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Self-Regulatory Couple Therapy

Self-regulatory couple therapy (SRCT) is both an extension of cognitive-behavioral couple therapy (CBCT) and an attempt to provide an integrating framework for applying other empirically supported couple therapies. Like CBCT, the procedures used in SRCT are developed from the substantial data on the determinants of relationship problems. That is, SRCT is aimed at changing patterns of behavior, cognition, and affect (couple adaptive processes) that are well established as associated with relationship distress. However, the emphasis in SRCT is on promoting metacompetencies for self-change. Once these metacompetencies are acquired, partners have the skills to change their adaptive processes within the relationship.

SRCT is intended to be brief couple therapy. Partners receive as few sessions of therapy as allows them to achieve their self-selected relationship goals. If partners struggle, then procedures developed within cognitive-behavioral, emotion-focused, and insight-oriented therapies are adapted to assist partners to produce self-directed change.

Self-Regulation and Couple Therapy

Concept of Self-Regulation

The terms "self-regulation," "self-control," "self-management," and "self-guidance" have been used extensively, and sometimes interchangeably, in the psychological literature to describe a process of self-directed change. Kanfer and colleagues (Kanfer, 1970; Kanfer & Karoly, 1972; Karoly, 1993) first

used a behavioral analysis to explain how individuals exercise control over their own behavior and then introduced these concepts into behavior therapy. In a comprehensive review of the research on self-regulation, Karoly (1993) highlights how self-regulatory concepts have pervaded many diverse areas of contemporary psychological inquiry, including personality theory, motivation and emotion, social, developmental, and health psychology, to name a few. Although there are clearly several alternative conceptual frameworks used to interpret and understand self-regulatory phenomena, much of the research into the component processes has been dominated by cognitive social learning theories (Bandura, 1977, 1986), operant theory, and control (cybernetics) frameworks (Karoly, 1993). For the purpose of the present discussion, the definition of self-regulation provided by Karoly is useful.

> Self-regulation refers to those processes, internal and or transactional, that enable an individual to guide his/her goal directed activities over time and across changing circumstances (contexts). Regulation implies modulation of thought, affect, behavior, or attention via deliberate or automated use of specific mechanisms and supportive metaskills. The processes of self-regulation are initiated when routinized activity is impeded or when goal directedness is otherwise made salient (e.g., the appearance of a challenge, the failure of habitual patterns; etc.). . . . (p. 25)

This definition emphasizes that self-regulatory processes are embedded in a social context that not only provides opportunities and limitations for individual self-direction but implies a dynamic reciprocal interchange between the internal and external determinants of human motivation. From a therapeutic perspective, self-regulation is a process whereby individuals are taught skills to modify their own behavior. There have been several comprehensive formulations of self-control phenomena and the role of self-generated events in the regulation of human behavior (Bandura, 1977, 1986; Catania, 1975; Karoly, 1993; Mahoney & Thoreson, 1974; Skinner, 1953). Although several self-control theorists acknowledge the interdependent nature of self-generated and externally imposed influences on behavior, the assumption that individuals can regulate their own behavior remains central to the overall conceptualization of self-regulatory processes.

A key characteristic of SRCT is an emphasis on a process that empowers individuals to change their relationship. Let me explain how this emphasis is similar to, but also substantially different from, the traditional CBCT approach to process. Descriptions of traditional CBCT emphasize that assessment serves multiple purposes (e.g., Baucom & Epstein, 1990; Beach, Sandeen, & O'Leary, 1990). For example, assessment goals include identifying and measuring the problem behaviors, establishing the environmental controlling variables, selecting intervention strategies, developing a therapeutic rela-

tionship with the client, and developing a conceptualization of the problem that is acceptable to the client and that promotes therapeutic change. A particular challenge in couple therapy, relative to individual therapy, is that the assessment process needs to achieve these assessment goals with both partners.

Within traditional behavioral couple therapy (BCT) assessment, typically there is an attempt to refocus each partner from reporting on dissatisfactions with his or her partner toward a more dyadic collaborative conceptualization of his or her problems. For example, if one person wants an increase in the amount of time that the couple spend together while the other partner requests a decrease, this issue could be phrased as follows: "The two of you have not yet achieved a mutually acceptable agreement about how much time you spend together." This formulation prompts both partners to attend to mutually acceptable goals and helps the therapist select therapeutic interventions relevant to the couple. The therapy goal in this case might be to develop the communication and problem-solving skills believed necessary to formulate a mutually acceptable agreement. Although this dyadic conceptualization may encourage the partners to think of their relationship problem in a more collaborative and less blaming manner, it fails to help either individual identify what to do to produce change. Implicitly the clients must wait on the therapist to conjointly teach them new ways to interact.

In the self-regulation approach, a dyadic problem formulation may still be used, but it would be followed by each partner self-selecting behavior change goals for him- or herself. For example, if the agreed problem was difficulty in communication about time spent together, a partner may decide that his current methods of communicating about concerns needed to be changed. A second possibility is that the manner in which the concerns of the partner are listened to needs changing. An important characteristic of the self-regulation approach is that the development of the skills to self-appraise one's relationship behaviors and to select and implement self-change is the explicit goal of therapy. Construing relationship problems in a dyadic manner can be an intermediate step in achieving this goal, but goals for personal change are the ultimate objective. These personal goals may include altering how one attempts to influence one's partner. Thus the partner's behavior is not ignored, but the emphasis remains on what the individual can do about aspects of the relationship that are distressing.

In emphasizing partner self-regulation, I am not advocating that the therapist passively accept whatever goals the client may generate. If a client stated that he or she would avoid any discussion of a difficult topic as a self-selected goal, this strategy might be self-evaluated as successful if it reduced immediate conflict. However, I highlight that the long-term consequences of avoiding conflict topics are likely to be continuing dissatisfaction and a deteriorating relationship and encourage a self-selected goal which achieved better long-term outcome. In other words, self-regulatory processes such as self-selection

of goals and realistic self-evaluation of the effects of behavior are skills the therapist helps the client develop across the course of therapy.

