

The History of Couple Therapy: A Millennial Review

ALAN S. GURMAN, Ph.D.†
PETER FRAENKEL, Ph.D.‡

In this article, we review the major conceptual and clinical influences and trends in the history of couple therapy to date, and also chronicle the history of research on couple therapy. The evolving patterns in theory and practice are reviewed as having progressed through four distinctive phases: Phase I—Atheoretical Marriage Counseling Formation (1930–1963); Phase II—Psychoanalytic Experimentation (1931–1966); Phase III—Family Therapy Incorporation (1963–1985); and Phase IV—Refinement, Extension, Diversification, and Integration (1986–present). The history of research in the field is described as having passed through three phases: Phase I—A Technique in Search of Some Data (1930–1974), Phase II—Irrational(?) Exuberance (1975–1992), and Phase III—Caution and Extension (1993–present). The article concludes with the identification of Four Great Historical Ironies in the History of Couple Therapy.

Fam Proc 41:199–260, 2002

COUPLE therapy is an area of psychotherapy practice that is long on history, but short on tradition. One tradition that has been established solidly, however, is that historians of the field periodically assess its status from a metaphorically developmental perspective. Olson (1970), the field's first chronicler, referred to marital therapy as a "youngster" which had "not yet developed a solid theoretical base nor tested [its] major assumptions and principles" (p. 501). Six years later, Olson and Sprenkle (1976), continuing the individually oriented metaphor, asserted that the field was "no longer in its infancy" and was "showing signs of maturing," although it "appeared like an adolescent, full of undirected energy . . ." (p. 326), and a mere four years later, asserted that it had "reached young adulthood" (Olson, Russell, & Sprenkle, 1980, p. 974). Unfortunately, such loose metaphorical assessments appear quite unreliable. For example, in 1995, Gurman and Jacobson (p. 6) declared that "couple therapy has come of age," by virtue of its

greater awareness of the significance of personal and cultural values; a more balanced appreciation of the interdependence of interpersonal and intrapsychic factors in couple relationships . . . an increasing emphasis on . . . operationalizing interventions . . . a more honest assessment of . . . the efficacy of couple therapies . . . and . . . more solid links

† Professor and Director of Family Therapy Training, Department of Psychiatry, University of Wisconsin Medical School, 6001 Research Park Boulevard, Madison, Wisconsin 53719; e-mail: asgurman@facstaff.wisc.edu.

‡ Associate Professor, Dept. of Psychology, City College of New York; e-mail: pfraenkel@aol.com.

with . . . relevant professions and disciplines. [p. 6]

But commentators Johnson and Lebow (2000) soon questioned this position as being “premature” (p. 34), while ironically documenting the striking developments in the field during the previous decade that, in fact, corresponded almost exactly to those identified by Gurman and Jacobson!

To strain an admittedly tired metaphor once more, just after the first year of the new millennium, we suggest that a more interpersonal, systems-oriented appraisal of the current evolutionary status of couple therapy is appropriate. Such an appraisal should include consideration not only of the field’s ability to stand on its own two feet, but also of its capacity to remain appropriately and respectfully connected to its origins, while at the same time, establishing viable, peer-like relationships with representatives of the contemporary world outside. In this article, we present just such an appraisal. But first, we must consider just why this millennial assessment is necessary.

Myth of Recent Ascendancy

It is certainly significant that the first (and, to our knowledge, only) invited millennial reviews of couple therapy appear in *Family Process*. While *Family Process* has never had explicit, formal affiliations with any professional mental health associations, highly influential and visible members of the journal’s governing board and its editorial advisors played pivotal roles in the founding of the American Family Therapy Academy (AFTA) (née “Association”) in the late 1970s. As Framo (1989), a leading historian of that period of AFTA’s saga, noted:

The founding of AFTA had . . . aroused considerable alarm in the AAMFC [now AAMFT, American Association for Marriage

and Family Therapy] . . . From AFTA’s point of view the fields of marriage counseling and family therapy were two separate areas, each with their own histories, concepts, and practices. [p. 12]

The AAMFT, of course, was the professional organization that had originated in the marriage counseling movement. The irony that such a special series on couple therapy appears here, rather than in any of several other more organizationally affiliated, similar journals, should not be minimized, and its meaning is, indeed, profound. Most of the early pioneers of family therapy either explicitly disavowed couple therapy as not central to their work, or effectively cast it into conceptual oblivion merely by not referring to its role. Rare, indeed, for example, were early family therapy textbooks that gave more than a passing nod to the theory or practice of couple therapy. Even widely acclaimed, recent state-of-the-art texts such as M.P. Nichols and Schwartz’ (1998) volume, devote only a small fraction of their pages to couple therapy (for Nicholas and Schwartz, about 2%). Indeed, even in our own family therapy textbooks (Gurman & Kniskern, 1981b, 1991), couple therapy accounted for about one quarter of the chapters.

Such representations of the less-than-secondary importance of couple therapy in the broader family field persist even today, despite family therapy’s unofficial founder, Nathan Ackerman, having identified “the therapy of marital disorders as the core approach to family change” (1970, p. 124). Although Fraenkel (1997) has suggested that, at least historically, “the two modalities [of family and couple therapy] draw from the same body of concepts and techniques” (p. 380), this is becoming increasingly less true, as we will show.

But such representations of couple therapy’s secondary status have flown in

the face of what Gurman & Kniskern (1992, p. 66) called "the long-denied fact that most 'family therapists' predominantly work with couples rather than two-generational families." Thus, Rait's (1988) survey of family therapists showed that about one-fifth of their typical caseload was couple work, and just over one-third was whole family work, notwithstanding the related finding that the most frequently identified (63%) patient complaints among the three most common problems identified by survey respondents were "marital difficulties." Similarly, Simmons and Doherty's (1995) first study of family therapists' practice patterns found that "couple problems" (59%) exceeded "whole family problems" (42%), and their followup national survey (Doherty & Simmons, 1996) of family therapists showed that these clinicians treated about twice as many couples as families. Whisman, Dixon, and Johnson's (1997) survey of practicing family psychologists and family therapists likewise showed that couple problems dominated the landscape of their clinical work. And recent multiauthor volumes, such as those by Donovan (1999) and Dattilio and Bevilacqua (2000) make it clear that therapists of every major (and some minor) "family" theoretical orientation regularly devote large portions of their work to couples. In sum, *the "family" therapy literature of the last thirty years presents a grossly distorted view of what family therapists actually do.*

Why has the professional myth that "family" therapists do little couple or marital work been both so pervasive and so persistent? This is one of the implicit themes found throughout the history of marital and couple therapy, which will be examined in our description of the conceptual history of the field. It is important to note that the undeniably increased visibility of books, articles, workshops, and conference presentations on couple ther-

apy in the past decade indirectly support the myth that this area of clinical practice has become commonplace only very recently. Certainly, some models of couple therapy and the scientific study of couple therapy have ascended only recently. But despite appearances in the broader family therapy field to the contrary, the practice of couple therapy never actually vanished. Still, it is undoubtedly the case that the credibility attributed to such clinical practice is much more recent. The increased visibility of this work via books, conferences, and the like, reflects increased recognition of the centrality of couple therapy. Indeed, as our analysis will show, there are understandable, though unfortunate, reasons why couple therapy remained hidden in the shadows of the world of family therapy and individual psychotherapy for many years, despite the fact that *couple therapy has probably been the modal clinical activity of family therapists for decades.*

The Public Health Importance of Couple Therapy

In addition to countering the myth of couple therapy's "disappearance," there is one other especially salient and far-reaching justification for this millennial review: the breakdown of marriage and other long-term, committed, intimate relationships, whether through divorce or chronic conflict and distress, exacts an enormous cost to public health, and so commands our attention at a societal level.

Couples seek therapy mostly because of relational concerns, such as emotional disengagement, power struggles, problem-solving and communication difficulties, jealousy and extrarelational involvements, value and role conflicts, sexual dissatisfaction, and violence, and this kind of help-seeking is not a recent phenomenon. Even more strikingly, a large percentage of persons seeking help from therapists

practicing individually based therapy do so for marital difficulties. For instance, as early as 1960, Gurin, Veroff, and Feld found that over forty percent of all people seeking psychological help viewed the nature of their problem as marital. Such concerns alone are sufficient to warrant the development of effective couple interventions. But recurring marital conflict and dissolution are associated with a wide array of negative noninteractional sequelae in both adults and children. The partners in troubled relationships themselves are more likely to suffer from anxiety, depression and suicidality, and substance abuse, and from both acute and chronic medical problems and disabilities such as impaired immunological functioning and high blood pressure, and health-risk behaviors such as susceptibility to sexually transmitted diseases and accident-proneness (Bloom, Asher, & White, 1978; Burman & Margolin, 1992; Kiecolt-Glaser, Fisher, & Ogrocki et al., 1993). Moreover, the children of distressed marriages are more likely to suffer from anxiety, depression, conduct problems, and impaired physical health (Gottman, 1994).

Defining Couple Therapy

In order to appreciate adequately the current status of couple therapy, and the significance of the pathways traveled to its current position, a historical perspective must be taken. In this article, we offer just such a history, but one that differs from earlier similar undertakings. By far, the most comprehensive and compelling history of couple therapy to date is that of Broderick and Schrader (1981, 1991), who trace the histories of marriage counseling and marital therapy with a primary emphasis on the development of the professionalization of these therapeutic movements. Our purpose here is quite different. Except when it is essential to do so, we will not address the emergence of

professional organizations and associations in the field, the decades-long (in the United States) struggles of relationship clinicians to achieve parity with other mental health service providers via licensing and graduate program accreditation, or the training and education of couple clinicians.

Rather, our focus will be on the conceptual history of the field of couple intervention, highlighting and commenting on emerging trends in theory and practice, and research pertaining to such practice. To do so, we must first define what we mean by "couple therapy." While we recognize that "couple therapy" can involve whole-family meetings, individual sessions, contact with other community members, etc., the emphasis here is on the prototypic case that focuses primarily on dyadic relational elements.

Thus, our focus is on conjoint therapy, a term coined by Jackson (1959) in regard to both family and couple work, and popularized by Satir (1964) in her classic, *Conjoint Family Therapy*. Of course, there are models of systems-oriented therapy (e.g., the Brief Therapy of the Mental Research Institute, Narrative Therapy) that regularly deal with couple issues with individual patients, just as there are many "individual" psychotherapists who do not subscribe to any particular systems orientation, yet who regularly work with individuals in troubled relationships. We believe that, for practical purposes, it is reasonable to consider couple therapy as involving the presence of both relationship partners. Although there exists a debate (e.g., Gurman & Kniskern, 1986; Gurman, Kniskern, & Pinsof, 1986; Wells & Gianetti, 1986a,b) as to whether individual treatment of couple problems is as helpful as conjoint treatment, we consider the formats of therapy just mentioned to be individual therapy, albeit, at times with a systemic twist. As one of us has commented, "ther-

apeutic intents are not the same as therapeutic events" (Gurman & Kniskern, 1979, p. 5).

On "couples" and "marriages": The term "couple therapy" has recently come to replace the historically more familiar and limiting term "marital therapy" because of its emphasis on the link and bond between two people, without the associated judgmental tone of social value implied by the more traditional term. We ourselves have followed this contemporary convention (Fraenkel, 1997; Gurman & Jacobson, 1995), along with others (e.g., Halford & Markman, 1997; Johnson & Lebow, 2000). In the therapy literature, the two terms are overwhelmingly used interchangeably. The word "couple" has been intended to mean, in effect, "committed, but not 'married' in the legal sense." With some important exceptions (e.g., Laird & Green, 1996), the relevant literature and clinical practices considered here, whether dealing with therapy or prevention, rarely address committed, nontraditional intimate relationships. The terms are the same, but different. Whether therapeutic methods operate similarly or differently with "couples" vs. "marriages" is presently unknown. For our present purposes, we assume that they do operate similarly. In this article, we generally use the more inclusive term "couple therapy," which, of course, subsumes "marital therapy."

The temporal aspect of couple intervention: In addition to the distinctions made above, it is useful to differentiate couple interventions in terms of the phase of the relationship at which they occur. The focus of most couple therapy is remedial, and therapy typically occurs during the long phase of the relationship that follows some sort of symbolic ritual affirming a long-term commitment. When nonremedial intervention occurs in this phase, it usually falls under the heading of "pri-

mary prevention" or "enrichment." Both of these areas are considered here.

When intervention occurs before a legal commitment ritual, it is usually considered "premarital counseling" if it has a remedial intent, and "prevention," if not. Preventive intervention has developed tremendously in recent years, but premarital counseling seems never to have developed either a substantial body of theory or research, and is not addressed here. Likewise, separation/divorce therapy with couples, though a common activity of couple therapists, contains no critical mass of clinical theory apart from generic couple therapy, or widely accepted practices, nor is its research base extensive (Sprenkle & Storm, 1983), and thus, it is also not addressed here as a distinct entity.

FOUR-PHASE CONCEPTUAL HISTORY OF COUPLE THERAPY

Our review suggests that there have been four main phases in the theoretical and clinical history of couple therapy. These phases, visually represented in the timeline in the Figure (see below), refer to conceptually distinguishable time periods in the development of the field. These phases, of course, are not discrete, i.e., they do not literally begin or end in particular years. This phasic representation serves as an organizational heuristic to examine the evolving conceptual and clinical trends of the couple therapy field. Moreover, this phasic analysis reflects the dominant, but not exclusive, thrusts and influences at work during each time period.

In this analysis, we will examine the major conceptual influences in couple therapy in each period, with particular attention paid to theories and methods that have shown clearly enduring and pervasive influences. We will also show the ways in which these four phases in-

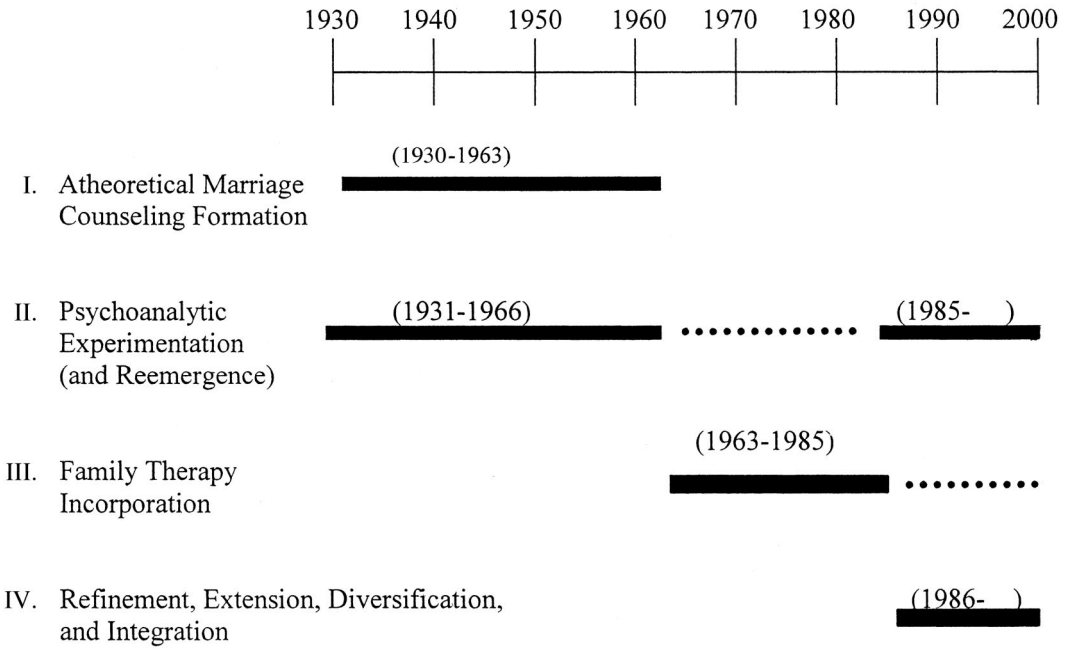


FIG. The four-phase history of couple therapy.

involved complex, mutual influence processes among the dominant forces in the field.

We will draw attention to certain basic elements that would seem to convey something of the essential character of the dominant couple therapies practiced in that period: the models' views of relational health vs. dysfunction; typical treatment goals associated with the models (e.g., degree of emphasis on the attachment vs. power dimension of couple interaction); the theory of change associated with the models (e.g., the balance between interpersonal vs. intrapsychic factors); the nature of the therapeutic relationship in the models (e.g., the degree of therapist directiveness); typical and preferred techniques (e.g., preferred time-frame perspective); and the types of problems and patients treated (e.g., remedial vs. preventive emphasis). Elsewhere, we have separately (Fraenkel, 1997; Gur-

man, 1978, 1979) presented comprehensive, comparative analyses of how such interventive dimensions and foci characterize significant distinctions among the different major schools of couple therapy, but without respect to the unfolding history of those schools.

PHASE I: ATHEORETICAL MARRIAGE COUNSELING FORMATION (1930-1963)

Broderick and Schrader's (1981, 1991) classic tracing of the history of marital counseling identified four distinct phases; Phase I (1929-1932), the "Pioneer" stage, dominated by a small handful of forward-looking practitioners; Phase II (1934-1945), the "Establishment" stage, signaled by the formation of the American Association of Marriage Counselors (AAMC); Phase III (1946-1963), the "Consolidation" stage, leading to the the first legal recognition of the marriage counseling

profession (in California, in 1963); and Phase IV (1964–1978), the “Formative” stage, marked by the building of a professional literature, an occasional effort at scientific study, and what L’Abate and McHenry (1983, p. 3) called “intense growth and clarification of standards and competencies” for training and practice. In our view, what clearly links these stages is the understandable and overwhelming emphasis on the formation of a professional identity for marital practitioners, especially those coming out of the “marriage counseling” tradition. For Broderick and Schrader (1981, 1991), there were four phases to the “marriage counseling” movement. For us, by contrast, these four phases conceptually constitute four subphases in one long phase in the atheoretical formation of the marriage counseling profession.¹

What Was “Marriage Counseling”?

As already noted, “marriage counseling” died a political-administrative death in 1978. If we arbitrarily date modern marriage counseling as having been born, organizationally at least, about 1930 (in that three major marriage counseling clinical institutes were formed from 1929 to 1932 in the United States; Broderick & Schrader, 1981, 1991), then we may justifiably wonder just what was going on in

the field for almost forty years, and why “counseling” came to such a sudden halt.

Broderick and Schrader (1981) described the early marriage counselors as “a more or less naively service-oriented group” (p. 11) for whom their counseling was “the auxiliary activity of a professional whose primary commitment was elsewhere” (p. 4), in their work, e.g., as obstetrician-gynecologists, clergyman, social workers, family life educators, etc. Their clients were pre-marrieds, newlyweds and married couples seeking guidance about the everyday facets of marriage and family life, in some ways presaging the contemporary psychoeducational-preventive movement, as we shall see. They most decidedly were not severely maladjusted or suffering from diagnosed psychiatric disorders, and marriage counseling, even later in its history, was not viewed by the world-at-large as a “mental health” discipline (Haley, 1984; Shields, Wynne, McDaniel, & Gawinski, 1994). Early marriage counseling, however, clearly took a health/strength perspective and, in this way, foreshadowed the later emergence of more comprehensively delineated preventive couple interventions, as we discuss later.

