Chapter 2
Couples' Cross Complaints: "I Want… but She/He Doesn't Want to…"

An eye for an eye only ends up making the whole world blind.

—Mahatma Gandhi

Ellen Rosario was reluctantly convinced by her husband, Frank, to seek the help of a couple therapist, but privately she had already decided to attend only one session. If she did not feel markedly better about their 27-year marriage after that session, it was all over for her. In her mind, Frank was far too similar to his father—"both of them are overbearing and emotionally aloof." At age 63, Ellen felt she only had a few good years left to find a better partner. One therapy session—that's all she would give Frank. But you, the therapist, have no idea that this is her intention.

You open the first session confidently, warmly introducing yourself to the couple. Then you turn to Ellen and say, "In our brief conversation on the phone, Frank told me that you're looking for help with some marital issues that have been troubling you both for awhile. That's about all I know. Could you give me some idea of how I can be of help, from your perspective?" Your intention in starting off this way is to draw Ellen in, since Frank was the one who had called for the appointment. It's your usual practice to begin therapy this way with couples.

Ellen doesn't look at Frank. She demurs: "Oh, I don't know. The problems have been going on for a long time." Silence.

"Can you be more specific?"

"Well, I'm not happy. I don't think Frank is happy either, actually."

Since it's clear that Ellen is disinclined to say much more, you wonder how to engage her in the intake process. Knowing that agreement on therapeutic goals is one component of a strong working alliance (Bordin, 1979), you decide to summarize the little she's said to this point, hoping for an agreement: "So, I understand that there are longstanding problems in your relationship as a couple and you, Ellen, have not been satisfied with the way things have been going for a while now. So, our work together would be to help you with these problems, right? to improve your marriage?" Looking at Ellen, you smile encouragingly. She simply says, "You got it."

With a different component of the alliance, the tasks of therapy (Bordin, 1979), in mind, you then ask, "Ok, so could you fill me in on what you'd like to discuss today?"

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"Frank can tell you."

This is not going well. You figure that Ellen's deferral to her husband might be characteristic of their style—Frank, holding the power in their relationship, speaks for Ellen. You're wrong, of course, but you don't know that.

"Frank, what are you and Ellen hoping to get out of our work together?"

Ellen repositions herself in her chair so that she is turned away from Frank. She stares out the window, seemingly disinterested. Frank replies, "Like you said, we need to work on our marriage. I love my wife." He tries to catch Ellen's eye, but she refuses to look at him.

Figuring that you might be able to win Ellen over by focusing on your bond with her, you say, empathically, "Ellen, I gather this process is somewhat difficult for you. I'd like to help."

Silence.

At this point, you realize that your alliance with this couple is in trouble. Although Frank seems willing enough to have a conversation with you about the potential goals and tasks of couple therapy, Ellen clearly is not. What to try next?

The classic model of the working alliance, as defined by Bordin (1979), requires clients to negotiate the goals and tasks and be interested in creating an emotional bond with the therapist. However, as illustrated in this example, this negotiation process can fail even in the first moments of the initial session. Something else needs to happen for the therapy to get off the ground.

In this case, Ellen privately thinks that therapy will save their marriage only if Frank changes his overbearing manner, but she is too fearful to say that aloud. She is not feeling safe in the therapeutic context—one she didn't choose and doesn't trust. If you, as the therapist, do not take action to help her feel safe, there is little hope of her becoming meaningfully involved in the therapy. Even attending a second therapy appointment is unlikely.

Here is where, in our view, the classic model of the working alliance falls short when applied to conjoint couple therapy. In particular, safety is essential for effective negotiation of goals and tasks. Unlike safety in individual therapy, which is of course essential, in the couple therapy context, partners need to feel safe with each other. Although the emotional bond aspect of the therapeutic alliance is also essential, in the absence of safety, a strong connection with the therapist is not sufficient. The therapy is likely to falter, later if not sooner.

Couples like the Rosarios are not unique. Indeed, couples often seek professional help for their relationship problems when they are at the end of their rope. A major obstacle to successful couple therapy occurs when the partners disagree on the problem, with each person locating the difficulty within the other, and when their goals for treatment are dissimilar. Even if both partners were to view the problem *and* the goal similarly (say, "We don't have nearly the same kind of emotional or physical intimacy we had when we got together and we'd like help finding it again"), they may disagree about whether therapy is the optimal way to go about addressing their problems.

Unfortunately, the most challenging couple cases tend to be ones in which both partners feel unsafe in therapy. Their conflicts and insecure attachments with each

other result in polarized views about the therapist or about the value of obtaining professional help in the first place.

Not only do these kinds of couples have a hard time fully engaging in the therapeutic process, but when they feel particularly unsafe, they also tend to lack a strong sense of "we-ness" about working together toward common goals. However, when the therapist is able to significantly enhance the within-couple alliance, the partners can come to see their situation similarly, and they may even begin to feel excited about working together in therapy to improve their lives. Generally, this attitude bodes well for the treatment, regardless of the therapist's preferred therapeutic approach.

