1

SHORT-TERM COUPLE THERAPY AND THE PRINCIPLES OF BRIEF TREATMENT

JAMES M. DONOVAN

Forty percent of mental health referrals involve marital conflict (Budman & Gurman, 1988). Some 120 million patients receive their mental health coverage through one or another managed care arrangement (Shore, 1996). If we ever needed workable models of time-effective couple therapy, we need them now.

In the preface, I emphasized the need for a practical, specific guide to what actually works and doesn't work in brief treatment with couples, but there are other reasons I edited this volume. Effective time-managed therapy for couples clearly represents a key goal for mental health practitioners, but couple therapy has an identity problem, which we address in this book. No one seems sure whether couple treatment is individual therapy in double focus, a subspecialty of family work, or some unique enterprise (Gerson, 1996). Marital counseling, in various formats, has been with us for decades (Nichols & Schwartz, 1998), but couple therapy as a definitive treatment form has only come into its own in the last decade (Jacobson & Gurman, 1995). Couple therapy is, thus, a less mature field than its close cousins on either side—short-term individual therapy (see Gustafson, 1986, and Budman & Gurman, 1988) and family therapy (see Nichols & Schwartz, 1998). As recently as

1991, Susan Johnson noted that we still lack a comprehensive theory of couple intimacy and therefore of marital dysfunction on which to base our work (Johnson, 1991).

We constructed this book to assemble examples of the major schools of short-term couple therapy in one place. An examination of the similarities and differences between these approaches represents the only reliable method to ascertain the present conceptual and technical state of the field. Our hope is that the book will then propel couple therapy toward a consolidation phase, one reached by short-term individual therapy and family therapy in recent years. These two other fields of psychotherapy boast many well-defined schools of approach, multiple treatment manuals, substantial outcome statistics covering many methods, and their own journals. By illustrating where we are now in the field, perhaps we can take stock and outline where we need to go next.

"Couple therapy" is part of our title, and an additional reason for writing the book can be found in the title as well. Couple treatment is the only form of psychotherapy that began as *brief therapy* (Budman & Gurman, 1988). (Freud originally conceived of psychoanalysis as a short treatment, but as we see today, it became the longest of all therapies.) Two-thirds of couple treatment still comprises fewer than 20 sessions (Budman & Gurman, 1988), so when we refer to couple treatment, we are inevitably speaking of a brief modality.

With the advent, some would say the outbreak, of managed care, practicing brief therapy has become singularly important. Brief treatment is not just rapid long-term therapy, it carries specific principles of its own that we will learn much more about as we study each chapter. The book, then, is about *couple therapy* but also about how to do time-effective treatment. The balance of this chapter outlines the important principles about brief therapy.

In this volume we encounter a spectrum of approaches: dynamic–gestalt (Johnson), structural (Nichols and Minuchin), narrative (Neal, Zimmerman, and Dickerson), solution-focused (Friedman and Lipchik), and on and on. Neither research evidence (Johnson, 1991), nor clinical experience, nor common sense, can persuade us that one model here is superior to others. Couple therapy will never have a world series or choose a most valuable player. Rather than competitively contrasting our models, it seems more rewarding to trace the common struggles of our authors and to search for parallel elements in the models that they have constructed to help couples toward effective change within the brief therapy format.

Reading through the chapters, we discover that all the authors, sometimes explicitly, sometimes not, grasp and then integrate within their systems at least six principles of brief therapy. These represent the

same action premises that organized the work of the brief individual treatment pioneers 20 years earlier (Donovan, 1998). We will encounter these six guidelines frequently, so let's name them now:

1. Find the focus.
2. Maintain flexibility.
3. Build affective intensity.
4. Encourage the alliance.
5. Arrange an emotionally affirming experience.
6. Plan the treatment.

The differences among the models emerge from the alternate positions that our writers assume on each of these principles, but if the treatment promises efficacy and brevity, each of these six sign posts that mark the trail must be carefully observed and heeded.

PRINCIPLE 1: FIND THE FOCUS

If the three most important attributes of real estate are location, location, location, then the three most important features of time-effective therapy are *focus, focus,* and *focus*. Our practitioners ask themselves again and again what emotional conflict, blurred boundary, behavioral snare, or misplaced view of self lies at the core of this couple's dilemma? How will I clarify, deepen, or reframe that focus to bring it to the center of the treatment?