SRCT is focused on self-regulation for two reasons. First, most distressed partners inaccurately attribute most or all of their relationship problems to their partner's negative behavior (Bradbury & Fincham, 1990; Fincham & Bradbury, 1992). As they have no direct control over their partner's behavior, this often leads partners to feel powerless to produce any change in a distressed relationship (Vanzetti et al., 1992). The focus of SRCT on self-change empowers the partners to do something constructive about their relationship. Second, the focus on self-regulation promotes metacompetencies that not only allow the partners to change the interactions that are current relationship problems but also help them to produce self-change, which enhances the relationship in the future.

The Metacompetencies for Self-Regulation of Relationships

Self-regulation within the context of relationships refers to partners engaging in self-change processes to enhance their relationship satisfaction and stability. Self-regulation can be thought of as a set of metacompetencies that allow effective self-change. Table 3.1 summarizes the metacompetencies needed for relationship self-regulation (Halford et al., 1994). They are self-appraisal, self-directed goal setting, self-implementation of change, and evaluation of change efforts.

SELF-APPRAISAL

Self-appraisal of relationship functioning involves being able to articulate current relationship functioning, and the major influences on that functioning, in a manner that facilitates relationship enhancement. In practice, that means being able to analyze the relationship adaptive processes in terms of both the helpful cognitions, affect, and behavior one is doing and what is unhelpful. It also means being able to identify stressful events, personal vulnerabilities, and contextual variables that influence relationship adaptive processes. Examples of poor relationship self-appraisal are the common pattern of distressed partners focusing on partner-blaming attributions for relationship problems and ignoring the impact of contextual factors and life events on couple adaptive processes. The assessment process in SRCT is designed to facilitate self-appraisal in the couple.

The following is a concrete example of effective and ineffective relationship self-appraisal. Grace and Mick undertook *in vitro* fertilization in an attempt to overcome long-standing problems in fertility. The recurrent visits to the medical system, the need for Mick to provide sperm samples for fertiliza-

TABLE 3.1. Self-Regulation Metacompetencies

Metacompetency	Definition	Example
Self-appraisal	To accurately define key strengths and weaknesses of own behavior, and of interactions with spouse, in specific instances. To describe contextual factors, key stressful events and individual vulnerabilities which may lead to the development of current patterns of own and partner's behavior without blame or hostility.	After an argument with the spouse the partners identify the pattern of interaction that occurred and identify behaviors, thoughts, and actions of their own which were helpful and unhelpful in the interaction.
Self-directed goal setting	Individual defines specific actions he or she can take which can enhance relationship functioning.	Individual identifies specific behaviors or thoughts which he or she will attempt to use in managing the conflict in the future (e.g., person might resolve to attempt better conflict management by restarting conversation but stating desire to hear partner's perspective, to listen more effectively by not interrupting, asking open questions, and to focus on thought "I need to hear my partner's perspective.")
Self-change	Individual describes and then carries out specific plan to enact self-selected goals.	Individual resolves to initiate discussion at appropriate time and then carries through with intention.
Self-evaluation of change efforts	Individual self-appraises the extent to which the desired changes were actually implemented, and appraises the functional impact of those changes that did occur.	Individual evaluates correctly that she or he did start discussion as planned, asked open questions, but then interrupted partner during discussion. Notes that discussion began well but deteriorated to anger again.

tion attempts on just a few hours' notice at the optimal ovulation time, and the repeated waits to see if Grace became pregnant were taking their toll on the couple. When they presented to me they were considering separation, they had not had sex together for months, and both were overwhelmed by the stress of the attempts to become pregnant. Both partners gave vague descriptions of the relationship problems in terms of "arguing lots, and just not getting on anymore" and attributed these relationship problems primarily to their partner.

The initial phase in therapy was helping them (1) to identify the current thoughts, feelings, and actions of each partner, and their patterns of interaction; (2) to analyze how these had changed in the last few years; and (3) to identify what was helpful and unhelpful. At the point of presentation the couple were so stressed they could not do this self-appraisal. After two sessions of assessment they were able to articulate the behaviors, thoughts, and feelings that were problems, and they began to view their problems as an outgrowth of a complex of factors. These factors included long-standing difficulties with conflict management, the stress of the *in vitro* fertilization process, Grace's inability to imagine life without being a mother, and Mick's inability to respond constructively to women who were highly distressed.

SELF-DIRECTED GOAL SETTING

Self-directed goal setting is the process of defining specific, actionable goals for change in oneself, based on the self-appraisal of relationship functioning. The revised appraisals of Mick and Grace allowed them to consider goals for self-directed change. For example, Grace defined a goal of changing her thoughts and feelings so that if having a child proved not to be possible for them, she could still have a positive relationship with Mick. Mick defined improving his ability to support Grace when she was upset as a key skill he needed to learn.

SELF-IMPLEMENTATION OF CHANGE

Self-implementation of change is the process of each partner taking active steps with the aim of changing future adaptive processes. For example, Grace resolved to read a book on the effects of cognitions on feelings and to attempt to apply these ideas to her current feelings about the possibility of not being able to have children. Mick resolved to have a series of conversations with Grace about the *in vitro* fertilization process and how upsetting she found the process. He also resolved to ask Grace for feedback on what he did that she found supportive.

SELF-EVALUATION

Self-evaluation is the process by which the individual appraises the extent to which the desired behavior change was achieved and then the extent to which that change produced the desired relationship changes. In Grace's case she did buy the book and read it. She said the ideas made sense to her, and she applied an idea in the book called rational self-analysis, which involved writing down

her negative thoughts about not being a mother. Grace found identifying and reflecting on these negative thoughts upsetting, and then she became discouraged and did not complete the process of self-change. The therapist reviewed her attempts at self-change and noted how Grace had successfully identified negative thoughts but had not proceeded to identify or apply positive coping thoughts. Based on this discussion Grace's evaluation was that she had made significant progress but still needed to complete the rational self-analysis process to evaluate if it would help her. Thus, in each step the partners are prompted to develop self-regulatory skills to self-direct relationship change.