Therapy with a couple is a triadic system: two partners + one therapist. Generally, the addition of a third person to an anxious dyad tends to stabilize the system (Bowen, 1978), which is what happens when couple therapy works well. However, when members of a couple are in deep conflict with one another and the therapist supports one person's position over the other's position, he can wind up destabilizing the dyad.

Clients like Ellen Rosario, who see their problems in black and white terms, often take note of the therapist's personal characteristics, particularly gender, in order to figure out whose side she's likely to take. With same-sex couples, the therapist's gender is either the same or different from the partners' gender, but with opposite-sex couples, the therapist's gender is the same as one partner's and different from the other partner's. In some cases, gender matters in couples' choice of a therapist, while in other cases gender only becomes salient as the therapy progresses.

Consider these other examples. Oscar, who was furious about Hector's reluctance to "come out," preferred a female therapist, believing that a (straight) male therapist would be less accepting of their gay lifestyle. Denyse and Jonathan, on the other hand, did not consider gender to be important in choosing a therapist to help them settle their dispute about whether or not to start a family. Early on, however, Denyse sensed that the female therapist was critical of her refusal to have children—in fact, Denyse became convinced that the therapist was making a play for Jonathan. Feeling unsafe, Denyse told her husband that the therapy was going nowhere and she would not continue.

Gender is not the only personal characteristic that affects the therapist's alliance with couples. Effective therapy with sexual, religious, or racial/ethnic minority couples requires therapists to be knowledgeable about these clients' unique concerns, self-aware, and vigilant of their own biases. Navigating a couple's culturally rooted relationship disputes requires considerable skill, particularly when there are multiple sociocultural differences between the therapist and the couple or when the partners themselves have diverse backgrounds.

Gayle, an atheist, was married to Al, whose family of origin was strongly evangelical. The religious difference seemed manageable when the couple first met but became a central focus of their difficulties when Gayle's extramarital affair with a co-worker came to light. Knowing that she had no future with her

lover, Gayle agreed to begin couple therapy with Al, who desperately wanted to save their marriage.

In the second session, the couple's stark religious differences took center stage. Al explained that due to "the sanctity of marriage," absolutely nothing could make him want to end it, even Gayle's "disgusting behavior with an even more disgusting human being." Reacting to Al's condemnation of her, Gayle countered by accusing him of being a "hypocrite" who hid behind his religious beliefs: "*You* can do *whatever*, since your *god* will forgive you, but *I* will never forgive you."

Not knowing what was behind this provocative statement, the (female) therapist asked Gayle to explain. At first Al listened to his wife with undisguised hostility. When he began talking over her, the therapist interrupted, asking him to "just listen, to try and understand where Gayle is coming from." Incensed, Al turned on the therapist, yelling, "Of course, we know *you're* a Jew, and *everyone* knows Jews are okay with divorce!" Then he stomped out of the session…and out of the therapy.

In this case, Gayle's and Al's religious differences became a lightning rod for many deep-seated betrayals of trust that threatened the couple's relationship. Even though they had begun therapy with a strong shared sense of purpose—to rekindle their 15-year marriage—the within-couple alliance plummeted when Al attacked Gayle and she defended herself by hinting at a shameful secret in their past. At that point, Al's fear of what his wife might disclose in the heat of the moment threatened his safety and fueled his mistrust of the therapist. Covertly, he had already convinced himself that the female therapist would take Gayle's side against him due to her gender and what he assumed to be her religious values.

Like hidden agendas ("We'll find a therapist and *then* I'll tell him our marriage is over – the therapist can take care of him"), secrets can cripple therapeutic work. When the secret involves a betrayal of any kind, couple therapy will be rough going. The challenge is compounded when rather than directly addressing the betrayal of trust, partners cross complain about one another's personality, attitude, or past behavior. In the case of Gayle and Al, diverse religious beliefs fueled their cross complaints, and the therapist's personal characteristics wound up becoming entangled in the couple's power struggle.

How is it that lovers can become bitter enemies? While there is no clear answer to this question, couple therapists need some way to understand how such a transformation can come about in each unique case. In this chapter, we discuss the challenges of working with high-conflict couples in which one partner refuses to engage in treatment or feels unsafe in the therapeutic context, couples who define their conflicts in zero-sum (win-lose) terms, and partners whose divergent views on the problem compromise their alliance with each other and with the therapist. After a review of relevant literature, we describe and illustrate how alliance-empowering strategies can help couples who have seemingly intractable conflicts.

Unique Challenges

"I Will…But S/he Won't Come to Therapy"

Eve had a horrible trauma history. Although she frequently attended Narcotics Anonymous meetings where she spoke candidly about her background, she balked when her partner, Julia, asked her to start couple therapy. Julia, for her part, had seen therapists regularly since her adolescence and believed that conjoint therapy could save her relationship with Eve, which was deteriorating rapidly. The two women fought over every issue, small and large, but as Julia told the therapist over the phone, "We do love each other."

