012

be much different. Or, as Hauck (2002) noted, we would have fewer divorces if people put as much effort into their marriages as they do their jobs.

What happens to these marriages that begin with love, romance, passion, and high expectations? Obviously couples want a successful marriage and after they "toss the bouquet and return the tuxedo, couples often assume they are headed for marital bliss" (Parrott & Parrott, 2006, p. 14). At least in the beginning, most are confident that their relationship is so unique that their love will only intensify and will "transcend such prosaic barriers as cultural dissimilarities, parental objections, money, and social position" (Lazarus, 2001, p. 13). Unfortunately, this is all too often not the case, so we must ask ourselves why so many marriages fail. Along with that, we need to understand why it is that when divorced partners pick up the pieces and move into other relationships that may again result in marriage, these marriages may also be in jeopardy. One key to this puzzle is to look at how we get "set up" for marriage in the first place.

It begins when we are young. Females in particular start dreaming of their wedding day before they are even old enough to know what marriage is about. And because of wide exposure to the media, young people are indoctrinated with myths about what constitutes a good relationship or a marriage. As Olson and Stephens (2001) stated, the movies, television, and music convey these myths to teenagers who "absorb the messages the myths convey without ever realizing it … and these myths become their models for a good marriage" (p. 11). The fact that these myths are rarely questioned and that they become the standard for evaluating healthy relationships contributes to the demise of relationships.

According to Olson and Stephens (2001) people believe the myths because they fail to realize that marriage is an "ever-changing relationship between two ever-changing people" (p. 12). Consequently, they end up with unrealistic expectations and standards that are impossible to meet. Parrott and Parrott (2006) stressed that one of the most destructive myths is the belief in the happily-ever-after marriage, but that this is "only the tip of the marital iceberg" (p. 20).

The purpose of this chapter is to identify myths and misconceptions that sabotage healthy couple relationships and to present other factors that interfere with couples' inability to maintain a satisfying partnership. Cognitive, emotive, and behavioral interventions that practitioners can use in couple counseling are also described.

Myths and Misconceptions

As Ellis and colleagues long ago stated (1989), when couples start with unrealistic expectations and rigidly demand that their idealistic goals be satisfied, problems ensue because myths and misconceptions create expectations that are difficult, if not impossible, to meet. They constitute a major roadblock to successful relationships. Therapists working with couples need to address these in order to help them develop a strong relationship based on reality rather than disillusionment. Common myths and misconceptions are subsequently described.

Change Requires Two People

Although many people believe that changing a relationship requires two people, this is a myth, according to Olson and Stephens (2001). In fact, you can only change yourself. O'Hanlon and Hudson (1995) pointed out, however, that the dynamics of the relationship will change even if only one partner changes because the relationship is no longer static.

Couples who buy into the myth that it takes two people to change a relationship focus much of their energy on changing their partner, which rarely works and generally only makes things worse. And, partners who try to change each other often use the same unsuccessful strategies year after year to no avail, as was the case with a client who thought he could control his partner's compulsive spending by hiding the checkbook and credit cards, returning purchases to stores, or getting angry and lecturing her about her bad habits. Not only did his attempts to change her fail, but also he became increasingly frustrated and angry because he hadn't been successful. Although changing another person doesn't work, it is, however, destructive to think that others aren't capable of changing on their own if they are motivated to do so. People who insist that their partner is incapable of change sabotage the relationship, because by not giving the other person the benefit of the doubt, they thwart all attempts that may improve the relationship.

Pointing Out Your Partner's Flaws Promotes Change

A second myth which is also related to changing your partner is that he or she will change if you just point out his or her inadequacies and fatal flaws (Larson, 2003). In fact, the reverse is usually true … the more one partner nags and criticizes, the less likely the other person wants to change. What generally ensues is a power struggle, so even though the partner may actually want to change his or her behavior, there is very little likelihood that this will happen with the finger pointing method.

Other problems result from this method as well. In addition to anger and resentment, the partner who is accused of having flaws may begin to personalize the criticism, as was the case of Saul and Irma. Irma constantly reminded Saul about all of the things that he failed to take responsibility for, things he "should do." Initially Saul would be defensive and angry, which usually resulted in an argument. At other times he would withdraw and think he was no good because he could never please his partner. Neither scenario enhanced the quality of the relationship.

It Isn't Necessary to Communicate Expectations

Another myth is that partners assume they have the same expectations about what they want their relationship or marriage to be like, but ironically, most couples don't

verbalize their "picture" to each other (Parrott & Parrott, 2006). In fact, they individually develop their ideas about what their life will be like from family, traditions, media, books, and so forth over time and simply assume that the person they select as their partner will have the same priorities or practices. This assumption that people are mind readers and know exactly what others are thinking or wanting creates problems because unmet expectations result in disappointment and disillusionment about the relationship. Logically speaking, if a person was going to a hairdresser and wanted his or her hair cut a certain way he or she would definitely communicate that clearly to the stylist—so if individuals have expectations for their couple relationship, wouldn't it make sense to clearly communicate them to their partner rather than assuming that their partner should intuitively know their needs and wants? As Lazarus (2001) noted, the myth that lovers automatically know each other's thoughts and feelings is akin to them having the "powers of telepathy!" (p. 75).

To illustrate, take the case of Jason and Jennifer. Jennifer had been raised in a family which had many traditions, and celebrating holidays, birthdays, and anniversaries with gifts and parties and family get-togethers were very important. Jason, on the other hand, grew up in a family where there were very not many family traditions. Family get-togethers were few and far between, and birthdays and anniversaries were acknowledged but without much fanfare. Holidays were celebrated, but not to the extent to which Jennifer was accustomed. But because this couple hadn't communicated their vision regarding these functions, their first conflict occurred when Jennifer informed Jason that they would be leaving for her parents' anniversary party the night before the event, which was the following Saturday. Jason looked confused and told her that he had to work. Jennifer was dumbfounded and couldn't understand why he hadn't taken that time off since he knew the anniversary was next week. But to Jason, whose parents had never celebrated their anniversary with a party, this was a foreign concept. Similar incidents occurred throughout their first year of marriage, resulting in disappointment and anger for Jennifer, as well as confusion for Jason. Fortunately they sought counseling and were able to address these issues by sharing their assumptions and how they had developed and how they could form a new vision based on clearly communicated desires.

Marriage Should Not Be a Lot of Work

Another myth that Olson and Stephens (2001) described is that marriage should not be a lot of work—a successful marriage just comes naturally. As ridiculous as it sounds, many couples in marital therapy assume that if they love each other the marriage should work … without having to put energy into it or making personal sacrifices. The reality is that there is a lot of "work" to be done because two people are coming from backgrounds that may be diverse, they have probably had little or no training about how to be married, and they don't realize that marriages move through developmental stages that present challenges as well as opportunities for emotional and relational growth. Without taking these factors into consideration

and working hard to overcome the obstacles, relationships suffer. Thus, clinging to the myth that marriage should not be hard work is like sitting in a sinking ship without trying to save the people in it. Realistically, most people expect that they will have to work hard to be successful at a job, so why wouldn't they apply that same logic to relationships and marriage? Successful couple relationships require time and energy, as well as flexibility. Lazarus (2001) stressed that relationships and marriage need adjustment and readjustment, as well as compromise.

Marriage Can Fulfill All Your Needs

Another myth is that marriage can fulfill all your needs (Larson, 2003) or that partners should meet all of each other's needs. Olson and Stephens (2001) noted that relational needs such as companionship, sex, role sharing, and so forth are quite obvious and not as difficult to meet, but there are other needs that are not as apparent. These authors cited several examples, such as needing validation and affirmation that they didn't receive as a child, or needing a safe and psychologically secure relationship because they were raised in an abusive family. In this case, even minor conflict might be a red flag that they aren't safe and they may distance themselves emotionally from the relationship. Oftentimes they are not even aware of their own needs, but somehow expect their partner to be, which creates problems. According to Parrott and Parrott (2006), most people have unfulfilled needs and therefore look to their lover or spouse for support and reassurance, but spouses can't "make each other whole" (p. 30); they complement, not complete, one another. Unhealthy dependency and enmeshment are common when couples expect that their partner should meet all their needs and be their sole source of emotional support.

Marriage Never Changes

Yet another myth is that marriage is a constant that never changes. In reality, to expect that things won't change is terribly simplistic because circumstances are always changing, which often necessitates a change in roles, routines, and relationships. Parents undoubtedly expect their children to change as they get older, so why would people assume that marriage won't change as years go by? Relationships go through stages, and the challenges newlyweds face are very different from what a couple transitioning into retirement experience, for example. Adaptation and change are the keys to a healthy relationship, so buying into the myth that things will stay the same forever is destructive.

Sheikh (2010) maintained that couples would be better off if they looked at marriage as a journey of understanding each other's needs and accepting the changes in each other as the years pass by as a critical element of a successful marriage.

Conflict and Disagreement Must Be Avoided

Partners who think that all conflict and disagreement are bad buy into another relationship myth. In fact, to expect that there won't be conflict at times is ignoring reality, and the ability to work through inevitable conflict is critical. Looking at it from another perspective, if one or both parties ignore conflict and pretend that it doesn't exist, resentment and anger build up over time. Eventually it becomes impossible to ignore it, but by then it may be too late to save the relationship because the negative feelings are too strong. This happened to be the case with Anna and Ned who had been married 10 years. When something bothered Anna, she would usually bring it up, but Ned would generally get defensive and nothing really was resolved. After years of trying to address the conflicts, Anna felt frustrated and defeated and slowly started to disengage from the relationship. She worked harder, became involved in several professional organizations, had an affair, and eventually filed for divorce. Had they been able to communicate more openly and address the issues before they escalated beyond the point of no return, the ending might have been different.

All You Need Is Love

Buying into the myth that romantic love makes a good relationship or marriage can also be destructive (Larson, 2003). Individuals typically fall in love and marry during the infatuation stage, which, according to Love (2001), is an altered state of consciousness. Ellis and colleagues (1989) noted that during this stage, people often mistake sexual attraction for love and rush into marriage without realizing that this feeling of romantic love will eventually fade. However, "love is blind," and during the infatuation stage, it is not at all uncommon to believe that love will conquer all because partners are so in tune with each other … to the point that they can finish each other's sentences, overlook incompatibilities and discrepancies in their backgrounds and interests, and have high hopes that they can change things that might interfere with the relationship. They assume that their partner will be a best friend, an exciting sex partner, a phenomenal parent, a fantastic provider, an outstanding emotional supporter, and so forth. Realistically, this is impossible, but yet people cling to the myth. As a result, they become frustrated, disillusioned, and disappointed.

During the infatuation phase, people "wonderfulize" the relationship and only look selectively at the positive aspects. But it is unrealistic to think that this phase can last forever and it shouldn't be confused with true love that is everlasting (Love, 2001). In fact, Lazarus (2001) posited that couples would be spared a great deal of emotional pain if they were to "replace romantic love with conjugal affection as the basis for a truly successful marriage" (p. 16). He maintained that the affection that promotes an enduring marriage is deeper and more rewarding than romantic love found in fairy tales. In essence, couples who are compatible, committed, and

affectionate are more successful in dealing with the practical problems that need to be addressed on a daily basis and that can't be solved just because they are "in love." In addition, Caldwell and Woolley (2008) reported on research suggesting that it is not romantic love that contributes to marital success, but rather, couples' perceptions of the quality of their friendship.

Ellis (2001, 2004) pointed out that because loving feelings are very strong, people readily tell themselves that they *need* love. Unfortunately, the more they buy into that belief, the more anxious they become when problems develop in the relationship because love alone wasn't "all they needed" to keep the relationship viable.

In a similar vein, love doesn't cure everything and make all problems go away, as they did when Prince Charming rescued Cinderella from her wicked stepfamily. As Parrott and Parrott (2006) noted, "a marriage certificate is not a glass slipper" (p. 29). Nevertheless, many people enter relationships and marriage expecting that love will weave its magic and make everything wonderful. But as Ellis and colleagues (1989) maintained, romantic love is an overvalued concept that results in disturbance and disillusionment. Love is a complex emotion, not a magic wand, and couples have to deal with the realities of the world that aren't magically solved through love.

The misconceptions epitomized by these myths are unfortunately reinforced by the media, romance novels, movies, the greeting card industry, and popular songs, so people easily become ingrained with this way of thinking. A major challenge for professionals working with couples is not only to help them debunk these myths and misconceptions but also to help them recognize other destructive relationship patterns.

Games Partners Play

Although many couples are unaware that they engage in game playing, the fact is that it is fairly common practice that they inadvertently participate in. The following cases illustrate four different games that may look familiar to many readers.

If You Don't Ask, I Won't Tell

Anita and Mike presented in counseling with issues they described as insurmountable. Anita complained that Mike didn't care about her and she was tired of putting up with his lack of interest and failure to communicate with her. The therapist asked for an example and Anita explained that when she came home from work, she expected her partner to ask her how her day was. When he didn't, she grew resentful and angry and ignored him for the rest of the evening. From Mike's perspective, Anita wasn't presenting the whole picture because he claimed that later in the

evening he did ask her about her day, but she would cut him off and say she didn't want to discuss it. In probing further, it became apparent that Anita was playing the "if you don't ask I don't tell" game that goes something like this.

Anita would walk in the door and within a few minutes expected Mike to ask how her day was, despite the fact that he might be fixing dinner or reading the paper. When he didn't ask, she interpreted that as lack of interest and caring and her negative feelings took over. She gave him the silent treatment throughout the evening and when he finally asked about her day, she was too angry to respond. Her demand was that he ask her immediately upon arrival, and if he didn't, that meant he didn't care. Each time this cycle repeated itself, Anita withdrew more from the relationship until she reached the point of wanting out. The therapist worked with the couple to show them how Anita's demands and interpretations set them up for a no-win situation and also helped them learn to communicate more openly about their differences in terms of timing and need to share. For example, Mike didn't really see a need to rehash his day at work, so he assumed it wasn't that important for Anita. Anita assumed that if he didn't ask, he didn't care. Once these assumptions were made explicit and had been discussed, Anita realized that if something was important enough to share with Mike, she could—and that if he didn't ask when she thought he should, it didn't mean that he didn't care about her. Working on her demands reduced her anger and stopped the game playing.

I Spy

Carla and Ken, a newly engaged couple, played the "I spy" game. When the couple presented at the first session, Carla was about to break off their engagement because she had caught Ken trying to get into her e-mail. When confronted, Ken defended himself by saying that he was suspicious that Carla was involved with another man at work and that he didn't want to be engaged to a cheater. Carla was dumbfounded at this confession and asked him to explain why he was so suspicious. Ken told her that he was tired of having Carla call to say that she couldn't see him that night because she had to work late. And when they were together, she frequently had to return calls to her coworker, a man Ken had never met. In addition, Ken thought Carla was more distant and withdrawn. Based on a few facts, Ken's mind spun out of control and his assumptions exaggerated the problem. Carla admitted to being distracted and somewhat withdrawn, explaining that the project she was working on was very challenging and the time frame was very tight. Furthermore, the coworker Ken thought she was involved with was a 60-year-old grandfather who Carla regarded as a mentor but not a lover. Had Ken reined in his assumptions and communicated his concerns to Carla, they probably could have resolved things without needing counseling. The therapist helped them distinguish between facts and assumptions and discussed other examples of cognitive distortions that can be problematic in relationships. Armed with these tools, the couple left in a much better place.

I'll Do This If You Do That

Another game couples play is "I'll do this if you do that," as exemplified by Terry and Teresa who sought counseling because this game was sabotaging their relationship. When asked for an example, Terry explained that he resented the fact that Teresa would only agree to have sex if he did romantic things for her everyday. He explained that he felt like he was on an approval scale and that if what he did wasn't enough, Teresa played her power card. He didn't think he could ever really please her because she kept raising the bar with regard to what she wanted. Consequently, Terry was so frustrated that he was considering having an affair. From Teresa's standpoint, she felt it was worth playing the game because if she didn't, she had no proof that her husband cared about her other than for sex. In working with the couple, the counselor helped them see that this game was getting them nowhere and that if they wanted the relationship to work, which they both seemed in agreement about, they had to give up the game. She suggested that they each make a list of how they would like the other person to show that they cared and commit to doing one of those things on a daily basis. In addition, she helped them see that men and women have different ways of defining caring—that men often express caring by doing something for their partner which women might not categorize as caring. By giving up the demand that they both had to express caring in the same way, they were able to let go of the game and relate more effectively and affectionately.

Hint Hint

Another familiar game is "hint hint" which Antonio and Miquel played to no avail. Instead of communicating directly to Antonio that he wanted him to take out the garbage each week, Miquel put the trash can beside the door and became angry and frustrated when Antonio didn't get the hint. On the other hand, Antonio didn't want to always be the one who fed the dogs, but instead of asking directly for help, he would often tell Miquel that the dogs looked hungry. Although Miquel would acknowledge that they needed to be fed, he didn't make a move to do it. Learning to communicate more assertively helped this couple stop playing their game.

Distorted Cognitions and Irrational Beliefs

Not only do myths and game playing create problems for couples, but also so do distorted cognitions and irrational beliefs. Albert Ellis, who began his career as a marital and sex counselor, maintained that a major task for marriage counselors was to "tackle not the problem of the marriage, nor the neurotic interaction that exists between the marital partners, but the irrational ideas or beliefs that cause the

neurosis a deux" (Ellis, 1962, p. 210). It is the irrational beliefs which are exaggerated, rigid, illogical, and absolutistic that result in relationship disturbance. Ellis and Dryden (1997) differentiated between relationship dissatisfaction and relationship disturbance, noting that couples who are dissatisfied may not be getting what they want from the relationship, but when they become disturbed about this, they feel angry, anxious, hurt, depressed, or guilty. These negative emotions, resulting from irrational or distorted thinking, interfere with clients' ability to communicate and solve problems. Therefore, a first step in helping couples deal with relationship disturbance is to identify dysfunctional/irrational thinking patterns.

Ellis (2001) described irrational beliefs as emanating from three absolutistic "musts" (p. 156) or demands on self, others, and the world:

1. I must perform well and be approved by others. It is awful and terrible if I am not, which proves that I am an awful, worthless person.
2. Others must treat me exactly as I expect to be treated. It is horrible if they don't, and it makes them rotten people that I can't stand.
3. Conditions in the world must be exactly as I want them to be. It is terrible if they are not, and I can't stand it.

To further illustrate, couples often become anxious and depressed if they are not able to make the relationship work or if their marriage ends in divorce, which is related to the first demand of performing well. They erroneously think that if the relationship fails, there is something wrong with them; in their eyes, they are worthless. Or, they may put demands on their partners, expecting them to be perfect and always treat them exactly as they think they should be treated. Inevitably this doesn't happen, which results in anger, blame, and condemnation. Another irrational belief is related to the third demand, otherwise known as discomfort anxiety or low frustration tolerance. Partners who cling to this irrational belief think that everything in the relationship should be exactly as they want it to be, and if it isn't, it's intolerable. For example, it is common to hear a husband say that he can't stand the irritating things his wife does, or that he cannot tolerate the problems in the relationship. In reality, no relationship is perfect and couples who have high tolerance for discomfort and frustration are less emotionally disturbed and have more satisfactory relationships. Finally, it is common practice for couples to engage in awfulizing and catastrophizing, blowing problems out of proportion by thinking that it is awful when things go wrong or horrible that the relationship isn't as perfect as they think it should be. As Ellis and colleagues (1989) noted, "this kind of thinking exaggerates the badness of an unfortunate situation" (p. 21).

Aaron Beck, in *Love is Never Enough* (1988), identified several cognitive distortions that apply to relationships, including the following:

1. *Tunnel vision*: Focusing on one small detail and basing an interpretation of an entire event on this, ignoring or minimizing other salient details. For example, a couple went to a nice restaurant to celebrate their anniversary, but he neglected to send flowers to commemorate the day, so she complained to others that he did nothing to acknowledge their anniversary.

2. *Selective abstraction*: Taking a statement or event out of context and arriving at an erroneous interpretation. For example, a wife went to a meeting across town and her husband called to make sure she had gotten there. She felt that he was checking up on her, when he had really called when he had realized there wasn't much gas in the car and he wanted to make sure she filled the tank before returning home.
3. *Arbitrary inference*: Making an unfavorable judgment even if there is no basis for it. For example, a wife accepted an invitation to a baby shower and told her partner that she would probably be home around 10:00 p.m. Instead, she arrived at 9:00 and her partner assumed she returned early because she didn't trust him to put the children to bed properly.
4. *Overgeneralization*: Statements like always or never; absolutistic statements which ignore the reality. For example, "You never do anything loving or caring; you'll always be insensitive."
5. *Magnification*: Exaggerating the qualities of the partner as either all good or all bad, and catastrophizing the consequences of an event. For example, a man says to his partner, "Every time you go out you drink too much. If you don't cut back, you'll become an alcoholic" (when his partner routinely had no more than 2 drinks in 4 hours).
6. *Biased explanations*: Coming up with negative or malicious motives to explain a partner's behavior. For example, a woman says to her partner, "You forgot to pick up the groceries we needed; you did that just because you didn't want to have to fix anything for dinner."
7. *Personalization*: Believing that the actions of others are directed at them personally. For example, a wife called her husband to tell him that she would be late getting off work, and he thought that she is just trying to prove that she works harder than he does.

Helping couples challenge these distorted thinking patterns by asking them to provide evidence to support the inferences, overgeneralizations, biased explanations, and so forth can be a first step in developing more rational beliefs that strengthen the relationship. Other techniques for helping couples function more effectively are subsequently described.

Cognitive, Behavioral, and Emotive Interventions

When addressing problem resolution from a cognitive perspective, therapists focus on emotional as well as practical problems, keeping in mind that practical problem solving is generally ineffective unless the emotional problems which are generated by distorted cognitions are dealt with first. Various interventions that have proven successful in couple therapy are described as follows.

Cognitive Interventions

Disputation is the most common cognitive intervention, the "heart and soul" of the theory. Disputation may be didactic, where the therapist educates the client about the myths, games, and distorted beliefs. While this can be very effective, a Socratic approach is preferred, in which the therapist asks questions to help clients clarify their beliefs. In this manner, the therapist employs logical, functional, and empirical disputes to help clients challenge the irrational thinking (Dryden, DiGiuseppe, & Neenan, 2003). For example, if a wife presents in counseling complaining that her husband never takes any responsibility for the children or the household and therefore doesn't care about the family as much as he cares about his job, the therapist may initiate empirical disputes as follows: "Where is the evidence that he cares more about his job than his family?" Or, she might use a functional dispute such as: "How does it help your relationship to think that he doesn't care about the family?" An example of a logical dispute might be: "*Never* means all the time … is it really logical to say that he *never* helps out at home?"

A second cognitive intervention is to assign bibliotherapy in the form of self-help books or pamphlets as homework assignments, or to ask couples to watch a movie or selected movie clips and look for examples of healthy versus unhealthy relationship patterns. It is very important to process this in the following session, focusing on what they learned and how this can apply to their relationship. Books such as *Love is Never Enough* (Beck, 1988), *Can This Relationship Be Saved*? (Broder, 2002), or *The Seven Principles for Making Marriage Work* (Gottman & Silver, 1999) are useful resources.

Another effective cognitive intervention is to share examples of anniversary greeting cards with clients, asking them to identify myths, overgeneralizations, and "love slob" concepts, a term developed by Ellis to explain "needing" others' love and approval to feel worthwhile. It is not difficult to find examples of cards that overidealize love and marriage, conveying concepts that are difficult if not impossible to live up to, which often results in guilt or dissatisfaction (what's wrong with our relationship—it's nowhere close to the message in the card). After working with the couple to identify the exaggerations and misconceptions, the therapist invites them to write a more rational message that realistically reflects their thoughts and feelings.

Another cognitive intervention is to have each member of the couple write an advertisement for the "ideal mate." After they have finished, invite them to share these with each other and then talk about the similarities and differences in their advertisements, as well as the unrealistic and zealous characteristics they undoubtedly identified. A good follow-up is to have them write another advertisement, this time based on more realistic concepts. This technique can help couples differentiate between the real and the ideal which helps them stay out of the "expectations trap," which often sets couples up for failure.

Emotive Interventions

Role-playing is perhaps one of the most effective emotive techniques and can be implemented in several ways. If only one member of the couple is present, he or she describes an issue to work on and provides a bit of background on how his or her partner typically responds. The therapist then assumes the role of the partner and the client plays him- or herself. Or, a reverse role-play could involve the therapist playing the part of the client and the client assuming the role of the partner. This is a good approach to help develop perspective from the other person's point of view. Depending on the circumstance, it may be helpful for the therapist, in the role of a client, to exaggerate the irrational beliefs to help the client see them more clearly. Following the role-plays, it is important to debrief what happened and discuss what the client was thinking or feeling, as well as what was learned. If both members of the couple are present, they can do either type of role-play. Tape recording these interactions so that the client(s) can listen to them between sessions is another way of reinforcing the concepts.

Another effective emotive technique is rational emotive imagery, where clients practice changing unhealthy negative emotions to less disturbing emotions by visualizing a problematic situation involving extreme negative emotions and then focusing on changing those strong emotions to more moderate, reasonable emotions (Dryden et al., 2003). Following the imagery experience, the therapist engages the client in discussion about how successful he or she was in changing the intense negative emotion to something less extreme, emphasizing how changing beliefs contributed to the more positive outcome.

One of Ellis' favorite emotive techniques was to use humor, especially through humorous songs. For example, a therapist could use Ellis' self-composed song *Love Me, Love Me, Only Me!* (sung to the tune of Yankee Doodle):

> Love me, love me, only me or I will die without you,
> Make your love a guarantee, so I can never doubt you!
> Love me, love me totally; really, really try, dear;
> But if you must rely on me, I'll hate you till I die, dear!
> Love me, love me all the time, thoroughly and wholly;
> Life turns into slushy slime 'less you love me solely!
> Love me with great tenderness, with no ifs or buts, dear:
> For if you love me somewhat less I'll hate your goddamned guts, dear! (Lyrics by Albert Ellis. Copyright by the Albert Ellis Institute. Reprinted with permission).

A variation of this is to have clients find examples of dysfunctional thoughts in popular music, sing the lyrics, and then rewrite them to make them more realistic. Tape recording both versions and playing them back is good reinforcement.

Behavioral Interventions

There are a variety of behavioral interventions that can be helpful to couples. One approach is to use props, such as a rubber band, a sponge, and a pair of dark glasses

(Vernon, in press). To illustrate, consider the case of Nick and Krista, who sought counseling because they were experiencing considerable stress in their relationship. Nick complained that Krista always personalized things and assumed blame for things he wasn't even blaming her for and he didn't like the way she put herself down. Krista felt that Nick always looked at everything in a negative light and she didn't even like spending time with him because it seemed like he always found something wrong with everything. Using the props, the therapist gave each partner a rubber band and asked them to stretch it to show how much tension each felt in the relationship. Next, after some dialogue to clarify the issues, the therapist got out a sponge and a small bucket of water. She asked Krista to tell her how the sponge felt when it was dry, and then how it felt when it had been soaked in water. Obviously the sponge was heavier when it had been immersed in water, and the counselor drew an analogy, asking Krista is she was like a wet sponge, soaking up negative assumptions and overgeneralizations based on her interactions with Nick. If so, how could she "wring" the sponge out so that she wasn't personalizing as much? This proved to be a powerful metaphor for Krista and after working with the couple to distinguish between facts and assumptions and dispute other irrational beliefs involving guilt and self-blame, Krista was thinking more rationally. The therapist next used a pair of dark glasses and a pair of clear glasses to help Nick work on dwelling on the negative. She asked the couple to identify several different scenarios involving activities they might participate in. First she asked Nick to put on the dark glasses and talk about what these various activities might be like from that perspective. Then she had him switch to the clear glasses and verbalize what it might be like if he didn't have his "doom and gloom" glasses on. Through this process the therapist was able to detect overgeneralizations, selective abstractions, and other distorted cognitions that affected the way he perceived things. Disputing helped him develop a more realistic viewpoint and the concrete approach seemed effective in his ability to identify his negative thinking.

Another strategy is to have each member of the couple make a list of "red" light behaviors (things that they need to stop doing so that they don't sabotage the relationship) and a list of "green light" behaviors (things that promote a healthy relationship). After sharing their lists with each other, the couple makes a poster listing all the positive and negative behaviors. Each person then selects two green light behaviors he or she wants to work on and at the end of the day, they sit down to discuss how that process went and identify whether there were any negative, "red light" behaviors.

A final intervention is to ask the couple to plan a rational relationship celebration. After working with them to dispute irrational beliefs, invite them to celebrate their success by writing their irrational beliefs on balloons, blowing them up, and letting them go. As they drink a glass of champagne, they can make rational toasts to each other to commemorate the occasion.

Conclusion

Although it would be a revolutionary concept if couples received a detailed set of instructions to guide them through the challenges that are intensified by myths and misconceptions, irrational thinking and other cognitive distortions, and games couples play, the reality is that there is no such thing. Granted, there are numerous Web sites and other publications that give advice about what constitutes successful relationships, but in the final analysis, a couple relationship consists of human beings who are complex creatures, which in turn makes their relationships more complex and challenging. Aniqa Sheikh (2010) compared successful marriages to kaleidoscopes that constantly evolve as needs, situations, and expectations change. In fact, flexibility is one of the contributors to strong relationships.

This chapter described myths, misconceptions, distorted cognitions, and games that couples play that negatively impact their relationships, with specific suggestions and practical interventions that practitioners can use with couples to help them develop and maintain healthy unions. Whether working with couples conjointly or concurrently with partners in individual sessions, the objective is to help them identify the factors that sabotage relationships and empower them cognitively, emotively, and behaviorally. Therapists must help couples change their demands to desires, develop tolerance for the inevitable frustrations that occur in relationships and marriage, and encourage them to minimize their emotional blocks so that practical, behavioral techniques such as effective communication and assertion skills will be more effective. The goal is to help couples "maintain and/or deepen an intimate relationship" (Ellis & Crawford, 2000, p. 4) by practicing the seven guidelines for good relationships: developing unconditional acceptance for each other, expressing appreciation frequently, communicating from integrity, sharing and exploring differences, supporting each other's goals, allowing each other the right to be wrong, and reconsidering wants as goals (p. 13).

References

Baker, J. (n.d.). Retrieved April 30, 2012 from http://www.divorcerate.org/

Beck, A. T. (1988). *Love is never enough: How couples can overcome misunderstandings, resolve conflicts, and solve relationship problems through cognitive therapy*. New York, NY: Harper.

Broder, M. (2002). *Can your relationship be saved? How to know whether to stay or go*. Atascadero, CA: Impact.

Caldwell, B., & Woolley, S. (2008). Marriage and family therapists' endorsement of myths about marriage. *American Journal of Family Therapy, 36*(5), 367–387.

Dryden, W., DiGiuseppe, R., & Neenan, M. (2003). *A primer on rational emotive behavior therapy* (2nd ed.). Champaign, IL: Research Press.

Ellis, A. (1962). *Reason and emotion in psychotherapy*. Secaucus, NJ: Lyle Stuart.

Ellis, A. (2001). *Overcoming destructive beliefs, feelings, and behaviors*. New York, NY: Prometheus.

Ellis, A. (2004). *Rational emotive behavior therapy: It works for me—It can work for you*. Amherst, NY: Prometheus Books.

Ellis, A., & Crawford, T. (2000). *Making intimate connections: 7 guidelines for great relationships and better communication*. Atascadero, AC: Impact Publishers.

Ellis, A., & Dryden, W. (1997). *The practice of rational emotive behavior therapy* (2nd ed.). New York, NY: Springer.

Ellis, A., Sichel, J. L., Yeager, R. J., DiMattia, D. J., & DiGiuseppe, R. (1989). *Rational-emotive couples therapy*. New York, NY: Pergamon.

Gottman, J. M., & Silver, N. (1999). *The seven principles for making marriage work*. New York, NY: Three Rivers Press.

Hauck, P. A. (2002). Idiosyncratic REBT. In W. Dryden (Ed.), *Idiosyncratic rational emotive behaviour therapy* (pp. 48–60). Ross-on-Rye: PCCS Books.

Larson, J. H. (2003). *The great marriage tune-up book*. San Fransisco, CA: Jossey-Bass.

Lazarus, A. (2001). *Marital myths revisited: A fresh look at two dozen mistaken beliefs about marriage*. Atascadero, CA: Impact.

Love, P. (2001). *The truth about love*. New York, NY: Fireside.

O'Hanlon, B., & Hudson, P. (1995). *Stop blaming start loving: A solution-oriented approach to improving your relationship*. New York, NY: W.W. Norton.

Olson, D., & Stephens, D. (2001). *The couple's survival workbook*. Oakland, CA: New Harbinger Publications.

Parrott, L., & Parrott, L. (2006). *Saving your marriage before it starts*. Grand Rapids, MI: Zondervan.

Sheikh, A. (2010). *Successful marriage: A myth or reality*. Retrieved April 1, 2012 from http://www.suite101.com/article/successful-marriage-a-myth-or-reality-a302543/print

Vernon, A. (in press). I will always love you: Dispelling marital myths through applications of rational-emotive behavior therapy. *Journal of Rational-Emotive Cognitive-Behavior Therapy*.

Chapter 4
Helping Couples Deal with Relationship Ambivalence

Richard Dowling, Siobhan O'Leary Evarts, and Ann Vernon

To be or not to be in this relationship … that is the question. Undoubtedly, couples throughout history have grappled with the complex issue of relationship ambivalence. However, given that our life expectancy is greater now than ever before, we undoubtedly spend more time in relationships, which also increases the possibility that we will experience more ambivalence if those relationships do not continue to be satisfying throughout the adult life cycle. Broder (2002), commenting on the reality that major life changes in relationships are very common in this day and age, noted that "women coming of age during the first decade of the twenty-first century will, on the average, have more husbands than children!" (p. 2).

When a couple comes to therapy with ambivalence, one or both individuals are likely asking themselves the infamous question: *Should I stay or should I go?* Kirshenbaum (1996) described the issue of relationship ambivalence as one of "dancing in the dark" (p. 13), commenting that while everyone experiences occasional doubts about whether or not they want to be in a relationship with his or her partner, relationship ambivalence is when major attention is focused on trying to decide whether to stay or leave. As this author noted, couples experiencing relationship ambivalence are struggling with the fact that the relationship may be too good to leave but too bad to stay.

R. Dowling (✉)
The Thought Exchange, LLC: Center for Personal Achievement, Morristown, NJ, USA
e-mail: smartway@mindspring.com

S. O'Leary Evarts
Albertus Magnus College, New Haven, CT, USA
e-mail: siobhanoleary@gmail.com

A. Vernon
University of Northern Iowa, Cedar Falls, IA, USA

Albert Ellis Institute, New York, NY, USA
e-mail: ann.vernon@yahoo.com

A. Vernon (ed.), *Cognitive and Rational-Emotive Behavior Therapy with Couples: Theory and Practice*, DOI 10.1007/978-1-4614-5137-2_4,
© Springer Science+Business Media New York 2012

The purpose of this chapter is to focus on the therapeutic task of helping couples evaluate the degree to which they want their relationship to continue. The authors will provide practical techniques for facilitating this assessment and strategies for helping each person (and the couple) to either separate or stay together. The applicability of these strategies will be illustrated through a case study.

What Is Relationship Ambivalence?

Ambivalence is defined as simultaneous and contradictory attitudes or feelings (as attraction and repulsion) toward an object, person, or action (www.merriam-webster.com). At times, the decision of whether or not to stay in a relationship is subjectively clear to the individual, particularly if there is abuse, infidelity, or a substance use problem. More often than not, however, relationship ambivalence is a painful state of feeling "stuck," where one or both members of the couple are pondering the following questions: Is it better to stay or is it better to leave? Can he/she/we/I actually change? And what if he/she/we/I don't change—then what? What would life look like without this relationship? What about all the memories and the history we share? As Kirshenbaum (1996) noted, dealing with relationship ambivalence is not as simple as evaluating the pros and cons of the relationship.

Relationship ambivalence is a very subjective state that cannot or should not be eradicated by adopting the values and opinions of others. When one or both members of a couple are in a state of relationship ambivalence, she or he may seek support and guidance from family members, close friends, or others who have dealt with similar relationship problems. In some ways this can be helpful, if it helps to clarify values and viewpoints and provides a sense of support. Too often, however, the barrage of opinions will result in increased anxiety and confusion because nobody really understands the dynamics of another person's relationship, and the things that might be contributing to ambivalence for one person or a couple probably would not be the same for another. A further complicating factor is that when one or both partners feel ambivalent, it is not uncommon for there to be distancing—spending less time together, talking less, or not discussing important things, thus creating further complications.

Strategies to Address Relationship Ambivalence

There are strategies that therapists can use to help couples and individuals battle their way out of the pain of the ambivalence and move toward acceptance and rebuilding, whether that means being together or apart. The rubric for these strategies includes the development of five main areas or skills: healthy secondary emotions surrounding the ambivalence, as well as disputing distorted cognitions; communication and assertiveness; consequential thinking; existential questioning; and comparative analysis.

Healthy Secondary Emotions and Cognitions

One of the fundamental theoretical tenets of Rational-Emotive Behavior Therapy (REBT) is to assess and subsequently treat any secondary disturbance that is related to the presenting problem. The state of ambivalence is both thought-centered and feeling-centered. People experience the discomfort of ambivalence in the conflict of beliefs and attitudes, as well as emotions. In the ABC model of REBT, the Activating Event (A) does not trigger the emotional Consequence (C). Rather, the Belief (B) is responsible for unhealthy emotions. Even though the experience of ambivalence involves both thoughts and feelings, it is usually distressing feelings such as anxiety, depression, anger, or guilt (C-Consequence) that bring clients to therapy. They may also be exhibiting unhealthy behaviors that are becoming problematic (also a C-Consequence).

Ellis (1994) strongly recommended that one of the first tasks of the therapist is to focus clinical attention on the secondary disturbance about the ambivalence. Therapists hear versions of such secondary disturbance in statements such as the following:

- I can't stand feeling stuck like this; I can't stand the anxiety.
- I should be able to figure this out; I must make a decision.
- I can't take it anymore.
- I'm a horrible person for thinking about leaving her (or him) after all these years.

These examples of beliefs may be creating secondary disturbance. It may be that the individual is in the process of deciding whether to stay or leave; however, if this creates anxiety or depression regarding that decision-making process, the problem worsens because the individual also has to deal with guilt, self-downing, and anxiety in addition to the fundamental problem of staying or leaving. Obviously leaving a relationship is a major life decision for most people and they don't want to make a decision of this magnitude if they are depressed, guilty, or anxious because these unhealthy negative emotions can cloud their ability to effectively evaluate the options. So it is best to deal with demands, awfulizing, low frustration and discomfort tolerance, and negative global ratings of worth (self, other, and life) before exploring the viability of the relationship and its future course. The therapist achieves this by challenging irrational beliefs like the ones listed above in the example and replacing them with rational alternatives, such as the following:

- I do not like feeling stuck, but I certainly can stand it for the time being. I don't like being anxious, but it won't last forever and I can tolerate the moments of discomfort while I try to come up with other ways to reduce it (i.e., diaphragmatic breathing, progressive muscle relaxation, cardiovascular exercise, problem solving).
- There's no timeline on making a decision as important as this one; if it takes time, it takes time. I just have to deal with it.

- I want to have a clear direction, but I don't actually *need* to have it *immediately*; I can survive right now despite it, and even find moments of happiness as I work through this challenging time in my relationship.
- Considering leaving my wife/husband/partner after all these years doesn't make me a completely *horrible* person; there are many other aspects about myself and my past that are positive/strengths.

Once the therapist is able to help the client to work through this secondary disturbance and cultivate healthy secondary emotions about what it means to be in a state of ambivalence, the next step is to help the individual or the couple identify and dispute irrational beliefs and distorted cognitions that may be contributing to the ambivalence, such as the following:

- I must have a perfect relationship.
- I shouldn't have to work on a good relationship.
- I should know what I want.
- Relationships shouldn't be so complicated.

Logical, empirical, and functional disputes can be effective ways for the therapist to address these beliefs: How logical is it to think that there is a perfect relationship? Where's the evidence that relationships don't need work? How realistic is it to think that you should always know what you want? How does it help you to think that relationships shouldn't be so difficult? It is also helpful to deal with distorted cognitions, such as the following:

- *Tunnel vision*: We haven't had good sex in years (when in fact it has only been bad in recent months).
- *Arbitrary inference*: My partner is acting this way because she (or he) no longer trusts me.
- *Overgeneralizing*: We never have good times together.
- *Mind reading*: My partner should know what I want out of a relationship without having to tell him or her.

Educating the couple about how these thoughts distort the reality of the relationship is important because it is difficult to work on ambivalence if they don't have a realistic picture of the relationship.

Communication and Assertiveness

Communication and assertiveness skills facilitate both a healthy relationship as well as successful work regarding the decision to stay or leave the relationship. If these skills are lacking, the therapist should begin helping clients develop these skills, particularly focusing on "I" messages as opposed to "You" messages which tend to put people on the defensive (Gordon, 2000). For example, the therapist can teach the couple the difference between these two forms of communication

through role-playing. Taking one of the couple's issues, the therapist would play the role of the wife, telling her husband, "I'm sick and tired of this relationship; you never act like you care about me and I don't see the point of trying to make it work." Most likely, the husband will be defensive in his response and the communication will go nowhere. In contrast, the therapist can role-play an example of an "I" message: "I'm worried about where our relationship is going; we've become so distant and I don't know what's going to happen." Chances are this type of message will result in more open communication. It is also important for clients to learn how to communicate assertively, without displaying aggressiveness, passivity, or passive-aggressiveness. One basic assertiveness strategy is to break up the unit of communication into four parts (Fuller, DiGiuseppe, O'Leary, Fountain, & Lang, 2010):

When ______________________________

I Feel ______________________________

Because ____________________________

I would like _________________________

Part 1: *When* → Here, it is important to explain to clients that they should avoid using the word "you" in this section. As noted above, using "you" language can create a defensive reaction in the listener. As a result, the other person will not be optimally listening to, considering, understanding, or hearing what their partner is saying; rather, a good portion of the listener's cognitive energy is spent simultaneously constructing a defense to your statement. Teach the client to use either "I" language or a description of the event/scenario instead, such as "When we don't speak for long periods of time …"

Part 2: *I Feel* → In this section, it may be appropriate to educate the client about the different types of emotions, and in fact, this may become part of a larger therapeutic goal of self-awareness. Encourage clients to genuinely communicate their emotions; help them choose words that may be less likely to elicit a defensive response. Saying "I feel anxious and confused," "I feel concerned," or "I feel frustrated" will probably affect the listener differently than "I feel like I want to rip your ugly face off," which is actually not a feeling response; it is just a description of a feeling. Regardless, a comment like this will likely provoke anger. "When we don't communicate for long periods of time I feel anxious and concerned …"

Part 3: *Because* → Here, clients will be instructed to describe their thought processes, reasoning, or rationale that drive their emotional reaction. It is important to describe the situation with the least amount of an overgeneralized, accusatory tone so as to minimize a counterproductive reaction from the listener, by saying something like "When we don't speak for long periods of time I feel anxious and concerned because I think our relationship is in jeopardy."

Part 4: *I Would Like* → The task for clients in this section is to present an alternative. Often, it may seem difficult for listeners to cooperate, compromise, validate, or solve a problem if they are having difficulty generating another option for the scenario. Here, the client requests an alternative as specifically as possible, without merely saying "I don't want you to do that anymore." Rather, try to move the client toward an alternative. Based on the previous example, one partner might say to the other, "I would like us to spend quality time together each day for at least 30 min."

A key feature of assertiveness training is to prepare the client for perceived failure and frustration. It is possible, and even likely, that one member of the couple could communicate assertively to his or her partner and still not achieve the desired effect. It is important to explain to the couple that this style of communication is much healthier and much more likely to move them toward their goal; however, it is not a guarantee.

Communication skills can help a relationship thrive or lead to its demise. The Uncertainty Reduction Theory (URT) posits that individuals are motivated to reduce daily uncertainty across a plethora of lifestyle domains, including intimate relationships (Berger, 1987; Erber & Erber, 2001). Research has suggested that there may be a relationship between communication, certainty, and relationship dissolution (Erber & Erber, 2001; Parks & Adelman, 1983). Individuals' frequent communication with partners, as well as family and friends of their partners, was related to greater certainty about the individual's own relationship. Skilled communication may prevent the internal process failure within the relationship that could lead to dissolution (Erber & Erber, 2001). Therefore, it will be beneficial for the therapist to address communication and assertiveness skills with the intention of de-muddling the ambivalence and propel a movement toward greater certainty.

Consequential Thinking: The Cost–Benefit Analysis

An analysis of consequences for each potential choice can be very helpful to the partner or the couple who is experiencing relationship ambivalence, creating a list of pros and cons of staying or leaving the relationship: What are the benefits of staying in the relationship? What are the drawbacks of staying? Then, the other side: What are the benefits of leaving the relationship? What are the drawbacks of leaving? However, the basic Cost–Benefit list is not the ultimate answer to eradicating relationship ambivalence. While this exercise may be effective in helping couples articulate and organize their thoughts, it is rarely possible to come to a decision regarding the ambivalent state of the relationship through this exercise alone because it fails to address the emotional and all-encompassing discomfort of relationship ambivalence. A Cost–Benefit Analysis (CBA) may help a couple with a more objective decision such as whether or not to buy a new house or take jobs with longer hours and higher pay, but when the decision involves whether or not to leave the

relationship and venture into the unknown with uncertain financial resources and familial/religious/social support, this exercise may be marginally useful. As Kirshenbaum (1996) stated, "When it comes to relationships, the balance-scale approach is the problem, not the solution … How can you weigh the things you know about your relationship in the present against a huge uncertain future?" (pp. 19–20). A couple could spend hours constructing an intricate and detailed CBA, but in the end, they are probably going to look at the therapist and say, "So what do we do?" This question is often followed by, "What if we make the wrong decision?" The short answer is that there will rarely be a clear answer to whether a relationship can be saved, and whatever the client or the couple chooses will rarely be accompanied by certainty that it was the "right" choice. This is why the next skill set, existential questioning, is important to address, albeit outside of the purist realm of REBT/CBT.

Existential Questioning and the Subjectivity of Equity Theory

Relationship ambivalence is like being in limbo, and it can be very detrimental because it results in significant emotional distress and it depletes an individual's or a couple's energy. As Kirshenbaum (1996) noted, "Ambivalence doesn't produce real answers. It's just a dangerous trap" (p. 7). Getting out of the "trap" isn't simply a matter of listing the pros and cons of the relationship, which is why existential questioning is important.

Existential questioning. The consequential thinking exercises of a CBA can actually be more effective after engaging the client or the couple in a philosophical, existential-humanistic questioning exercise about the subjective meaning in one's life. Afterwards, he or she may have a better lens through which to evaluate the level of importance of each of the factors on the CBA list. After this exercise, the list becomes infinitely more valuable as a tool. Please see Appendix A for an example of this modified CBA.

The modern blend of existential-humanistic psychology asserts that people have a natural proclivity toward positive, healthy development and are fundamentally capable of providing themselves with direction in life. Take the metaphor of an acorn as an example. If an acorn is given the right conditions (soil, water, sunlight), it will automatically grow in positive ways, resulting in a tremendous oak tree. For those that are struggling with issues such as ambivalence, the therapist–client relationship can provide them with the positive environment necessary to work through their struggles. The client's experience of a genuine interaction with the therapist (including unconditional positive regard and accurate empathic understanding) enables the client to become more aware of his or her values and subjective meaning of life. The client or the couple learns to trust himself or herself as an internal gage of right or wrong rather than looking to others for direction. The therapist maintains a deep respect for and acceptance of the values of the client, regardless of whether

or not they differ from the therapist's own, consistent with Ellis' (1994) concept of unconditional other acceptance, UOA.

Ellis' theory of REBT is based on a similar humanistic philosophy of existence. The therapist is not the "all knowing" expert; rather, the therapist and client work together collaboratively. If the therapist is successful at challenging distorted, irrational thoughts that are leading to disturbance and helps clients replace those irrational beliefs with rational alternatives, they will be more emotionally stable. When anxiety has been transformed into concern, depression into sadness, anger into annoyance or tolerable frustration, and guilt into regret, clients will now be experiencing healthy negative emotions related to the ambivalence. Answering the powerful question—*should I stay or should I leave*?—becomes the responsibility of the client alone; for now she or he possesses a greater sense of self-awareness and is able to answer the question independently. The client can now use his or her own phenomenological subjective experience and value system as a guide to working though the CBA.

The client may benefit from various exercises that address values clarification and goal-setting. Some examples of such existential exploration are as follows:

- What do I want from my life?
- What gives my life purpose and meaning?
- When I look at the future, what elements would be unfathomable to have as a part of my life? What elements would be unfathomable if they were missing from my life?
- If my obituary highlighted three personal traits, three relationships, and three behavioral patterns (or accomplishments) that best represented my life, what would I want them to be?
- How would staying in the relationship contribute to these factors listed in the obituary? How would leaving affect it?

Equity theory. While reviewing the material from the CBA, the client may struggle with the idea of reciprocity between one's self and his or her partner. Proponents of Equity Theory (Adams, 1965; Erber & Erber, 2001; Hatfield, Utne, & Traupmann, 1979; Walster, Berscheid, & Walster, 1973; Walster, Walster, & Berscheid, 1978) posited that individuals evaluate their own outcomes in relation to their inputs and efforts, and then compare their status to that of their partners. Adams (1965) developed this idea into a formulaic model:

$$\frac{O_A - I_A}{I_A} = \frac{O_B - I_B}{I_B}.$$

In sum, it would be optimal for a partner in a couple relationship to provide or give those things that are more valuable to his or her partner than the cost for him- or herself to give, and to receive from the partner those things that are more valuable to the individual than the cost for the partner to give. If a client's partner really

appreciates the bed being made every morning, and the client couldn't care less either way and doesn't really mind doing it, it might make sense to just make the bed before leaving for work since the payoff (partner's appreciation) far exceeds the effort that the client exerts to do it.

This concept of Equity Theory can be applied to the task of the CBA. Discussing this idea with a client or a couple who is struggling with ambivalence might help him or her see what is really important and what is worth compromising. However, the essence of Equity Theory is highly subjective, and in some cases, the couple is in an inextricable place where neither person is willing to input anything at all because of the cycle of resentment.

After an existential exploration of the client's subjective value system and personal meaning (for life and the relationship), it is important to revisit the CBA. Guide the client or the couple through each item and present the challenge of identifying whether those advantages and disadvantages are for short term or long term. The fruits of the existential exploration and values clarification can serve as a platform for rating the level of importance of each advantage and disadvantage on a subjective Likert-type scale. For example, the therapist might say, "Given that these are your main goals in life, and this is how you derive meaning and purpose, how important is it that your partner is a mediocre cook who only initiates sex once a week and gets cranky when she is tired?" As Broder pointed out in *Can Your Relationship Be Saved*? (2002), it is important for the clients to use their imagination and honestly assess the following during the CBA: Can I live with this forever? Is there potential for change? If not, then is this where I still want to be?

Comparative Analysis

Since the path out of ambivalence is subjective and the aftermath is so very different from one couple to the next, it is challenging to find data to clearly support a specific treatment for relationship ambivalence. There are, however, a number of relationship therapists who have made thoughtful clinical observations throughout their years of work and subsequently have developed helpful tools to use when working with such clients.

Kirshenbaum's qualitative diagnostic system. Mira Kirshenbaum (1996) adopted a quasi-diagnostic system to help couples diagnose the viability of their relationship. This system is based on the years of feedback she obtained from other couples in her outpatient clinic in Chestnut Hill, Massachusetts. The exploratory research that guided the development of these diagnostics was based on a sample of over 800 participants who were more or less equally divided between men and women and patients as well as research participants. According to Kirshenbaum's coinvestigator:

> The participants were asked to retrospectively report whether they were pleased with or regretted their decision to leave or stay in a relationship. The participants were then asked to identify which issues most influenced them in making the decision. This enabled the

> researchers to generate correlation estimates, demonstrating whether focusing on a particular issue was positively correlated or not with decision satisfaction. The book only included issues that had a strong correlation and the issues were roughly ranked in order of correlation. So, for example, "Were things ever very good?" was very powerful: No one who said things had never been very good was unhappy at having left. This is exploratory research because (a) the sample was not random and (b) a much larger sample would have been needed for proper validation. But we also checked our findings against our own clinical experience and that of other clinicians. The findings not only fit the data, they made sense to us clinically (Dr. Charles Foster; personal email communication, 11/9/2011).

If a therapist decides to utilize a comparative analysis such as Kirshenbaum's (1996), including diagnostic questions such as: has your partner violated what for you is a bottom line? (p. 165) is there something your partner does that makes your relationship too bad to stay and he or she acknowledges it but is unwilling to do anything about it? (p. 146), or, putting aside your anger and disappointment, do you sincerely like your partner and does he or she appear to like you? (p. 113), it is imperative that the client realizes that these are not absolute in their diagnostic predictability. In other words, these are tendencies based on correlational data and clinical observation. People who answered yes to the question "Have you already made a concrete commitment to pursue a course of action or lifestyle that definitely excludes your partner?" at the time of entering therapy for ambivalence were usually happy that they left the relationship. As every statistics book will iterate and reiterate, correlation is not causation. The therapist can, however, use this comparative analysis as a set of talking points for the couple to explore the areas of potential weakness or strength in the viability of the relationship.

Factors Contributing to and Complicating Relationship Ambivalence

Broder (2002) maintained that passion and comfort are needed for relationships to thrive. He described passion as the romantic and sexual energy that initially brings the couple together, but as was pointed out in Chap. 3, this passion fades over time and is replaced by comfort, which Broder defined as "the ability to work things out, to enjoy each other's company, to respect each other, to share a common lifestyle, goals and values, and to live a peaceful and contented co-existence" (p. 8).

When couples are lacking in comfort and erroneously assume that there must be significant passion, problems ensue. The relationship may be conflictual, one or both partners may become indifferent, or the relationship becomes one-sided, where one partner puts more effort into the relationship than the other. When couples present in therapy, it is important to determine the level of indifference or one-sidedness in particular because these factors make sorting through the ambivalence much more difficult. It is not at all unusual that by the time a partner or a couple present in therapy that at least one of the partners already has a foot outside the door, so to speak, either because he or she has reached a level of indifference, is tired of putting all the energy into what he or she perceives as a one-sided relationship, or one or

both partners are "out the door" because of an affair. Whatever the case, the therapist will need to help one or both members of the couple assess factors such as the following (Broder, 2002, pp. 14–15):

- What was the relationship like when it was at its best?
- When and how did things first change?
- How have you changed within the relationship?
- How has your partner changed within the context of the relationship?
- How would you describe your relationship at its worst?
- What have you tried to do to make it better?
- What has worked?
- What hasn't worked?
- What do you believe you really want now (as opposed to what you should want or would merely accept)?

It is also important to assess whether as a couple, they still enjoy doing things together, how they feel when they are with their partner, and what would need to happen for the relationship to be fulfilling enough to make a commitment to stay. Asking the couple if they would become involved with this same partner if starting over again can also be a very revealing question.

Case Study Application

As has been noted, helping couples deal with relationship ambivalence is a challenging task for the therapist because there are many factors that can impede progress. This case study illustrates what happens when energy isn't put into the relationship and the couple begins to drift apart.

The Case of Peter and Tonya

Peter is a 34-year-old divorced/remarried male with no children who is currently living with second wife, Tonya, who is 36. This is Tanya's first marriage. Peter was originally referred by the Intoxicated Driver Resource Center (IDRC) for further assessment following an arrest for a DWI. Even though no further treatment was recommended based on Peter's reported abstinence from alcohol for the 12 months prior to the first therapy session, Peter asked if he could meet for issues related to his relationship with his spouse. He explained that over the past couple of years they have been drifting apart to the point where they now do very little together. He said that when they first met just after his first divorce, they had so much in common and enjoyed being together. Communication came easily and they had a lot of common interests and values, something that he had not had in his first marriage which lasted only briefly. Peter couldn't remember exactly when things started going

downhill, but he thought it might have been after they celebrated their tenth wedding anniversary by going on a cruise two years ago. Just shortly after the cruise Peter was having some struggles at work which necessitated long hours on the job, therefore preventing him from spending more time with Tonya. He didn't recall that Tonya had actually complained much about this; instead, she spent more time with a couple of her friends who were single on the nights that Peter had to work late.

Peter shared that over the course of the last two years, he has been less interested in Tonya sexually; it's as if they are roommates as opposed to lovers. There isn't much passion, they don't do romantic things together like they used to, and communication is becoming increasingly difficult. At times when he does try to communicate with her about issues at work he becomes angry because Tonya gives him unsolicited advice and seems much more critical than before. He stated that he just wants to express his frustration, not be told what he should or shouldn't do about it, but Tonya just won't give up. He has at times gotten to the point where he thinks he can't stand it and he just wants out of the relationship. On the other hand, he can still remember when things were better and he doesn't want another failed relationship. He admits to feeling guilty about not trying harder because basically Tonya is a very easy person to live with and on some level, he thinks he still loves her. He denies having any extramarital involvement, but admits that he would like the excitement and passion he had when he first met Tonya. He is really conflicted and thinks he should be able to figure out what to do. His ambivalence causes him to reject any attempts on Tonya's part to improve the relationship, which also results in guilt. He is torn—Should he stay or should he leave? In the case of his first marriage, it was easy to decide to leave because his wife had had an affair, but in this case, it's nothing that significant. Yes, Tonya does get on his nerves at times, but the more important issue is that he just feels rather "emotionally drained" and doesn't know if he has the energy or inclination to stay in the marriage.

Interventions. As Ellis strongly suggested it is helpful for the client to identify the upsets about the upsets first. Using the ABCs of REBT as a guide, the therapist helped Peter identify guilt and anxiety as emotions resulting from his thinking about being indecisive and ambivalent about his relationship. After the therapist helped him replace these negative unhealthy emotions with frustration and regret rather than high anxiety and guilt, Peter was more motivated to do what it took to overcome the ambivalence and make a decision. He also taught Peter how to clearly communicate with Tonya about what he needed from her when he attempted to talk to her about his frustrations at work. Instead of getting angry when she gave him advice, the therapist suggested that he send an "I" message, something like: "Tonya, I really just need you to listen to me; I'm not looking for advice." Peter was willing to try that.

Existential questioning was also used, initially with Peter, and later with the couple. In an individual session with Peter, the therapist asked him a series of questions (adapted from Broder, 2002, pp. 14–15): What was the relationship like when it was good, and what is different about it now? What has he done to try and make it better,

and how has that worked? What do he and Tonya have in common—what interests and values do they share? If he were to leave, what would he miss most (and least) about the relationship? Following this, the therapist guided Peter through a CBA which helped him clarify some of his reasons to stay or leave. Although this is often done before the existential questioning, in this case the therapist felt that since Peter's reasons for staying and leaving were rather vague, it might be more helpful to do this following a more careful analysis of the relationship that the questioning provided.

Because Peter had not really shared, for the most part, his ambivalence about the relationship with Tonya, the therapist suggested that it might be appropriate to do so at this point. He worked with his client on clear and assertive communication strategies so that Peter would be able to communicate effectively with Tonya about his relationship ambivalence. In a joint session, Peter told Tonya that he had been having mixed feelings about their relationship and was concerned that they were drifting apart. He shared some of his disappointments and disagreements with her in an appropriate way and Tonya concurred that she also felt some distancing but hadn't known how to bring it up or what to do about it. This is actually a very common occurrence, but the longer it continues, the more difficult it is to deal with because avoiding the issues doesn't make them go away. At this point the therapist asked them both individually to think about the last time they felt the relationship had been stronger and what was different about that from how things were now. Both partners were able to identify concrete differences and the therapist suggested that they might want to try doing some of the things that contributed to a more positive relationship. He and the clients outlined several different things to do, including spending an afternoon hiking together, which was something that had given them pleasure in the past, watching a movie together, and having a date night once a week, alternating as to who would plan the activity.

Behavioral strategies often are like band-aids, however, unless distorted cognitions are also addressed. In Peter's case, the therapist worked with him to dispel the myth that passion should never die and that without passion, there was nothing left. He used a psychoeducational approach which helped the couple understand that infatuation decreases over time, but that it can be replaced with a more companionable relationship. He also disputed Peter's irrational beliefs that in order to stay, the relationship had to be perfect, that there should be no conflict, and that he and Tonya must be in agreement about everything. He asked both partners to do an imagery exercise, in which they were to imagine that it would be like to stay together and how they might feel, versus ending the relationship. Following this intervention, it appeared that both partners had more of a desire to maintain the relationship, but Peter still struggled with "needing" more passion and excitement to jump-start the relationship again and at the same time, felt like he shouldn't have to "work" too hard at building a good relationship. To counter this, the therapist asked if he did routine maintenance work on his car or lawnmower to keep them functioning well, and if he did that and it worked, why couldn't he apply the same thinking to his relationship?

After several months in therapy, Peter and Tonya were in a much better place, albeit Peter still struggled with some ambivalence. The therapist pointed out that it takes awhile for a relationship to deteriorate if it doesn't get much attention, so it will take time and effort to rebuild it. He assigned bibliotherapy, *Can Your Relationship Be Saved* (Broder, 2002), as homework, and when each member of the couple took the self-assessment inventory (pp. 20–22), it was apparent that they had many positives that would bode well for their relationship.

As this case illustrates, relationship ambivalence is not something that is easy to work with. It would be easier if there were clear-cut issues that one or both partners simply found intolerable, such as infidelity, abuse, addictions, or other such issues. In reality, myths and misconceptions about relationships as discussed in Chap. 3 often contribute to relationship ambivalence because one or both partners cling to the idea that the relationship shouldn't change, it shouldn't take effort to jump-start it, and the passion should never die. Helping couples arrive at what Broder (2002) termed *comfort*, which is a more realistic concept based on mutual values and goals, common interests and lifestyles, and enjoyment of each other's company, is a much more realistic picture.

Conclusion

There is no easy answer to the issue posed at the beginning of this chapter, "to be or not be (in the relationship): that is the question." Couples throughout history have struggled with this dilemma, but it is perhaps more common now because people have less tolerance for relationships that aren't "perfect," as evidenced by a high divorce and remarriage rate in the United States in particular.

Cognitive therapists can work with relationship ambivalence by helping the couple see that there is no such thing as a perfect marriage, that relationships require work, that unrealistic demands and other distorted cognitions wreck havoc on relationships, and that there are not only various skills that can help the couple assess the degree to which the ambivalence is affecting the present and future of their relationship, but also there are techniques that can strengthen the relationship if they decide to stay together.

This chapter identified strategies that cognitive therapists can use to help couples and individuals deal with relationship ambivalence, including developing healthy secondary emotions, dealing with irrational beliefs, learning effective communication and assertive skills, doing a CBA, examining the relationship through existential questioning, and comparative analysis. Application of these techniques can facilitate the therapist's ability to help couples deal with a complex issue common to many relationships: to stay or leave. A primary focus for practitioners is helping the couple realistically assess the relationship by developing rational thinking skills, as well as other practical skills that can help them deal with the ambivalence.

Appendix A: Modified CBA Exercise Template Relationship Ambivalence: Should I Stay or Should I Go?

Staying

Advantages (benefits or rewards)			Disadvantages (costs and risks)		
S/T	L/T	Imp	S/T	L/T	Imp

Going

Advantages (benefits or rewards)			Disadvantages (costs and risks)		
S/T	L/T	Imp	S/T	L/T	Imp

Note: *First column* instructs client to identify whether each item is long term (L/T), short term (S/T), or both. *Second column* instructs client to identify the degree of importance, each item ranging from 1—not at all important, 2—slightly important, 3—moderately important, 4—very important, and 5—extremely important.

References

Adams, J. (1965). Inequity in social exchange. *Advances in Experimental Psychology, 2*, 266–300.

Ambivalence. (2012, February). Retrieved from Merriam-Webster: http://www.merriam-webster.com/dictionary/ambivalence

Berger, C. (1987). Communicating under uncertainty. *Interpersonal Processes: New Directions in Communication Research, 14*, 39–62.

Broder, M. (2002). *Can your relationship be saved?: How to know whether to stay or go*. Atascadero, CA: Impact.

Ellis, A. (1994). *Reason and emotion in psychotherapy: A comprehensive method of treating human disturbances*. New York, NY: Carol Publishing.

Erber, R., & Erber, M. (2001). *Intimate relationships: Issues theories and research*. Needham Heights, MA: Pearson.

Fuller, J. R., DiGiuseppe, R., O'Leary, S., Fountain, T., & Lang, C. (2010). An open trial of a comprehensive anger treatment program on an outpatient sample. *Behavioural and Cognitive Psychotherapy, 27*, 1–6.

Gordon, T. (2000). *Parent effectiveness training*. New York, NY: Three Rivers Press.

Hatfield, E., Utne, M., & Traupmann, J. (1979). Equity theory and intimate relationships. In R. Burgess & T. Huston (Eds.), *Social exchange in developing relationships* (pp. 99–133). New York, NY: Academic.

Kirshenbaum, M. (1996). *Too good to leave, too bad to stay: A step-by-step guide to help you decide whether to stay or get out of your relationship*. London: Penguin Books.

Parks, M., & Adelman, M. (1983). Communication networks and the development of romantic relationships: An expansion of uncertainty reduction theory. *Human Communication Research, 10*, 55–79.

Walster, E., Berscheid, E., & Walster, G. (1973). New directions in equity. *Journal of Personality and Social Psychology, 25*, 151–176.

Walster, E., Walster, G., & Berscheid, E. (1978). *Equity: Theory and research*. Boston, MA: Allyn and Bacon.

Chapter 5
Helping Couples Deal with Anger and Conflict

Vanessa Woods

Conflict among couples is inevitable, but if these difficulties are not addressed, anger and resentment toward partners gradually builds and may lead to aggression and the dissolution of the relationship. Although the 2007 United States Bureau of Justice Statistics reported a decline in the rates of nonfatal and homicidal partner victimization, the fact is that any form of aggression in couple relationships is a salient issue for some who seek counseling, so it is imperative to address this early on in therapy. That is not to say that anger typically results in aggressive behavior, but anger can impact couple relationships in numerous negative ways. Scherer and Wallbott (1994, as cited in DiGiuseppe & Tafrate, 2007) noted that anger has a more negative impact on relationships than any other emotion.

According to Kassinove and Tafrate (2002), as well as DiGiuseppe and Tafrate (2007), anger is universal and a common human response that people of all ages, cultures, educational levels, income levels, and backgrounds experience. In fact, Kassinove and Tafrate (2002) posited that it would be difficult to find a person who hasn't experienced anger. That having been said, anger becomes very problematic for some people when it is "excessive in frequency and duration and disproportionate to the event or people who triggered it" (Kassinove & Tafrate, 2002, p. 1). As we know, when people are angry they often say things they don't mean; they overgeneralize and blow things out of proportion or label their partner as lazy, irresponsible, or selfish. When things like this are during the heat of an argument, they are often stated in an aggressive tone that inhibits constructive communication. Seldom does this type of anger result in anything productive; in fact, it can destroy relationships.

The purpose of this chapter is to explore the types and functions of anger and to identify how to assess a couple's suitability and readiness for participation in treatment. The author will also explore irrational beliefs associated with anger and

V. Woods, M.A. (✉)
Integrated Forensic Psychiatry Program, Royal Ottawa Mental Health Centre, Ottawa, ON, Canada
e-mail: vanessa.woods@theroyal.ca

A. Vernon (ed.), *Cognitive and Rational-Emotive Behavior Therapy with Couples: Theory and Practice*, DOI 10.1007/978-1-4614-5137-2_5,
© Springer Science+Business Media New York 2012

provide case examples to illustrate how these beliefs manifest themselves in couples who have dysfunctional anger. Cognitive, emotive, and behavioral interventions that can be used to address issues related to anger and conflict in couple relationships will also be a focus of this chapter.

What Is Anger?

Kassinove and Sukhodolsky (1995) described anger as a negative emotion that varies in frequency, intensity, and duration. It is associated with distorted cognitions as well as verbal and physical behaviors. Tafrate and Kassinove (2009) stated that "anger is something that happens inside your body. It's an emotional response you consciously feel" (p. 6). Anger is a galvanizing emotion that is intended to address a given goal at times in which it is perceived to have been thwarted. In fact, many people would argue that their anger is justifiable; that they have a "right" to be angry if someone or something interferes with their goal. Kassinove and Tafrate (2002) noted that there is usually a perception of blame associated with anger, as if another person is seen to be the cause for it. According to Tafrate and Kassinove (2009), people become angry when they perceive a threat to their well-being, comfort, image, or property.