Structure of Self-Regulatory Couple Therapy

In the self-regulation approach to couple therapy a typical course of therapy can range from only 1 or 2 to as many as 20 conjoint sessions. SRCT is structured hierarchically so that partners receive the smallest number of sessions of therapy necessary to produce the desired relationship changes. Table 3.2 summarizes the typical content of SRCT at three different levels of intervention: brief self-guided change consisting of 1 to 6 sessions, relationship psychoeducation and self-guided change consisting of 7 to 10 sessions, and therapist-guided change consisting of 11 to 25 sessions.

Brief Self-Change

Minimizing the number of therapy sessions is achieved by focusing therapy initially on developing partners' self-regulation metacompetencies of relationship appraisal and goal setting. The processes of assessment and structured feedback are attempts to promote adaptive relationship appraisal and goal setting (Chapters 4 to 6 describe in detail how to do this). The assessment process is a structured, interactive examination of the key factors discussed in Chapter 1 that influence a couple's relationship. This form of assessment plus collaborative goal setting are key steps in promoting self-regulatory change. The process of assessment described in Chapters 4 and 5 is intended to prompt and reinforce each partner's attempts to appraise the context, life events, and adaptive processes in the relationship. Ultimately this is intended to promote a functional self-appraisal of the relationship. By functional I mean an appraisal that effectively guides self-directed change. After completion of assessment, the therapist uses a collaborative process of sharing assessment results to help each partner develop a functional self-appraisal of the relationship, define self-change goals, and develop self-change strategies. Chapters 5, 6, and 7 describe the process of feedback and negotiation.

I believe that commitment to self-change is necessary to achieve relationship improvements in distressed couples, and for many distressed couples this

TABLE 3.2. Structure of Self-Regulatory Couple Therapy

Structure of couple therapy	Stage	Tasks
Brief self-change (1–6 sessions)	Engagement (Chapter 4).	Building empathy with individual partners; identifying immediate threats to individual or relationship; building positive therapeutic expectations.
	Assessment (Chapters 4–5).	Building shared understanding of relationship problems to facilitate change; assessing individual vulnerabilities and problems; evaluating feasibility of couple therapy.
	Feedback and negotiation of goals (Chapter 6).	Providing structured feedback of assessment; negotiating working model of relationships; identifying shared couple goals.
	Evaluating possibility of brief self-change (Chapter 7).	Assessing self-change competencies.
	Supporting self-change (Chapter 8).	Evaluating self-change outcomes; promoting generalization and maintenance.
Relationship psychoeducation plus self-change (7–10 sessions)	As for brief self-change: engagement, assessment, feedback and negotiation of goals, evaluating possibility of brief self-change.	As for brief self-change.
	Relationship psychoeducation (Chapter 8).	Interactive relationship psychoeducation; assessing self-change competencies.
	Reevaluating possibility of self-change.	Testing self-directed change outcomes.
	Supporting self-change.	Evaluating self-change outcomes; promoting generalization and maintenance.
Therapist-guided change (11–25 sessions)	As for brief self-change: engagement, assessment, feedback and negotiation of goals, evaluating possibility of brief self-change.	As for brief self-change.

(*continued*)

TABLE 3.2. (*continued*)

Structure of couple therapy	Stage	Tasks
	Behavior exchange (Chapter 9).	Self-directed change of key relationship behaviors.
	Cognitive change (Chapter 9).	Rational self-analysis; cognitive restructuring.
	Intimacy (Chapter 9).	Intimate communication; shared positive activities.
	Support (Chapter 9).	Emotional support; practical support.
	Conflict management (Chapter 9).	Communication skills; patterns of conflict management.
	Supporting self-change.	Evaluating self-change outcomes; promoting generalization and maintenance.

commitment is necessary and sufficient to achieve relationship improvement. For those couples for whom commitment to self-change goals is necessary and sufficient for relationship improvement, brief couple therapy of three to four sessions can be effective. For other couples more extended courses of therapy sessions may be necessary. If couples produce the desired changes in their relationship at this point (Chapter 6 describes in detail how to assess this), this may be all the therapy required. This is brief self-guided change and most often takes three to six sessions.

Relationship Psychoeducation and Self-Change

Therapy includes relationship psychoeducation if couples are unable to self-appraise their relationship or to define self-change goals. Relationship psychoeducation assists couples in exploring themes in their key relationship adaptive processes and how individual characteristics, context, and life events might influence those processes. The goal is to facilitate more effective self-appraisal and goal setting.

In using the term "relationship psychoeducation" I am not suggesting that the therapist give the couple extensive didactic lectures about research on couple relationships. Rather, relationship psychoeducation uses such processes as guided discovery, cognitive-affect reconstruction, and guided reading with discussion. (Chapter 8 describes each of these processes). For example, I routinely explore with couples issues such as the work–family interface, the impact of interactions with extended family, and family-of-origin and cul-

tural influences on the development of expectations and behavior in relationships as a means of helping couples appraise their relationship difficulties in a more helpful manner.

A key notion in relationship psychoeducation is that partners' inability to implement self-change reflects one of two problems. One problem is that strong negative thoughts and feelings interfere with self-change. For example, some couples agree that reducing conflict is a desired relationship goal but find that they repeatedly escalate into destructive arguments about key issues. In this instance relationship psychoeducation focuses specifically on exploration of these negative thoughts and feelings in an attempt to help the couple understand their negative responses to each other, move away from partner blaming, and then to move toward self-change. A second problem is that the partners lack knowledge of what constitutes really helpful self-change to address their relationship goals. For example, in stepfamilies many partners agree that developing a good stepparent–child relationship is important but are unsure what are reasonable expectations for such a relationship.

The aim of relationship psychoeducation is to help the partners develop the thoughts, feelings, and knowledge that enable them to operationalize how they will self-implement their desired relationship goals. Once this is achieved, often the couple are then able to self-change. (Chapter 8 describes in detail the nature and content of relationship psychoeducation.) Typically, relationship psychoeducation occurs after the feedback and negotiation session and consists of three or four sessions. The couple would then attempt self-change, as described in Chapter 7, or if self-change looked unlikely, the couple would be offered therapist-guided change. A typical course of relationship psychoeducation plus self-change would last from 7 to 10 sessions.