Eve's staunch refusal to consider therapy was rooted in her long-standing mistrust of authority figures, stemming from the severe abuse she'd endured at the hands of multiple foster parents. Learning of Eve's history in the first session with Julia, the therapist agreed to focus on improving the couple's relationship in Eve's absence. The situation was far from ideal, but in time the therapist helped Julia disengage from cross complaining, and the couple's fights decreased in intensity and frequency.

Sometimes one partner is far too mistrustful to engage in conjoint treatment. As in Eve's case, the aversion to therapy may stem from trauma. In these cases, the unwilling partner may feel certain that any therapist would blame her for the couple's problems. In other cases, one member of the couple refuses treatment, fearful that acknowledging difficulties in the relationship will invariably result in separation or divorce.

In situations like these, therapists should carefully consider whether individual therapy with the willing partner might wind up harming the couple's relationship. After all, spending an hour each week with an empathic listener is likely to heighten a person's dissatisfaction with a partner who doesn't listen, who doesn't seem to care, who resists compromise, and so on. When the client is aware of the potential pitfalls, however, is able to see her contribution to the relational conflict from her partner's point of view, and is motivated to change her own behavior, individual work may well be beneficial for the couple.

Resistance is common when divorce is imminent. For most people, divorce spells failure, and the typical polarization—one person holding onto the relationship at all costs, the other person all too ready to abandon it—often results in cross-blaming. Resistance is particularly common when one spouse, the husband, for example, is convinced that *any* therapist would support his wife's contention that he is alienating the children from her.

Even psychologically healthy individuals tend to feel helpless and defeated in the face of divorce, which can evoke a flood of feelings that exceed the person's ability to self-regulate (Baris et al., 2001). In high drama cases, such as when the sexual abuse of a child is alleged, conjoint therapy may be contraindicated, even if the resistant partner eventually agrees to be seen.

"I Feel Comfortable Here, but S/he Doesn't"

A client who feels unsafe in the therapeutic context with her partner is unlikely to engage freely in the process. As a *therapy hostage* (Friedlander, Escudero, & Heatherington, 2006a, p. 88), he may have been coerced ("You'll come or else I'll…"), or if he is initially willing, he may be highly uncomfortable when certain topics are raised. If he shuts down in the session, therapy cannot proceed without addressing the lack of safety.

Safety can also become an issue when one member of the couple believes that her personal problems are at the root of the relational conflict. Sandy, an unemployed landscape artist, knew that her obsessive-compulsive disorder had escalated to such a degree that life had become unbearable for her partner, Dale, and their three children. Reluctantly, she agreed to "go with" Dale to see a mental health professional. Sandy's comfort improved considerably after spending some time alone with the therapist, who normalized her embarrassment and compassionately pointed out Dale's apparent caring and concern for her.

"I Want This*, but S/he Wants* That*"*

Since much of society is organized around winners and losers (sports, politics, the justice system, and so on), it is not surprising that couples' problems often feel like a tug of war. Indeed, some polarizing issues invariably result in a "win" and a "loss"—Will we relocate for your job? Will we have another child? Will we invite my mother to move in with us? Will we force Junior into rehab?

Relationships, however, are not a zero-sum game. In fact, "winners" sometimes wind up feeling like losers. And "losers" who nurture their loss at the other's expense sometimes feel like winners.

On the other hand, partners who feel cared for, supported, and respected in their relationship are usually able to negotiate zero-sum problems to a satisfactory conclusion. Sometimes he gets his way, sometimes she does. They figure out that the "winner" in a particular conflict situation should be the person for whom the decision matters most, or they decide on a third choice of action, one that they both can live with and that neither person abhors (Wachtel, 1999).

In therapy, zero-sum problems may mask a covert quid pro quo: "Since I gave in and came to therapy with you, now you need to give in and do things my way." Often the therapist gets caught in the conflict, feeling a push to pronounce who's right and who's wrong. In the absence of significant health and safety concerns, however, choosing sides is likely to result in a seriously split alliance, possibly irretrievably so.

Stuart Hoffman and Madeline Thayer were locked in a bitter zero-sum fight over finances. He wanted to declare bankruptcy and start afresh. She insisted that they ask her parents to lend a hand. The couple's attack/defend fights had become particularly acrimonious, with cursing, name-calling, and even some minor property damage. Like other seemingly unresolvable conflicts, theirs was clearly deep-

seated. However, as they began to trust the therapist to contain their hostility, hidden emotions slowly came to light. Stuart felt like a failure as a provider—going to Madeline's parents for help would make him feel less of a man. Madeline didn't see Stuart as a failure—rather, she was sure he blamed her for having purchased some "luxuries" that they clearly couldn't afford. When the therapist helped them see how they both projected their experience of self-blame onto the other, they were able to make some financial decisions that suited them both.