Barker (1984) vividly described the modal clinical activity of clergy and social worker marriage counselors in the 1920s: “They told their clients how to make their marriages work better. They educated couples as to their legal and social obligations and they extolled the values inherent in family life” (p. 11). Marriage counselors stayed close to couples’ presenting problems, provided advice and information, e.g., about the biological aspects of marriages, and helped couples solve relatively uncomplicated practical problems of everyday life. A marriage counselor’s approach was typically very focused, very short-term, and quite didactic.

¹ Parenthetically, but significantly, we think Broderick and Schrader (1981, p. 30) erred in identifying the early contributions of behavioral marriage therapists in the 1970s (e.g., Jacobson & Martin, 1976; Stuart, 1969) as having any connection to the “marriage counseling area.” At that time, Stuart was a university-based Professor of Social Work, and Jacobson was affiliated with an academic program in clinical psychology. They both came from, and were leaders in, the field of behavior therapy. With this in mind, we have amended Broderick and Schrader’s Phase IV to end, not in 1981 when their chapter was published, but in 1978, when the term “marriage counseling” was officially terminated as the AAMFC became the AAMFT.

Treatment Format

If all of this seems to bear little resemblance to modern couple therapy (though it has more in common with modern psychoeducational programs), there is even less resemblance than may meet the eye. Ironically, though interested in the emotional welfare of couples, early marriage counselors rarely met in what we now consider the routinely preferred format of the conjoint interview. In 1963, thirty years into the history of the profession, Michaelson estimated from the case records of the three major marriage and family clinics in the United States that, in the 1940s, only 5% of marriage counselors' cases met conjointly, rising to 9% during the 1950s and to a whopping 15% in 1960. By the mid-1960s, clinicians who primarily identified themselves as marital therapists overwhelmingly used the conjoint format in couple cases, while mental health professionals from other disciplines who also practiced marital therapy were more divided between conjoint and individual approaches (Alexander, 1968). It was not until the end of that decade, now forty years after the founding of marriage counseling, that Olson (1970), in the field's first comprehensive analytical review, identified the "predominant use of the technique of conjoint therapy" (p. 503). As we shall soon see, the conjoint approach did not originate within marriage counseling, but within psychoanalytically dominated psychiatric circles (Sager, 1966), thus portending the virtual downfall of the marriage counseling profession.

Dominant Treatment Models

While Olson (1970) correctly identified the routine emergence of the conjoint approach, he also noted that the field was "seriously lacking in empirically tested principles, and it is without a theoretically derived foundation on which to op-

erate clinically" (p. 503). Likewise, Broderick and Schrader (1981) noted that during this period, there was a "lack of clear commitment to any particular clinical philosophy" (p. 12). And Manus' (1966) classic and often-cited article provocatively declared that marriage counseling was a mere "technique in search of a theory" (p. 449).

And when marriage counselors of the day went searching for a theory, where did they find it? In the "peer group" of psychoanalysis. Apparently, few heeded the warning of psychiatrist/marriage counselor Laidlaw (1957): "If, as therapy progresses, unconscious factors are discovered . . . the case ceases to be in the field of marriage counseling" (p. 56). By the mid-1960s, marriage counselors had latched onto the independently emerging psychoanalytic and psychodynamic approaches to marital therapy. As Manus (1966) noted, "The most generally influential hypothesis . . . is that marital conflict is based on the neurotic interaction of the partners . . . a product of psychopathology in one or both . . . partners" (p. 449). And, in a classic and very influential marriage counseling article of the mid-1960s, Leslie (1964) identified the central technical issues in working with couples: the "identification of distortions" (p. 68) in the partners' mutual perceptions; the "handling of transference and countertransference" (p. 69); the "drawing out of conflict" (p. 70), i.e., allowing the marital conflict to be fully manifest in-session; and the "direct alteration of interaction (p. 70)." Whereas marriage counseling in its first thirty-plus years had maintained an almost sole focus on the present and on patients' conscious experience, the past and the unconscious were now explicitly entering the conjoint counseling process, albeit with a focus still maintained on the current relationship. And yet, as Leslie (1964, p. 66) unabashedly acknowledged, and indeed emphasized, "There is no

sharp line between marriage counseling and reconstructive therapy." Marriage counseling, as W.C. Nichols (1973) would say in another influential article, included "long-term, intensive psychotherapeutic work" (p. 5).

It was understandable that marriage counseling had begun to take on a psychoanalytic flavor. First, family therapy was in the wings, but had not yet gained credibility in the broader world of psychotherapy. While the marriage counseling movement had taken the bold and groundbreaking step of defining marriage as a suitable target for social science investigation and for clinical intervention, marriage counseling was becoming professionally and intellectually marginalized, and, as clinical psychology had done after emerging post-World War II, attempted to attach itself to the most prestigious peer group it could.

Unfortunately, marriage counseling had unwittingly chosen to consort with the devil, as the growing and soon-dominating field of family therapy would generally come to view psychoanalytic thought. Although many of family therapy's early leaders had been trained in psychoanalytic thinking, and some in psychoanalysis proper, family therapy largely emerged as a collective statement against the excess and limitations of highly individual-oriented theory and practice. The marriage counseling profession had not produced an influential clinical theorist in its first four decades, and now it had hitched its wagon not to a rising star, but to the falling star of psychoanalytic marriage therapy that would soon be in a different psychotherapy atmosphere, and would evaporate and largely disappear from visibility for about two decades.

PHASE II: PSYCHOANALYTIC EXPERIMENTATION (1931-1966)

While all the feverish ferment involved in establishing a professional identity

was taking place in the field of marriage counseling over a period of four decades, an entirely separate type of marriage interventionist was straining to emerge as a viable therapeutic force. A small coterie of psychoanalytic clinicians (all psychiatrists, of course, since non-M.D.'s were not then allowed entrance to psychoanalytic training institutes), were growing impatient with the ineffectiveness of treating analysands with primary marital complaints, and even of the sluggish pace of success when it did occur. Despite their understandable cautiousness, a few rebels began an era of daring experimentation.

Precursors to Conjoint Approach

Psychoanalytic writers for decades had been deeply interested in the complex processes of mate selection, the meaning of marriage in family life, and the effects of psychoanalysis on the spouse (Meissner, 1978). As early as 1931, Oberndorf made the first presentation at a major professional (psychiatric) conference on the psychoanalysis of married couples, focusing on the role of "interlocking neuroses" in symptom formation. This paper was followed by one (Oberndorf, 1934) on the phenomenon of "folie à deux" in couples. The original paper, appearing in print several years later (Oberndorf, 1938), described the "consecutive" psychotherapy of marital partners treated by the same analyst, in which the second analysis commenced only when the first ended.

A significant step forward, especially in terms of therapeutic efficiency and length, was taken by Mittelman (1948), who conducted "concurrent" treatment, in which "both spouses are treated individually but synchronously by the same therapist" (Greene, 1965, p. 3). This action was quite a divergence from the psychoanalytic tradition that warned of the dangers of the analyst's contact with the relatives of analysands, because of its assumed contamination and complication of transfer-

ence and countertransference phenomena. But Mittelman's next step was even more daring for its time. He initiated two joint sessions with one couple, as Sager (1966) noted, "because their stories conflicted" (p. 460).

This action was certainly theoretically and politically very incorrect in this tradition, but more tellingly, it also captured the essence of the presumed mechanism of change in concurrent treatment. That is, it was the *therapist's* task to disentangle the partners' irrational, distorted mutual perceptions, as if he (few analysts were then female) "knew" what was rational, and what was not. Significantly, it was when Mittelman had trouble keeping his patients' stories straight, when he could not understand their different stories, that he arranged for conjoint meetings. His conceptual error (from our constructivist-informed, millennial perspective), and the possible error of all the early psychoanalytic marital therapists, was to search for "truth," rather than to entertain and incorporate multiple perspectives. In addition, concurrent therapy, which excluded joint sessions, certainly must have heightened certain technical problems, such as the maintenance of impartiality and the regulation of countertransference reactions. But even Mittelman was not wholly enamored of the conjoint method, and believed that it was the indicated approach for only about twenty percent of couples, with the rest requiring two analysts.

Other psychanalytic experimentation cautiously occurred during the late 1950s and early 1960s. But, as Sager (1966) noted, "Most of these contributions . . . evidenced no new fundamental development of theory . . ." (p. 460). These contributions mostly involved alternative formats for therapy, e.g., "collaborative" therapy (Martin, 1965), in which partners simultaneously were "treated by different therapists, who communicate for the pur-

pose of maintaining the marriage (Greene, 1965b, p. 3), and "combined" treatment, which involved combinations of family therapy, group therapy, individual, concurrent, and, later, conjoint sessions "in various purposeful combinations" (Greene, 1965b, p. 3). Greene's (1965a) classic, *The Psychotherapies of Marital Disharmony*, summarized the extant theories of marital therapy circa the mid-1960s.

In all the emerging nonconjoint psychoanalytic marital treatment methods, the centrality of the individual(s) prevailed. At the same time, there was increasing intuitive sense among practitioners (so it seems in retrospect) that "something" was still missing from the dominant conceptualizations of both marital conflict and of requisite therapist interventions. As long as the marital partners remained either exclusively or predominantly in individually formatted therapies, the therapist remained the central agent through which change must perforce occur. Psychoanalytic marriage therapists challenged rigid adherence to core analytic practices, such as the necessity of free association and dream analysis, and a focus on the patient-therapist transference, and increasingly recognized the salience of the "real," as well as the transferential, marital relationship. These therapists, however, continued to practice in ways that kept them in the position of being *the* pivotal agent of change. They did not yet recognize the healing potential within couples' own relationships (Dicks, 1967; Lewis & Gossett, 2000).

The ambivalent transition to the conjoint approach: To be sure, by the early 1960s, psychoanalytic couple therapy was moving inexorably toward an emphasis on the conjoint approach. But the transition had not yet been completed. Thus, for example, even A. S. Watson (1963), in one of the most influential articles of the decade on the "conjoint treatment of marriage partners," still regularly held two or

three individual anamnestic, formulation sessions with each spouse before convening the threesome on a regular basis. The assumption was still that, in order to understand a couple's "interlocking adaptive and communication systems" (p. 914) and their "interlocking homeostatic balance" (p. 913), the therapist needed to have a clear appreciation of each partner's individual psychodynamics and developmental history, assessed not in the couple transactional setting, but in the traditional patient-therapist dyadic setting. There was still, to an important degree, a belief in content over context.

During the 1960s, therapeutic methodology remained largely unchanged, even as conjoint practice increased. Treatment emphasized the interpretation of defenses (which now also included joint as well as individual defenses); the use of the techniques of free association and dream analysis (which now also included each spouse's associations to the other's, as well as their own, productions); and the ventilation and examination of previously unexpressed feelings (which now included feelings toward both one's partner and the therapist).

Even as psychoanalytic therapists were moving inevitably toward modern conjoint methods, they seemed to still cling to a core individual mindset. Thus, Sager (1967b), certainly the most widely influential marriage therapist in the psychoanalytic tradition during the 1960s and 1970s (e.g., Sager, 1967a, 1976, 1981; Sager, Kaplan, Gundlach et al., 1971) wrote, "I am not primarily involved in treating marital disharmony, which is a symptom, but rather in treating the two individuals in the marriage" (Sager, 1967b, p. 185). Sager had not yet moved (cf. Sager, 1976, 1981) to a balanced intrapsychic/interpersonal approach, and still emphasized "triangular transference transactions" (p. 185), including attention to "oedipal elements."

The same year Sager penned the above, he also recognized a common therapeutic problem, and an associated therapist error involved in "the attempt of husband or wife to talk to the analyst rather than to one another. The alert therapist avoids an omnipotent role so that he allows patients to work toward finding their own creative solutions . . ." (Sager, 1967a, p. 144). In effect, the (traditional) transference should be paramount, but the therapist paradoxically should be more decentralized.

Such paradoxes expressed psychoanalytic marriage therapists' profound uncertainty in their work about the centrality of the defining characteristic of psychoanalysis, the analysis of transference. And yet, the marital therapist still had primary responsibility to serve what would later be thought of as the essential "holding" function (Catherall, 1992; Scharff, 1995) for both members of the couple, when partners experienced unacceptable feelings, thoughts, and impulses.

More than a decade after Sager's early influential writings, Skynner (1980), one of the most widely cited psychoanalytic marital/family therapists (e.g., Skynner, 1976, 1981), already strongly influenced by the object relations theories that had not yet influenced most psychoanalytic marital therapists of this era, discussed the conjoint therapeutic aim of "getting the projections back somehow into the individual selves" (p. 205). He emphasized, after Gurman (1978), that the psychodynamic approach seemed to have "lost [its] way" (p. 276) in identifying change-inducing techniques, beyond the basic psychoanalytic understanding of couple dynamics that it clearly offered. He attributed this technical vacuum to "the inappropriate focus on the concept of 'transference' . . . in relation to the *therapist* (usually cast in a parental role)—and interpretation to bring it to awareness . . ." (p. 276; original emphasis). Skynner emphasized that "the unconscious conflicts

are already fully developed in the mutual projective system between the couple, and could be better dealt with directly rather than by the indirect methods of ‘transference’” (pp. 276–277).

The psychoanalytic conjoint approach in apparent limbo: One of psychoanalytic marital therapy’s most influential articles, Sager’s (1966) “The Development of Marriage Therapy: An Historical Review,” appeared “at the very zenith of its independent development” (Broderick & Schrader, 1981, p. 17), and yet psychoanalytic couple therapy would soon almost drop out of the race for leadership and influence for nearly two decades. It suffered from two interrelated, near-fatal challenges. The first challenge, the lack of effective interventions, came from within the field. As already noted, to the degree that it continued to include a significant emphasis on the traditional patient-therapist transference, it reciprocally failed to evolve interventions that significantly emphasized the partner-partner transference, thus placing a solid ceiling on its capacity to help induce change. But the second challenge was not self-imposed and could not be fended off. It was called the family therapy movement. Despite the fact that most of the pioneers of family therapy had been trained psychoanalytically, and the fact that some of the field’s early influential clinical theorists (e.g., Ackerman, 1970; Framo, 1965) creatively integrated psychodynamic and systems concepts, in large measure, the early history of family therapy was marked by a strong, and at times, unyielding, disavowal of most accepted psychoanalytic/psychodynamic therapy principles and the practices of traditional mental health disciplines (Gurman, 2001; Nichols & Schwartz, 1998). Psychoanalytic marriage therapy soon publicly plummeted from its mid-1960s “zenith” to a two-decade nadir. Psychoanalytic and psychodynamic thought seemed to disappear from

the marital therapy scene. In fact, it did not really vanish, but it did really recede in visibility, although important, though undervalued, contributions from theorists such as Framo (1976, 1981), N. Paul (1969; N. Paul & B. Paul, 1975), and Sander (1979) appeared during this period. Psychoanalytic thinking did not actually die out, but, as we shall see, it was certainly fragmented and marginalized by the dominant therapy schools of the era.

PHASE III: FAMILY THERAPY INCORPORATION (1963–1985)

The changes in clinical practice that were reflected by increasing attention to conjoint couple therapy were experienced not merely as controversial, but as revolutionary, within psychoanalytic circles. But these changes paled in comparison to the magnitude of the changes among the influential conceptual forces in marital therapy that had just begun, near marital therapy’s “zenith.” Family therapy had arrived.

It is interesting to note the varied tones with which the impact of family therapy’s arrival on couple therapy, and psychotherapy more generally, has been described. For example, a perfectly accurate and tempered representative description was offered by Fraenkel (1997): “Systems approaches developed in large part as a reaction against the perceived limitations of therapies that attributed psychological and social dysfunction to problems solely within the individual, whether these were viewed as biological, psychodynamic or behavior in nature” (p. 380).

In similar tones, widely cited historians of the field have described seemingly gentle processes of change in marital therapy. For example, Broderick and Schrader (1991, p. 15) speak of the “amalgamation” and “merger” of the fields; Nichols and Schwartz (1998, p. 37) refer to family therapy as “absorbing” marital therapy;

and Olson et al. (1980, p. 973) write somewhat wistfully that, by 1980, the "traditional distinctions between marriage counseling and family therapy [had] faded." Politically correct, understated descriptions of the changes taking place abounded, and were nowhere more strikingly expressed than in Olson et al.'s (1980, p. 973) euphemistic conclusion that the fields had become "unitary, but not fully unified and integrated."

Part of the reason for what Olson (1970, p. 501) referred to as the "parallel but unrelated development" of the marital and family therapy fields was that, as he put it, "None of the pioneers were recognized as innovators in both fields" (p. 506). And Haley (1984) more caustically argued that there was not "a single school of family therapy which had its origin in a marriage counseling group, nor is there one now" (p. 6). More generally, as Haley (1984) put it, "marriage counseling did not seem relevant to the developing family therapy field" (pp. 5-6).

The second related major reasons for the "parallel but unrelated development" of the two fields, beyond the mere matter of creative personnel, was also trenchantly touched upon by Haley (1984), who noted, "Marriage counselors adopted the ideas of other therapies. When individual therapy was psychodynamic, marriage counseling tended to propound those ideas" (p. 7). And, of course, as discussed earlier, "those ideas" that couple therapists adopted were those of the psychoanalytic/psychiatric establishment. Although L'Abate and McHenry (1983) have offered the perplexing view that "marriage counseling evolved rapidly in the 1970s" (p. 325), it is more accurate to say that, in what Nichols and Schwartz (1998, p. 9) referred to as "family therapy's golden age" (1975 to 1985), family therapy essentially killed marriage counseling (although it could be argued that the demise was the result of self-inflicted wounds),

and severely maimed psychoanalytic marital therapy.

Four Influential Voices

As a reasonably thorough reading of the history of the family therapy movement and its most influential theories inevitably reveals (Broderick & Schrader, 1981, 1991; Framo, 1989; Guerin, 1976; Kaslow, 1980; Nichols & Schwartz, 1998), almost every major family therapy theorist and clinical innovator has had something to say about the place of marriage in overall family functioning and individual symptom formation, the requirements of a healthy marriage and the sources of couple disharmony, and guiding principles for intervening with couples in conflict. Still, it is well beyond the scope of this article to review and comment on all these contributions to our understanding of long-term, committed relationships (see Fraenkel, 1997, for a review). Of the numerous approaches to family therapy that flowered during this Third Phase of couple therapy, we identify four clinical theorists as having made signal contributions to theory development and/or clinical practice: Don D. Jackson, Virginia Satir, Murray Bowen, and Jay Haley. These contributions either generated ground-breaking new ideas or stimulated a line of thinking that continues strongly to influence contemporary practices. What is more, we believe these pioneers' contributions are the most representative of the kinds of conceptual changes family therapy brought to bear on couple therapy during its "golden age."