Therapist-Guided Change and Self-Change

If, after relationship psychoeducation, the partners still are unable to produce the desired relationship changes, then therapist-guided change is used. The assumption in therapist-guided change is that the partners have either never learned or have forgotten important skills of couple interaction. In therapist-guided change selections of procedures are used from empirically supported couple therapies, particularly BCT. As in BCT, the goal in therapist-guided SRCT is to help partners develop skills that enhance the relationship. But in SRCT, procedures are adapted to a self-regulatory framework. For example, in the self-regulatory adaptation of behavior exchange, partners self-identify goals for change that they believe will enhance the relationship. The focus on self-defined change goals has two effects. First, self-direction promotes a sense of self-efficacy in being able to produce change. Second, the process promotes individual responsibility for the enhancement of the relationship. (Chapter 9 describes the procedures most often used in extended SRCT.) They

are procedures for increasing positive day-to-day interactions, better communication, conflict management, and changing negative thoughts and feelings. Chapter 9 includes a number of specific exercises and handouts for teaching these skills.

Once the couple has developed the necessary relationship skills using therapist-guided change, the process reverts to self-change. Typically a course of SRCT that involves relationship psychoeducation, therapist-guided self-change, and self-change consists of 11 to 20 sessions. The first three to four sessions are assessment, feedback, and negotiation of goals; the next three or four sessions are devoted to relationship psychoeducation; then comes a series of sessions of therapist-guided change, culminating in a final few sessions of self-change.

For clarity of exposition, the different levels of intervention within SRCT are presented as if they are quite different. In practice, these levels of intervention form a continuum of increasing numbers of sessions and increasing therapist guidance in helping couples define and achieve their relationship goals. The ultimate goal in SRCT is to help partners to self-regulate their relationships. Some couples can move straight to self-change after assessment. Other couples need relationship psychoeducation or therapist-guided change, but for them therapy eventually shifts to promotion of self-change, as illustrated in Figure 3.1. Once the couple is successfully implementing self-change, the final step in therapy is promoting the generalization and maintenance of that self-change process.

At each level of intervention in SRCT, sessions usually occur at least weekly at the beginning of therapy and often become less frequent toward the end of therapy. The initial session establishes contact with the couple and determines whether therapy is an appropriate response to the couple's problems. A further one or two sessions usually are occupied by assessment. Assessment most often consists of a combination of interview, completion, and review of self-report and self-monitoring instruments and completion of interaction tasks. Next the therapist provides feedback of the assessment results to the couple and negotiates their relationship goals. The therapist then negotiates the structure of therapy to be used: self-change, relationship psychoeducation or therapist-guided change. In essence the therapist helps the couple test their capacity to self-change at that point. Relationship psychoeducation and therapist-guided SRCT are used only if self-change is not sufficient to achieve relationship goals.

Throughout the course of therapy, beginning with the first assessment session, couples are asked to complete various tasks between sessions. The essence of therapy is to help partners to alter their adaptive processes outside the therapy sessions, in the settings in which they usually interact such as at home, at friends' places, and so forth. To that end what happens in the therapy session is relevant only to the extent that it facilitates such change. Therefore

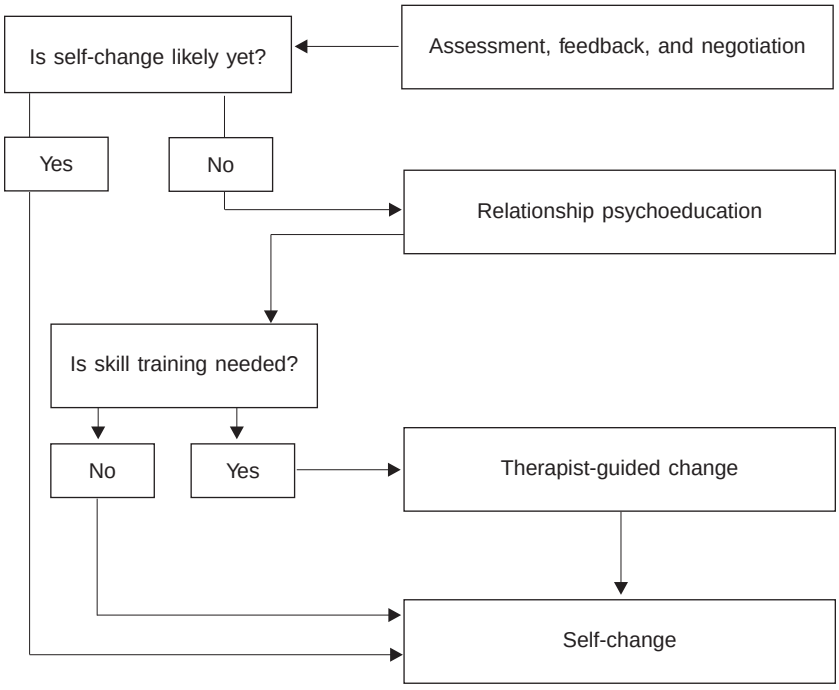

FIGURE 3.1. The decision-making process in negotiating the structure of self-regulatory couple therapy.

the tasks undertaken between sessions are what are important in therapy. Therapeutic tasks in SRCT initially are related to assessment of problems (e.g., completion of questionnaires or self-monitoring forms). During therapy tasks are developed collaboratively by the therapist and clients as a means of the partners experimenting with new ways of responding to each other.

The Process of Self-Regulatory Couple Therapy: Making It Succeed

Couple therapy is effective to the extent that the partners are able to identify, implement, and sustain changes that enhance their relationship. But, there are a variety of potential barriers to achieving effective couple therapy. In this section I want to address how to structure therapeutic process to maximize the chance of making couple therapy effective. I use the concept of therapeutic momentum to describe how to establish and maintain change in couple therapy.

Therapeutic momentum is the rate and the strength of change processes occurring both within and between therapy sessions. High momentum is characterized by a high level of energy and involvement in therapeutic process and tasks by the partners and high levels of personal initiative being shown in generating positive change between sessions. Low therapeutic momentum is characterized by lack of engagement, anger, and hostility in therapy sessions; low levels of therapeutic effort; and failure to engage in tasks between sessions.