"I Think the Problem Is This*, but S/he Thinks the Problem Is* That*"*

Even when both members of a couple are equally committed to their relationship and to working out their problems in therapy, their views on the issues may be in stark contrast. Alec thinks Don drinks too much. Don thinks Alec is a workaholic. Jalil thinks Aaliyah is too close to her sister and not fully committed to him. Aaliyah thinks Jalil criticizes her because he is depressed and needs medication.

It is a rare couple that can see through these kinds of cross complaints to recognize the circularity of their problems. After all, she is focused on his problematic behavior and not her own, while he is focused only on her behavior. For the therapist, the key is to avoid taking sides but rather to help the couple see the circularity: Don drinks alone since Alec works late most nights, and Alec stays at the office to avoid watching Don drink. Jalil criticizes Aaliyah for spending more time with her sister than with him, and Aaliyah escapes to her sister's home to avoid Jalil's criticism.

The challenge of developing a new understanding of relational problems is made all the more difficult when partners argue about *how* they communicate. Don complains that Alec shuts down when he brings up problems to discuss, and Alec counters that Don becomes enraged whenever he takes too long to answer. Aaliyah complains that Jalil follows her from room to room with his demands, and he complains that she gets defensive when he tries to "reason with her." Eventually every argument ends with despair: "We just can't communicate." The impasse shows up in therapy conversations time and time again. If the therapist can't help the partners break the self-perpetuating cycle, all too often they drop out, demoralized.

Recommendations from the Literature

Not All Conflicts Are the Same

Some level of conflict is inevitable in intimate relationships. There is, however, a difference between *destructive* and *constructive conflict* (Cummings et al., 2016, pp. 125–127). Destructive conflict is emotionally intense, often nonverbal

(withdrawal or "the silent treatment" on the one hand, aggression or violence, on the other hand) and can threaten the very existence of the relationship. In contrast, partners who are able to use conflict constructively are able to do so because they each have a capacity to self-regulate in response to the other's feedback (Beach, 2016). Constructive verbal conflict results in resolution or, if not, involves some degree of problem solving that is approached from an emotionally centered place of mutual respect (Cummings et al., 2016).

Since conflict tends to highlight partners' differences and each person's individuality, it is important to consider the forces that impede constructive conflict. One author (Basham, 1992) theorized that resistance to conflict resolution, and thus resistance to couple therapy, derives from sociocultural influences, including ethnicity, socioeconomic class, and religion; systemic factors like patriarchy and social class; the couple's interactional patterns, such as reactive distancing and detouring to the children; and intrapersonal factors, particularly those described by object relations theorists. In object relations terms, people who have achieved "object constancy" are best able to tolerate ambiguity and conflict in their relationships. They can see that their own point of view is subjective and accept that the other person sees the situation differently. On the other hand, people who resist conflict resolution tend to be those who project negativity onto others or who isolate themselves emotionally in order to focus on gratifying their personal needs (Basham, 1992, p. 253).

Individual Differences Matter

Results of many research studies suggest that men and women tend to experience couple therapy differently. Moreover, the gender dynamics in couple therapy are complex. Whereas a strong within-couple alliance seems to be most influential for women (Anderson & Johnson, 2010), maintaining a favorable alliance with the therapist is particularly important for men (e.g., Anker, Owen, Duncan, & Sparks, 2010; Knobloch-Fedders, Pinsof, & Mann, 2007), who are traditionally less likely to request couple therapy.

In a study of micro-processes (Thomas, Werner-Wilson, & Murphy, 2005), both members in a sample of heterosexual couples had stronger bonds with the therapist when their partners were disclosing and weaker bonds with the therapist when their partners made disparaging remarks about them. However, the men were less likely to concur with the therapist about the *goals* for treatment (e.g., to increase emotional intimacy) when their partners challenged them, whereas the women were less likely to agree with the therapist about the *tasks* of therapy (e.g., plan a "date night" during the session) when challenged by their partners.

Gender dynamics were particularly notable in a larger study with 168 married couples (Knerr & Bartle-Herring, 2010). At the beginning of therapy, husbands whose wives reported relatively more distress tended to be dissatisfied with their marriage. As treatment progressed, though, the alliance with the therapist overshadowed these individual differences. Alliance development differed for the men and women in this sample, however: When the wives had a strong bond with the thera-

pist, their marital satisfaction improved slowly, but the husbands' satisfaction increased only when their wives' bonds with the therapist improved.

In building strong alliances, clients' gender interacts with their levels of psychological and relational functioning. Although having psychiatric symptoms does not seem to deter alliance formation (Knobloch-Fedders, Pinsof, & Mann, 2004; Mamodhoussen et al., 2005), being more distressed with one's partner and having less trust in the couple relationship seem to hinder the development of a strong alliance with the therapist (Johnson & Talitman, 1997). In one study (Knobloch-Fedders et al., 2004), sexual dissatisfaction also hindered alliance development, but only for women.