Susan Johnson searches for the point of "emotional softening." Does fear of abandonment underlie the angry wife's tirade as she lashes out at her withdrawn husband? Steven Friedman and Eve Lipchik hunt for positive interactions between the couple and use these as an antidote to the problem-laden story. Richard Vogel looks for the pathogenic belief in one partner that will explain his or her proclivity to respond in some unhelpful way: to withdraw, explode, or provoke.

The landscape becomes more cluttered, though, the further we study the focus. The authors choose their focus based on a conceptual framework, which underlies their approach. Johnson relies on Bowlby's attachment theory to help her understand the largely unconscious affects surrounding loss of connection. These she will map as she pursues an intervention that will help the couple share an empathic experience. One partner must "soften" in his or her affective response to the other. Michael Nichols and Salvador Minuchin keep a structural framework as they search for enmeshed boundaries in the family seated before them,

the nexus of the couple or family conflict. To develop an understanding of each author's approach, examine first his or her *theoretical base*.

Understanding the different approaches becomes still more complex, since each author has developed *core technical maneuvers* that will allow him or her access to the focus he or she seeks. Joseph Eron and Thomas Lund know a great deal about enlarging upon preferred views of self. Susan Johnson has become expert at integrating into the couple's relationship the repressed affect behind their paralyzed stance. I comb the past of the patient and bring it into the present at the right moment: "Your mother was hypochondriacal. You learned to ignore her, but what will you do now with your wife's current complaints?" Study the core techniques that emerge from each theory that the authors use to work their focus.

PRINCIPLE 2: MAINTAIN FLEXIBILITY

However artfully framed the focus, and well-honed the core techniques, brief therapy provides little time to convince the patient of your point of view. Therapists practicing brief couple therapy have learned to flexibly engage patients no matter what their thoughts and feelings when they first come for treatment. Alexander and French (1946), the grandfathers of today's brief treatment, articulated the principle of flexibility early and often in their remarkably modern 1946 book describing short-term dynamic therapy. In one celebrated case, Alexander tolerated rebelliousness at the hands of the glass manufacturer's son because this was exactly the relationship offer that the patient's father could not abide. Eron and Lund and Friedman and Lipchik place flexibility at the center of their approaches and encourage us to understand and work with the patient's world view and preferred view of self from the very first phone call. Different authors promote flexibility in different ways, again consistent with their theoretical outlook. Flexibility, however, remains at the center of time-managed couple therapy.

Flexibility does not imply a free-for-all treatment in which anything goes. Each writer grapples with the question of *patient selection*. Not every set of clients is encouraged to continue with couple therapy after the assessment period. Again proceeding from their theory and their core techniques, Johnson and Erika Lawrence, Kathleen Eldridge, Andrew Christensen, and Neil Jacobson designate the first three or four sessions as evaluative. I organize a pregroup workshop before offering couples group therapy. Daniel Wile, though, is less concerned with exclusionary criteria and is more likely to start right out in helping his

couple partners construct a shared platform from which to view their relationship.

All our authors engage a wide variety of patients in their treatment, espousing as they do the principle of flexibility, but most exclude psychotic, actively addicted, or assaultive individuals. Trace how these writers confront and work with the patient selection issue.

PRINCIPLE 3: MANAGE THE EMOTIONAL INTENSITY—TO STOKE THE FIRE OR COOL THE JETS?

Brief, dynamic, individual therapists assumed that change could only come through stirring emotional intensity. Malan (1963), Davanloo (1980), and Gustafson (1986), as a central technique of their therapies, attempted to put the patient in touch with as much of his or her true feelings as he or she could tolerate at any given moment. Johnson and I stand as the couple therapy heirs to Malan, Davanloo, and Gustafson. Johnson's therapy turns on the breakthrough of "hard" feelings into the "soft" emotions beneath. Anger covers fear of abandonment. Silent withdrawal masks confusion and guilt. I, too, search for the affect. I push my patients to connect the bitter disappointments of the past with the present marital conflict.

Wile takes a midway position on emotional expression. He coaches his couples to feel entitled to their affective storms and to incorporate these reactions into the relationship conversation. However, he is not primarily interested in fanning the coals to create greater heat. Friedman and Lipchik and Eron and Lund attempt to circumnavigate the tornado of feeling by emphasizing present positive experiences and resurrecting the preferred views of self within the relationship. We know all too vividly that couples present with plenty of emotional intensity. All our authors assume a definitive position toward that intensity dictated by their conceptual stance and enacted through their core clinical techniques. The fascination comes in the different paths that therapists take as they confront the affective storm.