Anger can be further characterized as both functional and dysfunctional based on the quality of an individual's thoughts at the time of a given anger episode. When people experience functional anger, their thoughts are flexible with respect to addressing a given goal, while dysfunctional anger develops "from rigid and highly extended boundaries to the personal domain. Preferences are no longer personal and flexible guidelines for behavior, but become dictatorial commandments of self and others" (Eckhardt & Deffenbacher, 1995, p. 31). When individuals experience dysfunctional anger in the face of a threat to a given goal, "goal-directed behaviors become imperative rather than preferential" (Deffenbacher, 2011). The experience of dysfunctional anger is further characterized by an increase in frequency and intensity of anger episodes and may also include outbursts of aggression, periods of rumination, and the holding of grudges. Kassinove and Tafrate (2002) emphasized the longer-term negative impact of dysfunctional anger on individuals, including problems with interpersonal relationships, substance abuse, physical health concerns, problems in the workplace, and increased risk taking. Without a doubt, all of these can be very problematic for couple relationships.

Behaviors Associated with Anger

It is often assumed that if someone is angry, he or she is also aggressive. As previously noted, this is a falsehood, so it is important to distinguish between anger and aggression. Anger, as described above, is defined as an emotion, while aggression is

defined as a "motor behavior enacted with the intent to do harm and the expectation that harm will occur" (DiGiuseppe & Tafrate, 2007, p. 31). Anger may not always be accompanied by aggression and aggression may not always be accompanied by anger. More specifically, anger can be both inwardly and outwardly directed and the behavior associated with anger may either be goal-defeating or goal-enhancing. Individuals may behave aggressively when they experience anger because they have rigid, inflexible beliefs related to the fact that their goals are blocked and they have very little patience to address the issue at hand. This can be demonstrated in couples when one of the partners uses aggression with the intent to harm his or her partner who is perceived to be blocking the goal rather than remaining focused on addressing the actual goal. An example of this would be when Brad went through a great deal of effort to arrange a night out for himself and his partner, yet Sandra was not enjoying herself and was complaining. Brad then raised his voice, called Sandra names, yelled at her, and proclaimed that she never enjoyed any event that he arranged for them. The couple continued to disagree for the rest of the evening, and Brad abandoned his goal of having a pleasant evening with Sandra in favor of condemning her for the fact that she wasn't enjoying the evening. As a result, Brad's goal of experiencing an enjoyable evening with his partner was thwarted.

Specific examples of aggressive behavior include verbal aggression such as yelling and screaming and cursing, or physical aggression which may include throwing or banging inanimate objects, as well as pushing, shoving, or hitting another individual. It is important to note that aggression may be directed at the target of the person's anger, or it may be displaced, in which the target of the anger is different from the target of the aggression. For example, a woman might come home from work and behave aggressively toward her spouse because she didn't express her anger towards her boss earlier in the day.

Individuals may also behave passively when they feel angry by disregarding their goal rather than addressing the concern directly. Anger episodes with passive behaviors may be defined as dysfunctional because the goal has been abandoned. In the case of Brad and Sandra, if Brad chose not to say anything to Sandra when she was complaining, he may still have abandoned his goal of a pleasant evening since he was most likely consumed with his anger toward her. Individuals may also behave passive aggressively toward their partner and the target of their anger when the intent is to harm their spouse indirectly, such as intentionally not completing a favor or a task for him or her.

Individuals may also behave assertively in the face of an anger episode, which allows them to remain focused on attaining the goal while ensuring that no harm will come to them or others in the process. Those who are able to behave assertively when angry have flexible beliefs and use their anger in a functional manner. For instance, if Brad had behaved assertively when Sandra began to complain, he could have expressed his thoughts and feelings about the situation to her at the time, while articulating his intended goal for the evening. By addressing his concerns to Sandra in this fashion, he is more likely to achieve his goal because he remains focused on it.

Beliefs Associated with Dysfunctional Anger

From an REBT/CBT perspective, dysfunctional anger is the result of beliefs, primarily in the form of demands, that interfere with individuals' ability to think rationally and address conflicts in a healthy manner. These beliefs may or may not be true, and they are usually exaggerated, distorted, or inaccurate. Helping couples identify their beliefs associated with their anger is a key element in the therapeutic process.

Demandingness. Demandingness is considered to be the primary irrational belief that underlies most dysfunctional negative emotions (Dryden & David, 2008), and Kassinove and Tafrate (2002) posited that demandingness is the most common anger-related belief. A demand is an unrealistic and absolute expectation of a situation or of another person (Walen, DiGuiseppe, & Dryden, 1992): a partner *must* or *must not* do something. When couples engage in demandingness they escalate their preferences to absolutistic "rules" that others should adhere to. Instead of wishing that her spouse would be more romantic and attentive, a woman might think that her husband *must* be more loving and is angry when he doesn't treat her exactly as she thinks he should.

Low-frustration tolerance (*LFT*). LFT is very common in couples who present with relationship difficulties, especially those with anger issues. LFT is defined as "the person's perceived inability to withstand the discomfort of an activating event" (Walen et al., 1992, p. 129), and individuals who experience this are likely to think they cannot stand something or that things shouldn't be so hard or take so much effort. When partners demand that their counterpart behaves in a certain fashion but doesn't, they often get frustrated and their thinking escalates to "he's doing this again and I can't stand it. His (or her) behavior is intolerable." With beliefs of this nature, anger remains at a high level of intensity.

To illustrate, let's take the case of John and Sarah who have lived together for approximately 15 years. Both are in their 50s and have presented in couple's counseling as a result of long-standing difficulties related to what they define as poor communication. Sarah is also in group therapy to address issues related to dysfunctional anger. The couple acknowledges frequent anger episodes but believe Sarah is the only one who has a problem with anger.

Sarah: "John and I had another fight last week and I'm still angry about it."
Therapist: "Can you tell me what happened?"
Sarah: "John keeps taking phone calls while we are having dinner together and I find his behavior to be very disrespectful toward me."
John: "But it's not just any phone call, Sarah, it's my boss that's calling me. You know that."
Therapist: "Does this happen often?"
Sarah: "Almost every night."
John: "Sarah, you're exaggerating. It has been most evenings, that is true, but only since I received my promotion."

Therapist: "Sarah, when this happens, how do you feel?"
Sarah: "Really angry."
Therapist: "And when you are so angry, can you tell me what you are thinking?"
Sarah: "That he's rude and doesn't care about being with me. I think he should tell his boss that he is eating and will call him back. And it's not just his boss; he'll take calls from anyone."
Therapist: "And what do you typically do when you are angry?"
Sarah: "I tell him how angry I am and I usually yell at him."
Therapist: "John, how do you tend to behave when Sarah tells you she's angry and yells at you?"
John: "I just get up from the table and leave the room."
Therapist: "Sarah, do you think your anger toward John's behavior is functional or dysfunctional?"
Sarah: "Dysfunctional."
Therapist: "And why is that?"
Sarah: "Because I probably shouldn't have such a strong reaction to him taking a call. I also don't think it does any good to yell, but sometimes I just get so frustrated. Meal time is one of the only times we have together and I just wish he would stop taking calls."
Therapist: "Wishing he wouldn't take the calls is very reasonable. But suppose that you don't have any control over that, and let's just assume that John continues to answer his phone at the dinner table. How would you like to handle the situation?"
Sarah: "I would like to ask him politely to end the call as quickly as possible."
Therapist: "And what is preventing you from doing that?"
Sarah: "I don't know…I guess just thinking that he shouldn't be so disrespectful to me and that I can't stand it."
Therapist: "And suppose John continues to do this; do you think you *really* can't stand it? Can you think of anything worse?"
Sarah: "When you put it that way, of course there are things that are worse, and it's not that I really can't stand it; I just don't like it."
Therapist: "When you think to yourself that you can stand it, you just don't like it, is your anger less intense?"
Sarah: "Yes—then I guess I'm just more irritated."
Therapist: "I see. John, has Sarah ever behaved disrespectfully to you?"
John: "Yes."
Therapist: "And is there any rule that states that Sarah *musn't* be disrespectful?"
John: "I'd like her to be more respectful at those times, but she doesn't have to be. She can do whatever she wants and I'll just have to deal with that."
Therapist: "Sarah, what is the difference between what you said that John *musn't* be disrespectful and what John said, which was 'I'd like her to be more respectful, but she doesn't have to be. She can do whatever she wants and I can deal with that?'"
Sarah: "Well, the way John puts it sounds nicer, I suppose."
Therapist: "Which one is more compatible with reality, would you say?"

Sarah: “John’s.”
Therapist: “And why is that?”
Sarah: “Because, at the end of the day, I can’t control him—I can only control myself, so demanding that John does or doesn’t do something doesn’t make any sense.”
Therapist: “Sarah, where’s the evidence that when John behaves in a manner that you perceive as disrespectful that you ‘can’t stand it?’”
Sarah: “There isn’t any; I *can* stand it, but I don’t like it.”
Therapist: “That’s fine. You don’t have to like it. But let’s suppose John behaves disrespectfully in the future and you tell yourself that you’d like him to be more respectful, but he doesn’t have to be, how are you likely to behave?”
Sarah: “I’m not sure. Maybe I’d just go on eating my dinner and keep telling myself that I don’t have to get upset. I suppose I’d ask him politely to end the call as soon as possible.”
Therapist: “John, how do you think you would respond if Sarah reacts in this way when you take a phone call during dinner?”
John: “I would do my best to end the call as soon as possible so we could enjoy our meal together.”
Therapist: “So can you see that it isn’t the fact that John is taking the calls that upsets you so much, Sarah? It’s what you are thinking—that he *shouldn’t* do this and that you *can’t stand it*—that causes you to get so angry?”
Sarah: “Yes, I see it. I just hope I can keep thinking that way because I don’t like getting angry.”
Therapist: “That’s great. So, as a homework assignment between sessions, I would like the two of you to continue to eat dinner together every night. Sarah, before the meal is served, I would like you to imagine John receiving a call from his boss and talking on the phone over dinner, and to then remind yourself of your new, rational belief, and to picture yourself addressing your concern with John in a polite, respectful manner. Do you think you can do that?”
Sarah: “Yes.”

As the therapist has illustrated here, rather than trying to change Sarah’s perspective of John’s behavior, the session focused on identifying Sarah’s underlying, demanding belief that John *musn’t* be disrespectful and her LFT for John’s behavior at those times. The therapist also employed disputation techniques that involved John in the process. A key component of couples’ sessions includes the assigning of homework to help them internalize their new rational beliefs between sessions.

Awfulizing. Kassinove and Tafrate (2002) described awfulizing as the “tendency to exaggerate the level of hardship associated with aversive life events” (p. 37). An *awfulizing* belief overstates a situation with the use of key words such as *terrible*, *awful*, and *horrible*. When a demand is preceded by the belief that something is *awful*, it can readily result in anxious feelings and avoidant behaviors. When

individuals feel anxious, they may also make a connection between the A (activating event) and the C (emotional and behavioral consequence), thinking that their partner is responsible for their anxiety, leading to a secondary anger episode directed at their partner. This is often the case with couples who have financial concerns. In these situations, the therapist has two tasks: to address the anxiety about the future and to address the anger in the present. The therapist should help the couple understand that dysfunctional anger is not helpful to them if they want to achieve their goal of improving their relationship.

To illustrate, consider the case of Robert and Janet who have been living together for 5 years, presenting in counseling because of conflict related to financial stressors. After some preliminary data gathering, the therapist initiated the session by asking them to describe the problem with a recent example.

Janet: "Well, just this week Robert and I got into a disagreement and I'm still angry about it."

Therapist: "Tell me more about the disagreement."

Janet: "I'm just fed up with him just lying around the house all day, basically doing nothing while I'm at work trying to make enough money for us to live on. It's not fair that I'm the only one who takes on this responsibility."

Robert: "What are you talking about? I resent what you just said. I'm not just lying around. I'm doing the best I can; it's not my fault that I don't have a job that's as important as yours."

Therapist: "Robert, you said that you resent what Janet said about your behavior, so I assume that you are angry?"

Robert: "You better believe it."

Therapist: "What is it specifically about what Janet said that you are angry about?"

Robert: "Janet thinks I contribute nothing to our relationship when I'm really trying my best to be a provider. She *should* be more understanding of how hard it is for me to find work."

Therapist: "I understand that you would like Janet to be more understanding of your situation, but is there anything to say that she *should* be?"

Robert: "But she's my partner; of course she has to be."

Therapist: "If Janet were in your shoes without a job, is there any rule that says that you should be more understanding of how difficult it is for her to find work?"

Robert: "No, there's no rule."

Therapist: "I see. So if you don't have to be understanding of Janet's difficulties, is there any reason that Janet has to be understanding of yours?"

Robert: "No, but it would be nice if she was more understanding."

Therapist: "That is true, it would be nice, but can you change the way Janet thinks or behaves any more than she can change the way you think and behave?"

Robert: "No; we can't control each other."

Therapist: "That's right. Now, Janet, I understand that you don't want Robert to just lie around the house when you are at work. First of all, where is the evidence he is just lying around, and what would you prefer he do with his time instead?"

Janet: "Well, I don't know exactly what he does all day, but I assume that if he wasn't just lying around he'd have a job by now. I want him to be looking for work."

Therapist: "And why is it so important to you that he get a job?"

Janet: "Because money is a huge problem for us. We can hardly make ends meet; for the past two years we've barely managed to pay our bills. This really stresses me out and we wouldn't be in this situation if he had a job or tried harder to find one. It's not fair that I have to handle all of this by myself."

Therapist: "And suppose Robert remains unemployed?"

Janet: "It would be awful. I just don't know if I can stay in this relationship if something doesn't change."

Therapist: "I understand that you are both in a very difficult situation here. Janet, how do you feel when you tell yourself that your situation is *awful*?"

Janet: "I'm so anxious! I worry all day and I can't sleep at night. I keep thinking we won't have enough money to make our mortgage and car payments."

Therapist: "And suppose that "worst case scenario" actually happens."

Janet: "I don't know…it's too awful to think about."

Therapist: "Can you think of anything you could tell yourself that would help you deal with the possibility of the worst case happening?"

Janet: "I don't know. It hasn't happened yet, so maybe we will continue to scrape by."

Therapist: "Exactly. Is it really helpful to you to think the worst?"

Janet: "Not at all…because then I don't sleep at night and I'm less effective at work and things bother me more when I'm tired, so then I worry that I might get fired because I am less productive. Then when I get home I guess I take it out on Robert."

Therapist: "And how helpful is it to get angry at Robert?"

Janet: "It probably doesn't help, but it's his fault that I'm so anxious and angry."

Therapist: "Oh, so Robert has the power to make you feel angry and anxious?"

Janet: "I guess. I wouldn't be angry and anxious if he had a job."

Therapist: "I wonder if other women in your situation would feel as angry and anxious as you do under these circumstances?"

Janet: "I don't know. I suppose some wouldn't."

Therapist: "And if they wouldn't be as anxious and angry, what do you suppose they might be thinking?"

Janet: "Maybe that it doesn't do any good to worry about it and that getting angry isn't going to help the situation."

Therapist: "Exactly. So can you apply this thinking to your situation?"

Janet: "I can try."

Therapist: "And if you think about it, who controls whether or not Robert gets a job?"

Janet: "Robert does."

Therapist: "I agree. How does it help you, then, to demand that Robert *must* get a job?"

Janet: "It doesn't. I just really want him to get one."

Therapist: "Of course. That's very realistic. But if you just *want* him to get a job, rather than thinking he *must* get one, how does that affect your relationship with Robert?"

Janet: "I wouldn't be as angry and we probably wouldn't fight as much."

Therapist: "Right. And even though it's been very difficult, have you been able to tolerate this difficulty over the last few years?"

Janet: "Barely, but we have gotten by."

Therapist: "So if you were to say that your present difficulties are very, very hard rather than *awful*, do you think you would feel differently?"

Janet: "Yes….maybe I'd just be very worried but not quite as anxious."

Therapist: "And if you were able to be only worried about it, how would that affect your interactions with Robert relative to his getting a job?"

Janet: "I can't make him get a job, but I could sit down with him and go over our financial situation and maybe we could think of ways to address this problem."

Therapist: "And Robert, how would you react if she were to do that?"

Robert: "I'd be more willing to talk about it and try to do something about it. I just don't like her yelling at me or nagging me constantly because I haven't been able to find a job. I just don't like to let her down and I know how hard she is working. And I have been trying to find work… she just doesn't give me any credit for that."

Janet: "It would help if you would communicate with me about these efforts. I can't read your mind."

Robert: "I just hate to even bring up the topic because I feel like whatever I do it won't be enough."

Janet: "Well, I am glad to know you have been looking. We just need to talk about this more without yelling and screaming about it."

Robert: "I agree."

Therapist: "I think the way in which you have just been talking is a good example of how you can work together on the issue because without the anger and resentment you're in a much better position to work on the real issue in a productive manner."

As this case illustrates, the therapist initially addressed Robert's anger related to his demand that Janet be more understanding of his difficulties in finding work in order to help diffuse Robert's anger to allow him to participate more fully in the session. The therapist then turned the attention to Janet's anger toward Robert and only when that was addressed could the anxiety be explored. Had the therapist dis-

puted the irrational belief related to Janet's anxiety first, he or she would run the risk of either minimizing Janet's anger related to Robert's lack of employment or not addressing the secondary anger at all.

Global evaluations of human worth. When people are angry they frequently condemn the person they think has offended them, often resorting to global evaluations and overgeneralizations (Kassinove & Tafrate, 2002), such as "He's an idiot; he can't even keep our finances straight." Obviously when one or both partners engage in negatively rating the other person, anger can be intense and result in arguments or more escalated verbal or physical aggression.

In addition to negative rating of partners, couples will often describe themselves as "unlovable" in the eyes of their partner, rating their own worth and associating this with something their partner does or doesn't do. Individuals in such situations feel hurt, humiliated, anxious, or angry. This anger is seen as secondary to the initial problem. While the anger episode and its corresponding irrational beliefs can be reviewed with the couple, it is also beneficial to explore the idea that one is "unlovable." The identification of the inability to accept oneself unconditionally may be achieved through the use of inference chaining (Walen et al., 1992), a technique that assumes that the person's appraisal of a situation is true in order to reveal the corresponding, irrational belief. Let's take the case of Michael and Jennifer, a couple who have been married for the last 12 years. They have presented in couples counseling as a result of frequent disagreements over what they report to be trivial issues. These episodes have led to increasing resentment and a decrease in sexual intimacy.

Therapist: "What would you like to work on in this session?"
Jennifer: "We had a big fight last Monday."
Therapist: "Tell me more about what happened."
Michael: "I had made a wonderful, romantic dinner just for the two of us and she didn't come home from work until after 8:00 p.m."
Therapist: "How did you feel when she came home so late?"
Michael: "I was angry and wouldn't talk to her for the rest of the night."
Therapist: "Michael, what did that mean to you that Jennifer was late coming home to your wonderful meal?"
Michael: "It meant that she doesn't appreciate me and that I'm unlovable in her eyes."
Therapist: "Alright, let's just assume that you are unlovable in Jennifer's eyes. What does this mean to you?"
Michael: "It means that I'm worthless to her."
Therapist: "And suppose that's true? Then what?"
Michael: "Then it must mean that I'm unlovable."
Therapist: "So are you telling me that your self-worth depends on whether or not Jennifer comes home from work in time for your romantic meal?"
Michael: "Well, when you put it that way…"
Therapist: "Suppose the tables were turned and it was you who arrived home late from work after Jennifer had prepared a romantic meal. Would that mean she's unlovable?"

Michael: "No, it would just mean that I was late getting home work; it says nothing about her as a person."

Therapist: "So why is this not the case for you?"

Michael: "Good point. I guess it doesn't make much sense to think that she considers me unlovable just because she spoiled my romantic dinner."

If individuals have difficulties accepting themselves unconditionally, numerous cognitive distortions related to their partners' behaviors are likely to surface in order to avoid experiencing the discomfort of thinking negatively about themselves. Therefore, by helping Michael accept himself unconditionally, he is less likely to define his self-worth by what Jennifer does or doesn't do and is more likely to have a normal, negative emotional experience related to Jennifer's late arrival, such as disappointment or irritation.

Often couples report that they engage in name calling or they make derogatory comments which distract them from dealing with the initial problem. It may be beneficial at this junction to help the couple understand the concept of unconditional acceptance of others (UOA). Since there is no way to define human worth, one assumes that all human beings are of equal worth (Walen et al., 1992). If a couple can accept this, they can choose to dislike their partner's behaviors while not condemning them as a human being. In the example involving Michael and Jennifer, if Michael is truly able to accept himself unconditionally, he is more likely to accept Jennifer and her fallibilities unconditionally. As a result of his unconditional acceptance of both himself and Jennifer, Michael may then be able to manage his anger in a more functional manner when conflicts arise for the couple. Jennifer and Michael may also be able to use these skills outside of the marriage in their ability to accept the fallibilities of the world around them.

Emotional Responsibility

According to Ellis, individuals are largely responsible for their emotions that are influenced by their beliefs about a given situation (Ellis, 1962, 2001). Yet, many couples who present in counseling often blame their partner for their own emotional upset. The concept of emotional responsibility is best explored early on in couple's therapy in order to help both parties understand that they can control their own emotions, regardless of how their partner behaves, but most likely they will not be successful in trying to change their partner. This will then allow the couple to focus on identifying the irrational beliefs associated with their anger episodes rather than blaming one another. By helping couples take responsibility for their own emotions, couple sessions can focus on helping individuals change their thoughts, and in turn their feelings and behaviors in order to improve the relationship, rather than partners focusing on how to change the other person. It can also be very empowering for partners to be aware that they ultimately control their own emotions in the face of their partner's behaviors.

Couple Assessment of Anger and Conflict

Assessment in cognitively based couples counseling is an ongoing process and is interwoven with treatment techniques even during the initial session. One of the early goals of a couples' assessment is to identify the dysfunctional emotions and how they contribute to the conflict, as well as to identify distorted cognitions. In addition, it is important to determine whether or not individuals have their own specific problems. Another key component of the assessment in the initial sessions includes determining if there has been a history of physical aggression in the relationship as well as the potential for it to occur in the future. Professionals in the field recommend that separate interviews be conducted with each person to determine the presence and extent of physical aggression in the relationship as couples may not spontaneously share such experiences with the therapist or may not believe it safe to do so if their partner is present (Heyman & Neidig, 1997; Lataillade, Epstein, & Werlinich, 2006). Should the presence and future risk of physical aggression be so high that an individual is fearful for his or her life, couples counseling may be contraindicated and the creation of a safety plan with relevant community resources such as distress lines, shelters, and emergency services may be warranted in such a circumstance. If there have been episodes of physical aggression yet there is a commitment by both individuals to address these issues, it may be possible for the couple to engage in the counseling process, but a safety plan may still be warranted and a risk assessment should be conducted at every session.

Another aspect of the assessment is to understand what each member of the partnership experiences and each person's perception of how it impacts their relationship. The frequency, intensity, and duration of these episodes, as well as the corresponding triggers, should also be explored. It is helpful for the couple to define times in which they have been able to resolve conflicts by using their anger in a functional manner and how their episodes of dysfunctional anger differ qualitatively.

Typically individuals with anger issues tend to justify their anger and externalize it by blaming others for "making them angry." It is often helpful to have a structured assessment at the beginning and at various intervals of the treatment. Useful quantitative measures for anger and aggression include the State Trait Anger Expression Inventory—2 (STAXI-2) (Speilberger, 1999), the Buss–Perry Aggression Questionnaire (Buss & Perry, 1992), and the Anger Disorder Scale (ADS) (DiGiuseppe & Tafrate, 2004).

Helping the Couple Set Treatment Goals

Early in therapy, it is important for the couple to establish treatment goals for ongoing sessions. Couples are encouraged to set their individual treatment goals as well as what they hope to achieve as a couple. This may be very difficult for couples to do if they have little insight into their experience of anger. Initial sessions may begin by defining how anger has been a problem for each person and how this has impacted the couple's relationship to date with specific examples to illustrate this.

These earlier sessions should also focus on psycho-education related to functional versus dysfunctional anger, and the corresponding behaviors which may be passive, assertive, or aggressive in nature. Couples also may not have the vocabulary to easily identify their emotions; therefore a discussion regarding ways to describe their experience of anger may be very useful in the early sessions.

Interventions

There are numerous cognitive, emotive, and behavioral interventions that can be employed within session as well as assigned as homework so that couples can reinforce concepts learned during the therapy sessions. Several examples of interventions will be described.

Cognitive Techniques

During the session, the clinician may use a variety of disputation methods which include logical questioning (i.e., "What's wrong with that way of thinking?"), reality-testing (i.e., "Where is the evidence for this?"), pragmatic questioning (i.e., "How is your anger helping you?"), and didactic approaches in which the clinician provides brief explanations about irrational beliefs, anger, anger triggers, and so forth. Once couples have become familiar with the A–B–C framework, they are then better able to dispute one another's irrational beliefs and this can be particularly meaningful for both individuals.

It is also helpful to engage clients in self-monitoring to develop greater awareness of anger episodes. Kassinove and Tafrate (2002) suggested having clients monitor their bodily sensations when they experience an anger episode or having them keep a journal about their anger. Another exceptionally beneficial self-monitoring intervention is to use the Anger Episode Record (DiGiusseppe & Froh, 2002) which helps clients determine what triggered the anger, how they appraised it (i.e., awfulizing, LFT, demandingness, and so forth), the intensity and duration of the anger, physical sensations, how anger was expressed, and the outcomes. Therapists can also suggest that clients complete a Cost Benefit Analysis, where they identify advantages and disadvantages of holding onto their anger versus letting it go.

Emotive Techniques

One very useful technique is to use Rational Emotive Imagery (REI) (Walen et al., 1992). Through the use of positive REI, clients expose themselves in imagination to the anger-provoking situation in which they feel and behave in a more functional manner. As in the case of John and Sarah, Sarah was asked to imagine the scenario in which

John answers the telephone over dinner and she experiences a functional, negative emotion and behaves in a more appropriate manner. This technique allows Sarah to deepen her new, rational belief related to John's behavior and is conducted during the session and then practiced between sessions. Another version of REI is called negative rational emotive imagery in which the person closes his or her eyes and imagines him or herself in the problematic situation and experiencing the dysfunctional, negative emotion, raising a hand once the negative emotion is experienced. The therapist then instructs the client to change his or her emotion to a predetermined, functional, negative emotion and raise a hand once he or she has been able to do this. The client then opens his or her eyes and describes how he or she was able to do this, which is essentially describing a cognitive shift.

Role playing is another very powerful emotive technique that can be used to help couples manage their anger more effectively. The therapist might want to use a reverse role play, in which he or she plays the part of the angry client, using one of the identified issues, while the client plays the role of the partner who is the recipient of the anger. This strategy helps the client understand what it might be like to be in her partner's shoes when she has her angry outbursts. Tape recording the role play and playing it back is a good way to increase the client's awareness of his or her anger.

Behavioral Techniques

Behavioral techniques that can be applied in session include skills training. Specifically, it can be very helpful to teach couples how to actively listen to each other and to use *I messages* versus *You messages* (Gordon, 2000). The therapist should model the difference between these types of messages through a short role play, asking one of the members of the couple to be the recipient of the message while the other is the observer. The therapist, using one of the couple's issues, might say something like "You never do anything to help out around the house; I'm sick of this," versus "I would like some help with these chores." Debrief with the couple by discussing the fact that *I messages* do not put people on the defensive and are similar to assertive communication techniques, which are also helpful skills for couples dealing with anger to learn.

Behavioral techniques applied as homework for the couple can include behaving in ways that they have previously determined to be more appropriate. For instance, couples may engage in name-calling during disagreements and have determined that this is an inappropriate way for them to communicate and would like to address this issue. At that time, the therapist may recommend that between sessions the couple modify this behavior through the use of a name-calling jar, in which the offending person places a sum of money into the jar if he or she engages in name-calling. This technique encourages a modification of the predetermined bad behavior by employing a punishment if the behavior occurs. Another example of a behavioral technique is for couples to reward themselves with a positive behavior if they behave in a manner that they deem to be appropriate or to complete an undesirable task if they behave in a way that is deemed inappropriate.

Relaxation training is another important behavioral intervention to use with couples experiencing problems with anger. As Kassinove and Tafrate (2002) noted, there has been a significant amount of research confirming that relaxation training should be a part of an anger management program. Relaxation techniques help couples stay calm when something provokes them. Likewise, encouraging clients to exercise regularly as a way to release tension and stress that may result in anger is helpful.

Conclusion

RE and CBT couple's therapy is a combination of individual work within the context of the couple. The goal is to assist the couple to individually and jointly understand their dysfunctional emotional responses and their associated distorted cognitions/irrational beliefs that affect their interpersonal functioning. Disputing the irrational beliefs and distorted cognitions associated with anger may be direct or indirect. In the direct method, the individual with the irrational belief is engaged directly, using either a Socratic or a didactic approach. In indirect disputation, the other partner is involved in disputing the distorted cognitions. The advantage of this latter form of disputation is that it tends to hold more meaning for the couple, which may deepen the conviction in the new, rational belief. Particularly useful strategies in counseling couples with dysfunctional anger include disputations related to unconditional acceptance of self, others, and world, the concept of emotional responsibility, and addressing low-frustration tolerance. Setting treatment goals for each individual and for the couple together is also a very useful tool in keeping couples engaged in treatment. Progress is maintained between sessions via various homework techniques agreed upon by the couple. Working with couples with dysfunctional anger can be very challenging, and it is critical to continually assess safety issues that could occur if anger escalates and results in aggression. In addition, therapists must be aware of their own tendencies to become frustrated or angry when working with angry clients, particularly when they don't respond to therapy as the clinician thinks they *should*. Consequently, working with couples who present with anger also involves monitoring one's own emotions.

References

Buss, A. H., & Perry, M. (1992). The aggression questionnaire. *Journal of Personality and Social Psychology, 63*(3), 452–459.

Deffenbacher, J. L. (2011). Cognitive-behavioral conceptualization and treatment of anger. *Cognitive and Behavioral Practice, 18*, 212–221.

DiGiuseppe, R., & Tafrate, R. (2004). *The anger disorder scale: Manual*. Toronto, ON: MultiHealth Systems.

DiGiuseppe, R., & Tafrate, R. C. (2007). *Understanding anger disorders*. New York: Oxford University Press.

DiGiusseppe, R., & Froh, J. J. (2002). What cognitions predict state anger? *Journal of Rational-Emotive and Cognitive-Behavior Therapy, 20*(2), 133–150.

Dryden, W., & David, D. (2008). Rational emotive behavior therapy: Current status. *Journal of Cognitive Psychotherapy: An International Quarterly, 22*(3), 195–209.

Eckhardt, C. I., & Deffenbacher, J. L. (1995). Diagnosis of anger disorders. In H. Kassinove (Ed.), *Anger disorders: Definition, diagnosis, and treatment* (pp. 27–47). Philadelphia, PA: Taylor & Francis.

Ellis, A. (1962). *Reason and emotion in psychotherapy*. Secaucus, NJ: The Citadel Press.

Ellis, A. (2001). *Overcoming destructive beliefs, feelings, and behaviors: New directions for rational-emotive behavior therapy*. Amherst, NY: Prometheus Books.

Gordon, T. (2000). *Parent effectiveness training: The program for raising responsible children*. New York: Three Rivers Press.

Heyman, R. E., & Neidig, P. H. (1997). Physical Aggression Couples Treatment. In W. K. Halford & H. J. Markman (Eds.), *Clinical handbook of marriage and couples intervention* (pp. 589–617). New York: Wiley.

Kassinove, H., & Sukhodolsky, D. G. (1995). Anger disorders: Basic science and practice issues. In H. Kassinove (Ed.), *Anger disorders: Definition, diagnosis, and treatment* (pp. 1–26). Philadelphia, PA: Taylor & Francis.

Kassinove, H., & Tafrate, R. C. (2002). *Anger management the complete treatment guidebook for practitioners*. Atascadero, CA: Impact Publishers.

Lataillade, J. J., Epstein, N. B., & Werlinich, C. A. (2006). Conjoint treatment of intimate partner violence: a cognitive behavioral approach. *Journal of Cognitive Psychotherapy: An International Quarterly, 20*(4), 393–410.

Scherer, K.R., & Wallbott, H.G. (1994). Evidence for universality and cultural variation of differential emotion response patterning. *Journal of Social Psychology, 66*, 310–328.

Speilberger, C. D. (1999). *STAXI-2: State-Trait Anger Expression Inventory—2, professional manual*. Odessa, FL: Psychological Assessment Resources.

Tafrate, R. C., & Kassinove, H. (2009). *Anger management for everyone: Seven proven ways to control anger and live a happier life*. Atascadero, CA: Impact Publishers.

US Bureau of Justice Statistics. (2007). *Intimate partner violence in the US*. Retrieved from http://bjs.ojp.usdoj.gov/index.cfm?ty=pbdetail&iid=1000. Retrieved on Nove. 30, 2011

Walen, S., DiGuiseppe, R., & Dryden, W. (1992). *A practitioner's guide to rational emotive therapy* (2nd ed.). New York: Oxford University Press.

Chapter 6
Helping Couples Deal with Stress and Adversity

Mary Russell and Andrew E. Slaby

Although the impact of stress on couples has often been an overlooked in the literature, accumulating evidence over the past decade indicates that relationships are strongly affected by the environment, and when that environment presents challenges, relationship satisfaction often suffers (Neff & Karney, 2004). In light of these findings, the purpose of this chapter is to review theory and research relevant to how stress impacts couples and provide treatment recommendations consistent with research and principles of cognitive behavioral therapies. This chapter focuses on how external stressors directly or indirectly impact relationships, keeping in mind the way couples perceive events impacts how they react to stress, as well as how effectively they deal with it.

What Is Stress?

The use of the term *stress* varies greatly (Randall & Bodenmann, 2009). In this chapter, we differentiate between stressors and the responses that are triggered by these stressors. Specifically, stressors are referred to as situations perceived to be problematic to varying degrees. In contrast, the stress response is the biological or cognitive response initiated when something is viewed as stressful, while distress is the emotional result of a negative response to a stressor (Wheaton, 1996).

M. Russell, M.S (✉)
St. John's University, New York, NY, USA
e-mail: maryrussell1@gmail.com

A.E. Slaby, Ph.D., M.D., M.P.H
New York University and New York Medical College, New York, NY, USA
e-mail: aeslaby@aol.com

A. Vernon (ed.), *Cognitive and Rational-Emotive Behavior Therapy with Couples: Theory and Practice*, DOI 10.1007/978-1-4614-5137-2_6,
© Springer Science+Business Media New York 2012

Theories of Stress

Hans Selye is considered the father of stress research according to Sehnert (1981). Selye theorized that individuals have a certain amount of adaptive energy that helps them cope with their environment, but in the presence of multiple stressors, their energies may be insufficient to deal with the stressful events which can manifest itself in physical as well as psychological symptoms. In the following section, stress is reviewed from a theoretical basis as it affects both the individual and the couple relationship.

Stress and the Individual

Research and theory on stress initially focused on the individual. For example, Cannon (1927) described the physiological stress response as a series of reactions (e.g., autonomic nervous system arousal) that help us "fight or flee" when encountering a threat. It is notable that this response evolved to protect us, and for our ancestors, helped eliminate threats after which physiological conditions returned to normal (Carlson, 2010). Unfortunately, in contemporary society, this response is no longer always helpful because it is activated more frequently, and for a longer period of time than in our evolutionary past, in relation to ongoing work or family issues. Under these circumstances, it might not be appropriate to react by fighting or fleeing as our bodies are primed to do. As a result, these stress responses are associated with health problems such as heart attack and stroke (Carlson, 2010), psychological symptoms such as depression and anxiety (Howe, Levy, & Caplan, 2004), and relationship disruption (Neff & Karney, 2004). Interestingly, cognitive theories such as Transactional Stress Theory (Lazarus, 1966), Cognitive Behavior Therapy (CBT), and Rational Emotive Behavior Therapy (REBT) see the stress response as a mind–body interaction influenced by our beliefs. Therefore, changing one's beliefs about a stressful event minimizes the stress response (Randall & Bodenmann, 2009).

Stress and Couples

The effect of stress on couples has been viewed as separate from its effect on individuals in that it always impacts both partners, whether they face a common event, or when one partners' stress spills over and ultimately affects the couple's relationship (Bodenmann, 2005). The research on stress in couples is based on its own theories. Though no one prevailing theory on stress and couples exists, the vulnerability-stress-adaptation (VSA) model (Karney & Bradbury, 1995) and the stress-divorce-model (Bodenmann, 2000) are noteworthy. According to the VSA model, marital distress and dissolution develop from an interaction between partners' vulnerabilities (personality traits), stressful events, and difficulty adapting to

stressors (Karney & Bradbury, 1995). Alternatively, the stress-divorce-model sees stress as affecting relationships directly and indirectly through the quality of marital communication, the partners' psychological and physiological well-being, and the time partners spend together (Ledermann, Bodenmann, Rudaz, & Bradbury, 2009). Although these models differ in several ways, both propose that stressor and partner characteristics, as well as how couples interact and cope, ultimately impact how stress affects couples.

Additionally, theories of stress and couples may be enhanced when integrated with couples therapy models such as Epstein and Baucom's (2002) enhanced cognitive-behavioral model of couple's therapy. Overall, cognitive behavioral theories view thoughts, emotions, and behaviors as interconnected, so altering thoughts can lead to reliable changes in feelings and behaviors. While Epstein and Baucom's (2002) model also emphasizes the role of environment, individual partners, and the relationship, it also notes that therapy is most helpful when an equal emphasis is placed on reducing negative and increasing positive behaviors, thoughts, and emotions.

Research on the Effects of Stress on Couples

Considerable research indicates that couples coping with a variety of life demands are more likely to experience relationship distress and dissolution (Bodenmann, Charvoz, Cina, & Windmere, 2001; Neff & Karney, 2004, 2009; Story & Bradbury, 2004; Thompson & Bolger, 1999). For example, financial strain may prevent couples from meeting their basic needs, impact their interactions, and ultimately damage relationship quality (Conger & Elder, 1999; Conger, Reuter, & Elder, 1999). And while work may fulfill financial needs, it places demands on one's time and energy, forces individuals to balance multiple roles, and has been associated with decreased relationship satisfaction (Howe et al., 2004; Story & Repetti, 2006; Roberts & Levinson, 2001). Likewise, even though remarriage offers opportunities for growth, it also requires individuals to adjust to new marital relationships while also forming or maintaining relationships with stepchildren and existing children, which can result in increased marital distress (Stokes & Wampler, 2002).

Factors Impacting the Relationship Between Stress and Relationship Functioning

Considerable research indicates that stress is often detrimental to couple relationships. However, this research has been inconsistent, and it has been occasionally found that challenging events can provide opportunities to enhance relationships (Lehman, Lang, Wortman, & Sorenson, 1989; Story & Bradbury, 2004). Such findings suggest that the relationship between stress and relationship functioning may be influenced by other factors, several of which are reviewed as follows.

Stressor Characteristics

Characteristics of stressors may be one variable impacting relationship well being (Bodenmann, 2000; Ledermann et al., 2009). For example, chronic stressors having fairly stable effects over time may be more harmful than acute stressors with more limited effects (Karney, Story, & Bradbury, 2005). This may be because chronic stressors represent a constant drain on couples' coping resources while acute stressors require only short-term coping. Nonetheless, the ability to cope with acute stressors may be impaired by a couple's existing level of chronic stress (Karney et al., 2005), wherein the acute stress becomes the "straw that breaks the camel's back," so to speak. These findings have led researchers to distinguish between stressors that are major life events or minor daily demands, normative or non-normative, acute or chronic, and originating within or outside the couple (Randall & Bodenmann, 2009).

Coping Strategies

Research also suggests that how couples cope influences how stress impacts relationships. This literature emphasizes several functions of coping. Coping strategies can focus on changing one's emotional response to a situation or aim to improve the situation itself (Lazarus & Folkman, 1984), and may help manage threats to individual and/or relationship well-being (Story & Bradbury, 2004). While there are many coping strategies that may benefit couples, this chapter focuses on strategies found to be particularly relevant to distressed couples.

Individual Beliefs

Theory and research often focuses on how individuals' beliefs, particularly about environmental demands and relationships, influence how stress impacts couples. This research is largely based on theories including Cognitive Behavior Therapy (CBT) and Rational Emotive Behavior Therapy (REBT). For example, from a CBT perspective, distressing emotions in relationships, such as anxiety, anger, or depression, result primarily from negative automatic thoughts such as selective abstraction, attributions, or expectancies that stem from a set of broader beliefs, assumptions, and standards (Epstein & Baucom, 2002). As the Alcoholics Anonymous expression goes, "expectations breed resentment." Specifically, selective abstraction occurs when partners notice only some aspects of events but overlook others, attributions are explanations for events, and expectancies are inferences about the likelihood that something will happen. Assumptions refer to beliefs about characteristics that individuals or couples *do* have, while standards are beliefs about characteristics a partner or relationship *should* have (Epstein & Baucom, 2002).

Similarly, REBT sees distressing emotions as caused by irrational beliefs—demands, catastrophic thinking, low frustration tolerance, and global feelings of worth about themselves, others, or the world. These irrational beliefs are ridged, illogical, and dysfunctional (Ellis, 2003). REBT also distinguishes between healthy negative emotions such as concern or sadness, which stem from rational beliefs about challenging situations and correspond with helpful behaviors, and unhealthy negative emotions such as extreme anxiety or rage, which stem from irrational beliefs and correspond with unhelpful behaviors. While CBT and REBT exhibit slight conceptual differences, both theories share the belief that distress is created largely by dysfunctional thinking and altering these beliefs can reduce distress and increase the likelihood of behaving in more helpful ways.

Indeed, a reliable association has been found between beliefs and relationship outcomes with findings indicating that beliefs account for many of the effects of stress on individual and relationship satisfaction (Neff & Karney, 2004; Tesser & Beach, 1998; Addis & Bernard, 2002). At the most basic level, individuals who perceive a challenge as threatening and exceeding their coping abilities are likely to experience greater distress regardless of whether their appraisals are accurate or not (Epstein & Baucom, 2002). A crisis can be perceived as an opportunity for growth and mastery of new skills or as a danger and discombobulate a person. Once a challenge is viewed as threatening and stressful, subsequent thinking may be influenced in at least two ways. According to Neff & Karney (2004), stress may lead to additional negative thoughts or limit one's ability to organize thoughts in a relationship-enhancing way.

Indeed, stress does tend to correspond with a rise in negative thoughts. Increases in stress have been associated with more negative relationship perceptions and attributions, as well as decreased marital satisfaction (Neff & Karney, 2004; Graham & Conoley, 2006). Several types of thoughts may be particularly harmful for couples who are exposed to stressors. For example, negative attributions have been found to moderate the relationship between accumulated life stressors and decreased marital quality (Graham & Conoley, 2006). Given a negative event or behavior, negative attributions view it as directly attributable to their relationship or partner's broad, unchangeable traits, while positive attributions see it as attributable to external events, and/or unstable, fleeting individual or relationship traits (Epstein & Baucom, 2002). Additionally, studies have found that tendencies to link general relationship evaluations to specific daily events is likely to result in precarious feelings of relationship satisfaction that are vulnerable to decline (Arriaga, 2001; McNulty & Karney, 2001; Neff & Karney, 2009). Finally, irrational beliefs or standards about how one, one's partner, and/or one's marriage *should* be and thoughts related to global negative ratings of self and partner's worth, low-frustration tolerance, and catastrophic thinking have also been found to be damaging to marital quality (Moller & de Beer, 1998).

Further, exposure to stressors may tax an individual's cognitive resources and weaken his or her ability to think in a helpful way (Neff & Karney, 2009). Nonetheless, individuals may be able to adjust for the negative effects of stressors by changing their thoughts and tolerating their partner's negative mood and behaviors by making

stressors more salient and attributing a partner's distress to a specific stressor rather than to internal stable traits (Tesser & Beach, 1998; Thompson & Bolger, 1999).

Individual and Couple Behaviors

How couples behave towards one another also may impact the effect of stress on relationships. The consistent finding that distressed partners engage in less positive and more negative behavior than happy couples is concerning since stress corresponds with increases in negative behavior and decreases in positive behavior. Furthermore, negative behavior among distressed couples often escalates faster than among happy couples (Epstein & Baucom, 2002). Though couples present with distinct behavioral deficits and excesses, specific behaviors including poor communication, lack of social support, avoidance of conflict with one's partner, and deficient problem solving skills have been found to predict deterioration among distressed couples more than others.

Marital communication has emerged as a salient predictor in marital outcomes and has been found to mediate the relationship between stress and marital quality (Bodenmann & Shantinath, 2004; Ledermann et al., 2009). According to Baucom and Epstein (2002), marital communication includes interactions involving expression and listening to partners' thoughts and emotions. Exposure to stress has been associated with a reduction in the quality of communication between partners and an increase in negative communication patterns such as criticism, dominance, contempt, belligerence, and withdrawal (Bodenmann & Shantinath, 2004; Ledermann et al., 2009). In contrast, happy couples have been found to exhibit higher rates of positive communication and use more assent, approval, empathy, humor, smiling, positive physical touch, and problem description and solution (Osgarby, 1998).

It is widely accepted that social support can help minimize the effects of stress on individual well being; however, support from one's partner may offer unique benefits for coping with stress (Dehle, Larsen, & Landers, 2001; Katz, Monnier, Libet, Shaw, & Beach, 2000). Specifically, spousal support refers to the number or quality of supportive behaviors in marriages such as communicating love, providing useful advice or services, or encouraging belonging to a group of similar people (Cutrona, Hessling, & Suhr, 1997; Dehle et al., 2001), and has been found to moderate the association between stress and relationship functioning (Conger et al., 1999, Katz et al., 2000). Spousal support may impact marital well-being by initiating a series of emotional, cognitive, and behavioral events that facilitate a partner's adaptive coping (Repetti, 1989), reduce a partner's distress (Conger et al., 1999), and prevent conflict (Cutrona, Russell, & Gardner, 2005). Interestingly, little evidence suggests that specific behaviors are more helpful than others. Rather, whether or not a partner thinks he or she is receiving adequate support, has been more strongly associated with marital satisfaction than the number or type of behaviors (Delhe et al., 2001; Epstein & Baucom, 2002; Gardner & Cutrona, 2004).

Unfortunately, the emotional negativity that often accompanies distress may lessen one's ability to provide support and also reduce the likelihood that one's partner will support him or her (Story & Bradbury, 2004). Nonetheless, an individual may be more likely to support a partner who exhibits emotional negativity when this negativity is viewed as warranted and attributable to a salient stressor (Thompson & Bolger, 1999).

Couples may also engage in more avoidant forms of coping wherein individuals avoid disagreement with their partner or hide their distress (Story & Bradbury, 2004). Avoidant coping strategies such as withdrawing after days of high stress may benefit relationships when they serve to reduce emotional negativity and conflict (Repetti, 1989; Roberts & Levinson, 2001). Nonetheless, they have also been associated with marital deterioration and may be harmful over time (Heavey, Christensen, & Malamuth, 1995).

Upon encountering a stressor, many couples may utilize coping strategies aimed at minimizing a stressor; in doing so, their ability to problem-solve will be particularly important. Indeed, effective problem solving has been identified as a moderator in the relationship between life stressors and marital adjustment (Cohan & Bradbury, 1997; Cox, Paley, Burchinal, & Payne, 1999). For example, among couples experiencing economic hardship, those who displayed more effective problem solving behaviors were less likely to report future marital unhappiness than couples whose problems solving was less effective (Conger et al., 1999).

Overall, associations among stressors, coping strategies, and marital satisfaction are not straightforward, and future work is needed to examine the conditions under which stressors may independently affect psychological distress, behavior, and marital satisfaction to predict how couples may be predisposed to reacting to a stressor (Story & Bradbury, 2004).

Treatment of Couples Exposed to Life Stressors

Integrating theory and research on stress and couples yields valuable information relevant to treatment. The following section offers recommendations for treatment providers working with couples experiencing stressful periods in their relationships. Recommendations will reflect principles of Cognitive Behavior therapies with an emphasis on increasing positive and decreasing negative thoughts, feelings, and behaviors, keeping in mind that improvements in any one of these areas will likely correspond to improvements in others. Additionally, emphasis will be placed on minimizing stressors and increasing the use of helpful coping strategies. Measurement instruments relevant to treating distressed couples are also discussed, although research indicates a need to develop and refine these measures, suggesting that this data should be integrated with information from observation and interview (Story & Bradbury, 2004).

Eliminating or Minimizing Stressors

Though therapy will often focus on helping couples in light of stressors, treatment should begin by examining the extent to which any of the stressors can be minimized or eliminated since minimizing stressors may help limit the negative series of events they often initiate (Neff & Karney, 2009). In deciding if stressors can be minimized, it is important to note that it may not be feasible to alter a stressor. Nevertheless, the strength of a CBT and REBT approach to treatment is that by changing one's beliefs about life circumstances, individuals can reduce their level of distress even without changing the stressor.

It is interesting that couples may be unaware of stressors that have a negative impact on their relationship, indicating that stressors and their potential effects may need to be brought to their attention. Assessment instruments useful for identifying stressors include the *Family Inventory of Life Events and Changes* (McCubbin, Patterson, & Wilson, 1983), *Stressful Life Events* checklist (Sarason, Johnson, & Siegel, 1978), and *Chronic Strains Inventory* (Hammen et al., 1987).

In attempting to minimize stressors, a thorough evaluation of a couple's problem solving skills should be made since effective problem solving has been found to minimize the effects of stressors on marital adjustment (Conger et al., 1999). If effective problem solving skills are lacking, training should be provided to help couples generate realistic and nonexploitative solutions to conflicts and minimize environmental stressors. In this way, couples will be in a better position to minimize the impact of current and future stressors. Additionally, discussions should focus on increasing clients' awareness of available coping resources in their environment that they have not capitalized on. In so doing, it will be important to keep in mind that economic disadvantage may limit couples' available resources, such as childcare and finances.

Even after stressors have resolved, there appears to be a cycle of negative emotions and relationship disruption that at some point may become self-sustaining (Davila, Karney, Hall, & Bradbury, 2003; Howe et al., 2004). Thus, treatment should focus on enhancing couples' knowledge and application of coping strategies to help reduce the emotional sequelae of secondary stressors and prevent against further distress.

Psychoeducation on Stress

In teaching effective coping, psychoeducation relative to the physical, cognitive, and emotional effects of stress should be provided as a rationale for using specific strategies. Relaxation techniques such as deep breathing, mindfulness, muscle relaxation, yoga, and meditation may help reduce the physiological effects of stress and facilitate the engagement in other coping strategies (Ellis, 2003). However, the benefits of such techniques are temporary, so additional coping strategies aimed at addressing underlying issues contributing to the creation of distress should also be applied.

Cognitive Interventions

Since cognitive behavioral theories view distress as being created largely by one's thoughts, treatment should focus on teaching individuals to identify and dispute their patterns of dysfunctional thinking and engage in alternative ways of thinking leading to more healthy emotional responses and behaviors.

Initially, work should focus on thoughts about one's environment. Therapists should help clients view potential stressors realistically and as surmountable challenges rather than insurmountable threats. Choosing to view one's environment adaptively will minimize the likelihood that stress will result in additional negative thoughts and organize thoughts in a relationship enhancing way (Graham & Conoley, 2006, Neff & Karney, 2009). That being said, it is unlikely that effects of stressors on thoughts will be completely eliminated. Thus, therapists may use a variety of strategies to help partners reassess whether beliefs about their self, partner, or relationship are valid and reasonable (Epstein & Baucom, 2002).

For example, REBT therapists help clients identify and acknowledge irrational beliefs. In cases of distressed partners, special attention is given to thoughts that dictate how partners *should* act (Harris, Davies, & Dryden, 2006). Subsequently, these beliefs are vigorously and continuously challenged through functional, logical, and empirical disputes and other methods that will prove the irrational beliefs to be unfounded. Finally, clients can be taught to generate alternative rational coping statements that they can repeat to themselves when experiencing difficulties (Ellis, 2003).

In light of findings that negative marital attributions can be particularly harmful for couples coping with stress, cognitive behavior therapists help individuals identify and reduce negative marital attributions and increase tendencies to make positive attributions. Specifically, clients can be helped to view negative events or behaviors as resulting largely from external events and/or unstable, fleeting partner, or relationship traits. *The Relationship Attribution Measure* (Fincham & Bradbury, 1992) is helpful in identifying the causal attributions that couples make to negative marital behaviors.

Increasing the saliency of stressors in a couple's environment by encouraging couples to communicate about the stressors in their lives is also beneficial. Increasing awareness of the stressors in one's partner may facilitate one's ability to make positive attributions by attributing a partner's negative mood or behavior to external events rather than to inherent flaws (Thompson & Bolger, 1999). Increasing awareness of stressors in one's own life helps individuals compensate for effects of stress on mood, minimize negative behaviors, and increase one's ability to think in a relationship enhancing way (Neff & Kareny, 2009).

Couples should also learn to separate overall relationship judgments from perceptions of immediate experiences to help protect ratings of global satisfaction from specific negative experiences (Neff & Karney, 2009). Specifically, partners should explore reasons why one's global worth or satisfaction is far more complex than any single behavior.

Behavioral Interventions

Couples should also examine how they behave and interact. Increasing awareness of negative behaviors they engage in and making efforts to minimize these, while maximizing more positive behaviors, may serve as a buffer against certain stressors.

Impairments in marital communication are frequent among couples exposed to stress and mediate the relationship between stress and marital quality (Bodenmann & Shantinath, 2004; Ledermann et al., 2009). Therapists should help couples be more aware of the importance of communication for coping with stress and maintaining relationships. Therapists can evaluate how couples communicate using measures such as the *Marital Communication Questionnaire* (Bodenmann, 2000) and, if indicated, provide direct training on how to improve communication.

Couples will benefit from maximizing their social support systems, keeping in mind that support from a spouse or partner may be particularly helpful for minimizing the effects of stress on individual and relationship well-being (Dehle et al., 2001; Katz et al., 2000). Partners should be helped to identify individuals in their social support system while also examining each other's supportive behaviors. Therapy should focus on clarifying demands and expectations of each spouse so the partners may be more successful at matching their supportive behaviors to the needs of their spouse. This may impact the relationship directly by increasing positive affect in the relationship and indirectly by improving partners' attempts to cope and gain mastery over stressors in their environment (Dehle et al., 2001). The *Support in Intimate Relationships Rating Scale* (Dehle et al., 2001) is particularly helpful for identifying specific support behaviors that individuals perceive are under- or over-provided.

At times avoidant coping strategies such as withdrawing may be beneficial for relationships when they serve to reduce emotional negativity and decrease marital conflict (Repetti, 1989; Roberts & Levenson, 2001). Couples should be alerted to the harmful effects of avoidant coping on relationships (Heavey et al., 1995) and encouraged to combine active and avoidant strategies in response to stressors.

Formal Intervention Programs

Several formal intervention programs have been designed to strengthen relationships. Though most have not directly focused on couples exposed to stressors, many incorporate useful strategies. For example, the *Couples Coping Enhancement Training* (Bodenmann, 1997) is an empirically supported program designed to educate couples about effective stress management by helping couples develop communication skills and learn individual and dyadic coping strategies (Bodenmann & Shantinath, 2004). Likewise, the *Prevention and Relationship Enhancement Program* (Markman et al., 1993) is designed to prevent divorce and strengthen marriage; its module on problem solving skills training may be helpful for distressed couples.

In reviewing recommendations, it is notable that every couple is different and therapists should consider their unique characteristics in planning treatment. Furthermore, though a detailed review of gender differences is not possible given

the scope of this chapter, men and women have been found to react differently to stress (Gottman, 1999; Howe et al., 2004; Shultz et al., 2004). Likewise, stressors are embedded in cultural, social, and economic contexts. Thus, findings may not generalize across different sexes or couples of from diverse backgrounds.

Case Study

Mark and Julia were in their mid thirties and had been married for 5 years when they sought couple therapy. Mark and Julia reported increasing relationship conflict characterized by frequent arguments initiated by Julia when she returned home from work. Mark had been laid off from his job the previous year and had been unable to find new employment. Julia, an accountant, was experiencing increasing stress because she was working overtime to help compensate for Mark's lost income. Nonetheless, the couple struggled to pay their mortgage.

Treatment initially focused on identifying, disputing, and restructuring irrational beliefs and distorted cognitions contributing to the couple's distress. Julia's anger was targeted as a primary unhealthy negative emotion to decrease. The primary belief leading to her anger was identified as a demand that Mark *should* try harder to find a job, and because he was not trying hard enough, she concluded that he was lazy and worthless. Additionally, because Julia had been working overtime in addition to maintaining her household responsibilities, she reported additional anger towards Mark which stemmed from her belief that he *should* do more to help her around the house and he should know how stressed she is. Julia was helped to see that even though she wanted Mark to try harder to find work and help out at home that Mark was his own person with free will and that her ability to control his behavior was minimal at best. In addition, Mark's failure to live up to Julia's expectations was reframed as something Mark did, but was not a reflection of him as a person. Julia was encouraged to recall Mark's positive and negative attributes so that she could see him as a fallible human being who engaged in both good and bad behaviors, not one of which was logically representative of his global self-worth. Julia was also encouraged to examine the evidence that Mark should be able to know how she was feeling at all times and was helped to shift her thoughts to reflect her preference for him to be more empathic and understanding as opposed to demanding this, which resulted in unproductive anger.

Likewise, Mark's unhealthy feelings of depression were targeted for reduction and were conceptualized as being primarily caused by thinking he was worthless because that was how Julia was viewing him because he had not found a job. As with Julia, Mark was encouraged to see himself as a fallible human being with positive and negative qualities. As his employment status was just one of many things about him, he began to view himself as a person with inherent worth, which was not dependent on any one aspect about himself or on whether or not others saw him as worthy or unworthy.

In light of their frequent arguments, the couple was taught more effective ways to communicate with a focus on empathic listening. Mark made an effort to point

out that the bad economy was a significant stressor for him that in part explained why he struggled to find work and was feeling depressed. Julia was encouraged to share her feelings about her stress with Mark and help him understand how these stressors were impacting her. Both were encouraged to share the supportive behaviors they found helpful and unhelpful when they were experiencing stress.

Treatment also incorporated psychoeducation on the effects of stress on their well-being, both as individuals and as a couple. Given their mutual interest in yoga, this was identified as a way to increase the amount of enjoyable time spent together and to reduce physiological tension. Additionally, the couple was referred to a financial planner to help them establish a realistic budget and lifestyle.

Reduction in this couple's irrational beliefs and increases in their convictions to more rational beliefs corresponded with a decrease in Julia's anger and Mark's depression as well as an increase in supportive behaviors on the part of both individuals. As the anger and depression diminished, both partners reported feeling closer and more satisfied with the relationship. They were encouraged to continue working on their budget and use their new coping strategies to maximize their relationship satisfaction, which would help prepare them to cope with future stressors.

Conclusion

The recognition that environmental stressors impact satisfaction among couples has received increased attention (Randall & Bodenmann, 2009), with research indicating that couples with significant life demands are more likely to experience relationship distress. Nonetheless, findings indicate that stressors often impact couples differently, suggesting that the relationship between stress and relationship functioning is influenced by other variables, including cognitions. In particular, how individuals and couples cope may help explain how stress impacts relationships. Though the literature has emphasized a variety of strategies, several coping strategies may be particularly helpful for distressed couples, including cognitive restructuring, effective communication and problem solving, social support, and avoidance of relationship conflict. With these findings in mind, therapy can be particularly helpful to distressed couples. Educating couples about the effects of stress, minimizing environmental stressors to the extent possible, teaching them appropriate coping strategies, and helping them identify and dispute irrational beliefs and distorted cognitions are viable interventions that should reduce stress and increase marital satisfaction.

References

Arriaga, X. B. (2001). The ups and downs of dating: Fluctuations in satisfaction in newly-formed romantic relationships. *Journal of Personality and Social Psychology, 80*, 754–765.

Addis, J., & Bernard, M. E. (2002). Marital adjustment and irrational beliefs. *Journal of Rational Emotive & Cognitive Behavior Therapy, 20*, 3–13.

Bodenmann, G. (1997). Can divorce be prevented by enhancing coping skills in couples? *Journal of Divorce and Remarriage, 27*, 177–194.

Bodenmann, G. (2000). *Stress und coping bei paaren [Stress and coping in couples]*. Göttingen: Hogrefe.

Bodenmann, G., Charvoz, L., Cina, A., & Windmere, K. (2001). Prevention of marital distress by enhancing the coping skills of couples: 1-year follow-up-study. *Swiss Journal of Psychology, 60*, 3–10.

Bodenmann, G. (2005). Dyadic coping and its significance for marital functioning. In T., Bodenmann, G., Charvoz, L., Cina, A., & Windmere, K. (Eds.), (2001). Prevention of marital distress by enhancing the coping skills of couples: 1-year follow-up-study. *Swiss Journal of Psychology*, 60, 3–10.

Bodenmann, G., & Shantinath, S. D. (2004). The couples coping enhancement training (CCET): A new approach to prevention of marital distress based on stress and coping. *Family Relations, 53*, 477–484.

Cannon, W. B. (1927). The James-Lange theory of emotions: A critical examination and an alternative theory. *The American Journal of Psychology, 39*, 106–124.

Carlson, N. R. (2010). *Physiology of behavior*. New York: Allyn & Bacon.

Cohan, C. L., & Bradbury, T. N. (1997). Negative life events, marital interaction, and the longitudinal course of newlywed marriage. *Journal of Personality and Social Psychology, 73*, 114–128.

Conger, R. D., & Elder, M. A. (1999). Couple resilience to economic pressure. *Journal of Personality and Social Psychology, 76*, 54–71.

Conger, R. D., Reuter, M. A., & Elder, G. H. (1999). Couple resilience to economic pressure. *Journal of Personality and Social Psychology, 76*, 54–71.

Cox, M. J., Paley, B., Burchinal, M., & Payne, C. C. (1999). Marital perceptions and interactions across the transition to parenthood. *Journal of Marriage and the Family, 61*, 611–625.

Cutrona, C. E., Hessling, R. M., & Suhr, J. A. (1997). The influence of husband and wife personality on marital social support interactions. *Personal Relationships, 4*, 379–393.

Cutrona, C. E., Russell, D. W., & Gardner, K. A. (2005). The relationship enhancement model of social support. In T. A. Revenson, K. Kayser, & G. Bodenmann (Eds.), *Couples coping with stress: Emerging perspectives on dyadic coping* (pp. 73–95). Washington, DC: American Psychological Association.

Davila, J., Karney, B. R., Hall, T. W., & Bradbury, T. N. (2003). Depressive symptoms and marital satisfaction: Dynamic associations and the moderating effects of gender and neuroticism. *Journal of Family Psychology, 17*, 557–570.

Dehle, C., Larsen, D., & Landers, J. E. (2001). Social support in marriage. *American Journal of Family Therapy, 29*(4), 307–324.

Ellis, A. (2003). The nature of disturbed marital interaction. *Journal of Rational Emotive & Cognitive Behavior Therapy, 21*, 147–153.

Epstein, N., & Baucom, D. H. (2002). *Enhanced cognitive-behavioral therapy for couples: A contextual approach*. Washington, DC: American Psychological Association.

Fincham, F. D., & Bradbury, T. N. (1992). Assessing attributions in marriage: The Relationship Attribution Measure. *Journal of Personality and Social Psychology, 62*, 457–468.

Gardner, K. A., & Cutrona, C. E. (2004). Social support communication in families. In A. Vangelisti (Ed.), *Handbook of family communication* (pp. 495–512). Mahway, NJ: Erlbaum.

Gottman, J. M. (1999). The sound marital house: A theory of marriage. In The marriage clinic (pp. 87–110). New York: Norton.

Graham, J. M., & Conoley, C. W. (2006). The role of marital attributions in the relationship between life stressors and marital quality. *Personal Relationships, 13*, 231–241.

Hammen, C., Adrian, C., Gordon, D., Burge, D., Jaenicke, C., & Hiroto, D. (1987). Children of depressed mothers: Maternal strain and symptom predictors of dysfunction. *Journal of Abnormal Psychology, 96*, 190–198.

Harris, S., Davies, M. F., & Dryden, W. (2006). An experimental test of a core REBT hypothesis: Evidence that irrational beliefs lead to physiological as well as psychological arousal. *Journal of Rational-Emotive & Cognitive Behavior Therapy, 24*, 101–110.

Heavey, C. L., Christensen, A., & Malamuth, N. M. (1995). The longitudinal impact of demand and withdrawal during marital conflict. *Journal of Consulting and Clinical Psychology, 63*, 797–801.

Howe, G. W., Levy, M. L., & Caplan, R. D. (2004). Job loss and depressive symptoms in couples: Common stressors, stress transmission, or relationship disruption? *Journal of Family Psychology, 18*, 639–650.

Karney, B. R., & Bradbury, T. N. (1995). The longitudinal course of marital quality and stability: A review of theory, method, and research. *Psychological Bulletin, 118*, 3–34.

Karney, B. R., Story, L. B., & Bradbury, T. N. (2005). Marriages in context: Interactions between chronic and acute stress among newlyweds. In T. Revenson, K. Kayser, & G. Bodenmann (Eds.), *Couples coping with stress: Emerging perspectives on dyadic coping* (pp. 33–50). Washington, D.C.: American Psychological Association.

Katz, J., Monnier, J., Libet, J., Shaw, D., & Beach, S. R. (2000). Individual and crossover effects of stress on marital adjustment in medical school marriages. *Journal of Marital and Family Therapy, 26*, 341–351.

Lazarus, R. S. (1966). *Psychological stress and the coping process*. New York: McGraw Hill.

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. New York: Springer.

Ledermann, T., Bodenmann, G., Rudaz, M., & Bradbury, T. N. (2009). Stress, communication, and marital quality in couples. *Family Relations, 59*, 195–206.

Lehman, D. R., Lang, E. L., Wortman, C. B., & Sorenson, S. (1989). Long-term effects of sudden bereavement: Marital and parent–child relationships and children's reactions. *Journal of Family Psychology, 2*, 344–367.

Markman, H. J., Renick, M. J., Floyd, F. J., Stanley, S. M., & Clements, M. (1993). Preventing marital distress through communication and conflict management training: A four and five year follow-up. *Journal of Consulting and Clinical Psychology, 62*(1), 70–77.

McCubbin, H. I., Patterson, J., & Wilson, L. (1983). Family inventory of life events and changes (FILE). In H. I. McCubbin, A. I. Thompson, & M. McCubbin (Eds.), *Family assessment: Resiliency, coping and adaptation-inventories for research and practice* (pp. 103–178). Madison, WI: University of Wisconsin System.

McNulty, J. K., & Karney, B. R. (2001). Attributions in marriage: Integrating specific and global evaluations of close relationships. *Personality and Social Psychology Bulletin, 27*, 943–955.

Moller, A. T., & de Beer, Z. C. (1998). Irrational beliefs and marital conflict. *Psychological Reprint, 82*, 155–160.

Neff, L. A., & Karney, B. R. (2004). The dynamic structure of relationship perceptions: Differential importance as a strategy of relationship maintenance. *Personality and Social Psychology Bulletin, 29*, 1433–1446.

Neff, L. A., & Karney, B. R. (2009). Stress and reactivity to daily relationship experiences: How stress hinders adaptive processes in marriage. *Journal of Personality and Social Psychology, 97*, 435–450.

Osgarby, S.M. (1998). Memory and positive exchange in marital satisfaction. Unpublished doctoral dissertation, The University of Queensland, St. Lucia.

Randall, A. K., & Bodenmann, G. (2009). The role of stress on close relationships and marital satisfaction. *Clinical Psychology Review, 29*, 105–115.

Repetti, R. L. (1989). Effects of daily workload on subsequent behavior during marital interaction: The roles of social withdrawal and spousal support. *Journal of Personality and Social Psychology, 57*, 651–659.

Roberts, N. A., & Levinson, R. W. (2001). The remains of the workday: Impact of job stress and exhaustion on marital interaction in police couples. *Journal of Marriage and the Family, 63*, 1052–1067.

Sarason, I. G., Johnson, J. H., & Siegel, J. M. (1978). Assessing the impact of life changes: Development of the life experiences survey. *Journal of Consulting and Clinical Psychology, 46*, 932–946.