Don D. Jackson and the Marital Quid Pro Quo: Jackson, founder of the Mental Research Institute (MRI), was one of that group's groundbreaking investigators of the family's role in schizophrenia (e.g., Bateson, Jackson, Haley, & Weakland, 1956). His work made household names in family therapy of such influential concepts as the "report" and "command" di-

mensions of communication (Jackson, 1965b), the “double bind” (Bateson et al., 1956), and relational “symmetry” and “complementarity” (Lederer & Jackson, 1968). His most pervasively influential concept of “family homeostasis” (Jackson, 1957) has been aptly referred to by Nichols and Schwartz (1998) as “the defining metaphor of family therapy’s first three decades” (p. 39). Homeostatic mechanisms referred to systemic properties of families that resist change. And family “rules,” inferred patterns of redundant interaction (Jackson, 1965a), were the homeostatic mechanisms that received the most attention in Jackson’s study of marital relationships.

Nichols and Schwartz (1998) perceptively note that while Jackson sought to create a language descriptive of whole-family interactions, his “major success was in describing relationships between husbands and wives” (p. 41). Indeed, his best-known book, *The Mirages of Marriage* (Lederer & Jackson, 1968) focused entirely on couples. And the “defining metaphor” in Jackson’s discussions of marital relationships was the “marital quid pro quo” (Jackson, 1965a).

The marital “quid pro quo” was also the cornerstone concept in Jackson’s methods of couple therapy. As we will discuss, this concept would become absolutely central to the early development of behavior marital therapy (Azrin, Naster, & Jones, 1973; Jacobson & Margolin, 1979; Stuart, 1969). Indeed, Jackson’s two major treatments of this concept (Jackson, 1965a; Lederer & Jackson, 1968) are universally considered classics.

But, as Mark Twain (1897) said, a classic is “A book which people praise and don’t read.”² Contrary to common percep-

tions, for Jackson, the quid pro quo was “not overt, conscious or the tangible result of *real bargaining*” (Jackson, 1965a, p. 592; emphasis added), and was not “time-bound” (Lederer & Jackson, 1968, p. 272). That is, quid pro quo exchanges are not point-for-point exchanges, e.g., of the kind commonly found in the “behavioral exchange” interventions of behavioral couple therapists (Jacobson & Margolin, 1979).

The essence of the quid pro quo was “an *unconscious* effort of both partners to assure themselves that they are equals, that they are peers. It is a technique enabling each to preserve his *dignity* and *self-esteem*” (Lederer & Jackson, 1968, p. 179; emphasis added). The “*quid pro quo* pattern becomes an unwritten (usually not consciously recognized) set of ground rules” (p. 179). Consistent with the non-time-boundedness and nonliteralness of the concept, is the notion that the “marital quid pro quo is a *metaphorical* statement of the marital relationship bargain; that is, how the couple has agreed to *define themselves within this relationship*” (Jackson, 1965b, p. 12).

Despite Jackson’s efforts to throw off his psychoanalytic/Sullivanian roots, and to move from “mentalistic inference to behavioral observation of sequences” (Nichols & Schwartz, 1998, p. 39), he never fully succeeded in casting them aside. Indeed, his writings on the marital quid pro quo exude an emphasis on the importance of patients’ phenomenology, and humanistic sensitivity to self-perception and self-valuing. It might be said that they could take Jackson out of Chestnut Lodge, but they could not take Chestnut Lodge out of Jackson.³

² Twain, M. (1897). *Following the Equator*, vol. I: *Pudd’nhead Wilson’s New Calendar*, epigraph for Chapter 25.

³ Chestnut Lodge, in Rockville MD, is a private psychiatric hospital where Jackson did his psychiatric residency. Its training philosophy was heavily Sullivanian, i.e., both interpersonally and intrapsychically oriented.

Although he originated the term “conjoint therapy,” Jackson (1959, p. 122) did not publish a great deal on matters of therapeutic technique, and yet his writings were salient in two very different ways: first, for the ways in which they were misread and misapplied, and second, for the ways in which they presaged some of the practices in couple therapy that are most prevalent at the start of the new millennium.

Despite his efforts to minimize attention to the individual through his communicational analysis of dyads, Jackson wrote that “It is at the level of exchange of definitions of the relationship (and, therefore, of *self-definition within the relationship*) that we can *usefully analyze* in terms of quid pro quo” (Jackson, 1965a, p. 592; emphasis added). And one of the main ways to “usefully analyze” the quid pro quo was, Jackson said, “to bring it from the *unconscious* to the conscious level” (Lederer & Jackson, 1968, pp. 179–180; emphasis added). Later, in the *Mirages of Marriage*, Jackson added that “one of the *main functions* of the marriage counselor is to . . . *make them aware of those unconscious rules* which are causing friction . . . and *help them develop new rules* which *may be more workable*” (Lederer & Jackson, 1968, p. 442; latter emphasis in original).

To this end, Jackson added, “Insight alone is insufficient” (Lederer & Jackson, 1968, p. 442). But, note that, unlike most of the family therapy “systems purists” (Beels & Ferber, 1969) of the “golden era,” including some of his prominent MRI colleagues, Jackson did not assert that insight was either harmful, irrelevant, or unnecessary. It was merely not enough.

And Jackson believed that what was necessary in addition to insight was “to have them consciously engage in behavior that demonstrates the presence or absence of this [particular covert] rule, and then to help them begin to formulate a

new one” (Lederer & Jackson, 1968, p. 443). And, keep in mind that the “new one” was not a point-for-point exchange, but a new “bargain” about each partner’s definition-of-self-in-the-relationship.

To this end, Jackson described in great detail the “quid pro quo meetings” (Lederer and Jackson, 1968, p. 287) he used in order to help couples fashion new, more adaptive, conscious rules for their relationship. Interestingly, his procedures are rarely, if ever, specifically cited by contemporary writers on couple therapy. Yet, these procedures are more than mildly reminiscent of widespread (and empirically supported) treatment principles in behavioral couple (cf. Christensen, Jacobson, & Babcock, 1995) and preventive intervention programs (Floyd, Markman, Kelly, et al., 1995; Fraenkel, 1997; Fraenkel, Markman, & Stanley, 1997) aimed at improving couple communication. Examples of this overlap include: taking turns expressing one’s views on a focused topic, followed by the listener’s summarization of what he or she has heard; an emphasis on behavioral specificity in making relational requests; a prohibition against mind-reading; the use of “the floor” by the speaker; and the termination of negative quid pro quo meetings in order to prevent escalation, followed by calmer resumption of the conversation.

And Jackson was not at all insistent on what would soon become the fashionable push for ever-briefer therapy, noting that while some couples can be helped in “as few as three to ten sessions” (Lederer & Jackson, 1968, p. 447), couples with “serious marital problems” (p. 447) might wisely anticipate a treatment course of one to two years, with perhaps the majority requiring six months to a year!

In sum, Jackson struggled against the two-heavy individual emphasis of psychoanalytic psychotherapy, and used core ideas such as family homeostasis and marital quid pro quo to balance the extant

explanatory models in the mental health fields. He used such concepts, in effect, as pragmatic interventions into the field, noting that “notions of family rules and marital quid pro quo are levers to *force us* away from the characteristics of individuals onto the nature of their interactions” (Jackson, 1965b, p. 29; emphasis added). And, he urged that we “avoid the pitfalls of reification and acknowledge the fictitious nature of all our constructs” (p. 29). Jackson never intended to obliterate an awareness of and sensitivity to the individual, as others would soon do. Indeed, Jackson might well have constructed the much needed bridge between both the moribund field of marriage counseling and the floundering psychoanalytic marital therapy of the day, on the one hand, and the rapidly proliferating field of family therapy on the other, but his life was tragically cut short in 1969, at the age of forty-eight.

Virginia Satir, Self-Esteem, and Congruent Communication: There can be no doubt that the charismatic Virginia Satir was the most visible and influential popularizer of family and marital therapy among both professional and lay audiences from the mid-1960s until about the mid-1970s. The author of such mega-sales books as *Peoplemaking* (Satir, 1972) and *Conjoint Family Therapy* (Satir, 1964), she held a unique place in the early history of systems-oriented therapy, in that she was the only nationally and internationally influential female clinician in the field. Although the titles of most of her published work referred to family rather than couple therapy, the lion’s share of her systems-oriented therapeutic contributions, like Jackson’s, were about dyads, and especially the marital dyad.

Satir, like Jackson, was one of the MRI pioneers, arriving there in 1959. Unlike many of the pioneers of family therapy, Satir was not uncomfortable about her links to the field of psychiatry, and in fact

had established the first formal family therapy training program in a psychiatric residency program (at the Illinois State Psychiatric Institute, in 1955). Her clinical attitude of inclusiveness and acceptance was also manifest in the way she related to her colleagues and to the mental health professions in general.

Unlike the popular “systems purists” of the day, Satir was not disinterested in the historical family origins of presenting problems, nor was she mute on the matter of marital choice, a topic of great concern, of course, to psychoanalytic marriage therapists. She believed that people chose partners with similar difficulties and degrees of selfhood (Satir, 1964, 1967). And also unlike emerging systems theorists in the field, Satir had definite views on what constituted individual psychological health. These criteria included an ability to accept oneself and others, comfort in acknowledging such acceptance, awareness of one’s own needs and feelings, the ability to communicate clearly, and the ability to accept disagreements and others’ points of view. Symptoms in individuals, she argued, “develop when the rules for operating do not fit needs for survival, growth, getting close to others, and productivity . . .” (Satir, 1965, p. 122); and she believed that dysfunctional marriages follow dysfunctional rules that limited individual growth as well as dyadic intimacy. Little did Satir know that she was laying one of the cornerstones for later models of couple therapy grounded in attachment theory (e.g., Greenberg & Johnson, 1986, 1988; Johnson, 1996; Johnson & Greenberg, 1995).

In all of her thinking, primacy was given to the functioning and experiencing of the individual, as much as to the individual-in-relational context. For Satir, the narrow roles people assumed in close relationships (e.g., “victim,” “placater,” “defiant one,” “rescuer”), and the dysfunctional communication styles they exhib-

ited (e.g., “blamer,” “placater,” “being irrelevant,” “being super reasonable”), while certainly reinforced by pathological patterns of interaction over time, were fundamentally expressions of low self-esteem and poor self-concept. Significantly, self-esteem and one’s quality of communication were thought to exist in a circular relationship, so that poor self-esteem leads to poor communication (of various types), which in turn, leads to poor self-esteem, etc.

Although Satir was always aware of the systemic nature of problem formation and problem maintenance, she viewed the couple system rather differently than did most of the family therapy theorists of this era. Satir focused on one’s perceptions of self and other, how one thinks and feels and shows (“manifests”) these experiences, and how one reacts to others. For Satir (1965), “these three parts form the patterns of interaction that *compose the couple’s system*” (p. 122; original emphasis). In keeping with Jackson’s (1965b) warning about the dangers of reifying systemic constructs, Satir always kept in view what M. P. Nichols (1987) later called the “self in the system.”

The overriding ultimate goal of couple therapy for Satir, then, was to foster greater self-esteem and self-actualization, to be achieved through such mediating goals as increasing the congruence and clarity of self-expression about relational needs, self-perceptions, and perceptions of one’s partner; increasing self-awareness; removing protective “masks” that shield authentic self-revelation; and accepting and, indeed valuing, differences. These goals were toward growth, not stability. As Satir (1965) expressed it, the goal was “not to maintain the relationship nor to separate the pair but to help each other to *take charge of himself*” (p. 125; emphasis added).

To these ends, a wide variety of interventions and experiential techniques

were used, ranging from verbal methods such as emphasis on the use of “I-statements,” talking to rather than about one’s mate, emphasizing people’s positive motives more than their accumulated resentments, intensifying the immediacy of one’s emotional self-awareness, clarifying communication, urging direct expression of feelings, encouraging validation of one’s mate, and acceptance of differences: to nonverbal methods such as family sculpting and even, at times, dance movement, and massage. While the emphasis of Satir’s work was on the present, her “Family Reconstruction” method (Nerin, 1986) made special efforts to unlock patients from dysfunctional historical patterns learned in their families of origin. The therapist’s roles were multiple, and included prominently, pointing out unspoken family rules, eliciting conscious but unexpressed feelings, use of the therapist’s self through expressions of warmth and caring, and serving as a “model of communication” and “a resource person” who shares her “special knowledge” (Satir, 1965, p. 132). Satir saw the effective couple therapist as a nurturing teacher, whose aim was to help orchestrate corrective emotional experiences.

Satir left the MRI in 1966, to become the first director of the famous Esalen Institute in California. Her increasing involvement in the “human potential movement” of Rogers, Maslow, Perls, and others took her more and more outside the mainstream of family and couple therapy, despite her abundant popularity among laypeople. Her direct leadership role in the field was also decelerated by a pivotal public debate in 1974 with a leader of the “systems purist” forces of the field, in which she was criticized for her humanitarian zeal, and felt unappreciated and marginalized by the newer waves of (male) family systems engineers (Pittman, 1989).

Among the most influential values Satir almost singularly represented, and the therapeutic stances she adhered to during her heyday, were: the importance of direct, authentic communication and self-disclosure; the importance of esteeming both oneself and one's intimates; the salience of relational closeness and security over and above mere problem resolution; the relevance of having an explicit model of individual and relational health and pathology; the belief in the restorative potential of committed couple relationships rather than the notion that they almost inevitably resist change; and the role of the therapist as an encouraging, nurturant healer, rather than as either an intellectualizing "analyst" or an uninvolved, yet provocative, problem-fixer.

Satir died in 1988, leaving no true "school" of couple (or family) therapy with her name. While she had been seen by many leaders in the field, including some of her very own MRI colleagues, as a "naïve and fuzzy thinker" (Nichols & Schwartz, 1998, p. 122), it could be argued that she left a more enduring and pervasive legacy for the treatment of couple problems than any of her pioneering contemporaries.

Murray Bowen and the Differentiation of Self: For Murray Bowen, never one to be described as a "naïve and fuzzy thinker," theory was first and foremost, standing far ahead of therapeutic technique, the therapeutic relationship, and the like. The father of multigenerational or transgenerational family systems theories, Bowen began a conceptual approach that has outlived his own passing in 1990, and been carried on by a number of influential thinkers, not only in the family therapy realm (e.g., Friedman, 1985; Kerr & Bowen, 1988), but in the couple therapy realm as well (e.g., Aylmer, 1986; Gerson, Hoffman, Sauls, & Ulrici, 1993; Guerin, Fay, Burden, & Kautto, 1987; Papero, 1995, 2000; Roberto-Forman, 2002). In-

deed, while Bowen's earliest clinical involvement in intergenerational thinking occurred in the 1950s in the context of working with families with a schizophrenic member (Broderick & Schrader, 1991), his clinical work, and that of his students, strongly emphasized the marital dyad as the central treatment unit.

And yet, as Papero (1995) notes, "Bowen family systems theory (BFST) is not primarily a theory about marriage" (p. 11). Nonetheless, as Bowen (1976) emphasized, "Practically, the two spouses are usually the only ones who are important enough to the rest of the family and who have the motivation and dedication for this kind of [therapeutic] effort" (p. 392). Thus, working with the marital couple was Bowen's preferred format for therapy, even when the presenting problem was not marital conflict but, rather, the symptom of one partner, or even of a child. Bowen believed in relational causes of all psychological and psychiatric problems. He began working regularly with couples in part as a way of attempting to block pathological multigenerational processes.

And it was multigenerational process that Bowen focused on, even as his systemic family therapy contemporaries were highlighting observable, present-day interactions. The central concept of BFST was the differentiation of self, essentially the ability to distinguish between thoughts and feelings. Differentiation was, importantly, two-fold: differentiation within self, and differentiation from others. The latter required the former. Such two-fold differentiation was equivalent to psychological health, and a precondition for systemic health, including marital or couple health. Differentiation allows internal direction, autonomy, and the possibility of intimacy. Poor differentiation is associated with defensiveness, externalization, and discrediting of one's partner.

Like Satir, Bowen had strong views on the matter of marital choice, and believed that people choose partners who are at similar levels of differentiation. The pathological expression of low differentiation, according to BFST, could take four forms: emotional distancing, marital conflict, one spouse's symptoms, or scapegoating (e.g., of a child). Marital conflict might ensue when the anxiety level of one or both partners rose, whether because of factors outside the relationship, or within the relationship, e.g., anxiety over intimacy. In such circumstances of emotional tension, the partners inevitably intuitively recruit in ("triangulate") a third factor to stabilize the dyad. The third point of such pathological triangles can be persons (e.g., affairs) or individual symptoms. But, for Bowen, marital conflict pointed not only to problems in the dyad, but more prominently to problems in the larger family systems of the partners, i.e., the families of origin. Thus, dysfunctional marriages bespoke undifferentiated individuals who, by definition, were insufficiently differentiated not only within themselves (affectively), but, just as important, from their families of origin.

The therapeutic focus in BFST with couples, then, is the "recursive, repetitive, chronic cycles of symptoms between marital partners and key extended family members" (Roberto-Forman, 2002). The shift was from a marital focus to a self-focus. Before experimenting in direct interactions with each partner's family of origin, each partner had to focus on anxiety reduction. To this end, the process of therapy, and the nature of the therapist's role were central. Little attention was paid to the immediate couple interaction, and interpersonal skills per se were not taught. While the "therapeutic relationship," as usually conceived, with a view of the therapist as a healer, was downplayed, the therapist's stance as an involved, yet dispassionate, objective "coach"

would allow him to remain in contact with each partner, and still stay affectively "detriangulated." So central was this concept to Bowen's theory of change, that he even asserted that "Conflict between two people will resolve *automatically* if both remain in emotional contact with a third person who can relate actively to both without taking sides with either" (Bowen, 1978, p. 177; emphasis added).

To keep BFST sessions calm, partners are typically encouraged to communicate through the therapist rather than to each other. The therapist is generally cerebral and intellectual, regulating his own emotional reactivity, taking clear "I-positions" without judging the partners, and teaching the (BFST) principles of emotional processes in individuals and in relationships. This ("detriangulated") therapist stance was seen as more important than any specific therapist techniques or interventions. Indeed, the therapist's capacity for objectivity, and his knowledge of family systems principles (à la BFST) provided the central mechanism of therapeutic change. BFST even asserts that marital partners cannot achieve higher levels of differentiation than their therapist has achieved.

BFST has attained a most interesting place in the history of couple (and, of course, family) therapy. On the one hand, there are relatively few true "Bowenian" therapists, since high-level training centers in this approach are small in number and tend to cluster in the Northeast. On the other hand, there has definitely not been any other historically oriented, trans-generational method of couple treatment emerging out of the world of mainstream family therapy with as much widespread influence as BFST. The constructs and language of BFST have pervaded the practice of multigenerational couple therapy more than any other model.