PRINCIPLE 4: BUILD THE ALLIANCE

Brief therapists have learned that the satisfactory engagement of Principles 1–3 helps foster the therapeutic alliance. Gustafson (1995) repeats the one common finding across all psychotherapy research: Positive therapeutic alliance abets positive outcome, and negative alliance, negative

outcome. The couple must feel that the therapist has grasped their most important issue (the focus), that he or she can tolerate their most disturbing feelings (emotional intensity), and that the clinician accepts them in the distressed condition in which they arrive (flexibility).

Once again our authors build the alliance according to their own theories and move toward it with their own techniques. The Lawrence, Eldridge, Christensen, and Jacobson camp work hard to reduce the couple's polarization by increasing emotional acceptance. Then the partners will be sufficiently allied with each other and with the therapist to enter fully into the behavioral exchange and communication problem training, the second half of the treatment, which will increase their intimacy and satisfaction. Johnson's empathy with the hidden affective dilemma of each member of her couples helps each individual feel understood and attached, so they can reattach with each other in Steps 6 and 7 of her model. Johnson reports that her research on emotionally focused therapy suggests that therapeutic alliance, once again, is the most important predictor of positive outcome.

Whatever their approach to alliance building, it remains a high priority for our therapists, and they are willing to work for it, each in his or her own way.

PRINCIPLE 5: ARRANGE AN AFFIRMING EMOTIONAL EXPERIENCE

Every couple's treatment begins with more of the same. The members of the couple share their fight with their therapist by reenacting it for him or her. Each partner first enters the office feeling confused, blamed, frightened, angry, bitter, and most of all, powerless to alter the destructive downward plunge of this important relationship. Demoralization is the order of the day. To address this despair, any brief treatment, and particularly couple treatment, must offer an affirming emotional experience—"a new ending to an old beginning" (Alexander & French, 1946). Or, as Budman, Hoyt, and Friedman (1992) tell us, the time-effective therapist must rapidly introduce novelty into this complex situation to shed light on the first steps out. Implicitly or explicitly, our therapists guide their patients toward experiences and actions that lead to empowering capabilities, the only real antidote to their desperation.

The novelty introduced, of course, differs from therapist to therapist and reflects their core techniques. Wile teaches his couples to discuss the fight openly and to include it in their relationship. When they do this, they have a plan and a methodology to use that renders them less

powerless and returns them to the status of communicative adults, actively working toward shared goals. Friedman and Lipchik immediately start their couples in search of overlooked positive experiences in their relationship. Eron and Lund, from the first minute, work to help the partners reconnect with their preferred view of self through which they can activate solutions to their dilemma.

I help my couples to see that their fighting makes psychological sense, given their past family experiences, and then guide them in developing "tools" to understand and redirect the "fight." Eschewing subtlety, as is my wont, I exhort my patients to apply the just-learned techniques.

> "Paul, you've gained a new tool here. If you act condescendingly when Mary complains, you can always arrange a fight, but when you ask sincerely, 'Okay, tell me all your feelings about this; I'll help if I can,' then you've learned you simply aren't going to have a fight, and you'll gain some new knowledge in the process."

Note the number of optimistic, action words I have unconsciously piled into my coaching, "gained," "new tool," "learned," "gain" (again), "new knowledge." To avoid the trap of the fight, the patient must act in his or her own constructive fashion, the efficacy of which he or she already has proof.

We now have a hint about the secret of the emotionally affirming experience. The new skills need to be nurtured *less* with the therapist and *more* with the couple. The affirming emotional experience works outside the office as well—the true novelty. When members of the couple can practice and gain confidence in their "new tools," they no longer must travel to see their therapist. The treatment becomes both brief and effective.

PRINCIPLE 6: PLAN THE TREATMENT

"If you want therapy to be brief, plan it as brief" (S. Budman, personal communication, February 15, 1997). Malan (1963) and Mann (1973) demonstrated that treatment could be effectively planned within a preset number of sessions. My couples group always lasts 15 sessions, never more, never less. But Eron and Lund spy the possible pitfall here—the therapist can become procrustean and attempt to constrain therapy within too rigid a time limit. Both practitioner and patient might then lose confidence if positive change does not quickly appear. Better to keep the focus, nurture the alliance, search for the new perspective, and let these forces control the time limit. Budman, Eron and Lund, and Phyllis

Cohen space sessions more widely later on as couples practice their new skills. Therapy can be brief in number of sessions but long in elapsed time. All our authors agree, however, that termination must be anticipated and planned for rather than allowed to arrive willy-nilly.