Schulz, M. S., Cowan, P. A., Cowan, C. P., & Brennan, R. T. (2004). Coming home upset: Gender, marital satisfaction, and the daily spillover of workday experience into couple interactions. *Journal of Family Psychology, 18*, 250–263.

Sehnert, K. W. (1981). *Stress/unstress*. Minneapolis, MN: Augsburg Publishing.
Story, L. B., & Bradbury, T. N. (2004). Understanding marriage and stress: Essential questions and challenges. *Clinical Psychology Review, 23*, 1139–1162.
Story, L. B., & Repetti, R. (2006). Daily occupational stressors and marital behavior. *Journal of Family Psychology, 20*, 690–700.
Stokes, S. B., & Wampler, R. S. (2002). Remarried clients seeking marital therapy as compared to those seeking family therapy. *Journal of Divorce and Remarriage, 38*, 91–107.
Tesser, A., & Beach, S. R. H. (1998). Life events, relationship quality, and depression: An investigation of judgment discontinuity in vivo. *Journal of Personality and Social Psychology, 74*, 36–52.
Thompson, A., & Bolger, N. (1999). Emotional transmission in couples under stress. *Journal of Marriage and the Family, 61*, 38–48.
Wheaton, B. (1996). The domains and boundaries of stress concepts. In H. B. Kaplan (Ed.), *Psychosocial stress: Perspectives on structure, theory, life-course, and methods* (pp. 29–70). San Diego: Academic.

Chapter 7
Helping Couples Deal with Intimacy and Sexuality

Mike Abrams

Love and sex are universal themes in almost every aspect of art and culture. Unfortunately, many couples have a great deal of difficulty living up to the ideal portrayed in art and literature. Indeed, sex frequently fails to live up to its romantic apotheosis, and couples often end up disappointed or distressed. In literary depictions of romance, couples in love fall into each other's arms and make effortless love, and they go on loving and making love until the end of their days. Sadly, the ideal of the synchrony of love and sex is not as common as one may hope. And when love and sex are indeed coalesced, the bond between the two is often short-lived. Why does this happen? In examining this question we can turn to both Albert Ellis and Aaron Beck. Beck (1989) predicated much of his couples' therapy techniques on his observation that romantic passions that begin with the intensity of drug intoxication frequently wear off, as do drug induced highs. He noted that this fading leads to changes in the partners' perceptions of each other. As romance begins to fade, the partners begin to suffer an increase in cognitive distortions about each other. His prescription is quick and appropriate. He details a range of cognitive changes and exercises to give the couple tools to attenuate the conflicts that ensue from these distorted cognitions. However, what he fails to adequately address is why, after a few years of bonding, do couples that saw each with blurry-eyed passion suddenly become overwhelmed with distorted cognitions.

There is a theoretical drawback with most counseling for sex and intimacy problems. In essence, they all help couples make changes to address a degrading bond, but none clearly explain that why this so frequently occurs. This includes Cognitive Couples Therapy, Emotionally Focused Couples Therapy (Johnson, 2004), Acceptance and Commitment Therapy (Jacobson & Christenensen, 1996), and

M. Abrams, Ph.D., MBA, ABPP(✉)
New York University, New York, NY, USA

William Paterson University, Wayne, NJ, USA
e-mail: psymba@aol.com

A. Vernon (ed.), *Cognitive and Rational-Emotive Behavior Therapy with Couples: Theory and Practice*, DOI 10.1007/978-1-4614-5137-2_7,
© Springer Science+Business Media New York 2012

other approaches. However, as far back as the early 1940s, Albert Ellis recognized that a significant portion of couples' conflict has to do with waning sexuality. Importantly, he noted that sexuality is derived for evolutionary and biological reasons (Ellis, 1957), and the contributing factors to the experience of sexuality are not static. Consequently, he counseled counselors to treat sexual issues with an understanding of psychology, sexology, and anthropology (Ellis, 1954). Early in the development of sex therapy, Ellis recognized that sexual desire and choice are both malleable and ephemeral. It is for this reason that he saw sexual compatibility as often requiring outside sources of stimulation (Ellis, 1972). He did so in recognition of the problem discussed above—sexual passion and romantic love are often fleeting. This is the fundamental problem faced by counselors treating couples for sexual difficulties.

Relationships and Passion

Why do couples suddenly notice the flaws and blemishes that they have not seen in the early stages of the relationship? Why are they often exasperated by their lover's personality that they had once found charming and engaging? The answer is found in very old brain circuits that alter perception when in passionate states. Sexual arousal can subvert many limbic survival defenses. Disgust is attenuated when one is sexually aroused (Stevenson, Case, & Oaten, 2011). For example, think about your typical reaction to finding saliva on the rim of a soda bottle offered to you by a stranger—it most likely is handed back with haste and a grimace. Yet when sexually aroused we greedily suck the saliva of our paramour—this popularly known as French kissing. Also, when aroused we will orally stimulate portions of the body immediately adjacent to the sources of urine and feces. The same people who passionately make oral love will stop taking mints offered near the restaurant cashier when they are told that most restaurant patrons don't wash their hands. Sexual arousal even attenuates rational caution. The most sociopathic outlaw appears caring and loving when a woman is strongly attracted to him.

These biological predicates of love and sex need to be understood by counselors treating couples with sexual and physical intimacy problems. Too often sexual problems are viewed as primarily social, cultural, or learned. In contrast, the overwhelming evidence presented by sex researchers indicates that love is a biological phenomenon that bonds couples only long enough to mate and rear a child (Fisher, 2004). Studies have shown that romantic love is a result of activation of brain reward circuits such as the right ventral tegmental area, the right postero-dorsal body and the medial caudate nucleus (Aron et al., 2005), primitive brain regions that regulate motivation and pleasure. Importantly, romantic or sexual love is a cross-cultural universal constant that can best be explained by innate neuropsychological systems. These systems evolved to produce intense sexual yearnings and subsequent bonding. These cravings emanate from the reward centers of the brain and lead to intense withdrawal-like cravings for the absent lover. In addition, they tend to attenuate all

negative judgments about the lover. Sadly, for many couples these love bonds fade in a year or two (Fisher, Brown, Aron, Strong, & Mashek, 2010). Love scientist Helen Fisher pointed out that early prehumans in tribal groups began to lose interest in their mates after a child was old enough to integrate into the tribe.

Sometimes love lasts just long enough for sex, sometimes long enough to wean a child, and in rare and very romantic cases, love and sex remain intimately connected for a lifetime. Sadly, the third case is rare. The dismal reality, based on the high rate of divorce and relationship dissolution, is that the transition from romantic love to an enduring conjugal love commonly fails to evolve. Although, divorce rates remained fairly constant in the last two decades, there has been a trend towards fewer couples marrying (Kreider & Ellis, 2011). For example, approximately 85% of people born from 1940 to 1944 were married by the age of 30, in contrast to the 65% of people born from 1970 to 1974. Estimated divorce and separation rates range from 40% to higher rates as those found by Martin and Bumpass (1985), who concluded that when allowing for underreporting, the actual rate is closer to 66%. Whatever the precise rate of divorce, it likely understates the rate of relationship dissolution, as many relationships fail before marriage is achieved.

It is difficult to precisely measure the proportion of non-conjugal relationships that dissolve, but it is reasonable to assume that it is no better than for married couples. Studies that did manage to yield some estimates found the prospect of successful ongoing relationships to be somewhat bleak. In an Internet survey of 3,000 people, 35% reported having had a relationship breakup in the past 10 years. And of those between 18 and 34, 59% reported recently having had a recent relationship breakup (Fetto, 2003). This is concordant with the findings of Simpson (1987) who surveyed 234 non-married individuals with an average age just under 20. In a follow-up just 3 months later, 42% of those surveyed had broken up.

Irrespective of marital status, it seems that the strength of the coupling bond is enhanced by time spent together, personal commitment to the relationship, level of love, degree of social support and assessment of availability of better mates (Felmlee, Sprecher, & Bassin, 1990). This last variable is one that is often ignored. That is, on some level, partners are always vigilant for mates who can offer more. This was illustrated in a study of lesbian couples in relationships in which partners who perceived few alternatives to their mate tended to be more committed (Beals, Impett, & Peplau, 2002). The social exchange perspective of relationships appears to be supported by the high rates of relationship dissolution and infidelity (Byers & Wang, 2004). In short, it posits that relationships, irrespective of love, are founded on an exchange of perceived value. In the starkest terms, most members of loving relationships remain vigilant for a better mate. Couples' counselors often overlook this unfortunate reality.

Most relationships traverse several phases: the first is the initial excitement of romance, then a fading of passion, followed by a change in the way a partner perceives his or her mate. This perceptual change is such that physical and character flaws that were obscured by passion now become visible. Romantic attraction tends to mask the defects, blemishes, and idiosyncrasies of the partners. With the imperfections more salient, there is often a surge in complaints and criticisms that typically

leads to conflict. In order to apply rational emotive/cognitive behavioral solutions to the problems of marriage and love, it is first important to understand the essential nature of these two fundamental components of social interplay. As Nobel laureate Daniel Kahneman pointed out, we are prone to like, or feel we have knowledge, with things that are familiar (Tversky & Kahneman, 1973, 1974). Love relationships, coupling, and marriage are so ubiquitous that they seem quite scrutable. In fact, couples are bound together by a complex of nonconscious, social, cognitive, and personality factors that take a bit of analysis to fully grasp. A therapist who fails to address the hidden forces contributing to difficulties in relationships will undermine his or her best efforts to help.

Sexual Relationships and the Evolution of Human Sexuality

In 1895 Breuer and Freud published a book titled Studies in Hysteria that paved the way for a century of psychoanalytic explanations of human behavior. The theme of the explanations is that expressed or repressed sexuality and aggression underlie and direct all human behavior. Indeed, even the most creative acts are viewed as resulting from disguised sexual intentions in the form of sublimation. Although, psychoanalytic theory has largely failed to meet research support (e.g., Ellis & Abrams, 2008), it seems to have stumbled onto a key principle of today's zeitgeist, evolutionary psychology. Evolutionary psychology supports the idea that sex does permeate most every aspect of our lives. A man does not buy the expensive sports car only because he wants to drive fast. A woman does not dye her hair or buy a snug fitting dress because she wants to look good for herself. Even someone cramming for college entrance exams might be trying to bring his or her grades up for reasons other than college admissions. Entrance into a better school leads to increased income and consequently better access to a mate.

Supporting this perspective, psychologist David Buss (2005) theorized that virtually all male violence has a sexual basis. This point was compellingly detailed by authors Malcolm Potts and Thomas Hayden (2008) who cogently argue that most wars can be traced to innate sexual competition. This evolutionary perspective of violence is based on both direct and indirect sexual jealousy. Direct sexual jealousy usually involves a male guarding his mate, whereas indirect jealousy extends to encounters that are tangential to the love relationship. For example, the rage a man feels when slighted is abstractly sexual, as it may result in his losing prestige or social standing. Since all men are potential sexual competitors, loss of face typically leads to a diminution in a man's access to females. Indeed, many evolutionary psychologists opine that homicidal jealousy is an evolutionary adaption since killing a direct or indirect sexual competitor was an efficient solution during human evolution. Why not? There were no jails, lawsuits, or any consequences save for revenge by the slain man's kin. Killing one's sexual competitor smoothed the path towards passing one's genes to future generations. In short, evolution may have made it more adaptive to kill than be cuckolded.

The need to take an evolutionary view of sex is emphasized by Dobzhansky (1973), who said "nothing in biology makes sense except in the light of evolution." By logical extension it follows that nothing in sexuality makes sense except in light of evolution. Psychologists who attempt to understand and treat couples in distress must at least make an attempt to understand human social behavior in terms of our evolutionary past. Usually one can infer the underlying meaning of human behavior by looking at how that behavior would have been adaptive during our early evolution. Human sexuality during our distant past was unlikely to follow the Western ideal of long-term monogamous relationships. Indeed, sexual monogamy in nature is quite rare. Birds that are often cited as forming pair bonds for life often do so, but they rarely maintain sexual monogamy. Extra pair copulations (EPC's), or what married couples would denote as adultery, seems to be remarkably common among birds in pair bonds. Birds like the passerine and the cockatiel, which are known to be socially monogamous, have a substantial number of their offspring fathered by males outside the pair bond (Fossøy, Johnsen, & Lifjeld, 2006; Spoon, Millam, & Owings, 2007). Why do birds "cheat" on their mates? It seems that a pair bond is beneficial for raising the hatchlings that includes protection and procuring food. It is also beneficial for the female's genetic legacy to obtain genes from males that offer the best genes possible. It seems that female birds have developed the ability to discern good genes in males and in turn male birds work very hard at trying to highlight their genetic endowments. This is accomplished through extravagant displays such as that of the peacock (Loyau, Jalme, & Sorci, 2005), the ability to acquire prime territory as in the case of the bowerbird (Pruett-Jones & Pruett-Jones, 1994), and the ability to fight (Edler & Friedl, 2010). In short, sexual behavior in almost all species includes a strong tendency for females to seek males with the best genetic endowment. There is little doubt among evolutionary psychologists that this is case for humans.

This pattern is also observed in apes, animals that are quite genetically similar to humans. The most similar, Bonobos and chimpanzees, are both nonmonogamous and highly sexually competitive. When a female chimpanzee is in estrus, she will mate with numerous males in short order. If there is ever a semblance of monogamy, a chimp pair will go off for a few days on what primatologists label consort relationships (Fisher, 1992; McGinnis, 1979). However, upon their return the pair bond tends to rapidly dissolve. It is more common for chimpanzee sexuality to involve what amounts to mating frenzies with multiple male-female pairings. During these encounters there is rarely intermale aggression so long as the dominant male's access to females is not impeded. Despite the restrictions of the male hierarchy, females in estrus will mate with eight or more different males per day. Like their larger cousins, Bonobos also are quite promiscuous with virtually no sexual pair bonding. These close human relatives are not only extremely promiscuous but also seem to include both heterosexual and homosexual sex in all their social interactions (Parish & De Waal, 2000; Ryan & Jethá, 2010).

Primates who don't form pair bonds use a vicarious method of sexual rivalry; they let their sperm compete for them. A chimpanzee produces approximately 223 times more sperm than a gorilla (Fujii-Hanamoto, Matsubayashi, Nakano, Kusunoki,

& Enomoto, 2011). Why is this the case? Gorillas live in small groups in which one male mates with multiple females—no sperm competition, hence their small testicles. Chimpanzees are much smaller animals, tipping the scales at around 120 pounds but they have large testicles that together weigh about four ounces (Kenagy & Trombulak, 1986). Since female chimpanzees in estrus mate with several males a day, the male chimpanzees have evolved to be large and to produce a large number of sperm cells in order to increase the chance of fertilization. Humans have a testicular size that falls between gorillas and chimpanzees. This suggests that humans have evolved a mating system that is neither as promiscuous as that of the chimpanzee, nor as exclusive as that of the gorilla. Nevertheless, all indicators denote that humans are a promiscuous species whose sexual impulsiveness can be briefly held in check by romantic love.

In their book the *Myth of Monogamy*, Barash and Lipton (2001) compellingly argue for the innate human tendency for polygamy. They point out that virtually no animals are monogamous, including birds, the genus most often cited as emblematic of monogamy. This is also the disillusioning case for the paradigm of pair bonding, the prairie vole. These mate-for-life rodents do indeed stay together for life, but the female very often finds the time to mate with other males (Ledford, 2008). And what about human cultures? C.S. Ford and psychologist Frank A. Beach studied 185 human societies (1951) and found 39% approved of extramarital sexual relationships. More recently, Helen Fisher and her coworkers observed that 84% of human societies permit some form of polygyny (Tsapelas, Fisher, & Aron, 2011)

What does all this mean? In distilled form, it means that monogamy, especially sexual monogamy, is not the norm for primates—and every bit of social data demonstrate that this strongly applies to human primates. Indeed, the evidence points to the fact that serial monogamy with a substantial degree of infidelity is something that we are evolutionarily primed for. This being the case, couples are likely to confront many sexual challenges that are expressions of a biological rather than a psychodynamic unconscious. This fact is particularly important for the counselor working with sexual problems. The evolutionary tendency to lose sexual passion is just one of the problems couples face. Some of the more vexing ones will be subsequently discussed.

Paraphilias, Fetishes, and Problems of Preference

Just as humans seem to be evolutionarily primed for sexual interpersonal diversity, we need to be primed to be aroused by other people. However, for men there seems to be far more variety in this priming than in women. This greater variation in sexual arousal cues is in part due to the male's reliance on visual signals for sexual arousal. Ideally, the source of arousal would be the shape and form of another person's face and body. For a heterosexual man it will be the face and body of a woman, for a homosexual it will be that of a man. However, men are extraordinarily more prone to paraphilias than women. That is, some men are not aroused by a person's attributes

Table 7.1 Percentage of study sample participating in various sexual behaviors

	Tried	Tried and enjoyed
Spanking	81.9	66.1
Bondage	77.4	65.0
Master/slave (mental trip)	68.3	57.6
Humiliation	67.2	55.9
Whipping	65.0	49.7
Rope	64.9	54.2
Master/slave (physical trip)	60.5	52.0
Fetish behavior	60.4	51.4

Adapted from: Moser & Levitt, 1987

but by peripheral aspects, by social situations, or other cues that make the other individual largely irrelevant.

In contrast to animals, in which the mechanics of sex vary very little, with humans the range of sexual expression is far more diverse. Indeed, sometimes it is hard to recognize certain lustful behaviors as sexual at all. Some sexual acts are so far from the archetypal theme of physical intimacy that miss the target completely. Hence the term paraphilia, which is derived from Greek words meaning beside or to the side of love. Thus, the individual who has a paraphilic sexual focus is often denied the intimacy that sex can bestow. And for some, sexual arousal cues are so inconsistent with affection or tenderness that they serve to alienate potential lovers. It is this manner of paraphilic sex that is most often categorized as a disorder (American Psychiatric Association, 2000). Here the paraphilic individual is so focused on a sexual arousal cue that it is nearly completely divorced from the person who possesses it. Interestingly, as divorced as a paraphile may be from intimacy, he or she will almost always require a person consistent with his or her gender choice for the paraphilic act. For example, if a heterosexual man requires degradation for arousal, he will always want that degradation to come from a woman. For most people with paraphilias, the need for the fetish object or the paraphilic act is linked to no shame, distress, or social impairment. This fact is the basis for those who argue that paraphilias should not be categorized as sexual disorders. A cogent proponent of this position is Charles Moser (Moser, 2009; Shindel & Moser, 2011). In a study conducted prior to common access to the Internet, Moser and his colleagues (Moser & Levitt, 1987) took a survey of 178 men recruited at a sadomasochism support group, through an ad placed in a sadomasochism magazine. A portion of the findings are presented in Table 7.1 below.

Table 7.1 details the type of paraphilic interests found in those who were active in a fetish lifestyle. It shows that people who are active in a paraphilic lifestyle tend to be aroused by acts that are commonly considered shocking or offensive. Moser surveyed people who led active paraphilic lifestyles. An estimate of the prevalence in the general population was found in an informal ongoing Internet sex survey in which more than 70,000 anonymously responded (http://www.survey.net/sv-sex.htm). The checklist has three levels for each arousal cue—curious, mild, and heavy. Respondents were permitted to make multiple choices so that someone aroused by

Table 7.2 Prevalence of selected sadomasochistic sexual cues

Sadomasochism—curious	21.1%
Submissive—mild	19.0%
Domination—mild	19.8%
Bondage & Discipline—curious	18.3%
Domination—curious	16.4%
Sadomasochism—mild	13.8%
Bondage & Discipline—mild	13.3%
Pain—mild	12.1%
Pain—curious	9.6%
Submissive—heavy	9.6%
Humiliation—curious	8.5%
Domination—heavy	7.9%
Humiliation—mild	6.2%

mild pain could also select both curious and heavy pain. The results set forth in Table 7.2 indicate that paraphilic interests are quite common and therefore normal. However, like any sexual proclivity, when taken to an extreme, it becomes an acute barrier to sexual intimacy.

Normal or not, paraphilias present a particularly difficult problem to heterosexual couples, due to the fact that the great preponderance of women do not find most paraphilias arousing or even acceptable. In some cases an accommodating lover will indulge the paraphile, but more often the paraphilia becomes a shameful secret that is exercised outside the relationship or is relegated to fantasy. In either case it creates a sexual distance in the relationship. Interestingly, it appears that sadomasochistic sexuality or other paraphilias are far more accepted among gay men. In lesbians they are both less common or tend to be attenuated in intensity. This is in contrast to many male paraphiles who absolutely require the paraphilic cue for arousal or orgasm.

Counseling for a Paraphilic Partner

Paraphilia, an almost exclusively male disorder, may allow for a relationship with genuine love but typically has little in the way of sexual communication and intimacy. As noted earlier, the paraphile's lover will virtually never directly arouse him. Instead, the lover becomes one of several "props" that are necessary for sexual arousal. It is important for the counselor to be aware that paraphilias are as refractory to change as one's sexuality. That is, it is no easier for a man with a foot fetish to change to become aroused by a whole woman than it is for a straight man to become visually aroused by a penis.

Since more paraphiles have learned to keep their propensities secret, they will typically be exposed in a relationship when their guard is down. A man is caught masturbating to fetishistic pornography; his wife discovers sexual implements,

women's undergarments, or membership on a fetish site like FetLife. When exposed, fear and shame often lead to denial, explanations of experimentation, or if inescapable, vows to change. The essential fact that the shocked partner must be guided to accept is that her partner will not change. Counseling for this couple with this problem must include an assessment of the severity of the paraphilia. In the more severe forms it tends to exclude all traditional sexual intimacy and be obsessively consuming. In such cases the relationship is in great peril unless the non-paraphilic partner is extraordinarily accommodating. In less severe forms, if both members are willing, the couple needs to be helped to build a sex life that includes the fetish. Common beliefs among women who discover their mate is a paraphile are "He is a pervert and a terrible person for having these desires," "He completely deceived me about his love, and our relationship is a total lie," "He should be able to be turned on by me without his fetishes," or "If he really loved me, he would be attracted to me without needing his sex games."

The response of the male lover when his mate discovers his predilection is often shame, guilt, and denial. Counseling for a couple facing this difficulty needs to address this aspect of the problem. Men "outed" as paraphiles will suffer beliefs like: "I am a pervert and terrible person for having these desires," "I am not a real man if I need to be aroused in such a sick way," or "I can never be happy with these desires." The counselor should help the client challenge these irrational beliefs. Counseling for the woman must address beliefs about shame, rebuke, and betrayal. The woman needs to be helped to challenge beliefs that the paraphilia is a volitional betrayal of the relationship or that her lover's sexual desires denote a lack of love. If this can be successfully conveyed, then the next phase of counseling can commence.

This second phase of the counseling must involve strategies to help the couple develop a sexual compromise that permits limited expression of the paraphilia. For example, if the man has a lingerie fetish such that he is aroused by wearing women's undergarments, his spouse must find her comfort range with his dressing this way prior to or during sex. If she finds it offensive or distracting, a compromise can be reached in which he uses the lingerie for arousal prior to coitus. The therapist can facilitate the process by helping the paraphile's spouse explore the basis for her aversion to his arousal cues.

Problems with Arousal

The most common source of failure of sexual arousal is the fundamental gender difference in arousal cues. Men are visually aroused and tend to be less discriminating in who arouses them and when. Women typically require displays of emotional commitment, affection, stability, and quality from those who would arouse them. Both of these general rules have exceptions, but they are important starting points for inquiry in counseling couples with arousal difficulties.

One arousal problem that is particularly dreaded yet easy to treat is erectile dysfunction. Studies have shown that this is more common a problem than most afflicted men may think. And this fact is something that needs to be conveyed in couples' counseling. For example, in one study which surveyed the top sexual problems in men, these were listed as follows: problem getting an erection, problem maintaining an erection, premature ejaculation, and inhibited enjoyment (Dunn, Croft, & Hackett, 1999). The high prevalence of erectile dysfunction, especially among older men, was measured in a study of men over 40 by Laumann et al. (2007). The authors found that the prevalence of moderate to severe erectile dysfunction was 8.8% for men 40–49, 15.2% for men 50–59 and 29.2% for men 60–69. These rates among older men may not be surprising. However similar prevalence was found in a survey of younger men (Heruti, Shochat, Tekes-Manova, Ashkenazi, & Justo, 2004) in which 19% of men 25–28 reported mild erectile dysfunction and 5% reported a moderate to severe condition. Prior to the advent of the phosphodiesterase inhibitor (PDE5) medications, which include Viagra, Levitra, and Cialis, the predominant problem addressed in sex therapy for men was erectile dysfunction. Clearly, this is no longer the case.

For many couples, the problem is more complex than erectile dysfunction. One or both partners have ceased to find the other sexually interesting. This problem needs to be addressed by seeking sources of anger, resentment, and other negative emotions that may be barriers to finding new ways for the couple to excite each other again. As noted earlier, the waning of romantic love is usually linked to a decline in sexual arousal. Of course with all sexual problems, especially those with recent onset, organic bases must be ruled out. These can include endocrine problems—especially reduced free testosterone levels. Having ruled out organic bases for the problem, psychotherapeutic interventions can proceed.

Counseling for Loss of Arousal

Any therapeutic intervention must take into consideration the natural tendency to habituate to one's lover over time. As suggested above, men tend to habituate to lovers relatively rapidly, and women, although a bit slower in losing interest, will tend to do so when romance fades. When romantic love fades, arguments increase, the idiosyncrasies of one's lover become more vexing, and a partner may begin to attend to other possibilities. These tendencies conspire to make sex with one's mate less exciting. It is important that a couple's counselor ascertain whether problems like erectile dysfunction or anorgasmia result from a fundamental loss of attraction rather than organic problems. If attraction has indeed faded, the counselor then needs to determine if both members of the couple are committed to their partner. A relationship can survive a diminution of passion if there is a conjugal love and friendship. If such bonds have developed, then the counselor can help by exploring irrational beliefs that will invariably make the problem worse, such as: "It is a terrible affront that my lover does not get excited by me!" " I can't stand that she doesn't

excite me anymore," "I am a terrible person for fantasizing about other men," or "This relationship is a complete failure because he/she doesn't want sex."

The first approach in counseling for loss of sexual interest in a relationship is to explore the beliefs and emotions consequent to the change in sexual response. Then each partner needs to be helped to see the tacit rigidity, demandingness, and damning nature of their irrational beliefs. Ideally, each partner is guided to disavow the belief in front of his or her paramour. This will reduce much of anxiety, hurt, and guilt associated with loss of sexual interest. When this has been accomplished, the couple then benefits from tools that enhance the sexual response.

The Case of Hillary and Mark: Loss of Passion

Hillary and Mark had a romantic wedding, which was appropriate because they were very much in love. Hillary was senior administrator for a pharmaceutical company and Mark was a structural engineer with both a full time job and a part-time consulting practice. According to Hillary, sex in the first two years of their marriage was frequent and intensely pleasurable. It resulted in a daughter, Sara, and all remained well as they became increasing affluent and close as a family. Unfortunately, by the fourth year of the marriage, Hillary began to complain about Mark's assertiveness, his masculinity, and his ability to discipline their daughter. Mark said he was frustrated and hurt, as he felt that he had not changed in any way. Exacerbating the problem, Hillary had completely withdrawn from Mark sexually. She initially denied that this was the case, citing a single sexual encounter a month earlier. However, when questioned further, she responded with complaints about Mark's annoying behavior at home—especially his inconsistent parenting of Sara. Mark was articulate and clearly intelligent; but he was also quite shy and passive. He was frustrated and angry with Hillary's constant complaining and her sexual withdrawal. Yet he never expressed these feelings to her. Instead, he became sullen and passive aggressive.

Initially in counseling, Hillary insisted on enumerating Mark's flaws and failings and avoided the topic of sex, which was very important to Mark. In an individual session Hillary acknowledged that Mark did not arouse her anymore, but insisted it was a result of his behavior. In Mark's individual session he repeatedly insisted he could see no changes in the relationship that would account for Hillary's complaints about him, nor her sexual withdrawal. His tacit belief was "Hillary should act lovingly and be attracted to me because she is my wife." In response to this, the counselor suggested that he change his demeanor with Hillary. He asked Mark to be direct when distressed about relationship and parenting issues instead of avoiding conflict. Mark had also acknowledged that he felt that he could no longer be open with Hillary about his anxieties and life stressors. The therapist told him that this was indeed unfortunate, but the nature of the relationship had changed. Hillary had begun to see his frequent requests for succor and consolation as unattractive weakness. When together, Hillary acknowledged this and stated that in the past Mark's need for

emotional support and reassurance evoked maternal feelings, but now it was sexually alienating. Hillary's irrational demand was that Mark should know that she found his behavior a turnoff and should change without her having to ask. The therapist helped Hillary see that both she and Mark had changed in the relationship and that acceptance was required for growth. Mark was still not happy that he had to maintain a façade of machismo to keep Hillary sexually attracted. And Hillary continued to feel that she was compromising by staying with Mark. Nevertheless, the relationship continued and sex improved once the couple dealt with their irrational beliefs.

Infidelity

When one is emotionally and sexually committed to another person, there are few life events that are as traumatic as discovering that the loved one has been intimate with someone else. This intimacy is usually sexual, but it can be romantic sans sex. The latter is more common with a woman who might develop a deep romantic bond with a man (on occasion with a woman) without ever having sex. Although husbands and lovers tend to find this disturbing, it does not approach the emotional firestorm that ensues when the infidelity is indeed sexual. David Buss' contention that violent jealousy in the face of sexual infidelity is a male adaption is supported by the fact that a negative relationship between the length of the second finger to the fourth finger and increased anger at sexual jealousy (Fussell, Rowe, & Park, 2011). The second digit to fourth digit ratio is a correlate of prenatal testosterone levels such that men or women with ring fingers being longer than their index fingers were usually exposed to higher levels of testosterone. Thus, a masculinized brain is one that experiences greater distress at sexual infidelity.

Counseling Couples Facing Infidelity

As with all couples' therapy, treatment for a couple with an unfaithful partner should begin with an individual session with each partner. Very often one or both members of the dyad will use the couples' therapy as an exit strategy. It is painful to leave a relationship for reasons that include guilt, inertia, social responsibility, or feelings obligation. Thus, the difficulty in leaving is not based on a sincere desire to remain with the paramour. In this case the counselor is placed in a no win situation in which the partner who secretly desires a way out can claim that he or she has tried everything to make it work. Failing that rationale, the therapist's interventions can be blamed for pulling the relationship asunder. A requisite of doing couple counseling is being thick skinned, but the job does not include billing for wasted time. Thus, it is essential that the counselor make a determination if both partners are really committed to continuing the relationship. The research previously presented is important in that a great deal of sexual motivation is innate, evolutionarily old, and not immediately accessible to

the individual. As Beck (1989) emphasized, couples radically change their judgments when romantic passion attenuates. The role of the couples' counselor is to accurately assess the factors that led the one of the partners to seek sexual satisfaction from another.

A brief history of the sexual trajectory of the relationship needs to be compiled. This is to ascertain whether the infidelity is a result of problems such as:

- Diminished attraction on the part of one or both partners.
- Pairing for reasons other than sexual attraction such that one or both were never compellingly sexually attracted to each other.
- Succumbing to a brief intense temptation.
- Anger at the lover or spouse leading retribution through infidelity.
- Undisclosed sexual performance issues.
- Undisclosed sexual pathology.

When and if a change has taken place and becomes evident in counseling, the counselor must assist each partner to understand and accept the change. Such changes can include loss of sexual passion, the development of anger or resentment, or the introduction of a third party. When a change such as loss of passion leads to infidelity, the counselor must insist that the offended partner understand his or her hurt, anger, and vengefulness in terms of his or her demands and other irrational beliefs. The offended partner must be helped to see that retribution and rage are not compatible with restoring the relationship. To accomplish this, irrational beliefs must be elicited and collaboratively challenged, as illustrated in the following case study. Similarly, the irrational beliefs that led the unfaithful partner to stray must be identified. If the unfaithful partner hopes to remain in the relationship, the irrationality of his or her actions needs to be explored and challenged. Both partners must be helped to see that creating a new relationship without the ruminations about the past is the best path to resolution. If both can view the infidelity act as bad, but not terrible or unredeemable, it can eventually become no more relevant than the sexual encounters that took place prior to the relationship.

The Case of Donna and Sal's Marital Infidelity

Sal is a Latino who takes great pride in his physical prowess and his ability to manage tough laborers. His hobby is martial arts and he notes that he is quite proficient in self-defense and fighting when necessary. His manner and mien convey that this is not bluster. At the time of treatment he was cohabitating with Donna, an administrative secretary in the main office of a national corporation. Her job requires her to work late on many nights as well as attend corporate functions. Despite not being married, Donna and Sal have three children under age ten who are cared for by Donna's mother when both parents are at work. The couple sought treatment as a result of an increasing number of arguments about Donna's late hours at work and Sal's growing discomfort with her socializing with men at corporate functions.

When asked if he was jealous of any specific coworker, he said no, but he was not comfortable with her being away from home for several hours during the evenings. Donna insisted that attending these functions was essential for her career, but Sal angrily argued that her job was secretarial, not social. She responded, a bit dismissively, that he didn't understand the corporate world.

In employing Rational Emotive Behavior Therapy with this couple, the therapist helped each partner understand the irrationality or inflexibility of his or her demands. For example, Donna would insist that late work was necessary, but would make no offers of compromise about setting some limits. Her tacit irrational beliefs were to the effect "he has absolutely no right to restrict my behavior; he doesn't work in a corporate setting and is making completely unfair demands based on ignorance." Consequently, Donna was shown that her rigid stance only provoked Sal to become more demanding and hostile. Sal labored under beliefs to the effect, "she is the mother of my children and absolutely should make being with them a priority. Her failure to compromise is an absolutely unacceptable affront to my masculine role in this relationship." Sal was helped to see that although he had a strong desire to be in control of the relationship, Donna did not have to completely accept his standards for female behavior. In addition, Sal was helped to see that being less angry and demanding might yield more room for compromise. There was moderate success with this approach and treatment ended after five sessions, with both Sal and Donna agreeing to work on several homework assignments. The respite in conflict, along with helping the couple identify and dispute irrational beliefs such as those cited above did not completely attenuate Sal's suspicions about his partner's activities.

Sal continued to complain that Donna seemed indifferent and unaffectionate. She increasingly avoided sex and any forms of physical intimacy. She became quite dismissive of Sal's interest in sports and would criticize him for being unsophisticated and excessively machismo—some of the very qualities that had initially attracted her to him. In counseling sessions he would complain that she was pulling away from him and always putting him down, something Donna would consistently deny. So in spite of the reduction in conflict that counseling had accomplished, Sal continued to feeling increasingly frustrated with Donna. He insisted that these changes in the way she related to him were making him increasingly suspicious about the times she insisted she was working late. He hired a private detective who did his job, showing Sal a series of photos that stunned and enraged him—photos of the woman he loved entering hotels and restaurants with an executive in her company. Not only that, but she was very affectionate towards this man in the photos… the type of man Sal feared and resented.

Sal called this author in a state of agitated rage. He was hurt and very angry, criticizing the therapy and ranting about how all the work on communication, anger control, and irrational demands was worthless because all the while Donna was having sex with an executive coworker. The object of Donna's passions was almost as vexing as the infidelity. Sal, although a manager, managed labor. Although earning a respectable salary, he was very jealous of the educated high status male coworkers with whom Donna worked. This jealousy was frequently stoked when she would discuss these men with admiring adulation. Now the men he had been covertly competing with had won, and in his eyes had humiliated him.

Sal's Irrational Beliefs

- "I have been completely humiliated and must retaliate to save my honor."
- "Donna is a completely worthless slut, and I must punish her."
- "I can never trust a woman again."
- "I must punish Donna by fighting her for the kids."
- "I cannot stand the idea that people will know she cheated on me."
- "I absolutely must get the guy that stole my wife."
- "I am a worthless lover and cannot satisfy a woman."
- "Donna is tainted and I cannot be with her."
- "My marriage is a total failure."
- "Donna deceived me and everything she ever said must be a lie."

After meeting with Sal, this author requested that Donna come in for a solo session. She agreed, if for no other reason than that she wanted a means to communicate with Sal who had already confronted her in an angry and menacing way. During the session, she insisted that she still loved Sal but "not in the same way." She stated that he had changed and had become more demanding, "primitive," and suspicious. Donna insisted that it was Sal's behavior that drove her into someone else's arms. Her explanation was no doubt visceral, but might very well have reflected a change in perspective brought about by the type of change in romantic love discussed previously. Specifically, as the passion for Sal faded, flaws that to that point were tempered by passion became far more noticeable, leading to an increasing loss of sexual attraction.

Donna's Irrational Beliefs

- "I have an absolute right to pursue sexual gratification if Sal refuses to meet my needs."
- "It is completely Sal's fault that he let himself deteriorate. He has forced me into arms of someone else."
- "My new lover completely understands me and loves me far more than Sal, so I am doing absolutely nothing wrong in seeking his affections."
- "He is not the man I married. I had to find someone like Sal used to be."
- "I shouldn't have to be with man this bad, when there are nice men who like me."
- "Sal should understand that I needed to do this."
- "Sal made me lonely and dissatisfied, I have an absolute right to be happy."
- "It is very common to have an affair, I'm sure Sal wouldn't mind that much."

Even though these irrational or demanding beliefs are likely to arise due to innate factors, they can nevertheless be addressed through a Rational Emotive approach. Donna has to learn that her alienation from Sal is in part a result of a change in her perception. This can be accomplished by encouraging her to specify the exact nature of his change that is troubling her and to explore the reality of his alleged change.

A significant percentage of those suffering from infidelity will never forgive the offense (Cann & Baucom, 2004; Shackelford, Buss, & Bennett, 2002). This needs to be explored early in treatment. If indeed it seems that infidelity represents an unforgivable transgression, then the couple needs to be counseled accordingly. Specifically, the unfaithful partner needs to be warned that staying in the relationship will tend to be associated with ongoing hostility and resentment.

As the therapy proceeded, Donna accused Sal of changing for the worse, but she was unable to specify the exact nature of these changes. The therapist helped to see that it was her change in perception, not a change in Sal, that led to the disaffection. The irrational or demanding beliefs set forth above were elicited over several sessions of counseling. One by one they were directly challenged by the counselor or by the counselor guiding Donna or Sal to challenge the beliefs themselves. This is illustrated with a session excerpt with Donna; her irrational beliefs are identified in italics.

Therapist: "Donna, I guess if you weren't happy with Sal's behavior you had no choice but to find someone else?"
Donna: "Of course I had a choice, but…"
Therapist: "Oh, so you had other options; can you give me an idea what some were?"
Donna: "I guess I could have told Sal that I was unhappy."
Therapist: "But you were unable to do this?"
Donna: "No, I could have. I could have spoken to him, but he made it *too hard."*
Therapist: "I see. He made it too hard to talk to him; how did he do this?"
Donna: "Well, he's not the type of man you can talk to; he also gave me the impression that he didn't want to talk about things."
Therapist: "So because you had this impression, you thought you needed to someone else?"
Donna: "I didn't have to…. He just pushed me away and I *needed to."*
Therapist: "You needed to have an affair?"
Donna: "I guess it's something I wanted because he always turned me off with his macho behavior and his anger. I just didn't think he was into me anymore."
Therapist: "But it he wasn't "into" you, why do you think he agreed to come to counseling? Didn't that indicate that he cared to some degree?"
Donna" "Well, maybe he cares, but he's very angry. He's just so hard to deal with and I *can't stand it* when he acts so macho and ignorant."
Therapist: "It appears as if you could stand it during the early part of the relationship. Did he change so much that now you can't bear it at all?"
Donna: "I guess I can bear it; I think we've both changed."

In this session segment, Donna exhibited some irrational demands and low frustration tolerance. She was helped to see that although she still loved Sal, she had become less attracted to him and took the easy way out by finding another lover. Consequently, some of Sal's actions that were either acceptable or even attractive had now become off-putting, resulting in more negative judgments from Donna towards Sal. When made aware of this, she realized that Sal's change was largely based on her perceptions.

Helping Sal was considerably more problematic as he was very angry and ambivalent about continuing the relationship. In fact, he stated that he hated the fact that he still loved Donna. He felt trapped by a desire to stay with her and a vengeful anger. His anger alternately was directed at Donna and the man with whom she had strayed. The therapist initially focused on the pragmatics of staying with Donna and his children. He helped Sal challenge his irrational beliefs to the effect "I must hurt Donna or the man she cheated with or I am not a man. I absolutely cannot stay with Donna because a man who stays with an unfaithful wife is worthless. She must be punished and contrite or I would be a fool to stay with her." Over several individual sessions Sal was helped to identify these demanding, irrational beliefs and was taught how to challenge them.

At this writing Sal is still with Donna, but remains somewhat suspicious and bitter. The maintenance of the relationship requires some behavioral changes on both of their parts. Sal needs to become more attentive and less exaggeratedly masculine. Donna needs to be more attentive to Sal and reassure him that her infidelity does not negate her love for him. At this point the relationship is showing some gradual improvement.

Conclusion

Sexual intimacy in relationships is comprised of a complex interaction of ancient biological drives, unique personalities, and cultural forces. Treatment of couples with sexual problems must always begin with a cognizance of the range and complexity of the many expressions of sexuality. It is particularly important that the counselor eschew his or her own values of sexual propriety. Instead, the goal is to perform a differential evaluation of the couple's unique approach to sexuality and the basis of its malfunction. It is also important to be cognizant of the fact that a couple consists of two unique individuals, each of whom may have very different values and desires than his or her partner. The counselor needs to explore how these differences initially coalesced and how they began to unfold. This understanding is best accomplished by eliciting the beliefs each partner has about him or herself, the partner, and relationships in general. When the demanding, rigid, inflexible, or other irrational beliefs are exposed, disputing them collaboratively offers the best hope for the couple with sexual and intimacy problems.

References

American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of mental disorders* (4th ed.). Washington, DC: Author.

Aron, A., Fisher, H., Mashek, D. J., Strong, G., Li, H., & Brown, L. L. (2005). Reward, motivation, and emotion systems associated with early-stage intense romantic love. *Journal Of Neurophysiology, 94*(1), 327–337.

Barash, D. P., & Lipton, J. E. (2001). *The myth of monogamy: Fidelity and infidelity in animal and people*. New York, NY: Freeman.

Beals, K. P., Impett, E. A., & Peplau, L. (2002). Lesbians in love: Why some relationships endure and others end. *Journal of Lesbian Studies, 6*(1), 53–63.

Beck, A. T. (1989). *Love Is never enough: How couples can overcome misunderstandings, resolve conflicts, and solve relationship problems through cognitive therapy*. New York: Harper Perennial.

Buss, D. M. (2005). *The murderer next door: Why the mind is designed to kill*. New York: Penguin Press.

Byers, E., & Wang, A. (2004). Understanding sexuality in close relationships from the social exchange perspective. In J. H. Harvey, A. Wenzel, S. Sprecher, J. H. Harvey, A. Wenzel, & S. Sprecher (Eds.), *The handbook of sexuality in close relationships* (pp. 203–234). Mahwah, NJ: Lawrence Erlbaum Associates Publishers.

Cann, A., & Baucom, T. R. (2004). Former partners and new rivals as threats to a relationship: Infidelity type, gender, and commitment as factors related to distress and forgiveness. *Personal Relationships, 11*(3), 305–318.

Dobzhansky, T. (1973). Nothing in biology makes sense except in the light of evolution. *The American Biology Teacher, 35*, 125–129.

Dunn, K. M., Croft, P. R., & Hackett, G. I. (1999). Association of sexual problems with social, psychological, and physical problems in men and women: a cross sectional population survey. *Journal of Epidemiological Community Health, 53*, 144–148.

Edler, A. U., & Friedl, T. P. (2010). Plumage colouration, age, testosterone and dominance in male red bishops (Euplectes orix): A laboratory experiment. *Ethology, 116*(9), 806–820.

Ellis, A. (1954). Psychosexual and marital problems. In L. A. Pennington, I. A. Berg, L. A. Pennington, & I. A. Berg (Eds.), *An introduction to clinical psychology* (2nd ed., pp. 264–283). New York: Ronald Press Company.

Ellis, A. (1957). How Do I Love Thee? Let Me Count the Ways. *Psyccritiques, 2*(7), 188–189.

Ellis, A. (1972). *The civilized couples guide to extramarital adventure*. New York: David McKay.

Ellis, A., & Abrams, M. (2008). *Personality theories: Critical perspectives*. Thousand Oaks, CA: Sage Publications.

Felmlee, D., Sprecher, S., & Bassin, E. (1990). The dissolution of intimate relationships: A hazard model. *Social Psychology Quarterly, 53*(1), 13–30.

Fetto, J. (2003)—*Love Stinks: Statistics on Failed Relationships*. Retrieve from http://findarticles.com/p/articles/mi_m4021/is_1_25/ai_96734611/

Fisher, H. (1992). *Anatomy of love: A natural history of mating, marriage, and why we stray*. New York, NY: Random House.

Fisher, H. (2004). *Why we love: The nature and chemistry of romantic love*. New York: St. Martins Griffin.

Fisher, H. E., Brown, L. L., Aron, A., Strong, G., & Mashek, D. (2010). Reward, addiction, and emotion regulation systems associated with rejection in love. *Journal of Neurophysiology, 104*(1), 51–60.

Fossøy, F., Johnsen, A., & Lifjeld, J. T. (2006). Evidence of obligate female promiscuity in a socially monogamous passerine. *Behavioral Ecology and Sociobiology, 60*(2), 255–259.

Fujii-Hanamoto, H., Matsubayashi, K., Nakano, M., Kusunoki, H., & Enomoto, T. (2011). A comparative study on testicular microstructure and relative sperm production in gorillas, chimpanzees, and orangutans. *American Journal of Primatology, 73*(6), 570–577.

Fussell, N. J., Rowe, A. C., & Park, J. H. (2011). Masculinised brain and romantic jealousy: Examining the association between digit ratio (2D:4D) and between- and within-sex differences. *Personality and Individual Differences, 51*(2), 107–111.

Heruti, R., Shochat, T., Tekes-Manova, D., Ashkenazi, I., & Justo, D. (2004). Prevalence of erectile dysfunction among young adults: results of a large-scale survey. *The Journal of Sexual Medicine, 1*(3), 284–291.

Jacobson, N. S., & Christenensen, A. (1996). *Acceptance and change in couples therapy*. New York: Norton.

Johnson, S. M. (2004). *The practice of emotionally focused marital therapy: Creating connection*. New York: Bruner.

Kenagy, G. J., & Trombulak, S. C. (1986). Size and function of mammalian testes in relation to body size. *Journal of Mammalogy, 67*, 1–22.

Kreider, R.M. & Ellis, R. (2011). Number, timing and duration of Marriages and divorces: 2009. United States Census Bureau. Retrieved from http://www.census.gov/prod/2011pubs/p70-125.pdf.

Laumann, E. O., West, S., Glasser, D., Carson, C., Rosen, R., & Kang, J. (2007). Prevalence and correlates of erectile dysfunction by race and ethnicity among men aged 40 or older in the United States: From the male attitudes regarding sexual health survey. *The Journal of Sexual Medicine, 4*, 57–65.

Ledford, H. (2008). 'Monogamous' vole in love-rat shock. *Nature, 451*(7179), 617.

Loyau, A., Jalme, M., & Sorci, G. (2005). Intra- and Intersexual Selection for Multiple Traits in the Peacock (Pavo cristatus). *Ethology, 111*(9), 810–820.

Martin, T. C., & Bumpass, L. L. (1989). Recent trends in marital disruption. *Demography, 26*, 37–51.

McGinnis, P. R. (1979). Sexual behavior in free-living Chimpanzees: consort relationships. In D. A. Hamburg & E. R. McCown (Eds.), *The great apes* (pp. 429–438). Menlo Park: Benjamin.

Moser, C. (2009). When is an unusual sexual interest a mental disorder? *Archives of Sexual Behavior, 38*(3), 323–325.

Moser, C., & Levitt, E. E. (1987). An exploratory-descriptive study of a sadomasochistically oriented sample. *Journal of Sex Research, 23*(3), 322–337.

Parish, A., & De Waal, F. (2000). The other "closest living relative". How bonobos (Pan paniscus) challenge traditional assumptions about females, dominance, intra- and intersexual interactions, and hominid evolution. *Annals of the New York Academy of Sciences,* 90797–113.

Potts, M., & Hayden, T. (2008). *Sex and war: How biology explains warfare and terrorism and offers a path to a safer world*. Benbella Books: Benbella Books.

Pruett-Jones, S., & Pruett-Jones, M. (1994). Sexual competition and courtship disruptions: Why do male bowerbirds destroy each other's bowers? *Animal Behaviour, 47*(3), 607–620.

Ryan, C., & Jethá, C. (2010). *Sex at dawn: Why we mate, why we stray, and what it means for modern relationships*. New York, NY: HarperCollins.

Shackelford, T. K., Buss, D. M., & Bennett, K. (2002). Forgiveness or breakup: Sex differences in responses to a partner's infidelity. *Cognition and Emotion, 16*, 299–307.

Shindel, A. W., & Moser, C. A. (2011). Why are the paraphilias mental disorders? *The Journal of Sexual Medicine, 8*(3), 927–929. 2.

Simpson, J. A. (1987). The dissolution of romantic relationships: Factors involved in relationship stability and emotional distress. *Journal of Personality and Social Psychology, 53*, 683–692.

Spoon, T. R., Millam, J. R., & Owings, D. H. (2007). Behavioural compatibility, extrapair copulation and mate switching in a socially monogamous parrot. *Animal Behaviour, 73*(5), 815–824.

Stevenson, R. J., Case, T. I., & Oaten, M. J. (2011). Effect of self-reported sexual arousal on responses to sex-related and non-sex-related disgust cues. *Archives of Sexual Behavior, 40*(1), 79–85.

Tsapelas, I., Fisher, H. E., & Aron, A. (2011). Infidelity: When, where, why. In W. R. Cupach, B. H. Spitzberg, W. R. Cupach, & B. H. Spitzberg (Eds.), *The dark side of close relationships II* (pp. 175–195). New York: Routledge/Taylor & Francis Group.

Tversky, A., & Kahneman, D. (1973). Availability: A heuristic for judging frequency and probability. *Cognitive Psychology, 5*, 201–232.

Tversky, A., & Kahneman, D. (1974). Judgment under uncertainty: Heuristics and biases. *Science, 185*, 1124–1131.

Chapter 8
Helping Couples Deal with Betrayal and Affairs

David Stoop

Sam was a CPA who has been in a solo practice for over 10 years. Ever since one of his first clients, a wealthy woman, told him she found him to be very attractive, he began having a series of affairs with several of his female clients. For years his wife Vanessa was completely unaware of his infidelity. But Sam grew careless during his last affair and his wife found out that he was being unfaithful. When she confronted him, he not only confessed to the current affair, but seemed to be relieved that he had been caught and confessed to six other affairs that had taken place over the past 10 years.

When Sam and Vanessa arrived for their first counseling session, Sam was tearful and distraught. He repeatedly said that he never meant to destroy his marriage. To say that Vanessa was angry would have been an understatement, but she told the counselor she was willing to at least consider trying to work things out. She added that only time would tell her if there would be enough change in Sam, and whether she would get beyond the pain and be able to trust Sam again.

Cheryl's situation was different—she worked for her parents in a small market that her parents owned. For years, she had put in long hours at the store, much to the frustration of her husband. Throughout their 15 years of marriage, her husband Tom felt that Cheryl's loyalty was to her parents and not to him or even to their children. One of the things Tom resented was that at some point, he had been excluded from Cheryl's health insurance because it would be less costly for the store. Recently Tom also learned that for almost a year, Cheryl had been taking only half her salary in an effort to keep the business afloat. Cheryl had worked hard at keeping this a secret from Tom because she didn't want a battle over this issue like there had been over the health insurance issue. Tom was tired of being second on Cheryl's priority list and he decided to confront her, giving her the ultimatum: if she didn't quit the store, he was filing for divorce. Tom felt betrayed.

D. Stoop, Ph.D. (✉)
The Center for Family Therapy, Newport Beach, CA, USA
e-mail: drstoop@cox.net

A. Vernon (ed.), *Cognitive and Rational-Emotive Behavior Therapy with Couples: Theory and Practice*, DOI 10.1007/978-1-4614-5137-2_8,
© Springer Science+Business Media New York 2012

Betrayal, and especially the betrayal of an affair, is the most significant threat to marriages today. Even the most experienced clinician is faced with an enormous challenge and responsibility when counseling a couple through such a potentially devastating and turbulent crisis (Allen et al., 2008). The therapist must simultaneously assess risk, evaluate trauma, establish rapport, determine the couple's ability to resolve conflict, and do this when the clients may be experiencing anguish, rage, and even despair. At the same time, the clinician must work towards finding a balance between the intensity of the pain and the possibility of hope for the couple.

Betrayal or Infidelity?

To begin, let's define the differences between the situation where one partner is involved in an affair and the situation where one partner feels that he or she has been betrayed in the relationship (Finkel, Rustbelt, Kumashiro, & Hannon, 2002). For one thing, all affairs are a betrayal, but not all betrayals are affairs. An affair is a sexual or emotional betrayal of the terms of agreement in either a committed or marital relationship. The affair can be sexual, or it can be an emotional attachment to someone other than the spouse. When it comes to describing a betrayal that is not an affair, there are a wide variety of situations that would fit the category. In the case of Cheryl and Tom, the betrayal is the secret she withheld from Tom about taking half-salary the past year, which was a major breach of trust.

A betrayal always involves a breaking of trust, or the breaking of a clear agreement. (Hoyt, Fincham, McCullough, Miao, & Davila, 2005). It can be as simple as breaking a promise, lying, or keeping something secret that the partner has every right to know. A betrayal boils down to any breach of trust in an important relationship. It can also be described as any breaking of an agreement by one person without the knowledge or consent of the other person. Often, because we are so good at justifying our own behaviors, betrayals can best be defined by the person who feels betrayed.

Erroneous Beliefs Regarding Affairs and Betrayals

One of the major things that happens when partners betray another or become involved in an affair is that their thinking becomes distorted. They begin to adopt erroneous ideas as a means of justifying their behavior to themselves. One of the tasks of the therapist is to challenge these beliefs. Following are eight typical beliefs practitioners will encounter as they work with couples who are dealing with betrayal or affairs.

An Affair Can Be a Good Thing

Initially when people are involved in an affair they often experience euphoria and elation and wonder "How can this be bad when it feels so good?" Affairs are exciting and people wonder why they can't feel this exhilaration with their partner,

whether it be a spouse or a partner in a long-term relationship. But how does one compete with the emotions experienced during this stage of infatuation? “It must be good,” they insist, “for those feelings of passion are back!”

The good feelings are fed by the excitement that comes from the secrecy of what they are doing. When they are with their lover, there are no problems, no bills to pay, no kids to manage—it’s like being in a bubble. Both people involved in the affair are totally self-absorbed and on their best behavior. The longer an affair goes on, the more complicated it becomes to continue. In the beginning, they don’t think about consequences, but eventually reality starts to creep in and they begin to wonder what will happen if their spouses find out. If they consider ending the affair, their euphoria begins to diminish. But if they cling to the erroneous belief that there is nothing wrong with what they are doing and that the other people in their life will understand, they continue to live with their illusion. If the affair is discovered, they have to deal with the pain and havoc the affair has caused, not just in the marriage, but also in the extended family and their network of friends. Here are some examples of distorted cognitions when the betrayer thinks an affair can be a good thing:

- How can something that feels this good be bad for me?
- This is different—it’s not really an affair.
- I must have this break from my marriage.
- It won’t hurt anybody if I can keep it quiet.
- Maybe this will bring some spark back and help my marriage.
- I have every right to pursue the satisfaction of my sexual needs.
- My partner should understand that I have needs.

My Friends Are Doing It—So What’s the Problem?

Over a lifetime, almost half of all married men will have an affair, and a somewhat smaller percentage of women will be unfaithful in their marriage (Pittman, 1989). But statistics don’t always tell the whole story. Most of those who report having had an affair did so as a way to end the marriage. They didn’t even try to keep the marriage together—they were on their way out. This is true for both men and women, although for different reasons. A man will have an affair as his marriage ends because he needs someone to be with when he leaves his wife and his family. Women, on the other hand, often will have an affair as a means to end the marriage. It’s almost as if she knows that the fragile ego of her husband will not be able to handle the fact that she’s been with someone else, and so what she desires will happen—the marriage will end.

But there are reasons why we have the prevalence of affairs in our culture today. As a culture, we have a much higher tolerance for affairs today than we did 50 years ago, (Atkins, Yi, Baucom, & Christensen, 2005), so it’s very possible that several of a person’s friends will also be involved in an affair. If as a therapist you are working with someone who justifies an affair since their friends are doing the same, suggest that they talk with friends who had an affair that ended, asking what it was like

to live “post-affair” and whether it was worth it when they have to deal with the consequences. Following are examples of distorted cognitions that the betrayer endorses:

- Others are doing it, so why shouldn’t I?
- I should be able to have some fun.
- Everybody will understand.
- I have a right to my freedom and I deserve to be happy.
- It’s so common; I don’t know what all the fuss is about.
- I couldn’t really help it—I didn’t really have a choice.

If You Really Loved Me, You Wouldn’t Have an Affair

This is an erroneous belief usually held by the betrayed person in the affair. As we’ll see later in this chapter, most affairs are not based on love, even though the injured party will typically buy into this false belief and interpret the affair as being about love. Of course, at the beginning, the person having the affair may think it is love, but in looking back, very few people will say that it really was about love. In most cases, it was about lust, or something else that had nothing to do with love.

In working with a couple where the man has had the affair, it is helpful to explain to both of them early in the therapy that the husband has been caught in a very dangerous internal game called “splitting.” Most men think they can compartmentalize an affair and that it won’t affect the rest of their life. What they don’t realize is that an affair will quickly create a split in the heart. Half of his heart becomes attached to the affair person, but half of his heart may still be attached to his wife.

In the half that is attached to the person with whom they are having an affair, sex is frequent and exciting and makes him feel younger and more alive. The relationship is based on fantasies that can only be realized with the person with whom he is having the affair. He feels free again in that part of his heart. But in the half of his heart that is attached to his spouse or partner, which includes his nuclear, as well as extended family and friends, he has memories associated with their shared history. There is stability and predictability, but also other concepts and values that aren’t as exciting as what he associates with the affair.

Now the problem is that whatever is in the half of the heart attached to person with whom he is having the affair cannot exist in the half of the heart that belongs to the spouse or partner. So sex with the spouse or partner is boring or nonexistent. He doesn’t feel young or excited when he is with his spouse. On the other hand, when he reflects on the affair, he is aware that there is no family or long-term history that forms the foundation of their relationship.

In a long term affair, this heart split can become so strong that the man is paralyzed and cannot make a decision about who he wants to be with. It’s like an internal war, with each part of the heart asserting its desires and putting down the other part

of the heart. So it's not about love, it's about splitting the heart, and about lust, youthfulness, and excitement. The betrayed partner, as well as the person with whom he is having the affair, are both caught in the middle of his paralysis. Here are examples of betrayed partner's erroneous beliefs:

- I thought he/she loved me!
- How could he do this to me? It's not fair
- My life is ruined! Who will ever want me after this?
- I guess he never really loved me.
- How could I have been so blind all these years?
- I should have seen this coming years ago; what's wrong with me?

I Wasn't Sexy Enough—or Thin Enough, or … Enough

This is the false belief that the betrayed women in particular seem to struggle with more than men. It is second nature for a woman to blame herself when her husband or partner has an affair. She thinks she wasn't sexy enough, thin enough, or she spent too much time with the children and neglected her husband or partner. Women tend to personalize the affair and convince themselves that if they just been different, the affair wouldn't have happened.

The falseness of this belief is clearly seen when, for example, a woman loses weight but nothing changes with the husband and the affair. The truth is: In spite of what he says, his affair has very little to do with his spouse—especially in terms of sexuality or weight! The wife certainly was part of the marital scene that set the stage that allowed an affair to develop, but she didn't push him into the affair—he made that choice for his own reasons. He may buy into this false belief as a way to try to blame his spouse or to soothe his own guilt. The betrayed partner is full of self-blame and has erroneous beliefs such as the following:

- I should have lost weight earlier/I should have been smarter about this.
- If only I would have worn that sexy lingerie he wanted me to wear.
- I should have had sex with him more often.
- I'm a total failure, who would ever want to be with me after this?
- It must be true (whatever my partner is telling me) or why would he/she have done this?

He (or She) Made Me Do It

It is not uncommon to hear clients claim that their partner "made" them have an affair because they withheld sex, love, or attention. They are buying into the erroneous belief previously described, which may soothe their guilt, but only last a short time. The principle is this: both partners in a couple relationship contributed to the

environment in which the affair happened, but only one person is responsible for the affair and that is the person who had it. Here are examples of distorted cognitions of the partner who thinks the other one "made" him or her have the affair:

- If he/she would have just had sex with me more often, I wouldn't have strayed.
- I couldn't help it—I have sexual needs that must be met.
- He/she just didn't understand me—no wonder I got involved with someone else.
- If he/she had been a better partner this would have never happened.
- He/she should have paid more attention to me.

An Affair Marks the End of the Marriage

An affair doesn't have to signal the end of a marriage, but it always takes both parties to do the repair work to bring about the healing. Numerous clients have claimed that they would be gone if they found out their partner had had an affair. Although they were adamant about the fact that they would not put up with that kind of betrayal, once it happened, they weren't certain they wanted to leave; they would rather work things out. And more often than expected, couples not only put the marriage back together, they have a better marriage because of what they have learned in the process. There are false beliefs the betrayed partner thinks that can be a roadblock to making the repairs needed for the marriage to survive:

- How will I ever be able to face our friends when they know what happened?
- I know I should try to get past this, but I'm just too hurt and angry.
- I didn't deserve this!
- I'm going to make him/her pay dearly for doing this to me.
- It is completely his/her fault. I had nothing to do with this happening.

I Deserve Some Happiness

Often this is either the justification spoken by person having the affair, or it is the expression of the frustration felt by the betrayed partner. For some reason, people often think that the purpose of a marriage or a committed relationship is to provide happiness. And if they aren't, then they think the marriage or the relationship is the problem and therefore they need to either find someone else that can make them happy or get out of the marriage or relationship. This is a common distorted belief in our culture, but the truth is, no one can make someone else happy over any length of time. Happiness is always a by-product of the other things that the couple does in the relationship. One of the biggest false beliefs in our culture today is that the purpose of marriage is to make people happy! It simply isn't true!

My Lover is My Soul Mate

In the fantasy world of the affair, everything is possible. But how can someone who is cheating on his or her partner be someone else's soul mate? The other side of this false idea is the statement: "I know you say my affair sounds like a textbook example, but this is different—believe me, I've met my soul mate and this is the real thing." Some months after the affair has ended, this same person may say, "I can't believe how stupid I was; it definitely was infatuation, but I didn't meet my soul mate."

An affair is always built on fantasy, and only the persons who are having the affair think the fantasy is reality. Part of what keeps the fantasy alive is secrecy. Once an affair is discovered, it often ends simply because the bubble of fantasy has burst and reality has set in. This attitude is loaded with false beliefs such as the following that must be challenged:

- I have the right to a soul mate.
- It's so easy to talk with this other person; we can almost finish each other's sentences.
- He or she really understands me in ways my partner never really has.
- This is different—it's the real thing!
- We totally know each other like I've never experienced before.

Types of Affairs

While betrayals can take many forms, there are at least five varieties of affairs (Pittman, 1989). It is helpful for the therapist to understand the dynamics of the affair, regardless of the type of affair.

The Accidental Affair

With the accidental affair, there was no plan to have an affair—it just happened. If the therapist asks how they made the decision to have an affair, they appear clueless. Of course, there were all kinds of behaviors they engaged in that set the stage for the affair, but typically, neither party intended this to happen. There may have been some initial attraction, but in the beginning, they just talked. Gradually the conversations became more personal and intimate and they began discussing their frustration with their marriages and what they wanted out of life. Suddenly the relationship moved to a deeper level and they began to carve out a special relationship that they kept secret from both spouses. Over time, they developed a closeness that still seemed to be under control. But then an opportunity presented itself, and a sexual affair replaced the emotional affair.

To illustrate, Allen was drawn to one of his female assistants, who also traveled with him on business. He felt very comfortable talking to her on the plane or over dinner. At first, they simply enjoyed talking with each other. Then their conversations became more personal, and one of their business trips, they ended up sleeping together. The next morning they were both embarrassed and felt guilty about what had happened. They tried to act as if nothing had happened, but that didn't work. Although they would book separate rooms at the hotel when they were traveling, they would sleep together whenever they could.

When Allen's wife found evidence that suggested he was sleeping with his assistant, she was devastated and Allen felt humiliated and remorseful. Neither he nor his wife wanted their marriage to end, and both were willing to figure out what was missing in their relationship that made Allen vulnerable. It was a form of the accidental affair.

The Angry Affair

Sometimes an affair is an angry statement by one spouse to the other. He or she may have expressed frustration and concern about their relationship, but the spouse hadn't really taken it seriously. Gradually over time, anger builds and then the angry spouse acts out the anger by having an affair. He or she may not be aware that the affair was motivated by anger, but if they are honest in looking back, they can make the connection. If the spouse finds out, they at last have the attention they wanted, but at what price?

Early in her marriage, Martha had had a brief affair with a man who was doing some work on their house. She felt so guilty that she immediately confessed to her husband. He was obviously upset, but he wasn't one to show much emotion, so gradually the marriage settled into what seemed like a healthy, comfortable relationship.

Twenty years later, Martha discovered that her husband had been having a long term affair with some other woman. As we explored the dynamic of his long-term affair in therapy, which he insisted was only about sex—not about love, he kept referring to Martha's affair early in the marriage. Gradually it became clear that he had never worked through his pain and hurt about that affair and still harbored extreme resentment and anger toward Martha. He finally admitted that his affair was a way to "get even." Not every angry affair is an attempt to get even—sometimes it's just about getting the other person's attention.

The Regulator Affair

This type of affair describes the philanderer, whether they are male or female. Philanderers always have an affair on the side because they can only handle so much intimacy with one partner. Philanderers usually have no emotional investment in the person with whom they are having an affair.

Sam's affairs, which were described at the beginning of the chapter, also fit into this same category. As he worked with his individual therapist, he found that he was terrified of the intimacy he craved. He wanted to feel close and special to his wife, but if he thought about it very much, he felt overwhelmed. He was a rare philanderer in that he wanted to break the pattern. Most men who have this type of affair do not get caught, or if they do, their wives simply accept what happened and assume they will stop that behavior.

The Midlife Crisis Affair

Every adult goes through a midlife transition, where they evaluate who they are, what they have accomplished, and what they want out of life. More men than women turn this developmental stage into a crisis. As they face the issues surrounding what they have accomplished in life and the value of those accomplishments, they begin to think that their problems or failures have been caused by the significant people—in particular, their wives—and that they married the wrong person or need a younger wife in order to feel young again and more successful. It's as if they fold the play of their life so far, fire the lead actress—the wife—and begins the search for a new wife and a new life—a new play. Men, but also sometimes women, begin the recruiting process for the new lead in their play while still in the marriage. Since they are disillusioned with their spouse, this generally leads to an affair, and often signals the end of the marriage.

Those who successfully navigate this midlife transition are those who come to terms with the reality of their life and the acceptance of the people in their life. They may question and evaluate, but they know that if they fold the play and open a new play, it will probably fold rather quickly because it wasn't built on a sense of reality. It is healthier to try to do some work on the old play and keep the players in place.

The Romantic Love Affair

This is an affair that is based on the idea of romantic love which was described in Chap. 3. This type of love is akin to "Hollywood love," for it is what is often portrayed in movies (Alexander, 2008; Sternberg & Sternberg, 2008). A couple meets and passionately "falls in love." They sometimes don't even know their partner's name, but that makes little difference—the emotion of love rules! Of course, someone who can fall in love can just as easily fall out of love. Sternberg and Sternberg's (2008) description of romantic love involves passion, but lacks the knowing—the intimacy, as well as commitment. The couple having the affair may say they are "crazy in love," but in reality, it is only romantic love they are experiencing.

These affairs often start very strongly and those involved in the affair might be careless and risk getting caught. But they are so overwhelmed by their emotions that they don't really care. The sad thing about this type of affair is that when the

feelings of romantic love begin to fade and reality begins to creeps back in, they don't know how to handle the crisis they have created. The affair will become a burden and they don't know how to end it. They no longer are able to resurrect the strong romantic feelings for the person with whom they are having the affair, but they have caused so much hurt and pain with their spouses that reconciling with the marital partners is too overwhelming.