In another study (Anderson & Johnson, 2010), women's levels of personal distress increased as their husbands' alliance with the therapist increased, but women's distress decreased as the within-couple alliance increased. Anderson and Johnson explained these results in terms of split alliances: "In couples where the husband is forming an alliance with the therapist at the expense of his wife, her symptoms increase. In couples that come together to form a strong within-system alliance, her symptoms decrease" (p. 232). The authors concluded that, "a particularly dangerous scenario in therapy is one in which the therapist aligns with the male partner at the expense of the alliance with the female partner and couple's within-system alliance during the initial stage of therapy" (p. 233).

Clients who experienced distress in their family of origin seem to have a particularly difficult time developing a strong therapeutic alliance. Knobloch-Fedders et al. (2004) found that recalling negative family-of-origin experiences hindered early alliance formation for men and contributed to a split alliance for women. Differentiation of self, which develops from how well a person's family of origin functioned (Bowen, 1978; Skowron & Friedlander, 1998), seems to have important implications for progress in conjoint treatment. In Knerr and Bartle-Herring's (2010) study, for example, partners who were less psychologically differentiated and had more stress began therapy with significantly greater marital dissatisfaction. Being emotionally cutoff, one aspect of self-differentiation, was the most detrimental contributor to dissatisfaction for both male and female partners.

Conflict and the Within-Couple Alliance

Across the clinical literature, the key to success in treating distressed couples involves building and maintaining a strong within-couple alliance or, in SOFTA terms, a *shared sense of purpose* (similar views of the problems, common goals for treatment, and valuing time spent together in therapy). Many authors describe the need to transform couples' cross complaints into mutually acceptable goals, such as regaining intimacy (e.g., Johnson, Makinen, & Millikin, 2001; Karam, Sprenkle, & Davis, 2015) or learning to co-parent effectively (e.g., Baris et al., 2001).

In the research literature as well, a strong within-couple alliance has been shown to predict improvement (e.g., Anderson & Johnson, 2010; Knobloch-Fedders et al., 2007) as well as clients' (Heatherington & Friedlander, 1990) and therapists' session

evaluations (Friedlander et al., 2006). In one recent study (Biesen & Doss, 2013), for example, couples who agreed on the nature of their relationship problems before beginning therapy tended to remain in treatment for the recommended number of sessions and made more clinically significant gains than couples whose initial views on their problems were dissimilar. Notably, another study found when the goal was to reduce problems between the partners rather than to manage their psychological symptoms, starting therapy with a strong within-couple alliance predicted success more so than either partner's individual alliance with the therapist (Anderson & Johnson, 2010).

Establishing and maintaining a strong within-couple alliance is challenging, however. As in family work, this aspect of alliance tends to fluctuate over time (Escudero, Friedlander, Varela, & Abascal, 2008), and sharing a sense of purpose depends on the degree to which clients feel safe in the conjoint therapeutic context (cf. Friedlander et al., 2008). In recent case studies using the SOFTA-o with Spanish (Mateu, Vilaregut, Artigas, & Escudero, 2014) and Italian (Zaffarano, 2015) couples, both SAFETY WITHIN THE THERAPEUTIC SYSTEM and SHARED SENSE OF PURPOSE were highly variable. In Zaffarano's analysis of three sessions with four high-conflict heterosexual couples, all of whom dropped out of treatment prematurely, SAFETY was the most variable alliance dimension, particularly among the husbands, most of whom demonstrated problematic SAFETY in the first session. Whereas a negative SHARED SENSE OF PURPOSE was observed in three of the four couples, one of whom evidenced problematic ratings in every session, this dimension improved in the three other couples as therapy progressed. Of note, the fluctuations in these two aspects of alliance differed from the consistently positive ENGAGEMENT and EMOTIONAL CONNECTION observed over time in all four couples.

An analysis of the content of the four dropout cases supported the SOFTA-o analyses (Zaffarano, 2015). In the couple that had a consistently poor SHARED SENSE OF PURPOSE, for example, the cross complaints precluded the development of a relational perspective on the problem. Specifically, the wife complained of her husband's gambling, which he denied. Instead, he complained that his wife was not giving him enough "space." Based on the qualitative analyses and the SOFTA-o results, Zaffarano concluded that the premature termination of these couples was primarily due to the high conflict and lack of trust between the partners.

Alliance-Empowering Strategies

Managing Cross Complaints

Safety first. If members of the couple agree on the need for therapy but locate the problems in each other, it's likely that they will engage in cross complaining which, when intense, can escalate into cross attacking. Ground rules are essential to prevent

irreparable harm.[1] That is, the therapist must make it clear as soon as hostilities mount that name-calling, yelling, and physical outbursts will not be tolerated; rather, therapy is "the place to learn how to fight fairly." When it's put this way, couples will usually agree that despite their years together, they never learned to resolve their disagreements constructively, i.e., through problem solving.