Rising to prominence during the heyday of the powerful family therapy move-

ment, it was no small achievement that BFST bucked the dominant trends in the field toward present-centered, interaction-centered, and symptom-centered methods. In addition to the attractiveness of the theory itself, there are at least three interrelated contextual explanations for the status and influence earned by BFST. First, Bowen's well-known assertions that BFST had nothing in common with psychoanalytic/psychodynamic thinking notwithstanding, this approach certainly did seem to resonate with some central notions of object relations theory. In this way, BFST probably provided the field of family therapy not merely with "a bridge between individual and family therapy" (Lebow & Gurman, 1998, p. 486), but also a legitimized theory from outside the tradition of psychoanalytic marital therapy which retained the individual without ever losing sight of the larger family system. Psychoanalytic thinking was becoming *déclassé*, if not formally forbidden, within mainstream family therapy, and BFST provided a conceptual lifeline to the "inner man" for those who were not yet ready to abandon such interest.

Relatedly, BFST also seems to have provided if not an antidote to, then at least a reliable refuge from, the heavily technique-oriented, symptom-focused approaches that were rapidly overtaking the field of family therapy. Just as the "persons" of patients in couple (and family) therapy were being submerged, so, too, was the role of the therapist's own personhood being overwhelmingly downplayed.

When Bowen presented his (anonymously published) classic paper, "On the Differentiation of Self" (Anonymous, 1972), at a national conference of family researchers and family therapists in Philadelphia, he was not only sharing his twelve-year personal journey toward differentiation from his own family of origin, but was also strikingly differentiating himself from many of his peers in the field

of family therapy. BFST attended to the past as well as the present, to the intra-personal as well as the interpersonal, and to the affective as well as the cognitive. It was the only couple therapy theory of its day emerging from family therapy that simultaneously addressed the individual, the dyad, and the family of origin. Never one to be concerned with political correctness, Bowen treaded where most feared to go.

Jay Haley, Power, and the Reification of Systems: As influential as Jackson, Satir, and Bowen were as marital thinkers and clinicians, no one during the heyday of the family therapy movement had as much influence on the practice of couple therapy as Jay Haley. Indeed, the publication of Haley's early (1963) classic paper, entitled simply, "Marriage Therapy," arguably marked *the* defining moment at which family therapy incorporated and usurped what was left in the stalled-out marriage counseling and psychodynamic marital therapy movements. It was perhaps all the more ironic that this paper appeared in a major psychiatric journal, the *Archives of General Psychiatry*.

Beyond its very substantial content, Haley's (1963) article (and many subsequent publications) challenged virtually every aspect of extant psychodynamic and humanistic therapy principles. It disavowed widespread beliefs about the nature of marital functioning and conflict, what constituted the appropriate focus of therapy, the role of the therapist, and what constituted appropriate therapeutic techniques.

For Haley, the central relational dynamic of marriage involved *power* and *control*. As he put the matter, "... the major conflicts in marriage center in the problem of who is to tell whom what to do under what circumstances..." (Haley, 1963, p. 227). Problems arose in marriage when the hierarchical structure was unclear, when there was a lack of flexibility,

or when the relationship was marked by rigid symmetry or complementarity. When presenting complaints centered explicitly on the marital relationship, control was easily seen by Haley as the focal clinical theme. More subtly, though, Haley also believed that even when the presenting problem was the symptom of one person, power was at issue: the hierarchical incongruity of the symptomatic partner's position was central, in that the symptom bearer was assumed to have gained and maintained an equalization of marital power through his or her difficulties. Symptoms of individuals, then, became ways to define relationships, and they were seen as both metaphors for and diversions from other problems that were too painful for the couple to address explicitly.

In this way, symptoms of individuals in a marriage, as well as straightforwardly relational complaints, were mutually protective (Madanes, 1980), and were significantly seen as serving *functions* for the partners-as-a-dyad. Since symptoms and other problems were seen as functional for the marital unit, resistance to change was seen as almost inevitable, leading Haley (1963) to formulate his "first law of human relations," that is, "when one individual indicates a change in relation to another, the other will respond in such a way as to diminish that change" (p. 234; original emphasis omitted).

Such a view of the almost inherent property of marital (and family) systems to resist change was not limited to the husband-wife interaction. This view necessarily led to the position that the therapist, in his or her attempts to induce change, must often go about this task indirectly. Thus, for Haley (1963), the therapist "may never discuss this conflict (who is to tell whom what to do under what circumstances) explicitly with the couple" (p. 227). Haley (1976) believed that "the therapist should not share his

observations . . . that action could arouse defensiveness . . ." (p. 18). Achieving insight, while not entirely dismissed, was enormously downplayed in importance, in marked contrast to psychodynamic models.

Also viewed negatively by Haley were such commonplace and heretofore unchallenged clinical beliefs as the possible importance of discussing the past ("It is a good idea to avoid the past . . . because marital partners are experts at debating past issues . . . No matter how interested a therapist is in how people got to the point where they are, he should restrain himself from such explorations" (Haley, 1976, p. 164); the importance of making direct requests ("The therapist should *avoid forcing a couple to ask explicitly for what they want from each other* . . . this approach is an abnormal way of communicating," Haley, 1976, p. 166; original emphasis); and the possible usefulness of interpretation (" . . . the therapist should not make any interpretation or comment to help the person see the problem differently," Haley, 1976, p. 28). Nor was the expression of feelings, common to other couple treatment methods, valued by Haley ("when a person expresses his emotion in a different way, it means that he is communicating in a different way. In doing so, he forces a different kind of communication from the person responding to him, and this change in turn requires a different way of responding back. When this shift occurs, a system changes because of the change in the communication sequence, but this fact has *nothing to do with expressing or releasing emotions* (in the sense of catharsis)" (Haley, 1976, p. 118; emphasis added). Nor did Haley value expression of feelings for the enhancement of attachment or fostering a sense of security through self-disclosure. Indeed, feeling expression in general was of no priority to Haley (" . . . he should not ask how someone feels about something,

but should only gather facts and opinions," Haley, 1976, p. 28).

In contrast, Haley's preferred therapeutic interventions emphasized planned, pragmatic, parsimonious, present-focused efforts to disrupt patterns of behavior that appeared to maintain the major problem of the couple. The strategic therapist was very active and saw his or her central role as finding creative ways to modify problem-maintaining partners so that symptoms, or other presenting problems, no longer served their earlier maladaptive purposes. Directives were the most important therapist change-inducing tools. Some directives were straightforward, but Haley also helped to create a rich fund of indirect, and sometimes resistance-oriented paradoxical directives, e.g., reframing, prescribing the symptom, restraining change, and relabeling, for example, "whenever it can be done, the therapist defines the couple as attempting to bring about an amiable closeness, but going about it wrongly, being misunderstood, or being driven by forces beyond their control" (Haley, 1963, p. 226).

Haley's theoretical and technical contributions were enormously influential in the broad field of family therapy and couple therapy. More than any other individual, Haley influenced sizeable portions of at least an entire generation of marital (and family) therapists to see family dynamics "... as products of a 'system,' rather than features of persons who share certain qualities because they live together. Thus was born a new creature, 'the family system'" (Nichols & Schwartz, 1998, pp. 60–61). The notion of symptoms serving functions "for the system" was a hallmark of the strategic approach that pervaded clinical discussions, presentations, and practices in the late 60s through the 70s. The anthropomorphizing of the family or couple "system" seemed to "point to an inward, systemic unity of purpose" that rendered 'the whole' not only

more than the sum of its parts... [but] somehow *more important than its parts*" (Bogdan, 1984, pp. 19–20). Haley had not heeded the warning of his colleague Jackson (1965a) to "avoid the pitfalls of reification and acknowledge the fictitious nature of all our constructs" (p. 9).

In sum, Haley urged clinicians to avoid discussing the past, resist temptations to instill insight, and downplay couples' direct expression of wishes and feelings. As Framo (1996) would venture three decades after Haley's (1963) concept-shifting marriage therapy article, "I got the impression that Haley wanted to make sure that psychoanalytic thinking be prevented from ruining the newly emerging field of family therapy" (p. 295).

Family therapy had now not merely incorporated, merged with, or absorbed marriage counseling and psychoanalytic couple therapy; it had engulfed, consumed, and devoured them both.

PHASE IV: REFINEMENT, EXTENSION, DIVERSIFICATION, AND INTEGRATION (1986–present)

Marriage counseling, which had generated no enduring theoretical contributions, and almost entirely lacked a research base, had almost expired until it was legitimized and resuscitated by achieving licensure in the early to mid-1960s. It had accomplished its professional mission. Psychoanalytic marriage therapy was struggling with anxiety over maintaining its conceptual and technical integrity and boundaries, as it walked the fine line between intrapsychic and interpersonal emphases, and seemed to be immobilized by its ambivalence.

From about the mid-1960s until about the early 1980s, there appeared few major conceptual advances in the realm of psychoanalytic/psychodynamic couple therapy, and even the simple frequency of publications on the topic dwindled. Dicks' (1967) classic, *Marital Tensions*, which

eventually became the unofficial bible of object relations thinking in couple therapy, was not widely read at first, and was mostly unknown to American clinicians. Despite its ultimate status as a classic (but not Twain's sort of classic), it went out of print only a few years after its initial appearance. Probably, the only other influential conceptual and technical contribution in the psychodynamic realm from the mid-1960s until the mid-1980s was offered in Sager's (1976, 1981; Sager et al., 1971) concept of the "Marriage Contract," which we will comment on later in this section. Framo's (1976, 1981) work on couple groups and combined sessions with family of origin, steeped in object relations theory (Framo, 1965, 1996), was among the most innovative of its time. Unfortunately, because of the essential disavowal of most things psychodynamic by the overwhelmingly systems-oriented family therapy field, Framo's work never has had the full impact on the couple therapy world it otherwise might have.

At the same time, the humanistic-experiential wing of the field had been essentially silenced by Satir's marginalization during the period of family therapy's heyday, not to be heard from substantially again until the late 1980s.

During this period in couple therapy's conceptual history, only a handful of important texts appeared, including two multiauthor books (Paolino & McCrady, 1978; Sholevar, 1981), and two single-author books (Segraves, 1982; Wile, 1981). Emerging integrative (Segraves, 1982) and nontraditional (Wile, 1981) approaches largely stood on their own, lacking any organized following. The two leading edited textbooks of this period, incorporating multiple viewpoints and addressing a variety of central topics (Paolino & McCrady, 1978; Sholevar, 1981) were among the earliest signs that a critical mass of couple-focused psychotherapists was beginning to redevelop. The

first comprehensive assessment of the evidence about couple therapy's effectiveness (Gurman, 1973b) also appeared during this period.

By the mid-1980s, couple therapy had reasserted its existence and established what would become more sustained theory development and empirical research than had been seen in decades. We have identified 1986, the year of publication of Jacobson and Gurman's *Clinical Handbook of Marital Therapy*, as the approximate beginning of couple therapy's fourth, and current, phase. The *Handbooks'* (Gurman & Jacobson, 2002; Jacobson & Gurman, 1986, 1995) widespread readership and utilization seem to have signified couple therapy's highly visible and permanent return to the world of influential approaches to psychotherapy.

REFINEMENT

The last decade and a half have witnessed the appearance on couple therapy's center stage of three traditions of treatment in particular. In addition to their increasingly solid research base, what is especially compelling about these approaches is their continual modification and conceptual and technical refinement during this period.

Behavioral Marital Therapy: Expanding Functional Analysis

Behavioral Marital Therapy (BMT), a social learning theory-based approach, was visibly launched by the early works of Stuart (1969, 1980) and Jacobson (Jacobson & Margolin, 1979; Jacobson & Martin, 1976), which were among the most important publications on couple therapy outside mainstream family therapy. BMT, like all behavioral approaches, and more than any other approaches to psychotherapy, attempts to ground its clinical practices in empirical research. To date, BMT is the most intensively and

frequently investigated couple therapy method (Halford, 1998).

BMT has gone through four rather distinct phases in its short twenty five-year existence, each characterized by significant modifications and refinements of the underlying treatment model and its application.

The first two phases, which we call "Old BMT," correspond to what Jacobson and Christensen (Christensen, Jacobson, & Babcock, 1995; Jacobson & Christensen, 1996) call "Traditional Behavioral Couple Therapy." This phase is comprised of two subphases: the simple behavior exchange phase, and the skills training phase.

In the *simple behavior exchange phase*, the clinical emphasis was on influencing partners to identify desired changes in each other's overt behavior, and then to exchange these pleasing behaviors (Azrin, Naster, & Jones, 1973; Stuart, 1969) in "tightly structured . . . agreements" (Halford, 1998) based on the marital quid pro quo concept of Jackson (Lederer & Jackson, 1968). This style of contracting was somewhat replaced by "good faith contracts" (Weiss, Birchler, & Vincent, 1974), in which there was not to be the linked, paired exchange of highly specific behaviors, but where exchanges were to be activated unilaterally (and, hopefully, simultaneously). The behavioral exchange aspects of BMT are now generally considered an important but secondary element of social learning-based couple therapy, and with good reason. Early behavioral couple therapists had fundamentally misunderstood the essences of Jackson's quid pro quo by equating it with point-for-point exchange procedures rather than as a broader perspective regarding how marital partners define themselves-in-relationship (Gurman & Knudson, 1978; Segraves, 1982). Even as consummate a scholar as Gottman (1999) has misconstrued the original thrust of the marital

quid pro quo as involving "keep(ing) tabs on positives given and received" (p. 12).

In the *skills training phase*, BMT placed an almost unswerving emphasis on the therapist's teaching couples the communication and problem-solving skills that characterize healthy, satisfying marriages, and the absence of which were assumed to maintain recurrent marital conflict and dissatisfaction. These skills were often taught to couples in rather discrete learning modules, following a "relatively fixed curriculum" (Halford, 1998, p. 615). Interestingly, although the essence of behavior therapy, including BMT, is not the use of specific techniques but the clinical application of the functional analytic method (Kanfer & Phillips, 1970), behavior therapists in this phase seem often to have become so enamored of a learnable, teachable clinical methodology that they often called upon such skills-training components in therapy when they may not have been needed. Ironically, it appears that they often failed to make the important functional analytic distinction between a problem of acquisition (the requisite behaviors have not been learned) and a problem of performance (the behaviors have been learned, are used elsewhere, but appear insufficiently in this relationship).

The second aggregate phase in BMT's evolution, which we call "New BMT," corresponds to Jacobson et al.'s (Christensen et al., 1995; Jacobson & Christensen, 1996) development of "Integrative Behavioral Couple Therapy," but includes other important contributions as well. Jacobson and Christensen's work highlights the *acceptance phase*. The development of methods to increase partners' mutual acceptance (vs. a primary focus on behavior change) was motivated by the need to expand the therapist's intervention repertoire in the face of "the polarization of difficult couples" whose problems were not adequately addressed by traditional

skills-training (Cordova, Jacobson, & Christensen, 1998), e.g., in dealing with inherently unresolvable “perpetual issues” (Gottman, 1999), and in the face of accumulating research evidence (Jacobson & Addis, 1993) of BMT’s having apparently reached a ceiling in terms of its effectiveness. The addition of acceptance interventions (e.g., “empathic joining,” Christensen et al., 1995) not surprisingly appears to increase the odds of favorable clinical outcomes (Cordova et al., 1998) vs. traditional methods. More surprisingly, this shift to acceptance work seems to have signified that behavioral therapists “found that the nomenclature of trait psychology is useful for understanding their clients, just as it is useful to us in understanding others in everyday life” (Hamburg, 1996, p. 56). That is, Jacobson’s more recent emphasis on the importance of working with salient couple themes (in behavioral language, response classes) rather than narrowly defined problem events (reminiscent of “old” behavioral exchange interventions), exemplifies this profound shift from a decidedly “state”-oriented treatment philosophy, to a much more balanced “state/trait” attitude.

The most recent phase in BMT’s evaluation is the *self-regulation phase*, best exemplified by the work of Halford (1998; Halford, Sanders, & Behrens, 1994). These strategies add to the Old BMT emphasis on changing the partner’s behavior the central notion of changing one’s own marital relevant behavior to facilitate increased mutual satisfaction. Such self-regulating or self-control foci might include altering one’s response to one’s partner’s undesired behavior, meeting some unmet needs in other situations, changing one’s approach to trying to persuade one’s partner to change, etc. Halford (1998) suggests the possibility that “the disappointing long term maintenance of benefits from (BMT) may be attributable to this failure individually to

empower our clients” (pp. 621–622). Certainly, adding a “change thyself” component to traditional interactional change targets renders New BMT systemic, in the sense of attending to multiple levels of relevant human behavior, although still largely not examining some important domains, e.g., family-of-origin influences. (Note also the treatment-relevant role of problematic physiological responses in marital conflict, Gottman, 1999). It is curious and unfortunate that Old BMT approaches did not try to deal with self-change dimensions of couple disharmony of the kinds Halford (1998) has addressed. First, doing so is entirely consistent with the functional analytic approach to clinical problems, the core of all behavior therapy. Moreover, self-control principles and techniques had been written about widely by prominent behavior therapists (e.g., Franks, 1969; Kanfer & Phillips, 1970; Thoreson & Mahoney, 1974; Watson & Tharp, 1972) long before early seminal BMT works (e.g., Jacobson & Margolin, 1979; Stuart, 1980) appeared. Perhaps in an (unconscious?) effort to remain disconnected from the realm of psychodynamics, arising in a time still dominated by psychodynamic theories (if not within family therapy!), Old BMT inadvertently failed to look “inside” marital partners. While Halford (1998) pessimistically concludes that “there is no evidence that we have improved upon the efficacy obtained 20 years ago in [BMT]” (p. 617), it seems likely that the recent additions of both acceptance-enhancing interventions and self-control methods to Old BMT interventions are likely to significantly improve treatment results.

Emotionally Focused Couple Therapy: Reattachment to the Experiential Tradition

Although not as widely familiar as BMT, Emotionally Focused Couple Ther-

apy (EFT) (Greenberg & Johnson, 1986, 1988; Johnson, 1986, 1996; Johnson & Greenberg, 1995), has also established a strong empirical base (Johnson, Hunsley, Greenberg, & Schindler, 1999; and see below). Of at least equal importance historically, EFT represents the first significant reattachment among marital therapists to the broader marital/family therapy field of the experiential tradition in psychotherapy, exemplified by such contributors as Carl Rogers and Fritz Perls. Of more direct connection to the marital/family field, is the overall philosophical correspondence of EFT values and methods to those of Satir's (1965) humanistic approach discussed earlier.

The fundamental premise behind EFT's theory of adult intimacy and its vicissitudes is that all human beings have a wired-in need for consistent, safe contact with responsive and caring others, i.e., an innate need for relational security. EFT, then, sees marital conflict and harmony as dependent upon the degree to which the marital partners' basic needs for bonding or attachment are satisfied. In this fundamental way, EFT owes part of its conceptual heritage to object relations theory (Scharff & Bagnini, 2002), although its methods differ from those that prize an interpretive therapist stance.