The Therapist's Role

In working with clients who are having an affair, the therapist needs to identify the clients' erroneous beliefs and challenge them. One of the ways to do this is by having one or two individual sessions with the person having the affair, asking all kinds of personal, intimate questions about the affair. In a way, the therapist becomes a voyeur and when clients begin to talk about the "secret things" related to the affair, it begins to bring reality to the situation. This is especially effective soon after the affair has ended, but often works just as well as the affair is winding down.

Here's how I work with a couple when one of the partners is, or has been, involved in an affair. I first meet for two or three sessions with the couple conjointly in order to understand where they are with each other emotionally, to build rapport with them, and to get the overall picture of the marriage, both in the present and prior to the affair. When I get a sense that the couple is beginning to trust me, I will meet with each of them for one or two sessions individually.

Meeting with the Betrayer

I have several agenda items when I meet individually with the person having the affair. I have already made it clear to each individual that confidentiality belongs to them as a couple, not to the individual, so what is shared in the individual sessions can be shared conjointly. I first want to know the status of the affair. Is it really over? I reassure clients that I understand it is probably not over emotionally, but I want to know if contact has been terminated and have clear boundaries been set. Working with a couple when the affair is still active is like trying to help an alcoholic deal with his or her alcoholism while still drinking. Not much progress is going to be made in any direction. Therefore, it is very important to know that the physical aspect of the relationship is over.

Secondly, I want to know all the details of the affair. For example, how did they meet? How did it get started? Who made the first move to cross the boundary of marriage? What was sex like with this person? How did it compare with the sex they experienced in their marriage or partnership and why did they think it was so different,

given the likelihood that it was. What do they miss about that person? What is or was the most difficult part of ending the affair? And so on. My reason for asking all these "reality" questions is that I want to bring the affair out of the fantasy world. Because an affair is such a secret activity, they haven't really talked about it with anyone, so I want to become that person. I assure them that I'm not going to bring any of this up in the conjoint sessions—I just want to know what really happened. I've found that when I do this, it often breaks the hold the affair has on the person, and they are freer to move forward in conjoint therapy.

The Betrayed Person

I will also meet with the betrayed person for one or two sessions individually. I have a different agenda when meeting with this person, and I want to know several things. For one, I want to know where they are with the marriage—do they think they can, or even want to, get past the affair? I really take this opportunity to challenge their false beliefs about thinking they were responsible for what their spouse or partner has done. This is especially true when they are prone to blame themselves. I repeatedly point out that while they may be responsible for their part in the preexisting problems in the relationship, they did not push the other person over the line into infidelity.

I also want to help them understand the process of the "split heart," which explains how their partner can still love them even if they are having an affair. I point out that it takes time to heal a split heart. If the affair has been short, it may still take several months for the heart to heal. If it has been a long term affair, it will probably take longer. What they can expect during this time of "heart-healing" is for there to be times when their partner withdraws. This doesn't necessarily mean they want to rekindle the affair. In fact, it usually represents a time of reflection about what happened and how it affected others. There will be things that trigger the painful memories for the betrayed spouse, but they can tell when the heart is healed, for at that point the spouse who had the affair understands the enormity of what they did and how it impacted not only their family, but others as well.

The third thing to cover with the betrayed person is the process of grief…what has been lost in the relationship because of the affair. Trust has been destroyed for now, the image of a "good marriage or relationship" seems to be deeply marred, and the character of the betraying partner has been severely downgraded. These losses, as well as others, need to be grieved. One of the main issues that needs to be faced is the anger that is likely to be very prevalent at the discovery of the affair and may continue on and off for sometime. Therapists need to use their skills to move the person beyond the anger to address the profound sadness they need to experience over what has been lost. Both partners need to become involved in the grieving process for there to be any kind of healing. The primary issue to deal with will be the anger the betrayed person experiences, and even the anger of the betrayer. REBT

offers great tools for helping the couple get past the anger. The following is an example of how to work with a betrayed partner's anger:

Therapist:	"I understand that you are angry and you have every right to feel this way, but we need to work on getting past it so that you can deal with other issues."
Betrayed Partner:	"I know, but I just blow up at her over little things; it's just like I can't stop being angry at her."
Therapist:	"I understand how that could happen, but how is the anger helping you?
Betrayed Partner:	"It's clearly not. Sometimes I think it will just drive her away again. I'm tired of being angry, but I don't know how to get past it."
Therapist:	"First, you need to understand that you anger is a protest at what happened, but it is powerless to change what happened."
Betrayed Partner:	"How well I know that."
Therapist:	How would you rate the intensity of your anger, on a 1–10 scale?
Betrayed Partner:	It varies. Sometimes I'd say I'm at about a 9 and other times I'm at a 5 or 6—not as angry.
Therapist:	That's interesting. What do you suppose accounts for the difference?
Betrayed Partner:	Whenever I think of her being with another man I get livid."
Therapist:	"OK—so when you think that your partner shouldn't have been with another man or that she shouldn't have betrayed you, your anger is more intense?"
Betrayed Partner:	"Exactly."
Therapist:	"You probably thought this would never happen to you and maybe it felt like someone was punching you in the gut when you found out she was cheating, right?"
Betrayed Partner:	"That's it. She had no right to do this."
Therapist:	"Well, technically she has the right because she is an independent person, but at the same time, many couples have an agreement about being faithful to each other and your partner didn't live up to the agreement."
Betrayed Partner:	Yes—we promised each other that we'd never have outside relationships, but she broke the promise."
Therapist:	"I understand, but do promises ever get broken?"
Betrayed Partner:	"Sure, but it hurts like crazy."
Therapist:	"Of course it hurts. But when you keep thinking that she shouldn't have done this just because she promised she wouldn't, does it make things any better?"
Betrayed Partner:	"No—it actually makes it worse." I get angry and say mean things and I know that just pushes her away even more."
Therapist:	"So what could you think so that you wouldn't be so angry?"
Betrayed Partner:	"I don't know. I guess she did what she did and I can either accept it and feel sad and hurt or keep focusing on how she screwed me over and stay angry."

Therapist:	"Good thinking. Let's just reinforce that with a writing exercise to help you work through this anger."
Betrayed Partner:	"OK."
Therapist:	"Take a sheet of paper and turn it sideways. Make three columns. In the first column, I want you to list all the things about the affair that you are angry about." Then in the middle column, look at what you've written in the first column and identify the demands you are making about the past events. These will often be expressed in the form of 'shoulds', or 'musts'."
Betrayed Partner:	"Then what?"
Therapist:	"In the third column, restate the demands in the form of a wish, a longing, or a desire."
Betrayed Partner:	"That seems so 'wishy-washing'—how can that help?"

The therapist then can expand on how thoughts create emotions, and how turning the "shoulds" into wishes, wants, and desires helps tone down the anger which in turn helps the client work through the sadness and grief over the losses experienced as a result of the betrayal.

Additional Information for the Therapist

Once the individual sessions are completed, conjoint sessions resume. There may be occasions in the future where the therapist meets with the partners individually, but basically everything from this point on should be dealt with conjointly. It is important to know the type of affair so as to recognize the faulty beliefs that need to be challenged. It is also important to help the couple grieve the losses they have both experienced. Woven through those tasks will be an exploration of what the marriage was like at the beginning, during the time that led up to the affair, and where they want to the marriage to be, assuming they experience healing together.

It's during this period that it becomes clear to the couple that one of them just isn't into the healing process. They may express this directly in a session, or they may just quit the therapy process. If they just quit the process, it will be clear to the other person that they want out—they aren't interested, or able, to do the work of restoring the marriage. If this is the case, the therapist continues to work with the other spouse to help him or her deal with this reality.

Reconciliation

True reconciliation is a bilateral process. It takes both people to make it genuine. It takes genuine forgiveness on the part of the betrayed; and it takes genuine sorrow on the part of the betrayer. If either of these elements is missing or is superficial, the reconciliation will be superficial. Let's look at the two parts of the process.

Genuine Sorrow

This is the work that needs to done by the betrayer, and it is best shown by the ability to enter into the pain experienced by the betrayed person. In the second example in this chapter, Cheryl had difficulty understanding why Tom just couldn't get over it. After all, she had promised there would be no more secrets. But Tom wasn't convinced. At one point he said, "If I felt she understood how this has affected me, I might believe things could be different. But she won't even talk about any of it anymore. She just tells me to get over it because it's finished." Cheryl either didn't understand, or perhaps didn't care about how Tom experienced her betrayal.

Restitution

It is not easy to believe that a spouse who has betrayed his or her partner truly understands how this has affected the one who was betrayed. The concept of restitution is key. In Tom and Cheryl's betrayal, a monetary restitution might be considered, but how does money heal a broken heart? Of course it doesn't, but there are other ways to make restitution. One wife said to her middle-aged husband who had had an affair, "I want you to get braces for your teeth. I've always wanted you to do that. But I also want you to tell anyone that asks, 'I got these to straighten out my teeth, but I'm really working at straightening out my life as well." He did it, and it meant a lot to his wife. A husband told his wife that she needed to stop using her credit card for 6 months, and not to buy anything unless she paid for it with cash. She gave him her credit cards and did what he asked.

Betrayed partners can sometimes work through their hurt and anger more readily if there is some sort of restitution. However, they also have to be prepared to deal with the fact that their partner may not follow through, so the therapist needs to help them deal with this by reinforcing the notion that while they can ask for restitution, they ultimately have no control over what their partner does or doesn't do.

Genuine Forgiveness

Forgiveness is the task of the person who has been betrayed (DiBlasio & Benda, 2008; Greenberg, Warwar, & Malcolm, 2010; Gordon & Baucom, 2003; Hoyt, Fincham, McCullough, Miao, & Davila, 2005). Forgiveness is a three-part process that includes making the decision to forgive, processing the emotions, and grieving over what has been lost. The more painful the loss, the more time it takes. Forgiveness is a "selfish" process because the benefits are basically for the person doing the forgiving. It also is not a rapid process; the deeper the wound, the more time it takes

to forgive. However, this process can be expedited with a competent cognitive therapist who can help the betrayed individual accept the fact that his or her partner is a fallible human being who made many mistakes and poor decisions and that they, as the betrayed individual, can't change the reality of what happened, so clinging to the notion that this never should have happened is like saying that people should never get sick. The reality is that some do and some don't, and the betrayed partner's reality is that some people have affairs or engage in other sorts of betrayal and others don't. The sooner they accept that reality, the better. Forgiveness is also easier once the betrayed client has successfully disputed the "shoulds"—my partner shouldn't have done this; he or she shouldn't have been so inconsiderate and irresponsible. It is equally important to deal with the awfulizing and overgeneralizing—this is the worst thing that could ever happen, I'll never get over this, and I'll never be happy again. At some point they need to finish the forgiving by accepting the fact that their partner is a fallible human who made poor decisions.

It is also important to help clients understand that forgiving doesn't turn a bad thing into a good thing and it doesn't mean forgetting or minimizing the betrayal. For many people, betrayal shakes the very foundation of the relationship, so of course it is difficult to forget something that is so significant. At the same time, however, the betrayed partner has to decide how helpful it is to hold on to the hurt and anger, especially if he or she wants to stay in the relationship. It is possible, albeit difficult, to accept the fact that betrayal occurred because bad things do happen over the course of a lifetime. Helping clients look at the facts versus assumptions they are making about the betrayal is also helpful because when they make assumptions, they often selectively focus on certain aspects of the situation and ignore other salient facts, or they magnify the problem and think that is the worst thing that could ever happen to them, when in reality there could be something far worse. Thus acknowledging the hurt and anger, but helping them take control of what they can change in the present can be a very effective way of helping clients deal with betrayal.

Conclusion

Not every couple can rebuild a relationship after an affair or a major betrayal of another kind, and it's not up to the therapist to determine who should and who shouldn't make the effort because he or she doesn't have to live with the consequences. However, approaching this issue from a cognitive behavioral perspective provides clients with many different tools to help them work through the process of healing. Regardless of whether the couple chooses to stay together or not, the therapist can work with them, individually as well as conjointly, address the problems that resulted from the betrayal and deal with them rationally so as to reduce the intensity of the negative emotions and move forward, either together or separately.

References

Alexander, M. (2008). The couple's odyssey: Hollywood's take on love relationships. *International Review of Psychiatry, 21*(3), 183–188.

Allen, E. S., Rhodes, G., Stanley, S. M., Markman, H. J., Williams, T., Melton, J., & Clements, M. L. (2008). Premarital precursors of marital infidelity. *Family Process, 47*(2), 243–259.

Atkins, D. C., Yi, J., Baucom, F. H., & Christensen, A. (2005). Infidelity in couples seeking marital therapy. *Journal of Family Psychology, 19*, 470–472.

DiBlasio, F. A., & Benda, B. B. (2008). Forgiveness intervention with married couples: Two empirical analyses. *Journal of Psychology and Christianity, 27*(2), 150–158.

Finkel, E. J., Rustbelt, C. E., Kumashiro, M., & Hannon, P. A. (2002). Dealing with betrayal in close relationships: Does commitment promote forgiveness? *Journal of Personality and Social Psychology, 82*, 956–974.

Gordon, K. C., & Baucom, D. H. (2003). Forgiveness and marriage: Preliminary support for a measure based on a model of recovery from a marital betrayal. *American Journal of Family Therapy, 31*(3), 179–199.

Greenberg, L., Warwar, S., & Malcolm, W. (2010). Emotion-focused couples therapy and the facilitation of forgiveness. *Journal of Marital and Family Therapy, 36*(3), 28–42.

Hoyt, W. T., Fincham, F., McCullough, M. E., Miao, G., & Davila, J. (2005). Responses to interpersonal transgressions in families: Forgivingness, forgivability, and relationship-specific effects. *Journal of Personality and Social Psychology, 89*, 375–394.

Pittman, F. (1989). *Private lies*. New York, NY: W. W. Norton.

Sternberg, R. J., & Sternberg, K. (2008). *The new psychology of love*. New Haven, CT: Yale University.

Chapter 9
Counseling Same-Sex Couples: Dispelling Myths and Understanding the Unique Challenges

Paul Martin

Gays and lesbians grow up in a world which still sees same-sex attraction as being a stigma. From a very young age we are exposed to primarily negative images, concepts, and attitudes about those who are same-sex attracted. These messages are particularly potent for young same-sex-attracted people who hear derogatory comments from parents, religious leaders, politicians, and society at large. These stigmatizing messages are absorbed at a deep level, and prior to puberty, are rarely challenged as the individuals are often not aware that they are same-sex attracted (Herek, Gillis, & Cogan, 2009). The consequent negative core beliefs are termed *internalized homophobia*. Given that core beliefs are absorbed from such a young age, they are unlikely to completely abate.

Internalized homophobia has been shown to give rise to psychological disorders (D'Auguilli, 2002). Same-sex-attracted people are twice as likely to experience high levels of psychological distress, five times as likely to have suicidal plans, four times more likely to attempt suicide, and twice as likely to have used illicit substances (Australian Bureau of Statistics, 2007). Some of the specific negative beliefs under the umbrella of internalized homophobia that impact on same-sex relationships include that gay men are incapable of having healthy long-term relationships, gay relationships do not work, gay men are obsessed by sex, and their relationships are superficial. Beliefs about lesbians include that lesbians are man hating, aggressive separatists who end up in unhealthy obsessive relationships (Cover, 2004). These beliefs are often perpetuated in gay and lesbian communities and can become self-fulfilling prophecies which negatively impact couples

In Western cultures, the term homosexuality has historically been seen as a psychological disorder, a perversion, a criminal act that is sinful and predatory

P. Martin, B.A. (✉)
Australia Centre for Human Potential, Brisbane, QLD, Australia
e-mail: paul@centreforhumanpotential.com.au

A. Vernon (ed.), *Cognitive and Rational-Emotive Behavior Therapy with Couples: Theory and Practice*, DOI 10.1007/978-1-4614-5137-2_9,
© Springer Science+Business Media New York 2012

(Kitzinger & Coyle, 2002). In recent times, homophobia is often perpetuated by negative non-evidence based rhetoric from conservative religious lobby groups and leaders. It is only in very recent times that same-sex attraction has been removed from the Diagnostic and Statistical Manual (DSM), has been decriminalized in most Western countries, and is slowly becoming more mainstream. However, same-sex attraction is still perceived by many as being somehow wrong, something to be feared or discouraged. Many people still believe that being gay or lesbian is a choice and that it is caused by some damage during childhood and can therefore be "cured" or "healed." Ex-gay groups such as Exodus International, which comes from a Fundamentalist Christian context, maintain that homosexuality is a disorder. "Exodus upholds heterosexuality as God's creative intent for humanity, and subsequently views homosexual expression as outside of God's will. Exodus cites homosexual tendencies as one of many disorders that beset fallen humanity." They believe that through prayer, counseling, and reparative therapy, many homosexuals can be healed and can live a heterosexual life, including being married and having children. "Exodus believes that any individual can live a life free from the dominance of same-sex attraction and exists to offer support through professional counselors, pastoral care or a support group." (Exodus International. www.exodusinternational.org). This perception of same-sex attraction is not supported by modern psychological theory.

One pervasive core psychological dynamic which is often ignored is shame. In *Coming Out of Shame*, Kaufman and Raphael (1996) described how "the principal effects of shame on the self are hiding, paralysis, and a feeling of being transparent. The urge to hide and disappear from view immediately follows shame because we desperately want to reduce that agonizing scrutiny" (p. 38).

In this context it is surprising that gay and lesbian relationships not only survive, but their satisfaction levels are similar to their heterosexual counterparts (Blumstein & Schwartz, 1983; Kurdek, 2001). Relationships are also often enduring, as evidenced by survey data (Kurdek, 2004) which suggested that between 8 and 21% of lesbian couples and between 18 and 28% of gay couples have lived together 10 or more years. It is therefore important when counseling same-sex couples to remember that although they have been the victims of hate crimes and negative rhetoric, these couples are often psychologically resilient and are just as capable of having healthy long term relationships as heterosexual couples.

Gay and lesbian couples exist in a society which is at its core heterosexist. Heterosexism can be defined as "the continued promotion by the major institutions of the Society of Heterosexuality while simultaneously subordinating homosexuality and bisexuality" (Neisen, 1993, p. 50). This provides people with the deeply held belief that heterosexuality is the norm, is superior, and that anything that is not heteronormative is inferior.

Exploring the Therapist's Unconscious Bias

As therapists, we bring so much of who we are to the counseling relationship, including our own beliefs and biases which are deeply influenced by heterosexism and homophobia. This can lead to stereotyping, avoidance of certain issues that may

be important for the gay or lesbian couple, or comments and questions that can harm the therapeutic relationship in ways that may not be easy to identify. There is some evidence to suggest that denial of these biases may lead to negative treatment outcomes (McHenry & Johnson, 1993)

If you are just beginning to work with same-sex couples it may be useful to do some cognitive behavioral work on yourself first. One exercise is to activate and work on emotions which may be unhelpful in the counseling context, such as disgust, embarrassment or anxiety. Do this by finding images of both heterosexual and same-sex couples romantically kissing.

First, look at the straight couple and record your emotional response and cognitions, then do the same with the same-sex couple. It is important to be open about identifying distorted cognitions and negative feelings that you may not feel comfortable with. As professionals we are taught to be impartial and to try not to judge, however given that we have all grown up absorbing homophobic beliefs, it is natural to experience irrational thoughts which can include that affectionate and sexual intimacy between people of the same sex is bad, unnatural and wrong—they "shouldn't" do these things. Identify emotions that you feel may inhibit the efficacy of working with a same-sex couple and then identify the irrational beliefs and dispute them. For example, if you feel disgust and the thought is that men kissing each other "is revolting and just wrong," challenge these thoughts by asking yourself questions such as "logically speaking, what is the real difference between these same-sex people romantically expressing their love for each other and a straight couple?"

When counseling same-sex couples it is important to be open to your negative emotional responses and what you are saying to yourself rather than pretending that you are not experiencing negative reactions. Battling with these beliefs during the counseling session can be distracting, so accept that they are natural given that we are all brought up in a homophobic world. Then at another time, keep challenging these irrational beliefs about same-sex couples. It may take some time before you to get to a point where you are no longer reacting negatively given how deeply ingrained these myths about same-sex couples can be.

Part of being human is that we all stereotype others. When you see same-sex couples or gay or lesbian individuals, be aware of this. For example, what would you say to yourself if you saw an angry "butch" looking woman with short hair wearing a security outfit in the waiting area? Might you assume that she is an aggressive lesbian? Many lesbian women report that they end up becoming angry as people respond to them as though they are aggressive, as it can become a self fulfilling prophecy.

Lack of specific knowledge, negative attitudes and a discriminatory practice that reflects oppression and stigmatization found within the broader community can inhibit your cultural competency and capacity to work with same-sex-attracted clients (Eliason & Hughes, 2004). Therefore, it is recommended that before engaging in counseling work with same-sex individuals or couples that you participate in training that in particular focuses on the concept of internalized homophobia and become familiar with the social justice framework (Kashubeck-West, Szymanski, & Meyer, 2008). Furthermore, rather than accepting stereotypic representations of gay and lesbian people and replicating the social, religious and legal discrimination they face on a daily basis, it is important to accept and view each client as an individual human being and provide a safe space that benefits clients (Eliason, 2000; Telford, 2004).

The Psychosocial Context

Most same-sex-attracted people growing up in our society are exposed to negative portrayals and attitudes about gays, lesbians and bisexuals from a very young age. This naturally results in seeing themselves and the world in distorted ways that are unhealthy and irrational.

The Development of Unhealthy Beliefs

There are some common core beliefs held by gays and lesbians which include social exclusion, defectiveness, failure, and often subjugation. There are also some negative psychological outcomes from related dynamics, including concealable stigma and rejection sensitivity.

While couples do not often present with issues ostensibly directly related to internalized homophobia, it is helpful to understand what this is at a deep level and to learn some of the specific beliefs that are often present. For example, it is useful to know about these when a relationship is in difficulty because one person has come out and their partner has not. Knowing the core beliefs which may drive someone to avoid "coming out" can guide the types of questions you might ask and the focus on the therapy so each member of the couple can understand each other's personal journey with more empathy.

One of the dynamics which can give rise to the development of negative core beliefs can be what is termed *concealable stigma*. Having a concealable stigma encourages self-monitoring and takes a lot of psychological energy given obsessional ideation that can result from invisibility. Furthermore, not being able to speak to others who belong to the same stigmatized group for normalization and understanding compounds the problem. The psychological impact can be quite severe, resulting in depression, anxiety and self loathing.

Another negative outcome with concealable stigma is the possibility of developing *rejection sensitivity*. This is based on the realistic fears that same-sex-attracted young people have about the negative consequences of coming out, including being rejected when people find out who they really are. Some boys overcompensate through actively bullying effeminate boys or if they are effeminate, or isolate themselves by taking refuge in the library or other remote areas. For some, this may result in a self-fulfilling prophecy whereby they are so convinced that others they care for will reject them that they behave in ways that may drive others away, such as being overly needy, clingy, or unpleasant so that people do, in fact, not want to connect with them.

Another core belief frequently underlying same-sex-attracted people's psychological issues can be defectiveness. Quite often, although not always, children who end up becoming same-sex attracted are not interested in gender typical activities. Thus, boys will often be seen playing with the girls, dressing up in girls clothes,

playing with dolls, and engaging in other traditionally female activities such as dancing. Girls often act sportier and disinterested in wearing "girly" clothes. One of the dynamics that often occurs is that the parent of the same sex will send direct and covert messages to their son or daughter that they are an object of shame and disappointment. This can cause them to feel that when they are engaged in activities that they enjoy, others see them as defective and disordered.

When young gays or lesbians are pretending to be someone they are not, or isolate themselves to protect them from social exclusion and bullying, they also often develop the core belief of social exclusion. They correctly ascertain that at a very fundamental level they do not belong in any social group at school, apart from possibly the marginalized groups. Some end up in adulthood relying on alcohol and illicit substances to reduce the anxiety they experience when engaging with a social group.

Common Irrational Beliefs for Same-Sex Couples

Due to the damage that internalized homophobia can result in, combined with living in a world which stigmatizes same-sex couples, it is no wonder that many of these couples can be negatively impacted by irrational beliefs and distorted cognitions such as the following:

- Even when it is safe to do so, we absolutely shouldn't publicly express affection for each other.
- We must always have 100% support for our relationships from our families, our colleagues, and society in general.
- My partner must be out about his or her sexual orientation to everyone at all times.
- There must be no form of discrimination in any laws.
- All religions must accept us into their church no matter what their doctrine states.
- A gay or lesbian couple should always have the same respect as do heterosexual couples.
- I can't stand the unfairness of being in the minority.
- My partner and I must always have the same viewpoints on everything.

While it is important to continue to do what is possible to advocate for change in society, including allowing the choice for same-sex couples to marry, it can be problematic when couples insist that things be different than they are and that there must be no discrimination in society and the law. *Demanding* that things be different leads to unnecessary distress. When unhealthy negative emotions are replaced by helpful rationally based emotions, it is easier to advocate for changes in the injustices that face many same-sex couples. Following is an example of a couple who were negatively impacted by irrational beliefs related to the demand that as a gay couple, they must be treated the same as heterosexual couples.

Case Study

Andrew and Alan came to therapy to discuss issues of unhealthy levels of stress and issues of communication within the relationship. They were both emotionally stable and had been together for 15 years. They were now finally at the point where they wanted to go to the next stage of their relationship and have children. They had explored many options and decided that it would be best for them to adopt. Once they started to explore this option, they found out that in the area where they lived they were legally not able to adopt. In fact, when making inquiries they found that the person working in the local adoption agency seemed quite homophobic and shocked that they would even attempt to adopt as a gay couple. They were increasingly angry with this situation and said that rather than being victims, they would fight and do what they could to bring about changes in the law. They stated that they should be treated as any other couple in society. They had written letters to their local politicians and to newspaper editors, had spoken on the radio, and were extremely angry about the injustice of the situation. They were increasingly distressed given a significant number of written and verbal comments were made to them which they found to be offensive, including that gay men are not able to parent and that the child could be a victim of pedophilia. After 6 months of what they described as devastating and "beating their heads against a brick wall," they said they were exhausted and stressed and that this had taken a toll on their relationship. They said they were increasingly angry with each other, had less sexual and affectionate intimacy, and felt that they were drifting apart, although said that they were committed and would ride through this challenge as they had with so many others when it came to dealing with issues of discrimination.

After some exploration, they realized that they both had a belief that they should always be treated fairly by society, and that everyone, regardless of their religious views, should accept them as valued citizens who deserved to be parents just like any heterosexual couple. They said that the attitudes of bigoted people "drove them insane" and that these people were lobbying to uphold the unjust laws that prevented them from having the family have always dreamed of. They would constantly focus on how these people *should* be more intelligent and *shouldn't* say the homophobic and unintelligent things that they do about gays and lesbians.

During one session the therapist asked if they had explored alternatives regarding raising a child, such as perhaps being a donor and co-parenting with a lesbian couple, and they responded angrily by asking "Why should we? We should be able to have a child and raise it the way we want to just like straight people do."

Therapist: How would you describe the strength of your anger about these issues between 1 and 10, with 10 being high?

Partner #1: When we talk about this issue it usually gets to about 7 to 9 out of 10, and it means that we get stressed out, get upset with each other, and we become more distant just at the very time when we need to be the closest to support one another.

Therapist: If you could reduce the anger to a low healthy range, would this improve things for you?

Partner #2: Absolutely! But we don't want to give up fighting and standing up for our rights; our anger is the only thing that will change the situation.

Therapist: Is it possible that you could still keep advocating for change but not be quite as angry? Is your anger getting you anywhere? Have you managed to change laws or attitudes with your intense anger?

Partner #1: No, not really. Maybe it would be less stressful if we weren't always so angry about the unfairness.

Both individuals started keeping a log of their thoughts, and by identifying the irrational beliefs that society *must* or *should* always treat them fairly, that the laws *should* be different than what they are, and that life must be fair no matter what, they were able to see how holding onto these rigid beliefs was causing them to feel stressed. During the next two sessions the therapist helped them dispute these beliefs by asking them for evidence to support them, as well as how logical and functional they were.

The couple eventually realized that it would be wonderful if they lived in a society which was free from discrimination, stigmatization and ignorance, where they would even be encouraged to start a family, and where laws did not impede them doing this. However, they also recognized that this was highly unlikely at the present time and that by insisting that things be different than they are, they were only going to become irrationally angry which would harm their relationship and not get them any closer to changing society's views.

Once their anger dissipated, they were then more able to explore other ways of having a child and started planning a move to a place in the country where they were able to have a child legally through surrogacy. They continued to feel that it was unfair and certainly inconvenient as they had to disrupt both of their lives and start over again somewhere else, but at the same time, they saw this as a way to achieve what they wanted and take a different approach to dealing with the discrimination issues.

They were also able to be more effective with their lobbying efforts by taking a more rational response to people from the other side of the debate. In fact, they said that they had become a more resilient couple and stated that if they can feel good about themselves in the homophobic world that they lived in that that would be quite an achievement!' Their new rational emotional responses to discrimination fostered a more mutually respectful conversation with others who disagreed with them and they realized that this was a much more powerful way to get people to really listen to what they had to say.

Differences Between Heterosexual and Same-Sex Relationships

One of the key differences between straight and same-sex relationships regards socially conditioned gender-related sex roles. Individuals in heterosexual relationships usually behave in ways consistent with stereotypic traditional sex-roles, which is not the case with same-sex relationships (Shively & DeCecco, 1977). Same-sex couples usually do not take on traditionally male or female roles. This dispels the myth that one partner takes on more of the male role and the other assumes more of the female roles. This may be confusing, as in some relationships one partner may

be more overtly masculine or feminine in their presentation. For example, many lesbians identify with being somewhere on the "butch/femme" continuum, but this does not mean that one takes on the role of the male and the other the female.

It surprises some that another difference is that same-sex couples appear to have better conflict resolution mechanisms than heterosexual couples. In the face of adversity, same-sex couples are often more likely to use humor and affection. Gay partners tend to show less frequent use of the demand/withdraw pattern and more positive communication.

Another difference is that same-sex couples usually do not have role models in their personal lives or in the media regarding being in a relationship. This often results in same-sex couples having to "make it up as they go along" as they also do not have elders in their families who can advise or empathize with them about their relationship as do heterosexuals. While this provides certain freedoms, it also means they are limited in the opportunities for feedback, which may lead same-sex couples to believe that their issues are the result of the fact they are same-sex-attracted rather than simply the issue regardless of being same-sex attracted.

One of the beliefs that is often present as part of general internalized homophobia is that gay and lesbian relationships are not as valid, valuable, or healthy, and do not last as long as straight relationships. Clients have often stated that one of the first things their parents said when first coming out was "We just don't want you to be old and lonely," inferring that gay relationships are not enduring. When the belief exists that all gay relationships are short term and it not identified, it can have the effect of a self fulfilling prophecy which can result in terminating relationships prematurely due to the belief that it wasn't going to last anyway. This is also a belief which is often actively reinforced in gay male subcultures. An example is the well known joke that when a gay man says that he has been with his partner for 1 year, other gay people laugh and often say "Congratulations—that is 7 *gay* years."

A source of considerable stress to same-sex couples can be the exclusion from the social, economic, health, and psychological benefits of marriage. This can prevent couples from experiencing the sense of belonging to a kinship network which includes having mother/father/brother and sister-in-laws. It also leads to a further stigmatization and can reinforce prejudice against them (Badgett, 2009).

Minority stress has also been shown to have a negative impact on same-sex relationships. This can include shame, secrecy, isolation, and fears that can be activated through part of being a sexual minority (Meyer, 1995).

Issues in Lesbian Relationships

Even though some lesbian women may present as being more masculine or "butch," this does not mean that they have been impervious to the cultural conditioning that females experience throughout their lives. Well known gay and lesbian psychotherapist Joe Kort (2008) described a *doubling up effect*, which is the combined socialization of two women. This often results in lesbians being focused on relationship and

intimacy, which for some may be expressed in unhealthy ways. This can include a sense of "losing one's self" in the relationship where a person's identity can be subsumed by the relationship.

There has been considerable emphasis on the exploration of lesbian relationships and their association with the concept of *relationship fusion* (Burch, 1986; Ossana, 2000). This has been conceptualized as the dynamic which occurs when boundaries between each person are blurred and emotional distance is avoided (Telford, 2004). Intense emotional bonding and connectedness becomes the central focus. This can have ramifications for each partner's sense of their individual identity. This tendency for fusing seems to be a combination of socialization and a protective mechanism in response to stigmatization and negative stereotyping.

One of the problems with fusion is that each person can withdraw from their former social and individual lives and focus almost exclusively on each other. In combination with rejection sensitivity, this can develop into an unhealthy fear that the relationship may end, which can lead to clingy behavior and a lack of personal autonomy.

For these couples, it can be efficacious to work on individuation and interdependent behaviors, while also working on challenging the core beliefs that include that they must focus exclusively on the relationship and that any form of autonomy is a potential risk to the relationship. The goal is that the relationship works towards a healthier level of attachment (MacDonald, 1998). The following example explores some of these dynamics:

Therapist: What would you like to work on today?

Client: It's my relationship. In the beginning my girlfriend and I put heaps of effort into it and I felt incredibly strong. I think she was attracted to that. Now I find that each time I get into a relationship, I start off the same, but it always ends up with me almost losing myself in the relationship. My partners get sick of the clinginess and they leave, which is exactly what just happened.

Therapist: What do you think is the reason for this?

Client: I don't know, I guess whenever I become involved with a woman I eventually become insecure and end up thinking that they are going to leave me. Then I just get a bit too clingy, which is off-putting to them.

Therapist: Tell me about a situation in your current relationship where this has happened recently.

Client: Well the other night, my girlfriend said she was going to have dinner with her ex and they were going to see a play. I'm not really into the theatre and this is something that she used to do a lot with her ex. I was fine with it at the start, but when I knew she was there with her, I just kind of lost it.

Therapist: What did you do?

Client: I made a bit of a fool of myself and kept calling over and over again until she picked up the phone while the play was on. I told her she was a bitch for going to the theatre without me and she should have invited me along to be with them. I couldn't help myself.

Therapist: What was the main feeling you had in the moment when it was the worst?
Client: When she finally answered the phone, I was so angry I was livid.
Therapist: What were you saying to yourself at that exact moment?
Client: She shouldn't be doing stuff without me and now she is; she's probably going to lose interest in me and I'll be left alone. She should have invited me along and not left me alone at home.
Therapist: So it sounds like you think that you must be involved in everything she does and if she doesn't include you, you think you are going to be abandoned?
Client: Well it sounds a bit silly when you say it like that, but yeah, I guess you're right.
Therapist: Tell me, why *must* your girlfriend take you everywhere she goes?
Client: Well she doesn't have to, but it would mean that she wants to be with me if she did.
Therapist: Where is the evidence that she doesn't want to be in a relationship with you just because she sometimes wants to do things outside of the relationship?
Client: Well, there isn't any really…
Therapist: Can you tell me logically why you think that relationships are the healthiest when the couple never does anything apart?
Client: I'm not sure really, it just feels that way.
Therapist: Can you think of any healthy relationships that you've seen throughout your life where the couple had separate interests and at the same time were very close?
Client: Yeah, well actually my uncle and aunty are the closest couple I've ever seen in my life and they've been together for over 35 years. He has his golf and gardening and she has her bridge and porcelain painting group.
Therapist: How is it that they have such a great relationship and yet have separate interests and lives?
Client: I hadn't quite seen it in that way before. I guess I thought that because we are both women that things are supposed to be different and closer somehow, but I can see now that it would be helpful if I could just let go and allow my girlfriend to do her own thing at times. Maybe I should get back in touch with some of my old friends and get back into softball since I used to love that. Just because my girlfriend isn't interested in it does not mean the relationship is in jeopardy or that she'll leave me.

Another commonly identified issue within lesbian relationships is a reduction in the frequency of sex, sometimes known as the *lesbian bed death* (Telford, 2004). Lever (1995) found that lesbians engaged in less-frequent sexual behavior than married heterosexual couples did after 10 years. While not all couples experience such a significant reduction in sexual behaviors, there is evidence to suggest that it is an issue for a significant number of lesbian couples. One theory as to why this is the case is that women are culturally socialized to be less sexually assertive, leaving the relationship without a "trained initiator." Another theory is that internalized

homophobia can lead to guilt, self-loathing, self-doubt, and a belief that same-sex relationships are not valid or valued by society and are therefore not going to last (Telford, 2004). A therapeutic intervention that may be useful is psycho-education, helping lesbian couples explore ways of enjoying the physically pleasurable aspects of sexuality.

Issues for Gay Male Couples

Gay men are often stereotyped as sensitive, caring, and in touch with their emotional and feminine side and are often able to provide heterosexual women with safe and emotionally intimate friendships. However, the reality is that gay men have been deeply influenced by socialization as to what it means to be a male in the same way heterosexual males have been, and the impact of this dominant masculinity construct affects how gay men conduct themselves in intimate relationships as well as influences their emotional functioning (Worth, Reid & McMillan, 2002). The *doubling up effect* that Kort (2008) described is just as pronounced in gay male relationships as it is with lesbians.

Males in our society are conditioned to gain a sense of value through competing, through sexual conquests, by being independent and unemotional unless it is anger, and to avoid engaging emotionally with other men. Close emotional bonding between two males is often responded to by other males as being "gay," and therefore something to be avoided. Just because a male actually is gay does not mean that he is therefore immune to this type of conditioning which usually starts from a very young age. These strong dynamics often manifest in gay relationships in ways which are unhealthy. For example, it may be difficult for some males to open up and become emotionally vulnerable, and they may become jealous of anything that is connected with their partner's performance, such as finances and work. Communication with emotional content is often avoided and may remain reasonably superficial. Sexual intimacy may also be experienced as purely a physical act as opposed to a vehicle for deepening emotional intimacy.

Therapy with gay males may need to focus on ways of becoming more emotionally intimate, identifying jealously or other negative emotions, and challenging the underlying beliefs about not being good enough. It would also be important to include psychoeducation about ways of nurturing the relationship.

Some of these issues are explored in the following case:

Therapist: What would you like to focus on today?

Client: Well it's my partner. We've been together for 14 years, have a home together, and are still very committed, but I'm so angry with him almost all of the time now. I want to be close to him, but how can I be when this anger is in the way? It's hard getting emotionally close to guys anyway, let alone trying to do this when I'm always angry with him.

Therapist: What is the main focus of your anger?

Client: I'm an out and proud gay man and have been out since I was 22, so everyone knows I'm gay and they know that he is my partner. I can't believe he still isn't out to his parents and work colleagues. I feel like his "dirty secret." When his parents come over we have to "de-gay" the house and make it seem as though we're house mates. I think he is ashamed of our relationship, and over the years I've become quite resentful. I'm just so angry with him at times I just want to pack up my things and leave. He's also not out at work, so he has to lie when they all talk about what everyone did over the weekend or on vacation.

Therapist: What impact do you think that your anger is having on the relationship?

Client: Well it is making us quite distant, but it's his fault for not coming out.

Therapist: Do you feel that if you were less angry, that he'd be more open to talking about what might be preventing him from coming out?

Client: Yes, that's probably quite true, I hadn't thought of it like that.

Therapist: Ok, so is it alright with you if we first of all focus on reducing your anger to a more healthy level or to change it frustration? Once having done that we'll be in a much better position to work on how you two can improve the levels of emotional intimacy.

Client: Yes that sounds like a great place to start.

Therapist: When is the last time you remember feeling very angry with him?

Client: Well, he was out one night last week with his work colleagues, leaving me at home just because he still won't be honest about who he is with them.

Therapist: On a 1–10 scale, if a 10 is a high rating, how would you rate the anger?

Client: 8 out of 10.

Therapist: And when you were so intensely angry, how did you behave?

Client: I kept sending him nasty texts which I knew were childish, but I didn't seem to be able to control it.

Therapist: And in this worst moment, what were you saying to yourself?

Client: That he should just come out to everyone at work no matter what and because he doesn't, he's weak, pathetic and stupid. He should come out regardless of the consequences and just deal with it the same way I do. I can't believe I am with someone as pathetic as I sometimes think he is.

Therapist: Do you know other gay men who aren't as angry at their partners because they haven't come out?

Client: Yea, I do, but I also know there are lots of guys who feel the same way I do.

Therapist: I am sure you are right, but you did just say that some guys wouldn't be as angry as you are. What do you think is the difference between those who are as angry and those who aren't?

Client: I don't know. I guess those who aren't realize that their partner just isn't ready to deal with the consequences and that if the relationship matters, this doesn't have to be the "deal breaker."

Therapist: Okay, so can you see that it is your thinking rather than the fact that he hasn't come out that is causing the anger? In other words, if you were like those men who don't get so upset you might not like it, but you wouldn't get so angry about the fact that your partner is choosing not to come out, at least for the time being.

Client: Well, I guess that does make sense.

Therapist: And how does it help the relationship when you get so angry with him about this issue?

Client: It doesn't help at all. In fact, at times we've almost broken up over it and neither of us wants this to happen. I just wish he would be more open about who he is.

Therapist: Wishing he would be more open is different than demanding that he *must*—and in reality, how much control do you have over whether or not he ever chooses to come out with certain people in certain situations?

Client: None, I guess.

Therapist: So is it ok with you if we work on how to change your thinking so that your intense anger wouldn't get the best of you and jeopardize the relationship?

Client: Sure!

Therapist: So why *must* your partner come out in *all* situations?

Client: Because it would be easier for us as a couple and better for him psychologically.

Therapist: These are great reasons why it would be *better* if he came out, but why *should* he?

Client: There isn't any reason why he *has* to except that I want him to and I think it would be easier for him in the long run.

Therapist: It may be true that it would be easier, but suppose he never does…is he really a 100% pathetic person just because he won't come out in certain environments?

Client: When you put it like that, of course not, although it does seem that way at times.

Therapist: So what would be a more reasonable, rational way to think about him not being "out" in every circumstance?

Client: It would be ideal if my partner came out in every situation, but there is no reason why he *has* to, and just because he won't come out in this context doesn't make him pathetic, it just means he has some specific issues he could work on.

Therapist: Right! So if you thought like this, what impact would it have on your anger?

Client: It is already much lower, and in fact I don't think I feel angry at all—just frustrated.

Therapist: And if you were just frustrated rather than angry, how would that impact your discussions about this topic?

Client: I think we could talk things out and have a better understanding of where we each were coming from.

Therapist: I agree. Let's try a role play so you can really see the difference between having a discussion when you are angry versus when you are just frustrated.

Non-monogamy in Gay Male Relationships

One of the other key issues with gay relationships is that of the high prevalence of mutually agreed-upon non-monogamy, which is quite different from cheating. There is some evidence to suggest that 75% of gay male couples become nonmonogamous after 5 years (Nimmons, 2002). In fact, many gay couples over the course of their relationship move between monogamy and non-monogamy without any damage being done to the integrity or health of the relationship. This is often a source of confusion for some therapists who assume that monogamy is the optimal framework of a healthy relationship and that non-monogamy may be a symptom of an issue with attachment or commitment. While this is a controversial issue, suffice to say that when working with gay male couples, it is imperative that the therapist see consensual non-monogamy as potentially a healthy choice which for the couple. Whilst open relationships may be the norm for many gay couples, it isn't as prevalent with lesbian relationships.

A healthy framework for a couple if they decide to shift towards opening the relationship up can be to agree on a very specific set of guidelines for what is appropriate and what is not. For example, they might wish to minimize risks to the relationship and any potential for emotional attachment to someone they might have sex with by agreeing to only see another man once, having anonymous sex in "sex on premises venues" such as a gay sauna where sex occurs in cubicles or only having sex with another person when traveling away from home, and making sure that only certain forms of sex take place to diminish the risk of sexually transmitted infections, including HIV.

One of the most significant risks regarding opening a relationship up is when someone breaches the agreement and does not inform the partner. This can both breach trust when or if discovered and pose a sexual health risk to the partner.

If there are serious issues in the relationship that have not been identified or worked through, these can be exacerbated through entering into a nonmonogamous relationship. At times, there is the risk that one of the partners will experience emotional distress based on insecurities that are activated when the relationship is nonmonogamous.

Another area of concern in a gay relationship is when one partner is HIV positive and the other is negative. This can activate a range of issues both for the HIV positive and the negative partner. Some HIV men have a higher prevalence of sexual dysfunction, including erectile difficulties, decrease in sexual interest, sexual desire, and sexual satisfaction. It is also likely that there will be increased levels of anxiety and fear regarding infecting their partner with HIV.

An important intervention with gay couples in serio-discordant relationships is to encourage them to both talk about how they really feel about the HIV virus and what their thoughts are. If the couple have never discussed it, it is likely that their emotional response to the situation is unhealthy and not speaking at all about it can exacerbate the issue. The person who is HIV positive may not have grieved over the losses that the virus has brought to his life, and not have faced the shame he may feel regarding catching the virus and being "positive." His partner may not have expressed his anxiety when it comes to being accidentally infected, or his feelings of anger with his partner for contracting the virus. Once the feelings and the negative beliefs associated with the virus are identified and disputed, HIV simply becomes an issue of being safe when having sex and dealing with the issues around treatment, which currently is much more effective than in the past.

Conclusion

Working with same-sex couples can present therapists with complex dynamics that they may initially find difficult to deal with. Practitioners may also be faced with their own prejudice and irrational beliefs about same-sex attraction. However, once they have successfully dealt with these issues, there is a subtle shift as the therapist begins to realize that gay and lesbian couples present with many of the complexities that heterosexual couples experience.

Once the therapist has been able to help same-sex couples challenge their own distorted cognitions and thus reduce their negative emotional intensity, these couples are better able to deal with the many challenges they are likely to face, including issues in the work place and with their families, as well as legal and legislative discrimination. Same-sex couples who are able to navigate through the myriad of difficulties they face often become stronger and more resilient.

Working with same-sex couples can be challenging at a number of levels, ranging from internalized homophobia to helping them learn to live in a world characterized by stigmatization, discrimination, hatred, and exclusion. However, it is always encouraging to revert back to the fundamental premise of RE&CBT, which is that our circumstances do not determine how we feel, think and behave; it is the way we perceive them. This philosophy can be very empowering for all clients, including same-sex couples.

References

Australian Bureau of Statistics. (2007). *National survey of mental health and wellbeing: Summary of Results, 2007*. ABS catalogue no. 4326.0, Canberra. Available from: www.abs.gov.au. January 5, 2012.

Badgett, M. V. L. (2009). *When gay people get married*. New York: New York University Press.

Blumstein, P., & Schwartz, P. (1983). *American couples: Money, work, sex*. New York, NY: William Morrow & Company.

Burch, B. (1986). Psychotherapy and the dynamics of merger in lesbian couples. In T. S. Stein & C. J. Cohen (Eds.), *Contemporary perspective on psychotherapy with lesbians and gay men* (pp. 57–72). New York: Plenum Medical Book.

Cover, R. (2004). Bodies, movements and desires: Lesbian/gay subjectivity and the stereotype (Continuum). *Journal of Media & Cultural Studies, 18*(1), 81–97.

D'Auguilli, A. R. (2002). Mental health problems among lesbian, gay, and bisexual youths ages 14 to 21. *Clinical Child Psychology and Psychiatry, 7*, 433–456. doi:10.1177/1359104502007003010.

Eliason, M. (2000). Substance abuse counselor's attitude regarding lesbian, gay, bisexual, and transgendered clients. *Journal of Substance Abuse, 12*, 311–328.

Eliason, M. J., & Hughes, T. (2004). Treatment counselor's attitudes about lesbian, gay, bisexual, and transgender clients: Urban vs. rural settings. *Substance Use & Misuse, 39*(4), 625–644. doi:10.1081/JA-120030063.

Exodus International. www.exodusinternational.org. January 5, 2012

Herek, G. M., Gillis, J. R., & Cogan, J. C. (2009). Internalized stigma among sexual minority adults: Insights from a social psychological perspective. *Journal of Counseling Psychology, 56*(1), 32–43. doi:10.1037/a0014672.

Kashubeck-West, S., Szymanski, D., & Meyer, J. (2008). Internalised heterosexism: Clinical implications and training considerations. *The Counseling Psychologist, 36*, 615–630. doi:10.1177/0011000007309634.

Kaufman, G., & Raphael, L. (1996). *Coming out of shame*. New York: Doubleday.

Kitzinger, C., & Coyle, A. (2002). Introducing lesbian and gay psychology. In A. Coyle & C. Kitzinger (Eds.), *Lesbian and gay psychology: New perspectives*. Oxford: Blackwell Publishers Ltd.

Kort, J. (2008). *Gay affirmative therapy for the straight clinician: The essential guide*. New York: W.W. Norton & Company.

Kurdek, L. A. (2001). Differences between heterosexual-nonparent couples and gay, lesbian and heterosexual-parent couples. *Journal of Family Issues, 22*(6), 727–754.

Kurdek, L. A. (2004). Gay men and lesbians: The family context. In M. Coleman & L. H. Ganong (Eds.), *Handbook of contemporary families: Considering the past, contemplating the future* (pp. 96–105). Thousand Oaks, CA: Sage.

Lever, J. (1995). The 1995 Advocate survey of sexuality and relationships: The women. *The Lesbian Love Advocate,* 687–688.

MacDonald, B. (1998). Issues in therapy with gay and lesbian couples. *Journal of Sex & Marital Therapy, 24*, 165–190.

McHenry, S. S., & Johnson, J. W. (1993). Homophobia in the therapist and gay or lesbian client: Conscious and unconscious collusions in self-hate. *Psychotherapy: Theory, Research, and Practice, 30*(1), 141–151.

Meyer, I. H. (1995). Minority stress and mental health in gay men. *Journal of Health and Social Behavior, 36*(1), 38–56.

Neisen, J. H. (1993). Healing from cultural victimization: Recovery from shame due to heterosexism. *Journal of Gay and Lesbian Psychotherapy, 2*(1), 49–63.

Nimmons, D. (2002). *The soul beneath the skin: The unseen hearts and habits of gay men*. New York: St. Martin's.

Ossana, S. (2000). Relationship and couples counseling. In R. Perez & K. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, hay, and bisexual clients* (pp. 275–302). Washington, DC: American Psychological Association.

Shively, M. G., & DeCecco, J. P. (1977). Components of sexual identity. *Journal of Homosexuality, 3*, 41–48.

Telford, L. (2004). Therapy with lesbian couples. *Australian and New Zealand Journal of Family Therapy, 25*(3), 141–147.

Worth, H., Reid, A., & McMillan, K. (2002). Somewhere over the rainbow: Love, trust and monogamy in gay relationships. *Journal of Sociology, 38*, 237–253. doi:10.1177/1440783021756642.

Chapter 10
Helping Couples Deal with Cultural and Religious Diversity

Leonor Lega and Steve A. Johnson

According to Bergin and Jensen (1990), "every therapeutic relationship is a cross-cultural experience" (p. 19). Consequently, knowledge about culture and cultural differences is fundamental to competency in psychotherapy. Since religion is also an important aspect of culture, it is equally essential to understand fundamental concepts related to religion, as well as spirituality. Therapists working with couples need to develop competency with regard to the following:

- An awareness of cultural and religious heritage, values, and biases.
- A respect for cultures and religions other than one's own.
- A basic grasp of the place of culture and religion in one's worldview and experience of socially constructed reality.
- Requisite self-awareness to know when one's limitations of knowledge or sensitivity warrant referral of clients.
- An awareness of the role of authority figures within a culture or religion and how that potentially impacts the progress and dynamic of therapy (Richards & Bergin, 2000).

The first section of this chapter addresses issues specific to culture, and the second part focuses on religious differences and how they impact couple relationships.

L. Lega (✉)
Saint Peter's University, Jersey City, New Jersey, USA
e-mail: doctorlega@hotmail.com

S.A. Johnson
Center for Cognitive Therapy, Avon, CT, USA

New Englad Center for Cognitive Behavior Therapy and Psychiatry, Glastonbury, CT, USA
e-mail: stjohnson@valleycommunity.cc

A. Vernon (ed.), *Cognitive and Rational-Emotive Behavior Therapy with Couples: Theory and Practice*, DOI 10.1007/978-1-4614-5137-2_10,
© Springer Science+Business Media New York 2012

Cultural Diversity

During the past few decades, there has been a growing tendency to incorporate a multicultural perspective in mental health diagnosis and treatment, including individuals, couples, and family counseling and psychotherapy (Castillo, 1997; Robinson & Howard-Hamilton, 2000). Cultural background refers to ethnicity, but is also profoundly influenced by factors like social class, religion, and gender, to name a few (McGoldrick, Giordano, & Garcia-Preto, 2005). Furthermore, in a multicultural country like the United States, migration and acculturation are of central importance in the assessment and implementation of mental health strategies. Therefore, a model where single elements form the multidimensionality of acculturation (practices, values, and identifications of the original and receiving cultures) needs to continue to be developed and implemented (Schwartz, Unger, Zamboanga, & Szapocznik, 2010).

There is, however, a word of caution about the need for a careful balance between considering cultural variations in the assessment and treatment of couples and people in general, and under diagnosing a true case of psychopathology as a result of too much emphasis on those variables (Paniagua, 2001). Awareness of these factors becomes central in working effectively with these populations.

REBT and the Influence of Cultural Variations

Cross-cultural findings pertaining to REBT (Lega & Ellis, 2001) suggest that although *irrationality*—the *musts* and *demandingness* initially formulated by Ellis in the United States in the mid-1950s—generally applies to countries in Latin America, Europe, and parts of Africa and Asia, there seem to be some significant differences in the degree of musts and demandingness in some cultures. A multinational study (Lega & Ellis, 2001) showed an almost perfect correlation between *degree of irrationality* (measured by scores in the *demand* subscale of Burgess (1990) *Attitudes & Beliefs Inventory*) and the *Index of Violence* (*Pan American Health Organization*, 1997) for several countries, including the United States, Colombia, and Costa Rica. Although these results do not mean that every individual from each of those countries will necessary score in their countries' direction, some interesting differences were noted while conducting clinical work in New York City at the Institute for Rational-Emotive Therapy, currently known as the Albert Ellis Institute, with immigrants to the United States from Costa Rica and Colombia (respectively lowest rank and highest rank in the study). For example, although these clients were already living in the United States, less distress was expressed by Costa Rican wives than in their Colombian counter parts regarding the issue of their husbands arriving home late after work, suggesting a stronger tendency towards rigidity in their *demands* to have a *guarantee* for their safety in the Colombian group than in the Costa Rican group. The previously found differences in the overall

scores in the *demand* subscale between Colombia and Costa Rica in the Lega and Ellis study were specifically illustrated in a clinical context during the first author's practice at the Albert Ellis Institute in New York where Colombian wives had a stronger tendency to attribute late arrival to an accident, or some other serious trouble as the reason for their late arrival, as compared to the Costa Rican wives who thought the reasons may have something to do with getting distracted by activities with friends. This tendency was perhaps influenced by factors present in country of origin: while Costa Rica was a country without an army, considered the "Switzerland of Latin America," Colombia was at its peak in the war against the drug cartels.

In addition to differences in degree of the *musts*, as illustrated in the previous example where *demand* scores varied in size but were always present across cultures, cultural variations seemed to have an effect (Lega & Ellis, 2001) upon the content (approval, success, and comfort) and inferences (global rating, awfulizing, and low frustration tolerance or LFT). For example, over the three decades while I (first author) supervised REBT trainees who worked with a wide range of ethnocultural groups in North, Central, and South America, Europe, and Australia, differences also existed between some of the trainees' clients who came from *individualistic* societies where emphasis is placed upon concern for oneself and a very small group people versus others from *collectivistic* societies, where emphasis is placed upon the needs of the group being equal or more important than those of the individual (Lonner & Malpass, 1994). These differences seemed to be reflected in marital expectations and interactions. More often than not, clients from *collectivistic* societies tended to evaluate themselves as "good" or "bad" (global rating) based upon approval: "…I am a good wife and mother, and therefore a good person," in contrast to those from *individualistic* societies, where success seemed to be the central factor in rating their worth: "…I have a very well-paid job; I am a very important person."

The specific implementation of REBT techniques also seems to be influenced by cultural variations. For example, while supervising postdoctoral fellows at the Instituto de Terapia Racional Emotiva de Mexico, significant differences were found in the fellows' willingness to use *shame attacking exercises* with their clients in Mexico as compared to their United States counterparts at the Albert Ellis Institute in New York (Lega, 1993). The reason in favor or against the use of the shame attack technique seemed to be strongly influenced by culture. For example, differences in the willingness of clients to engage in a shame attack exercise seemed to be manifested in the Mexican's sense of ridicule, a function of their degree of awfulizing and low frustration tolerance over their sense of ridicule which was more engrained in this culture than in the United States. Although the B-C (beliefs-emotional consequences) connection ("I am behaving in a ridiculous way therefore I feel ashamed") was the same in both countries, Mexican postdoctoral fellows had a harder time convincing their clients of the potential benefits of this technique than did postdoctoral fellows in the United Sates. This issue was resolved by the way the technique was implemented. For example, one example of a shame attacking exercise in the United States involved calling out loud subway or bus stops, which would have probably resulted in being arrested for disturbing public order in Mexico. Consequently, it was replaced by asking the fellows, after they had eaten lunch, to

approach the cashier at the Mexican university cafeteria and ask if they could pay for their lunch the following day, which in turn would have probably had an entirely different consequence in the United States.

Ethno-cultural Variables on Couple Relationships

Understanding the influence of specific ethno-cultural variables on couple relationships is a significant factor in effective counseling. Following are three case examples illustrating how folk beliefs and religion, transnational family arrangements, and bicultural issues affect couples. Therapists need to be sensitive regarding these issues as they work with clients from other cultures.

Folk Beliefs and Religion

According to McGoldrick et al. (2005) the term *Latino* does not refer to Spain, but rather to its former colonies in Latin America, including territories in the United States that were taken from Mexico, as well as some of the Caribbean islands, and it takes into account the influences of indigenous cultures and African ancestry. Brazilians, coming from a former colony of Portugal rather than Spain are still included in the label upon arrival to the United States because of their Latin-American background. In contrast, *Hispanic* refers to the influences of the Spanish culture and language on a group of people who lived under years of colonization, but does not include the role played by indigenous cultures and African ancestry upon them. The assessment of folk beliefs and religion is a critical variable in diagnosis and treatment from a multicultural perspective because these beliefs may be wrongly considered "delusional" by clinicians that fail to interpret them in cultural terms. Paniagua (2001) suggested a cultural formulation in the treatment plans of culturally diverse clients which includes, among other variables, the client's ethno-cultural identity (language preference, immigration status), specific psychosocial factors (availability of social support, acculturation), and assessment of potential difficulties in terms of client-therapist (ethnic or racial differences leading to clinician rejection of cultural values).

For example, some individuals from Central and South America, as well as the Caribbean, may believe that to a certain extent mental health problems can be discussed and treated by "authority figures" outside the mental health professionals. These figures include priests and ministers, in the case of sins and violations of sacred beliefs, and *curanderos* and brujos in the case of evil spirits and supernatural forces. Let's examine two cases: Rosalba and Yamile.

Rosalba, born in a Caribbean island 72 years ago, migrated to the United States in her 30s with her husband, leaving behind many members of her family including her parents. Although she discussed her marital problems almost every time she went to confession several times a week, she was unwilling to admit that her priest's

advice has not helped her with her problems because from her cultural perspective, it would be a damnation of a "holy" figure to acknowledge this. She felt depressed and rated herself as a "bad" person for having chosen her husband over her parents. She also felt guilty on the rare occasions when she let herself question the effectiveness of the priest in helping her with her problems.

Yamile, a 28-year-old woman from South America had an affair with a married man several years ago. Consequently, he left his wife and moved in with Yamile, but there were problems in the relationship. Yamile attributed them in part to "punishment" for having hired a *bruja* (who uses the devil, while a *curandera* heals with the help of God) to help her attract this man. She experienced significant guilt, largely derived from global rating as a result of breaking rules/principles in two ways: breaking up a marriage and consulting a *bruja*. Like Rosalba, she was also unwilling to recognize the *bruja*'s failure. In therapy she admitted that she felt anxious about getting the evil eye if she were to criticize the bruja's inability to help her "… be happy with this man."

In both cases, sensitivity towards specific ethno-cultural variables helped the therapist postpone or even discard an attempt to directly confront these women's beliefs about the "authority figures" outside the mental health professionals. Direct criticism of these figures might have geared the sessions towards discussion of details of the "A" or activating event, instead of disputing their core belief that "… they *must* be good daughters and wives or virtuous, well-behaved women in order to be good human beings." Self-acceptance as fallible humans with good and bad behaviors was a central, rational alternative in their therapy process. Ellis' book, *A Case against Religiosity* (Ellis, 1980) was also assigned as homework. The next step was to help them apply their newly found rational acceptance of themselves as fallible human beings to their mates, who they also viewed as "globally flawed." Arguments between these two women and their mates constantly ended up in yelling matches, with each partner blaming the other's imperfections as a source of relationship failure. At that point in time, their mates refused to come to therapy, so it was also important to work with Rosalba's and Yamile's beliefs that a relationship *requires* two people to change. When they fully understood that they could change even though their partners wouldn't engage in therapy, they both resigned themselves to working on what they could change in themselves, which in turn had a positive effect on their marital relationships. As guilt (a product of global rating of self for breaking an established ethic or moral rule) and anger (a product of global rating of the other for not behaving as he *should*) were replaced by regret and annoyance, which were healthier emotional consequences, as well as accepting that they didn't have the power to change anyone but themselves, the number of fights significantly decreased in both couples.

Transnational Family Arrangements

Immigration from one country to another often results in several stressors, such as lack of recognition of professional degrees, equalization of income earning power,

and changes in sex roles. Also, the maintenance of relationships though reciprocal service and loyalty may not operate as constructively in the new culture. Additional conflict emerges from a generation gap widened by acculturation, where children's directness may be interpreted by parents as disrespectful (McGoldrick et al., 2005). For example, in the Philippines, the family as a cornerstone of social relations and identity is reflected in concepts like *pakikisama*, which means deference to a respected one and/or to the needs of the majority. The case of Greg, a man in his late 30s, further illustrates these principles.

Greg was born in the Philippines and migrated to the United States 2 years ago. Primarily for economic reasons, he left his wife and a child in his country of origin. Later on in therapy it became clear that this was also a face-saving way of dealing with the fact that he had marital problems but so no way out given that divorce was not permitted within the culture.

Since arriving in the United States, Greg has lived in a multi generation household with a brother and his wife and children, as well as their mother. Greg suffered from ulcerative colitis that seemed to get worse when his extended family, particularly his mother, confronted him with the possibility of a "resolution," which was to bring his wife and child to the United States or for Greg to go back to the Philippines. Any attempts to have a discussion with his mother about his reluctance to do this were met with a very negative attitude on her part, which only exacerbated Greg's physical problem. Consequently, he avoided the topic altogether. As with the previous cases, global rating of self was equated with failure to *pakikisama*. The relationship between ulcerative colitis and psychological factors, specifically cognitive distortions, was previously identified (Lega & Lega-Siccar, 1994) in a study where a sample of patients showed significantly higher *hopelessness* scores than a matched group of counterparts with equivalent demographic characteristics but with gastro intestinal problems that were not related to emotional factors (i.e., parasites). These researchers also observed that in many of the cases, a temporary change in their external conditions was necessary in order to foster short-term physical changes (i.e., reduce the number of acute episodes) that would eventually allow more comprehensive long term interventions.

From an REBT perspective, this may have been an initial intervention that largely emphasized a change in A, but in Greg's case, addressing practical issues first (moving away from his family), disputing of some of his irrational ideas about self (global rating), and addressing the failure of a marital relationship from his ethno-cultural perspective (also viewed as global rating of self if he would divorce the wife) was essential. In addition, Greg was able to dispute his low frustration tolerance (life *must* give me what I want with little or no effort on my part), and eventually deal directly with his wife and their marital difficulties (instead of his anxieties about his relationship with his mother, and meeting the expectations from his culture), including the acceptance of a normal change in the couple's relationship from one characterized by initial romantic love to a more realistic one, which incorporates the dealing of daily problems. Greg then decided to contact his wife, first by letter, and then by phone, and to start working directly with her in their demand for perfection

as an all-or-none criterion for determining if they had an acceptable relationship. In other words, the marital myth that the relationship *must* continue to be as perfect as it seemed when a large component of it was infatuation was dispelled (Lazarus, 1985). Eventually, Greg returned to the Philippines for a brief period of time and was able to face their situation in person. Then, they both decided that she was coming back with him to the United States for a trial period, during which they went to couples' therapy. She also had some individual therapy sessions that helped her with her own LFT and global rating over the possibility of a marital breakup within the specific context of her culture. As part of their couples' therapy, some of the techniques utilized in included the cost–benefit ratio inventory (Lega, Caballo, & Ellis, 2009), where each of them examined the short and long term advantages and disadvantages of staying together versus getting a divorce. After several months, they decided to remain together.

Thinking Biculturally: The Case of a Lebanese-American Woman

Regardless of identification with specific subgroups in Lebanon (i.e., Maronites vs. Muslims), intermarriage between their members is largely unacceptable (McGoldrick et al., 2005). As one could hypothesize based upon patterns of acculturation, the tendency to remain within a person's ethno-cultural subgroup becomes stronger upon migration to another country. The following case study illustrates this concept.

Wisan, a 22 year old who migrated to the United States as a baby, lived with Ted, unbeknownst to her parents who lived in another city. The couple initiated therapy because they wanted to maintain their relationship, and perhaps get married it in the future. In particular, they were having difficulties with the sexual aspect of their lives primarily because Wisan experienced a lot of guilt over premarital sex. As part of the therapy process, it was helpful to use her specific bicultural situation in helping her understand the connection between her beliefs and her emotional consequences. For example, when she viewed premarital sex "…as a Lebanese woman," she felt guilty because this was something she "shouldn't do" from the perspective of her culture, and consequently, she engaged in global self-rating, putting herself down because in her culture, a woman who has sex outside of marriage is considered to be an impure woman, a harlot. However, when she viewed premarital sex "… as an American woman" her guilt was not as strong. She did regret disappointing her family because she was having premarital sex, but she did not overgeneralize and think that a grown woman's choice of a particular behavior reflected on her worth as a person. The understanding of the connection between beliefs and feelings also influenced therapy in terms of the specific couples' issue of sexuality, an area where difficulties are common, but become even more complicated when dealing with two different cultures which have different perceptions about sex. It has been suggested (Ellis, 1960; Lega et al., 2009) that work in this area is most effective when therapy includes both cognitive restructuring and behavioral training

strategies. For example, openly identifying specific sexual behaviors as preferred or not by each partner and openly discussing them requires specific behavioral knowledge (trial and error), as well as an open attitude about it, derived from having previously disputed global rating, low frustration tolerance, and the marital myth that a perfect couple does not need to work at the relationship (see Chap. 2). Identifying and analyzing differences in the ethno-cultural frames of reference of each partner in regard to sexuality is also critical, as this case illustrates. Typically, sex is more openly discussed in the United States and premarital sex is more the norm than in the Lebanese culture, which is why Ted and Wissan sought counseling. Their cultural differences affected their relationship because Ted couldn't understand Wissan's guilt and felt she was jeopardizing their relationship because she was having so much conflict about living "in sin" and having sex before marriage. A culturally sensitive therapist was able to help them work through this.

Religious Diversity

Too often, religion is understood from an essentialist standpoint as a single phenomenon with clearly delineated attributes commonly shared by all religions. The result is an attempt to understand the phenomenon from a lowest common denominator that unfortunately misses the diversity within faiths as believed-in and practiced by religious adherents. The second author's assumption is that there is no religion, only *religions*, and extending this view more particularly, there is no Judaism, only Judaisms; no Christianity, only Christianities; no Islam, only Islams, and so forth. Thus, the basic assumption is that given the religious diversity throughout the world, and the multiple existent religious and spiritual practices, mental health practitioners will experience much of that diversity within their practices. They need to be sensitive to this diversity rather than embrace an essentialist view of "religion" or risk overlooking the religious and spiritual differences that are often operative in marital discord. The mental health professional will hear clients refer to a wide diversity of religious customs, beliefs, doctrinal statements, myths, rituals, music, places of worship, religious attire, religious texts, practices, attitudes toward the world, as well as attitudes toward emotional suffering, marriage ideals, helpers such as therapists, the role of suffering and pain in life, and the causes of emotional distress, and divorce. Religious diversity in the United States is even more complicated vis-à-vis therapy with couples when one realizes that intermarriage up to 1985 was occurring at more than triple the rate of the early 1970s (Geffen, 2005; McGoldrick & Giordano, 1996). Until 1985, more than 50% of Americans married outside their ethnic group and in the mid-1990s, 33 million Americans lived in a household where at least one adult had a different religious identity. However, by 1985 this trend peaked and in 2005 there were some indications that the incidence of individuals marrying outside their religious group had possibly even begun to decline.