Another planning dimension seems more subtle but carries equal importance. The therapy needs to unfold in a series of *general phases* so that therapists can gauge the couple's journey within the treatment plan as it develops. Johnson knows that if "softenings" seem few and hard to find by Session 7 or 8, her therapy is in trouble. I stay alert for couples who have yet to begin to process the fight psychologically by session 6 of my group or who have fashioned few tools by Session 12. Therapists need not view such aberrant courses with undue alarm, but they need to actively intervene to nudge their couples back on track. The lack of a therapy template introduces a virus into the system by exposing the treatment to the potential of uneven progress or the unfortunate surprise of a patient dropout: no therapy template, no safeguard for self-correction.

Not all of our authors describe definite phases of treatment. The postmodernists—for example, John Neal, Jeffrey Zimmerman, and Victoria Dickerson, and Friedman and Lipchik—stand resolutely as "anti-pattern and anti-normative structures" (S. Friedman, personal communication, March 20, 1997). They attempt to "co-create" a new language and a new conversation with each new client. However, a general outline of what to expect remains necessary for the working therapist and for us, the students. How to begin most treatments seems plain. How to end also clear, particularly if the outcome is a happy one, but the curative action tends to take place in the middle acts of the play. The therapist and the student must approach these middle sections alertly, learn how to recognize each, and how to predict which stage comes next.

Obviously no practitioner can or should plan a therapy in minute detail; this would violate the principle of flexibility. Therapists do need a good guidebook for the journey, though, and should be able to chart their location landmark by landmark. If they can't, they need to ask why.

CONCLUSION

Our introduction is becoming a place in which several truths about short-term couple treatment are revealed ahead of time. The last of these is that no one principle of time-effective therapy assumes more importance than another. The pioneers of brief individual treatment Malan, Mann, and Gustafson learned that the most important principle was to practice with all the principles in mind. Leave out any at your peril. Our

authors heed the same warning; we find most of our six principles fully on display in chapter after chapter.

Our writers have allowed us the privilege of entering their minds and their offices as they take on the exciting challenge of explaining and illustrating the brief couple therapy models they've worked so hard to develop. The education in this book can be found in the details. It's important to study exactly how our experts apply their trade. With which conceptual framework do the writers venture forth? What are their core techniques? How do our authors achieve focus, promote flexibility, build the alliance, and regulate emotional intensity? How do they use treatment planning to augment the strength of their interventions?

No book can substitute for actual clinical experience. However, our writers have given us a file of road maps. We must choose a few and start on the trip on our own, but we can refer back to this volume when we begin to lose our way.

REFERENCES

Alexander, F., & French, T. M. (1946). *Psychoanalytic therapy: Principles and applications*. New York: Ronald Press.

Budman, S. H., & Gurman, A. S. (1988). *Theory and practice of brief therapy.* New York: Guilford Press.

Budman, S. H., Hoyt, M. F., & Friedman, S. (1992). *The first session in brief therapy.* New York: Guilford Press.

Davanloo, H. (Ed.). (1980). *Short term dynamic psychotherapy.* New York: Jason Aronson.

Donovan, J. M. (1998). Brief couples therapy: Lessons from the history of brief individual treatment. *Psychotherapy, 35,* 116–129.

Gerson, M. J. (1996). *The embedded self.* Hillsdale, NJ: Analytic Press.

Gustafson, J. P. (1986). *The complex secret of brief psychotherapy.* New York: Norton.

Gustafson, J. P. (1995). *Brief versus long psychotherapy.* Northvale, NJ: Jason Aronson.

Jacobson, N. S., & Gurman, A. S. (Eds.). (1995). *Clinical handbook of couple therapy.* New York: Guilford Press.

Johnson, S. M. (1991). Marital therapy: Issues and challenges. *Journal of Psychiatric Neuroscience, 16*, 176–181.

Malan, D. H. (1963). *A study of brief psychotherapy.* New York: Plenum Press.

Mann, J. (1973). *Time limited psychotherapy.* Cambridge, MA: Harvard University Press.

Nichols, M. P., & Schwartz, R. C. (1998). *Family therapy: Concepts and methods* (4th ed.). Boston: Allyn & Bacon.

Shore, M. F. (1996). An overview of managed behavioral health care. In M. F.

Shore (Ed.), *Managed care, the private sector and Medicaid: Mental health and substance abuse services*. San Francisco: Jossey-Bass.

Guilford Publications
72 Spring Street
New York, NY 10012
212-431-9800
800-365-7006
www.guilford.com