In this vein, and in rather stark contrast to the views of behavioral and strategic couple therapists, EFT sees emotion as the primary organizer of intimate relational experience, influencing significantly both interactional tendencies and patterns, and perceptions and meaning attribution. Thus, Johnson (1986) made the crisp distinction between an emphasis on "bonds vs. bargains" as the bases for models of committed adult relationships, i.e., emotional attachment vs. rational negotiation.

In this light, EFT has the two basic aims of exploring each partner's views of self and other, as organized by their im-

mediate (in-session) affective experience, and helping them to access previously unacknowledged (often to oneself, as well as to one's mate) feelings so they may be expressed directly in the moment of the therapeutic session.

The overall corrective emotional experience sought in EFT is achieved through a mixture of Gestalt, client-centered, and general "systemic" interventions, in which affective immediacy is high. Such experiences, occurring through working with a therapist who herself feels safe to the couple, is assumed to increase mutual empathy, decrease defensiveness, and lead to an increased, but uncoached couple capacity for problem solving. EFT aims to restructure interpersonal patterns to incorporate each partner's needs for experiencing secure attachment. The treatment model itself has been described with unusual clarity (e.g., Johnson & Greenberg, 1995), and includes "cycle de-escalation" (creating a working alliance and delineating core conflict issues; mapping the recurrent problematic interaction patterns; accessing relevant unacknowledged feelings; reframing problems in light of these feelings); "changing interactional positions" (encouraging identification with one's disowned needs; encouraging acceptance of the partner's emotional experience; explicating very specific relationship needs); and "consolidation/integration" (developing new solutions to old problems; consolidating the "new positions" and attachment patterns) (Johnson, 1999).

The effective practice of EFT appears to require a very high level of therapist skill to evoke and contain unexpressed feelings, and a relatively high level of partner-partner trust. EF therapists do not typically explore the past, interpret unconscious motivations, or teach interpersonal skills.

In terms of its technical portfolio, EFT is probably "overweighted" in the priority given to the role of evoking emotion.

Nonetheless, it has accrued substantial research support. What is more, EFT, more than any other couple therapy method of recent times, has reelevated the "self" of each relationship partner to psychological and phenomenological prominence, along with the couple-as-a-system. Ironically, through EFT, the influence of that "naïve and fuzzy thinker" (Nichols & Schwartz, 1998, p. 122), Virginia Satir, has risen again in the marital therapy field. As Schwartz and Johnson (2000) recently noted, "the field is slowly catching up with that 'touchy/feely' visionary, Virginia Satir, and shaking off its no-emotion legacy" (p. 32). EFT has made all the more fitting the comment of the Duhls (1981), "It is hard to kiss a system" (p. 488).

Insight-Oriented Marital Therapy: Return of the Suppressed

Perhaps even less recognizable than EFT to many readers is the Insight-Oriented Marital Therapy (IOMT) of Snyder (1999; Wills, Faitler, & Snyder, 1987). Largely disseminated through a series of research studies discussing its development and demonstrating its long-term effectiveness (Snyder & Wills, 1989; Snyder, Wills, & Grady-Fletcher, 1991), IOMT, like EFT, provides the most substantial empirical grounding to date for the public reemergence of the suppressed psychodynamic couple therapy methods of the 1960s. Although IOMT is not a psychoanalytic or even a purely object relations approach, it emphasizes relational dispositions of individuals and their associated core (individual) relational themes generated over time in intimate (including family-of-origin) relationships. Its central relational theory base is closer to modern "interpersonal role theory" (Anchin & Kiesler, 1982) and cognitive "schema theory" (Young, 1994), but it is decidedly psychodynamic, and overlaps with models based on attachment theory. Un-

like most traditional BMT, IOMT recognizes as real and significant for marital quality those processes and conflicts that occur within, as well as, between partners, e.g., the frequent contradictions and incongruencies within individuals about their relational needs and expectations (Sager, 1976, 1981). Unlike EFT, one of the IOMT therapist's central technical role requirements is to interpret partners' behavior, feelings, and cognitions, both contemporaneously and genetically (historically). Like earlier psychoanalytic and object relations couple therapy approaches (e.g., Framo, 1965; Skynner, 1976, 1981), IOMT also acknowledges the reality of and clinically addresses collusive relationship elements (Catherall, 1992; Dicks, 1967; Scharff, 1995), or what Snyder (1999) refers to, gently, as "partners' inadvertent maintenance of maladaptive relationship patterns."

IOMT is an overarching framework for organizing therapeutic interventions and the sequencing of their use, and draws upon psychodynamic, experiential, and cognitive and behavioral techniques. Insight, affective immediacy, as well as attribution modification and skill enhancement (though not necessarily through systematic instruction) are all valued in this approach. The main phase of IOMT is called "affective reconstruction," and emphasizes the therapist's interpretation of maladaptive relationship themes in terms of their developmental origins and the connections of those earlier experiences to current relational fears, dilemmas, and interaction styles.

Although IOMT has not developed into a true "school" of therapy and is not widely known outside clinical and family psychology, its central assessment and treatment principles are widely known. That is, IOMT seems to embody a formal explication of many of the implicit principles and practices of the many workaday clinicians who describe themselves as "psy-

chodynamically oriented/eclectic," probably the largest theoretical orientation of marital and family therapists (Rait, 1988). In this sense, the principles of IOMT would probably be conceptually very accessible to numerous marital therapists. Like EFT, IOMT reflects and has contributed to the reemergence of the "self in the system" (M. P. Nichols, 1987). Together, IOMT and EFT remind us of Antonio Ferreira's (1978) comment about family systems, "We had to learn that the family was a system before we could learn that the family does not always act like a system."⁴

Reemergence of Psychodynamic Couple Therapy

We indicated in the Figure (see p. 204) the public reemergence of the psychoanalytic perspective in the marital field around 1985. This general perspective has been revived in the last decade and a half through three influential pathways. First, as in the development of IOMT, marital treatment researchers have begun to make significant contributions to the refinement of technique, e.g., in the construction of treatment manuals that guide practice in outcome studies. The second source of a renewal of interest in psychodynamic elements of marital therapy has been the growing number of integrative couple therapies, to be discussed below.

The third origin of reinvigorated interest in the psychodynamics of couple treatment is to be found among a sizeable handful of clinical theorists (e.g., Bader & Pearson, 1988; Nadelson, 1978; Scharff, 1995; Scharff & Scharff, 1991; Siegel, 1992; Solomon, 1989; Willi, 1982) who have been working independently of one another to clarify psychodynamic (typically, object relations) theory as it applies to

conjoint therapy, and to refine intervention strategies and techniques to achieve the types of changes usually sought in these therapy approaches, e.g., increased individuation, modified and more flexible individual and dyadic defenses, and improvement in capacities for containing and holding difficult emotions. An excellent brief history of the psychoanalytic and object relations theory tradition in couple therapy can be found in Scharff (1995) and in Scharff and Bagnini (2002).

All variant methods of psychodynamic couple therapy attribute central importance to the unconscious communication and behavior-maintaining processes that characterize all intimate relationships, and which are maladaptively rigid in conflict-ridden couples. While these approaches differ in technical particulars, most of them are conceptually indebted to the object relations contributions of Dicks (1967), undoubtedly the seminal thinker in this realm. Among the central concepts in this treatment approach are projective identification, splitting, collusion, holding, and containment (Catherall, 1992). As we previously noted, although most early psychoanalytic couple therapy focused alternately on the psychodynamics of the individual partners, modern object relations couple therapy maintains a balanced focus on the structure of shared, interactional marital defenses, and the joint avoidances they perpetuate (e.g., anxiety about intimacy). Often overlooked in critiques of object relations couple therapy is its fundamental belief in the reparative, healing aims of these shared defenses.

Perhaps psychodynamic elements in couple therapy have gained renewed support in recent years because of the burgeoning development of integrative approaches, which often are as concerned with the intrapersonal as with the interpersonal. Perhaps the rebirth of this interest is partially attributable to the

⁴ Framo, J. (1978). Personal communication.

broad field of family therapy having firmly established its place in the world of psychotherapy, and thus developing the "institutional security" to become more open to some of the very kinds of clinical views that had served so well as the adversarial foil for the growth of the family therapy movement. Whatever the explanation(s) of the resuscitation of interest in couple psychodynamics, at the birth of this millennium, it appears quite likely that this interest has returned for good.

EXTENSION

Treatment of Psychiatric Disorders: The current phase of couple therapy's history is characterized not only by increasing refinement of clinical treatment approaches, but also by an extension of the purview of marital therapy beyond the treatment of obvious relationship conflict and distress to the treatment of individual psychiatric disorders. Ironically, despite the historically ingrained disdain among many first- and second-generation family therapists toward psychiatric diagnosis, it seems often forgotten that a major impetus for the very beginning of the field was the study of major mental illness (Wynne, 1983). While family, and to a lesser extent marital, therapists have thus shown interest in the systems-oriented treatment of adult psychiatric disorders for some time, recent clinical research excursions into this realm represent the first significant advances on these matters in decades.

An enormous amount of attention has been paid in recent years to studying the role of marital factors in the etiology, maintenance, and diminution of three particular disorders: depression (mostly of women), anxiety (agoraphobia, mostly of women), and alcoholism (mostly of men). To date, the only major method of couple therapy that has been empirically tested in the treatment of these disorders is BMT, or at least couple therapies that emphasize communication training and

problem solving. For depression, such couples work has been of a general marital nature, i.e., traditional BMT; for alcoholism, it has usually been a combination of traditional BMT and alcohol consumption-specific response training; and for agoraphobia, either communication training or partner-assisted exposure. Other treatment approaches (e.g., Papp, 2000), not yet empirically tested, focus more on the tracing of intergenerational relational themes and identification of and intervention into constraining gender beliefs and power inequities.

Findings to date suggest that couple therapy may positively affect symptomatic outcomes by increasing the likelihood of initial engagement in treatment and adherence to medication regimens, e.g., disulfiram (Antabuse) (alcoholism), by increasing exposure to anxiety-eliciting stimuli and lowering treatment dropout rates (agoraphobia), and by developing more adaptive responses to drinking episodes. Moreover, only couple therapy appears to help alleviate marital distress often associated with depression, compared to either individual Cognitive or Interpersonal psychotherapy of depression (Beach, Fincham, & Katz, 1998). Given that marital conflict and distress predict relapse for all three of these disorders (Beach et al., 1998; Daiuto, Baucom, Epstein, & Dutton, 1998; Epstein & McCrady, 1998), inclusion of couple interventions seems routinely warranted in most comprehensive treatment plans.

Research to date suggests that couple therapy by itself is not a sufficient intervention for alcoholism (without, e.g., disulfiram) or for agoraphobia (without, e.g., in-vivo exposure), but it may be sufficient for the treatment of depression in married women whose relationships are seriously distressed, especially when the depressed wife is more concerned about the couple's marital problems than about her depression, or when the marital prob-

lems seem to have preceded the onset of depressive symptoms. These findings reinforce the clinical salience of the concordance between some adult psychiatric disorders and marital conflict and strongly support couple interventions for “individual” disorders. At the new millennium, couple therapy is extending its effective reach beyond its traditional and more limited role of treating relationship conflict.

Preventive Interventions: Interestingly, at the very same time that couple therapy has been extended to the treatment of psychiatric disorders, couple interventions have also seen more application at the opposite end of the clinical continuum. Over the past twenty years, increased interest has developed in distress and divorce prevention programs for couples (Bradbury & Fincham, 1990; Fraenkel et al., 1997; Stanley, Markman, St. Peters, & Leber, 1995). These programs are part of a broader trend toward prevention programs in mental health, and draw on the basic rationale and principles of prevention science (Coie, Watt, West, et al., 1993). Indeed, there are several good arguments for programs targeted to non-distressed couples (primary prevention) or couples showing early signs of difficulty (secondary prevention) to complement the usual range of therapy interventions targeted at distressed couples (tertiary prevention).

First, as we note in an upcoming section, although numerous studies and reviews have established the efficacy and effectiveness of couple therapy overall, many couples who improve in therapy do not move out of the distressed range or maintain their gains long-term (Hahlweg & Markman, 1988; Jacobson & Addis, 1993). Given that many distressed couples wait many years before seeking services, it seems logical to provide happy or only mildly distressed couples with research-based information, skills, and ideas

to help them deal with the inevitable conflicts that surface as people share a life together (Markman, Stanley, & Blumberg, 1994). As noted earlier, marital conflict and disruption are associated with a wide range of mental and physical health problems in both adults and children, and through these effects, have an impact upon the economy because of days lost at work and need for health services (see reviews by Bloom, Asher, & White, 1978; Fraenkel et al., 1997; Gottman, 1994a,b; Grych & Fincham, 1990). Programs designed to help couples maintain “relational wellness” and prevent destructive conflict could thus have wide-ranging public health benefits.

In addition, there is growing evidence that such programs can be efficacious in reaching these preventive goals. In an early meta-analysis of 85 studies of marriage enrichment and preparation programs, Giblin and associates (Giblin, Sprenkle, & Sheehan, 1985) found average effect sizes suggesting that participants improved more than 67% than those in control groups. Bradbury and Fincham (1990) later critiqued this analysis and the component studies—for one thing, most involved only pre- and post-program measures, rather than long-term followup—but concurred that the analysis showed a promising trend in prevention effectiveness, a conclusion originally reached by Gurman and Kniskern (1977), and more recently by Guerney and Maxson (1990).

More solid evidence has emerged from a program of research on the Prevention and Relationship Enhancement Program (PREP), based at the University of Denver (Markman, Floyd, Stanley, & Storaasli, 1988; Markman, Remick, Floyd, et al., 1993). These longitudinal studies have demonstrated that nondistressed premarital couples randomly assigned to a 15-hour PREP course showed significant benefits over control couples up to four

years later, including greater relationship and sexual satisfaction, lower problem intensity, greater longevity, and better communication skills. At five-year followup, PREP couples also reported significantly fewer instances of domestic violence than control couples. The program teaches communication and problem-solving skills, how to address differences in core values and expectations, how to identify and work with hidden issues, and how to strengthen fun, friendship, and sensuality in relationships.

Different prevention and enrichment programs draw upon different clinical theories, including cognitive-behavioral, systems, humanistic-experiential, and psychodynamic (Berger & Hannah, 1999). Moreover, some programs, such as Guerney's (1977; Guerney, Brock, & Coufal, 1986) Relationship Enhancement, are applied to both clinical and nonclinical couples. Some focus on skills training (cf. Markman et al., 1994), whereas others feature discussion of partners' responses to self-report inventories that examine expectations and basic values (cf. Olson, 1990). Program lengths vary from one-day workshops to courses held over several months. Formats also vary greatly, from group lectures followed by skill-practice sessions conducted privately with each couple, to more of an encounter group involving interaction among the couples. At this point, research has just begun to compare the effectiveness of the various programs. Studies thus far support the importance of couples learning and practicing communication and problem-solving skills over programs that focus on enrichment and identifying problem areas but do not teach skills (Stanley, Blumberg, & Markman, 1999).

An interesting and lively debate about the need for teaching communication skills recently emerged around findings published by Gottman and colleagues (Gottman, Coan, Carrère, & Swanson,

1998). These authors argued that their data did not support the preventive importance of these Rogerian active listening skills because couples who were satisfied at 6-year followup did not demonstrate behaviors that resembled such skills. Although the details of the debate are more complex than space allows, Stanley, Bradbury, and Markman (2000) countered that Gottman et al. had fallaciously translated their findings into intervention recommendations. Among other points, they noted that the communication skills taught in programs such as PREP are to be used only when couples sense that their usual approach to talking about problems is failing them, and they require more structure in order to create a safe space for dialogue. Although the specific debate about these skills is interesting and important in itself, at a broader level, the debate is a good reminder that while research is critical to the development of the field, care must be taken in the translation and interpretation of research findings for interventive practice.

One of the most interesting aspects of the prevention movement is that, in a way, it represents at least one aspect of the field of couple intervention coming full circle from where it started. As Broderick and Schrader (1981, 1991) have noted, the psychoeducationally oriented "family life education" movement focused largely on couples' preparation for marriage, and actually pre-dated the founding of the marriage counseling field.

Recall that we opened this historical review noting that the bulk of couple counseling was initially conducted by pastoral counselors, other clergy, or other non-mental health professionals and paraprofessionals. Because of the wish to disseminate the program widely and in contexts where nondistressed couples gather to focus on couple and family issues, a number of programs are designed to be delivered by clergy and paraprofes-

sionals within religious institutions. The difference is that, rather than interventions being derived solely from common sense or vague theory, as in the past, the current wave of programs are typically based at least in part upon some of the most rigorous research in the field on variables that discriminate distressed from happy couples or predict from groups of happy couples who become dissatisfied and/or dissolved years later (Gottman, 1994a,b; Gottman et al., 1998; Markman et al., 1988, 1993). In addition, the relative efficacy of different program "deliverers" is now being studied. For instance, the PREP/Denver group is currently conducting a large dissemination study in which premarital couples are randomly assigned to PREP delivered by university-based staff, or by clergy or lay leaders in their own religious settings, or partake of the usual premarital interventions offered in their church or synagogue (Markman, 2000).

Some have raised concerns about the degree to which psychoeducational and prevention programs for couples may become co-opted by conservative religious groups to advance their limited vision of family and family values (Laird, 1999). However, it should be noted that the notion and basic form of programs designed to strengthen relationships and prevent conflict are not by definition tied to such political and social agendas. For instance, with an expanded research agenda that includes more study of variables distinguishing distressed from satisfied gay and lesbian couples and predicting relationship outcomes over time, research-based programs for such couples could be developed and/or expanded (Fraenkel, 1999).

In sum, the development of couple distress prevention programs appears to hold great promise for reducing the likelihood of disruption and distress experienced by a large number of couples over the course of their relationships. As oth-

ers have (Lebow, 1997), we do not believe such programs will ever completely replace the need for tertiary preventive efforts (i.e., treatment). Moreover, as Bray and Jouriles (1995) point out, up to half the couples who are offered PREP and similar programs do not choose to participate, even when such programs are offered at no cost. In addition, in order for such programs to thrive, much work will be needed to shift couples from an attitude of "if it ain't broke, don't fix it" to one of proactive attempts to maintain wellness. The training of therapists would need to broaden as well, such that they see themselves as interventionists with a wide range of "targets," from healthy, happy couples to those needing intensive therapy.