Albert Ellis' Views on Religion and Religiosity

Ellis was known, if not notorious, within religious communities, for his early critical attitude toward religion. He often characterized it as a form of or collection of irrational beliefs. His position grew over the years to the point that in the early 1990s he distinguished "religion" from "religiosity," where religion was merely a cultural phenomenon but religiosity was a form of dogmatic demandingness about religious beliefs and attitudes. From Ellis' perspective, religion could either support or be at odds with mental health, but religiosity as grounded in irrationality typically gave rise to mental, emotional, and behavioral disturbance (Nielsen, Johnson, & Ellis, 2001). This important distinction opened the possibility that religion and REBT need not be at odds and that religion, so long as it did not embrace the core disturbance producing beliefs, including demandingness, could be consistent with rationality and thereby be an asset in diminishing human emotional and behavioral disturbance (Johnson, 2006). Regarding the relationship between mental health and religious commitment, Gartner (1996) stated, "…religion is a structure that provides both a floor, which prevents its adherents from falling too low, and a ceiling, which prevents them from riding too high" (p. 202).

Consistent with this, being nonreligious is associated with disorders of impulse control—that is, problems of under control (e.g., alcohol and drug use, antisocial behavior, and suicide), whereas religious participation is associated with problems of over control (e.g., rigidity and authoritarianism). Thus, while religious commitment can provide a moral safety net that may protect individuals from acting on impulse in destructive ways, it may also limit the development of higher personality functions and may contribute to cognitive and behavioral rigidity.

Jones and Butman (1991) noted that, "On the one hand, many Christians have uncritically accepted Rogerian person-centered therapy because its techniques of counseling superficially resemble one understanding of agape love, thus missing the deeper system of thought of Rogers which is radically incommensurate with the faith. On the other hand, the offensive atheism and hedonism of Albert Ellis, the founder of Rational Emotive Therapy, have led many Christians to an overly quick dismissal of the theory, thus causing them to miss some of the areas of compatibility between RET and Christianity in the understanding of the place of rationality in human emotional life" (p. 35).

Jones and Butman (1991), as well as Gartner (1996) use different words to express what Ellis meant by his distinction between "religion" and "religiosity." To use Gartner's insights, the potential contribution of REBT to marital therapy with religious clients could be that REBT, by supporting non-dogmatic expressions of religions, may help keep in place the moral safety net of religions but without embracing the rigidity of thinking that is at odds with the development of higher personality functions, the aspects that could enrich marriage by helping to minimize the irrational beliefs that contribute to marital discord. Jones and Butman's views are consistent with REBT relative to the advantages of rational thinking, even for religious adherents, or at least Christian religious adherents.

Disturbed Beliefs and Religion

REBT distinguishes rational and irrational beliefs in numerous ways. One way is to think of rational beliefs as those beliefs that are in agreement with socially constructed reality and help individuals to minimize emotional disturbance and attain valued goals. Irrational beliefs, on the other hand, are not in agreement with socially constructed reality and tend to contribute significantly to deeply disturbing emotions and behaviors that tend to sabotage and individual's attainment of valued goals (Nielsen et al., 2001).

Irrational beliefs have been divided into those beliefs that are core and those that are derivative, which means that they are associated with the core irrational beliefs. The core irrational belief is demandingness, which is often expressed in terms of statements containing words such as "should," "ought," "must," "have to," or "need." It is not the expression of these words that is revelatory of demandingness, but a belief that is demanding in nature, may give rise to the expression of statements using those words. The derivate beliefs are: awfuling, low frustration tolerance, self or other downing, and overgeneralization (though some REBT practitioners view overgeneralization as an inference rather than a belief).

McMahon expressed that much of human emotional misery can be diminished or eliminated if one embraces unconditional self and other acceptance. (J. McMahon, personal communication, October 2005). If unconditional acceptance is extended to unconditional life acceptance and unconditional acceptance of the world as it is, then even more human misery could be diminished.

Religious Beliefs and Marriage

Various beliefs found in the sacred literature of religions support unconditional self and other acceptance, while other statements in sacred literature appear to be at odds with such unconditional forms of acceptance. For example, in the Torah and the Bible, one finds that humans have been created in the image of God. Similarly within the Qur'an one finds that humans have been created in the best form. However, some religious beliefs seem to suggest that humans have a major proclivity to sin or are even depraved. For example, in the Bible and Torah, one finds that even the righteousness of humans is nothing but "filthy rags." The Doctrine of the Fall within Christianity, especially as understood by conservative or fundamentalist Christians, characterizes humans as depraved at every level of their being, necessitating the acceptance of Jesus as Lord and Savior in order to be saved and worthy of attaining heaven. In Islam, one finds the belief that Shaitan (Satan) flows through the veins of humans and can, when one's faith is weak, tempt the human to sin. One can see how, if a religious adherent embraces the negative view of human nature, that this could support emotional and behavioral disturbance unless this belief is counterbalanced

with a more positive view, or at least a way is given in the religion for the individual to move beyond the negative nature.

The conflict between the beliefs in the positive and negative natures of humans not only can be difficult within individuals as they vacillate between the two or subscribe overwhelmingly to the negative view, but differences about these natures within a married couple can contribute to conflict. For example, if a conservative Christian husband embraces the doctrine of the fall of humans and their depravity and views himself and his wife as needing to be saved, he may put pressure on the wife to change and leave the wife with the belief that she is not loved for who she really is—that her current self figuratively needs to die and that she becomes a new self before she can be acceptable to her husband.

Clearly, it could be helpful to a therapist working with couples to know about various expressions of unconditional acceptance and its limitations, not only within a given religion, but also within various expressions of a single religion. For example, considering the couple just mentioned, if the therapist was familiar with the intricacies of conservative Christian dogma or at least open to having the client educate the therapist on those intricacies, then the therapist might be able to discuss how, even within the face of the fallen nature of humans and the need for all to receive the grace of God to be saved, that grace is freely given by God and not the result of effort on the part of the individual. Thus, the husband might be able to focus more on the grace of God and take steps to pray with his wife that both of them receive the grace of God so that God is glorified. He could relieve himself of the pressure of creating his wife's salvation or pushing her to work toward that. All of this can be accomplished within the religious world view of the couple in support of unconditional acceptance and thereby help diminish the conflict within the marriage.

Another aspect of considering differences of religious beliefs for couples that share a religion is the conservative-liberal continuum within a given religion. Conservatives within religions tend to embrace a more literalist interpretation of religious texts, embrace dogmatic beliefs about those texts, and may be demanding of conformity to those beliefs by those within their religious tradition. More liberal religious adherents tend to view religious texts as ultimately important but often read those texts metaphorically rather than literally, tending to be more tolerant of the diversity of interpretations of texts and of beliefs. Therapists can help conservative religious clients search through sacred texts for those verses that seem to embrace more openness and the possibility of God's grace operative in those who are different from them. They can help liberals manage frustration tolerance in their interaction with conservatives and avoid viewing them as less informed or less intelligent and thereby slip into other downing. For example in the couple previously mentioned, the therapist could help the husband see that his demandingness that his wife be saved is actually a God-like demand that rightfully should be reserved for God alone and that it may be a disguised form of idolatry that his wife should be created in his image.

Examples of Typical Irrational Beliefs Regarding Religion and Marriage

The following section will be a listing of typical irrational beliefs regarding religion that are often seen within marriage when there is a religious difference between the partners.

Demandingness

My partner must agree with my interpretation of sacred texts.
My partner must worship as I do.
My partner must agree with me on how we are to fully support our religious place of worship.
My partner must agree with me on how we are to raise our children on religious matters.
My partner must agree with me on the roles within the marital relationship and follow them.

Awfulizing

It is awful that my partner does not share my faith.
It is awful that my partner is pressuring me about changing my faith.
It's awful that my partner is sexually attracted to or has fantasies about being with someone else.
It is horrible that God allowed my child to die despite my prayers for health.
It is awful that my partner and I do not attend the same place of worship (or that my partner doesn't worship at all).

Low Frustration Tolerance

I can't stand it that my partner and I do not agree about how we should raise the children religiously
It is too hard for me not to be worshipping with my partner.
I can't stand it that my partner and I do not share the same faith.
I can't stand it that our children have strayed from the faith.
I can't tolerate the fact that my spouse would rather seek help from a secular therapist rather than our rabbi (priest, pastor, imam).

Self/Other Downing

My partner is irredeemable for lusting after someone other than me.
My partner is beyond hope because she/he doesn't attend worship services.

I am hopeless because I don't feel God's love or presence.
I am beyond hope because I or my partner no longer believes in our faith.
I no longer consider my children a part of the family because they have strayed from our faith.
My partner is no good any more because she/he doesn't act according to the teaching of my faith.

Marital Interventions Grounded in Religion

Addressing distorted, irrational beliefs within marriage can be very challenging, especially when those beliefs are tied to religious beliefs. Below are possible ways of addressing those irrational beliefs that involve the religious beliefs of the partners.

Religious References and the Connection Between Beliefs and Emotional Consequences

Some very conservative religious clients can hold negative views of psychology or have heard Ellis' early negative views about religion. This can create a challenge for introducing the A-B-C model in a way that overcomes their resistance to psychology. One way that can be helpful is to use stories from the relevant religious text to demonstrate the model. This can be easily accomplished if the therapist helps the clients find an example of emotional or behavioral disturbance in sacred literature, identify the beliefs underlying those forms of disturbance, and see how the individual in the text overcame the disturbance. Two examples relevant to some Jewish and Christian clients are the stories of Jonah and Jeremiah in the Bible. The story of Jonah is about Jonah's anger toward God because God did not destroy the Ninevites, Jonah's enemy. It is simple to identify Jonah's demands that caused his anger, such as "God should have destroyed my enemies," "God shouldn't forgive everyone so quickly for the wrongs that they have done," and so forth. Another example is found in Lamentations where Jeremiah is in the midst of a serious depression. After describing all his depressive symptoms in detail, he says that he thinks about these negative events day and night, but in the next verse he says that when he changes his thoughts to positive ones about God's grace, then he feels relief from the depression and has hope again. So, if a client if a client is angry at his spouse, the therapist could ask the client to speculate about the thoughts

Muslims have a hadith qudsi (a saying of Muhammad whose content is from Allah but whose words are from Muhammad) that I (second author) have used in therapy with Muslims who are engaging in self or other downing. The hadith says, "When Allah decreed the Creation He pledged Himself by writing in His book which is laid down with Him: My mercy prevails over My wrath" (Ibrahim & Johnson-Davies, 1980, p. 40).

In working with a couple, I (second author) take the example of them putting the self or another person down and then use the hadith and pose the question, "How would you feel about yourself or the other person if you looked at yourself or the other in light of the fact that when Allah looks at you/them that Allah is looking at you through more mercy than wrath?" I can then explain the B-C connection in light of viewing the self/other through wrath and viewing the self/other through mercy. One can also see the potential of using this approach to deal with marital anger, depression or anxiety in the marital relationship.

Religious Adherents: Irrational Beliefs Are from God

Demandingness within marriage is common. Religious adherents often believe themselves to be justified in being demanding. This is especially true with anger, where the focus is more on being justified in being angry rather than on the helpfulness of that anger. These individuals can erroneously believe that REBT is an attack upon their morality, which they see as a demand from God or a demand deduced from the religious text. Distinguishing a metaphysical from a moral, legal, or practical demand can often help clear up this confusion. Metaphysical demands, which are the only demands associated with unhelpful negative emotions and behaviors, are always demands that reality, including perhaps a person, absolutely and unconditionally should be a particular way. For example, "Life should be fair," "You must love me in the way that I must be loved," and so forth. Legal, moral, or practical demands always have conditions on them. For example, legal demands are really "oughts" that are binding if one wants to be legal, practical demands are demands that are based on the condition of wanting to succeed at something, and moral demands are conditional on the individual wanting to be moral or ethical. More concretely, if a person wants to be law-abiding, he or she should drive no faster than 55 miles per hour in a 55 zone. If a person wants to be moral, then he or she should not commit murder to some other crime. If an individual wants to succeed on an exam, then he or she ought to study for it. Must one be within the law, moral, or practical? Of course, there is no necessity in these matters because of free will. Naturally one could demand that someone absolutely be moral, act legally, or take a particular practical step, but those demands are not moral, legal, or practical demands, but demands that one absolutely and unconditionally be moral, legal, or practical. It is only when one demands that reality absolutely must be a particular way, and reality isn't that way, that one disturbs oneself about that fact. It is a subtle distinction and some clients who do not have a philosophical bent may not grasp it, so it should not be belabored if not helpful.

Individuals often confuse metaphysical and moral demands. If a spouse is angry that his or her partner has done something that is against the law of God or the faith, then the spouse is really demanding that the partner *must* not do what the individual judges to be immoral. The problem with such a demand is that it eliminates the very basis of morality, which is free-will. If one doesn't have free will, but has the option either to do or not do that which is judged to be immoral, then there is

no basis for morality. Morality always presupposes freedom of action. Certainly, the partner shouldn't have done the immoral act if he or she cognitively judges the act to be immoral and the individual desires to be moral, understood as acting morally. However, this is different from saying that the partner absolutely should not have done the act. This subtle but important distinction may require some discussion before clients grasp it, but once this concept is understood, they can see that REBT fully supports their moral beliefs, just not the absolute demands that people ignore their free will and do only that which is moral. It can help to point out that if God permits freedom of action, then how can someone else prohibit that freedom? There may be consequences for doing something immoral, but freedom to do the act must be present for morality to be a reality.

Another misunderstood concept is awfulizing. Awfulizing is believing that some act or situation is so bad that it negates the possibility that life will have meaning, purpose, or joy. Consequently, people who awfulize think they have no choice but to feel terribly bad or devastated when something bad happens. Awfulizing is inconsistent with most religious faiths because most faiths hold to the belief that God can intervene and make the results of the bad situation good. Some faiths believe that because there is some future reward, as in a heaven, that evil never fully triumphs. Anti-awfulizing is grounded in the belief that God is always more powerful than evil and eventually God's desires for good will triumph. For example, in Islam there is a hadith in which a man is so grieved about a sin that he thinks is so awful that if the man isn't burned, crushed, and his ashes scattered upon his death, that Allah will punish him more than Allah has ever punished any one else. The hadith ends after the man's death, with Allah asking him why he did what he did to himself. The man answered that it was out of fear or respect for Allah. Allah then declared that the man's sins were all forgiven (Ibrahim & Johnson-Davies, 1980). What seemed to be awful was not awful in the eyes of God. Similarly in the New Testament, Paul calls what seems to be huge event to a human, as merely a slight momentary affliction that has an ultimate purpose. The history of the Jews within the Torah is largely about how the Jews failed repeatedly but how God brought triumph out of the failure.

Similarly, people of faith can be helped to see how their low frustration tolerance, as well as their self and other downing, is actually inconsistent within much of their faith. The grace, blessings, or barakah of God can be viewed as sustaining a person in the midst of a difficult situation. This does not mean that therapists trivialize negative events, but they can help the religious client search for the supports within the faith so that the couple realizes that there are things that they can do to tolerate the negative.

How the A–B–C Framework Can Help Clients Reframe Events

Some clients believe that God has ordained their misery, and thus, they have no choice but to be miserable. For example, a married couple with numerous challenges in their marriage might believe that they must feel miserable about the challenges. In a sense they are think that their problems are ordained by God.

The A-B-C can be used to help the couple think through this problem. For example, the therapist might point out that perhaps God has ordained the activating event, but that the belief comes from the clients, not from God. Perhaps the negative event is a challenge ordained by God, but God is helping them change their beliefs so that they do not make themselves miserable in the midst of the event, but instead learn to think differently so that they client is not angry, depressed, anxious, or jealous. The following case illustrates this concept of reframing.

The Case of Sam and Linda

Sam and Linda, 58 and 52, respectively, were raised in Roman Catholic homes, but Sam left the church and began attending a very conservative evangelical Protestant church several years ago after he and Linda had been married. They have three children, two adults living outside the home, and one son who is in junior high school and living at home. Sam first came to therapy seeking help because his wife had just announced that she was moving out because she needed some alone time to consider how they might save the marriage. Her chief complaint was that his "conversion" to the evangelical Protestant church had changed him so much that he no longer wanted to have dinner with friends when alcohol was served, he spent too much time at church rather than being with the family, and that he was pressuring her to go to his church and be "saved." Sam also reported that throughout his life that he suffered bouts of major depression and that recently he thought he might be in the early stages of a depressive episode because he was experiencing sleeping and eating disturbance, was having increasing difficulty concentrating, and he felt sad and helpless. At times he also felt like he was a failure as a person. He reported being angry with God because he had prayed never to be depressed again and was trying his best to live faithfully as a Christian.

Linda readily agreed to marital therapy for several reasons: to help the marriage, to help her understand and deal with Sam's depression, and to address their religious differences which were causing marital conflict. She was tired of dealing with the pressure Sam was putting on her to convert to his faith, so she agreed to engage in counseling if Sam stopped this and spent more time with the family and began entertaining friends as they used to do. She didn't mind that he no longer drank socially, but she didn't want him to be judgmental when others did. She also felt that Sam needed to be on medication for depression, but he was very reluctant to consider it because he thought that his depression was purely a spiritual issue and should be addressed spiritually. As Sam talked more about this, it became very clear that a considerable part of the therapy would have to be cast in biblical terms if Sam was to accept the counseling. The therapist addressed this by appealing to the Doctrine of the Fall that the client believed in. The therapist explained that in the Fall, perhaps the entire person was impacted, including the physical. Just as diabetes or heart disease could be thought of as a consequence of the Fall, so might depression. With this understanding, Sam agreed to see a psychiatrist and at the following session, shared that he had started taking an antidepressant.

In this second session, Linda also revealed that she felt that Sam was focusing on her deficiencies rather than her assets, which she thought meant that she was unacceptable to him and that he didn't love her as he used to love her. The therapist addressed this by first teaching Sam and Linda the ABC's with a focus on the B-C connection cast in biblical terms for Sam. He also addressed Sam's unconditional acceptance of Linda, again appealing to biblical language and having him meditate on II Corinthians 4 and Philippians 4, both books in the New Testament.

Next, the therapist addressed Linda's low frustration tolerance about some of the changes in Sam's lifestyle and her own unconditional acceptance of him in light of his spiritual changes. Linda believed that she couldn't stand Sam's new religious beliefs and she became very frustrated with Sam to the point of becoming angry. The therapist helped Linda see that it was her belief that she couldn't stand Sam's new way of being that largely caused her high frustration and that the reality was that actually Linda was standing it, even though she didn't like it. The therapist then discussed with Linda alternative thoughts that she could hold in those moments when she made herself highly frustrated, such as "I wish Sam hadn't embraced these new religious beliefs, but he did. I can't control him, so it doesn't do any good to get frustrated and angry. Things could be worse and even though it is hard to tolerate this, I can stand it."

Linda fairly quickly overcame her low frustration tolerance as Sam became less judgmental and pushy toward her. The couple decided at the end of six sessions that they could terminate, Linda would remain in the home, and that they felt considerably more hopeful about the marriage. They used the ABC model and were able to dispute their unhelpful beliefs in ways that brought them emotional relief and greater intimacy. Sam tended to dispute his irrational beliefs by employing scripture and Linda by using the traditional forms of REBT disputes.

The Case of Robert and Leah

Robert (age 62) and Leah (age 59) appeared for marital counseling to address a family conflict that began when their son David, who was 26 years old, announced he was marrying 26-year-old, Miriam, a Sunni Muslim of Lebanese descent. Neither Robert nor Leah described themselves as practicing Jews, and David had never attended temple after making his bar mitzvah. Miriam fasted during Ramadan but only prayed twice a year at the Eid celebrations rather than praying the five daily prayers. David and Miriam were both doctoral students in chemistry at the same university and described themselves as agnostics.

The conflict arose between Leah and Robert slowly after the marriage announcement when Leah began experiencing doubts about David's marriage. She voiced concern about the religious and cultural differences and admitted that it bothered her that the grandchildren might embrace Islam and Muslim practices rather than Jewish ones. Robert thought that these issues should be left to the children, but he wanted to help Leah address her worry that seemed to preoccupy her thoughts lately.

Robert and Leah were introduced to the ABC model and the connection between their beliefs and feelings, which they grasped very quickly and felt that it was a helpful framework to consider emotions and behaviors. During the second session they identified several of Leah's irrational beliefs, including the following:

- The children must participate in the Jewish holidays that Leah found important
- The grandchildren must not be raised exclusively as Muslims
- It would be horrible if the children spent more time with Miriam's family than with David's
- She couldn't stand the reaction to the extended family to having a Muslim in the family
- Robert should agree with her in this matter and support her.

Robert's irrational beliefs were the following:

- That Leah shouldn't be making such a big deal out of this matter
- That Leah shouldn't get overly involved with the life of the children and how the grandchildren would be raised
- That Leah should agree with him on this matter

Robert and Leah learned how to dispute these irrational beliefs, which permitted Robert to allow Leah to be concerned about the issues and Leah to accept that Robert didn't agree with her and that this disagreement didn't have to escalate into conflict. At that point, the couple became less emotionally reactive toward each other. The therapist deliberately addressed this emotional dimension of the problem before turning to the practical issues and inviting David and Miriam to the next session. With the two couples in session, Leah's concerns were discussed and some decisions or compromises were made that put everyone more at ease. First, David and Miriam agreed to spend Jewish holidays with Robert and Leah and Muslim holidays with Miriam's family. Second, Leah and Miriam would spend time together without the presence of the men so that they could enjoy their mutual love of music, fashion, and working for charitable causes. Once the women felt more comfortable with each other, the two couples determined that it was time for them to meet Miriam's parents. At this point Robert and Leah terminated therapy and seemed satisfied with the outcome.

Conclusion

Cognitively based therapies can be a valuable model for effectively addressing mental, emotional, and behavioral challenges in marital and domestic partner relationships, including when cultural and religious identity factors are prevalent. Although the particular content of distorted and irrational beliefs are often impacted by cultural and religious identity, REBT is a model that is flexible enough to address a wide diversity of particular cultural and religious expressions as found in marital and domestic partnerships.

If couple therapy is to be effective, it is essential to consider the clients' cultural and religious backgrounds. However, the therapist must approach this not only with cultural and religious awareness and sensitivity, but also without underdiagnosing problems because of an overemphasis on cultural and religious diversity. Within a psychotherapeutic setting, cultural identity can influence the degree to which interventions will be helpful, the range and content of erroneous beliefs, whether particular beliefs are pathological or not, and the nature of the helping relationship. Therapists who are religiously sensitive can also find aspects within a client's faith that could support healthy beliefs that minimize psychopathology and marital discord. The distinction between religion and religiosity can help the therapist focus on a client's cognitive rigidity and demandingness rather than the religious values associated with these beliefs but may not support psychopathology. Cultural and religious sensitivity is consistent with Rational Emotive Behavior Therapy, requiring minimal changes to the therapy process while maintaining the integrity of the model but at the same time, promoting a greater therapeutic alliance with the clients and developing more effective interventions.

References

Bergin, A., & Jensen, J. (1990). Religiosity of psychotherapists: A national survey. *Psychotherapy, 27*, 3–7.

Burgess, P. H. (1990). Toward resolution of conceptual issues in the assessment of belief systems in rational-emotive therapy. *Journal of Cognitive Psychotherapy: An International Quarterly, 4*, 171–184.

Castillo, R. J. (1997). *Culture & mental illness*. Pacific Grove, CA: Brooks/Cole.

Ellis, A. (1960). *The art and science of love*. Secacus, NJ: Lyle Stuart.

Ellis, A. (1980). *A case against religiosity*. New York: Institute for Rational-Emotive Therapy.

Gartner, J. (1996). Religious commitment, mental health, and prosocial behavior: A review of the empirical literature. In E. Shafranske (Ed.), *Religion and the clinical practice of psychology*. Washington, DC: American Psychological Association.

Geffen, R. (2005). *Intermarriage and conversion in the United States.* In Jewish Women's Archive. About "Jewish Women: A Comprehensive Historical Encyclopedia". <http://jwa.org/encyclopedia/about>. March 21, 2012.

Ibrahim, E., & Johnson-Davies, D. (1980). *Forty Hadith Qudsi*. Beirut: Dar al-Koran al-Kareem.

Johnson, S. (2006). The congruence of the philosophy of rational emotive behavior therapy within the philosophy of mainstream christianity. *Journal of Cognitive and Behavioral Psychotherapies, 6*, 45–56.

Jones, S., & Burman, R. (1991). *Modern psychotherapies: A comprehensive Christian appraisal*. Downers Grove, IL: InterVarsity Press.

Lazarus, A. A. (1985). *Marital myths*. San Luis Obispo, CA: Impact.

Lega, L. (1993). Diferencias transculturales en el uso de algunas tecnicas de terapia racional-emotiva: ejercicios para atacar la vergüenza. *Psicologia Conductual, 1*, 283–288.

Lega, L., Caballo, V., & Ellis, A. (2009). *Teoría y Práctica de la Terapia Racional Emotivo-Conductual* (2nd ed.). Madrid: Siglo XXI.

Lega, L. I., & Ellis, A. (2001). Rational emotive behavior therapy (REBT) in the new millenium: A cross-cultural approach. *Journal of Rational-Emotive and Cognitive-Behavior Therapy, 19*(4), 203–224.

Lega, L. I., & Lega-Siccar, J. (1994). Influencia de los factores emocionales en la colitis ulcerosa. *Colombia Med, 25*(1), 15–17.

Lonner, W. P., & Malpass, R. (1994). *Psychology and culture*. Boston: Allyn & Bacon.

McGoldrick, M., & Giordano, J. (1996). Overview: Ethnicity and family therapy. In M. McGoldrick, J. Giordano, & J. Pearce (Eds.), *Ethnicity & family therapy*. New York: The Guilford Press.

McGoldrick, M., Giordano, J., & Garcia-Preto, N. (2005). *Ethnicity & family therapy*. New York: Guilford.

Nielsen, S., Johnson, W., & Ellis, A. (2001). *Counseling and psychotherapy with religious persons: a rational emotive behavior therapy approach*. Mahwah, NJ: Lawrence Erlbaum.

Pan American Health Organization. (1997). *Index of violence in Latin American countries*. New York: UN/ PAHO.

Paniagua, F. A. (2001). *Diagnosis in a multicultural context*. Thousand Oaks, CA: Sage.

Richards, P. S., & Bergin, A. E. (Eds.). (2000). *Handbook of psychotherapy and religious diversity*. Washington, DC: American Psychological Association.

Robinson, T. L., & Howard-Hamilton, M. F. (2000). *The convergence of race, ethnicity, and gender*. Upper Saddle River: Prentice Hall.

Schwartz, S. J., Unger, J. B., Zamboanga, B. L., & Szapocznik, J. (2010). Rethinking the concept of acculturation. *American Psychologist, 66*(4), 237–251.

Chapter 11
Helping Couples Deal with Addictions

F. Michler Bishop

Jack has relapsed again and Jane can't figure out what to do. Should she stay in the relationship and tolerate his behavior? Should she get a divorce and be done with him and his problems? Would it be better to move out for awhile and go to Al-Anon? Or should she offer him the ultimatum: go to rehab, and if you don't....On the other hand, she did promise to stick by him in sickness and in health, and she certainly would never consider leaving him if he had cancer. But is alcoholism really a disease? He has promised so often to stop, but his promises mean nothing because although he stops for awhile, it doesn't last long.

Jane's plight is very common in couples in which one person is abusing a substance or engaging in some other addictive behavior such as sex, video games, or gambling. This is a complicated dilemma that results in conflict within the relationship and not only affects the couple, but their children, extended family, and close friends and colleagues. This chapter will address many of the issues couples face when one partner has an addiction, with emphasis on cognitive, emotive, and behavioral techniques that therapists can use to help couples more effectively manage the multitude of problems brought about as a result of the addictive behavior.

The Key Problem: Double Ambivalence—Confusion and Conflicted Goals

It is now fairly well accepted that one can become addicted to an activity as well as a substance; moreover, the impact on neuro-wiring may be very similar. Regardless of the addiction, when the couple presents in a private practitioner's office they are

F.M. Bishop, Ph.D. (✉)
Director of Alcohol and Substance Abuse Services,
Albert Ellis Institute, New York, NY, USA
e-mail: fmbishop@aol.com

A. Vernon (ed.), *Cognitive and Rational-Emotive Behavior Therapy with Couples: Theory and Practice*, DOI 10.1007/978-1-4614-5137-2_11,
© Springer Science+Business Media New York 2012

conflicted and ambivalent. The addicted member of the couple often has two conflicting desires: to maintain the relationship with his or her partner and to go on engaging in an additive behavior as much as he or she can get away with it. The partner, who is sometimes referred to as the concerned significant other (CSO) in the relationship also typically has two conflicting desires: to maintain the relationship and be a loving, supportive partner/spouse, and to have a different life, free from the anxiety and stress of living with a person addicted to some chemical or behavior (Meyers & Wolfe, 2004). The CSO wants to live without always wondering what is going to happen the next day or "who" will he or she come home to. The CSO may also want a life free from the emotional, physical and sexual abuse that is common in many marriages in which someone is abusing alcohol or drugs.

Addictions Versus Compulsions

The focus of this chapter will be on addictive behaviors because the partner in the relationship, the CSO, is often much more understanding and forgiving of compulsive behaviors as opposed to an addiction. Unlike an addiction, the person who is afflicted with a compulsive behavior often is not ambivalent; he or she also would very much like to be rid of the behavior. For example, the partner with a compulsion to wash his or her hands repeatedly is motivated to change and the CSO most likely has empathy for the partner.

Due to their nature, addictive behaviors include such things as shoplifting and "compulsive" internet sex, "compulsive" viewing of internet pornography, and "compulsive" internet gambling and gaming. Addictions are not included in the DSM-IVR, nor are the compulsive behaviors listed above, although one could use Impulse Control Disorder NOS (312.30).

Aspects of Addictive Behaviors

It is important to consider some aspects of addictive behaviors that research suggests are common. First, the majority of people (50% or more) get over their addictions to nicotine, alcohol, cocaine, heroin, and marijuana on their own, without professional help, a phenomenon called natural recovery (King & Tucker, 2000; Sobell, Ellingstad, & Sobell, 2000). Over 75% of people resolve their problems with alcohol on their own. This may also be true of internet addictions, shoplifting and gambling, although to date, there is little if any research regarding natural recovery from these behaviors.

Second, most people do not talk to a professional because they think they know what they are going to hear: "You have to stop"; "You have to go to AA." For a variety of reasons, they cannot see any reason to pay for that kind of advice. They don't want to hear it, and they probably wouldn't follow the advice anyway.

Consequently, those people who do come to therapy are different. They have tried many times on their own to moderate or stop their addictive behavior and failed. If they are in your office it may say something positive about the clients sitting in front of you: they acknowledge that they cannot fix the problem on their own, but, on the negative side, they have a serious addictive disorder that they haven't been able to resolve despite many attempts.

Assessment

As is common in most REBT/CBT sessions, assessment is ongoing from session to session. Usually if a client feels reasonably safe in your office, she or he will tell you what is going on. At times it is also helpful to use paper and pencil tests such as the AUDIT (Babor & Grant, 1989), developed by the World Health Organization. It is free, accessible online, and better than most short instruments at identifying risky or problem drinking that does not necessarily meet the DSM-IV criteria for abuse or dependence. *The Drinker's Check-Up* (Hester, Squires, & Delaney, 2005), is also free online and may be helpful (www.drinkerscheckup.com).

A full discussion of assessment is beyond the limits of this chapter (see Bishop, 2001). In brief, it is important to assess the following: What is the client's goal? How motivated is he or she to want to stop or moderate use? How long has the drinking or drugging or engaging in some other form of addictive behavior been going on? When did it start? How often does he or she drink, and how much? What kind of alcohol or drugs? When, where, and with whom does he or she engage in this behavior? How often has he or she stopped or attempted to moderate use and for how long? What derailed the last attempt to stop? Are there other reasons—spiritual and existential—that may motivate him or her to stop? How is the addictive behavior affecting the quality of his or her life and relationships with others?

As the therapist, you may want to take time, either in the first session or in a subsequent session to go back in time and then forward, "frame by frame," to try to understand as fully as possible what the clients' thoughts were relative to these questions. It is also important to assess the client's understanding of RE&CBT as well as what he or she has she learned from previous therapy or self-help groups that has been helpful. Assessing the type of external support structure the client has is also useful; for example, does the client have a caring partner or children whose lives are affected by the addictive behavior?

Assessing Distorted Cognitions

A key component of assessment includes an evaluation of inferences, distorted cognitions, and irrational beliefs. People with addictions often minimize their addiction and the consequences of it, arbitrarily infer that others are being too critical or controlling

regarding their substance abuse, and have selective abstraction regarding how their addictive behaviors impact themselves and others.

The most prevalent (and often hidden from consciousness) irrational beliefs include:

- I can get away with it. (Many clients, especially males, get a "dopamine hit" just thinking about getting away with something, so the irrational belief, "I can get away with it" has a facilitating impact in and of itself). This irrational belief is often paired in a circular fashion with the following:
- It doesn't matter if I have a few drinks; no one really cares.
- I can't stand the thought of quitting or of not getting or doing what I want. It's too hard and I can't stand the discomfort/distress of trying to stop. (This just fuels the urge to drink or drug or engage in some other form of addictive behavior).
- Screw it; nothing matters, no one cares.
- I'll just have one (drink, sip) and feel the way I want to feel. (This rarely turns out to be true, so one drink is usually followed by another and another until the individual feels "better").
- I have a right to feel the way I want to feel; I deserve this pleasure in my life
- It would be much too hard to change.
- I'm eventually going to resort to my addictive behavior, so why torture myself?
- Poor me; I'm such a failure/I'm worthless.
- It's pointless to try and change.

The concerned significant other also has his or her own beliefs frequently characterized by awfulizing, low frustration tolerance, dichotomous thinking, demanding, and over generalizing. Specific examples include the following:

- I can't stand it anymore.
- It's awful.
- He (or she) is awful and will never change.
- I'm trapped; I'm helpless and hopeless and I'll never have a good life.
- I should know what to do; I must fix this problem.
- He (or she) shouldn't lie to me about the addiction.
- There must be something wrong with me for staying with him.
- I shouldn't have married him (or her) to begin with.

A Menu of Treatment Options

Over the past 20 years, a menu of evidence-based treatment options has been developed, as is now true for other serious health issues, such as breast cancer, prostate cancer and diabetes (O'Brien & McLellan, 1996). REBT and CBT therapists can easily integrate these options into their approach with clients and couples. It is important to discuss treatment options with clients, as there is evidence that when

people choose their treatment(s), they tend to do better over time. The following have good-to-moderate research support:

- Brief interventions (BIs), including Motivational Interviewing (MI)
- Behavioral self-control training
- Case management
- Self-therapy (self-change manuals and internet-based self-change programs)
- Social skills training
- Behavioral Marital Therapy (BMT)
- CRAFT (Community Reinforcement and Family Therapy),
- Self-help programs, including 12-step programs and SMART Recovery®
- Medications, including Antabuse, Naltrexone, Campral, and Chantix, but also including SSRI and the newer atypical antipsychotics.

(For a discussion of the research supporting these approaches for alcohol abuse, see Bishop, 2008; Lash, Timko, Curran, McKay, & Burden, 2011; Miller, Wilbourne, & Hettema, 2003.)

REBT and other goal-focused cognitive behavioral therapies such as CBT, Dialectical Behavior Therapy (DBT) and Acceptance and Commitment Therapy (ACT) are particularly effective with people who have addictive problems. What clients learn in terms of managing their thoughts, emotions and behaviors will also help them better manage their relationship issues and their addictive behaviors.

Given these treatment options, let us assume that the spouse wants to stay. How can REBT and CBT therapies be helpful? The good news is that these approaches work effectively, given time and patience on the part of the therapist and the CSO. The bad news is that it may be a rocky road, given the ways in which ambivalence and motivation varies over time and across situations.

An Integrative, Six-Pronged Approach

Typically, REBT and CBT practitioners focus on cognitive techniques, especially disputing and reframing, but Ellis (A. Ellis, personal communications, 1987–2005) was adamant that therapists should use many more types of interventions. Although he tended to focus on cognitive, emotive and behavioral interventions in his demonstrations, he was also quite explicit about helping addicted clients develop a meaningful life and using medication when it could be beneficial. Ellis and staff at the Albert Ellis Institute also created and ran social skills workshops, assertiveness training workshops, and other types of groups, all designed to help clients learn to relate better interpersonally.

Following is a list of techniques that can be especially helpful in working with couples where addictive behavior is a problem. Note that these interventions are categorized as cognitive, emotive, or behavioral, interpersonal, etc. but in some cases that categorization is arbitrary in that some strategies could be listed in more than one category.

Cognitive Techniques

Techniques in this category are designed to help clients think differently about their addictive behavior. These can readily be combined with emotive and behavioral techniques for a more comprehensive treatment approach.

Goal setting. It is important to highlight a client's long-term goals. That is one reason that some people do ABCDEFG's, where F stands for new "philosophies" and G for "goal." In any case, the ultimate goal is very significant. No one gives up an addictive behavior just to give it up; there has to be a good reason for doing so.

Cost Benefit Analysis (*CBA*). Also referred to as Decisional Balance Exercises, CBA's are excellent for strengthening and maintaining a client's commitment to change. The idea is to help enhance the good things and not-so-good things of both continuing to engage in the addictive behavior and of stopping (or significantly cutting down). Have your client fold a piece of paper into quarters and ask him or her to label the top, left hand box *good things about using*; label the top, right hand box, *not-so-good things about using*; label the bottom, left hand box, *good things about stopping* (or moderating, if that is the goal) and the bottom, right hand box, *not-so-good things about stopping*. Clients could complete this in session or do it as homework. Although it might seem that the boxes diagonally opposite each other should contain the same content that is usually not what happens. Each box brings to awareness distinct reasons for and against continuing and for and against stopping the behavior. CBA's are powerful tools for enhancing motivation to change and for maintaining that motivation, and should be repeated throughout treatment.

Inference chaining. Inference chaining is one of the best techniques to help clients understand and deal with underlying anxiety which may be a major trigger for their addiction. Clients are often unaware of their thoughts, as in the example of a client jeopardized his career because he was not making cold calls and was drinking to deal with the consequent shame and anxiety. Careful work in a therapist's office can help him uncover a "chain" of inferences, e.g., "If I make a cold call, I may be rejected, then I won't make another call, then I could lose my job. If that happens, I won't have any money, my wife will leave me, and I'll wind up in the street, homeless," and so forth. Of course clients won't be able to uncover this long chain of irrational believes on their own, but a skilled therapist can easily do it (see a lengthier discussion as to how to do inference chaining in Bishop, 2001). But once uncovered, a client can better understand why he is not picking up the phone and the therapist and the client can begin to examine the rationality and functionality of each link in the chain over the course of the upcoming sessions.

Rewind the videotape. This technique helps clients clarify what they were thinking or "telling themselves" just before they had a drink or engaged in some form of problematic behavior. Ask clients to act as if they were rewinding a videotape: what were they telling themselves just before going into the liquor store? Then move back further to get some insight into the activating event: what happened during the day or

past week that may have contributed to the lapse or relapse? Addictive behaviors are most frequently ways of coping, albeit not effective ways over the long run.

Do the "D's." Many clients are initially very weak at disputing, so it is helpful to point out that disputes take the form of a question to test the validity or helpfulness of a particular belief. For example, suppose your client thinks he can get away with drinking. Demonstrate the disputing process by asking him "How has this thinking helped in the past?" "Does the idea of 'getting away with it' excite you?" And what might happen if you continue to think this way?"

Use self-help forms. Clients often find it very useful to complete a self-help form, which helps them identify the ABC's as well as disputes and functional rational thoughts. These can be used in session or assigned as homework. Self-help forms are an invaluable teaching tool, as well as an excellent assessment tool.

Emotive Techniques

To Ellis's credit, quite soon after he started Rational Therapy, he added the E, re-naming it Rational Emotive Therapy, and he consistently included in every demonstration an emotive technique, usually Rational Emotive Imagery, REI. However, emotive techniques are sometimes like the forgotten child for most cognitive therapists. Considering that addictive behaviors are usually engaged in to change the way a person feels, this may be particularly unfortunate.

Rational Emotive Imagery. Ellis pointed out that it is difficult to work on powerful emotions such as shame, anxiety, self-pity, and rage because they often come on so swiftly that a client may feel incapable of doing anything about them. Consequently, he developed Rational Emotive Imagery (REI), one of the core emotive techniques used in REBT, to help clients learn to identify more moderate emotions by first experiencing the extreme, dysfunctional emotion and then focusing on changing that emotion to a more reasonable negative response (Ellis & MacClaren, 1997).

Empty chair. With this technique, the therapist can have the client alternately move between two chairs, assuming the role of the "addicted self" and then the "healthy self," debating each position to help clients clarify their thinking about their addiction. It is very helpful to tape record this so that they can listen to their arguments for and against the addiction.

Shame Attack Exercises. This popular REBT technique is intended to help clients work on their shame, which Ellis considered the essence of a significant degree of our emotional disturbance (Ellis & MacClaren, 1997). The therapist suggests to the client that he or she do something shameful, such as refusing a drink at a party. The client probably thinks that this would be too uncomfortable or embarrassing, but the therapist encourages this so that the client realizes that he or she can tolerate the discomfort and not die of shame.

Behavioral Techniques

Drinking log. As a homework assignment, ask the addicted person to keep a log of the behavior. Encourage the client not to change the behavior; just log what was done, at what time, how much was consumed, and where. In many cases, despite being told not to, clients who write a log significantly reduce their addictive behavior in the first week.

Sobriety sampling. Collaboratively determine what might be a reasonable "sobriety sampling" homework for the addicted client: stopping for a month, a week, every other day? The objective is twofold: to help the client see that she or he can stand the distress or discomfort and to heighten the client's awareness of the conditions (intrapersonal, interpersonal, and environmental) which, in the past, in an almost automatized manner, led to resuming the behavior.

Role play. Engage the client in role plays related to drink-refusal situations. With the "addictive voice" sitting right behind the client's right ear, set up situations where the therapist, plays the role of a friend or colleague who invites the client to have a drink. Tape recording this interaction can be helpful for the client, listening to how he or she refuses or struggles not to give into temptation.

Interpersonal Techniques

When working with addicted clients, it is very important to work on interpersonal skills since in many cases addicted clients have isolated themselves or associated with other addicted people, so when they give up the addiction, they will need to establish new relationships. *Self help groups*. Help your client become involved in a group such as SMART Recovery or Alcoholics Anonymous (AA). It is preferable that they not only join the group, but also become a facilitator when appropriate, make the coffee, or serve as a greeter. If he or she isn't participating in a self-help group, use REBT/CBT to determine the distorted cognitions that may be stopping him or her from attending. Challenge irrational thinking such as "It probably will just be a waste of time," or "What if I see someone I know? What will they think of me?" *Community activities or psychotherapy groups*. Encourage clients to get involved in community activities to help keep them occupied, develop new interests, and also meet new people. Psychotherapy groups are also very helpful.

CRAFT. Following the model developed in CRAFT, encourage the couple to find different ways to enjoy time together. CRAFT and Meyers and Wolfe's (2004) book strive to help the CSO learn how to not reinforce the drinking behavior. In one example, the spouse comes home and finds her husband watching a football game and drinking beer. He asks her to join him. Instead of making herself angry and yelling at him, she politely declines the invitation and goes upstairs to spend the

evening knitting. CRAFT also focuses on teaching couples how to improve the quality of their lives together, independent of the addictive behavior.

Spiritual/Existential Techniques

Modern cognitive-behavioral research has focused on finding evidence-based treatments for many types of human disorders such as OCD, ADHD, and PTSD, as well as many mood disorders. However, many people are in counseling because they are suffering from problems in their significant relationships and/or problems that go to the heart of the human condition. If these issues aren't addressed, relationship problems and existential/spiritual problems often lead to anxiety attacks and depression, among other disorders, so clients are unwilling to let go of their major coping mechanisms such as drinking and drugging. Consequently, therapists who fail to discuss spiritual and existential problems may not have much long-term success with their clients in helping them change an addictive behavior.

USA and UOA. Central to REBT is the importance of a radical philosophical stance toward self and others, unconditional acceptance self-acceptance (USA) and unconditional other acceptance (UOA) (Ellis, 1994). Clients who feel that their therapists unconditionally accept them and their behavior—and are not irritated or disappointed when a client fails at changing—will see that clients do not lie as often (if ever) about slips and that they struggle harder to figure out how to prevent future slips. Clients who learn to be more accepting of their behavior and the behavior of others are more able to cope with the ups and downs of life without recourse to addictive behaviors.

Vital interests. Help your client find and develop an "all consuming, vital interest" which can enhance the meaning in their lives. This could include hobbies, learning another language, taking a course, or learning a new skill.

Place of worship. If your client is religious or spiritual but isn't attending a church, temple, or mosque, for example, encourage him or her to get more involved. If your client had cancer, would he or she pray? If so, would it also make sense to pray for help with his or her addictive and/or compulsive behavior(s)?

Wisdom stories. Use wisdom stories (parables and fables) in session to illustrate the long history of humans grappling with very difficult situations. For example, after the men in the story about Mary Magdalene put down their stones and left, Jesus said to Mary, "Neither do I condemn thee," an early example of unconditional acceptance, and then said, "Go and sin no more." That is, go and change your behavior. He does not tell her "You have been an adulteress; you deserve punishment." He did not tell her to be ashamed, simply to change her behavior. Therapists can follow up this example with questions such as: "How does beating yourself up after you have relapsed help?"

Chemical Approaches

In addition to the above-mentioned interventions to help addicted clients, the following suggestions may also be incorporated as part of an overall comprehensive treatment plan.

Nutrition. Recent research (Gaillot et al., 2007) indicates that people do not self-regulate as well when their glucose levels are low. That is, after a long day of regulating their behavior, besides the fact that the sun is setting and coworkers are going to bars and restaurant, research suggests that people's glucose levels are so low that they are less likely to self-regulate in terms of their goals and values. Something like Coke or Gatorade that increases their glucose levels has been shown to improve their ability to self-regulate.

Medication. If appropriate, encourage clients to combine medical help such as Antabuse, Naltrexone, or Campral, as well as other types of medication, like SSRI's or atypical antipsychotics with psychotherapy and give them the names of psychiatrists who will work with them in an ongoing, non-judgmental manner.

Combining Motivational Interviewing and REBT

Initially, REBT and CBT were both practiced with clients who were somewhat or highly motivated to change. Most people who have sexual problems want to get over them; similarly, most people who are depressed want to become undepressed. No one who has an anxiety disorder wants to keep anxietizing. In reality, however, many clients are not motivated to change, as is typical for many clients with addictive behaviors.

Miller and associates (Miller & Rollnick, 2002) created Motivational Interviewing (MI) partly to address the problem that drinkers are often under-motivated. There is a great deal in MI that is worth learning and integrated into REBT and CBT (Bishop, 2001; Westra & Arkowitz, 2011) because using traditional cognitive approaches immediately with ambivalent, under-motivated clients may not work. If clients do not even acknowledge that they have a problem, they are certainly not going to be interested in learning how to work on it. Initially, other specifically motivating approaches will work better.

Validate the Pain

Many good therapists know to do this, but it has also been one of the distinguishing characteristics of Dialectical Behavior Therapy (DBT) and is also part of Integrative Behavioral Couples Therapy (IBCT) (Christensen & Simpson, 2004). It was also a

significant part of the Rogerian concept of active listening (Rogers, 2003) and, more recently, Motivational Interviewing.

Express Empathy

Empathy is a key ingredient in all good therapy and fundamental to Motivational Interviewing and other brief interventions (Bishop, 2002; Norcross & Wampold, 2011; Rogers, 1957). When a therapist shows that he or she can understand what it like to be in a client's shoes—what it may be like to have lapsed again, sometimes a stunningly unexpected happening for the client—that experience may strengthen the therapeutic relationship and increase the likelihood that future therapy will be more effective.

Open-Ended Questions

"How were you feeling the last time you had a drink?" makes clients feel as if you are really interested in their dilemmas. In contrast, closed-ended questions such as, "Did you drink last week? Does your partner know?" are more likely to put clients on the defensive and make them feel as if they are being interrogated and judged.

Practice and Teach UOA and USA

The "spirit" of Motivational Interviewing is based on Roger's concept of unconditional regard. Rogers (2003) believed that humans were innately good and that with the right setting and the right information, they would make the right changes. However, many cognitive therapists think that clients benefit from a more directive, educational form of therapy, including coaching.

Develop the Discrepancy

This is somewhat similar to the "Colombo technique." The idea is to bring to greater awareness to the apparent discrepancy between what clients say they want to do and what they are actually doing. For example, following the example of the ever-puzzled and ever-questioning detective Colombo, played by Peter Falk, the therapist can look confused, scratch his or her forehead, and say: "I'm a bit confused. I thought you said you wanted to stop using cocaine because you need to stay clean if you want to adopt a child, and yet you used every day last week. Help me out. I must be missing something."

Roll with the Resistance

Historically, addictions treatment has used very confrontative, shaming techniques. In contrast, MI and REBT/CBT encourage clients not to argue with clients, but rather, focus on helping clients uncover and dispute their own irrational beliefs. In addition, it is often very helpful to motivate under-motivated clients by doing a Cost Benefit Analysis during various sessions as the therapy progresses to increase the likelihood of staying on track.

Another strategy is to have the client do an ABC exercise on another person. This is especially effective when a client does not really believe she or he has a problem; it is the other person who has the problem. Not only does the client learn to do the ABC process, but it also raises his or her awareness. The client may more rapidly learn how the ABC approach works because it is not about him or his behavior. It is about someone else's irrational way of thinking about an activating event, perhaps your client's drinking. So it not only helps an under-motivated client who does not think he has a problem learn ABC thinking, but also helps him gain some insight into the another person's issues and possible irrational beliefs.

Therapist: "What do you think your husband is telling himself to make himself so nuts?"

Client: "He's probably thinking that I'm going to turn out just like my mother, who was still an alcoholic when she died at 82."

Therapist: "So how does he upset himself with such an idea?"

Another helpful strategy is to use Glasser's (1989) three questions: What do you want? What are you doing? How do you like the results? These are simple but profound questions that "cut to the chase" with addicted clients. The first question, however, is the tricky one because many people want two conflicting things at the same time: they want to have a drink and have a good relationship with their spouse. Nevertheless, asking these questions time and time again is a very powerful way of highlighting the difficulties in the situation.

Working on the Behavior First, the Secondary or Meta-Emotion Second

It is common for therapists to help clients identify and address the depression about the depression or the anxiety about the anxiety, referred to as the secondary emotion or meta-emotion (Ellis, 1994). Most therapists want their clients to feel better, but if an addiction is the focus of the therapy, this may be problematic. In essence, the client wants to do better as well as feel better.

If the therapist (T) asks, "How did you feel after you relapsed?" the session is liable to evolve as follows:

Client (C): "Awful."
T: "How did you make yourself feel awful?"
C: "Well, I'm such a failure. I always screw up. I have disappointed my family again, for the hundredth time."
T: "Where is the evidence that you are a failure?"

If the therapist continues along these lines, focusing on helping the client feel better, the client may leave the room a happier addicted person. No time will have been spent on the therapeutic goal: learning how to do better, which is to manage and perhaps overcome the addictive problem. Ellis (personal communication, 1990) agreed that in working with a client with an addictive problem, the behavioral problem should be addressed first. No doubt the feelings of shame and depression that follow an addictive episode also often contribute to more addictive behavior, as an antidote. Consequently, a key to relapse prevention is helping clients better manage such feelings. But the primary focus should be on doing better, not just feeling better.

Other Useful Research

In carefully studying couple interactions, Gottman (1999) discovered that men physiologically tend to get aroused (angry, anxious, etc.) and stay at an elevated level for hours, while women may get angry and cool down in 5 min. From an evolutionary perspective, men survived better if they remained "up," alert and ready for the hunt or to do battle. In contrast, women who often lived, worked, and talked in close proximity to each other, did better over time if they were able to cool down rapidly.

What does that mean for couples, and especially for couples where one person, for example the husband, has an addiction problem? Addictions are designed to change the way people feel; they are also avoidance behaviors, similar in ways to procrastination. Men, knowing that a discussion about a difficult topic, such as finances, disciplining the children, or fixing up the house, will create distress that may last for several hours, may engage in one of several coping mechanisms: have a drink or a toke first; delay the conversation with a series of excuses; and/or resist going to a therapist.

Assuming that Gottman (1999) is correct, how can cognitive behavioral therapists help couples? The therapist can take advantage of these findings in at least three ways: First, they can share the findings with their clients. Avoidance of difficult conversations is very common, and discomfort and anticipated discomfort (Ellis, 1978–1979) are common triggers for all types of addictive and compulsive behaviors. Both members of a couple usually laugh or look stunned to realize that there is a

possible, underlying, rational explanation for this aspect of their marriage. Second, they can teach clients about the ABC'S, unconditional self-acceptance (USA), unconditional other acceptance (UOA), and how to identify and challenge distorted cognitions. As couples practice staying in a discussion, they have an opportunity to observe their thoughts, emotions and behaviors. In the past, they may have become so uncomfortable that they torpedoed the discussion or simply left in order to avoid distressing emotions altogether. Learning to stay in a discussion and/or argument helps clients combat their normal low frustration or distress tolerance and develop higher frustration tolerance (HFT). It also helps one or both members of the couple learn to manage feelings more effectively and better accept the way his or her partner behaves.

The addicted individual may also be engaging in what Gottman (1999) called *stone walling*, or saying nothing. The client may have decided that stonewalling is the best way to handle accusations about addictive behaviors such as drinking or gambling. That way, he or she doesn't have to lie and it may seem like an effective strategy. But, again, the addicted person fails to realize that an effective short-term strategy often proves destructive over the long run. Cognitive techniques are very effective for dealing with stonewalling. For example, a therapist can ask: "What are you telling yourself when you simply shut down? How does that work for you?"

O'Farrell and associates (O'Farrell & Clements, 2012; O'Farrell & Murphy, 1995) at Harvard spent over 20 years studying how to help couples where one member of the couple is abusing alcohol. They created *Behavioral Marital Therapy* (BMT) as central to their studies. The key "contract" in most of their studies involved the wife giving her husband his Antabuse pill each morning. He was instructed to reply by saying, "I do not intend to drink today," and she was instructed to say, "thank you." He was also allowed to say, if appropriate, something like, "And please don't attack me with all of the bad things that have happened in the past twenty years because it does not help." Then they got on with their day. The results were impressive; 53.4% of the wives reported violence before treatment, 18.2% after treatment, and 10.3% 1 year after treatment for wives of remitted husbands (O'Farrell & Murphy, 1995). REBT and CBT therapists can help couples develop similar contracts, with or without the use of medication.

Case Study

The woman on the telephone said, "I want to talk about Bob." "I don't talk about my clients," I answered, not acknowledging whether I knew Bob or not. "Well, I want to know how he is doing." "As it turns out, I don't have a Bob as a client." "What?" the woman screamed back at me over the phone. "No, I don't know a 'Bob,'" I replied. "I don't believe it," the voice yelled back. "I've been giving him $200 every week for therapy for the past six months. You mean he's never come?" "I'm sorry. All I can tell you is that I do not know a 'Bob.'"

"Bob" called later that day, and showed up in my office 2 days later. He was abusing cocaine on a daily basis. I asked him what he wanted to do and he said he wanted to stop and he wanted to repair the damage to the relationship with his wife. During the first session, we talked about confidentiality and Bob announced that I could tell Ruth "everything." I explained that I did not want to do that, but I knew Ruth wanted to know whether he was coming or not. I recommended that he sign a release restricted to only telling Ruth about his attendance or lack of attendance in therapy. I did not think I could work effectively with Bob if he knew that I could tell Ruth "everything," including whether or not he had lapsed or relapsed. I wanted him to have at least one person on the planet that he could talk to without any fear that it would hurt him to do so.

At the second session, Ruth came along and we discussed the goals for therapy. They seemed to be on the same page—stop the cocaine and improve the relationship—and because I was helping him get off of the cocaine (and, later, to stop drinking excessively), I also saw them together as a couple.

Bob, who was 50 at the time, and Ruth, who was 45, had been married for almost 20 years but had no children. Ruth was not happy about that because it wasn't as if they had decided not to have kids; it just hadn't happened, but they had not pursued fertility counseling either. Bob had used and abused a variety of drugs his whole life, but he had also managed to make a living in New York City running outlet malls. Ruth worked as well, partly in a clothing shop and partly as a Reiki therapist, something she was still in training for.

Bob did not have much difficulty stopping cocaine, but, like many others, he switched to drinking alcohol, "only two drinks" per night, he said. At this point I was primarily working with Bob individually, but Ruth, the concerned significant other (CSO) called to tell me that he was drinking too much, acting drunk, slurring his words, and not going to work on a consistent basis.

I told Ruth that I could listen to her but that I would not say anything about what was going on in therapy with Bob. Therefore, I opened our next session by telling Bob that his partner had called. I shared what I thought was helpful from the conversation. I asked Bob if he would be willing to measure his drinks as part of his homework assignment. He was. At the next session hr reported—and seemed surprised—that each drink consisted of about three to four jiggers of alcohol. One drink made with one jigger (one and a half ounces) was simply not enough. We calculated that he was probably drinking 8 jiggers or 12 ounces of alcohol or more per night.

I spent the next year helping Bob learn to manage his emotional ups and downs without addictive behaviors and his disappointment with not having done more with his life. We also worked on creating new work goals and on developing new ways that he and Ruth could spend more enjoyable time together. Sobriety Sampling helped him see that he could go for a day or two without alcohol. He liked to drink and smoke cigars, and he never wanted to abstain completely. We worked together 2 years until finally he and Ruth felt things were better, and he gradually tapered off coming to see me, although I kept his folder on file in case of a relapse.

Other Ways to Help a CSO

Get Your Loved One Sober, *Alternatives to Nagging*, *Pleading and Threatening* by Meyers and Wolfe (2004) is, without a doubt, the best resource for both CSO's and cognitive behavioral therapists. The book is based on the program CRAFT (Community and Reinforcement Family Training) that the authors designed and researched for over 30 years. In CRAFT, "community" does not necessarily refer to a large number of people; it is often just the CSO. CRAFT offers an alternative and a very different approach from what is offered in AL-ANON. AL-ANON urges a participant to accept that his or her spouse or family member has a "disease." She (or he) should primarily learn how not to enable the behavior and should focus on working on his or her own problems. The underlying premise is that the addicted person's "stinking thinking" got him where he or she is, and he or she (and the CSO) are helpless to change it…without "surrendering" to the disease. As noted earlier, CRAFT and Meyers and Wolfe's (2004) book teach CSOs how to reinforce desirable behavior and not reinforce drinking behavior.

Should Interventions Be Arranged?

Should CBT and REBT therapists help clients like Jane arrange an intervention? The answer to that is not clear. Johnson Institute Interventions are well known in the United States and thought by many people to be very effective. As a result, interventionists can be found online in almost all U.S. cities, although they are usually not credentialed. The Johnson intervention approach entails arranging a meeting with the addicted client, but unbeknownst to him or her, numerous friends and family members are also present. These individuals each take a turn sharing concerns they have about the client, including at times, ways in which the client has hurt them. Finally, the client is given an ultimatum: Go into treatment immediately or lose contact with all of the individuals in the room. Given that the logistics of inpatient rehabilitation, this option isn't always feasible for some clients. Although some people do go into treatment, others are left with impaired significant relationships, which are often critical for recovery.

In one study (Meyers & Wolfe, 2004), CRAFT was compared with the Al-Anon and Johnson Institute interventions. CRAFT resulted in 64% of the participants entering treatment as compared with 30% of those confronted with an intervention like the Johnson approach; only 10% of the group in which the non-abusing member went to Al-Anon agreed to enter treatment. Those who enthusiastically promote Johnson-style interventions as effective not only ignore the low success rate, but also the potential serious negative effects on significant relationships as the result of an intervention of this nature.

Is Rehabilitation Effective?

Many CSO's want the addicted client to do something serious about his or her addictions, and rehab has become a very popular option, currently embraced by the media and celebrities. In some rare cases, an addicted client may benefit from an extended period away from home, but the results are often poorer than the media hype suggests (Carey, 2008; Johnson, 2010). The quality of the therapy delivered is often not as good as people expect, especially because group members come and go. Intensive outpatient therapy, with or without continued sessions with the referring REBT/CBT therapist, is often a more effective option. In that case, the client can learn to manage the addiction within the environment in which he or she lives. And the ongoing, intensive, group approach used by most outpatient clinics may be very helpful to a client, and may also help the CSO remain hopeful and in the relationship.

Should the CSO Change the "A"?

Changing the A—the Activating Event or Adversity—is thought to be heretical behavior by some REBT practitioners. REBT's underlying theory proposes that people upset themselves about A's because of what they believe about the A and because they deeply believe that A causes C. For example, the wife's nagging or refusal to make love causes the drinking and the husband's drinking causes the wife's anger, anxiety and depression. No doubt, in her case, the drinking is a contributing factor, but from a cognitive perspective, it is what the wife is saying to herself about the drinking that causes her emotional turmoil. Consequently, if she wants to feel differently, she had better try to think differently.

However, there are clearly times when she should probably behave differently, including changing the A. What does that mean? In all likelihood the CSO cannot change his or her partner's behavior, although CRAFT teaches the CSO how to try and affect it. What other options exist?

First, let's assume that the husband is the CSO. He can continue to make himself upset—perhaps psychologically and/or physically ill. Second, he can accept his spouse and her behavior. Third, he can try hard to change his spouse's behavior, usually to no avail, and finally, he can accept his spouse and the fact that she abuses substances but decide not to stay in the relationship.

At times, it is helpful to explore with clients what they might be saying to themselves that prevents them from changing the activating event. For example, if the CSO has to practice rational thinking all day to stay in a very bad relationship, what are the underlying beliefs that are preventing him from leaving? The CSO may have a number of irrational beliefs, such as: "This marriage must work and I must get what I want. I love him/her, but I can't keep on living this way—but I also can't stand the thought of living alone after all these years. I'd never find someone else and I'd be so unhappy."

Although a therapist may not want to advise a client to leave his or her spouse, working through the irrational beliefs underlying a sense of being trapped in a relationship and the feelings of hopelessness and helplessness, as well as depression, that go along with feeling trapped may help the client feel clearer about options.

Major Road Blocks along the Way to Recovery

A variety of factors can impede recovery, including ambivalence on the part of the addicted person as well as the CSO.

Ambivalence. Because the addicted client will often change his mind about stopping or moderating his or her addiction, it is often very frustrating for the CSO. The original questions—"What should I do? Do I want to stay in this relationship? Will he/she ever really change?" will immediately resurface. Standard ABC's will help the CSO, and REBT combined with MI and the suggestions above will help the addicted client.

Shame. Shame and anticipated shame often underlie lapses and relapses. REBT and CBT therapists should continually be on the lookout for evidence of its enduring, negative impact, which is almost always related to global rating and a lack of USA.

Emotional dysregulation. As noted above, addicted behaviors are designed to change the way the person feels. Hence, any work that an REBT/CBT therapist does to help both members of the couple become better at managing emotions and anticipated emotions will be of immense value.

Physical and psychological dependence. Neuroscience and operant and classical conditioning all suggest that a client can become dependent on a chemical and/or behavior. REBT and CBT therapies like DBT and ACT focus on helping clients become more aware (more "mindful") of the role of low frustration tolerance ("low distress tolerance" in DBT and "escape-oriented" behaviors in ACT) in sustaining addictive behaviors. Dependence cannot be diminished without enduring some discomfort, and clients may lapse or relapse solely because they anticipate the discomfort of trying to quit or moderate.

Environmental factors. Alcoholics Anonymous teaches members to avoid certain persons, places, and things, and REBT/CBT therapists need to help clients identify and work on ways to either withstand the temptations inherent in some situations such as weddings and office parties, or avoid them altogether.

Spiritual/existential factors. Ellis (1962/1994) often talked about the importance of an "all-consuming vital interest," and SMART's fourth point (www.smartrecovery.org) encourages members to work on "enduring satisfactions of life." Something larger and more important in life must motivate a person to quit and help the person maintain the commitment to stay sober.

How Can Cognitive Behavioral Therapists Best Proceed?

First of all, therapists should never terminate with an addicted couple because typically clients with serious addictive problems (unlike the easier cases, where people recover on their own or with only little professional help) are like clients with other serious health issues such as bipolar disorder, diabetes, hypertension, and obesity. Over time, they will have more and less success managing the problem. And as is true with other chronic illnesses, relapse is common. Given the non-psychoanalytic nature of REBT/CBT, there seem to be few reasons to terminate clients. What other profession does so? More sensibly, keep their files and be prepared to help them when they come in for future sessions, perhaps only for a "booster shot."

Second, it is important to keep good notes because people who have addictive problems may relapse and disappear for periods of time. For this reason, it is helpful to have notes that help you reconnect with them when they do reappear. Unlike Ellis, who deemphasized the importance of the relationship (A. Ellis, personal communication, December 5, 2004), most cognitive therapists recognize the importance of a good therapeutic alliance is, especially when the problems often involve intense self-downing, strong lack of USA, and strong feelings of shame. Keeping track of personal details in your notes will help you start off a session after a long absence with something that reinforces the idea that you are listening carefully and that you care.

Another good suggestion it so practice the "internist" model. Internists do not "refer out" diabetic or asthma patients who relapse for the umpteenth time and reappear in their office. They try to be helpful and they are rarely, if ever, judgmental and condescending…something that is not that common in the addition treatment field. Therapists should do the same. Alternatively, if your client really needs to learn how to do REBT, the "piano teacher" model may be better—the client should come at least once a week and should have assignments to work on between sessions.

Following the internist model, you may find that seeing people only sporadically will be more helpful as they learn how to live an addictions-free life. And following the research that shows that continuing care and case management work (Lash et al., 2011; Zweben, Rose, Stout, & Zywiak, 2003), it would be good to call your clients occasionally to see how they are. It is especially important to call if they miss a session (Koumans, Muller, & Miller, 1967).

It is also critical for therapists to work on their own distorted cognitions. In reality, many therapists prefer not to work with clients who have addictive problems because they find them "too difficult." Actually, they are rarely more difficult than clients suffering from other serious mental health problems such as major depression, bipolar disorders or eating disorders. Perhaps therapists are loath to work with addicted clients because they have their own irrational beliefs that interfere with effective therapy, such as "he'll never change" (but isn't it true that many clients with chronic problems like major depression relapse often), "I'm not a good therapist and the family is mad at me because I have not 'cured' my client." It is true that family members and spouses often have a very difficult time accepting that the problem is, in fact, chronic and recurring, but is that a reason for the therapist to give up?

Therapists also don't like working with addicted clients because they think they are lying or in denial. In reality, addicted clients, and even many non-addicted people, will lie if they fear that telling the truth will jeopardize their relationships, their homes or their jobs. If as a therapist you sense that a client is fudging the truth, this may be due lack of trust, particularly with regard to confidentiality. Furthermore, the client may also be ashamed of his or her behavior and want to gloss over the truth to avoid being judged or rejected by the therapist. How to help clients be more accepting of themselves with their behavior is a major challenge for the practitioner.

Conclusion

REBT and CBT provide an extremely effective combination of treatment approaches for helping couples in which one or both partners are struggling with addiction. Working with these couples is challenging because the motivation to change often waxes and wanes. During the past 30 years, a wide variety of evidence-based approaches have been developed for the treatment of addictive disorders which can be easily integrated into standard REBT/CBT work. They offer clients and therapists a menu of treatment options and greatly increase the likelihood that one or both members of the couple can become better at managing their addictions. Many couples—even those in which there is no addiction—are often grappling with complex, interacting problems. The two people may differ significantly in terms of their ability to manage their thoughts, feelings and behaviors, and they also may have diverged over time in terms of their goals and values. A cognitive behavioral therapist, however, can work in a multiplicity of ways in six distinct domains: cognitive, emotive, behavioral, interpersonal, spiritual/existential, and nutritional/medical. The work may be challenging, but ultimately, can help people live more enjoyable lives together.