A number of the client behaviors I describe as low therapeutic momentum are similar to behaviors referred to as resistance or low adherence by other writers. I dislike the notions of resistance or adherence; to me these terms imply that the therapist drives the change process. Implicitly, the terms "resistance" and "nonadherence" attribute slow therapeutic progress to whether the client did as the therapist suggested. As I view couple therapy predominantly as driven by the self-change efforts of the partners, I think adherence and resistance are inappropriate constructs for considering the therapeutic process.

Establishing Therapeutic Momentum

Establishing therapeutic momentum is, in my opinion, important at the beginning of any therapy. It is particularly important in couple therapy. Many partners in distressed relationships present feeling discouraged about attempting to alter their relationship. Frequently, the long periods of relationship distress prior to presentation have left one or both partners ambivalent about whether to remain in the relationship and possibly skeptical about the possibility of relationship change. Early in couple therapy it is necessary to establish a sense of reasonable optimism about the possibility of positive change.

What might establish reasonable optimism at the beginning of couple therapy? First and foremost I believe each partner needs to feel understood in terms of the pain and suffering he or she is experiencing in the relationship. Typically in distressed relationships partners invalidate each other's experiences and partners rarely feel understood. In the initial interview structure described in Chapter 4, the therapist meets with each partner individually. This allows the therapist to join with each partner and then synthesize the two partners' individual experiences into a coherent whole.

In writings and workshops on couple therapy I have attended, I have heard therapists advocate the benefits of having only conjoint sessions. Those same couple therapists also describe a variety of strategies they use to help partners to relate their relationship pain in the presence of their spouse. A high degree of structure and effort seem necessary to avoid the expressions of individual hurt and anguish leading to destructive conflict in these initial conjoint sessions. Often the therapist is busy stopping partners' cross-talking or inter-

rupting each other, or reframing and doing all sorts of verbal gymnastics to keep the couple on task. Conjoint sessions in which there is a high degree of therapist structuring can make it difficult to establish empathy and intimate personal contact between therapist and client. I find it easier to get to know someone intimately on a one-to-one basis. I find it much easier to empathize with complaints, hurt, and pain about the spouse if the spouse is not present at the time. Then I can focus on understanding the person's message to me, and I do not constantly have to play traffic cop to prevent the sessions from becoming acrimonious or unproductive.

SUMMARIZING CONCERNS IN A WAY ACCEPTABLE TO BOTH PARTNERS

Ultimately, one goal of couple therapy is to build a consensus about the nature of the relationship problems and their potential solutions. With the foundation of some understanding of each individual, I then bring the couple together and summarize the key things that each of them has told me. In Chapters 4, 5, and 6 I describe how these summaries reframe the individual concerns and complaints, complaints that usually are about the partner, in terms of relational processes. This reframing process makes the anguish of the partners accessible to each other.

To establish a personal, empathic relationship with each partner and to summarize the couple's major presenting concerns in a manner acceptable to each partner builds a major platform for therapeutic momentum. If the first therapy session allows the couple to express their concerns and pain without destructive conflict, this is a major achievement for many couples. For most distressed couples prior attempts to address their relationship problems only lead to pain, more hurt, and frustration. Avoidance often becomes a key means by which the couple deals with relationship pain. If the initial therapy session is full of anger, hurt, and pain, then the couple may seek to avoid any further such sessions, or at least to avoid raising the most difficult and painful relationship problems. If the initial therapy session gives them a sense that the issues can be raised without severe pain, their willingness to engage in therapy is likely to increase.

OFFER EVIDENCE FOR HOPE

Based on my established understanding of their feelings, often I can describe how one or both partners may feel discouraged and identify their sense of powerlessness to produce change. I then can offer research-based evidence for hope. Based on the research reviewed in Chapter 2, I state how many couples enter couple therapy feeling discouraged and ambivalent about the relation-

ship, but that 80% or more of couples report significant improvement in their relationship across the course of couple therapy. Even those couples that do not report any relationship improvement often make an informed decision to leave the relationship, and many couples are able to negotiate low-conflict separations. In my experience, when these facts are presented by a therapist who relates this information to the couple in a personal manner, they become a powerful instigator of hope.

ENGAGE THE PARTNERS IN ACTION

I almost always give couples tasks to do between the first and the second therapy sessions. I do this for multiple reasons. One reason is to increase the efficiency of information gathering during the assessment phase. Another reason is that I wish to give the partners a sense that they can do something to shift the problems that until now they found intractable. I state the importance of the tasks, and I urge the partners to tell me if any task I suggest does not seem reasonable or useful. I check, by specifically asking each partner, whether he or she will complete the task(s) before the next session. In drawing out the partners' commitment to undertaking these tasks I am keen to develop their sense of excitement about the possibility of change.

In the second session I always follow up on the tasks that the partners agreed to do between sessions. Most people do the tasks, and I make a point of praising their commitment. To me the effort people expend, despite their often having a history of feeling powerless in their relationship, is an important sign of developing therapeutic momentum, and I point this out to the couple. Completing a few questionnaires between sessions rarely solves a 20-year relationship problem, but the couple's effort can be an important start to the change process.

The first two, or sometimes three, sessions are assessment sessions which build toward the feedback and goal-setting session. Across these sessions I typically spend an increasing proportion of the sessions with the couple conjointly. I adjust the proportion of time spent in individual versus conjoint sessions according to the extent to which the sessions allow exploration of difficult relationship issues in a constructive manner. I am keen to establish in each partner a view of therapy sessions as a safe environment in which risks can be taken in order to relate in a more intimate manner. As the partners experience, often for the first time for years, an ability to understand something about their relationship, an appreciation of the spouse's perspective, and a feeling of being understood, I find that positive expectations develop.

Maintaining Therapeutic Momentum

If assessment proceeds well and the couple have a shared understanding of the

key relationship issues, then the possibility of brief self-change therapy needs to be considered. I probe the partners to establish the extent to which each can identify personal change goals relevant to achieving the desired therapy goals. (Chapter 6 describes details of this process.) If the partners do have clear self-change goals, and therapeutic momentum is high, I discuss the option of brief self-change therapy with the couple. Usually this means giving the couple a break of an agreed period between sessions to establish the extent to which partners can successfully implement their desired self-change goals.