DIVERSIFICATION

Beginning in the late 1970s to mid-1980s, the field of couple and family therapy was challenged to question many of its fundamental assumptions. The challenge came from three overlapping sources that, in turn, mutually influenced one another: feminism, multiculturalism, and postmodernism. Whereas earlier systemic theories shifted therapists' focus from individuals to dyads, all three threads of this movement toward a more diversified view of couple and family life essentially involved conceptually "stepping back" to view couples one concentric ring wider than the previous close focus on dyadic interchanges. Stepping back in this way forced therapists to examine the impact of broader social beliefs and forces that reached the couple through the channels of gender, race, ethnicity, social class, and sexual orientation, in turn shaped by how these "demographic characteristics" of persons had been construed differently in different historical eras. As Goldner (1985a) states, "Erecting a conceptual boundary around the family was clearly essential for the development of family systems

theory, but it also deflected theoretical attention away from an encounter with the ways in which participation in family life is not merely an idiosyncratic accommodation to the 'needs of the family system' but is regulated by social forces operating above and beyond the family's affective field" (p. 33).

Feminism: Feminist therapists such as Goldner (1985a,b, 1988), Hare-Mustin (1978, 1987), James and her collaborators (James & McIntyre, 1983; James & MacKinnon, 1990), Libow and colleagues (Avis, 1988, 1989; Libow, Raskin, & Caust, 1982), and the Women's Project (Walters, Carter, Papp, & Silverstein, 1988) argued that how men and women view and act out their roles as partners and parents is tied to historically rooted societal beliefs about gender, power, and intimacy, as well as to how men and women are differentially encouraged to focus on work or home life. Through this lens, fundamental systemic concepts such as complementarity are seen not as inevitable dyadic patterns determined within the cocoon of the relationship by the particular, idiosyncratic match between partners' emotional and behavioral proclivities, but largely as organized along gender lines in accordance with the society's implicit and explicit expectations.

For instance, the long-held academic and popular belief that men are more instrumental (logical, action-oriented) and women more emotional (able to communicate, expressive) by nature and, if anything, become more so as their qualities accentuate one another's in a complementary developmental spiral, is understood from a feminist perspective as social *prescription* masked as scientific *description*. This constructed complementarity is, in turn, rooted in the larger economic and societal forces that emerged from the Industrial Revolution onwards that assigned men to work outside the home and women to work inside the home (Hare-

Mustin, 1978). To fulfill the needs of a modern economy that requires increasingly long hours and, for some, days to months away from home on business trips, the notion that men lacked the emotional capacities necessary for parenting that women had in abundance (and that relative to men, women lacked the analytic, problem-solving acumen of their husbands) was a convenient conceptual artifice evolved to help men and women to adjust to their socially mandated roles. As Goldner (1985a) writes, "marital complementarity must be understood not only as a psychological arrangement between husband and wife but also . . . *structured* into intimate relations by the larger social context" (p. 38; emphasis in original). Goldner goes on to trace the impact of this fundamental, rigid complementarity on the functioning of the couple as a parenting dyad, arguing in this and a later article (1988) that systems thinkers neglected the gender-based hierarchy situated within the generational hierarchy that formed the organizing frame for most family therapy interventions of the time.

Likewise, the systemic project of conceptualizing all problematic couple interactions as being the result of circular patterns was called into sharp question by feminists, who noted how such a formulation laid equal responsibility on both parties for the intimidation, constraint, and battering of women (Avis, 1992; Goldner, 1985a,b, 1998, 1999; Goldner, Penn, Sheinberg, & Walker, 1990). By committing the ultimate systemic sin of violating the premise of circularity by proposing that some patterns are *linear* in causal direction (the violence perpetrated by a man against a woman), the Ackerman Violence Project (Goldner et al., 1990) highlighted that we can choose how and when to apply our theories, and that theories are constructions we use to make sense of events rather than being inherent in phenomena. Moreover, they reminded the field

that, perhaps unlike in the nonhuman sciences, the act of theorizing and (therapizing) occurs within a moral context, and that our choice of a theoretical explanation must be determined both by careful observation as well as by moral sensibilities and implications (Goldner, 1985; Hare-Mustin, 1978; Papp, 1988).

In addition to offering a critique of systemic conceptions of couple and family functioning, feminists pointed out the ways in which the process of therapy is guided by gender stereotypes. Hare-Mustin (1978) notes the paternalistic quality of a hierarchical relationship between therapist and clients, and therapists' either unwitting or deliberate reinforcement of sex role-stereotyped behavior as the solution to couple problems. She recommends a variety of approaches to bring a feminist sensibility to conducting therapy. Goldner (1985) notes the paradoxical position of women in couple therapy: on the one hand, as default monitor of the couple's emotional well-being, the wife signals to the husband the need for help, and typically arranges the first appointment. But once in therapy, the wife is simultaneously the key ally of the therapist in keeping the couple coming, yet is often told to back off from critiquing the husband, lest he exercise his ultimate power to discontinue the therapy. Papp (1988, 2000) demonstrates use of a range of established techniques for disrupting constraining gender beliefs.

Interestingly, as with the other developments in couple therapy, feminism emerged as a critique most directly of *family* therapy—questioning assumptions about men and women as they made the transition from partners to parents and struggled with the division of labor between out-of-home work and domesticity (Goldner, 1985). Goldner notes that although there was already a large feminist literature on couplehood in psychoanalysis, sociology, and history, the femi-

nist critique of couples and family therapy emerged only around the time that these (primarily) feminist women writers reached the age of motherhood. Another explanation is that the birth of the first child often dramatically shifts the distribution of household tasks from more to less egalitarian (Hare-Mustin, 1978), revealing more traditional sex-role assumptions in male partners who seemed to espouse feminist values, or revealing the economically structured sexist bind in which only one partner can work and the man can bring in the higher income. Feminist family therapists identified the resulting inseparable, recursive link between the marital and parenting “subsystems,” and the ways in which power inequities and unequal distribution of housework and childcare influence a couple's level of intimacy. Research findings from Gottman and colleagues have substantiated the impact of sharing housework, and husbands' willingness to be influenced by their wives, on relationship satisfaction and longevity (Gottman, 1991, 1994a,b; Gottman et al., 1998).

In any case, by “problematizing” the parenting relationship and locating the basis of these problems in the hidden gendered assumptions underlying marriage, feminism played a major role in bringing forth the more direct interest in couple therapy that characterizes the field today. In terms of the theme of diversification, feminism introduced the notion that the two members of a heterosexual couple will likely have systematically different experiences of their relationship based on differential access to power and different expectations regarding intimacy (Walters et al., 1988). With its attention to the extreme (although common) expressions of differential power between men and women in intimidating and violent behavior, feminism also introduced the notion that not all couple problems could be “ground” through the same “mill” of sys-

temic theories and techniques—that different ways of thinking and intervening are needed for different problems.

Multiculturalism: Closely accompanying the emergence of the feminist perspective came the beginning of the field's recognition of the diversity in couples' experiences as a function of differences in ethnicity, race, social class, religious affiliation, sexual orientation, age, and geographic locale. With the exception of work in the area of gay and lesbian couples (Laird & Green, 1996; Sanders, 2000; Slater, 1995), as with feminism, the multicultural perspective on couples has been largely hidden within writings on families (e.g., Boyd-Franklin, 1989; Falicov, 1983, 1988, 1995; McGoldrick, 1993; McGoldrick, Pearce, & Giordano, 1982; Pinderhughes, 1989). To date, there are still few writings specifically on couples as affected by these or other sources of diversity (although see recent writings by Black, 2000; Fraenkel & Wilson, 2000; Mohr, 2000; Perel, 2000).

Writings from the multicultural perspective emphasize two main points. First, the norms regarding quality and quantity of intimacy, the distribution of power between partners, the degree of involvement of other persons in the couple's life (friends, other lovers, extended family), and other core aspects of couple life may vary across couples depending on their ethnicity and race, social class, sexual orientation, and other group affiliations. Second, depending on the standing of each group within the larger social context, partners' group affiliations provide them experiences of privilege or oppression, as well as more or less hospitable living conditions, and these affect couple process and satisfaction. Because all couples (and their constituent partners) are "nested" within a complex matrix of these group affiliations (Falicov, 1995), it is important for therapists to explore the sum total of opportunity or deprivations af-

forded each particular couple based on who they are in terms of this level of identity. For instance, Boyd-Franklin (1993) writes, ". . . for poor, inner-city, African-American families, the day-to-day realities of racism, discrimination, classism, poverty, homelessness, violence, crime, and drugs create forces that continually threaten the family's survival" (p. 361).

The advent of the multicultural perspective in couple therapy has wide-ranging implications for theory, practice, and training, many of which are only beginning to be identified (Lazloff & Hardy, 2000; Markowitz, 1994). As in the response to the challenge posed by feminism, sensitivity to the impact of differences in cultural affiliations and the accompanying oppression/privilege dimensions, requires a focus not only on the experiences, beliefs, and process of the client couple, but also on the cultural affiliations and accompanying experiences, beliefs, and level of privilege/oppression of therapists. The therapist's ethnic, racial, class, and other group affiliations provide potential biases in observing, interacting, and thinking about couples, as well as being stimuli that may affect the formation of the therapeutic alliance. Hardy (1991) and others argue that training institutions need substantial renovation in terms of curricula, clinical practices, and personnel (involving more professionals and students of color) in order to meet the multicultural challenge. Each couple potentially represents a particular, unique combination of group-based characteristics, experiences, and identifications, and many therapists encounter at least some degree of cultural heterogeneity in their work. As a result, the multicultural perspective at times seems to require stepping down from the expert-observing position more characteristic of traditional systems approaches. Such an orientation calls for a more collaborative, ethnographic approach in which the therapist

turns to the couple to inform her or him about the values, rules, and other sources of expectation that characterize their culture(s), and within which couple problems and patterns gather their meaning. This flexibility in hierarchy between therapist and couple is especially critical when the therapist's race, educational level, and class, or other group affiliations automatically place him or her in a position of greater power beyond that accrued by being the designated expert in mental health. It should be considered, however, that hierarchy and expertness are not inherently antithetical to collaboration and humility. A therapist can be an expert about human behavior and still learn from his patients. He can collaborate and still function in a mutually agreed upon hierarchical role with greater knowledge-based power and authority.

Postmodernism: Over the past decade or so, through the constructivist (Watzlawick, 1984), social constructionist (Anderson & Goolishian, 1988; Hoffman, 1990), narrative (White, 1988; White & Epston, 1991), and solution-oriented theories and approaches that draw upon them, postmodern ideas have had an enormous impact on family therapy. The postmodern critique of positivism (the belief in an objective reality that exists apart from the perceiver and that can be known through scientific study) and its alternative concept of reality as socially constructed and relative to historical and personal contexts has resulted in a number of shifts in the basic assumptions of systemic therapy (Fraenkel, 1997). These include: a shift from the stance of therapist as expert to one of therapist as collaborative investigator (with couples) of the meanings of their problems and the range of their solutions; a shift away from observing behavior, intervening in interaction sequences, and cybernetic/mechanistic systemic explanations (Hoffman, 1990), and toward a focus on how the language cou-

ples use to describe relationship problems constrains their perceived range of possible solutions (Hudson & O'Hanlon, 1992; Zimmerman & Dickerson, 1994). In addition, because of its critique of positivism and concern about the constraining effects of "grand narratives" (descriptions and explanations that apply to large numbers of persons), postmodern therapists emphasize the unique experience and meaning system of each individual, couple, or family over research- or clinically based general descriptions of problems (Fraenkel, 1995). Although not a deliberate aspect of these approaches, some have noted that postmodern therapies seem to involve an increased tendency to work with individuals on their relationship problems, rather than conjointly (cf. Freedman & Combs, 1996; Minuchin, 1998).

A small but excellent literature has amassed from a narrative perspective on couple therapy. The few pieces written (e.g., Freedman & Combs, 1996a,b, 2000; Neal, Zimmerman, & Dickerson, 1999; White, 1986/1987; Zimmerman & Dickerson, 1993a,b, 1994) well capture the use of this perspective and its translation into actual therapy practices. Such practices include helping couples recognize the constraining impact of particular descriptions and beliefs about their problems; separating themselves from these descriptions through tracing their source, typically in beliefs sustained in the dominant culture ("deconstruction"); and finding creative ways to "externalize" (or separate) these problem-saturated narratives from the couple's core identity and develop alternative ones that provide more satisfaction and opportunities for change at the level of action.

Like narrative therapies, solution-focused couple therapies (Hudson & O'Hanlon, 1992; Weiner-Davis, 1992) are based on the notion that the language used to describe problems limits couples' capacity to generate alternatives. These

therapies work with couples to locate and build upon exceptions to the usual problem pattern, and use some creative techniques (such as the “miracle question”) to assist couples to move away from a focus on present and past problems and toward their vision of a preferred future (see also Furman and Ahola, 1992, for a wide range of creative approaches in their “solution-oriented” approach). However, in contrast to narrative therapies’ focus on how the larger society may negatively affect couples’ lives through its promulgation of constraining descriptions and beliefs, solution-focused therapies generally focus on the more micro level of the couple’s interaction and experience. In this way, they more closely resemble the earlier strategic approach of the Mental Research Institute, with its focus on changing perceptions through reframing and pattern interruption, albeit with a postmodern twist. Solution-focused approaches have also been both praised (by managed care, for one) and criticized for what can seem like a relentless focus on the future and on moving persons to more positive experiences, without making space for clients to talk about and come to terms with the painful events of their pasts (Efron & Veenendaal, 1993). Moreover, postmodern models of couple therapy may at times commit the same type of logical error regarding hierarchy (i.e., therapist-as-expert) as noted above in our consideration of the impact of multiculturalism on couple therapy theory and practice.

Given the current popularity of the solution-oriented approaches, the narrative metaphor, and postmodern ideas more generally, it is likely that much more will emerge on couples therapy from this perspective in the years to come. Yet the postmodern approaches have not developed without criticism—including from feminism and multiculturalism. Like the feminist and multicultural perspectives, some of the postmodern approaches (par-

ticularly narrative) emphasize the effects of the larger social context on how couple partners experience their relationship. But whereas the emphasis in postmodern therapies is on constraining descriptions and beliefs imposed by dominant groups over less powerful groups, feminism and multiculturalism also recognize the very real, “objective” oppressive forces in society that affect the lives of women and persons of color. It is around this point that feminism and multiculturalism experience “dilemmas and points of resistance” with some postmodernism (Hare-Mustin & Marecek, 1994), because of the latter’s rejection of “grand narratives” or general statements about what is “true.” Whatever their differences and overlaps, perhaps the major combined effect of all three perspectives on the theory and practice of couple therapy has been to force the field to recognize the diversity of experiences of couplehood for men versus women, and for persons of different races, ethnicities, classes, sexual orientations, and other sources of meaning and experience, privilege or oppression.

INTEGRATION

Another major thrust in the development of couple therapy in Phase Four, has been the “quiet revolution” (Lebow, 1997b, p. 1) in the movement toward integrative clinical theory and practice, paralleling related developments in the world of individual psychotherapy (e.g., Norcross & Goldfried, 1992; Stricker & Gold, 1993), and exposing the reality that eclecticism and integration are probably the modal orientations of couple therapists (Rait, 1988). This movement, begun in response to the recognition of common factors that affect treatment outcomes, and the limited evidence of differential effectiveness of various psychotherapies, asserts that a broad base for understanding human behavior is necessary. Integrative treatment approaches allow

greater treatment flexibility and increase treatment applicability, therefore potentially leading to more positive outcomes (Gurman, 1981; Lebow, 1984). Although integrative approaches ultimately equip therapists with a wider range of theories and techniques, there are special challenges in both learning and teaching such couple approaches (Fraenkel & Pinsof, 2001).

The three major strategies of integrative model development (Stricker, 1994) are the common factors approach (focusing on elements of therapy found in most treatments), the technical eclecticism approach (combining techniques from more than one treatment model, with one model remaining dominant), and theoretical integration (creating a superordinate framework drawing upon multiple viewpoints). Recently, Fraenkel and Pinsof (2001) have proposed a fourth approach, theoretical eclecticism, which uses multiple theoretical perspectives either simultaneously or sequentially, without integrating the respective theories, yet specifying principles for relating and making decisions about when to use different theories and techniques.

In couple therapy, two major integrative patterns have emerged. The first involves the combining of conjoint couple therapy with other treatment formats and modalities, such as individual therapy, and the other involves the combining, at theoretical or technical levels, existing conceptual models of couple treatment.

Integration of Marital Therapy Approaches: Within the integrative approach that emphasizes the combining of treatment formats and modalities, Feldman's (1985, 1992) "Integrative Multi-level Therapy" stands out. While also paying attention to behavioral, psychodynamic, systemic, and biological aspects of couple relationships, Feldman (1979) particularly emphasizes the judicious use of

both individual and conjoint sessions, with sequences and balances between the two determined on a case basis. Pinsof's (1983, 1995) "Integrative Problem-Centered Therapy" exemplifies both flexible combinations of intervention methods and formats and the use of an underlying and verifying theoretical framework and specific theoretical principles for relating and making decisions about different theories and techniques. In Pinsof's approach, the therapist combines interventions from disparate therapy traditions by moving from model to model according to a clearly delineated treatment planning decision tree model, e.g., from present-focused approaches such as structural and cognitive-behavioral, to historically focused approaches, such as object relations and Bowenian. His model also allows for the inclusion of biological intervention. Similar to Pinsof's approach, Fraenkel's (1997; Fraenkel & Pinsof, 2001) integrative approach, the "Therapeutic Palette," delineates a set of principles for how to select one theory over another at any particular time.

As Martin (1976, p. 8) emphasized, and was perhaps the earliest marital therapist to do so: "Those who prefer to stress either the intrapersonal or the interpersonal aspects alone . . . limit themselves. The separation . . . is an artificial separation that does not occur in the nature of the human being . . ." (p. 8). The perspective of simultaneously including both the interpersonal and intrapsychic domains of experience has been developed in several theoretically integrative models of the marital relationships and marital therapy. Sager's (1976, 1981) "Marriage Contracts" Model, which addressed "conscious and verbalized" expectations, "conscious but not verbalized," and "beyond awareness" or unconscious "contracts," was grounded in psychoanalytic theory (Sager 1967a,b), but selectively used behavioral exchanges (such as point-for-

point quid pro quos) and other assigned out-of-session tasks. W. C. Nichols' (1988) integrative approach is grounded in developmental and object relations theory, yet also calls upon behavioral exchanges, and communication and problem-solving training. Schwartz' (1995) Internal Family Systems Approach also blends recognition of historically based, intrapsychic experience and internalized representations of "parts" of self, and how these influence and are influenced by current interactions.

The early 1980s saw the independent emergence of at least four integrative, interpersonal/intrapersonal models that, unlike the eclectic approaches considered above, were more theoretically integrative in balancing their attention to both psychodynamic and social learning perspectives. Bagarozzi and Giddings (1983) presented a cognitive-attributational analysis of how partners reinforce and punish each other's behavior that conforms to or fails to conform to their inner representational models, and thus engage in a "mutual shaping process" that maintains projection-based collusion. Both conscious and unconscious dimensions of relationships were explored in therapy. These rich conceptual mapping of two distinctly different theoretical orientations, which was both a marital and family treatment model, unfortunately, has not been developed further by the authors.