References

Babor, T. F., & Grant, M. (1989). From clinical research to secondary prevention: International collaboration in the development of the Alcohol Use Disorders Identification Test (AUDIT). *Alcohol Health and Research World, 13*, 371–374.

Bishop, F. M. (2001). *Managing addictions: Cognitive, emotive and behavioral techniques*. Northvale, NJ: Jason Aronson.

Bishop, F. M. (2002). Brief interventions for the treatment of substance abuse. In F. W. Bond & W. Dryden (Eds.), *Handbook of brief cognitive behavioural therapy* (pp. 162–185). London: John Wiley & Sons.

Bishop, F. M. (2008). Alcohol abuse. In M. Hersen & J. Rosqvist (Eds.), *Handbook of assessment, conceptualization and treatment (HACT)*. New York: John Wiley.

Carey, B. (2008, December 22). Drug rehabilitation or revolving door? *The New York Times*. Retrieved from http://www.washingtonpost.com/wp-dyn/content/article/2010/08/06/AR2010080602660.html

Christensen, A., & Simpson, L. E. (2004). Acceptance, mindfulness, and change in couple therapy. In S. C. Hayes, V. M. Follette, & M. M. Linehan (Eds.), *Mindfulness and acceptance: Expanding the cognitive-behavioral tradition* (pp. 288–309). New York: Guilford press.

Ellis, A. (1962). *Reason and emotion in psychotherapy.* (Rev. ed., Secaucus, NJ: Carol Publishing Group; Revised 1994, New York: Birch Lane Press). Secaucus, NJ: Citadel.
Ellis, A. (1978–1979). Discomfort anxiety: A new cognitive behavioral construct. Parts I and II. *Rational Living, 14*(2), 3–8; *15*(1), 25–30.
Ellis, A. (1994). Reason and emotion in psychotherapy: A comprehensive method of treating human disturbances (revised and updated). New York, NY: Carol Publishing.
Ellis, A. E., & MacClaren, C. (1997). *Rational emotive behavior therapy*. San Luis Obispo, CA: Impact Publishers.
Gaillot, M. T., Baumeister, R. F., DeWall, C. N., Maner, J. K., Plant, E. A., Tice, D. M., Brewer, L. E., & Schmeichel, B. J. (2007). Self-control relies on glucose as a limited energy source: Willpower is more than a metaphor. *Journal of Personality and Social Psychology, 92*, 325–336.
Glasser, W. (1989). *Control theory in the practice of reality therapy*. New York: Harper & Row.
Gottman, J. M. (1999). *The seven principles of making marriage work*. New York: Three Rivers Press.
Hester, R. K., Squires, D. D., & Delaney, H. D. (2005). The Drinker's Check-up: 12-month outcomes of a controlled clinical trial of a stand-alone software program for problem drinkers. *Journal of Substance Abuse Treatment, 28*, 159–169.
Johnson, B. A. (2010, August 8). We're addicted to rehab. It doesn't even work. *The Washington Post.* Retrieved from http://www.washingtonpost.com/wpdyn/content/article/2010/08/06/AR2010080602660.html
King, M. P., & Tucker, J. A. (2000). Behavior change patterns and strategies distinguishing moderation drinking and abstinence during the natural resolution of alcohol problems without treatment. *Psychology of Addictive Behaviors, 14*, 48–55.
Koumans, A. J. R., Muller, J. J., & Miller, C. F. (1967). Use of telephone calls to increase motivation for treatment in alcoholics. *Psychological Reports, 21*, 327–328.
Lash, S. J., Timko, C., Curran, G. M., McKay, J. R., & Burden, J. L. (2011). Implementation of evidence-based substance use disorder continuing care interventions. *Psychology of Addictive Behaviors, 25*, 238–251.
Meyers, R. J., & Wolfe, B. L. (2004). *Get your loved one sober*. Center City, MN: Hazelden.
Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people to change addictive behavior* (2nd ed.). New York: Guilford.
Miller, W. R., Wilbourne, P. L., & Hettema, J. E. (2003). What works? A summary of alcohol treatment outcome research. In R. K. Hester & W. R. Miller (Eds.), *Handbook of alcoholism treatment approaches: Effective alternatives* (3rd ed., pp. 13–64). Boston: Allyn & Bacon.
Norcross, J. C., & Wampold, B. E. (2011). Evidence-based therapy relationships: Research conclusions and clinical practice. *Psychotherapy, 48*, 98–102.
O'Brien, C. P., & McLellan, A. T. (1996). Myths about the treatment of addiction. *The Lancet, 347*, 237–240.
O'Farrell, T. J., & Murphy, C. M. (1995). Marital violence before and after alcoholism treatment. *Journal of Consulting and Clinical Psychology, 63*, 256–262.
O'Farrell, T. J., & Clements, K. (2012). Review of outcome research on marital and family therapy in treatment for alcoholism. *Journal of Marital and Family Therapy, 38*, 122–144.
Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*, 95–103.
Rogers, C. (2003). *Client-centered therapy*. London: Constable and Robinson.
Sobell, L. C., Ellingstad, T. P., & Sobell, M. B. (2000). Natural recovery from alcohol and drug problems: methodological review of the research with suggestions for future directions. *Addiction, 95*(5), 749–764.
Westra, H. A., & Arkowitz, H. (2011). Integrating motivational interviewing with cognitive behavioral therapy for a range of mental health problems. *Cognitive and Behavioral Practice, 18*, 1–4.
Zweben, A., Rose, S. J., Stout, R. L., & Zywiak, W. H. (2003). Case monitoring and motivational style brief interventions. In R. K. Hester & W. R. Miller (Eds.), *Handbook of alcoholism treatment approaches: Effective alternatives* (3rd ed., pp. 113–130). Boston: Allyn & Bacon.

Chapter 12
Helping Couples Deal with Chronic Medical or Mental Illness of a Partner or Child

Robyn E. Kurasaki and Mark D. Terjesen

A common theme seen in therapy is helping the couple recognize and resolve conflicts by helping them manage their roles as parents and partners. These conflicts can be even more difficult when the couple is parenting a child with a physical or mental difficulty or when one member of the couple is experiencing psychiatric or medical issues. An illness or disability experienced by an individual family member can have a significant impact on the couple as well as the family as a whole in terms of communication, closeness, and alteration of roles within the couple and the family. The purpose of this chapter is to address couples therapy from an REBT/CBT perspective as it relates to working with couples who have a partner or child with a mental disability or chronic medical condition.

Working with Couples with a Chronic Illness

In their special issue of *Contemporary Family Therapy: An International Journal* that focused upon family therapy and medical issues, Canavarro and Dattilio (2011) stressed the impact that health matters may have on both the couple relationship as well as family functioning. Highlighting a bidirectional nature to this relationship, the authors suggested that health matters can adversely affect the quality of the relationship and that the quality of the relationship may affect health matters by further exacerbating difficulties in the relationship. Further, specific variables such as poor communication and lack of support may actually contribute to further health challenges.

R.E. Kurasaki, Psy.D. (✉)
St. John's University, Queens, NY, USA
e-mail: rkurasaki@gmail.com

M.D. Terjesen, Ph.D.
St. John's University, Queens, NY, USA
e-mail: terjesem@stjohns.edu

A. Vernon (ed.), *Cognitive and Rational-Emotive Behavior Therapy with Couples: Theory and Practice*, DOI 10.1007/978-1-4614-5137-2_12,
© Springer Science+Business Media New York 2012

In addition to understanding how a mental or medical illness can affect a couple's relationship, it is also important to consider the type of illness that a partner may be experiencing as it may influence the impact the illness has on the couple or family functioning. Illnesses that are chronic in nature may put forth more practical or extensive implications on the couple and family. For example, while a psychiatric illness like depression or anxiety can contribute to some alterations in the family functioning, a more chronic disease such as diabetes or lupus may also have some significant practical considerations that further impact upon familial functioning such as financial and management of medical issues. Furthermore, it stands to reason that in comparison with a temporary illness or disability, a life-threatening disease or terminal illness will lead to significant changes in roles and responsibilities in the home, increased affective states among family members, and subsequently have a significant impact on the dynamics of the relationship. These are important variables to consider when working with couples and are subsequently discussed.

There is a consistent body of research that has demonstrated the benefits of being in a relationship in terms of lower partner mortality rates (Liu, 2009), increased compliance with medical regimes (Trivedi, Ayotte, Edelman, & Bosworth, 2008), and higher survival rates once an illness is diagnosed (Reifman, 1995). Although it is unclear as to the mechanism or how the partner serves as a protective function against subsequent health issues, clinicians may wish to consider how both individuals cope with the mental/medical illness. If one partner does not perceive that the other partner (client) is putting forth effort to manage the illness effectively or follow the prescribed medical regimen, it may lead to negative attributions (e.g., "He does not care and he should") and increase the likelihood of unhealthy negative affect or poor communications with his or her partner which ultimately may lead to additional negative health consequences. If clients with a mental or medical illness do not feel that they are being supported by their partners, this would certainly have to be addressed over the course of therapy.

The Challenges of Working with Couples with a Chronic Illness

Mental or medical illness can impact numerous aspects of the couple or family functioning, some of which are related to the demands of the illness itself (Ruddy & McDaniel, 2008). It is important that the clinician consider the practical impact, the quality of the relationship, and the behavioral changes associated with the illness. By examining the extent of the impact, clinicians may be more equipped to design a treatment plan that is comprehensive and will better help the couple reach their goals and improve their overall functioning.

The *practical impact* looks at changes that may have had to occur as a function of the illness or disability. For example, if there is a restriction in one's physical activities, the partner now may be required to take upon additional responsibilities in and out of the home. It is very common for clients to report feeling bad for what their partner is going through, but at the same time, they may feel frustrated because they

are now "pulling more than their share" and this is not how they thought "things should be". Further, the partner may feel guilty about having such negative thoughts and may avoid communicating with his or her partner, further negatively impacting the communication and the relationship. In addition, as one partner is experiencing a mental or medical problem, the quality of interactions, along with satisfaction in the relationship, will also be affected. This effect need not only be seen as a negative one, but rather a change in the interaction. However, most often it is viewed in a negative light (i.e., "We cannot go hiking or biking like we used to. It's awful that we can't do what we used to be able to do. This is so sad and terrible."). This would be an important variable for the clinician to consider as building dissatisfaction as a function of the changes in the relationship may in some cases lead to increased negative affect and a subsequent deterioration of the relationship. In addition to examining changes, it may also be important to examine pre-illness quality of the relationship. Finally, it is important to consider specific relationship behaviors that may have changed as a function of one individual experiencing an illness. More specifically, these may be seen in some critical remarks that are made as well as some passive aggressive behavioral tendencies that one may be engaging in due to their difficulties in managing the illness. Awareness of these behaviors can have a negative impact on the relationship and may warrant being addressed in couple therapy sessions.

Working with Couples with a Chronic Illness: A CBT Rationale

Traditionally, cognitive behavioral couple therapy focuses on improving relationships through enhancing communication (Epstein & Baucom, 2002). With significant empirical support behind this approach, it may become complicated when one individual of the couple is experiencing a mental or medical illness. Given this, Baucom and colleagues (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998) developed an approach for couple and family interventions that specifically dealt with psychopathology that is applicable to both mental and medical illnesses. Baucom and colleagues suggested that the couple and family based interventions be catered towards the specific area of psychopathology within a couple's format. That is, when one member of the couple is experiencing depression, the intervention should be targeted for depression as well as providing opportunities for support and activity scheduling in conjunction with helping the partner who is not experiencing the psychopathology increase his or her understanding of the difficulties that the partner is experiencing and how this may have a negative impact upon the relationship. Therefore, cognitive behavioral couple therapy warrants an assessment and consideration of issues related to psychiatric and medical issues that may interfere with the relationship and warrant alteration of a traditional couples therapy approaches to address these concerns.

Recently, Kirby and Baucom (2007) proposed a couples therapy model that integrated Dialectical Behavior Therapy (DBT) with Cognitive Behavioral Couples Therapy (CBCT) that focuses on three primary areas: (a) emotion regulation,

(b) relationship skills, and (c) the interplay of strong emotions and relationship dynamics. As DBT has traditionally focused on working with Borderline Personality Disorder (BPD) clients, a similar model could be applicable for working with couples in which one member is experiencing a mental or medical issue with a slight modification to the areas of focus. We propose that in the beginning, efforts are made to increase understanding of some of the observable and not so observable symptoms associated with the mental or medical illness. This will help both partners clearly understand how the individual with the disability experiences symptoms, as well as how the other partner perceives this experience. It is here that we propose that the rationale and basic tenets of CBT and REBT be discussed and that the couple is made aware of the role that their cognitions play in the experiencing of their own emotions. Subsequent to this, integration of more traditional communication skills training that would involve how to communicate about practical issues related to the illness, as well as thoughts and feelings experienced within the context of their relationship (Epstein & Baucom, 2002), should be conducted. Consistent with the REBT model, clinicians may wish to look for specific demands that partners may be making about themselves ("I shouldn't be a burden") or one another ("She should understand what I am experiencing") along with the awfulizing ("It's terrible that she is sick"), low frustration tolerance ("I can't stand that I have to keep going for dialysis") and ratings of worth ("He is a rotten person because he does not support me") derivatives. Along with enhancing the communication, more behavioral strategies could be adopted to focus on such things as increasing the frequency of positive interactions, perspective taking, activity scheduling, and so forth. Finally, it is important to examine how the individual's affect and relationship functioning are intertwined and offer strategies to help reduce conflict through managing negative affective states more effectively. Collection of data from between session assignments may provide an opportunity to further examine this relationship and collaboratively develop strategies to manage negative affect and conflict going forward.

A Case Study: Medical Illness of a Spouse

Working with a couple with a mental or medical illness presents many unique clinical challenges that may require additional consideration beyond the interventions geared towards working with couples throughout this book. To highlight these considerations and illustrate the cognitive behavioral couple therapy model proposed, a case study describing the case conceptualization, assessment procedures, and interventions specific to the case is presented.

Kelly is a 48-year-old woman who has been married 21 years and is the mother of two children, ages 14 and 7. After taking a number of years off to raise her children, she returned to work 2 years ago when her daughter started kindergarten, not only because it was a financial necessity but also because it was a way for her to achieve some balance in her life. She works in a media office and was recently promoted to office manager. While she welcomes the increase in salary, Kelly

reports being very stressed as a result having to spend more time at work because two positions were merged into one. She describes her current life as chaotic and reports that she struggles constantly to juggle all of her responsibilities. She cannot recall the last time that she felt stress free. She describes her relationship with her children as generally good, although she has some concerns that her 14-year-old had been spending more time with friends she does not particularly approve of. Her major concern is about her husband Nick's health. Almost 3 years ago he was in a major accident which required numerous back surgeries that resulted in unemployment for 6 months and disability services for 18 months after that. Approximately a year ago, his doctor released him from care and stated that he was ready to resume work. However, Nick has not returned to work because he claims that he is still in pain. According to Kelly, her husband was never very healthy to begin with, and the accident and subsequent surgeries have resulted in less frequent exercise and increased weight gain to the point of obesity. Kelly finds this particularly concerning in the fact that she's unable to motivate him to try to get healthy and she's concerned that he "may not be there" for the family if he doesn't take better care of himself. He constantly makes lists of things to do and tells her he's motivated to change, but he repeatedly fails to do so. Kelly senses that he is ashamed about his weight because he has significantly withdrawn from social outings since the only clothes that fit him are sweat pants. She has gone with him to his doctor, as well as a nutritionist, to try to help him manage his health and weight, but he doesn't follow through with anything. His doctor is concerned about his high blood pressure and is surprised that he is not yet diabetic. Kelly thinks that it will just be a matter of time, and last week a major argument ensued when she returned home from work and found empty pizza and cookie boxes in the garbage.

Kelly thinks that Nick is depressed and has encouraged him repeatedly to see a mental health professional, but up until now, he has refused because he thought he could help himself. Since Nick wouldn't see a therapist on his own, she made the initial appointment with a couple therapist for both of them. Nick finally agreed to attend because he suddenly realized that this was his "last shot to make things work" since Kelly had told him that if it weren't for the children, she would just pack up and move on. He realizes that he hasn't been an active parent of late and says he appreciates Kelly's efforts to keep the family together and be the major bread winner, but he doesn't think she actually believes that he is trying to get a job or that he understands how his depression is affecting him.

Assessment and Initial Steps

It is important at the beginning of the therapy process to clarify what the couple's different affective states are as well as focus on some of the attributions and unhealthy cognitions that they may each be endorsing. It may be helpful to view the first session as one of assessment of affect, behaviors, and cognitions on behalf of both individuals. Further, the clinician may want to consider to what degree this

couple is in distress and what their goals are for therapy. In the case of Kelly and Nick, they may in fact have different goals that might make the therapeutic process more challenging. Assessment can be done during a couple session as well as through individual sessions. Initially a couple session may be very helpful to allow the clinician to observe the behaviors that may arise as a result of some of the difficulties that the couple is experiencing. In the case of Kelly and Nick, perhaps Kelly's frustration with Nick is so strong that she may engage in both verbal (e.g., cutting him off when he speaks) and non-verbal (e.g., rolling her eyes) behaviors that may negatively impact upon their communication style. Individual assessments may also provide an opportunity for greater clarity towards understanding their respective commitment to the relationship.

A component that may often be overlooked in couple therapy is to focus on the couple's strengths and past successes, both as a couple and in their roles within the relationship. Christensen, Jacobson, and Babcock (1995) posited that focusing on some of the positive interactions when couples get along provides an opportunity to discern these behaviors from the unhealthy behaviors that they may be currently experiencing that lead to negative interactions. This may then warrant a discussion about how these unhealthy behaviors are influenced by negative affective states and accompanying cognitive distortions and irrational beliefs which would be a target for change.

Case Conceptualization

In this case, there are a number of issues that the clinician may wish to focus on. To begin with, Nick appears to be experiencing depression which has impacted upon his health, vocational status, and his relationship. Regarding Kelly, the clinician needs to recognize that she is experiencing multiple stressors with her job, raising her children, and dealing with her husband's medical issues, as well as the behavioral and social ramifications of his difficulties. For the couple, it is apparent that negative affective states are contributing to difficulties in their relationship.

Preparing for Treatment

Upon completion of the assessment, the CBT/REBT couple clinician will meet with the couple, attempt to summarize his or her perceptions regarding how the couple see the issues, ask for clarification when necessary, point out where there may be some discrepancies in their perception of the problem, and help to align them towards working toward a mutually agreed upon goal(s). In the case of Nick and Kelly, the clinician might say:

> From having spoken to you as a couple as well as individually, there appear to be a number of areas that with effort on all of our parts could lead to more positive interactions. Nick, it sounds like the injury and subsequent back surgery have had a significant negative impact

upon your health, vocational status, and socialization patterns. I would imagine that at times this seems particularly challenging, and while you wish things were different, they are not, and you are experiencing some depression as a consequence. Additionally, while you say that you understand that Kelly is concerned about your health, you believe that at times she is not as supportive as you would prefer. Kelly, you present as someone who is experiencing considerable stress in some of the changes that you have experienced professionally as well as the demands that go along with being a parent. You have expressed a desire for Nick to be healthier and more active in the parenting, social, and occupational worlds and when that does not occur, it sounds like you are very frustrated. At points you may assume that Nick is not motivated to try and get healthier, which concerns you as well as angers you. While there are some differences in the perception of the problem, there are similarities in that you want to be able to get back to where you were previously as a couple, which is a good thing. Recognizing differences in perception as well as the role that our thoughts and emotions may play in how you interact with one another will be an important component of the treatment process. We are going to work on increasing effective communication strategies and problem-solving as a couple, but also on strategies to promote acceptance of each other and how to manage your affective states to enhance effective communication and problem-solving.

Clinical Interventions

Before initiating communication skill building and problem-solving interventions that are common in couple therapy, the clinician should educate the couple about the role of cognitions in developing unhealthy negative emotions and subsequent behaviors that may affect the relationship. It is important to do this at the beginning of therapy as failure to help manage negative affect may in fact lead to difficulties in applying some of the behavioral strategies utilized in communication skill building and problem-solving interventions. For example, in this case, if Kelly is still upset at Nick for not making an effort to change, it is unlikely that she will be able to process, internalize, and then produce the effective communication skills taught without addressing these cognitions and negative affect.

While psycho-education about the CBT/REBT model can be done didactically with a specific amount of time dedicated towards instruction in the model, it can also be done through the natural flow of the session. Couples frequently present with many "hot issues" related to how they want their partner to change. For example, Kelly wants Nick to take better care of himself, get a job, and be more involved in their children's education and activities. Nick wants Kelly to be more supportive and understanding. By focusing on one hot issue for each person, the clinician can use that to discuss the REBT model and the accompanying cognitions, emotions and behaviors associated with it, stressing that if they just *want* these changes, they will be less upset than if they think the partner *must* change. Using Kelly as an example, the clinician may say:

Clinician: Kelly, you mentioned a recent example of coming home from work and finding empty pizza and cookie boxes in the garbage. How did you feel with regard to that incident?

Kelly: I was upset—no, actually I was angry. This was just after we had been to the doctor who had talked to him about his unhealthy eating habits.

Clinician: So, when you were feeling so angry, what were you thinking?

Kelly: I just couldn't believe it. The doctor has continually warned him and he should be smart enough to take control of his life. It's like he doesn't want to be around for his family. I've done everything I can to help him, so he should make a better effort to at least let me know he is trying.

Clinician: And Kelly, when you are angry and thinking these things, how do you behave?

Kelly: Well, in this case I took the pizza boxes out of the garbage and yelled at him as I threw the boxes across the garage. Then I just stopped speaking to him until the next day.

Clinician: I can understand your frustration at this situation and your desire to help Nick, but do you see how certain thoughts you have about his behavior, such as "he should try harder," result in anger, conflict, and avoidance of him? Do you think this helps the relationship in any way?

This approach allows the clinician to assist the couple in not only recognizing the role that their cognitions and affect may play in managing the illness and communicating as a couple, but also prepares them for their thoughts being a target for intervention. That is, the focus of the therapy will not be exclusively on behavioral change, but also on affective and cognitive change.

Before a clinician targets cognitions and affect, it is important to normalize some of the experiences that clients may report and promote acceptance of their partner and their illness. For example, one partner may be afraid to say what he or she thinks because the other partner may see it as hurtful, which could have a detrimental effect on the relationship. However, promoting acceptance of their partner and the illness, as well as healthy negative affect such as sadness, frustration, and concern will promote increased communication and problem-solving in the relationship. To that end, consistent with integrative behavioral couple therapy (IBCT) (Christensen et al., 2004; Jacobson & Christensen, 1996), clinicians would be better served to work towards acceptance strategies with a greater focus on acceptance of the illness and its consequences while also accepting that while desirous, it is not absolutely necessary that the partner change.

It is also important to help couples identify others, both in and out of the family, who may serve as a source of support, as well as people who might be problematic. Assisting clients in accessing information from their health care providers that is clear and understandable may be another role that the clinician plays. Further, given the stress that may be associated with some of these appointments, it may be helpful to the couple to consider having another individual participate in these meetings to serve as "note-taker" and perhaps ask the questions that may be too difficult for the clients to ask. There may be affective and cognitive barriers on the part of the clients that may interfere with solicitation and utilization of support. This may warrant intervention from the clinician as clients may not want to burden others with their problems or do not wish to seek support because they think they should be able to manage this by themselves.

Promotion of healthier affective states and more rational thoughts may provide an opportunity for implementation of more commonly used behavioral interventions seen in the couple therapy literature such as skill-based interventions like communication training and decision-making conversations. Practicing in session while also monitoring affective states may then lead to greater generalizability outside the therapeutic setting. These skills, as well as the CBT/REBT approaches, may be further built upon through collaboratively developed assignments between sessions. These types of assignments are discussed more in-depth towards the end of the chapter.

Working with Couples with a Child with Chronic Illness

Having one's own child experience mental or severe medical problems can be overwhelming and extremely difficult for a couple. Depending on the degree or severity of the illness, the strain the illness has on the family can be diverse, significant, and impairing (Hamlett, Pellegrini, & Katz, 1992; Knapp, Madden, Curtis, Sloyer, & Shenkman, 2010). The remaining part of the chapter discusses the impact that a mental or medical illness in children can have on the couple and also includes how clinicians can work with a couple to help them cope with their child's illness and its effects on the family unit, including their own relationship. A case study is provided to highlight assessment practices and key factors to consider in treatment planning and implementation when working with couples.

Families who have a child with a serious physical or mental illness may undergo stress and hardship from both direct and indirect effects of the child's illness or problems. These effects may be diverse in nature, including both short and long-term effects that include both financial and emotional strain from the child's symptomology, treatment, and/or caregiving needs (Bradley-Klug, Grier, & Ax, 2006). These effects may also be attenuated by the type of illness the child is experiencing. Financially, the child's illness may put many demands on the family's time and resources (Fish, 2002) and may compound stress experienced by the family. The expenses of medical care, equipment, or costs related to therapy and treatment may be quite significant. Depending on the extent of the illness or course of treatment, parents may have to decrease their employment to take care of their child's needs or take him or her to appointments. Further, the child's illness may also cause or exacerbate significant emotional distress to the caregiver's psychological well-being and the quality of the couple's relationship. Caregivers may experience unhealthy negative emotions such as stress, guilt, anger, anxiety, and depression. These emotions may also contribute to difficulties within family relationships, including marital stress, and may affect the couple's attitudes and behaviors towards seeking out and participating in mental or medical treatment (Barlow, Kirkpatrick, Stewart-Brown, & Davis, 2005).

Not all couples with a child with a chronic illness may experience negative family functioning (Machado da Silva, Jacob, & Nascimento, 2010; Rodrigues & Patterson, 2007). Therefore, coping with a child's mental or medical illness may also be related to child and family characteristics (Day et al., 2011). First, the nature and symptoms of each disorder may affect how parents cope with the illness. For example, chronic or serious health disorders like leukemia may be very difficult to manage practically and emotionally. The child will undergo chemotherapy or radiation treatment that can be rigorous and straining, possibly having multiple present and future complications both medically, socially, and even academically for the child. The child will have numerous medical appointments and expensive medical bills. A parent with a child with severe mental health problems such as conduct disorder may also have significant difficulty managing their child's behavior. In addition to costs related to psychological intervention, the parent may also endure costs related to problems with the law due to the child's behavior. These caregivers may also experience home environments that are highly coercive and full of conflict. These problems may be lasting and difficult to cope with ultimately having a negative impact upon the child, the couple, and the family unit.

The extent or impact of the child's illness may also be related to the family's structure or background. Dysfunctional familial factors such as poor communication or problem-solving skills may affect how the caregivers cope with the diagnosis and participate in treatment. For example, a couple who communicate poorly may experience high levels of conflict and anger towards each other, resulting in difficulties in seeking treatment and effectively participating in treatment for their child, especially when the parent's involvement is so necessary to improving the child's outcomes. A couple's finances may also affect the extent of emotional and financial strain. Couples with limited income may experience significant difficulty keeping up with treatment costs or coping due to limited social support. Although limited research exists on religious or cultural beliefs, it is hypothesized that both may influence how a family copes with the diagnosis, responds to the child, and approaches a course of treatment. These variables may wish to be considered by clinicians when working with a couple as they may be a barrier to effective treatment.

In addition to the couple's financial situation and social support, individual characteristics may also explain how the parents respond to and cope with their child's mental or medical illnesses. Several factors have been linked to caregiver stress and warrant consideration when working couples (Pinderhughes, Dodge, Bates, Pettit, & Zelli, 2000; Rutter, Kim-Cohen, & Maughan, 2006). These include, but are not limited to, parent practices (Lundhal, Risser, & Lovejoy, 2006), parent psychopathology (McClure, Brennan, Hammen, & Le Brocque, 2001; Nelson, Hammen, Brennan, & Ullman, 2003), and parent cognitions (Hassall, Rose, & McDonald, 2005; Pinderhughes et al., 2000). In addition, consideration by case on the roles each member of the couple plays in daily family functioning, as well as addressing their child's needs is imperative and may warrant consideration by the clinician. The interplay of these factors may moderate or mediate the effects of the child's illness on the couple's relationship, family functioning, and the child's prognosis or response to treatment.

Working with Couples with a Child with Chronic Illness: A CBT Rationale

While not all couples who have a child with a chronic mental or medical condition may experience significant levels of distress, many do, and therefore warrant assistance in effectively coping with their child's condition (Hassall et al., 2005; Rodrigues & Patterson, 2007). As their child's illness may cause or exacerbate premorbid conditions among the family and its members, the strain the child's illness has on the couple relationship and family functioning can be immense, ultimately affecting the quality of life of all parties. Therefore, a cognitive behavioral couples therapy model that is multifaceted, addressing the couple's background and resources, while taking into account the factors related to the child's illness, would be beneficial. Similar to the model proposed earlier with the ill partner, we are proposing that priority be given to addressing the individual caregiver's cognitions and affect that may affect the client's involvement in their couples treatment, their child's treatment, and so forth.

In line with the CBT/REBT model, the caregiver's behaviors may be explained by how they perceive and feel about themselves, their partner, their child's illness, their parenting practices, and so forth. Examination of specific unhealthy beliefs (e.g., "It's awful that my child is ill") across these areas that may contribute to unhealthy negative emotions and behaviors that would warrant being targeted clinically. Additionally, the type of parent practices the caregiver employs (e.g., coercive discipline practices, positive parenting practices, & supervision) may affect whether the child receives treatment and the child's response to treatment will be influenced by their affect and cognitions. This is particularly true for couples who have a child with an externalizing disorder like Oppositional Defiant Disorder as the empirically supported treatment for this disorder involves the parent particularly parent training (Day et al., 2011; Eyberg, Nelson, & Boggs, 2008). Stressed parents may find it challenging to engage in treatment ("It's too difficult to find time to come to therapy"), change parenting practices ("I shouldn't have to change"), and apply them consistently ("It's hard not to always given in to his tantrums"). Similarly, the needs of a child with a chronic medical condition like Cystic Fibrosis may require a lot of caregiver supervision and consistency adhering to prescribed medical procedures. Clinicians should assess both past and current caregiver practices as they may need to be addressed to improve outcomes.

From a CBT/REBT perspective, the types of parent practices a caregiver employs can be explained by the caregiver's, negative affect and cognitions. Plainly, how the couple thinks and reacts to a situation or to themselves can affect what they do as partners and as parents. Therefore, a point for clinical intervention should begin with targeting the individual's cognitions. These cognitions, also referred to as thoughts, beliefs, or attributions, can be both similar and markedly different from their partner's and may explain differences in the roles and responsibilities the individuals take on. Numerous studies have highlighted different caregiver cognitions characteristic to caregivers of children with mental or medical illness, including

interpretation or appraisals of their child's behavior (Bugental, Blue, & Lewis, 1990; Bugental & Happaney, 2001) and irrational beliefs (Bernard, 1990; Ellis & Bernard, 2006; Joyce, 1995). These include but are not limited to attributions of caregiver outcomes or parental perceived control (Bugental & Happaney) and irrational beliefs. Ellis and Bernard (2006) described parent irrational beliefs as they relate to parent negative affects and parenting practices, noting that parent demands are unrealistic and absolute expectations of events, of themselves as parents, or of others such as their children. An example of a parent irrational demand is "My child shouldn't have so many problems," and parents who hold irrational demands like this may often experience anger (Joyce, 1995). Awfulizing beliefs are often exaggerations of negative consequences that are now seen to be terrible and awful in nature. Such beliefs include "It's awful that my child has a problem" (Bernard, 1990, p. 300), and anxiety often accompanies parent awfulizing irrational beliefs (Joyce, 1995). Low frustration tolerance is characterized as intolerance for discomfort. Parents with low frustration tolerance often have irrational beliefs such as "It is too hard to solve my child's problems" (Bernard). The last core irrational beliefs are global evaluations of self-worth. These beliefs imply that the self as a parent or others can be given a single rating of value or worth. An example is "I am worthless because my child has so many problems" (Bernard). Global ratings of self-worth often elicit parental depression and guilt (Joyce). Caregiver cognitions have also been linked to parent's willingness to participate in treatment (Davidson & Fristad, 2006). Therefore, an assessment of the couple's individual cognitions is imperative as they may explain how they respond to each other and to their child's illness and also be a target for intervention.

Assessment

For couples who have a child with mental or severe medical illness, an assessment of their social-emotional well-being can help gauge the level of distress and may guide treatment planning. Assessment tools such as observations, interviews, questionnaires, or rating scales can help assess the couple's affective states (e.g., *Parenting Stress Index*, Abidin, 1995), cognitions (e.g., *Revised Belief Scale*, Joyce, 1995; *The Treatment Beliefs Questionnaire* (TBQ), Davidson & Fristad, 2006), and parenting practices (e.g., *Alabama Parenting Questionnaire*, Frick, 1991). In addition, if multiple members of the family seek some form of treatment, collaboration with the service providers may be useful in addressing family focused problems or in addressing the needs of the child.

Interventions and Considerations

As evidenced-based practice (EBP) shapes the treatment of psychological disorders multiple considerations need to be made regarding the effective delivery of these

interventions to couples. Furthermore, many EBP's are multidimensional, addressing multiple areas and contexts. Factors including, but not limited to the couple's parent practices, stress, and cognitions should all be assessed and targeted in a comprehensive treatment plan that also includes psycho-education about the child's illness and the provision of additional resources or social support to cope with the illness. Therefore, prior to treatment, it is imperative for clinicians to adopt a multimodal and multi-informant assessment that target the multiple domains discussed earlier—risk factors, individual parent characteristics, and couple characteristics.

Treatments should be evidenced-based. They should be collaborative and communicative, enlisting competent professionals to address areas with their expertise. Treatment plans should also be frequently monitored to ensure effectiveness and assist a practitioner in modifying or continuing a treatment regime. Also, treatment plans should not only be child-focused, and variables that may moderate or mediate treatment effectiveness should be identified and addressed. Lastly, treatment should involve a psycho-education piece that provides appropriate information to the parents or client regarding the child's diagnosis and treatment.

A Case Study: A Child with a Mental Disability

Upon referral, Joshua was a fifth grade student who was exhibiting intense irritability, some distractibility, and limited work productivity in the classroom. He also was having difficulties getting along with classmates and his younger brother. As an average student, Joshua had consistently met grade level standards. A review of his report card only noted bouts of distractibility in the first and second grade and an isolated, minor difficulty getting along with a classmate in third grade. No history of medical or mental health concerns were reported by the family. As a fifth grade student, Joshua began having difficulty in the classroom. He reported being very angry at his peers and became aggressive during peer interactions at recess and in the classroom. He described his emotions as being on a rollercoaster going from feeling fine 1 minute to being extremely angry the next. A recent disruptive incident during art class prompted a referral for a psychiatric evaluation and Joshua was diagnosed and began treatment for Bipolar Disorder.

According to his parents, Joshua's mood swings also took a toll on his family. There were frequent verbal altercations with his brother and parents. As a result, the parents reported that their marital relationship was deteriorating as they often argued about how each other handled Joshua's behavior. They were so focused on their son's problems that they had stopped doing enjoyable things together and were not supporting each other through this process. Normal disagreements were easily blown out of proportion and there was a great deal of stress in the relationship. As Joshua's behavior became more aggressive and disrespectful, both parents reported that in response, they would yell at him and take away his privileges, which caused further conflict within the home. On some days he had difficulty waking up in the morning, had tantrums, and refused to go to school. His parents found him to

be unmanageable and his diagnosis was extremely difficult to cope with because of the inconsistency of his behavior and mood—not only was he disruptive and aggressive, but he could be very sad and withdrawn. When he withdrew and did not want to do things that his parents knew he loved, they reported that this was heartbreaking for them. They used to do family days that Joshua enjoyed a great deal, but when he did not want to go and just stayed in his room and slept, his parents became very concerned and upset. During one interview, it was evident that the parents experienced Joshua's situation differently. His mother felt extremely guilty and depressed and attributed her son's problems to her own ineffectiveness as a parent. She also reported feeling overwhelmed and helpless because she had no idea how to deal with her son's mood shifts. Her husband reported experiencing anger and fear. He acknowledged that he would become enraged when Joshua would be disrespectful and disruptive, thinking "How dare he act like that," or "He should never talk like that to a parent." As Joshua's aggressive behavior in school increased, his father admitted that he was worried and embarrassed about his son's behavior. He feared that his behavior would get worse and he would be kicked out of school or seriously hurt someone. He also worried about the potential stigma a psychiatric diagnosis could have for his son and worried about his son's well-being under treatment.

Case Conceptualization and Treatment

Prior to a referral to his clinician, Joshua received pharmacological treatment and collaboratively, the psychiatrist and psychologist worked to inform diagnosis and develop a comprehensive treatment plan with Joshua's parents. Besides pharmacology, Joshua also received individual Cognitive Behavior Therapy weekly. In light of the interdependent nature of the family dynamics, intervention that focused on the family context was included in Joshua's comprehensive treatment plan. First and foremost, the therapeutic relationship across parties was established and maintained. Included across initial sessions was motivational interviewing to develop willingness to change. Second, psycho-education was delivered across several sessions, which included information about pediatric Bipolar Disorder and child behavior management. His parents were informed about the etiology, symptoms, prognosis, and empirically supported treatment for Pediatric Bipolar Disorder. They were educated on medication management, crisis intervention, and on the principles of behavior management. An assessment of parent practices and well-being indicated that Joshua's mother's parenting was high with inconsistency and low supervision while his father's was high with aversive punishment.

Due to the overwhelming levels of stress and unhealthy negative emotions for both parents, therapeutic sessions were also conducted for both the parents together as a couple. During the sessions, the clinician used REBT with the couple to challenge the identified irrational beliefs that led to their negative affect and behaviors. Specifically, the clinician first assisted the parents in identifying the unhealthy negative emotions and examined the impact that these emotions have on their relationship as

a couple and in their role as parents. Educating the parents about the connection between irrational/rational beliefs, unhealthy/healthy negative emotions, and their dysfunctional/functional behavior was highlighted and emphasized. Through the use of relevant examples connecting the beliefs-affect-behavior and through further discussion, the parents were able to comprehend the impact of their child's mental illness and behaviors on their lives, their relationship with one another, and also importantly how their responses further influenced their son's well-being. Next, once the irrational beliefs were identified, and the parents understood the thought—emotion connection, the practitioner disputed and assisted the parents in challenging these beliefs. Multiple techniques and strategies were used, including Socratic questioning, empirical and logical disputes, as well as functional disputes ("How is thinking this way about your child's behavior, helping the two of you as a couple?").

With regard to the mother, the clinician targeted irrational beliefs pertaining to self-downing and low frustration tolerance. Both beliefs were targeted as it was hypothesized that self-downing and LFT (e.g., "I am so worthless because I am a bad parent and I can't handle this") hindered the mother's ability to employ effective parenting practices such as consistency and appropriate supervision. Joshua's father's beliefs that were targeted included demandingness and awfulizing (e.g., "My son shouldn't act like this/he shouldn't have these problems"). These beliefs were identified as being related to his anger in response to his son's behavior, marital dissatisfaction, anxiety, and embarrassment and his use of corporal punishment. After disputation the practitioner assisted the mother in generating new healthy rational beliefs (e.g., "My worth as a parent isn't based on my son's behavior; and although this is really difficult, I just have to work hard to handle my son's problems"). Further, specific beliefs that related to their relationship with one another were targeted. As an example, Joshua's mother may be thinking: "Joshua's father should not be so hard on him and I can't stand it when he is." Homework, such as rehearsing of coping statements and rational beliefs, self-monitoring activities, relaxation training, and visualization were also used to help the couple apply what they learned in session to real life situations in order to reduce their stress. In addition to cognitive restructuring as it related both to their relationship with one another and their role as parents, both parents also received parent training in the principles of behavior management, medication management, and relapse prevention. Ongoing and frequent progress monitoring through the use of inventories, rating scales, and tallies administered to both the parents and the child were used to evaluate the effectiveness of the treatment plan.

In addition to addressing their individual irrational beliefs, the clinician also worked on enhancing the couple's communication and took steps to increase overall marital satisfaction. Specifically, the clinician worked on perspective taking to help the couple become aware of each other's thoughts and feelings and problem-solving to help them identify issues or difficult situations and to brainstorm and effectively evaluate solutions to deal with current and future problems in a more effective and adaptive manner. In addition, the clinician also used activity scheduling to create more opportunities for quality time with the couple where they could engage in

enjoyable activities together and with their children. Finally, behavioral contracting was also a key intervention and was used between the couple and with the couple and their children. These contracts and other additional behavioral strategies were believed to be most effective once the clinician was able to help the couple manage their negative emotions by targeting their cognitions.

Interventions for Couples Between Sessions

There are a number of interventions that may be used when working with couples that are experiencing difficulties with mental or severe medical illness with one member of the couple or with a child. Jacobson (1989) discussed the importance of homework in couple therapy as it relates to therapeutic outcome. Because some individuals react adversely to the term *homework*, clinicians may choose to use the term *experiment or task* as it may appear to less threatening and more useful. L'Abate (1985) proposed a systematic homework system involving a minimum of three home work assignments per session, one assignment for each member of the couple to do individually and one assignment for the couple to do together. These assignments can be cognitive, behavioral, or affective in nature.

Deciding which homework to implement and at what point can be very crucial for the clinician and for therapy outcome. Linking homework to the specific content of the session so that there is the perception of meaningfulness of the assignment is important. Clinicians should check with their clients to make sure they understand the rationale for the specific assignment and find it acceptable. As communication is often an issue in many couple therapy sessions, it may be important to review what specific behaviors are required for each individual as part of the homework and if there is subsequent session disagreement as to who was supposed to do what then future assignments may need to be written down. Further, it is important to explore when homework is not completed and identify what were some of the practical and emotional barriers that may have interfered with completion. While developing the homework assignment, clinicians should ask clients to identify any barriers that may have a negative impact on homework completion.

There are a number of and varied types of homework assignments that can be used with couples when dealing with a medical or psychiatric health issue. Specifically, to assist in the utilization of REBT, having clients keep thought or mood assessments throughout the week is helpful. Identifying specific affective states and the irrational beliefs that accompany them as they relate to the relationship can then be used to target for change during the course of therapy. Further, this assists clients in becoming aware of patterns of thoughts and emotions that they may have as they relate to the illness. A good homework assignment for couples experiencing the illness of a spouse or a child is activity scheduling, where the clinician helps the couple identify specific activities that they currently find pleasurable or have had in the past and then having them examine to what degree these activities can still be practical given the medical and psychiatric difficulties that the couple or family are experiencing.

Bibliotherapy may take on a new meaning when it comes to working with couples who have a member of the family with a health issue. In these cases, bibliotherapy may involve reading about the illness and some of the accompanying difficulties. Sometimes the healthy partner develops expectations about what the ill partner can and cannot do, but this may be based on inaccurate information. Educating each member of the family about the illness can remove overgeneralizations and assumptions that have a negative impact on the relationship.

Practicing communication and problem-solving techniques between sessions is another way to further reinforce adaptive and helpful styles. Relaxation training, brainstorming solutions to problems, and scheduling times to discuss emotions as well as practical activities may be helpful. Scheduling specific times to practice these skills when there are no distractions is important. Promoting a beginning of the week planning session to discuss and assign tasks for the upcoming week may be helpful to avoid any miscommunication. Discussion of any potential obstacles towards achieving those goals may be beneficial as well.

General Considerations

From a treatment perspective, there are a number of areas that clinicians may wish to consider as they engage in the therapeutic process. First, establishing and maintaining the therapeutic alliance with the couple is key. This can be particularly challenging as there are at least two clients who may differ on many factors including, but not limited to, their philosophy about parenting, their attitudes toward each other, their expectations for treatment and their role in the process, and their overall functioning, including the degree to which their thinking is rational. Clinicians would benefit from assessing the couple on these dimensions and address them as they may impact both the therapeutic relationship and treatment effectiveness. To overcome barriers that may impede therapeutic progress, clinicians could use motivational interviewing or discuss disagreement with goals or interventions with the couple. Second, from a cognitive behavioral perspective, having clinicians work towards identifying and selecting the appropriate irrational beliefs or cognitions to target for change via cognitive restructuring and disputation is imperative. Specifically, after having identified irrational beliefs, attributions, or appraisals, the clinician should then target the cognitions that most negatively impact their client's functioning as individuals and as a couple and distinguish between those thoughts that are realistic and appropriate. For example, the child or spouse's illness can be very chronic and debilitating, and watching the individual go through the illness can be very difficult and be seen as "awful" from the perspective of the client. However, the manner in which one targets awfulizing beliefs in specific instances can be invalidating for the client. Instead, targeting other maladaptive beliefs that can cause or exacerbate negative affect and behaviors like self-downing or low frustration tolerance can be more appropriate and helpful for the client.

From a treatment planning and implementation consideration, clinicians may also want to examine the socio-ecological context of the family. Understanding the

family's environment and conditions in which the family operates within can be useful as these factors may affect treatment adherence and effectiveness. These could include but are not limited to the family's socioeconomic level, education/ employment, and cultural or religious practices. Furthermore, the inclusion of additional family members/ caretakers such as grandparents or siblings as they may directly or indirectly affect the family functioning and treatment effectiveness and maintenance of results is imperative. Additionally, it is important for clinicians to consider that parents may not be currently married, or together, or they may significantly differ in their parenting roles, expectation, and involvements. Obtaining a clear understanding of these dynamics may affect the development and implementation of the treatment plan.

Conclusion

The current chapter focused on couple therapy with a CBT/REBT perspective for couples with a partner or child with a mental or medical illness. Coping with a partner's or child's illness can be very difficult as many factors influence how the illness impacts the couple. The CBT/REBT model of couple therapy highlights the importance of first addressing the couple's individual cognitions that may impact the quality of interactions with each other and their ability to cope and or manage the illness of the partner or child. It was recommended that couple therapy begin with a thorough assessment of the partner's functioning, including specific factors that may help develop a comprehensive case conceptualization to guide treatment. Along with traditional CBCT approaches, interventions such as psycho-education, communication training, and problem-solving should be employed to help the couple practice skills and enhance therapy outcomes. Lastly, careful consideration for additional therapeutic factors such as the therapeutic alliance and financial, cultural or religious factors should also be integrated in process.

References

Abidin, R. R. (1995). *Parenting Stress Index*. Odessa, FL: Psychological Assessment Resources Inc.

Barlow, J., Kirkpatrick, S., Stewart-Brown, S., & Davis, H. (2005). Hard-to-reach or out-of- reach? Reasons why women refuse to take part in early interventions. *Children and Society, 19*, 199–210.

Baucom, D. H., Shoham, V., Mueser, K. T., Daiuto, A. D., & Stickle, T. R. (1998). Empirically supported couple and family interventions for marital distress and adult mental health problems. *Journal of Consulting and Clinical Psychology, 66*, 53–88.

Bernard, M. E. (1990). Rational-emotive therapy with children and adolescents: Treatment strategies. *School Psychology Review, 19*, 294–304.

Bradley-Klug, K. L., Grier, E. C., & Ax, E. E. (2006). Chronic illness. In G. Bear & K. M. Minke (Eds.), *Children's needs III. Development, prevention, and intervention* (pp. 857–869). Bethseda, MD: National Association of School Psychologists.

Bugental, D. B., Blue, J., & Lewis, J. C. (1990). Caregiver beliefs and dysphoric affect to difficult children. *Developmental Psychology, 26*, 631–638.

Bugental, D. B., & Happaney, K. H. (2001). The role of attributional bias in parenting: When are caregiving relationships transformed to power struggles? In J. R. M. Gerris (Ed.), *Dynamics of parenting: Nature and sources of parenting in childhood and adolescence* (pp. 17–31). Hillsdale, NJ: Erlbaum.

Canavarro, M. C., & Dattilio, F. M. (2011). Family therapy and medical issues. *Contemporary Family Therapy: An International Journal, 33*(2), 87–90.

Christensen, A., Atkins, D. C., Berns, S., Wheeler, J., Baucom, D. H., & Simpson, L. E. (2004). Traditional versus integrative behavioral couple therapy for significantly and chronically distressed couples. *Journal of Consulting and Clinical Psychology, 72*, 176–191.

Christensen, A., Jacobson, N. S., & Babcock, J. C. (1995). Integrative behavioral couple therapy. In N. S. Jacobson & A. S. Gurman (Eds.), *Clinical handbook of couples therapy* (pp. 31–64). New York: Guilford.

Davidson, K. H., & Fristad, M. A. (2006). The Treatment Beliefs Questionnaire (TBQ): An instrument to assess parent and child beliefs about the severity of the child's illness and treatment needs. *Psychological Services, 3*, 1–15.

Day, C., Kowalenko, S., Ellis, M., Dawe, S., Harnett, P., & Scott, S. (2011). The helping families programme: A new parenting intervention for children with severe and persistent conduct problems. *Child and Adolescent Mental Health, 16*, 167–171.

Ellis, A., & Bernard, M. E. (2006). *Rational motive behavioral approaches to childhood disorders: Theory, practice, and research*. New York, NY: Springer.

Epstein, N., & Baucom, D. H. (2002). *Enhanced cognitive-behavioral therapy for couples: A contextual approach*. Washington, DC: American Psychological Association.

Eyberg, S. M., Nelson, M., & Boggs, S. (2008). Evidence-based psychosocial treatments for children and adolescents with disruptive behavior. *Journal of Clinical Child and Adolescent Psychology, 37*(1), 215–237.

Fish, M. (2002). Best practices in collaborating with parents of children with disabilities. In A. Thomas & J. Grimes (Eds.), *Best practices in school psychology IV* (pp. 363–376). Bethseda, MD: National Association of School Psychologists.

Frick, P. J. (1991). *The Alabama Parenting Questionnaire*. Birmingham, AL: University of Alabama.

Hamlett, K. W., Pellegrini, D. S., & Katz, K. S. (1992). Childhood chronic illness as a family stressor. *Journal of Pediatric Psychology, 17*, 33–47.

Hassall, R., Rose, J., & McDonald, J. (2005). Parenting stress in mothers of children with an intellectual disability: The effects of parental cognitions in relation to child characteristics and family support. *Journal of Intellectual Disability Research, 49*(6), 405–418.

Jacobson, N. S. (1989). The maintenance of treatment gains following social learning-based marital therapy. *Behavior Therapy, 20*, 325–336.

Jacobson, N. S., & Christensen, A. (1996). *Integrative couple therapy: Promoting acceptance and change*. New York, NY: W.W. Norton and Company. 283 pp.

Joyce, M. R. (1995). Emotional relief for parents: Is rational-emotive parent education effective? *Journal of Rational Emotive and Cognitive Behavior Therapy, 13*, 55–75.

Kirby, J. S., & Baucom, D. H. (2007). Integrating dialectical behavior therapy and cognitive-behavioral couple therapy: A couples skills group for emotion dysregulation. *Cognitive and Behavioral Practice, 14*(4), 394–405.

Knapp, C. A., Madden, V. L., Curtis, C. M., Sloyer, P., & Shenkman, E. A. (2010). Family support in pediatric palliative care: How are families impacted by their children's illnesses? *Journal of Palliative Medicine, 13*(4), 421–426.

L'Abate, L. (1985). A training program for family psychology: Evaluation, prevention and therapy. *American Journal of Family Therapy, 13*, 7–16.

Liu, H. (2009). Till death do us part: Marital status and U.S. mortality trends, 1986–2000. *Journal of Marriage and Family, 71*(5), 1158–1173.

Lundhal, B. W., Risser, H. J., & Lovejoy, M. C. (2006). A meta-analysis of parent training: Moderators and follow-up effects. *Clincial Psychology Review, 26*, 86–104.

Machado da Silva, F., Jacob, E., & Nascimento, L. C. (2010). Impact of childhood cancer on parents' relationship: An integrative review. *Journal of Nursing Scholarship, 42*, 250–261.

McClure, E. B., Brennan, P. A., Hammen, C., & Le Brocque, R. M. (2001). Parental anxiety disorders, child anxiety disorders, and the perceived parent-child relationship in an Australian high-risk sample. *Journal of Abnormal Psychology, 29*, 1–10.

Nelson, D. R., Hammen, C., Brennan, P. A., & Ullman, J. B. (2003). The impact of maternal depression on adolescent adjustment: The role of expressed emotion. *Journal of Consulting and Clinical Psychology, 71*, 935–944.

Pinderhughes, E. E., Dodge, K. A., Bates, J. E., Pettit, G. S., & Zelli, A. (2000). Discipline responses: Influence of parents' socioeconomic status, ethnicity, beliefs about parenting, stress, and cognitive-emotional processes. *Journal of Family Psychology, 14*, 380–400.

Reifman, A. (1995). Social relationships, recovery from illness, and survival: a literature review. *Annals of Behavioural Medicine, 17*, 124–131.

Rodrigues, N., & Patterson, J. M. (2007). Impact of severity of a child's chronic condition on the functioning of two-parent families. *Journal of Pediatric Psychology, 32*, 417–426.

Ruddy, N. B., & McDaniel, S. H. (2008). Couple therapy and medical issues: Working with couples facing illness. In A. S. Gurman (Ed.), *Clinical handbook of couple therapy* (pp. 618–637). New York: The Guilford Press.

Rutter, M., Kim-Cohen, J., & Maughan, B. (2006). Continuities and discontinuities in psychopathology between childhood and adult life. *Journal of Child Psychology and Psychiatry, 47*, 276–295.

Trivedi, R. B., Ayotte, B., Edelman, D., & Bosworth, H. B. (2008). The association of emotional well-being and marital status with treatment adherence among patients with hypertension. *Journal of Behavioral Medicine, 31*(6), 489–497.

Chapter 13
Helping Couples Deal with Terminal Illness

Kristene A. Doyle

The goal of this chapter is to assist readers in understanding the complexities of working with couples when one partner is directly experiencing an illness with implications of death and the concomitant consequences, while both partners are both implicitly and explicitly facing emotional and practical challenges around this inevitable outcome. In a thorough review of the literature on this topic, it became clear that while there are significant cognitive, emotive, behavioral, and practical matters to consider and address, there is still a dearth of literature which addresses such matters, in particular with couples (Rolland, 1994). Furthermore, most of the literature on couple's therapy with terminal illness tends to focus on one spouse diagnosed with cancer. As such, this chapter addresses the psychological components couples face using a diagnosis of cancer as the framework. It should be noted that one could extrapolate that many of the suggestions and considerations in this chapter could apply to other forms of terminal illness. At the conclusion of this chapter, a case example is provided to demonstrate how a practitioner working with couples facing this circumstance can incorporate the concepts reviewed and highlighted throughout this chapter.

Issues Related to a Diagnosis of Terminal Illness of a Spouse

When two individuals make the decision to spend the rest of their lives together, many recite the vow of "in sickness and in health, …til death do us part." The days leading up to marriage and the months following are often the most exciting and enjoyable for many couples. It is very likely that few couples will spend any significant time contemplating the real, albeit unfathomable, prospect of one partner

K.A. Doyle, Ph.D., Sc.D. (✉)
Director, Albert Ellis Institute, New York, NY, USA
e-mail: krisdoyle@albertellis.org

A. Vernon (ed.), *Cognitive and Rational-Emotive Behavior Therapy with Couples: Theory and Practice*, DOI 10.1007/978-1-4614-5137-2_13,
© Springer Science+Business Media New York 2012

receiving a medical diagnosis with implications of death. While intuition or logic may intimate that a terminal diagnosis would have a more profound psychological impact on the "patient," it has been documented that often such a diagnosis results in more psychological distress on that of the partner as opposed to the patient (Carlson, Bultz, Speca, & St. Pierre, 2000). Additionally, Northouse, Dorris, and Charon-Moore (1995) indicated that there is a positive correlation between patients' and partners' level of distress, indicating that if one member of the couple is experiencing distress, the other member of the couple is likely to be undergoing a comparable level as well.

One factor that is often overlooked when considering the psychological adjustment to a terminal illness is the gender of the partner. When the partner is male, studies have shown that some of the best predictors of negative emotions at the time of diagnosis and thereafter include support within the marriage (Carlson et al., 2000). A lack of perceived support within the marriage has been shown to result in more anxiety and tension on the part of husbands. Thus, social support appears to be an important component in the adjustment or maladjustment of husbands when their spouse receives a terminal diagnosis. This finding is noteworthy for the practitioner working with couples facing terminal illness in both the assessment phase as well as the intervention phase in order to facilitate effective coping. On the other hand, when the patient is male, research suggests that the wife's ability to communicate about the illness and diagnosis can impact coping (Kalayjian, 1989). Interestingly, Lewis and Deal (1995) reported that couples coping with terminal illness have identified discussing the topic of dying as one of the most challenging. While this may be true, much of the literature on the topic of terminal illness within a couple suggests that communicating about the emotional and practical experiences of both the partner and patient plays a significant role in healthy adjustment and coping to the fatal diagnosis. Avoiding and/or escaping the couple's reality have not been shown to be an effective coping strategy for reducing distress and improving adjustment (Carlson et al., 2000). Therefore, it is important to assess whether or not couples are engaging in such avoidant coping strategies and if so, collaborate in the development of healthier alternative behaviors for managing the challenges they are facing, such as more open communication. Teaching assertiveness training and the use of "I" statements may be necessary when working with couples. The concept of emotional and behavioral responsibility will be highlighted while doing so. Having each member of the couple express how he or she feels about what is occurring (while at the same time avoiding blame of the other partner), as well as make a specific request of their spouse may prove beneficial in terms of coping.

Regardless of gender, there also have been reports that both husbands and wives of terminally ill patients identify heightened anxiety, depression, fear, sleep deprivation and sleep disturbance, as well as a general negative impact on their own health (Howell, 1986). Thus, targets of intervention that are addressed later in this chapter will include the *unhealthy negative emotions* of anxiety and depression as well as the *self-defeating behaviors* of sleep deprivation. While anxiety, depression, fear, and sleep deprivation are quite understandable given a terminal diagnosis, it is nonetheless important to address these emotions and behaviors to help achieve optimal coping during the most difficult of times for couples.

Treatment for Couples with a Terminally Ill Spouse

It should be noted that there has been a lack of empirical research examining the efficacy of couples therapy involving a terminally ill spouse (Mohr et al., 2003), as well as cancer specifically (Mi Baik & Adams, 2011). In response to this weakness, Mohr et al. (2003) examined the efficacy of an uncontrolled 8-week couple's intervention to determine if such an approach has merit and should be a consideration if faced with end of life/terminal illness of a spouse. Of note, the goals of couple's therapy for terminal illness in this study did not differ much from the goals of most forms of couple's therapy (i.e., distress reduction within the couple, enhancing communication between the couple, and improvement of intimacy). Treatment involved assisting the couple in providing one another with support and sharing concerns about death and dying. Results from this study indicated a significant reduction in patient distress about dying as well as the frequency of partner's worry about the patient dying, as well as improvement in the quality of the relationship. Due to the small sample size, one cannot generalize to the greater population. However, this study does suggest that further research should be conducted on couple's therapy for terminal illness (Mohr et al., 2003).

The most common empirically tested treatments for couples are behavioral couple's therapy and emotion-focused couple's therapy. The goals for behavioral couple's therapy include adaptive communication, conflict resolution, and problem-solving skills. Emotion-focused couple's therapy works towards reorganizing the couple's interpersonal patterns, taking into account each partner's needs for feeling secure attachment (Mi Baik & Adams, 2011). Attachment theory views humans as individuals whose goals are security and protection. Attachment theory describes adult love relationships as comprised of emotional connections, innate needs for safety and security, and bonds with significant others. In couples with marital distress, these components are lacking and often create anxiety, resulting in an escalation of attachment behaviors (e.g., one partner clinging while the other withdraws). The therapist will attend to such matters by confirming the needs of both partners while addressing subjects such as dependence, safety, trust, and being open to getting hurt (Johnson & Greenberg, 1995).

Helping Couples Deal with Psychological Distress

As previously mentioned, psychological distress is common in both partners when one is facing death. Obviously this is one of the most difficult situations couples must deal with in the course of their relationship. When working with couples regarding issues and emotions related to terminal illness and impending death, it is important to communicate to couples that they have every right to feel whatever it is that they are experiencing, but that some emotions (i.e., anger, depression, anxiety, and guilt) *are unhealthy negative emotions* that are counterproductive to the couple. Rational emotive and cognitive behavior therapists do not challenge an individual's emotions. Emotions are to be respected. It is critical, however, to make a distinction

early on in the therapeutic process between healthy (i.e., frustration/annoyance, sadness, concern, and regret/remorse) and unhealthy negative emotions. Once this task is accomplished, the therapist can challenge the irrational beliefs or cognitive distortions that are largely contributing to the unhealthy emotions. Several common distressing emotions, as well as interventions, are subsequently described.

Frustration Intolerance

One or both members of the couple often will experience *frustration intolerance* for uncomfortable feelings or circumstances (e.g., anxiety, uncertainty, anger, etc.). To address frustration intolerance, it is recommended that the therapist encourage the couple to express their emotions, thereby exposing them to what they *believe* they cannot tolerate as well as demonstrating that while they may not like the discomfort of the uncertainty of the future, they can and are enduring it, oftentimes quite well (Manne, Dougherty, Veach, & Kless, 1999). When couples avoid discussing their respective emotional experiences, they fail to learn that they can in fact cope with their emotions, as well as deprive their partner of the opportunity to support them.

Anxiety

Anxiety is also a common emotion experienced by couples facing terminal illness. Anxiety from a Rational-Emotive Behavior Therapy perspective is considered to be catastrophizing about some future event, and concluding that if that event were to happen it would be the end of the world (Ellis, 1998). Addressing anxiety in one or both members of a couple facing terminal illness is particularly sensitive and needs to be dealt with cautiously. In the case of terminal illness, or other types of trauma, for many clients it is or will be the end of the world and the worst thing that could happen. Preserving the therapeutic alliance is of utmost consideration. As such, challenging the belief that "this is awful that this is happening" is counter therapeutic and it is strongly recommended that it be avoided. It may prove more fruitful to demonstrate to the couple that *awfulizing about* what is happening (i.e., repeatedly telling oneself or the partner that this is the worst thing that could be happening) is not improving circumstances, is possibly preventing effective problem-solving, and perhaps creating additional problems on top the problems associated with terminal illness. In essence, the therapist is demonstrating to the couple that awfulizing serves no pragmatic use for them, while simultaneously avoiding the invalidation of their emotional experience.

Depression

In addition to anxiety, depression in one or both members of the couple will also be a target of couple's therapy. Beck's cognitive distortions of dichotomous thinking and overgeneralization are often seen in individuals presenting with depression. Dichotomous thinking in the case of terminal illness refers to the idea that if a cure for the illness is nonexistent, there is no point to pursue any meaningful activity. The therapist can work with either the patient or the partner to restructure this line of thinking with a coping statement such as, "While there may be no cure for my illness, I will make the most out of whatever time I have." One of the goals to help couples facing a terminal illness is to be in the moment as much as possible, for worrying about what is to come, or ruminating on what is happening, is robbing them of what they do and can have, meaningful time spent together. Overgeneralization refers to extrapolating limited experiences and evidence to broad generalizations (Beck, Rush, Shaw, & Emery, 1979). One of the biggest challenges facing couples with a terminal illness that often is a target of therapy is the inherent loss of independence and abilities in the patient (e.g., losing the ability to drive, unable to continue working, unable to participate in physical activity). The distortion of overgeneralization is seen when patients endorse some idea such as "If I can't drive anymore than that means I can't do anything." It is important for therapists to challenge this leap. It should be emphasized that sensitivity is especially important when addressing issues of loss of independence. Validation of the patient and partner's emotions is crucial, and there should be time allowed for both members of the couple to express their feelings without challenge by the therapist. Helping the patient to alter this overgeneralization by thinking "I may not be able to drive, and that is very disappointing, but I can still do other activities I enjoy" will assist the patient from being overly focused on one negative consequence of the illness while helping him or her refocus on the positive aspects of life at the current time (Edelman & Kidman, 2000).

Other cognitive distortions that may be present and contribute to depression include personalization, magnification, and emotional reasoning. Some patients receiving a terminal diagnosis may engage in personalization. In other words, he/she attributes causal blame for the diagnosis which is largely out of his/her control. There is an attribution of personal responsibility for the patient. Thinking "I got cancer because I was not as nice as I could have been to others" reflects personalization. RE & CBT therapists will want to assist patients and their partners in addressing this distortion and work towards Unconditional Life Acceptance, a concept that is quite difficult for many to grasp. Unconditional Life Acceptance (ULA), a term Ellis used in his writings (Ellis, 2004), refers to accepting life with all of the obstacles that come with it, especially those obstacles that are out of one's control to change. Unconditional Life Acceptance does not imply that couples *like* the terminal diagnosis. Couples that are able to achieve ULA acknowledge the reality of

what is happening, and choose not to demand it be different, thereby bypassing dysfunctional emotional disturbance. Essentially, ULA can be equated with an "it is what it is" philosophy. Magnification involves magnifying a situation to a point that it no longer corresponds to objective reality. This distortion can be tricky for therapists to challenge, depending on the stage of illness. Magnification at the end stages may not be a distortion, and would therefore best not be addressed. However, magnification at the early stages of illness may be a target of therapy. In the early stages, patients and/or partners may be catastrophizing (a subtype of magnification) about what is to come down the road, preventing them from enjoying the positives that still exist (e.g., the ability to take a long walk; the ability to go out for a nice dinner; the ability to intimately connect with their partner). It will be helpful for therapists to identify the negative aspects of catastrophizing, while at the same time being sensitive to the couple's perspective that the diagnosis is indeed a catastrophe. Finally, emotional reasoning involves believing what we feel to be indicative of reality (Beck, 1976). In other words, if I feel anxious then something bad is going to happen. In REBT terms, this is when we have a C (emotional consequence) looking for an A (activating event). Therapists will want to address this distortion by helping couples examine the evidence that every time they experience anxiety something bad has happened. Couples will soon realize that their emotions are not always indicative of reality.

Anger

In addition to frustration intolerance, anxiety and depression, couples therapy may need to target anger associated with the illness on the part of the patient and/or spouse. Ellis defined anger as stemming from demandingness and rigidity with oneself, others, and the world (Ellis & Tafrate, 1997). Thus, beliefs such as "This *shouldn't* be happening to me," "My spouse *should not* have to deal with this," and "Life is *unfair*" will likely lead to anger. As noted throughout this chapter, therapists who work with individuals or couples facing terminal illness need to pay special attention to preserving the therapeutic alliance, perhaps more than what one would do with other presenting problems. It is recommended that the therapist validate the strong *preference* of the member of the couple who is demanding that circumstances be different, while at the same time pointing out the reality of what is in fact happening. Empathy, warmth, and timing are key ingredients when intervening. Using a functional dispute such as "I understand and agree that life is unfair and that this shouldn't be happening, but unfortunately, the reality is that it is, and expecting or demanding it be different is not helping you cope and is hurting your relationship with your spouse" may prove most useful. In such instances, initially "joining" with the couple in their anger may communicate that the therapist is on their side and understands them. If the therapist intervenes too quickly, chances of a rupture in the therapeutic alliance are likely.

Other Interventions

Behavioral interventions for couples facing terminal illness may also prove useful in more effective coping. Relaxation training is a helpful strategy for members of the couple experiencing anxiety about the uncertainty of their death (Edelman & Kidman, 2000). Teaching the couple relaxation training in session, recording the script for them, and having them practice together and independently may assist in coping with their understandable stress and anxiety. A recommended progressive muscle relaxation script can be found in Goldfried and Davison (1994).

To address potential depression, couples are encouraged to engage in activity scheduling to avoid large gaps of time spent doing nothing, allowing for rumination. Activity scheduling involves the therapist and couple identifying activities they can engage in throughout the week, both as a couple as well as on their own. Exercise, depending on the stage of the illness for the patient, can be a helpful activity to help ward off depression and anxiety. It has been documented that exercise can be effective for depression and anxiety (Byrne & Byrne, 1993). It is important for the therapist to identify any practical or emotional obstacles that may impede performing such activities prior to the end of the session. Doing so will increase the likelihood that the couple is successful in engaging in their activities.