Managing safety also involves attending to each partner's expressions of vulnerability and protecting the more vulnerable partner from acrimonious blame and hostility. If the emotional heat becomes unbearable, one partner may get up and leave the office. This reaction signals that safety is sorely compromised. Generally speaking, it's unwise to coax the escaping client to return to the session, since such extreme discomfort needs to be respected and high-conflict partners need to give one another the space to calm down before reengaging.

Safety also involves teaching couples that people have varying needs for closeness or distance, especially in the face of conflict. Elena and Carlos Guzmán had different appetites for lovemaking, which were reflected in how they argued about this problem. Carlos blamed Elena for leaving the room when he got loud. Elena blamed Carlos for not comforting her when she sobbed during their fights. Elena felt supported when the therapist explained to Carlos that a "cooling-off period" was acceptable, even desirable, so that Elena could "re-center" before returning to the argument. Carlos felt supported when the therapist helped him explain to Elena that his way of re-centering made it difficult for him to comfort her when emotions ran high. Both members of the couple were relieved when the therapist explained that neither partner had the corner on Truth: When Carlos brought up problems in their sex life, his *intention* was not to "hurt" Elena, but the *effect* of his doing so did hurt her. In other words, just because Elena felt hurt didn't mean that Carlos's intention was to hurt her.

By empathizing with each partner's pain, a therapist can create emotional connections with both members of the couple. Then, by pointing out their common experience of feeling hurt, misunderstood, and unloved, the therapist begins to formulate a shared sense of purpose around improving the couple's relationship. And, by refusing either partner's subtle or not-so-subtle attempt to align with her, the therapist demonstrates that her role is not to take sides in the fight but rather to strengthen the partners' bonds with each other.

Some conflicts are so intense that the partners need to be restrained from interacting with one another in the session. To maximize safety in her emotion-focused approach to couples work, Johnson (e.g., 2004) typically directs her comments about attachment needs and fear of abandonment to each partner separately. In this way each partner hears the other's deepest feelings without being put on the spot to respond.

Therapy sessions like these tend to be quite emotional. When the session ends, the therapist can direct the couple to refrain from discussing the same issues for the

[1] A careful assessment of a history of intimate partner violence is necessary before undertaking conjoint therapy, which is contraindicated in these cases. The discussions in this chapter only reflect conjoint therapy in which violence is not a concern.

remainder of the day or, when emotions are running particularly high, until the next therapy appointment.

When conflicts center around the children, couples often request family therapy. If, however, the partners begin cross complaining about one another's parenting[2] in front of the children, the therapist should work with the couple alone, at least at first. Doing so protects the children and sends the message that as parents, they need to avoid using the children as pawns in their fight.

When separation or divorce is unavoidable, each partner should be seen individually to create a strong bond with the therapist. Hopefully, a strong individual alliance will help the therapist foster a within-couple alliance focused on the children's needs. Unfortunately, not all clients can set aside their complaints with their partner to engage in problem solving around co-parenting. To do so requires each parent to forego the gratification of personal needs (like revenge or monetary gain) for the good of the children. When only one partner can put the children first, conjoint couple therapy may be unworkable.

Managing Zero-Sum Conflicts

Not surprisingly, when there is a zero-sum conflict, one member of the couple may actively resist engaging in therapy. It is important to recognize, however, that resistance is a systemic dynamic, not an individual trait. That is, while resistance may be located within one member of the couple, it actually reflects both partners' ambivalence about therapy and/or their fear of change. Janice mostly wanted to leave Dave but a part of her wanted to hold on. For his part, Dave was fed up with Janice but was very afraid to end their 10-year relationship. Finally, he acceded to her demand that they consult a therapist. At first the couple's polarization intensified: The more Janice voiced her determination to leave, the more Dave pleaded with her to stay. Once the therapist helped them recognize their shared ambivalence, they were able to make a less emotionally charged decision about their future.

Illustrating the successful resolution of resistance, Basham (1992) described the process of working with Mary Lou and Paul Jensen. As explained to the therapist, the couple sought help due to "intense arguments" over Mary Lou's infidelity with a family friend; their goal was to decide whether to separate and eventually divorce or to reconcile (p. 257). At the outset, the therapist recognized that the partners' sociocultural and religious backgrounds made Paul, in particular, "averse to therapy" (p. 257).

To reduce resistance and enhance engagement, the therapist began by explaining the purpose, processes, and potential outcomes of couple therapy. Early on, the objective was to create an individual bond with each client. Safety was of concern for both partners: Paul, who was on active duty in the Navy, worried about confiden-

[2] See Chap. 4 for a discussion of the challenges of working with one parent when the other parent is absent or not involved with the children.

tiality, and Mary Lou asked the therapist not to tell Paul a secret about her extramarital affair. Addressing these issues, the therapist assured the couple of confidentiality and contracted with them about the policies (e.g., not keeping secrets) and length of therapy.