The marital interaction model of Berman, Lief, and Williams (1981), which evolved into the "Intersystem Model" (Weeks & Hof, 1987) of the PENN Council for Relationships (formerly the Marriage Council of Pennsylvania), brought together into a coherent framework Sager's (1976) blend of contract theory and object relations theory, multigenerational family systems theory, adult developmental theory, systems theory, and social learning theory. The Intersystem Model simultaneously addresses the interlocking indi-

vidual, interactional (dyadic), and intergenerational systems, and draws upon a wide array of techniques from several therapeutic traditions. The Intersystem Model clearly stands as one of the most ambitious integrative couple therapy models proposed to date.

Two other integrative couple therapy models have a great deal in common, though they were developed independently. Gurman's "Depth-Behavioral" Brief Integrative Marital Therapy (1978, 1981, 1982, 1990, 1992, 2002) and Segraves' "Combined Psychodynamic-Behavioral Approach" (Segraves, 1978, 1982) both attempt to modify couple partners' inner representational models and interpersonal schemas by both direct (e.g., behavioral) and indirect (e.g., interpretive) means. Both authors argue that since people shape (and maintain important aspects of) each other's personalities, couple therapy can lead to individual change, both behaviorally and intrapsychically. In effect, both approaches also agree that directive and behavioral interventions can serve as a powerful means to intrapsychic ends.

Couple Therapy and Brief Therapy—Integration with the Broader World of Psychotherapy: In addition to the important recent integration activity within marital therapy per se, significant links to the broader field of psychotherapy have evolved of late. Among the most viable of these links is the connection recently being forged between couple therapy and brief therapy. By "brief therapy," we do not mean any particular couple therapy model, such as the Brief Therapy of the Mental Research Institute (Segal, 1991). Rather, we refer to broad-gauged efforts to keep treatment short-term irrespective of theoretical orientation. These efforts focus on identifying the basic elements of effective brief therapy in order to understand core change mechanisms, and to maximize the development of change-inducing techniques, as has been done in

the field of brief individual psychotherapy (Bloom, 1992; Messer & Warren, 1995). The first book-length treatment of various models of short-term couple therapy appeared only recently (Donovan, 1999).

Gurman (2001) has provided an extensive analysis to date of the “essential redundancy” between couple (and family) therapy and brief therapy. He emphasizes (p. 53) that “there has never been a dominant long-term (family) couple treatment method that served as a standard against which other methods came to be compared,” as was true of individual therapies. At the same time, he notes that most couple therapy has been brief compared to traditional psychotherapy standards, by default, not by design. Most couple therapy lasts only up to about 15–20 sessions (Doherty & Simmons, 1996; Rait, 1988). Gurman argues that this naturally occurring brief couple therapy is attributable to particular common marital therapist attitudes and values, and to certain technical factors involved in couple therapy. He suggests that couple therapists overwhelmingly accept all of the central treatment values of brief individual therapists (Budman & Gurman, 1985) (e.g., clinical parsimony, a developmental perspective focused on the question, “Why now?”; an emphasis on patient strengths; the importance of change inducement outside of, as well as inside, therapy; and present-centeredness), plus the unique perspective that the partner-partner relationship is potentially more healing than the patient-therapist relationship emphasized in traditional psychotherapy.

Gurman (2001) also elaborates the ways in which the “four central technical factors of brief therapy” are manifest in the majority of couple therapies. First, the meaning and use of time as a therapeutic resource in couple therapy includes engaging a developmental perspective on problem formation and presentation, early therapist intervention, and flexible

treatment session length. Second, the therapist-patient (couple) relationship in couple therapy requires a relatively high level of therapist activity, and yet the therapist’s interaction with marital partners is less salient than their interaction with each other, so that change in the natural relational context is emphasized. Moreover, among empirically validated couple therapies, therapists accept their roles as experts, and share their expert knowledge with couples collaboratively. Third, treatment techniques in couple therapy tend to include a balanced emphasis on change both in and out of therapy sessions. Finally, the treatment focus, the cornerstone of all brief therapies, regularly is directed toward behavior patterns of the couple that center on the presenting problem, symptom, or dominant theme (e.g., Pinsof, 1995).

In sum, Gurman (2001) argues that most couple therapy is inherently brief because it activates the same dimensions of effective brief therapeutic intervention found in individual psychotherapies, yet, of course, with a particular interactional (or systemic) awareness that is usually far more muted in individual treatment. Gurman’s analysis demonstrates and illustrates many of the important ways in which couple therapy and brief individual therapy may be usefully integrated at the conceptual level. Identifying such common ground is likely to benefit synergistically both domains of clinical practice, and the consumers of such services.

Couple Therapy and Sex Therapy—A Still Unconsummated Relationship: Paralleling the increasing attention of late to the inclusion of biological factors in treating marital relationships, especially regarding psychiatric disorders (e.g., Pinsof, 1995), some couple therapists (e.g., Schnarch, 1991, 2001; Weeks & Hof, 1987) have advocated for the integration of marital therapy and sex therapy. Indeed, there is even a professional journal, the *Journal*

of *Sexual Marital Therapy*, that has fostered such an integration for many years. And there is good reason to support such a clinical connection. Marriage is the one and virtually only social and familial relationship in which society-at-large deems sexual expression to be appropriate. In addition, as groundbreaking as was the creation of the early field of marriage counseling, that intimate sexual behavior has become an explicit focus for theory, research, and intervention in the second half of the last century, is truly a profound development. Moreover, at a very practical level, it is probably the rare couple therapy case that has not included at least some discussion of sexual matters, if not outright sex therapy intervention.

And yet, the worlds of the "marital" or "couple" therapist and the "sex therapist" seem rarely to intersect. For example, while sexuality is occasionally referenced in clinical writings and workshop presentations (e.g., Pincus, 1999) on couple therapy, discussion of commonly used principles, methods, and techniques for the treatment of sexual dysfunctions is almost non-existent.

This unfortunate theory vs. practice gulf may be attributable to two particular aspects of the world of the mental health professions. First, as McCarthy (2002) has succinctly explained, "The traditional marital therapy approach was to view sexual dysfunction as symptomatic of an unresolved relationship problem (e.g., poor communication, power imbalances . . . family of origin conflicts"). Sexual dysfunctions have typically been viewed by family and marital therapists not as real problems in their own right, but as indirect, disguised symbolic expressions of another problem, or as an expression of a problem at some other level of relationship organization or structure. As a result, McCarthy (in press) continues, "The marriage therapy field has not given sufficient attention to sexuality and sexual

dysfunction. Few marriage therapy training programs have courses, practice, or internships in which sex therapy is an integral component."

The second force in the mental health professions that has worked against the needed integration of sex therapy and marital therapy involves the pivotal role of behavior therapy. Although some of the most influential early clinical pioneers of sex therapy, such as Helen Singer Kaplan (1974, 1983), had significant psychoanalytic backgrounds, the overwhelming majority of technical innovation and clinical treatment research has come from clinical psychologists, and primarily from psychologist-behavior therapists (e.g., Heiman & LoPiccolo, 1988; Leiblum & Rosen, 1989; McCarthy, 2002; Wincze & Barlow, 1996). Behavior therapy, the clinical foundation of most sex therapy methods, has never occupied a central role in the formal training of marital and family therapists. Ironically, even when behavioral marital therapy is included in the professional training of psychologists (which is not routinely the case), specific training in the treatment of sexual dysfunctions is not common.

Also ironically, at the same time that some marital therapists (e.g., Pincus, 1995; Schnarch, 1991; Weeks & Hof, 1987) are calling for a more systematic integration of sex therapy and couple therapy, the overall field of sex therapy is shrinking rather than growing (McCarthy, 2002). This appears to be happening for reasons that have nothing to do with the inappropriateness of such integrative urgings, but rather with such real-world considerations as the non-existence of licensing for sex therapists and the vanishing payment for treatment of sexual dysfunction by insurance companies and other health care "providers" such as managed care corporations. If there is to be a substantive and substantial integration of the fields of sex therapy

and marital therapy, new leaders must emerge with expertise in both clinical domains, and with a balanced respect for the complementary, and potentially synergistic, attributes of both domains.

THE BRIEF, BUT SIGNIFICANT, HISTORY OF MARITAL THERAPY RESEARCH

In this modern era of clinical practice, with its manifold pressures for accountability and evidence of efficacy and effectiveness, it may be difficult for non-gray-haired readers to appreciate just how recent the existence of reasonably credible research on couple therapy actually is. In this section, we will survey and summarize what we consider the most significant and robust findings on marital therapy that seem to have at least a modicum of relevance for public health policy, clinical decision-making, or refinement of theories of couple therapy. We will not ourselves exhaustively review existing treatment research as we (ASG) have done in the past (e.g., Gurman, 1973b; Gurman & Kniskern, 1978b, 1981b; Gurman, Kniskern, & Pinsof, 1986), but will draw upon a large body of existing, integrative reviews, both narrative and meta-analytic, both recent and not-so-recent (especially Alexander, Holzworth-Monroe, & Jameson, 1994; Baucom, Shoham, Meuser, et al., 1998; Beach et al., 1998; Bray & Jouriles, 1995; Christensen & Heavey, 1999; Daiuto et al., 1998; Dunn & Schwebel, 1995; Emmelkamp & Gerlsma, 1994; Epstein & McCrady, 1998; Friedlander, Wildman, Heatherington, & Skowson, 1994; Gurman, 1973b; Gurman, 1978; Gurman & Kniskern, 1978, 1981; Gurman, Kniskern, & Pinsof, 1986; Hahlweg & Markman, 1988; Halford, 1998; Jacobson & Addis, 1993; Johnson et al., 1999; Lebow & Gurman, 1995; Pinsof, 1981; Pinsof & Wynne, 1995; Shadish, Montgomery, Wilson, et al., 1993; Shadish, Ragsdale, Glaser, & Montgomery, 1995;

Whisman & Snyder, 1997). Readers who wish to consider methodological issues regarding both research design and measurement might consult Alexander et al. (1994), Baucom and Hoffman (1986), Beach and O'Leary (1985), Christensen and Heavey (1999), Gurman and Kniskern (1978b), Pinsof (1981), Pinsof and Wynne (1995), and Whisman and Snyder (1997).

Three-Phase History of Marital Therapy Research

There seems to have been three rather distinct phases in the history of couple therapy research. For each of these phases, we will highlight the most clinically relevant findings of the era, comment on emerging concerns or shifts of emphasis from one phase to the next, and occasionally offer some of our own idiosyncratic views on the salient research themes and findings of a particular phase.

Phase I: A Technique in Search of Some Data (1930–1974): Just as Manus declared that, as of 1966, marriage counseling was a “technique in search of a theory,” so too, it could be said that for more than its first 40 years, marital counseling/therapy was a field in dire need of some data.

In 1957, Mudd published an article on the “knowns and unknowns in marriage counseling research.” Since, by anything even crudely approaching modern standards, there was no empirical research in the field (keep in mind that, at that time, the rise of interest in psychotherapy research in clinical psychology and, to a lesser extent, psychiatry, had not yet taken hold), Mudd could do little more than raise questions worthy of study.

In 1970, Olson reported that the handful of marriage counseling research papers were “mostly . . . descriptive in nature” (p. 524), and that the “best” outcome studies were typically reports of one practitioner on a sample of his own treated

cases, using only his own outcome ratings.

Three years later, Goodman (1973) examined all the existing research in the field ($N = 170$) published from 1931 to 1968, and containing "some empirical data" (p. 111). She found that 56% of these works were based on subjective reports, and only 22% included a "specified sample" (p. 112), i.e., they were "so poorly defined . . . as to provide no information concerning the populations to which the findings might apply" (p. 113). Goodman concluded that the "usual standards for evaluation research could not be applied to the marriage counseling papers" (p. 113). Moreover, she found that research was so sparse that "it is not possible to identify an active research front for the field" (p. 116). That same year, Gurman (1973a,b) reviewed the emerging trends in the literature on research and practice in marital therapy, and found that while the overall literature had a very fast growth rate, only a handful of measurement-based papers touched on matters of treatment outcome or process.

As Broderick and Schrader (1981) noted, by the late 1960s, marital therapy had reached its "zenith" before what, as we have shown, would turn out to be a 20-year drought. It was now the mid-1970s, and marital counseling/therapy had essentially nothing to show for itself empirically.

Phase II: Irrational (?) Exuberance (1975–1992): The middle to late 1970s marked a turning point in the research history of marital (and family) therapy. For the first time, the field had accumulated a critical mass of empirical studies of treatment outcomes that seemed to have implications for clinical practice, at least at a broad level of guiding some important aspects of treatment planning. Moreover, several of the key findings seemed to help the credibility of the field of couple and family therapy (by now typ-

ically referred to as if they were unitary) in both professional, psychotherapeutic circles, and in governmental policy-making circles.

A series of research reviews by Gurman and his colleagues (Gurman, 1971, 1973b; Gurman & Kniskern, 1978a,b, 1981a; Gurman, Kniskern, & Pincus, 1986) set forth the following major conclusions about the empirical status of the efficacy and effectiveness of couple therapy:

1. Nonbehavioral couple therapies produced beneficial outcomes in terms of marital distress and satisfaction in about two-thirds of cases.

2. The positive effects of couple therapy exceeded those of no treatment.

3. Conjoint therapy was more effective than individual therapy for marital difficulties.

4. These outcomes occurred in treatments of relatively very short duration, by traditional psychotherapeutic standards, i.e., about 12–20 sessions.

5. Couple therapy was helpful, alone or in combination with other (e.g., individual) interventions, in the treatment of certain psychiatric disorders (e.g., depression, alcoholism, anxiety disorders) usually treated in individual psychotherapy.

6. As in individual psychotherapy (of nonmarital problems), couple therapy at times (up to 10%) was associated with individual or relationship deterioration. Such negative effects were especially associated with a therapist style, early in therapy, of confronting patients with highly affective material, while providing minimal support and structure to treatment.

7. Co-therapy was no more effective than single therapist treatment.

Although the validity of some of these conclusions would later be challenged on occasion (e.g., Bednar, Burlingame, & Masters, 1988; Raffa, Sypek, & Vogel, 1990; Wells & Gianetti, 1986a,b), an even more methodologically sophisticated se-

ries of studies of several different types of couple therapy (see below), often analyzed by more powerful (statistical, vs. narrative, or “eye-ball”) methods, would corroborate virtually all of Gurman and colleagues’ initial assessments. Given couple therapy’s decades-long difficulties in establishing its rightful place in the psychotherapy sun, these findings were greeted with both widespread relief and enthusiasm. Although, in the language of recent financial markets, these findings may at times have been “overvalued,” particularly by leaders in the field with primary guild interests, they clearly did not generate unwarranted or “irrational” exuberance. Couple therapy, having established its essential helpfulness, could now direct its attention to more refined and focused questions and concerns.

Phase III: Caution and Extension (1993–present): By the mid-to-late 1980s, a meaningful corpus of research had begun to accrete, studying primarily the three models of couple therapy (Behavioral, Emotionally-Focused, Psychodynamic/Insight-Oriented), which we described as the dominant models in the Fourth Phase of marital therapy’s history. But the exuberance of the previous decade’s evaluators would soon be toned down by some important warnings and cautionary notes from leaders in the field. Before turning to those considerations, let us establish a baseline for this body of work. Here, we address a series of questions commonly asked of the research literature (e.g., Christensen & Heavey, 1999; Halford, 1998; Lebow & Gurman, 1995; Whisman & Snyder, 1997).

Does conjoint couple therapy work for relationship problems? This fundamental question addresses the matter of whether couple therapy, generally speaking, is more helpful than no treatment. Helpfulness, or positivity of outcome, is typically assessed in terms of levels of patient-reported relationship distress or

conflict, observational ratings of couple interactions, or couples’ global ratings of relationship satisfaction.

Consensus on this question is nearly absolute. For example, as Christensen and Heavey (1999) assert, “The result of dozens of [comparisons vs. no treatment] indicates unequivocally that couple therapy increases satisfaction more than no treatment” (p. 167). Bray and Jouriles (1995) elaborate that positive overall effects of couple therapy have been found by reviewers of varying theoretical orientations, using different analytical methods, based on “dozens of studies” (p. 462). And Lebow and Gurman (1995) conclude that the “unequivocal” (p. 32) overall evidence of helpfulness confirms “the general finding of efficacy found in less rigorous research” (p. 32), as previously alluded from the first wave of research reviews in the field. Moreover, every efficacy study (controlled, randomized clinical trial) of any method of couple therapy investigated to date has found treatment to outperform no treatment.

How powerful is conjoint couple therapy? Researchers have addressed this question in several ways. The first way involves the computation of *effect sizes* (a statistical quantification of treatment outcome data across a variety of change measures across studies) that allow inferences about not merely whether treatment has had an effect, but also how large that effect was. The second statistic used to answer this question is a simple descriptive one, i.e., the *rate of improvement*, that is, the percent of couples, “improved,” “satisfied,” etc., at termination of treatment or at followup, most often based on patients’ self-ratings.

Overall, couple therapy research has found effect sizes for the three most commonly studied treatment methods that are considered by statisticians to be “medium” (.50) to “very large” (1.0), with the majority falling in the “large” (.80) cate-

gory or better. Effect sizes in this range translate to a “percent of couples improved” rate of approximately 60–75% (vs. roughly 35% improved among distressed couples not receiving treatment), almost identical to what Gurman (1973b) reported 28 years ago using the traditional “narrative” approach to evaluating large bodies of research data. These effect sizes and improvement rates approximate or exceed what has typically been found in studies of individual (non-couple-focused) psychotherapies. At the individual level, these findings suggest that, overall, a randomly selected treated couple is better off at the end of therapy than about 70% of untreated couples, i.e., that the chances of improvement hover around seven in ten.

In addition to effect sizes and improvement rates, three other indices of the power of couple therapy have been used: measures of clinical (vs. statistical) significance, assessment of the durability of post-treatment effects, and assessment of possible “negative effects” as a result of treatment.

Clinically significant change is said to occur when, say a couple’s score on a measure of functioning, changes to such a degree that the post-therapy score moves the couple from within the pre-therapy range of “abnormal” scores to within the post-therapy range of “normal” scores (Jacobson & Truax, 1991). Using such stringent criteria, some data have suggested (Jacobson & Addis, 1993; Shadish et al., 1993) that as few as 35–40% of treated couples may actually move from “distressed” to “nondistressed” levels.

The *durability of change* is also extremely important, of course, because treatment effects that are limited to those that are short-lived may well not justify the costs, of various sorts, involved to produce them. The data on this question are not yet extensive, but suggest the following: there is reason to believe that while

there appears to be only minimal “relapse” at 6-to-9-months post-therapy, a significant portion of couples may relapse (i.e., return to the “distressed” or “unsatisfied” range) between 1 and 4 years after treatment (Hahlweg & Markman, 1988; Jacobson & Addis, 1993; Shadish et al., 1993). Most reports of such data have involved behavioral couple therapy.