If brief self-change is not appropriate, then brief therapy involving relationship psychoeducation may be appropriate, or therapist-guided couple therapy may be the treatment of choice. In SRCT, even if positive therapeutic momentum initially is established, maintaining that momentum across the course of couple therapy remains a challenge. Many couples experience setbacks across the course of therapy. Sustaining a positive self-change focus requires careful attention to process by the therapist. There are three important broad strategies of momentum maintenance: matching therapy process to partner affect, matching the sequence of therapy content to couple needs, and reviewing and highlighting therapeutic gains.

MATCHING PROCESS TO PARTNER AFFECT

Maximizing therapeutic momentum involves matching the therapeutic process in session to the affective states of the partners. For example, rational problem solving rarely works when one or both partners are really angry with each other. Rational problem solving requires a degree of acceptance of the perceptions of the problem by the partner and only moderate arousal of negative affect. Similarly, asking partners to expose their vulnerabilities to each other when one or both partners are feeling misunderstood by the therapist also is unlikely to work. Partners need to feel positive toward the therapist for this process to be effective. In both the foregoing examples, I would try to establish strong empathy with each partner before moving to rational problem solving or self-disclosure of vulnerabilities in the presence of the partner.

The therapist needs constantly to monitor the affective expression of the partners. In couple sessions this means constantly visually scanning the faces of both partners. It also means that if the therapist is speaking primarily with one partner, the therapist must monitor the reactions of the other partner. If the nonspeaking spouse is withdrawing or becoming hostile, the therapist needs to change strategies. Any time I see marked hostility or withdrawal by either partner, I am prompted to consider whether the therapy process needs adjustment at that time.

In my view good couple therapy often is emotionally intense, but the emotions should not be restricted to anger. A range of emotions should be evident in couple therapy: tenderness as the partners feel and express closeness

for each other, humor as the partners see the absurdity of what we all do in our attempts to deal with problems, sadness for the losses and pain experienced, and joy as gains are made. If therapy is predominantly hot, negative emotions, then different approaches are needed. The therapist needs to enable the couple to experience the positive aspects of their relationship.

I find that establishing positive affect in the partners at the beginning and the end of sessions helps sustain therapeutic momentum. Positive affect at the beginning of the session sets the tone for partners' behavior during the session. A warm greeting by the therapist to each partner and asking the partners about the best aspects of their relationship over the last week often prompt attention to positive aspects of the partner. This can establish a positive frame for tackling negative aspects of the relationship. It is easy to allow sessions to begin with negativity and for this to establish the tone for the whole session. The negative bias of distressed partners means that if the therapist begins the session with an open question such as "How have things been in the last week?" often the partners focus on the most negative aspects of the relationship over that period. If the therapist draws the couple out on those problems, often this arouses the negative affect associated with the problems. Then couples find it difficult to access positive memories or feelings in the session.

MATCHING THE SEQUENCE OF CONTENT TO COUPLE NEEDS

Most couples present with complex relationship problems, and therapy typically involves addressing a number of goals. Therapy needs to sequence the order in which problems are addressed to enhance therapeutic momentum. Problems of high salience to partners that are resolved reinforce change efforts by the partners. Changes that increase positive experiences of the partner and interaction with the partner reinforce change efforts. In my work with couples I make these considerations explicit and negotiate with the couple the order in which we will tackle the goals they have established.

In common with many cognitive-behavioral approaches to therapy, I negotiate an agenda with the couple at the beginning of each session (e.g., Beck, 1995). I usually begin that process by summarizing where we are up to in therapy. That summary typically involves highlighting the number of sessions we have had so far, what we have done up to now, and what we have negotiated to do in future sessions. The goal of this process is to ensure that the content of the couple therapy is addressing those issues salient to the couple.

HIGHLIGHTING THERAPEUTIC GAINS

Every two to three sessions of couple therapy I review with the couple the progress in therapy to that point. In this summary I reinforce the positive efforts by

the partners and underscore the successes in therapy to that point. I also ask questions intended to prompt partners' attention to the positive effects of their self-change efforts. For example, if the couple report a reduced level of conflict in their relationship, I often ask them what each has done to bring about this change, (e.g., "What have you done differently to bring about this reduction in arguing?"). I also draw out descriptions of the positive effects of changes on the relationship, (e.g., "What difference does it make when the arguments are not happening?"). This process is meant to support effort and sustain momentum.

Responding to Slowing Therapeutic Momentum

Extended couple therapy often proceeds in bursts, and rarely does the initial establishment of therapeutic momentum carry the couple through to a satisfied relationship without some periods of waning therapeutic momentum. The most obvious source of slowing momentum occurs when the spouses have a major argument. Often couples who were making reasonable progress and feeling good about the impact of therapy on their relationship feel very discouraged when a destructive argument occurs. In many instances I have had partners initially report they feel like giving up on therapy and the relationship after destructive arguments. Failure to complete agreed tasks is a second source and signal of slowing momentum. Both situations are described next.

RECOVERING FROM DESTRUCTIVE CONFLICT

The occurrence of a destructive argument can rekindle the negative feelings and hurts that brought the couple to therapy. The partners' focus can shift from self-directed attempts to promote positivity to self-protective strategies to reduce pain. The therapist's challenge is to reestablish therapeutic momentum again. If this occurs, the couple learns that their relationship can transcend the negativity which inevitably is a part of any long-term relationship.

I see three important steps in responding to destructive arguments that slow therapeutic momentum. First, the partners often need assistance to self-regulate their feelings about the argument. Second, the couple needs to appraise why one argument changed feelings about the relationship so dramatically. Third, each partner needs to select practical self-change goals that will help them better manage future arguments. For the first step, most often I use the guided cognitive-affect reconstruction procedure described in Chapter 9 to explore the strength of feelings that the argument elicited. The core underlying relationship themes need to be identified and resolved. The second step of reestablishing therapeutic momentum is to explore the partners' emotional response after the argument, to focus on why one argument changed the partners' feelings so dramatically. Guided-discovery cognitive procedures often

can be useful here. Consider the following interaction that illustrates this process.