Problem-solving may also prove useful for couples facing terminal illness (Edelman & Kidman, 2000), especially when they are feeling a sense of hopelessness and helplessness. Typically in rational emotive behavior therapy, therapists first address the emotional disturbance in the client(s) (i.e., the emotional solution) before addressing practical problem-solving (Ellis, 2001). The rationale for doing so is that emotional disturbance in the form of anger, depression, anxiety, and guilt will make it more difficult for individuals to (a) think coherently to generate practical solutions; (b) be able to process and/or execute any solutions or suggestions the therapist proposes; (c) sometimes there is no practical solution to a problem. Engaging in cognitive restructuring may be the first step in working with couples facing terminal illness, but sometimes assisting them in problem-solving first may alleviate some of the helplessness and lack of control often experienced. When to engage in problem-solving in treatment will be decided based on the clinical judgment of the therapist as well as the couples' goals. It should be noted that each couples' experience is idiosyncratic, and treatment goals and plans should be made accordingly.

Other interventions that may prove helpful include bibliotherapy and journaling. Bibliotherapy can be therapeutic for both the terminally ill client and the spouse in that selected pieces of literature can validate feelings and experiences of others who have been down this road before. Depending on the selection, bibliotherapy can convey to the spouse who will at some point be the survivor that although difficult, life does go on and people do recover from grief. Journaling can be an effective way to express feelings if communicating them verbally proves difficult, as it did for the couple in the case study. Another form of journaling, letter writing, may be another way for the couple to communicate how they are dealing with this difficult situation. Both members of the couple could write letters to each other in order to express

thoughts about their relationship to this point, including things they wish had been different or better, as well as what they will miss most about their partner and their life together.

Depending on availability, support groups or grief groups may be a viable option. In such as group the couple could relate with others who are going through a similar experience, which can be very therapeutic. It is important to find groups that are compatible with the RE&CBT philosophy because sometimes groups of this nature focus primarily on catharsis without an emphasis on the importance of cognitions in moderating negative emotions.

Case Study Demonstrating the RE&CBT Couples Therapy

By way of background, the couple was a 32-year-old male diagnosed with Glioblastoma Multiforme (an aggressive form of brain cancer with no cure) at age 31 following a first-time seizure. The wife was 34 years old with a background in Cognitive Behavioral Therapy. The couple had been married for 9 months when the husband had his first seizure, and at the time of diagnosis had been married for just over 1 year. The wife was notified by the brain surgeon of the diagnosis following biopsy and she was left to inform her husband of the results.

Approximately 15 min following the news that her husband had a terminal illness with a typical lifespan of 18 months following diagnosis, she met with her husband in his hospital room to discuss the results. A concerted attempt was made to provide the information in a manner that did not suggest danger, a need for heightened concern, or most importantly, the ultimate outcome of such a diagnosis. She told him he had a brain tumor and they were going to get the best medical treatment available and that they would get through this together. She purposely did not share the statistics with him at this time, or throughout the trajectory of his illness. The couple joked about having cancer and the wife internalized that this humorous approach, while not for everyone, was going to be how they coped as a couple. It is noteworthy that throughout the course of the illness, neither partner discussed his impending death. Rarely did they discuss with one another how they were feeling emotionally about what was happening. While there is a body of literature suggesting that communication between couples should be a primary focus of couples therapy (McLean & Jones, 2007), this particular couple implicitly chose to avoid open discussions of the illness and its affects. It was only in the early stages of diagnosis that at times the husband would ask his wife if she wanted to move on and meet someone new because she didn't deserve this. It was only during these times that the couple together was most emotional and verbal with one another about what was happening. The husband's perceived sense of burden to his wife was highlighted during these times and a source of distress for him. This sense of burden to others has been shown to be linked to other psychological variables, including depression and anxiety (Wilson, Curran, & McPherson, 2005).

Approximately 8 weeks following diagnosis, the husband was having both manic and depressive symptoms related to the brain tumors themselves, the medication he was taking, and/or the practical effects of the diagnosis (i.e., no longer being allowed to drive; forgetting things; no longer working). Given her background in Rational Emotive and Cognitive Behavioral Therapy, the wife thought it prudent to seek out assistance from an objective therapist to discuss some of the issues they were facing as a couple. Specifically, the goals of therapy were to address the following:

- Hostility from the husband in response to his lack of independence following diagnosis;
- Anger towards his wife for what he considered was her being a martyr;
- The wife's anxiety about her husband's sometimes erratic behavior given the tumors, medications, and general understandable frustrations.

The couple met with a cognitive behavior therapist specializing in cancer diagnoses to address these concerns.

Although the wife believed her husband could benefit from individual therapy to address his emotions and behaviors as a result of his illness, she also believed they needed some immediate assistance as a couple in learning more effective ways to cope. Prepared to eventually have her husband do individual therapy, she decided to first try and receive some guidance for them as a couple and then intended to phase herself out of couples therapy. When asked by the therapist why they were there for the session, the husband reported he didn't know- that it was his wife's idea. The husband was clearly frustrated and angry, and this appointment, that he was "forced" to attend, was yet another example of how he was no longer permitted or capable of making his own decisions. The wife took the lead on addressing some anxieties she had, including her husband's understandable yet still concerning anger at not being allowed, per doctor's orders, to do certain activities, most notably, driving. The therapist attempted to address and validate the husband's frustrations about this privilege being taken away, while at the same time trying to educate him on the reasons for such a decision. The cognitions contributing to the husband's anger were also addressed. Through Socratic questioning, it was uncovered that the husband believed he *should* be able to drive, that this *should not* be happening to him, and that he couldn't stand all that was happening. A cautionary note for the reader—challenging the idea that *this should not be happening to him* would most definitely have lead to a rupture in the therapeutic alliance, and the therapist was astute and avoided such a path. While on an empirical level it may be true that there is no evidence that supports the idea that 32 year olds should *not* be diagnosed with terminal illnesses or that it does not logically follow that because one does not *want* something to happen it therefore *must* not, challenging this would lead many clients to the conclusion that their therapist is a cold and disconnected individual. The most helpful approach that was taken in this instance given the information provided was the functional/pragmatic dispute: The therapist asked the husband if it was helping him or hurting him to keep telling himself that he *should* be able to drive, that this *should not* be happening to him, and that *couldn't stand* what was happening. The therapist was successful at helping the husband to connect how demanding his

reality be different than it actually was only resulted in his emotional response of anger and his behavioral response of being verbally aggressive towards his wife, none of which was changing his ability to drive or his medical diagnosis. In addition, the therapist provided a semantic dispute to challenge the husband's frustration intolerance (FI). The therapist explained that if the husband really could not tolerate or stand what was happening to him, he would not be in his office discussing all that was happening. By challenging the husband's semantics (i.e., tolerate, can't stand) and illustrating to him that he was indeed tolerating what was happening and doing an impressive job to say the least, helped result in the husband's relinquishing some of his irrational beliefs. Note that the term *frustration intolerance* (FI), rather than the term l*ow frustration tolerance* (LFT) was used purposefully again to avoid a sense of invalidation or a possible alliance rupture. It was not that the husband had LFT with all that he was dealing with; rather, his situation required even higher tolerance than what he was already demonstrating. Making an emotional shift from unhealthy anger to extreme, yet functional frustration then allowed the husband and wife to engage in some practical problem-solving around the issue of driving. The husband was shown that while not ideal, he could still maintain some of his independence, although it would require some flexibility on his part in how he viewed the term and degree of independence. Homework was assigned to the couple to identify alternative means of travel for the husband other than driving himself, in addition to rehearsing the following coping statement: "It is not helping me to demand or expect my situation be different than it is at the moment. I don't like not being able to drive, but I can and am tolerating it."

The next session addressed the husband's anger towards his wife for acting like a martyr. When asked to clarify what he meant by "martyr," the husband revealed that he believed his wife was overly sacrificing her life for his, which was making him angry. The therapist corrected the husband and reiterated the concepts of emotional and behavioral responsibility, stressing that it was up to both members of the couple to determine how they were going to feel and behave, largely depending on how they viewed the events that were happening. The husband saw that he was demanding that his wife not be so sacrificing for him. When asked how the wife felt about being referred to as a martyr, she responded feeling angry and hurt with her husband. She was able to identify her demand that he not tell her how to act in response to this situation, as well as the idea that he should understand this is what partner's do for one another, in sickness and in health. Time was spent disputing the demands of both members of the couple, and there were even some moments of laughter as the couple looked at one another and referred to each other as hypocrites. The husband responded to his wife, "Hey, I have brain cancer. What's your excuse?" Homework was given to the couple to watch for their demands of each other and if and when they popped up, to help one another by pointing out to the other what was happening and help to modify the demands to preferences.

Finally, the issue of the wife's anxieties about her husband's erratic behavior was addressed. The therapist had the challenge of validating her concerns of potentially harmful behaviors while at the same time not reinforce the unhealthy, dysfunctional anxiety. Most would agree that it is understandable for her to be anxious about her

husband's manic behaviors as they were at times quite dangerous (e.g., jumping out of the car as she drove with him when he became frustrated with something she said). Some might even challenge the notion that her anxiety was quite healthy. However, upon further examination by the therapist, it was clear that her anxiety was impairing her ability to concentrate while driving as well affecting the way she talked to her husband, which led him to become more frustrated (thereby increasing the possibility that there could be a car accident or he would jump out into moving traffic). She was also experiencing difficulty concentrating at work and was finding it hard to sleep at night because she was afraid that her husband might leave the bed and go out on his own (this did in fact happen and he was found to be at a bar downtown with his friends after midnight). She also was having difficulty taking care of herself physically (i.e., eating regularly and properly) because she was so overwhelmed with anxiety and the "what if" game she played incessantly in her mind. After the therapist had her list the behavioral consequences of her anxieties, he discussed the concepts of catastrophizing and awfulizing and how they contributed to her experience of anxiety. It was emphasized that although the average person would probably have similar anxieties given the circumstances, that did not mean that it was healthy for neither she as an individual nor they as a couple. The therapist avoided challenging the idea that a diagnosis of GBM was awful, or that *not* driving was horrible, with the intention of maintaining the alliance. What one perceives to be as awful or terrible is an arbitrary conclusion, and disputing what is horrible for a client can be very invalidating. The more suggested route is challenging the functionality of catastrophizing about what is happening; bypassing the definition of what is awful. The homework assignment that the couple collaborated with the therapist on involved the wife rehearsing the coping statement: "Telling myself over and over that… (whatever is happening in the moment) is horrible does not help me optimally manage what is in front of me." In addition, the husband and wife were encouraged to contact their doctor and discuss the recent change in behavior to identify potential reasons as well as ways to ensure safety.

After only three sessions, the husband and wife determined that they met their identified goals and learned and developed the skills necessary to cope with their situation. Together they decided that individual sessions for the husband were more of a priority. Although the couple acknowledged they could have benefitted from additional sessions to work on communication skills, the therapist respected the various emotional and time demands the couple was experiencing. Individual therapy for the husband was pursued. The husband indicated that having experienced therapy within the context of working as a couple, he was motivated to continue therapy focusing on individual issues and goals.

As noted at the beginning of the case study, the wife had a background in Cognitive Behavioral Therapy. She in fact was trained as a rational emotive and cognitive behavioral therapist. As such, many of the concepts the therapist discussed were not new for her. However, she did acknowledge that all the training she had in RE & CBT did not prepare her for her emotional responsiveness and irrational beliefs that manifested following the diagnosis. This is an important point as it highlights that all humans, irrespective of their profession, training, or experience, have

the ability to think irrationally and respond emotionally and behaviorally in an unhealthy manner. It is important for therapists to validate this tendency, while at the same time highlighting the self-defeating nature of it. It is also important for therapists to assess for meta-disturbance (secondary disturbance) in couples. In other words, the therapist in this case study should determine if the wife was "beating herself up" for making herself anxious because she knows that getting anxious only creates more problems, and better yet, she does this for a living and should "know better." The philosophies of Unconditional Self-Acceptance, Unconditional Other-Acceptance, and Unconditional Life-Acceptance are important to work towards when working with couples experiencing a terminal illness.

Conclusion

Many of the interventions discussed in this chapter are well-supported cognitive behavioral interventions for use with individuals. The use and efficacy of couple's therapy when one member is facing terminal illness, in the case of this chapter, cancer, has not been well documented. It is clear that more research is needed to determine what aspects (e.g., therapeutic alliance, interventions, etc.) of couple's therapy may prove beneficial.

The topic of terminal illness in therapy, be it individual, couples, or group, is not an easy one for either therapists, patients, or partners. It taps into existential issues of the meaning of life, one's purpose, etc. that many humans grapple with. The practitioner would benefit from remembering that we are all human beings first, therapists second, and rational emotive and cognitive behavior therapists third. The intervention strategies discussed in this chapter should be applied with care, caution, sensitivity, and timing. A cognitive dispute is only as good as its delivery. Validation of a client's experience is essential in any form of therapy with any problem being addressed. However, in the case of terminal illness, special attention should be paid to validating the emotional experiences both in and out of session for each member of the couple. The interventions discussed in this chapter should never trump one's clinical judgment about what is best for the couple in the moment.

References

Beck, A. T. (1976). *Cognitive therapies and emotional disorders*. New York: New American Library.

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York: The Guilford Press.

Byrne, A., & Byrne, D. G. (1993). The effect of exercise on depression, anxiety, and other mood states: A review. *Journal of Psychosomatic Research, 37*(6), 565–574.

Carlson, L. E., Bultz, B. D., Speca, M., & St. Pierre, M. (2000). Partners of cancer patients: Part I. Impact, adjustment, and coping across the illness trajectory. *Journal of Psychosocial Oncology, 18*(2), 39–63.

Edelman, S., & Kidman, A. D. (2000). Application of cognitive behavior therapy to patients to have advanced cancer. *Behaviour Change, 17*(2), 103–110.
Ellis, A. (1998). *How to control your anxiety before it controls you*. New York: Kensington Publishing Corporation.
Ellis, A. (2001). *Overcoming destructive beliefs, feelings, and behaviors*. New York: Prometheus Books.
Ellis, A. (2004). *The road to tolerance*. New York: Prometheus Books.
Ellis, A., & Tafrate, R. C. (1997). *How to control your anger before it controls you*. New York: Kensington Publishing Corporation.
Goldfried, M. R., & Davison, G. C. (1994). *Clinical behavior therapy*. New York: Wiley & Sons.
Howell, D. C. (1986). The impact of terminal illness on the spouse. *Journal of Palliative Care, 2*(1), 22–30.
Johnson, S. M., & Greenberg, L. S. (1995). The emotionally focused approach to problems in adult attachment. In N. S. Jacobson & A. S. Gurman (Eds.), *Clinical handbook of couple therapy* (pp. 121–141). New York, NY: The Guilford Press.
Kalayjian, A. (1989). Coping with cancer: The spouses perspective. *Archives of Psychiatric Nursing, 3*, 166–172.
Lewis, F. M., & Deal, L. W. (1995). Balancing our lives: A study of the married couples' experience with breast cancer recurrence. *Oncology Nursing Forum, 22*, 943–953.
Manne, S., Dougherty, J., Veach, S., & Kless, R. (1999). Hiding worries from one's spouse: protective buffering among cancer patients and their spouses. *Cancer Research, Therapy and Control, 8*, 175–188.
McLean, L. M., & Jones, J. M. (2007). A review of distress and its management in couples facing end-of-life cancer. *Psycho-Oncology, 16*, 603–616.
Mi Baik, O., & Adams, K. B. (2011). Improving the well-being of couples facing cancer: A review of couples-based psychosocial interventions. *Journal of Marital and Family Therapy, 37*(2), 250–266.
Mohr, D. C., Moran, P. J., Kohn, C., Hart, S., Armstrong, K., Dias, R., Bergsland, E., & Folkman, S. (2003). Couples therapy at end of life. *Psycho-Oncology, 12*, 620–627.
Northouse, L. L., Dorris, G., & Charon-Moore, C. (1995). Factors affecting couples' adjustment to recurrent breast cancer. *Social Science and Medicine, 41*, 69–76.
Rolland, J. (1994). In sickness and in health: The impact of illness on couples' relationships. *Journal of Marital and Family Therapy, 20*(4), 327–347.
Wilson, K. G., Curran, D., & McPherson, C. J. (2005). A burden to others: A common source of distress for the terminally ill. *Cognitive Behaviour Therapy, 34*(2), 115–123.

Chapter 14
Helping Couples Deal with Parenting and Grandparenting

Ann Vernon and Dom DiMattia

A young mother paces the floor as she tries to get her newborn baby to stop crying. In the next room, her husband struggles to deal with their 2-year-old's temper tantrum. Both parents are frustrated and annoyed because they are sleep deprived and overwhelmed. They haven't had any couple time for months and there is a great deal of tension in their relationship. Despite having read numerous books on parenting and trying many different approaches, nothing seems to be working. They just wish their children came with a set of detailed instructions.

Ironically, parenting is certainly one of the most important jobs that exists, and certainly one of the most challenging. Once you sign on, parenting is a full-time job for life. While it can be very rewarding when things go well, parents often feel like failures when things go awry. Unfortunately, there is a lack of formal training for parents, so couples embarking on this venture may feel uncertain and insecure about assuming this responsibility. Others might cling to the myth that parenting is innate and they should instinctively know what to do and then feel guilty and inadequate when they find out that what they assumed might be an easy task is more difficult than they thought it would be. And while it is probably fair to assume that most parents are generally well meaning when it comes to raising children, their emotional disturbances can interfere with their ability to be effective (Vernon, 2009b). Therefore, no matter how many Internet sites they consult or how many parenting

A. Vernon, Ph.D., Sc.D., RLPC (✉)
University of Northern Iowa, Cedar Falls, Iowa, IA, USA

Albert Ellis Institute, New York, NY, USA
e-mail: ann.vernon@yahoo.com

D. DiMattia, Ed.D.
The Univeristy of Bridgeport, Bridgeport, CT, USA

The University of Northern Iowa, Tucson, AZ, USA
e-mail: dimattia@fastmail.fm

A. Vernon (ed.), *Cognitive and Rational-Emotive Behavior Therapy with Couples: Theory and Practice*, DOI 10.1007/978-1-4614-5137-2_14,
© Springer Science+Business Media New York 2012

books they read, having information and doing something about it is often easier said than done because irrational beliefs in the form of demanding, need for approval, low frustration tolerance, and self-condemnation interfere with their ability to deal with their anger, anxiety, guilt, frustration, and other troublesome emotions.

Likewise, being a grandparent can present challenges because they are on the outside looking in, so to speak. They are usually not in control of the decisions their children make regarding childrearing, and their beliefs might be in conflict with those of the grandchildren's parents. While grandparents can share their wisdom and offer suggestions based on their own experiences as parents, in the final analysis, they are not in charge. Furthermore, their children may resent what they perceive to be the grandparents' interference, and numerous conflicts can arise not only regarding childrearing philosophies and practices but also over boundaries, the amount of time spent together, and so forth.

The purpose of this chapter is to present information about how therapists can help couples deal with issues pertaining to parenting as well as to grandparenting. Because strong negative emotions have been shown to be directly related to the many irrational beliefs which parents and grandparents hold, the major focus of this chapter is on irrational beliefs that interfere with the ability to be an effective parent or grandparent, with some emphasis on parenting styles and practices.

Irrational Beliefs

Albert Ellis developed the concept of irrational beliefs and began applying this theory to parenting in the 1960s, maintaining that to be an effective parent, parents must learn to identify and challenge the irrational beliefs that interfere with effective parenting (Ellis, Moseley, & Wolfe, 1966). Vernon (2009a) described the following irrational beliefs that have a significant negative impact on parents' emotions as well as their behaviors:

Self-downing—Parents readily place demands on themselves, expecting that they should be perfect in their role as nurturers and caretakers. They think that if their child has problems or performs poorly, it is a reflection of their poor parenting. Consequently, they equate their self-worth as parents with their child's performance. Not only do they condemn themselves if they don't perform well in their parenting role and rate themselves as terrible parents, but they also think that they *must* have the approval of others with respect to their parenting. Likewise, grandparents can place similar expectations on themselves and behave in ways that will hope will "guarantee" love and approval from their children or grandchildren and putting themselves down if they don't receive it.

Demanding. Demanding parents require their children to behave perfectly at all times and think that it is awful if they don't behave as they *should*. Demanding parents have little tolerance for children who misbehave and they become angry and resentful when children fail to abide by their rigid and unrealistic standards.

Low frustration tolerance/discomfort anxiety. Parents who adhere to this irrational belief think that their children should not have to endure any hardship or discomfort, and they also think that parenting should be easy—they shouldn't have to experience any frustration or discomfort as parents.

To illustrate the first irrational belief, Kaleb and Angie have an out-of-control teenage daughter named Larissa. Angie is afraid to enforce the rules because she thinks her daughter would hate her for doing it, and she can't stand the thought of that. Kaleb goes along with his wife because he doesn't want her to disapprove of him and he can't stand the thought of conflict between them. At the same time, both parents think they should know how to control their adolescent and they feel guilty and inadequate as a result. Kaleb's parents also figure into the equation. They are in total disagreement with the way he and Angie let Larissa get by with everything and they have voiced their opinion on several occasions, even to the point of offering specific suggestions about what they think these parents should do, which of course is in dire opposition to what Angie thinks is right. This creates tension between Angie and her in-laws; she is angry because she thinks they shouldn't interfere. On the other hand, Kaleb feels anxious because he needs his parents' seal of approval on his performance as a parent. He feels caught between a rock and a hard spot; if he avoids conflict with Angie and Larissa, he puts his relationship with his parents in jeopardy.

This short vignette also illustrates the second irrational belief, the demand on others. Angie thinks that her in-laws *shouldn't* interfere in their lives and she is angry with them for doing so. Instead of judging them so negatively, her belief is that the in-laws should treat her and Kaleb with respect and not question the way they parent. When they voice their opinions and suggestions, Angie can't stand to be around them and thinks they are awful people. Furthermore, she and Kaleb both think their daughter *shouldn't* be so defiant and hard to handle. It's not fair that they have to put up with this when they are certain that other parents of teens have it so much easier.

The third belief, low frustration tolerance (LFT) and discomfort anxiety, results from parents or grandparents demanding that executing their respective roles should be easy and hassle-free and that neither they nor the children should have to experience any discomfort, inconvenience, or frustration. Applied to the vignette, one can easily see how Angie and Kaleb endorse this belief about raising their teenager: it *shouldn't* be so hard, it *shouldn't* be so frustrating, and at times they *can't stand* the inconvenience of having to modify their behavior in order to keep their daughter under control; why should they have to stay home and miss out on time with their friends in order to make sure Larissa obeys her curfew? They certainly didn't bargain for this and they don't know how they are going to get through these teen years because it is almost intolerable to be around their daughter.

As these short examples illustrated, irrational beliefs resulted in multiple problems: preventing the parents from implementing effective discipline strategies, negatively impacting the relationship between the parents and grandparents, and creating tension in the marital and parent–child relationship. Another consequence

is that if beliefs of this nature are verbalized or manifested through behaviors, children are quick to pick up on this, which can influence how they deal with issues.

Nobody said that raising children is easy, and parents in particular have a lot of uncertainly because they often don't know what will be the outcome of anything they try, since children don't come with operating instructions. Most parents, like Kaleb and Angie, think that they *should* know what to do and what the outcome will be—and if they don't, they aren't good parents. And, if their child has emotional or behavioral problems, that really proves that they are terrible parents who couldn't do anything right. But as Ellis and colleagues (1966) pointed out long ago, parents aren't the only influence on their children, especially in today's society with so much available with the click of a mouse. When parents assume the blame for everything related to their child, they feel guilty, worthless, and incompetent. Therapists need to help them learn to accept themselves as fallible human beings who will try their best but inevitably make mistakes because children are also humans with different temperaments and sources of influence. They must convey to parents that they should try to do the best they can but they can't control every aspect of their children's lives. And if the inevitable happens and their children don't turn out perfectly, the parents aren't worthless.

Other cognitive distortions that have a negative impact on parenting and grandparenting (adapted from Beck, 1988) include the following: overgeneralizing (things will never change; our daughter/granddaughter will always be a troublemaker), arbitrary inference (she's acting this way because she hates us), catastrophizing (nothing could be worse than having a child who behaves like this), minimizing (so what if she's only 14 and stays out all night without us knowing where she is; it's not a big deal), negative labeling (she's so lazy), or personalization (when my daughter talks back to me, I deserve it because I'm a lousy parent). Some parents or grandparents also have discomfort anxiety, previously referred to, that interferes with their ability to allow the child to be independent because they are so afraid that something bad will happen to the child or that he or she will be in an uncomfortable situation that would be intolerable. This contributes to "helicopter" parents who hover over their children to make sure that they don't experience anything that might be too difficult or uncomfortable. For example, if the child forgets to take lunch money to school, parents or grandparents drop everything and rush to school to rescue him or her from probable starvation if he or she had to go without lunch. Or, parents might demand that their adolescent be switched to a different class when the teen complained that the teacher was strict and mean. Unfortunately, this doesn't help children become more responsible or learn to tolerate discomfort or frustrations which are inevitable in this world.

Irrational beliefs have a significant impact on how we feel and behave as parents and grandparents. In the following paragraphs, information on specific negative emotions that correspond to irrational beliefs is described.

Negative Emotions

An underlying premise of Rational-Emotive Behavior Therapy (REBT) is that negative feelings are a direct result of irrational beliefs and distorted cognitions (Ellis, 2001; Dryden, DiGiuseppe, & Neenan, 2003). Furthermore, there is a distinction between healthy and unhealthy feelings; healthy feelings result from rational beliefs and unhealthy feelings such as depression and guilt, anger, and anxiety are attributed to irrational beliefs. Parents and grandparents alike need to learn how to manage these negative emotions.

Depression and Guilt

Therapists frequently hear parents put themselves down, saying that if they had only done such and such their child would have turned out differently. Their guilt stems from the irrational belief that they should know exactly what to do and that they should be capable of raising a highly functioning child. Guilty parents incorrectly assume that if they make a mistake it will always negatively affect their children and that they should be able to prevent their children from having problems. Guilt can be cyclical, involving grandparents as well. If the parents make a decision regarding their child that doesn't meet with the approval of the grandparents, they may experience even more guilt because now they have let down their parents as well as their child. Parents who harbor excessive guilt think that they are the sole cause of their child's problems and if they make mistakes in childrearing it may ruin their child. Guilt can easily result in depression, characterized by thoughts such as the following, modified from Joyce (2006, p. 209):

- You are not a good parent or grandparent if the child has a lot of problems.
- Your worth as a parent or a grandparent depends upon the child's performance.
- If others think you're a poor parent or grandparent, you're worthless.
- If the child misbehaves frequently, you are a failure as a parent or a grandparent.
- If the child does not love you, you are worthless.
- When you don't perform as you think a good parent or grandparent should, you are a complete failure.
- It is awful if you make mistakes as a parent or a grandparent and it proves your worthlessness.
- When the child misbehaves, it is because he or she doesn't like you.
- You must have your parents' approval to be a good parent.

Anger

Anger is one of the strongest negative emotions parents experience and comes from the demand that children must always behave according to parents' expectations (Vernon & Al-Mabuk, 1995). It is reasonable and desirable to have expectations, but anger results when those desires are escalated into demands. When parents are angry they often say or do things that they may later regret, and in the heat of anger, it is impossible to solve problems. Naturally parents will get angry occasionally because they are human beings with other responsibilities and stressors in life in addition to childrearing. However, parents who firmly hold onto the belief that their child *should* behave a certain way or *should* get perfect grades or be the best athlete or ballerina will most likely get angry when things don't turn out as expected. Practitioners working with parents need to help them recognize the following irrational beliefs that result in their anger (Joyce, 2006, p. 208):

- Children must always do well and behave correctly.
- It is awful when children do not do well, misbehave, or disobey.
- Children should always behave as you expect them to; they must do what you demand.
- Children who act badly are bad children and must be punished.
- Children should treat their parents fairly and considerately at all times.

Anxiety

Anxious parents and grandparents are not only anxious about their own performance, but they are also anxious *for* their children: they must make sure that their children or grandchildren are never hurt or in danger or uncomfortable. While it is normal to want to keep children safe from harm, overanxious parents and grandparents stifle their children's natural tendency to explore their world, taking reasonable risks that help them develop. They think it would be terrible if something bad happens to the child. While nobody wants anything bad to occur, most things are not that terrible and bad things can happen even when parents are being vigilant. Not only do they feel anxious if something bad happens, but they also feel guilty, thinking that they should have done something more to prevent the misfortune. Other beliefs of anxious parents and grandparents include the following (Joyce, 2006, p. 208):

- If I'm not always anxious about my child's welfare, that proves I'm a bad parent or grandparent.
- It would be awful if others were critical of my parenting or my grandparenting.
- If something is too difficult regarding parenting or grandparenting, it should be avoided; conflict is intolerable.

This last irrational belief ended sadly for a parent who was too anxious to confront her teenage daughter who had been sneaking out of the house with her boyfriend at

night. The mother also didn't want conflict with her husband who she knew would be furious with her for not addressing the issue, so she didn't tell him that this had been going on for some time. Unfortunately, one night while she was anxiously waiting for her daughter to sneak back into the house, she received a phone call from the police informing her that her daughter had been in a serious accident. Now, on top of the anxiety about her daughter's safety, she felt guilty and depressed. To complicate things even further, her husband was angry, blaming her not only for being too lenient but also for the accident.

While parents might have the most intense negative emotions, grandparents who are raising their grandchildren most likely experience these emotions quite strongly as well. They may be more anxious about doing the right thing because they are older, or they may feel more of a need for their grandchild's approval and be more lenient. In the final analysis, whether working with parents or grandparents, practitioners need to help their clients reduce the intense negative emotions by helping them think more rationally and also understanding how their style of parenting or grandparenting is affected by how they think.

Parenting Styles

Needless to say, not all people parent or grandparent in the same way. Some adopt the patterns of their parents because they think it is the right thing to do or they don't know of an alternative. Others may behave in an opposite manner because they felt their parents were overly strict, unfair, cruel, or perhaps too permissive. What parents and grandparents alike need to realize is that as children grow older, they may need to modify their style or methods so that they are more age-appropriate (Nelson & Lott, 2000; Vernon, 2009a).

Issues may arise when grandparents disapprove of the way their grandchildren are being raised, or parents may disapprove of how the grandparents interact with their children. For example, Lynda and Mark had strict rules about bedtime for their 5-year-old twins and were very firm about restricting sweets and only giving their children healthy snacks. They felt that the grandparents should adhere to the same rules as they did at home, and a major conflict erupted when the grandparents didn't enforce bedtime and allowed the children to have candy and sodas which Mark and Lynda felt were in excess. Another issue was that Mark and Lynda really did not want their children to get everything they wanted, but when they were at Grandma's house, they always came home with trinkets and toys. Mark and Lynda tried to discuss the issue, but Lynda's parents said that that's what grandparents do—spoil their grandchildren. Obviously there was a significant difference in childrearing styles, with the parents being firm but reasonable and the grandparents being overly permissive. The issues became more serious when Mark wanted Lynda to tell her parents that they couldn't see the children unless they adopted their childrearing approach, which caused conflict between Mark and Lynda and between Lynda and her parents. Lynda and her mother finally agreed to go to counseling, where the

therapist facilitated a discussion about their individual perspectives of childrearing, starting with what they agreed on. As it turned out, Lynda had been making some assumptions about the degree to which her parents were permissive, and the grandparents also had some misunderstandings about Lynda and Mark's parenting style. After several sessions, they were able to work on some acceptable guidelines that they both could live with. Four styles of parenting, which also apply to methods grandparents use, are subsequently described.

The Permissive Style

Permissive parents or grandparents are caring but conflict-avoidant, thinking that it is easier to give than argue or cause a scene—if they let things go, everyone will be happier. With this style there are usually very few rules, and those that exist are unclear and inconsistent. They adhere to the belief that punishment is wrong and that children should be free to do what they want (Vernon, 2009b). An example of a permissive style would be telling a teenager to be home by 10:00 p.m. but never doing anything about it when he or she comes in at 11:00. Consequently, children learn that rules have little meaning or consequence and may think that their parents or grandparents really don't care what they do. While it may seem as if children (and especially adolescents) would thrive on this style, the fact is that when adults are too permissive, children get anxious because rules aren't clear or consistent and they don't have a safety net with some structure to fall back on. Developmentally they may not be able to handle all the freedom and more often than not would rather have reasonable limits and know what is expected of them (Vernon & Clemente, 2005). The permissive style impacts children negatively because they do not develop self-control or learn to take responsibility for their actions.

The Authoritarian Style

Authoritarian parents and grandparents are strict and harsh, believing that getting angry is an effective way to make children behave and to modify their behavior. They have very rigid rules and employ harsh discipline techniques to make their children behave. Grandparents in particular may have been raised in an era where physical punishment was rather commonplace. Adults who adopt the authoritarian style think that children shouldn't misbehave or disagree with their elders, but if they do, their bad behavior must be punished. They do not think that children need praise or rewards, and they believe that the adults are always right and have the power to make the children behave as they so desire.

Anyone who has been a parent or a grandparent knows that children will misbehave because they are not perfect, but strict parents or grandparents have little tolerance for this. Those adhering to this parenting style do not express much support or caring or show physical affection.

I (first author) remember giving a workshop on parenting and distributing a checklist to help parents identify their style. One man boasted about how he learned to obey his father because he got whipped if he misbehaved. He went on to explain that that was what he did with his children too. Others questioned him, asking if he really thought it was effective to instill fear in children as a means of getting them to obey. He rigidly defended his position, saying that he learned right from wrong and although he had been afraid of his father when he was growing up, he still felt it was the right way to parent.

Just as the permissive parenting style can result in anxiety on the part of the child, authoritarian parenting begets fear and resentment. Although the children may be well behaved, it comes with a price because the parent–child relationship is very tense. These children may ultimately succumb readily to peer pressure, suffer from low self-worth, and do poorly in school (Vernon & Al-Mabuk, 1995).

The Ignoring Style

Ignoring parents or grandparents put their own needs first because it is too hard or too much hassle to stay involved in their children's lives. They consider their children a bother and don't think they *should* have to expend much effort in parenting or grandparenting. These children receive very little guidance and certainly do not feel loved or cared about. Consequently, they often go to extremes to get adults to notice them, failing at school, acting out at home, or engaging in delinquent behaviors (Vernon & Al-Mabuk, 1995).

The Authoritative Style

Authoritative parents and grandparents have reasonable rules and consequences. They are firm but loving, are supportive, and believe in collaboration and reasonable control (Vernon, 2009b). Authoritative parents and grandparents do not adhere to rigid beliefs. They are logical, consider the facts, and invite communication with the children, depending of course on age. Authoritative parents and grandparents are kind and caring. They have clear expectations and explanations and discuss behavior with the child, helping him or her develop tolerance for the inevitable frustrations of life by setting realistic limits and thinking well of the child even when he or she misbehaves. "I love you but I don't like how you are behaving" is the message they give to their children. Children raised with this parenting style feel secure, confident, and respected. They are self-reliant, have higher self-esteem, perform better in school, and have more positive social skills (Karpowitz, 2000).

Nelson and Lott (2000) differentiated between short-term parenting that is discouraging and long-term parenting that is encouraging. Short-term styles are similar to the authoritarian, permissive, and ignoring methods which take power away from

children. In contrast, long-term parenting is kind and firm, similar to the authoritative style that provides opportunities for children to learn and grow.

Managing Emotions, Not the Child

Quite frequently when parents and grandparents are trying to manage a misbehaving child their focus is on getting the child to do what they want in the quickest possible way. It is unreasonable to expect a child to listen when a parent or a grandparent is angry, anxious, and/or hysterical. As therapists, we must help them learn to focus on their own behavior and emotional reactions first and then they will be in a better position to implement strategies that might bring the child under control. The first question parents or grandparents should ask themselves is: "How am I feeling right now?" Once they recognize that they may be getting angry or feeling anxious, guilty, or depressed, they need to learn how to manage their emotions, first by understanding how they reached that level of intensity.

Identifying Beliefs

In order to effectively manage one's emotions, it is essential to identify the irrational beliefs and distorted cognitions that cause them. As previously described, irrational beliefs in the form of demands against self and others, along with discomfort anxiety and LFT, result in anger, guilt, depression, and anxiety that interfere with parents' and grandparents' ability to effectively manage their child's or grandchild's behavior. For instance, if parents are in the supermarket and their child is throwing a tantrum, they may start to get anxious when they attempt to stop the tantrum because they think that all the other shoppers will be looking at them and disapproving of the way they are dealing with it. Their belief, "We must be approved of by others and if we aren't, it means there is something wrong with us" is irrational, and the idea that all the other shoppers will be looking at them is an overgeneralization that contributes to their anxiety. Furthermore, where is the proof that they are bad parents even if others disagree with the way they handled the situation? Challenging these irrational beliefs and distorted cognitions will result in a more rational belief system that will keep them calm in these unpleasant situations and then allow them to implement parenting strategies that will be more effective.

Disputing Beliefs

A major task for the therapist working with parents and grandparents is to teach them how to dispute their demands and catastrophic thoughts and replace them with more helpful thoughts. If they are able to do this effectively and consistently, they

will eventually change their belief system, which will in turn reduce the intensity of their emotions and help them stay composed when their children are misbehaving. They then will be able to calmly implement contingencies which over time will help manage their children. However, they also must realize that their children are individuals who ultimately will do what they want and not what their parents or grandparents want. No parenting approach program is foolproof.

There are four types of disputes that are helpful relative to parenting and grandparenting: functional or pragmatic disputes, empirical disputes, logical disputes, and philosophical disputes (Dryden & Branch, 2008).

Functional or pragmatic disputes. The functional or pragmatic dispute is used to help parents or grandparents evaluate whether their current interventions are working or helping solve the problems. For example, Michael and Angela are parents of a teenager who doesn't do his homework. They have tried reminding him repeatedly, grounding him, yelling at him, and threatening to take away his e-mail and cell phone, all to no avail. They need to ask themselves questions such as: "How are your current practices helping you manage your son's behavior?" "How does getting angry and frustrated and yelling or threatening work for you?" " Do your strong emotional reactions help you think clearly and implement reasonable contingencies?"

Empirical disputes. Empirical disputes ask parents or grandparents to check the facts and evidence that their belief is true, moving from assumptions to facts. For instance, Juan Diego is a single father raising a daughter. He is a strong believer in high academic achievement and was extremely angry when his daughter failed her chemistry test because he thinks this will become a pattern in other classes as well and ultimately jeopardize her chances of getting into college. Furthermore, he is embarrassed that she has a nose ring and has red stripes in her blond hair and thinks she is a misfit. Disputes such as the following could be helpful to this father: "Where is the evidence that just because your daughter failed one test in one subject she will fail everything from here on?" "Where is the evidence that your daughter won't get into college because she failed one test or even several?" "Where is written that if child has a nose ring she is a misfit?" "Prove to me that there is nothing worse than having a daughter with streaks in her hair."

In addition, therapists will want to teach parents and grandparents not to awfulize: "Can you think of anything worse than having a daughter who occasionally fails an exam?" "Is it really *so* terrible that your grandchildren don't want to pick up after themselves?" "Is it the end of the world if your son or grandson doesn't do his homework?" Disputes of this nature help parents and grandparents put problems in perspective.

Logical disputes. The purpose of a logical dispute is to help clients stop escalating preferences into demands. This should be helpful to Martha who is upset about her daughter's refusal to do her homework as soon as she comes home after school because she wants to Skype with her friends. The therapist can ask Martha, "How logical is it for you to think that just because *want* your daughter to do her homework as soon as she gets home that she will do it?" "How logical is it for you to get angry about this … does it motivate her to get it done?"

Philosophical disputes. These disputes are designed to challenge the rigid absolutistic beliefs which parents and grandparents hold. They challenge the "should and musts" or the catastrophic attitudes which lead to extreme emotional reactions and poor decision making. For example, Dora is a grandmother who takes care of grandchildren, ages 8 and 10, everyday after school at the children's home. It has become very stressful for her because she wants the house to be picked up when her daughter comes home from work, but getting the children to do this results in a battle every time. By the time her daughter gets home, Dora is almost in tears and the children have shut themselves in their rooms and refuse to talk to her.

Disputes such as the following would be helpful to Dora: "Why must the children always behave like you think they should?" "Do you think you can live with the fact that they will disagree with you at times?" "How awful is this?" By challenging her beliefs in this way you are helping the parent or the grandparent become more flexible and move from *shoulds* to *preferences*, making it easier to implement behavioral strategies that might be successful in resolving the problem.

Analogies and Metaphors

It is often helpful to use analogies and metaphors to help parents and grandparents change their rigid beliefs. When they are very perfectionistic and think that their children or grandchildren should not make mistakes it is helpful to point that even elite athletes make mistakes and are still considered very successful. If parents or grandparents are feeling guilty because they behaved harshly with the child or the grandchild, use the metaphor of the peach. If a peach has a bruise, does it mean that the entire peach is rotten? Therefore if parents or grandparents make a mistake does it mean that they are rotten or worthless?

Coping Self-Statements

As parents and grandparents are learning to change their beliefs, which realistically takes time, it is helpful to help them develop specific coping self-statements or phrases to help them stay calm in difficult situations (Ellis & MacLaren, 1998). For instance, they could write the following on index cards and keep them visible to help them remember to stay calm: I don't need to correct every mistake my child or grandchild makes, my child or grandchild does not have to be happy all the time, I am not a bad parent if my child is unhappy with me, if my grandchild doesn't listen to me now it doesn't mean he or she will never listen to me again, and being a teenager is a stage and my son or daughter will outgrow this rebellious stage.

Effective Child Management

Once parents and grandparents have effectively reduced the intensity of their negative emotions they are better able to implement practical problem-solving strategies in the areas of discipline and communication in particular. Several approaches that practitioners can share with their clients who present with parenting and grandparenting issues are subsequently described.

Discipline

Unfortunately, discipline is often equated with punishment, but in reality it is very different. According to Nelson, Lott, and Glenn (2007), discipline is about caring and helping children learn appropriate behavior, self-discipline, responsibility, and cooperation. Punishment, on the other hand, is often delivered in anger and uses blaming, scolding, shaming, and harsh physical punishment to stop negative behavior. Punishment, which is characteristic of the authoritarian parenting style previously described, is not effective and has a negative impact on the relationship between the child and his or her parents and grandparents.

Obviously children and adolescents need rules and consequences that will change somewhat depending on their age. An effective strategy is to implement logical consequences, which are arranged by the caregiver, relate to the specific problem, and are respectful and reasonable (Nelson et al., 2007). Adults administering the consequences should be calm and not deliver the message in an angry tone. They should make sure that they can follow through with the consequence and make certain that the consequences aren't dangerous or detrimental to the child. Logical consequences involve choice language: "You have a choice … you can stop playing with your food or leave the table now and not have anything to eat before bedtime." If the 7-year-old says she will stay at the table and then within a few minutes resumes the inappropriate behavior, the adult should calmly say, "I see that you have made a different choice so you will need to leave the table now." If the child kicks and screams, a new consequence can be delivered: "You have a choice; you can leave quietly or spend the rest of the evening in your room. Which do you choose?"

It is important to determine that the consequence will have its desired effect before administering it. For example, a parent told his teenager that she needed to be home by 11:00 p.m. on Friday and Saturday nights and if she wasn't, she couldn't go out the next night. She never went past her curfew on Friday nights, but Saturdays were a different story … she would often come in an hour or two late. Finally her parents realized that it was of no consequence to her if she couldn't go out on Sunday because she just went to church youth group and she didn't even like going! They modified the consequence so that Saturday night applied to the following Friday night and the problem was solved.

This approach will not work if parents are stubbornly hanging onto irrational beliefs such as: she shouldn't misbehave, I can't stand her behavior, or she should know better, which usually results in anger. When angry, it is difficult to remain calm, which sabotages the effectiveness of this strategy.

Time-out is another technique that is especially effective with younger children. While time-out does not teach children how you want them to behave, they do learn that their behavior is not acceptable and it gives them a chance to cool down and think about what they did that resulted in this isolation. The time-out area should be in a boring place so that the child wants to modify his or her behavior in order to do something more enjoyable.

Communication

Thomas Gordon (2000) identified effective communication skills that facilitate more positive parent–child interactions. He first distinguished between *I messages* and *You messages*, noting that a *You* message is more accusatory and puts the child on the defensive, whereas an *I message* is a clear statement reflecting the parent's or the grandparent's requests or feelings. Clients should clearly be able to see the difference between the parent who says to the child, "You stop that; you should know better," versus the grandparent who says, "I don't like the way you are behaving and I would like you to stop acting this way."

Unhelpful communication techniques include warning and threatening, ordering and commanding, moralizing, advising or giving suggestions, blaming and criticizing, and ridiculing or shaming. Practitioners can help their clients give up these ineffective methods and teach them how to use active listening, which is "opening the door for the child to talk" (p. 58) by using phrases such as "tell me about it," "let's discuss it," "tell me the whole story," or "sounds like you have strong feelings about this" (p. 56). Although it may seem unnatural at first, employing active listening and *I messages* can greatly enhance communication between adults and children.

Case Study

Amy and Josh are parents of two children, ages 4 and 6 years. They both work hard to make ends meet and the children are cared for during the day by Amy's mother. They are very frustrated because Grandma never disciplines the children and believes they need constant love and approval since their mother and father are not with them daily. She was a stay-at-home mom and thinks her daughter should be as well, despite the fact that Josh and Amy have made it very clear that they both have to work in order to adequately provide for their children. Because Grandma has very few rules at her house, the children are very unruly when they return home each day.

Amy feels guilty about having to leave them but is also angry at her mother for not maintaining some control over the children. Josh is also angry because he wants peace and quiet after a hard day at work and often takes his anger out on the children, but then feels guilty for overreacting and indulges them or gives them special attention. Josh and Amy have tried to set some rules for the children but have never been able to consistently follow through because they are tired and frustrated and it seems to be too much hassle because the children don't respond as they think they should. In order to create a more consistent pattern of behavior the therapist needs to help the parents and grandmother manage their own emotions by changing their irrational beliefs. Let's deal with each person at a time.

Amy's Irrational Beliefs

- I am a bad mother because I have to leave my children.
- My mother should support me more by controlling the children.
- It should not be so hard to get these children to obey our rules.
- Our children should be easier to control.

Amy's beliefs keep her angry and guilty, so her behavior is very inconsistent. The therapist can help her dispute these beliefs as follows:

- Prove that you are a bad mother because you have to work.
- Does the fact that you work automatically make your children misbehave?
- Why must your mother manage the children so your life will be easier?
- Where is written that raising children should be easy?
- Are your children deliberately making your life difficult or are they just being children?

Josh's Irrational Beliefs

- I must have peace and quiet after a hard day at work.
- The children should be easier to manage.
- The children will behave if just give them some love and attention.
- Amy's mother should be more firm with the children.
- I can't deal with the children after a hard day at work.

Josh's beliefs keep him irritated and angry most of the time and the therapist can use disputes such as the following:

- How reasonable is it to expect peace and quiet with a 4- and 6-year-old at home?
- Why MUST you need peace and quiet?

- Where is it written that childrearing should be easy?
- Prove that love and attention alone will teach your children to behave.
- Why must Amy's mother manage the children better to make your life easier?

Grandma's Irrational Beliefs

- I must give the children love and attention because their parents are too busy to give them enough.
- As a grandmother, I have the right to spoil the children.
- It would be awful if the children were unhappy with me.
- I cannot stand to see the children unhappy.

Grandma's irrational beliefs keep her from managing the children effectively. The therapist could help her dispute them as follows:

- Is there any evidence that children of working parents need extra love and attention?
- Where is it written that grandmothers have the right to spoil children?
- What awful thing would happen if the children were unhappy with you?
- Is it realistic for children to be happy all the time?
- What's the worst thing that would happen if you said no to them?

Once these beliefs are effectively disputed, the emotional intensity will be reduced, making it much easier for the parents and grandmother to implement more effective discipline and communication strategies with the children.

Conclusion

In today's society, couples are increasingly faced with challenges related to raising children. Homes, once dominated by traditional two-parent families, now consist of single-parent, intergenerational, blended, and never-married couples. Children are growing up in a more complex world with a high prevalence of poverty, crime, and violence, as well as changing societal values. Parents and grandparents alike struggle with contemporary stressors that can result in emotional distress and impact the nature of their relationship with their children and grandchildren.

In this the authors have addressed the importance of dealing with emotional problems by helping couples identify and challenge irrational beliefs that interfere with effective parenting and grandparenting. Parenting styles that correspond to specific beliefs and feelings were described, as well as communication and discipline techniques that facilitate more positive interaction. Case studies illustrated application of concepts based on RE&CBT principles.

References

Beck, A. T. (1988). *Love is never enough: How couples can overcome misunderstanding, resolve conflicts, and solve relationship problems through cognitive therapy*. New York: Harper.

Dryden, W., & Branch, R. (2008). *The fundamentals of rational emotive behaviour therapy* (2nd ed.). West Sussex, England: Wiley.

Dryden, W., DiGiuseppe, R., & Neenan, M. (2003). *A primer on rational emotive therapy* (2nd ed.). Champaign, IL: Research.

Ellis, A. (2001). *Overcoming destructive beliefs, feelings, and behaviors*. New York: Prometheus.

Ellis, A., & MacLaren, C. (1998). *Rational emotive behavior therapy: A therapist's guide*. Atascadero, CA: Impact.

Ellis, A., Moseley, S., & Wolfe, J. (1966). *How to raise an emotionally healthy, happy child*. New York: Institute for Rational Living.

Gordon, T. (2000). *Parent effectiveness training: The program for raising responsible children*. New York: Three Rivers.

Joyce, M. (2006). A developmental, rational-emotive behavioral approach for working with parents. In A. Ellis & M. E. Bernard (Eds.), *Rational emotive behavioral approaches to childhood disorders: Theory, practice, and research* (pp. 177–211). New York: Springer.

Karpowitz, D. H. (2000). American families in the 1900's and beyond. In M. J. Fine & S. W. Lee (Eds.), *Handbook of diversity in parent education: The changing faces of parenting and parent education* (pp. 3–12). San Diego: Academic.

Nelson, J., & Lott, L. (2000). *Positive discipline for teenagers: Empowering your teen and yourself through kind and firm parenting* (2nd ed.). Roseville, CA: Prima.

Nelson, J., Lott, L., & Glenn, H. S. (2007). *Positive discipline a–z* (2nd ed.). Rocklin, CA: Prima.

Vernon, A. (2009a). Working with parents. In A. Vernon (Ed.), *Counseling children and adolescents* (4th ed., pp. 427–456). Denver, CO: Love.

Vernon, A. (2009b). *More what works when with children and adolescents: A handbook of individual counseling techniques*. Champaign, IL: Research.

Vernon, A., & Al-Mabuk, R. (1995). *What growing up is all about: A parent's guide to child and adolescent development*. Champaign, IL: Research.

Vernon, A., & Clemente, R. (2005). *Assessment and intervention with children and adolescents: Developmental and multicultural approaches*. Alexandria, VA: American Counseling Association.

Chapter 15
Helping Couples Deal with Aging

Michael Hickey, James McMahon, and Margaret Swarbrick

There are several biological, evolutionary, and psychological theories of aging, generally found within the field of developmental psychology. However, a casual review of aging within developmental schemes beginning with Freud and proceeding to Vaillant (2002) offers little on how to help couples deal with aging. As the reader will note, Rational Emotive and Cognitive Behavioral Therapy (RE&CBT) have had their "aging giants," so to speak—Albert Elis, Aaron Beck, Arnold Lazarus, and others have served as role models for applying their theory to their aging process. Ellis urged that humans work against the "musts" of must get old, must sit back, must slow down, and similar absolutes. During an interview when he was 80 years old, Ellis quipped that he did not worry much about death and decline that comes with aging: he likened death to that condition which existed before he was born when there was no pain, no memory, and no feeling, so he refused to be afraid of death and instead opted for activity and creativity in spite of lifelong health difficulties such as management of diabetes and poor eyesight (Laidlaw & Pachana, 2011). In fact, Ellis (2004) felt that RE&CBT had much to offer to help people deal with the aging process, claiming when he was 90 that he had no doubt that he would recover from recent serious surgery and probably work another 90 years!

M. Hickey, Ph.D. (✉)
Albert Ellis Institute, New York, NY, USA
e-mail: michael.hickey@albertellis.org

J. McMahon, PsyD., Ph.D., Th.D., Sc.D.
State University of Oradea, Oradea, Romania

Abert Ellis Institute, New York, NY, USA
e-mail: bjpsymac@comcast.net

M. Swarbrick, Ph.D. OTR, CPRP
Collaborative Support Programs, New Jersey Institute for Wellness
and Recovery Initiatives, Freehold, NJ, USA
e-mail: pswarbrick@cspnj.org

A. Vernon (ed.), *Cognitive and Rational-Emotive Behavior Therapy with Couples: Theory and Practice*, DOI 10.1007/978-1-4614-5137-2_15,
© Springer Science+Business Media New York 2012

This chapter examines how RE&CBT can help couples deal with the physical and psychological changes due to aging, as well as from conditions such as stroke, arthritis, diabetes, and other ailments that are more commonly experienced as one ages. The transition to retirement for individuals and couples is also addressed, as well as the stress on a couple when one partner has to assume the role of caretaker. Following a review of RE&CBT techniques with older couples, a case study is presented and the chapter authors reflect on various types of interventions to address issues illustrated by this case.

The Concept of Aging

Without a doubt, the concept of aging is much more complex than in previous years where a linear perspective characterized the aging process, portraying older people as feeble, incapable of significant work, and lifeless (Hudson, 1991). Indeed, this viewpoint perpetuated the myth that there is little value in old age, and that beyond 50, there is an inevitable decline as the body, mind, and spirit begin to deteriorate. According to Hudson, this ageist attitude "robs thousands of people of enormous possibilities that they are capable of attaining as they get older" (p. 33).

Goldsmith (2009) argued that there is yet no specific theory explaining this change process called *aging*, but instead presented three main theories: (1) physical and mental deterioration, or wear and tear theories; (2) disengagement or nonadaptive aging, a phase whereby the person acts out a mindset that began in midlife to slow down, retire, back away, and generally accept that the end of life is approaching; and (3) aging by design or self-adaptive aging, characterized by pursuit of activity, involvement, and continued influence and socialization.

The first theory merely indicates that as we age, our minds and bodies begin to deteriorate, albeit at different rates. But it is a well-known fact that as a society, we are living longer than ever. Recently, a National Institute on Aging report issued under the direction of Richard Suzman (2011) indicated that currently there are about two million Americans who have reached age 90, and that 8.7 million Americans are projected to do so by the mid twenty-first century. Longevity has been attributed to good nutrition and access to quality medical care. This longevity has not come without problems, however, including arthritis, diabetes, and cardiovascular and Alzheimer's disease, among others.

The second theory, disengagement, is akin to the notion that aging is a steady downhill decline; that the "good years" are over. As Hudson (1991) stated, "to be old is to prepare to die" (p. 33). As a consequence, elderly people who buy into this theory have little motivation, low self-esteem, and not much to look forward to. Lawrence-Lightfoot (2009) characterized this as a "depressing image of people slowing down, losing interest, and fading away" (p. 11).

The third category concerning active planning by elderly people has been championed historically by Robert Havinghurst and also by Bernice Neugarten, one of the pioneers of adult development. According to her obituary, Dr. Neugarten 2001 debunked disengagement myths and had been a long-time advocate of studying adult

Table 15.1 Selected data for comparison of the three cohorts of a longitudinal study on aging

	Harvard cohort	Inner city cohort	Terman women
Mean birthdate	1921	1930	1911
Date entered study	1939–1942	1940–1944	1920–1922
Number in study	268	456	682
% Dead last study data	38%	37%	37%
IQ average	130–135	95	151
Dead by age 70	23%	37%	20%
Mean income at age 50	$105,000	$35,000	$35,000

Note. Table adapted from Vaillant (2002)

development with the same fascination that we studied childhood and adolescence. In contrast to the disengagement theory, this third theory portrays aging as a multifaceted process that challenges some of the anachronistic images of aging. Instead of the "roll over and die," concept, the newer theory on aging is that the years between 50 and 75 or older can be generative and transformative (Lawrence-Lightfoot, 2009), characterized by exploration, new challenges and insights, and growth based on our wisdom and past experiences. This is a time, according to Whitbourne (2010) to take an honest look at life, assess your life journey to this point, take small steps to make changes if that is desirable or possible, and seek professional help if necessary.

From these three theories, then, there seems to be no set definition of aging, and as Vaillant (2002) noted the concept of aging is oxymoronic: there is physical decline, but it need not be psychological decline in terms of activity, creativity, and determination. The years between 50 and 75 are being studied in this century as a distinct phase of life that will expand our understanding of human development and potential for these people who are considered "neither young nor old" (Lawrence-Lightfoot, 2009). As Lawrence-Lightfoot noted, we are redefining our viewpoints about aging and challenging old myths and stereotypes.

Research About Aging: Implications for Couples Counseling

Vaillant, Director of the Harvard Study of Adult Development, described a three part longitudinal study that continues to take place, now in its sixth, seventh, and eighth decades for three cohorts: (1) 682 young female students in the Berkeley, California public school area where testing and interviews began, generally, under the leadership of Lewis Terman around 1920; (2) 268 Harvard undergraduate men which started, generally, under the leadership of Arlie Bock and Clark Heath around 1937; and (3) a control group cohort of 456 inner-city young men who were interviewed by Sheldon and Elinore Glueck starting around 1938. The purpose of this study was to look at how people age—how they "get to where they are" in their old age. Arguably, these cohorts represent the most comprehensive data on aging assembled, replete with interviews in developmental psychology. Vaillant (2002, p. 25) summarized the three cohorts as seen in Table 15.1.

The following are some important facts to understand regarding the cohort. First 99% of the participants were Caucasian and many of the women were stereotyped into roles that differed from their expressed vocational choices. In general, each participant was interviewed and had a physical examination every 2 years, although for the women it was every 4–5 years. Seventy-six (76%) of the Harvard cohort pursued graduate degrees compared to just 23% of the women (who interestingly tested significantly brighter than the other two cohorts) and 2% of the inner city group. Among the many significant findings from all cohorts were these pointed out by Valliant (2002, p. 13):

- A good marriage at age 50 predicted positive aging at age 80; surprisingly, however, low cholesterol levels at age 50 for couples did not predict positive aging at age 80 for couples.
- Healing relationships are facilitated by a capacity for gratitude, for forgiveness, and for "taking people inside" (by this metaphor, Vaillant meant becoming eternally enriched by loving a particular person).
- It is not the bad things that happen to couples that doom them: nurturing relationships with good people facilitate enjoyable old age.
- Alcohol abuse in a relationship consistently predicted unsuccessful aging because alcoholism damaged future social supports within and outside of the couple relationship.
- Learning to play and create after retirement plus learning to gain younger friends as one lost older ones added more to life's enjoyment than retirement income.
- Objective good health was less important to successful aging than subjective good health. Vaillant concluded that it was all right to be ill so long as one did not act sick.

Vallient also stressed that individuals and couples could change—and change positively at any age.

Concerning aging and marriage specifically using data from the Harvard men, Vaillant (2002) commented, "…for 28 men a happy marriage became unhappy following the onset of alcoholism; in only seven cases did alcoholism become obvious following a failing marriage. Second, divorce does not cause early death, rather alcoholism causes accidents and divorce and early death (p. 217)." He further commented, "In a large prospective community study divorced men and women were far more likely to die than the stably married…the divorced die more often only of illnesses made worse by the very factors that may have led to the divorce" (p. 217).

In other related research, Alex Kuczynski (2004) reported on some of the work by Claudia and David Arp who wrote several books on relationships and marriage. The Arp's work, including their writing as well as training seminars and workshops, focused on the importance of not dismissing many years invested in marriage and the importance of learning new ways to be creative during the older years in order to maintain a satisfying relationship. And while the evidence suggests that long term happiness is best achieved by having staying married, as well as having a healthy attitude, the divorce rate among seniors is on the rise, as Kuczynski's article *The 37 Year Itch* describes. Sadly, there seem to be no programs for helping older couples work on their relationship.

Changes and Challenges for Aging Couples

Throughout the life cycle human beings experience changes and challenges, but as we age, these take on greater significance as many of the changes are also associated with losses. Losses that aging couples typically experience include the following:

- Transitioning to retirement, which can result in loss of identity, fixed income realties and other challenges that impact the couple as one or both partners retire.
- Declining health of one or both partners, including chronic pain or dealing with other debilitating illnesses which, with aging, are more likely to be terminal.
- Death of parents, relatives, close friends, children, or life partners—as well as facing the inevitability of one's one death.
- Declining ability to perform activities of daily living (ADL)—self-care responsibilities such as hygiene, dressing, bathing, mobility, and ambulation.
- Declining ability to perform instrumental activities of daily living (IADL)—ability to do housework, prepare meals, take medications as prescribed, manage finances, shop, communicate through technology, and so forth.
- Declining mobility and independence, which may require relocating to assisted living or another type of care facility.

The changes and challenges listed above can impact overall wellness in eight dimensions: spiritual, occupational, intellectual, social, emotional, environmental, financial, and physical, as described in Table 15.2. At the same time, it seems clear that people who approach aging by capitalizing on wellness strengths such as maintaining healthy minds and bodies, good health habits, strong social networks, and a sense of meaning and purpose, may be less susceptible to the challenges of aging. Self-adaptive aging (see Table 15.2) can be an important focus in helping couples pursue activities in some or all of the eight dimensions of wellness to counteract or diminish the intensity of negative impacts of aging.

Self-adaptive aging can be facilitated when couples plan and pursue activities that counteract or diminish the intensity of negative impacts of aging (outlined in Table 15.1). Planning daily habits and routines with a focus on spending time together engaged in activities such as walking, pursuing hobbies, or leisure pursuit can counteract negative impacts of aging. Physical wellness, for example, can be improved by remaining active in practical tasks such as household chores, walking a pet, gardening, or engaging in mutually satisfying sexual activity. These activities often require some level of exertion that enhances agility and maintains mobility and circulation. Planning and preparing healthy meals together and supporting one another's efforts to self-monitor blood pressure, blood glucose levels, or weight are tasks that can lead to improved physical wellness. Couples should be encouraged to accompany one another to their primary care provider for regular screenings and checkups, as well as support one another in the management of any medical conditions that require care. Intellectual wellness can be enhanced by reading, doing crossword puzzles, or by researching hobbies or interests on the internet.

Table 15.2 Impacts of aging on wellness

Dimension	Impacts
Physical Wellness involves the maintenance of a healthy body, good physical health habits, good nutrition and exercise, and obtaining appropriate health care	Bodies age, often impacting hearing, vision, and ambulation as well as strength, flexibility, and balance. Health care becomes a bigger part of life activities. Pain becomes more common and chronic. Regular exercise becomes more inaccessible. Chronic pain can be emotionally challenging. Medical conditions require care and management, and multiple medications may increase risk for drug-drug interactions
Intellectual Wellness involves lifelong learning, application of knowledge learned, and sharing knowledge	Mental declines become more pronounced and cognitive status can change over time. Vision and other sensory losses can impact safety in the home and community, and participation in functional activities such as driving. Short term memory deficits impact new learning and sometimes safety and functional independence
Environmental Wellness involves being able to be and feel physically safe, in safe and clean surroundings, and able to access clean air, food, and water. It includes both our microenvironment (the places where we live, learn, work, etc.) and our macro environment (our communities, country, and planet.)	Reduced mobility and sensory faculties can lead to greater feelings of vulnerability to crime and accident. More time spent at home can lead sensory deprivation and impact the social and other dimensions
Spiritual Wellness involves having meaning and purpose and a sense of balance and peace	Stressors and losses can contribute to reduced sense of meaning, purpose, and value. This can impact hope and resilience, especially when recovering from a medical procedure, illness, or injury
Social Wellness involves having relationships with friends, family and the community and having an interest in and concern for the needs of others and humankind	Physical isolation and leaving the workplace all create greater social isolation. Reduced interaction with friends and family, and the perception of aging itself which carries a stigma, can negatively impact social and emotional well-being. Sense of connection and community can be impacted by losses and both role transitions and reversal
Emotional Wellness involves the ability to express feelings, enjoy life, adjust to emotional challenges, and cope with stress and traumatic life experiences	Stressors and losses contribute to anxiety, depression and self-medicating through use of alcohol or both over the counter or prescription medications. Decline of faculties, increased reliance on caregivers, possible reliance on public benefits, inability to drive, and institutional living can all contribute to reduced sense of empowerment
Financial Wellness involves the ability to have financial resources to meet practical needs, and a sense of control and knowledge about personal finances	Ending of career, loss of life partner, reliance on fixed incomes and assets, and the rising costs of healthcare can all lead to stress, strain and sometimes chronic stress leading to secondary medical conditions. Cognitive deficits impact memory, executive function, and ability to fulfill responsibilities such as paying bills, managing credit, and dealing with predatory scams that often target older adults
Occupational Wellness involves participating in activities that provide meaning and purpose, including employment, or pursuit of volunteer	Medical conditions resulting in disability impact employability. People leave their workplace, which offered identity, income, social support, and more. Declining heath and faculties can interfere with active involvement in purposeful activity

Note. Reprinted with permission from Swarbrick (2012)

In the following section, we discuss several changes and challenges impacting couples as they are.

Retirement

"Although retirement has been considered one of the most important later life status transitions, our knowledge of its psychological consequences is fragmentary" (Kim & Moen, 2002). These authors noted that this milestone signals the passage into later stages of adulthood and is much more than an objective transition because it impacts physical and psychological well-being as well. As with any transition, some individuals do not adjust well and may experience depression and other psychological disturbances (Kim & Moen, 2002), which can impact not only the individual, but the couple as well. Van Solinge and Henkens (2005) supported the notion that retirement impacts the individual as well as the couple, noting that this transition requires adjustment by both members of the couple.

Beliefs are a key factor in how individuals and couples experience retirement (Van Solinge & Henkens, 2005). This transition may either be a positive experience associated with reduced stress and greater freedoms, or as a negative event associated with loss of identity, role and status, as well as loss of purpose and mattering, among other things. There are also many variables related to retirement, including gender and culture, whether or not both partners had careers, the timing of their retirement, their economic resources, their sense of personal control, and the support of the partner (Kim & Moen, 2002). According to Kim and Moen, retirement is a relational transition in that the degree of emotional support from a spouse may be a mediating factor in how the transition is experienced. Their research suggested that men who are newly retired may experience less psychological distress if their spouses are still employed, and that women approaching retirement initially have higher levels of depressive symptoms and lower levels of personal control.

Clearly retirement is a significant transition that necessitates a change in roles, relationships, routines, and responsibilities (Schlossberg, 2009). As Kim and Moen (2002) and Van Solinge and Henkens (2005) emphasized, this adaptation is complex and is affected by the quality of the couple relationship, as partners influence each other in the adjustment process.

Physical Health Challenges

Physical health changes may include reduced strength, endurance, and/or reduced flexibility, as well as impaired balance and sensory changes which impact mobility, independence, and capacity to perform ADL and IADLs. Inability to perform these activities is known to have negative impacts on perception of self, sense of control, mastery, self-worth, and confidence. Table 15.2 depicts how declining physical health can impact overall wellness.

There are a number of physical health conditions associated with aging impacting the overall wellness, and three common ones are Cerebral Vascular Accident (CVA or stroke), Diabetes, and Arthritis. CVA is leading cause of death worldwide and adults age 55 and older are at greater risk (Miniño, Murphy, Xu & Kochanek, 2011). CVA is a medical emergency that can cause neurological damage and serious complications interfering with ADLs and employability and emotional regulation. Arthritis is another common painful condition, characterized by joint pain, stiffness impact on functional performance of ADLs, and has emotional and social effects that seem to worsen with age. Type 2 Diabetes Mellitus (T2DM) historically affected people in later life, though now is a worldwide crisis, driven almost entirely by modifiable health factors including diet and active engagement in physical activity. Type 2 Diabetes Mellitus can impact muscular range-of-motion and performance ADLs and IADLS. There is a complex "bidirectional relationship" between depression and T2DM, with diabetics having higher rates of depression, and depressed people having higher rates of T2DM (Bowser, Utz, Glick, & Harmon, 2010; Renn, Feliciano, & Segal, 2011). Sensory, motor and functional impairments impact the disability experience; however, perception of limitations may be a stronger predictor accepting limitations and movement towards active engagement and involvement in valued life activities and roles.

Couples can help one another self-monitor modifiable risk factors (smoking, weight, blood pressure, physical activity) and support efforts to improve lifestyle habits and routines. Supporting one another's active efforts to maintain functional independence can be shared goals. Couple's counseling can be beneficial in helping the couple adjust and adapt. Physical, occupational, or speech therapy or other short-term rehabilitative treatments for the affected individual affected, as well as caregiver training, can help restore ADL and IADL independence. Active involvement together in wellness activities which is mentioned later will be equally as important for adjustment to health and recovery.