The therapist began fostering the couple's shared sense of purpose by exploring their views on marriage, family, and power dynamics in relationships. Early discussions revealed that both partners' family backgrounds, although different (Paul was raised in a Scandinavian farming community and Mary Lou's Irish Catholic family worked in the coal mines), stigmatized professional help seeking.

Shared purpose was also addressed when the therapist explained that the specific goals for treatment needed to be determined by the partners themselves. Helping them do so, the therapist pointed out their mutual feelings of hurt, mistrust, and anger, "review[ed] the strengths and problem areas in the marriage" (Basham, 1992, p. 258), and emphasized "empowerment and enhanced self-differentiation for each partner" (p. 260). A sailing metaphor was introduced to describe the therapist's role: "to guide the couple through various impasses to meet their destination, much as a navigator might assist a sailing crew with their journey" (p. 258).

Undoubtedly, the therapist's consistent focus on the relationship was instrumental in helping the couple to heal. During treatment the partners created a "fidelity agreement," which they then solidified in a "renewal ritual" that symbolized a renewed commitment to their marriage (p. 259).

Case Example: The Singh-Whalens

Camille lamented, "I gave up *everything* for you – my religion, my *family*!" Joel, furious, threw back at her, "And what did I do for *you?!"* (negative SAFETY[3]). Then, turning to the therapist, he said, "Do you see how she twists everything?"

On the surface, Joel (35) and Camille (33) Singh-Whalen led a privileged lifestyle. They were solidly middle class and well educated, and both of them had achieved some important milestones in their respective professions. Nonetheless, they were miserable with each other, emotionally cutoff from their respective families of origin and struggling to raise a hyperactive 6-year-old with little support from others.

Refusing Joel's bid to align with him (negative SHARED PURPOSE[4]), the therapist pointed out that both he and Camille were hurting "with the way things stand between you now" (SHARED PURPOSE[5]). Quick to interrupt, Camille lashed out at the therapist sarcastically, "Do you think you're really prepared for this fight?" (negative EMOTIONAL CONNECTION[6]).

[3] Client responds defensively to another family member.

[4] Family members try to align with the therapist against each other.

[5] Therapist draws attention to clients' shared feelings.

[6] Client comments on the therapist's inadequacy.

The Singh-Whalens argued about virtually everything. In their first session, Joel blamed Camille for being "a workaholic"—she was "never home, never available for the family." Defensive, Camille reacted: "I converted [to Catholicism] for *you*, and what did it get me? My parents won't talk to me, and yours are barely civil to me! What do I have besides my work?" (negative SAFETY[7] and negative SHARED PURPOSE[8]).

Surprised at their bitterness toward one another, the therapist asked to see each partner alone before contracting for conjoint treatment, an approach that enhances safety and emotional connection. In his individual session, Joel tearfully revealed the source of the problems from his perspective: Camille had no sexual interest in him and wouldn't even allow him to touch her with affection (SAFETY[9]). In her individual session, Camille explained that while she loved Joel, she felt that she'd lost her "self" in their relationship along with her religion and her family. In both of these sessions the therapist worked to create a bond with each partner (EMOTIONAL CONNECTION[10]) that he hoped would foster a within-couple alliance in the subsequent conjoint session.

With both partners present, the therapist explained his role (ENGAGEMENT[11])—not to take sides but rather to "help you step outside of the deep rut you're both in, to stop blaming each other and instead find the kind of love and commitment you once had, which led you, Camille, to convert to Catholicism over the protests of your parents and you, Joel, to take her side against your own parents. This won't be easy – you'll need to open up to each other in a way you haven't in a long time" (SHARED PURPOSE[12] and SAFETY[13]). Leaning forward (ENGAGEMENT[14]), Joel murmured, "I only want the best for us both." Camille looked at the floor (negative CONNECTION[15]), stoically silent.

Focusing his efforts on SAFETY, the therapist proposed four ground rules for their work together (SAFETY[16]): (1) not talking over one another; (2) discussing only one problem at a time; (3) focusing on observable behavior rather than on motives, attitudes, or personality; and (4) not characterizing each other's behavior using the terms "always" and "never" (e.g., "You never listen to me"; "You always treat me badly"). In response, Joel suggested that he and Camille commit to these rules "even at home" (ENGAGEMENT[17]). Smiling for the first time, Camille teased him, "If you really think we can do this, then maybe you'll finally agree to let me

[7] Client responds defensively to another family member.

[8] Family members blame each other.

[9] Client shows vulnerability (e.g., discusses painful feelings, cries).

[10] Therapist expresses empathy for the clients' struggle.

[11] Therapist explains how therapy works.

[12] Therapist draws attention to clients' shared experiences and feelings.

[13] Therapist acknowledges that therapy involves taking risks.

[14] Client leans forward.

[15] Client avoids eye contact with the therapist.

[16] Therapist provides structure and guidelines for safety.

[17] Client describes a plan for improving the situation.

buy the car I want!" (SAFETY[18]). "Only if you let me drive it from time to time!" Joel quipped with a smile (SHARED PURPOSE[19]).