THERAPIST: Julie, we have talked about why you responded so strongly to Tony not coming down to see you Friday night. The argument and the feelings you had over the weekend make a lot of sense given that you were thinking that Tony did not want to spend time with you. The argument really got to you didn't it? You were still very upset about it when you came in here, and it's nearly a week later. Help me to understand why you are so upset. What is it about what happened that gets to you so much?

JULIE: It's, well, you know everything seemed to be on the mend. You know. Not perfect, but better. Tony was trying. I was trying. We were talking, starting to have fun together again. Then, well, he no-shows.

THERAPIST: And when he no-showed, what did that mean to you?

JULIE: It made me wonder if he was giving up on us. Just sort of feeling it was all too hard.

THERAPIST: So, after the no-show you thought that the marriage might just fall apart?

JULIE: Sort of. I thought Tony was throwing in the towel.

THERAPIST: Help me to understand this bit. How was the one argument showing that things would not work out?

JULIE: Well, I know that one argument does not mean the end of the world, but it was because we were supposed to be fixing things. So if he is not trying now, now we are in therapy, will he ever really try for us?

THERAPIST: So if anything goes wrong at this stage, that's really bad, really bad?

JULIE: Well, it feels bad. Look, I know things can't be perfect, no marriage is perfect.

THERAPIST: OK. So you seem to be saying that no relationship is perfect, that arguments are going to happen. No disagreement from me there. I never met a couple that did not argue sometime. So what made this one so bad?

JULIE: Timing, I guess. The changes we are trying to make, you wonder if things have really changed, if we can make it work. I thought we had, but then. . . .

THERAPIST: So an argument when you are feeling the relationship is brittle, when you are not confident. . . .

JULIE: Yeah, I am still scared we might blow it. And things seem to be fine, then wham we're back to the old arguments.

THERAPIST: Back to the old arguments. Has anything changed?

JULIE: Sorry?

THERAPIST: Do you think anything has changed in your relationship? Is it really exactly as it was 4 or 5 weeks ago?

JULIE: No. No. Tony and I are much better with each other. Politer you know. Even in the argument we did not tear strips off each other.

This transcript illustrates a common theme evident early in couple therapy: Many couples still feel unsure about the future of their relationship. An argument often prompts thoughts about the difficulty of change. Any positive gains from therapy may be overlooked when the couples are feeling negative. Here the therapist gently guides the partner to describe a more complete picture of therapy, recognizing the positive changes that have occurred, and the limitations of what has been achieved. Relationship psychoeducation can be useful at this point, highlighting how most couples struggle to reestablish a sense of certainty in the future of their partnership. It is important for partners to understand that some set backs are inevitable, and that such set backs do not necessarily reflect on the future of the relationship.

The final step in reestablishing therapeutic momentum is to have partners self-select goals for managing setbacks. Questions such as "What could you do to reduce the negative effect of arguments in the future?" are useful. Most couples understand that some arguments are inevitable in any relationship, and the help the therapist gives to partners to self-regulate their adaptive processes after conflict can be a crucial therapeutic achievement.

RECOVERING FROM FAILURE TO COMPLETE AGREED UPON TASKS

Another key index of slowing therapeutic momentum is the failure of partners to carry through on agreed tasks between sessions. I see this as a critical event in therapy. Self-directed change is the essence of effective therapy, and so the failure to attempt a given task is vital information concerning the therapeutic process. When supervising therapists I often have seen them minimize the importance of uncompleted tasks with such phrases as "Well, see if you can get around to it next week." However, this phrase implicitly carries the message that the task was not important. Most people have lots to do in their lives, and a therapist should only suggest tasks that are important and should convey a sense of the importance of self-directed effort. Many couple therapists dismiss or minimize uncompleted tasks because they are unsure of how to deal with

the issue. Certainly the question "Why didn't you do as you said you would?" often leads to defensive explanations which do not advance therapy.

Shelton and Levy (1981) suggest responding to nonadherence to therapeutic tasks based on three possible reasons for noncompletion of tasks. Although I do not like the concept of adherence, I think their classifications of reasons for noncompletion is useful. Table 3.3 summarizes suggestions based on their classification system. The first reason people fail to carry out agreed-on tasks is that the task was unclear or the person lacked the skill to carry out the task. The therapist can ask the client to restate the task. This request provides a check on whether the client has a clear understanding of the task. If the task is one in which a skill deficit might explain the failure to complete the task, then the skill level can be assessed. For example, if the partner was supposed to initiate a problem-solving discussion with his or her spouse, the therapist can ask the partner to do this in the therapy session.

If it is established that the client did understand the task and had the skills to carry out the task, then negative cognitions may explain the failure to complete the task. The person simply may not see the value of the task or may believe negative consequences will result from completion of the task. Exploring the beliefs the person has about the task often helps clarify whether the task is indeed useful. Sometimes the task is useful but the therapist has not explained the rationale clearly to the client, or unhelpful thoughts by the client need to be restructured. Other times, the therapist may be persuaded by interaction with the client that the task is not appropriate, and it may be necessary to renegotiate that aspect of therapy.

Finally, if it is established that the partner can do the task, and wants to do the task, circumstances in the environment may prevent the task from being completed. For example, suppose one partner is asked to arrange a special outing for the couple but the spouse refuses to go, or work demands prevent time being set aside. This is important information for the therapist to understand; often it can initiate further problem solving.

A case example illustrates the process of how to respond to noncompletion of a client task. Gena (56) and Joseph (58) married 3 years ago. Joseph's first wife died 7 years ago, and Gena had been divorced 30 years earlier from her first husband. They were struggling in adjusting to being married to each other. Gena had a wide variety of community and social activities she was engaged in, while Joseph preferred to spend time at home. These preferences reflected how each had lived their lives before meeting each other. They often argued about how much to go out. Joseph did not like Gena going out without him; he wanted her to spend time with him at home. Gena was unhappy that Joseph rarely wanted to do things outside the home. Joseph had decided on the task of organizing a dinner out with friends as part of his attempt

TABLE 3.3. Responding to Loss of Therapeutic Momentum through Failure to Complete Agreed-Upon Tasks between Sessions