Mental Health Challenges

Mental health seems inseparable from physical health and overall wellness. Depression and anxiety are concerns among older adults (Kastenschmidt & Kennedy, 2011), and are sometimes overlooked and untreated because they coincide with medical illnesses and/or are viewed as common responses to life events (e.g., loss of loved ones, loss of valued social roles, declining independence etc.). Late life depression is common and associated with disability, reduced quality of life, mortality, and high health care costs. Depressed older adults frequently encounter comorbid medical illnesses and cognitive impairment (Unützer, Bruce, & NIMH Affective Disorders Workgroup, 2002). Individuals who encounter anxiety, cognitive impairments, depression, and other mood disorders often neglect their own or their partner's needs and do not readily acknowledge these problems nor seek treatment. This is particularly true for older adults who are racially, ethnically, and culturally diverse (Alegría et al., 2008).

Older adults may not seek mental health services for a variety of financial, emotional or social reasons. They may deny or not recognize symptoms or the need for treatment. Untreated depression, anxiety, and substance use disorder in older adults contribute to significant disability, and increase the risk of hospitalization and institutionalization. Untreated depression creates a stronger risk for suicide, especially for men. Despite the availability of safe and effective treatment, mood disorders remain a significant health care issue for older adults and are associated with disability, functional decline, diminished quality of life, mortality from comorbid medical conditions, demand on caregivers, and increased service utilization (Insel & Chamey, 2003). Discriminatory coverage and reimbursement policies for mood and other mental disorders are a challenge, especially for people with modest incomes, and results in other perceived stressors and conflicts among older couples and family members.

Substance abuse among older adults is a looming public health concern. The number of Americans aged 50+ years with a substance use disorder is projected to have doubled from 2.8 million in 2002–2006 to 5.7 million in 2020 (Bartels, Blow, & Van Citters, 2005). Rates of treatment admissions involving primary use of illicit and misuse of prescription drugs have increased. Older adults appeared to be less likely than younger adults to perceive substance use as problematic and do not readily seek treatment or pursue help, which often impacts the couple's relationship as well as their physical health status.

Older adults with diabetes and depression are less likely to adhere to self-management, increasing their risk of complications. Habits such as poor diet and nutritional intake, inactivity, and alcohol and tobacco use contribute to the onset of chronic illnesses, while other habits such as medication compliance, a controlled diet and exercise program often assist in the treatment and recovery (or remission) of such medical conditions (Speer & Schneider, 2003).

Depression often coexists with multiple chronic diseases, which may complicate effective diagnosis and treatment (Druss & Reisinger Walker, 2011). In a study of 1,801 adults aged 60 or greater who presented at any of 18 primary care clinics, patients suffered from an average of 3.8 chronic medical conditions (Harpole et al., 2005). Arthritis, cardiovascular disease, hypertension, heart disease, diabetes, hearing loss, cataracts, pulmonary and respiratory conditions (Speer & Schneider, 2003) are common chronic conditions that have implications on subjective status in terms of physical and functional status. However, subjective perception is a stronger predictor of adjustment, adaptation and recovery.

Utilizing Wellness Activities

Active engagement in wellness activities is central for healthy aging, and to prevent or effectively manage the common conditions many older adults may have to contend with. Helping couples pay attention to their own and to their partner's modifiable risk factors, including but not limited to high blood cholesterol levels, high blood pressure, diabetes, smoking, weight issues, heavy alcohol consumption

and drug use, and lack of physical activity can be a very important. When affected, it is critical to help couples support one another to maintain independence in valued social roles and associated ADLs and IADLS. Helping couples remain active through "doing"—exercising the body and mind—is an essential focus. Active pursuit of valued social roles is important. Computer technology offers opportunities for couples to connect virtually and continue to use intellectual capacities as they age. Helping couples towards self-adaptive aging may be important for overall well-being and longevity.

Appearance and Body Function Changes in Aging: Implications for Couples

Changes in Physical Appearance

To this point, several health-related issues in the aging process have been covered. Attention is now shifted to the physical changes that occur in later adulthood. Change in body appearance is a normal part of the aging process. As individuals age, they may be more prone to weight gain, hair loss, increased wrinkles, and other physical changes (Williams & Wood, 2006). Along with these bodily changes come changes in body functioning which may impact the ability to remain active as well as changes in sex drive and sexual activity (DeLamatar & Sill, 2005). Change in physical appearance may serve as an activating event for depression and anxiety in some individuals and can have a significant impact on relationships (Oh & Damhorst, 2009). When working with couples in mid-to-late adulthood, it is important to consider the emotional impact of these changes and the effects it may have on the relationship. Assisting couples in understanding, accepting, and supporting each other with regard to changes in physical appearance can help to promote a healthy relationship.

When working with these issues, it is important for therapists to understand gender similarities and differences. Age has been determined to be a predictor of satisfaction of body appearance in both men and women, with a higher age corresponding to a lower level of satisfaction in body appearance (de Souto Barreto, Ferrandeaz, & Guihard-Costa, 2011). For example, Body Mass Index (BMI) has repeatedly been shown to be the strongest predictor of body appearance satisfaction for both older men and women (de Souto Barreto et al., 2011; Umstattd, Wilcox, & Dowda, 2011). Given this research, fostering acceptance of current weight in addition to providing weight loss/maintenance interventions will probably have an impact on both older women and men's satisfaction with their appearance. Furthermore, when undergoing age-related changes in appearance, research demonstrates that it may be beneficial to feel a sense of control over one's physical appearance, even if the chances for making the desired changes are low (Thompson et al., 1998). Additionally, those with less emotional distress may have a greater sense of

control over their appearance. This being said, utilizing both rational motivational self-statements (e.g., I care about my appearance and will do the best I can to look good), and planning physical health-related behavioral activities (e.g., walks, swimming, etc.) may allow for a greater sense of control over appearance, and thus increase overall satisfaction with appearance and positive emotion.

Though age has been found to affect satisfaction with physical appearance in both women and men, women tend to be more frequently dissatisfied than men with their weight, body, shape, and overall physical appearance (de Souto Barreto et al., 2011). This may be partially due to the societal expectations of unattainable beauty set forth by the media, which may be more readily apparent, and has been shown to foster anxiety in women in later adulthood (Saucier, 2004). Consistent with RE& CBT philosophy, values clarification, assertiveness training, and cognitive modification can be used to assist women in developing a more positive attitude about themselves as a valued partner in the couple relationship and perhaps even developing an individualized standard of beauty that can be shared with her partner.

In most women, menopause is a significant event in the aging process and can also impact beliefs about physical appearance. Body esteem has been found to be related to menopausal attitudes that are related to appearance (McKinley & Lyon, 2008). Specifically, having negative attitudes towards menopause or anxiety about aging may lead to greater dissatisfaction with appearance. It may be important to explore these issues in a couples counseling context, and to assist both the individual undergoing menopause and her partner work toward understanding and accepting of these changes, as well as to reduce emotional upset that may occur on both sides.

From a couples counseling perspective, it may be helpful to know that when examining beliefs about physical appearance, research suggests that reciprocity exists, where husbands evaluate their spouses' appearance in similar ways that wives evaluate their spouses' appearance (Oh & Damhorst, 2009). Furthermore, older husbands' rating of their spouses' physical appearance was found to be positively correlated with their wives' self-assessment of appearance and the same relationship was found in the reverse. This indicates that older married partners' favorable repair bid regarding each other's appearance over time may influence both partners' self-perception in a similar direction. It may therefore be helpful for therapists to provide a setting for couples to identify positive physical characteristics that they find in each other, which may help to not only provide a way to reconnect on an emotional level, but also may influence their own self-directed beliefs about appearance.

Changes in Body Functioning

As age increases, so does the shift from body appearance to body functioning, though this has been evidenced more consistently in women (Umstattd et al., 2011). This makes intuitive sense, as age tends to have a positive correlation with incidence of physical disability and chronic illness. There may, in fact, be a bidirectional

relationship between depression and body appearance satisfaction. For example, Umstattd and colleagues (2011) found that reductions in depressive symptoms were associated with increases in both body function and body appearance satisfaction and perception. Furthermore, body function satisfaction had a stronger impact on mental health, than changes in body appearance. This relationship was shown to be the strongest for older men, whose masculinity may often be culturally defined by amount of strength and ability to perform tasks.

Changes in body functioning, physical appearance, and hormonal changes such as menopause and erectile dysfunction can all have an impact on sexual desire and activity. Each case may vary, though therapists should assess for satisfaction with intimacy in the relationship. Though physical and hormonal changes are natural causes of change in sexual activity, beliefs about such changes can be addressed in RE&CBT couples counseling. First, it is important that irrational beliefs leading to shame, depression, or anxiety around sexual performance be explored. For example, decreased sexual activity due to lack of energy, fatigue or other chronic physical impairments may be misperceived as a lack of love or attraction by the other partner, thus leading to depression. A male experiencing sexual dysfunction due to the aging process may think, “I must get an erection and if I don’t it would be awful and I am no longer a man.” He will likely then experience shame and/or anxiety, even further lessening the likelihood of gratifying sexual activity. Examining and disputing such beliefs will help members of the couple better understand some of the reasons for their partners’ behavior and could help to decrease feelings of depression, anxiety, and shame which all can impede intimacy and sexual activity. If the sexual activity is limited due to physical causes, therapists can first encourage couples to move toward acceptance while looking for alternative ways to display intimacy or aids to help physiological performance. Pros and cons of seeking medical attention for conditions, and /or alternate practice strategies for self-pleasure can be explored.

Rational Emotive and Cognitive Behavior Therapy: Implications and Treatment Strategies for Aging Couples

As discussed in the various sections of this chapter, the aging process can activate a number of emotions that affect couples, both individually and as part of the relationship. According to RE&CBT philosophy, aging can serve as an activating event for a variety of unhealthy emotions. During the aging process, individuals and couples can experience a number of activating events ranging from declining health and physical changes to lifestyle changes such as retirement, caring for elderly parents, or being a caregiver for one’s partner. The views a person takes regarding the aging process as a whole, and the multiple components that are involved in it, will highly influence the psychological and emotional health of the individual and the couple.

As with any challenging life experience, change, or adversity, the A-B-C model of REBT can be applied to the aging process. When a person thinks about aging or is reminded about the aging process (A), he or she may begin to feel a number of unhealthy emotions (C’s) such as depression and anxiety in particular, two emotions

found to be common in the aging process (Laidlaw, 2010). Other emotions such as anger, jealousy, shame, and guilt may also be experienced in relation to the aging process. Of course, according to RE&CBT theory, it is not the aging process or its accompanying adversity, but rather the irrational beliefs and distorted cognitions regarding these situations that result in the unhealthy emotional experience. Fortunately, older couples may be at a slight advantage than younger couples in experiencing and managing unhealthy emotions. For example, age has been shown to be associated with improved emotional regulation; and furthermore, positive affect states remain stable throughout the lifespan (Hay & Diehl, 2011). In addition, rumination has been shown to decline with age in both men and women (Nolen-Hoeksema & Aldao, 2011). This may reflect a generational process where older adults have not been socialized into self-exploration and expression of feelings, or they may be better at avoiding activating events that cause rumination. Though these factors may provide some resilience, proper identification and challenging of irrational beliefs associated with the aging process should be addressed.

When asked in an interview about the types of irrational beliefs common in the later years of life, Albert Ellis identified demandingness, low frustration tolerance, and "awfulizing" (Ellis, Shaugnessy, & Mahan, 2002). Anxiety about death can be associated with beliefs such as, "I must not die, and my loved ones must not die" (p. 358). When speaking about the aging process, Ellis often urged individuals to identify and dispute their "shoulds" and "musts" and to replace them with rational beliefs that help to change anxiety and depression about aging to that of concern (Ellis, 2003). Handicaps, illness, loss of loved ones, and limited mobility due to aging were also identified as activating events for awfulizing and low frustration tolerance (LFT). For example, an individual may think, "I must not become older and it is awful that I have to deal with the challenges of aging, I can't stand getting old." This example demonstrates a combination of demandingness, awfulizing, and low frustration tolerance (LFT). With this type of thinking, an individual will likely become depressed, anxious, or angry regarding the aging process. It would be much better to think, "I'd prefer not to deal with the adversity of aging, but it is not 100% awful. Though I don't like it, I can stand it and focus on the things that I can still do while I am alive." This type of rational-emotive thinking will likely result in healthier emotions, such as sadness, disappointment, concern, and annoyance.

Ellis frequently commented on his own aging process and use of REBT to cope with aging, "The main thing I've done is to accept the unfortunate things I can't change, and to accept that I am lucky to have lived as long as I have" (Ellis et al., 2002, p. 359). He spoke about his adversity with health issues such as chronic diabetes, arthritis, and wobbly legs. "I wish like hell it weren't so, but I accept it as it is. I'd certainly prefer to be younger, healthier, and more agile like I used to be" (p. 359). Here, Ellis implied that the concept of acceptance was one of the keys to aging gracefully. It would be unrealistic to think that people would have a positive attitude regarding some of these challenges associated with aging, however the absence of a positive attitude does not necessarily result in a negative attitude and unhealthy emotion. When accepting the adversity that comes along with aging, there are no demands that it be different. Instead, we may prefer to not experience the illness or other adversity related to the aging process, without demanding that it not be present.

Research shows that positive views on aging are beneficial in the wake of a serious health event. Furthermore, a serious health event affects subjective health and life satisfaction to a lesser extent when perceived as on-time in life (Wurm, Tomasik, & Tesch-Römer, 2008). In other words, the more an individual accepts that illness and chronic health issues are a normal part of the aging process, the less disturbed an individual makes oneself. This reflects the well-researched idea that there is objective illness, but it need not be followed by subjective illness (McDonald-Misczak, Wister, & Gutman, 2001; Seligman, 2008). Emphasis on positive behaviors and cognitions rather than on illness can decrease the subjective experience of the illness.

With the increased amount of adversity experienced in the aging process, Ellis urged individuals to remain positive and focus on the advantages. He noted that certain positive experiences come with aging such as less daily stress of holding a job, freedom to travel, and less responsibility to partake in care-taking activities (Ellis, 2003). Individuals can choose to focus on the negative aspects of aging and feel miserable, or they can take advantage of the benefits while accepting the adversity.

It is probable that unhealthy emotional reactions activated by the aging process can interfere with relationships. In a study examining the effects of irrational beliefs on marital adjustment, Addis and Bernard (2002) found that self-downing and need for comfort emerged as the dimensions of thinking that were most strongly related to marital dissatisfaction. This demonstrates how the processing of aging can influence the interaction of couples, particularly with regard to need for comfort. Demands for comfort in the face of some uncomfortable aspects of aging are likely to lead to martial or couples dissatisfaction.

If even one member in the couple becomes more depressed, anxious, or guilty, it will likely impact the satisfaction and functioning of the relationship. Instead of aging gracefully together, individuals may become more unhealthily depressed, angry, or anxious. This then typically results in avoidance of enjoyable activities. Such avoidance behaviors can exacerbate both the emotional and physical problems that also make it more difficult for couples to share common positive experiences. At this point, couples may grow apart and become overly involved in their own unhealthy mindset. An accepting and rational attitude about the aging process, on the other hand, may facilitate support and emotional connectedness. The couple can engage in behaviors together and focus on what they can still do as opposed to what they can not. Research has demonstrated that a positive attitude about aging can increase positive health-related behaviors, such as exercise (Wurm, Tomasik, & Tesch-Romer, 2010). This may generalize to increased activity in other commonly shared interests.

Case Example

The following case study provides an example of a couple dealing with some of the issues discussed in this chapter related to aging. First, background information and the couple's presenting issues are outlined. Then a discussion about how RE&CBT

would be applied to this case and the expected outcome of these interventions concludes the chapter.

Betty (74 years old) and Stan (79 years old) have been married for 52 years. Betty is a retired school teacher and Stan, a former physician who had recently sold his medical practice due to declining health related to mild dementia. They have two adult children; their daughter lives nearby, and their son lives in a different state with his wife and two young children.

Though Stan is only in the earlier stages of dementia, the emotional impact is playing heavily on the couple. Before Stan sold his practice, Betty had become used to being retired and home alone for much of the time throughout the week. For the past 9 years, she took care of the household chores while Stan worked. With the changes in Stan's health and their new living situation, new pressures are being added to the daily life of the couple. Though Stan's dementia is not quite severe, Betty has been considerably anxious regarding the declining health of her husband. She is often checking in with him and providing reminders to do various household tasks. Stan has begun to isolate himself and spends much of his time alone reading in the office of their home. The couple has been growing apart over the past several months and has decided to seek couple therapy due to Betty's increasing level of anxiety, Stan's depression and anger, and their mutual dissatisfaction with the marriage at the present time.

In the assessment phase of therapy, it was quickly evident that both Stan and Betty were suffering from emotional issues that were affecting their daily life and their ability to communicate and relate to each other. It was revealed that Stan's depression was most likely a reaction due to the beliefs that he was a failure for having to give up his practice earlier than expected. The more Betty reminded him about picking up his belongings or other mundane chores like taking out the garbage, the more resentful and angry he became. When asked what he thought about this, Stan replied, "She shouldn't be making me feel like I'm an idiot. Maybe I am really worthless."

When examining Betty's belief system, a pattern of awfulizing fueled her anxiety and behaviors. "Stan's condition is only going to deteriorate and I won't be able to take care of him, the household and myself. This is a horrible situation." Her behavior of "nagging" Stan about everyday things appeared to be a source of brief escape from the anxiety she was feeling. This provided her with a false sense of control over the situation.

After making sure Stan was under proper medical care and obtaining consent to speak with his physician, the goal of the RE&CBT therapist in this case was to first show how each individual's belief system was contributing to his/her emotional disturbance. First, the therapist validated the difficulty of the situation and the changes that come with the process of this stage of life. Once rapport was established with the couple, the B-C connection was reviewed and the therapist helped to show that their individual belief systems were the sources of feeling anxious, depressed, and in some cases angry. The therapist disputed Stan's ratings of worth to help to show that there was much about his life that was worthwhile, despite the loss of his job and his role as primary provider and caretaker. When his beliefs were

revealed, Betty gained a better understanding of his anger and isolation. The therapist encouraged her to engage in the process of helping Stan change his belief systems. She offered many characteristics about Stan that were positive in nature and that helped him build a new acceptance of himself and also of his understanding that limitations are related to the illness. Stan was also soon able to give up his demand that Betty not be "nagging" him and the therapist helped him to reframe her behavior as being fueled by love and concern. He was still frustrated at times, but was able to feel less angry.

When working with Betty's beliefs, the therapist showed Stan that it was not her intention to belittle or nag Stan, but that her behavior was highly related to her anxiety and perceive lack of control over the situation. The therapist helped Betty accept the changes in Stan's health and her responsibilities as a challenge, while disputing that the situation was truly awful and intolerable. In addition, Betty initially perceived Stan's isolation as an indicator of his love and physical attractiveness to her. "I am no longer the attractive woman I used to be, he does not want to be near me because he is no longer in love and attracted to me." By assessing the belief systems of each individual in the context of marriage therapy, they were able to see that some of their assumptions were false. As the couple began to better understand each other, they started to develop empathy for one another, bringing them closer together.

Next, the therapist addressed the maladaptive chain of behaviors that was highly a result of each of the individuals' emotional disturbance and lack of understanding of each others' beliefs and emotions behind their behaviors. The couple was given behavioral homework assignments to address their individual issues and also to bring them closer together. Betty was challenged to give Stan a bit more freedom and to reframe from the constant checking and reminders, while Stan was asked to spend less time isolated in the office. With the therapist's suggestion, they agreed upon structuring a routine where they could do some of the household chores together. In addition, due to the accumulation of stressors, the couple had stopped doing some of the things they enjoyed together, such as going for morning walks and having movie nights on a regular basis. The therapist encouraged them to start doing these activities again, and the couple even planned a small trip to visit their son and grandchildren.

Ultimately, Stan was able to pull out of his depression and became less angry about his situation and about Betty's behavior. Though concerned, Betty learned that her anxiety was not going to change the situation and that her acceptance of the changes in routine and Stan's health served as a motivator to spend more quality time together while they still had the ability to engage in certain activities.

As a result of therapy, Stan and Betty were more harmonious as a couple and what they had learned was helpful to Betty as she eventually had to assume more of a caregiver role as Stan's dementia worsened and he began to develop more physical problems. Understandably, this was challenging for Betty who had to work hard to avoid awfulizing about Stan's illness, their lack of ability to leave the house much or to engage in pleasurable activities, and their future. She eventually did return to therapy to deal with some of these issues, as well as her increasing depression, fueled by such thoughts as "this existence is horrible; the future is hopeless, there's no point in anything anymore." The therapist was supportive in acknowledging the

difficulty of the situation, helped Betty challenge her depressing beliefs, and assigned various homework tasks such as practicing relaxation, taking some time for herself each week (after disputing Betty's belief that she shouldn't be selfish and shouldn't desert her spouse), and using rational coping self-statements.

Conclusion

As addressed in this chapter, the process of aging can present a number of challenges, including changes in physical health and appearance, increased susceptibility to chronic illness, coping with the illness and loss of friends and loved ones, and other major life changes and stressors such as retirement, and serving as a caregiver for an ailing spouse. The impact of such challenges have been linked to increased likelihood for emotional disturbance, particularly anxiety and depression. Given the pronounced impact on the individual, it is not surprising that the process of aging affects couples in numerous ways.

In arguably one of the most significant and highly cited research studies on aging, Vaillaint (2002) referenced a three-part longitudinal study, emphasizing its implications for the importance of healthy and nurturing love relationships on factors associated with a positive aging experience. Though there is research indicating the importance of healthy love relationships on aging, it does not imply immunity to the challenges that it can place on the relationship. It is therefore important that couples therapists understand the challenges that are unique to the aging process and integrate the knowledge, research, and techniques that have been proven to be effective for this population.

Albert Ellis, the founder of REBT and grandfather of CBT, has been a model of acceptance and coping when it comes to the adversities of aging. In both his personal life and his therapeutic approach, which emphasizes acceptance and tolerating frustration, Ellis has provided a personal model and therapeutic framework to assist individuals and couples in working through the aging process. The case study in this chapter demonstrated the effectiveness of an understanding approach to the challenges of aging for couples. Utilizing RE&CBT concepts, in particular the identification and disputation of erroneous beliefs about aging, can reduce emotional disturbance related to the aging process and allow the couple to foster an understanding and nurturing relationship as they progress into a new stage of their lives and deal with the challenges unique to later adulthood.

References

Addis, J., & Bernard, M. E. (2002). Marital adjustment and irrational beliefs. *Journal of Rational Emotive and Cognitive-Behavior Therapy, 20*, 3–13.

Alegría, M., Chatterji, P., Wells, K., Cao, Z., Chen, C. N., Takeuchi, D., Jackson, J., & Meng, X. L. (2008). Disparity in depression treatment among racial and ethnic minority populations in the United States. *Psychiatric Services, 59*(11), 1264–1272.

Bartels, S. J., Blow, F., & Van Citters, A. (2005). Substance abuse and mental health among older Americans: The state of the knowledge and future directions. Substance abuse and mental health services administration. Retrieved April 7, 2012 from http://gsa-alcohol.fmhi.usf.edu/Substance%20Abuse%20and%Mental%20Health%20Among%20Older%20Adults-%20The%20State%20%of%20Knowledge%20and%20Future%20Directions.pdf

Bowser, D. M., Utz, S., Glick, D., & Harmon, R. (2010). A systematic review of the relationship of diabetes mellitus, depression, and missed appointments in a low-income uninsured population. *Archives of Psychiatric Nursing, 24*(5), 317–329.

DeLamatar, J. D., & Sill, M. (2005). Sexual desire in later life. *Journal of Sex Research, 42*, 138–149.

de Souto Barreto, P., Ferrandeaz, A. M., & Guihard-Costa, A. M. (2011). Predictors of body satisfaction: Differences between older men and women's perceptions of their body functioning and appearance. *Journal of Aging and Health, 23*, 505–528.

Druss, B. G. & Reisinger Walker, E. (2011). *Mental disorders and medical comorbidity*. Robert Wood John Synthesis report No 21. Princeton, NJ: Robert Wood Johnson Foundation.

Ellis, A. (2003). *How to age with style*. New York: Albert Ellis Institute.

Ellis, A. (2004). *Rational emotive behavior therapy: It works for me—it can work for you*. Amherst, NY: Prometheus.

Ellis, A., Shaugnessy, M. F., & Mahan, V. (2002). An interview with Albert Ellis about rational emotive behavior therapy. *North American Journal of Psychology, 4*, 355–366.

Goldsmith, T. (2009). Theories of biological aging: and implications for public health. www.azinet.com/aging

Harpole, L. H., Williams, J. W., Olsen, M. K., Stechuchak, K. M., Oddone, E., Callahan, C. M., Katon, W. J., Lin, E. H., Grypma, L. M., & Unützer, J. (2005). Improving depression outcomes in older adults with comorbid medical illness. *General Hospital Psychiatry, 27*(1), 4–12.

Hay, E. L., & Diehl, M. (2011). Emotion complexity and emotion regulation across adulthood. *European Journal of Ageing, 8*, 157–168.

Hudson, F. M. (1991). *The adult years: Mastering the art of self-renewal*. San Francisco: Jossey Bass.

Insel, T., & Chamey, D. (2003). Research on major depression strategies and priorities. *JAMA, 289*(23), 3167–3168.

Kastenschmidt, E. K., & Kennedy, G. J. (2011). Depression and anxiety in late life: Diagnostic insights and therapeutic options. *The Mount Sinai Journal of Medicine, 78*(4), 527–545.

Kim, J. E., & Moen, P. (2002). Retirement transitions, gender, and psychological well-being: A life-course, ecological model. *Journal of Gerontology: Psychological Sciences, 57b*, 212–222.

Kuczynski, A. (2004, August 8). The 37 Year Itch. *New York Times*, Sunday.

Laidlaw, K. (2010). Are attitudes to ageing and wisdom enhancement legitimate targets for CBT for late life depression and anxiety. *Nordic Psychology, 62*, 27–42.

Laidlaw, K. & Pachana, N. (2011, November). Aging, with grace. *Monitor on Psychology*, pp. 66–71.

Lawrence-Lightfoot, S. (2009). *The third chapter: Passion, risk, and adventure in the 25 years after 50*. New York: Sarah Crichton Books.

McDonald-Misczak, L., Wister, A. V., & Gutman, G. M. (2001). Self-care among older adults: An analysis of the objective and subjective illness contexts. *Journal of Aging and Health, 13*, 120–145.

McKinley, N. M., & Lyon, L. A. (2008). Menopausal attitudes, objectified body consciousness, aging anxiety, and body esteem: European American women's body experiences in midlife. *Body Image, 5*, 375–380.

Miniño, A. M., Murphy, S. L., Xu, J., & Kochanek, K. D. (2011). *Deaths: Final data for 2008*. National Vital Statistics Reports; vol 59, no 10. Hyattsville, MD: National Center for Health Statistics.

Neugarten, B. L (obit). (2001). Pioneering U of C gerontologist died Sunday, July 22. *New York Times*, Editorial Preview, 29.

Nolen-Hoeksema, S., & Aldao, A. (2011). Gender and age differences in emotion regulation strategies and their relationship to depressive symptoms. *Personality and Individual Differences, 51*, 704–708.

Oh, K., & Damhorst, M. L. (2009). Coorientation of body image among older married couples. *Body Image, 6*, 43–47.

Renn, B. N., Feliciano, L., & Segal, D. L. (2011). The bidirectional relationship of depression and diabetes: A systematic review. *Clinical Psychology Review, 31*(8), 1239–1246.

Saucier, M. G. (2004). Midlife and beyond: Issues for aging women. *Journal of Counseling and Development, 82*, 420–425.

Schlossberg, N. K. (2009). *Revitalizing retirement: Reshaping your identity, relationships, and purpose*. Washington, DC: American Psychological Association.

Seligman, M. E. P. (2008). Positive health. *Applied Psychology: An International Review, 57*, 3–18.

Speer, D. C., & Schneider, M. G. (2003). Mental health needs of older adults and primary care: Opportunity for interdisciplinary geriatric team practice. *Clinical Psychology: Science and Practice, 10*(1), 85–101.

Suzman, R. (2011). *Study on aging*. Washington, DC: National Institute on Aging.

Swarbrick, M. (2012, March 2). Wellness and aging. *Words of wellness*, vol 5, Number 9.

Thompson, S. C., Thomas, C., Rickabaugh, C. A., Tantamjarik, P., Otsuki, T., Pan, D., et al. (1998). Primary and secondary control over age-related changes in physical appearance. *Journal of Personality, 66*, 583–605.

Umstattd, M. R., Wilcox, S., & Dowda, M. (2011). Predictors of change in satisfaction with body appearance and body function in mid-life and older adults: Active for life. *Annals of Behavioral Medicine, 41*, 342–352.

Unützer, J., Bruce, M. L., & NIMH Affective Disorders Workgroup. (2002). The elderly. *Mental Health Services Research, 4*(4), 245.

Vaillant, G. (2002). *Aging well*. New York: Little, Brown and Company.

Van Solinge, H., & Henkens, K. (2005). Couples' adjustment to retirement: A multi-actor panel study. *Journal of Gerontology: Social Sciences, 60B*, 811–820.

Whitbourne, S. K. (2010). *The search for fulfillment: Revolutionary new research that reveals the secret of long-term happiness*. New York: Ballantine Books.

Williams, P. T., & Wood, P. D. (2006). The effects of changing exercise levels on weight and age-related weight gain. *International Journal of Obesity, 30*, 543–551.

Wurm, S., Tomasik, M. J., & Tesch-Römer, C. (2008). Serious health events and their impact on changes in subjective health: The role of age and a positive view on aging. *European Journal of Ageing, 5*, 117–127.

Wu, L. T., & Blazer, D. G. (2011). Illicit and nonmedical drug use among older adult review. *Journal of Aging and Health, 23*(3), 481–504.

Name Index

A
Abarbanel, A., 3
Abidin, R.R., 202
Abrams, M., 100
Adams, J., 56
Adams, K.B., 213
Addis, J., 85, 256
Adelman, M., 54
Al-Mabuk, R., 230, 233
Aldao, A., 255
Alegría, M., 250
Alexander, M., 125
Allen, E.S., 118
Arkowitz, H., 178
Aron, A., 98, 99, 102
Arriaga, X.B., 85
Ashkenazi, I., 106
Atkins, D.C., 119
Ax, E.E., 199
Ayotte, B., 192

B
Babcock, J.C., 196
Babor, T.F., 171
Badgett, M.V.L., 140
Baer, R.A., 19, 20
Baker, J., 33
Barash, D.P., 102
Barlow, J., 199
Barnes, S.J., 18, 22, 23
Bartels, S.J., 251
Bassin, E., 99
Bates, J.E., 200
Baucom, D.H., 6, 8, 19, 83, 130, 193, 194
Baucom, F.H., 119
Baucom, T.R., 112
Beach, S.R.H., 85, 86
Beals, K.P., 99
Beck, A.T., 2, 4–6, 12, 44, 97, 109, 215, 216, 228
Beck, J.S., 12
Behrens, B.C., 21
Benda, B.B., 130
Bennett, K., 112
Berger, C., 54
Bergin, A.E., 149
Bernard, M.E., 85, 202, 256
Berscheid, E., 56
Birch, P.J., 9
Bishop, F.M., 171, 173, 174, 178, 179
Blow, F., 251
Blue, J., 202
Blumstein, P., 134
Bodenmann, G., 81–84, 86, 90
Boggs, S., 201
Bohlmeijer, E., 20
Bolger, N., 83
Bond, F.W., 7
Bosworth, H.B., 192
Bowser, D.M., 250
Bradbury, T.N., 21, 82–84, 87–89
Bradley-Klug, K.L., 199
Branch, R., 235
Brennan, P.A., 200
Broder, M., 44, 49, 59, 60, 62
Brown, K.W., 17–21
Brown, L.L., 99
Bruce, M.L., 250
Bugental, D.B., 202

A. Vernon (ed.), *Cognitive and Rational-Emotive Behavior Therapy with Couples: Theory and Practice*, DOI 10.1007/978-1-4614-5137-2,
© Springer Science+Business Media New York 2012

Bultz, B.D., 212
Bunge, S.A., 21
Burch, B., 141
Burchinal, M., 87
Burden, J.L., 173
Burgess, P.H., 150
Burman, R., 157
Burns, D.D., 5
Burpee, L.C., 22
Buss, A.H., 76
Buss, D.M., 100, 112
Byers, E., 99
Byrne, A., 217
Byrne, D.G., 217

C
Caballo, V., 155
Caldwell, B., 39
Campbell, W.K., 18
Canavarro, M.C., 191
Cann, A., 112
Cannon, W.B., 82
Caplan, R.D., 82
Carey, B., 185
Carlson, L.E., 17–19, 212
Carlson, N.R., 82
Carmody, J., 20
Carson, J.W., 8, 12, 19, 21, 23, 24, 26–28
Carson, K.M., 8, 19
Case, T.I., 98
Castillo, R.J., 150
Cavuoto, N., 24
Chamey, D., 251
Chapman, K.E., 23
Charon-Moore, C., 212
Charvoz, L., 83
Chiesa, A., 20, 21
Christenensen, A., 97
Christensen, A., 87, 119, 178, 196, 198
Cina, A., 83
Clemente, R., 232
Clements, K., 182
Cogan, J.C., 133
Cohan, C.L., 87
Collard, J., 8
Conger, R.D., 83, 86–88
Conoley, C.W., 85
Cordova, J.V., 22
Cover, R., 133
Cox, M.J., 87
Coyle, A., 134
Crawford, T., 47
Creswell, J.D., 17, 21
Croft, P.R., 106
Cuijpers, P., 20
Curran, D., 218
Curran, G.M., 173
Curtis, C.M., 199
Cutrona, C.E., 86

D
Daiuto, A.D., 193
Damhorst, M.L., 252, 253
Dattilio, F.M., 6, 191
D'Auguilli, A.R., 133
David, D., 68
Davidson, K.H., 202
Davidson, S., 8
Davies, M.F., 89
Davila, J., 88, 118, 130
Davis, H., 199
Davison, G.C., 217
Day, C., 200, 201
de Beer, Z.C., 85
De Claire, J., 11
de Souto Barreto, P., 252, 253
De Waal, F., 101
Deal, L.W., 212
DeCecco, J.P., 139
Deffenbacher, J.L., 66
Dehle, C., 86, 90
DeLamatar, J.D., 252
Delaney, H.D., 171
Delhe, C., 86
DiBlasio, F.A., 130
Diehl, M., 255
DiGiusseppe, R., 4, 7, 44, 53, 65, 67, 68, 76, 77, 229
DiMattia, D.J., 4
Dobzhansky, T., 101
Dodge, K.A., 200
Dorris, G., 212
Dougherty, J., 214
Dowda, M., 252
Druss, B.G., 251
Dryden, W., 3, 6, 42, 44, 45, 68, 89, 229, 235
Dunn, K.M., 106

E
Eckhardt, C.I., 66
Edelman, D., 192
Edelman, S., 215, 217
Edler, A.U., 101

Eisenberger, N.I., 21
Elder, G.H., 83
Elder, M.A., 83
Elfert, G.H., 8
Eliason, M.J., 135
Ellingstad, T.P., 170
Ellis, A.E., 2–5, 12, 34, 38, 39, 41, 42, 44, 45, 47, 51, 56, 60, 75, 85, 88, 89, 97, 98, 100, 150, 151, 153, 155, 157, 173, 175, 177, 180, 181, 186, 187, 202, 214–217, 226, 228, 229, 236, 243, 255, 256, 259
Ellis, R., 99
Emery, G., 215
Enomoto, T., 101–102
Epstein, N.B., 6, 76, 83–86, 89, 193, 194
Erber, M., 54
Erber, R., 54, 56
Eyberg, S.M., 201

F
Feingold, T., 8
Feliciano, L., 250
Felmlee, D., 99
Ferrandeaz, A.M., 252
Fetto, J., 99
Fincham, F., 118, 130
Fincham, F.D., 89
Finkel, E.J., 118
Fish, M., 199
Fisher, H.E., 98, 99, 101, 102
Flinders, T., 19
Folkman, S., 84
Fossøy, F., 101
Fountain, T., 53
Frick, P.J., 202
Friedl, T.P., 101
Fristad, M.A., 202
Froh, J.J., 77
Fujii-Hanamoto, H., 101–102
Fuller, J.R., 53
Fussell, N.J., 108

G
Gabrieli, J.D.E., 21
Gaillot, M.T., 178
Garcia-Preto, N., 150
Gardner, K.A., 86
Gartner, J., 157
Geffen, R., 156
Gil, K.M., 8, 19
Gillis, J.R., 133
Giordano, J., 150, 156
Glasser, W., 180
Glenn, H.S., 237
Glick, D., 250
Goldfried, M.R., 217
Goldsmith, T., 244
Gordon, K.C., 130
Gordon, T., 52, 78, 238
Gottman, J.M., 11–13, 44, 91, 181, 182
Gottman, J.S., 12, 13
Graham, J.M., 85, 89
Grant, M., 171
Greenberg, L.S., 130, 213
Grier, E.C., 199
Gross, J.J., 21
Grossman, P., 19, 20
Guihard-Costa, A.M., 252
Gutman, G.M., 256

H
Hackett, G.I., 106
Halford, W., 21
Hall, T.W., 88
Hamlett, K.W., 199
Hammen, C., 88, 200
Hannon, P.A., 118
Happaney, K.H., 202
Harley, W.F., 10
Harmon, R., 250
Harper, R.A., 4
Harpole, L.H., 251
Harris, S., 89
Hassall, R., 200, 201
Hatfield, E., 56
Hauck, P.A., 34
Hay, E.L., 255
Hayden, T., 100
Hayes, S.C., 2, 7, 20
Heavey, C.L., 87, 90
Henkens, K., 249
Heppner, W.L., 20
Herek, G.M., 133
Heruti, R., 106
Hessling, R.M., 86
Hester, R.K., 171
Hettema, J.E., 173
Heyman, R.E., 76
Hofmann, S.G., 20
Howard-Hamilton, M.F., 150

Howe, G.W., 82, 83, 88, 91
Howell, D.C., 212
Hoyt, W.T., 118, 130
Hudson, F.M., 244
Hudson, P., 35
Hughes, T., 135

I
Ibrahim, E., 161, 163
Impett, E.A., 99
Insel, T., 251

J
Jacob, E., 200
Jacobson, N.S., 97, 196, 198, 206
Jalme, M., 101
Jensen, J., 149
Jethá, C., 101
Johnsen, A., 101
Johnson, B.A., 185
Johnson-Davies, D., 161, 163
Johnson, J.H., 88
Johnson, J.W., 135
Johnson, S.M., 97, 213
Johnson, W., 157
Jones, J.M., 218
Jones, K.C., 23
Jones, S., 157
Joyce, M.R., 202, 229, 230
Justo, D., 106

K
Kabat-Zinn, J., 2, 8, 17, 19, 23, 25, 26
Kahneman, D., 100
Kalayjian, A., 212
Karney, B.R., 21, 81–85, 88
Karpowitz, D.H., 233
Kashubeck-West, S., 135
Kassinove, H., 65, 66, 68, 70, 74, 77, 79
Kastenschmidt, E.K., 250
Katz, J., 86, 90
Katz, K.S., 199
Kaufman, G., 134
Kenagy, G.J., 102
Kennedy, G.J., 250
Kidman, A.D., 215, 217
Kim-Cohen, J., 200
Kim, J.E., 249
King, M.P., 170
Kinsey, A., 3
Kirby, J.S., 193
Kirkpatrick, S., 199
Kirshenbaum, M., 49, 50, 55, 57, 58
Kitzinger, C., 134
Kless, R., 214
Knapp, C.A., 199
Kochanek, K.D., 250
Kort, J., 140, 143
Koumans, A.J.R., 187
Kreider, R.M., 99
Krusemark, E., 18
Kuczynski, A., 246
Kumashiro, M., 118
Kurdek, L.A., 134
Kusunoki, H., 101–102

L
L'Abate, L., 206
Laidlaw, K., 243, 255
Landers, J.E., 86
Lang, C., 53
Lang, E.L., 83
Langer, E.J., 18, 22
Larsen, D., 86
Larson, J.H., 35, 37, 38
Larson, P.J., 9
Lash, S.J., 173, 187
Lataillade, J.J., 76
Laumann, E.O., 106
Lawrence-Lightfoot, S., 244, 245
Lazarus, A.A., 2, 34, 36–38, 155
Lazarus, R.S., 82, 84
Le Brocque, R.M., 200
Ledermann, T., 83, 84, 86, 90
Ledford, H., 102
Lega, L.I., 150, 151, 154, 155
Lega-Siccar, J., 154
Lehman, D.R., 83
Lever, J., 142
Levinson, R.W., 83
Levitt, E.E., 103
Levy, M.L., 82
Lewis, F.M., 212
Lewis, J.C., 202
Libet, J., 86
Lieberman, M.D., 21
Lifjeld, J.T., 101
Lilis, J., 7
Linehan, M.M., 2, 20, 26, 28
Lipton, J.E., 102

Liu, H., 192
Lonner, W.P., 151
Lott, L., 231, 233, 237
Love, P., 38
Lovejoy, M.C., 200
Loyau, A., 101
Lundhal, B.W., 200
Luoma, J.B., 7
Lykins, E.L.B., 20
Lyngstad, T.H., 10
Lyon, L.A., 253

M
MacClaren, C., 175
MacDonald, B., 141
Machado da Silva, F., 200
MacLaren, C., 236
Madden, V.L., 199
Madison, L., 9
Mahan, V., 255
Malamuth, N.M., 87
Malcolm, W., 130
Malpass, R., 151
Manne, S., 214
Markman, H.J., 90
Mashek, D., 99
Masuda, A., 7
Matsubayashi, K., 101–102
Maughan, B., 200
McClure, E.B., 200
McCubbin, H.I., 88
McCullough, M.E., 118, 130
McDaniel, S.H., 192
McDonald, J., 200
McDonald-Misczak, L., 256
McGinnis, P.R., 101
McGoldrick, M., 150, 152, 154–156
McHenry, S.S., 135
McKay, J.R., 173
McKinley, N.M., 253
McLean, L.M., 218
McLellan, A.T., 172
McMahon, J., 3, 10, 12
McManus, H., 9
McManus, M., 9, 10
McMillan, K., 143
McNulty, J.K., 85
McPherson, C.J., 218
Meyer, I.H., 140
Meyer, J., 135
Meyers, R.J., 170, 176, 184
Mi Baik, O., 213
Miao, G., 118, 130
Millam, J.R., 101
Miller, C.F., 187
Miller, W.R., 173, 178
Miniño, A.M., 250
Moen, P., 249
Mohr, D.C., 213
Moller, A.T., 85
Monnier, J., 86
Montgomery, R., 1
Moseley, S., 226
Moser, C.A., 103
Mueser, K.T., 193
Muller, J.J., 187
Murphy, C.M., 182
Murphy, S.L., 250
Murray, J.D., 11

N
Nakano, M., 101–102
Nascimento, L.C., 200
Neenan, M., 6, 44, 229
Neff, L.A., 81–83, 85, 89
Neidig, P.H., 76
Neisen, J.H., 134
Nelson, D.R., 200
Nelson, J., 231, 233, 237
Nelson, M., 201
Neugarten, B.L., 244
Nielsen, S., 157, 158
Niemann, L., 19
Nimmons, D., 146
Nolen-Hoeksema, S., 255
Norcross, J.C., 179
Northouse, L.L., 212

O
Oaten, M.J., 98
O'Brien, C.P., 172
Ochsner, K.N., 21
O'Farrell, T.J., 182
Oh, D., 20
Oh, K., 252, 253
O'Hanlon, B., 35
O'Hanlon, W., 10
O'Kelly, M., 2, 8
O'Leary, S., 53
Olendzki, N., 20
Oliver, T.C., 23

Olsen, J., 9
Olson, A.K., 9
Olson, D.H., 9, 34–37
Oman, D., 19
Osgarby, S.M., 86
Ossana, S., 141
Owings, D.H., 101

P
Pachana, N., 243
Padesky, C.A., 6
Paley, B., 87
Paniagua, F.A., 150, 152
Parish, A., 101
Park, J.H., 108
Parks, M., 54
Parrott, L., 33, 34, 36, 37, 39
Passarelli, V., 24
Patterson, J.M., 88, 200, 201
Payne, C.C., 87
Pellegrini, D.S., 199
Peplau, L., 99
Perry, M., 76
Peterson, B.D., 8
Pettit, G.S., 200
Pinderhughes, E.E., 200
Pittman, F., 119, 123
Plante, T.G., 19
Pomeroy, W., 3
Potts, M., 100
Prenger, R., 20
Pruett-Jones, M., 101
Pruett-Jones, S., 101

R
Randall, A.K., 81, 82, 84, 92
Rankin, L.A., 6
Raphael, L., 134
Rathus, J.H., 24
Reid, A., 143
Reifman, A., 192
Reisinger Walker, E., 251
Renn, B.N., 250
Repetti, R.L., 83, 86, 87, 90
Reuter, M.A., 83
Richards, P.S., 149
Risser, H.J., 200
Roberts, N.A., 83, 87, 90
Robinson, T.L., 150
Rodrigues, N., 200, 201
Rogers, C., 179
Rogge, R.D., 18, 23
Rolland, J., 211
Rollnick, S., 178
Rose, J., 200
Rose, S.J., 187
Rowe, A.C., 108
Rudaz, M., 83
Ruddy, N.B., 192
Rush, A.J., 215
Russell, D.W., 86
Rustbelt, C.E., 118
Rutter, M., 200
Ryan, C., 101
Ryan, R.M., 17, 18

S
Saavedra, M.C., 23
Sanders, M.R., 21
Sarason, I.G., 88
Saucier, M.G., 253
Sawyer, A.T., 20
Schlossberg, N.K., 249
Schmidt, S., 19
Schneider, M.G., 251
Schulz, M.S., 91
Schwartz, P., 134
Schwartz, S.J., 150
Segal, D.L., 250
Segal, Z.V., 20, 26
Sehnert, K.W., 82
Seligman, M.E.P., 256
Selye, H., 82
Serretti, A., 20
Shackelford, T.K., 112
Shantinath, S.D., 86
Shapiro, S.L., 17–19
Shaugnessy, M.F., 255
Shaw, B.F., 215
Shaw, D., 86
Sheikh, A., 37, 47
Shenkman, E.A., 199
Shindel, A.W., 103
Shively, M.G., 139
Shochat, T., 106
Shoham, V., 193
Sichel, J.L., 3
Siegel, J.M., 88
Sill, M., 252
Silver, N., 11, 44
Simon, R., 1

Simpson, J.A., 99
Simpson, L.E., 178
Sloyer, P., 199
Smith, S., 7
Sobell, L.C., 170
Sobell, M.B., 170
Sorci, G., 101
Sorenson, S., 83
Speca, M., 212
Speer, D.C., 251
Speilberger, C.D., 76
Spoon, T.R., 101
Sprecher, S., 99
Squires, D.D., 171
Stephens, D., 34
Sternberg, K., 125
Sternberg, R.J., 125
Stevenson, R.J., 98
Stewart-Brown, S., 199
Stickle, T.R., 193
Stokes, S.B., 83
Story, L.B., 83, 84, 87, 88
Stosny, S., 10
Stout, R.L., 187
St.Pierre, M., 212
Strong, G., 99
Strosahl, K.D., 20
Suhr, J.A., 86
Sukhodolsky, D.G., 66
Suzman, R., 244
Swanson, C., 11
Swanson, K.R., 11
Swarbrick, M., 248
Szapocznik, J., 150
Szymanski, D., 135

T
Taal, E., 20
Tafrate, R.C., 65, 66, 76, 216
Tanner, M.A., 19
Teasdale, J.D., 20
Teasdale, J.T., 7
Tekes-Manova, D., 106
Telford, L., 135, 141–143
Tesch-Römer, C., 256
Tesser, A., 85, 86
Thoburn, J.W., 23
Thompson, A., 83, 86, 87, 89
Thompson, S.C., 252
Thoresen, C.E., 19
Timko, C., 173
Tomasik, M.J., 256
Traupmann, J., 56
Trivedi, R.B., 192
Trombulak, S.C., 102
Tsapelas, I., 102
Tucker, J.A., 170
Tversky, A., 100
Tyson, R., 11

U
Ullman, J.B., 200
Umstattd, M.R., 252–254
Unger, J.B., 150
Unützer, J., 250
Utne, M., 56
Utz, S., 250

V
Vaillant, G., 243, 245, 246, 259
Van Citters, A., 251
Van Solinge, H., 249
Veach, S., 214
Vernon, A., 3, 46, 225, 226, 230–233
Viterito, J., 12

W
Wachs, K., 22
Walach, H., 19
Walen, S., 68, 74, 75, 77
Wallbott, H.G., 65
Walster, E., 56
Walster, G., 56
Wampler, R.S., 83
Wampold, B.E., 179
Wang, A., 99
Warwar, S., 130
Way, B.M., 21
Weed, S.E., 9
Weil, E., 1
Wells, A., 20
Welton, S.R., 23
Werlinich, C.A., 76
Westra, H.A., 178
Wheaton, B., 81
Whitbourne, S.K., 245
Wilbourne, P.L., 173
Wilcox, S., 252

Williams, J.M.G., 20
Williams, P.T., 252
Wilson, K.G., 20, 218
Wilson, L., 88
Windmere, K., 83
Wister, A.V., 256
Witt, A.A., 20
Wolfe, B.L., 170, 176, 184
Wolfe, J., 226
Wood, P.D., 252
Woolley, S., 39
Worth, H., 143
Wortman, C.B., 83
Wurm, S., 256

X
Xu, J., 250

Y
Yeager, R.J., 3
Yi, J., 119

Z
Zamboanga, B.L., 150
Zelli, A., 200
Zweben, A., 187
Zywiak, W.H., 187

Subject Index

A
A-B-C model
  irrational beliefs, 166
  LFT, 165
  REBT, 51
  religious and cultural differences, 165
Acceptance and commitment theory (ACT)
  defined, 7
  individuals, 8
  mindfulness processes, 7–8
Acceptance of the illness, 198
Accidental affair, 123–124
Acculturation, 154, 155
ACT. *See* Acceptance and commitment theory (ACT)
Activities of daily living (ADL)
  aging couples, 247
  physical health changes, 249
  type 2 diabetes mellitus, 250
Addictions
  assessment, distorted cognitions, 171–172
  behavioral techniques, 176
  chemical approaches, 178
  cocaine, 182–183
  cognitive behavioral therapists, 187–188
  cognitive techniques, 174–175
  vs. compulsions, 170–171
  CSO, 184
  double ambivalence-confusion and conflicting desires, 169–170
  emotive techniques, 175
  evidence-based treatments, 172–173
  factors, recovery, 186
  interpersonal techniques, 176–177
  interventions, 184
  MI and REBT, 178–180
  REBT/CBT, assessment, 171
  rehabilitation, 185–186
  secondary/meta-emotion and behavior, 180–181
  spiritual/existential techniques, 177
  stone walling, 182
  therapist, advantage, 181–182
ADL. *See* Activities of daily living (ADL)
Adversity and stress
  behavioral interventions, 90
  cognitive interventions, 89
  coping strategies, 84
  and couples, 82–83
  couples, life stressors, 87
  definition, 81
  eliminating/minimizing stressors, 88
  formal intervention programs, 90–91
  and individual, 82
  individual and couple behaviors, 86–87
  individual beliefs, 84–86
  irrational beliefs and distorted cognitions, 91–92
  psychoeducation, 88
  and relationship functioning, 83
  research, effects, 83
  stressor characteristics, 84
Affair
  accidental, 123–124
  angry, 124
  midlife crisis, 125
  regulator, 124–125
  romantic love, 125–126
Aggression
  and anger, 66–67
  experience, dysfunctional anger, 66
  physical, 76
  verbal, 67, 74

A. Vernon (ed.), *Cognitive and Rational-Emotive Behavior Therapy with Couples: Theory and Practice*, DOI 10.1007/978-1-4614-5137-2,
© Springer Science+Business Media New York 2012

- Aging
  - active planning, elderly people, 244
  - appearance and body function changes, 252–254
  - couples counseling, 245–246
  - defined, 244
  - dementia, 257
  - developmental psychology, 243
  - disengagement, 244
  - emotional disturbance, 259
  - impacts, wellness, 247, 248
  - maladaptive chain, behaviors, 258
  - physical and mental deterioration, 244
  - physical health challenges, 249–252
  - RE&;CBT, 254–256
  - retirement, 249
- Ambivalence
  - CBA (*see* Cost-benefit analysis (CBA))
  - communication and assertiveness, 52–54
  - comparative analysis, 57–58
  - defined, 50
  - Equity theory, 55–57
  - factors, 58–59
  - guilt and anxiety, 59–62
  - healthy secondary emotions and cognitions, 51–52
  - modified CBA exercise, 63
- Anger
  - assessment, 76
  - behavioral techniques, 80–81
  - behaviors, 66–67
  - cognitive techniques, 77
  - description, 65–66
  - dysfunctional (*see* Dysfunctional anger)
  - emotional responsibility, 75
  - emotive techniques, 77–78
  - episodes, 68–70, 74, 77
  - treatment objectives, 76–77
- Angry affair, 124
- Arousal
  - erectile dysfunction, 106
  - gender difference, 105
  - loss, counseling, 106–107
- Assertion
  - anger episode, 67
  - and communication, 52–54
- Attitude, 18
- Automatic thoughts, CT, 6
- Avoidance, 86, 92

B

- Balance-scale approach, 55
- Behavioral interventions, 45–46
- Behavioral stimulus-response model, 2
- Behavioral techniques, 78–79, 176
- Behavior management, 204, 205, 234, 239
- Betrayal
  - accidental affair, 123–124
  - angry affair, 124
  - betrayed person, 127–129
  - distorted cognitions, 119–120
  - end of the marriage, 122
  - erroneous beliefs, 118
  - euphoria, 119
  - genuine forgiveness, 130–131
  - genuine sorrow, 130
  - happiness, 122
  - meeting, betrayer, 126–127
  - midlife crisis affair, 125
  - reconciliation, 129
  - regulator affair, 124–125
  - restitution, 130
  - romantic love affair, 125–126
  - splitting, 120
  - therapist’s role, 126
- Betrayed partner, 121, 122, 127–129, 131
- Bias
  - emotional response, 135
  - heterosexism and homophobia, 134

C

- CBA. *See* Cost-benefit analysis (CBA)
- CBCT. *See* Cognitive behavioral couples therapy (CBCT)
- CBT. *See* Cognitive behavior therapy (CBT)
- Chemical approaches, addictions
  - medication, 178
  - nutrition, 178
- Children
  - anger, 230
  - anxious parents and grandparents, 230–231
  - demanding parents, 226
  - discipline, 237–238
  - grandchildren, 231
  - guilty parents, 229
  - “helicopter” parents, 228
  - ignoring parents/grandparents, 233
  - permissive style, 232
- Chronic medical/mental illness, parents/child
  - assessment, 195–196
  - case conceptualization, 196
  - CBCT (*see* Cognitive behavioral couples therapy (CBCT))
  - child and family characteristics, 200
  - clinicians, socio-ecological context of the family, 207–208
  - decrease, parents employment, 199
  - depression, 194–195

disability, 203–206
dysfunctional familial factors, 200
factors, caregiver stress and warrant consideration, 200
interventions, 197–199, 206–207
negative thoughts, 193
quality, relationship, 191, 192
REBT/CBT model, 201–203
treatment, 196–197
Cognitions, 91, 92
Cognitive behavioral couples therapy (CBCT)
DBT, 193–194
psychopathology, 193
Cognitive behavior therapy (CBT). *See also* Couples therapy
defined, 2
models, couples counseling intervention, 2
objective, 5
Cognitive distortions
depression, 215
dichotomous thinking and overgeneralization, 215
and irrational beliefs, 41–43
Cognitive interventions, 44
Cognitive techniques, addictive behavior
CBA, 174
disputing process, 175
inference chaining, 174
objectives, 174
rewind, videotape, 174–175
self-help forms, 175
self-monitoring, 77
Cognitive therapy (CT)
defined, 4–5
distortions, 5
and REBT, 5–7
Comfort, 62
Communication
adaptive, 213
and assertiveness, 52–54
illness/disability, 191
mindfulness-based programs, 28, 29
quality, 86
techniques, 238
training, 208
Community reinforcement and family therapy (CRAFT), 176–177, 184, 185
Comparative analysis, ambivalence, 57–58
Concerned significant other (CSO)
activating event/adversity, 185–186
CRAFT, 184
defined, 170
factors, 186
Conflicts, 110
Consequential thinking, 54–55
Coping strategies, 84
Cost-benefit analysis (CBA)
defined, 174
enhancement, motivation, 174
Equity theory, 57
exercise, consequential thinking, 54–55
modified CBA exercise, 63
phenomenological subjective experience and value system, 56
Counseling intervention, couples
ACT (*see* Acceptance and commitment theory (ACT))
CBT (*see* Cognitive behavior therapy (CBT))
CT (*see* Cognitive therapy (CT))
defined, 1–2
education, 9
marriage savers, 9
MATES, 10
MBSR, 8
REBT (*see* Rational-emotive behavior therapy (REBT))
smart marriages, 10
sound couples house, 11
training program, mentor couples, 12
Couple relationships
cognitive, behavioral and emotive interventions, 43–46
description, 33–34
distorted cognitions and irrational beliefs, 41–43
games, 39–41
myths and misconceptions, 34–39
and passion
innate neuropsychological systems, 98
non-conjugal relationships, 99
rational emotive/cognitive behavioral solutions, 100
Couples. *See* Mindfulness, couples
Couples counseling, 245–246
Couples therapy
ACT, 8
awareness, passive aggressive behaviors, 193
cognitive-behavioral model, 83
communication, 206
feature, 4
homework, 206
integration, 193–194
objectives, 4
RE &; CBT
cancer diagnosis, 219
erratic behavior, 220–221

Couples therapy (*cont.*)
glioblastoma multiforme, 218
interventions, 12
objectives, 219
strengths and past successes, 196
terminal illness, 213
CRAFT. *See* Community reinforcement and family therapy (CRAFT)
Cross cultural approaches, 149, 150
CSO. *See* Concerned significant other (CSO)
CT. *See* Cognitive therapy (CT)
Cultural and religious diversity
A-B-C framework, 163–166
cross-cultural experience, 149
disturbed beliefs and religion, 158
ethno-cultural variables, 152–156
marital interventions, religion, 161–163
psychotherapy, 149
REBT, 150–152
religion and religiosity, 157
religious beliefs and marriage, 158–161
Cultural diversity, 150–152

D
Decisional balance exercises. *See* Cost-benefit analysis (CBA)
Demanding beliefs, 68, 70
Diagnostic and Statistical Manual (DSM), 134
Disability. *See* Mental disability, child
Disputation, 44, 77, 79, 207, 259
Disputing dysfunctional, 235
Distress
and dissolution, 82
emotional negativity, 87
negative response to a stressor, 81
Disturbing emotions, 45, 158, 225
Diversity. *See* Cultural and religious diversity
DSM. *See* Diagnostic and Statistical Manual (DSM)
Dysfunctional anger
awfulizing, 70–74
demandingness, 68
evaluations, human worth, 74–75
LFT, 68–70

E
EBP. *See* Evidenced-based practice (EBP)
Ellis' theory, REBT, 56
Emotional management, 234, 239
Emotional responsibility, 75
Emotive interventions, 45
Emotive techniques, 77–79, 175
Environmental stressors, 88, 92
Equity theory, ambivalence, 55–57
Erroneous beliefs, 118
Ethno-cultural variables
folk beliefs and religion, 152–153
Lebanese-American woman, 155–156
transnational family arrangements, 153–155
Evidence-based treatments, addictions, 172–173
Evidenced-based practice (EBP), 202–203
Evolutionary psychology, 100
Evolution, human sexuality
human behavior, 100
polygamy, 102
primates, 101
Existential questioning
defined, 56
Ellis' theory, REBT, 56
Equity theory, 56–57

F
Family functioning, 191, 192, 200, 201, 208
Finger pointing method, 35
Folk beliefs and religion
assessment, 152
ethno-cultural variables, 153

G
Games
"hint hint", 41
"I'll do this if you do that", 41
insurmountable, 39–40
"I spy", 40
Gay
emotional bonding, 143
non-monogamy, 146–147
Gender cultural conditioning, 140
Global evaluations of human worth, 74–75
Grandparenting
analogies and metaphors, 236
anger, 230, 239–240
anxiety, 230–231
authoritarian, 232–233
authoritative, 233–234
child management, 237–238
coping self-statements, 236
defined, 225–226

depression and guilt, 229
disputing, beliefs, 234–236
identification, beliefs, 234
ignoring style, 233
irrational beliefs, 226–228
management, emotions, 234
permissive, 231–232

H

Heterosexism
counseling relationship, 134
defined, 134
HFT. *See* Higher frustration tolerance (HFT)
Higher frustration tolerance (HFT), 182
"Hint hint" game, 41
Homework techniques, 79
Homosexuality, 133
Human sexuality. *See* Intimacy and sexuality

I

Inference chaining, addictive behaviors, 74, 174
Infidelity
counseling couples, 108–109
defined, 108
irrational beliefs, 111–113
Instrumental activities of daily living (IADLs). *See* Activities of daily living (ADL)
Internalized homophobia, 133
Interpersonal techniques, addictions, 176–177
Intimacy and sexuality
arousal, 105–106
assertiveness and masculinity, 107–108
corporate functions, 109
counseling couples, 108–109
counseling for loss of arousal, 106–107
evolution, human sexuality, 100–102
infidelity, 108
irrational beliefs, 111–113
love and sex, 97
paraphilic partner, 104–105
rational emotive behavior therapy, 110
relationships and passion, 98–100
sadomasochistic sexual cues, 16
sexual behaviors, 103
Irrational beliefs
ABC approach, 180
assessment, 171–172
and cognitive distortions, 41–43
CSO, 185
and emotional responsiveness, 221
emotions, 213–214
grandmother, 240
parents' emotions and behaviors, 226–228
practitioners work, parents, 230
therapists, 187
"I spy" game, 40

K

Kabat-Zinn, Jon
breathing exercise, 25
MBSR program, 17, 19, 23
mindful eating exercises, 26
mindfulness, 17
walking meditation, 25–26
Kirshenbaum's qualitative diagnostic system, 57–58

L

LAMP. *See* Love and Marriage Program (LAMP)
Lesbian
cultural conditioning, 140–143
psycho-education, 143
relationship fusion, 141
Lesbian bed death, 142
LFT. *See* Low-frustration tolerance (LFT)
Love and Marriage Program (LAMP), 3
Low-frustration tolerance (LFT)
anger episodes, 68–70
defined, 68
irrational beliefs, religion and marriage, 160

M

Managing addictive behaviors
HFT, 182
intensive outpatient therapy, 185
relapse prevention, 181
Marital interventions, religion
emotional consequences, 161–162
irrational beliefs, 162–163
Marriage Assistance through Educational Seminars (MATES) Foundation, 10
Marriage savers, 9
MATES Foundation. *See* Marriage Assistance through Educational Seminars Foundation
MBSR program. *See* Mindfulness-based stress reduction program (MBSR)

Mental disability, child
bipolar disorder, 203
treatments
activity scheduling, 205–206
irrational beliefs, 205
parent training, 205
REBT, 204–205
MI and REBT, addictions
development, discrepancy, 179
empathy, 179
resistance, 180
UOA and USA, 179
validation, pain, 178–179
Midlife crisis affair, 125
Mindfulness-based stress reduction (MBSR) program
benefits, practicing mindfulness, 19
couples-focused mindfulness activities, 26, 27
defined, 8
intervention, non-distressed couples, 23
Mindfulness, couples
benefits, individual, 20–21
breathing exercise, 25–26
components, 17–18
couples-focused mindfulness activities, 26, 27
dyadic eye gazing exercise, 27–28
eating exercise, 26
formal and informal exercises, 18–19
individual psychological problems, 28–29
intervention studies, 23–24
non-meditative skills, 26
personality trait, 22–23
psychological treatment programs, 20
Mindfulness techniques, 24, 25
Motivational interviewing (MI). *See* MI and REBT, addictions
Multicultural approaches, 150, 152
Myths and misconceptions
avoidance, conflict and disagreement, 38
changes, partner, 35
changes, relationship, 35
communication, expectations, 35–36
defined, 34
love, 38–39
marriage, 36–37

N
Negative rational emotive imagery, 78
Non-judgemental, mindfulness, 17–19, 178

P
Paraphilia, 104
Parenting
caregiver's behaviors, 201
clinicians, 208
defined, 225
and grandparenting(*see* Grandparenting)
inconsistent, 107
practices, 201, 202, 205
Physical conditions
ADL, 250
mental health challenges, 250–251
wellness activities, 251–252
Present focus, attention, 17–18
Psychoeducational approach, 61
Psychological distress
anger, 216
anxiety, 214
defined, 213–214
depression, 215–216
frustration intolerance, 214

R
Rational beliefs, 229, 234
Rational emotive and cognitive behavioral therapy (RE&;CBT). *See also* Couples therapy
aging process, 243
couples, 12
distorted cognitions or inferences, 7
Rational-emotive behavior therapy (REBT). *See also* MI and REBT, addictionsABCs model, 60
anxiety, 214
CBA, 51
cognitive factors, relationship disturbance, 6
and cultural variations, 150–152
defined, 5–6
Ellis' theory, 56
emotional disturbance, 217
individuals' schemas, 6
LAMP, 3
management, horsemen, 12
neurotic behaviors, 3–4
objectives, 7, 219
Rational emotive imagery (REI), 45, 77–78, 175
REBT. *See* Rational-emotive behavior therapy (REBT)
Regulator affair, 124–125

REI. *See* Rational emotive imagery (REI)
Relationship ambivalence. *See* Ambivalence
Relationship counseling
  fetishistic pornography, 104–105
  infidelity, 108–109
  paraphilia, 104
Relationships
  dissatisfaction, 21
  emotional functioning and stress management, 21
  happiness and stress, 24
  intimate, 21, 22
  inverse, 21
  levels, psychological functioning, 25
  measurements and mindfulness, 22
  negative, 20
  positive, 23
  romantic, 22
  satisfaction, 23
  well-functioning couples, 29
Relaxation techniques, 79
Religiosity, 157, 167
Religious beliefs and marriage
  awfulizing, 160
  demandingness, 160
  LFT, 160
  self/other downing, 160–161
Religious diversity
  emotional distress, and divorce, 156
  religion and religiosity, 157
Retirement, 249
Rewinding a videotape, addictive behaviors, 174–175
Rituals, 156
Role-playing, 45
Romantic love affair, 125–126

S
Same sex couples
  core psychological dynamic, 134
  development, unhealthy beliefs, 136–137
  DSM, 134
  gay male couples, 143
  heterosexual *vs.* same-sex relationships, 139–140
  internalized homophobia, 133
  irrational beliefs, 137
  lesbian relationships, 140–143
  psychosocial context, 136–137
  therapist's unconscious bias, 134–135
  unhealthy levels of stress, 138–139
Secondary/meta-emotion, 180–181
Sex role conditioning, 139
Sex therapy, 98, 106
Sexuality. *See* Intimacy and sexuality
Smart marriages, 10
Social support, 90, 92
Socratic/didactic approach, 77, 79
Spiritual/existential techniques, addictions, 177
Spirituality, 149, 156
Stigmatization, 140, 147
Stone walling, 182
Stress. *See also* Adversity and stress
  management, 22, 28, 29
  psychological, 20, 21
  relationships, 18

T
Terminal illness
  activity scheduling, 217
  bibliotherapy and journaling, 217–216
  diagnosis, 211–212
  problem-solving, 217
  psychological distress, 213–216
  RE&;CBT couples therapy, 218–212
  relaxation training, 217
  treatment, 213
Theories of aging
  design/self-adaptive, 244–245
  developmental psychology, 243
  disengagement, 244
  physical and mental deterioration, 244
Therapeutic homework, 205, 206
Transitions, 247

U
Uncertainty reduction theory (URT), 54
Unconditional acceptance of others (UOA), 6, 75, 177, 179, 182
Unconditional self-acceptance (USA)
  REBT and CBT therapists, 186
  and UOA, 177, 179
UOA. *See* Unconditional acceptance of others (UOA)
URT. *See* Uncertainty reduction theory (URT)
USA. *See* Unconditional self-acceptance (USA)

W
Wellness activities, 251–252
World view, 149, 159