Encouraged by this shift in tone, the therapist pointed out the partners' common experience of feeling rejected by the other "in the ways that hurt most" (SHARED PURPOSE[20]). The remainder of the session was devoted to exploring, separately with each partner, "how you fell in love." Uncharacteristically, Camille began crying (SAFETY[21]) when Joel mentioned his admiration for her professional achievements and her "spunk in standing up to her sexist boss."

Paying attention to Camille's vulnerability in the moment, the therapist got up, gently turned Joel to face his wife and motioned for him to take her two hands in his (SHARED PURPOSE[22]): "Joel, tell her how much you miss her" (SAFETY[23]). Joel did just that (ENGAGEMENT[24]), and Camille began sobbing in earnest. To give them privacy, the therapist said, "I'll be back," and stepped out of the office for a few minutes.

The therapist realized that as encouraging as this intimate moment had been, Camille and Joel were likely to revert to cross complaining. For this reason, he ended the session by proposing a "homework assignment" and asking if they would be willing to commit to trying it in the coming week (ENGAGEMENT[25]). The task was to keep a writing pad on the table next to their bed; each person should write a brief note to the other every day, starting with the affirmation "I appreciate you for…." Smiling, Joel remarked, "It seems like we do need something like this to stay positive" (ENGAGEMENT[26]), to which the therapist replied, "I'm impressed by both of you – you seem willing to do the hard work to get back on track. I'm hopeful that we can do this together" (ENGAGEMENT[27]).

Of course, the mutual blaming did not end quickly, but the couple kept their appointments and, from time to time, spontaneously mentioned that "things seem a little better at home" (ENGAGEMENT[28]). Each partner saw progress in the other that mattered: Joel was encouraged by Camille's occasional affectionate touch. Camille was encouraged by Joel's genuine interest in what she was doing at work. The therapist was encouraged when Camille told him, "Well, we started to get into it [a fight] last Sunday, but then we looked at each other and stopped. We remem-

[18] Client varies her emotional tone during the session.

[19] Family members share a lighthearted moment with each other.

[20] Therapist draws attention to clients' shared experiences and feelings.

[21] Client shows vulnerability (e.g., discusses painful feelings, cries).

[22] Therapist encourages clients to show caring, concern, or support for each other.

[23] Therapist helps clients talk truthfully and nondefensively with each other.

[24] Client complies with therapist's request for an enactment.

[25] Therapist asks clients whether they are willing to do a specific homework assignment.

[26] Client expresses optimism.

[27] Therapist expresses optimism.

[28] Client indicates that a positive change has taken place.

bered the ground rules you set when we started here (ENGAGEMENT[29]) and so we decided to wait till we came today to talk about it" (SAFETY[30]).

As the therapy progressed, the couple's conflicts slowly eased. In Session 8, Camille began the session by saying that they'd agreed it was time to work on "solving the Parents Problem" (ENGAGEMENT[31]). Joel explained that now that their son was 6 years old, they'd decided that it was "time to bring down the walls with his grandparents – on both sides." Recognizing that developing a common goal outside the therapy office signaled an improving within-couple alliance, the therapist asked for an explanation of their intentions. Although he'd surmised that Camille's conversion to Joel's religion over the protest of both families might be at the heart of the couple's difficulties, the therapist took a step back to observe how well the partners were approaching this problem together. Camille put it eloquently: "It's time we stopped using our parents to destroy each other."

The plan was not altogether successful. Camille's parents were unforgiving, but Joel's parents warmed considerably toward her when she told them how important she thought it was to raise their son in Catholicism. More notable than the couple's project to restore bonds with their parents, Joel and Camille demonstrated that they'd learned to trust and respect one another in a way that was altogether new for them.

Naturally, the couple's other problems did not magically disappear. When they decided to end the therapy, Joel still wanted more sexual contact than Camille was comfortable with, and Camille sometimes found it hard to assert herself with Joel. On the whole, though, this very challenging case was remarkably successful.

Final Thoughts

Although most people expect the outcome of couple therapy to be positive, they tend to have higher expectations for their own engagement in the process than for that of their partner (Friedlander, Muetzelfeld, Re, & Colvin, 2016). Nonetheless, clients expect their partners to participate freely in the therapeutic process, and they expect their therapists to be supportive and provide an alternative perspective on the relational problems they bring to treatment (Tambling, Wong, & Anderson, 2014).

We began this chapter with the question of how is it that lovers can become enemies. Of course every couple is unique, and this question has no answer. As therapists, we just need to muddle through. Although high-conflict couples rarely turn their enmity into romantic bliss, they can make meaningful progress. The key for the therapist is to maintain a consistent focus on safety and the within-couple alliance in order to leverage the hard work of relational transformation.

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[29] Client mentions the therapeutic process.

[30] Client implies that therapy is a safe place.

[31] Client introduces a problem for discussion.

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