Reasons for failure to complete	Recommendations for enhancement of therapeutic momentum
Type 1: The client lacks the necessary skills and knowledge to complete some or all of the tasks in the assignment.	The therapist should prompt the client to self-define goals that contain specific detail regarding response and stimulus elements relevant to the desired behavior.
	The therapist should give direct skills training when necessary.
	The therapist should prompt the client to begin with small homework tasks and gradually increase assignments.
	The therapist should encourage the client to use cognitive rehearsal strategies to improve success with assignments.
Type 2: The client has cognitions that interfere with completion of the assignment.	The therapist should have the client review the self-selected goals, and make a public commitment to complete the tasks if that is the goal.
	The therapist should help the client develop a private commitment to comply (e.g., prompting attention to the positive effects of previous behavior change).
	The therapist should try to anticipate and reduce the negative effects of task completion.
Type 3: The client's environment elicits failure to complete task.	Completions should be reinforced by the therapist and self-reinforcement encouraged.
	The therapist should introduce the client to appropriate self-control strategies such as cuing.
	The therapist should prompt the client to try to anticipate and reduce the negative effects of completion of the task.
	The therapist should explore with the client context changes that might enhance the completion of the task.

to be more outgoing and meet Gena's need for more stimulation in the relationship.

THERAPIST: In the couple of weeks since we last saw each other, Joseph, you were going to organize a dinner out with friends. What happened with that?

JOSEPH: Well, it was pretty hectic you know. So it didn't happen.

THERAPIST: I see. Look, when someone says, "I am going to do *X*, but then

does not, I think that is important. Often I find there are important lessons to be learned here. Just to check that we all left with the same understanding, Joseph tell me what you intended to do.

JOSEPH: I was going to organize dinner for Gena, me, and some friends. Probably the Newtons.

THERAPIST: OK, and when were you going to do that?

JOSEPH: Oh, just in the next week or so.

THERAPIST: OK. Well that is what I remember as well. Now sometimes the ideas we come up with in therapy seem not very good later on. Sometimes people come up with lousy ideas to improve their relationships. Sometimes I make lousy suggestions. Other times I do not explain a good suggestion well enough. Let's check how we're thinking about this idea now. Joseph, do you think organizing a night out for you and Gena with friends is a good idea?

JOSEPH: Yeah. Yeah, I do. It's just that it was a busy week you know.

THERAPIST: Uh huh, sure. Sometimes things get in the way of something we really want to do. Was the dinner something you really wanted to do?

JOSEPH: Well, sort of, you know. I mean Gena wants to go out more, so I guess I should do this.

THERAPIST: It sounds like you are not sure this is for you. Is that true?

JOSEPH: Well, I never went in much for racing around. I am a kind of quiet home body, you know?

THERAPIST: So organizing this dinner is really something you are doing for Gena, it's not something you really want to do yourself, is that it?'

In this example, the therapist initially checks that Joseph had a clear understanding of the task and then explores the cognitions Joseph holds about the task. Initially Joseph restates that it was just a time thing, but the therapist pushed to check whether Joseph really wanted to do the task. At this point some of Joseph's underlying cognitions emerge. As the interaction proceeded, Joseph described his desire to make Gena happy. He saw becoming more outgoing as the only means to achieve that, yet he felt uncomfortable with that role. Ultimately he stated that he felt he could never be sociable enough to keep Gena satisfied, and that maybe she regretted marrying him.

This issue proved to be central to their relationship problems. When they were dating Joseph had gone out more, but he saw that as a transient phase of dating. Gena thought that their level of social activity during dating reflected how they would live their lives together. Joseph's failure to com-

plete the task reflected his deep concern that he would not measure up to what he saw as Gena's need for an outgoing, sociable man. He described his fear that he could never measure up to Gena's expectations. The exploration of the failure to complete the task of organizing a dinner engagement allowed identification of this issue. (Postscript: As Gena came to see Joseph's reluctance to go out as his preference to spend time with her alone, her desire to get Joseph to go out more diminished. She came to place greater value on shared time together at home. Joseph came to see Gena's desire to go out as an individual difference based on prior experiences, such as her long period of time as a single woman, rather than a rejection of spending time with him at home. As his view changed he felt more comfortable with her level of independent activity and reduced his criticism of her activities. Joseph also did become somewhat more outgoing once he experienced decreased pressure to be more outgoing.)

The foregoing transcript above reflects a common experience of mine in couple therapy. The failure to complete agreed-on tasks often is important information. The three-step structure summarized in Table 3.3 is invaluable to responding well to a loss of therapeutic momentum.

Completion of Couple Therapy

Ideally self-regulatory couple therapy is completed when the couple has achieved their self-selected relationship goals and each of the partners has developed the metacompetencies to self-regulate change in their relationship in the future. In practice, therapy sometimes is terminated by a partner or partners before this point is reached. To optimize the timing of completion, the issue needs explicitly to be negotiated between the therapist and the partners.

To ensure that therapy meets a couple's needs and continues only for as long as is necessary, I usually raise the issue of completion of therapy in the first session of SRCT. I state that couple therapy is not appropriate for all couples, and the first session or two should help us to determine whether couple therapy is appropriate. (Chapters 4 and 5 describe in some detail the contraindications for couple therapy.) I also describe that many couples find they can work out what they need to change in their relationship in three or four sessions. I explain that once we have done an assessment together I will review with the couple the changes they want to achieve and their perceptions of their capacity to produce those changes. At that point they might want to attempt to make those changes themselves, and in that case I would support them, but this would take relatively few sessions. Alternatively, the couple might still feel unclear on their relationship goals, or how to achieve those goals. In that

case we would negotiate a set number of sessions with a clear agenda for the goals of those sessions.

As described in the section on maintaining therapeutic momentum, every few sessions I review therapy progress with the couple. If the couple is getting close to having achieved their relationship goals, I discuss with them what else they feel they need to achieve before therapy is completed. I also would explore with them any concerns they have about the future of their relationship after the end of therapy. Chapter 7 provides details on promoting the generalization and maintenance of therapeutic change in couple therapy.

To this point I have provided a model and analysis of the nature of relationship problems, reviewed the empirically supported approaches to couple therapy, and presented an overview of self-regulatory couple therapy. That is enough of the preliminaries; a couple await us in the waiting room, and I do not like to keep my clients waiting. Thus, let us turn to assessing the needs of couples.

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