At this time, two models of couple therapy have provided data that counter this disquieting trend. Emotionally Focused Therapy appears to maintain, and even improve, its effects at up to 2 years’ followup (Johnson et al., 1999), and Insight-Oriented Marital Therapy (Snyder, Wills, & Grady-Fletcher, 1991) has shown very robust effects at 4 years’ followup.

Finally, as has been known to be true of individual therapy for a long time (Bergin, 1963), couple therapy is not always either helpful or unhelpful, but may even make matters worse, leading to so-called *negative effects* or *deterioration*. This possibility, which certainly should not be surprising, was first discussed over twenty years ago by Gurman and Kniskern (1978a). Although the matter seems almost never to have been raised again in over two decades of research writing on couple therapy, a recent report by Hahlweg and Klann (1997) of couple therapy in Germany suggests that up to ten percent of treated couples consider themselves worse off after therapy than before. These data correspond very closely to Gurman and Kniskern’s much earlier estimation of a negative effect rate of 5–10%.

What is the relative effectiveness of different couple therapies? To borrow a borrowed phrase from Luborsky, Singer, and Luborsky’s (1975) discussion of the comparative efficacy of individual psychotherapies, “Everybody has won, and all must have prizes” (p. 995). More accurately, all those couple therapies that have been reasonably well put to the empirical test to date have won, i.e., have

proven superior to no treatment. These methods are Behavioral (including cognitive-behavioral) Therapy, Emotionally Focused Therapy, and Insight-Oriented Marital Therapy. Thus far, there is no strong evidence that any one of these approaches is more effective than the others, or any other. To date, there have been very few head-to-head comparative studies in clinical trials, so that the occasional differences that have been found may be quite unreliable, and, in any case, have not been replicated.

At the same time, not all influential approaches to systems-oriented therapy even deserve consideration for “prizes” to date for their treatment of couples, e.g., Structural, Strategic, Bowen Family Systems, Solution-Focused, and Narrative methods with couples have essentially never been tested empirically. This fact should certainly not lead us to dismiss outright treatments that have not yet been tested empirically. Nonetheless, the proponents of such untested methods have a collective obligation to provide more than anecdotal evidence of their efficacy and effectiveness.

What predicts responsiveness to treatment? To whatever extent a therapy method “is effective,” not all of its effectiveness can be attributed to method-based interventions per se, as decades of research in individual therapy have made quite clear (Lambert & Bergin, 1994). In individual therapy, therapy techniques account for far less of the variance in outcome than patient factors and therapist-patient relationship factors. As no one knows better than couple and family therapists, psychotherapeutic change is interactional. Beyond our overall awareness of the general power of any particular approach, it is especially meaningful to clinicians to be able to identify predictors of couples’ responsiveness to therapy.

Nontechnique predictors of treatment outcome can be usefully divided into those

that are measurable outside the therapy context (e.g., patient factors, therapist factors), and those that are usually measured in the conduct of treatment itself (Gurman & Razin, 1977). In the “outside” measures, of course, the mechanism of action by which an extratherapy variable exerts its influence may not be immediately obvious.

To date, the body of research on both in-session and out-of-session predictors of outcome is not especially large, and yet, taken as a whole, does seem to create a meaningful picture with potential implications for both treatment planning and treatment monitoring. In Behavioral Marital Therapy (BMT), couples seem to be more likely to benefit from therapy if they are younger, less distressed, less gender-polarized, more emotionally engaged in the relationship, and committed to it. In Emotionally Focused Therapy (EFT), couples more likely to benefit may be older (average 35) and emotionally engaged, whereas neither pre-therapy distress level or sex-role traditionality appear associated with outcome. In Insight-Oriented Marital Therapy (IOMT), lower distress levels, (younger) age, and emotional engagement seem, as in BMT, predictive of change. As for in-session behavior, positive predictors of outcome include active collaboration with the therapy process (BMT), patient alliance with the therapist, especially in terms of the “task” components thereof (EFT), a couple’s ability to “soften” their interactions and their level of emotional experiencing (EFT), and a couple’s emotional engagement, marked especially by a low frequency of negative nonverbal affective display (IOMT).

While some of these statistical associations may be method-specific (e.g., EFT pushes for emotional experiencing more than BMT), two meaningful patterns may be identified. First, the rich seem to get richer, so to speak, as is often true in

individual psychotherapy: couples who are younger, less distressed/dissatisfied, and more emotionally attuned to each other seem most likely to benefit from conjoint therapy. Second, couples who collaborate well with both each other and the therapist, and engage in cooperative, affectively meaningful exchange, seem to do better. This first conclusion may be relevant to the allocation of treatment resources, while the second may offer guideposts to therapists for early in-therapy predictors of outcome that may require their attention. Moreover, these composite findings certainly reinforce the relevance of couple prevention programs.

Is couple therapy helpful for “individual” problems? Earlier, we summarized the existing research findings on the treatment role of couple therapy for individual disorders such as depression, substance abuse, and anxiety disorders. It is worth noting here that, consistent with the empirically based conclusion reached fifteen years ago by Gurman et al. (1986), studies in this realm have never found any evidence that might be construed as supporting the notion that individual symptoms serve relational functions (note the difference between relational functions and relational consequences), an idea strongly advanced by some marital therapists (e.g., Haley, 1976; Madanes, 1980).

Coda on Couple Therapy Research: To conclude this section, we will not address the numerous and important methodological and conceptual issues that clearly still need a great deal of the field’s attention, such as the choice of criteria to assess change, matters of possible differential effectiveness of different methods with different types of problems (whether defined by interpersonal/dyadic or individual criteria), or considerations of cost-effectiveness as well as clinical effectiveness. Others have done an especially good job of addressing these issues in great detail (e.g., Alexander et al., 1994; John-

son & Lebow, 2000; Lebow & Gurman, 1995; Pincus & Wynne, 1995). Rather, we offer some contextualizing comments on the general thrust of Third Phase couple therapy research.

In the title of this phase of the history of couple therapy research, we chose the word “extension” to refer to the emerging applications of couple therapy methods to problems that are in addition to the traditional bread and butter of marriage counseling/couple therapy practice, i.e., relational distress, conflict, and dissatisfaction. Several reliably diagnosed adult disorders of individuals that, together, account for a large portion of the presenting problems in a general psychotherapy or psychiatric practice, also benefit from couple therapy. These difficulties exact a tremendous toll from those who suffer these disorders, those with whom they have intimate relationships, and contemporary society at large, and the field of couple therapy should be pleased with itself for adding effective treatment procedures for such disabling conditions to the standard regimen of psychiatric and psychological interventions.

At the same time, we would like to offer the view that the field of couple therapy has perhaps responded with greater alarm than is warranted by recent data suggesting that treatment effects may diminish at followup, and that the kinds of changes that are achieved in therapy, while statistically impressive, may not, in truth, be “significant” in clinical terms. We (Gurman, 1978; Gurman & Kniskern, 1978a,b, 1981a,b; Gurman, Kniskern, & Pincus, 1986) certainly have applauded all efforts to improve the efficacy and effectiveness of couple therapy, and frequently have been critical of those in the field who dismiss such concerns (e.g., Gurman, 1983). Nonetheless, we think a few ameliorating observations and reflections on what recent couple therapy research has

shown are in order at this point in the field's history.

First, the overall outcomes of couple therapy, whether assessed in controlled "efficacy" studies or in uncontrolled "effectiveness" studies, have not been anything to scoff at. The effect sizes and improvement rates of various couple therapies are virtually indistinguishable from those that have been found for a wide variety of individual psychotherapies for decades (cf. Bergin & Garfield, 1994).

Second, while cost-effectiveness has rarely been addressed directly in empirical studies of couple therapy, we may usefully speculate about at least two manifestations of cost-effective couple therapy benefits. First, in an economic perspective, Pinosof and Wynne (1995) note that a typical course of ten-session couple therapy at \$100 per session is far less than the short-term legal costs of divorcing, and still less than the long-term economic costs of divorce. In addition, we note that, by definition, every course of conjoint couple therapy involves two patients/clients (not to mention indirect but likely positive effects on their children), a rather efficient use of psychotherapeutic time, to say the least. If we assume that, in at least most "improved" marital relationships, both partners have contributed to positive change, then the public health value of our work may be said to be greater than that which usually accrues to individual psychotherapy.

Third, while we fully agree that statistically significant outcomes are not an adequate alternative to clinically significant outcomes, we question the adequacy and appropriateness of the criteria used heretofore to establish "clinical significance." Requiring a couple to move into the statistical range of couples who are "nondistressed" or "normal," seems to beg the more relevant clinical issue of whether this particular (set of) change(s) for this particular couple with this particular

problem (cf. Paul, 1967) is clinically, i.e., experientially, significant. A good deal of couple/therapy is crisis intervention, within which changes that in one or two areas that seem "small" to an outsider may greatly enhance a couple's functioning, but not necessarily in ways that are usually measured by researchers, i.e., "normal" "adjustment" scores. Such a requirement would be analogous, in other therapy contexts, to requiring a depressed person to be almost depression-free, or a generally anxious person, almost anxiety-free, in order to be thought of as "significantly improved." Finally, as Lebow and Gurman (1995, p. 33) have noted, "For highly troubled samples, a fifty percent movement . . . into the non-distressed range may constitute effective treatment."

Fourth, we may rightly express concern about the apparently variable durability of couple therapy-induced change. But, rather than talking about the inadequacy of our therapeutic methods, we may also consider that the problem lies in the insufficiency of their application. That is, perhaps we are doing a lot of the right things with couples, but not doing them enough. Bray and Jouriles (1995) have asked whether "it is realistic to expect that one round of therapy is enough to last a lifetime" (p. 470), especially for people with a significant history of relational vulnerability and couples with a long history of high levels of conflict. Certainly, a developmental perspective on couple relationships would suggest that "brief, intermittent" (Cummings & Sayama, 1995) or "time-sensitive" (Budman & Gurman, 1988) treatment is more appropriate, both practically and conceptually, not unlike a sort of infectious disease model of therapy, in which the current intervention is expected to be helpful, but not to preclude all future infections.

Moreover, perhaps our typical therapies are just too brief (cf. Gurman, 2001). Consider that our typical 10–20 therapy

hours with couples face the challenge of offsetting and counterbalancing the destructive effects of many years, and possibly thousands of hours, of pain-inducing, distance-generating conflict. That our methods of therapy can yield the kinds of benefits they do in such short order is really quite impressive.

Finally, we may have erred to a degree in still another way in so harshly criticizing the helpfulness of our current couple therapy methods. Perhaps we have expected a good deal more of therapy methods qua techniques than is warranted. Over two decades ago, one of us warned of the dangers of "technolatry" (Gurman & Kniskern, 1978b), the worship of the false god of therapeutic technology. This tendency is very clear in the research literature on couple therapy, notwithstanding the empirical lessons learned in the broader domain of individual psychotherapy research, such as the often-cited and persuasive conclusion that technique factors appear to account for a rather small portion of the variance in treatment outcome, compared to patient factors such as degree of disturbance, therapy expectations, and demographics; therapist factors such as emotional health, credibility, and values; and common factors such as therapist feedback, providing a corrective emotional experience, giving advice, developing a therapeutic alliance, offering reassurance, taking risks, and reality testing (Garfield, 1994; Lambert & Bergin, 1994). This trend may be understandable in light of the fact that the overwhelming majority of couple therapy research has been conducted by behavior therapists. Perhaps BMT's incorporation of "acceptance" methods, and the increasing visibility and influence of research on alternative models of couple therapy, such as those that emphasize affective experience, insight, and the therapeutic relationship, will lead to further exploration

of nontechnique factors in couple therapy outcomes.

In conclusion, we are reminded of the advice of the famed statistician Ronald Fisher (1989); "We should use our brains as well as *F*-ratios to draw inferences."⁵ Moreover, just as we encourage more acceptance in our couples, perhaps we should aim for more acceptance toward both ourselves as therapists and our therapeutic methods.

A MILLENNIAL CONCLUSION

The field of couple therapy approaches the millennium with almost a century-long history of fragmented growth and identity diffusion. It also approaches that marker with a more recent history colored by renewed vigor and historically uncharacteristic rigor.

Four Great Historical Ironies

Rather than prognosticate about the field's future, or attempt to identify priorities for the continuing evolution of psychotherapy with couples, we have chosen to conclude this millennial account by noting four shifts and trends in the field that we think constitute not merely interesting evolutionary directions, but significantly altered shapes the field is taking on. Given couple therapy's history-as-we-have-seen-it, we consider these changes and configurations within the field to reflect profound ironies.

First, the *reinclusion of the individual*, roughly equivalent to what Nichols (1987) called the "self in the system," may be the most far-reaching irony of all. As we have argued, couple therapy nearly died during the pure systems period of usurpation by family therapy. Johnson and Lebow (2000), in their recent decade review of marital therapy, identified the renewal of interest in affect (e.g., in Emotionally Fo-

⁵ Hendricks, J. (1989). Personal communication.

cused Therapy) as one of the major changes in recent years. We think that this important change reflects a much broader shift of perspective. It seems to express renewed interest in the psychology of the individual, not only in terms of affect, but also in terms of the cognitive-attribitional elements of relationships, and even the capacity of individuals to influence relational systems by self-regulation. In this sense, then, we see it as strikingly ironic that while some very influential "systems" therapies almost rang the death knell for couple therapy by largely disavowing the relevance of what occurs "within" people in relationships, it is by the recent radical reinclusion of the individual, by dealing with multiple levels of human experience, that couple therapy has become more genuinely systemic.

Relatedly, the reinclusion of individuals has also included increasing acceptance of *the reality of individual psychiatric/psychological disorders*. Recognition that "systems" therapies such as couple therapy are not universally the treatment of choice for such problems had led to more moderate, realistic, and therefore, acceptable claims regarding the efficacy and applicability of couple therapy. Ironically, then, more muted and cautious claims about the power of such interpersonally oriented treatments has rendered them more, rather than less, credible in the mental health fields in general. This is especially so insofar as these more sober assessments lead naturally to the fostering of integration among intervention methods (e.g., couple therapy plus drug therapy), and among models of couple therapy. Many of the most recent advances in couple therapy have derived from scientific investigation of psychological disorders, mirroring the early history of the broader field of family therapy.

The third irony in the history of couple therapy history involves *the roots of influential couple treatment methods*. Haley

(1984) derisively noted that "there was not a single school of family therapy which had its origin in a marriage counseling group" (p. 6). Conversely, the couple therapy methods, both reparative and preventive, that have contributed the most in the last two decades to our understanding of intimate relationships and their treatment have all derived from traditional theoretical perspectives and therapeutic models. Ironically, then, it has been through extensions of social learning theory, psychodynamic theory, and humanistic/experiential theory, and not "pure" family systems theory, that new conceptual and scientific life has been injected into the field of couple therapy in the current generation.

The fourth, and final irony in the evolution of couple therapy, is the most historically telling. No other collective methods of psychosocial intervention have demonstrated a superior capacity to effect clinically meaningful change in as many spheres of human experience as the couple therapies, and many have not yet even shown a comparable capacity. Ironically, *despite its long history of struggles against marginalization and professional disempowerment, couple therapy at the millennium has emerged as one of the most vibrant forces in the entire domain of family therapy and of psychotherapy-in-general.*

REFERENCES

- Ackerman, N.W. (1970). Family psychotherapy today. *Family Process* 9: 123-126.
- Alexander, F. (1968). An empirical study on the differential influence of self-concept on the professional behavior of marriage counselors. Unpublished Doctoral Dissertation, University of Southern California.
- Alexander, J.F., Holtzworth-Munroe, A., & Jameson, P. (1994). The process and outcome of marital and family therapy: Research review and evaluation (pp. 595-630). In A.E. Bergin & S.L. Garfield (eds.), *Hand-*

- book of psychotherapy and behavior change* (4th ed.). New York: John Wiley & Sons.
- Anchin, J.C., & Kiesler, D.J. (eds.). (1982). *Handbook of interpersonal psychotherapy*. New York: Pergamon Press.
- Anderson, H., & Goolishian, H.A. (1988). Human systems as linguistic systems: Preliminary and evolving ideas about the implications for clinical theory. *Family Process* 27: 371–393.
- Anonymous (1972). On the differentiation of self (pp. 111–173). In J. Framo (ed.), *Family interaction: A dialogue between family researchers and family therapists*. New York: Springer Publishing Company.
- Avis, J.M. (1988). Deepening awareness: A private study guide to feminism and family therapy. *Journal of Psychotherapy and the Family* 3: 15–46.
- Avis, J.M. (1989). Integrating gender into the family therapy curriculum. *Journal of Feminist Family Therapy* 1: 3–26.
- Avis, J.M. (1992). Where are all the family therapists? Abuse and violence within families and family therapy's response. *Journal of Marital and Family Therapy* 18: 223–230.
- Aylmer, R.C. (1986). Bowen family systems marital therapy (pp. 107–148). In N.S. Jacobson & A.S. Gurman (eds.), *Clinical handbook of marital therapy*. New York: Guilford Press.
- Azrin, N.H., Naster, B.J., & Jones, R. (1973). A rapid learning-based procedure for marital counseling. *Behaviour Research and Therapy* 11: 365–382.
- Bader, E., & Pearson, P.T. (1988). *In quest of the mythical mate*. New York: Brunner/Mazel.
- Bagarozzi, D.A., & Giddings, C.W. (1983). The role of cognitive constructs and attributional processes in family therapy: Integrating intrapersonal, interpersonal, and systems dynamics (pp. 207–219). In L. Wolberg & M. Aronson (eds.), *Group and family therapy 1981*. New York: Brunner/Mazel.
- Barker, R.L. (1984). *Treating couples in crisis*. New York: The Free Press.
- Bateson, G., Jackson, D.D., & Weakland, J.H. (1956). Toward a theory of schizophrenia. *Behavioral Science* 1: 251–264.
- Baucom, D.H., & Hoffman, J.A. (1986). The effectiveness of marital therapy: Current status and application to the clinical setting (pp. 597–620). In N.S. Jacobson & A.S. Gurman (eds.), *Clinical handbook of marital therapy*. New York: Guilford Press.
- Baucom, D.H., Shoham, V., Meuser, K.T., Daiuto, A.D., & Stickle, T.R. (1998). Empirically supported couple and family interventions for marital distress and adult mental health problems. *Journal of Consulting and Clinical Psychology* 66: 53–88.
- Beach, S.R., Fincham, F.D., & Katz, J. (1998). Marital therapy in the treatment of depression: Toward a third generation of therapy and research. *Clinical Psychology Review* 18: 635–661.
- Beach, S.R.H., & O'Leary, K.D. (1985). Current status of outcome research in marital therapy (pp. 1035–1072). In L. L'Abate (ed.), *The handbook of family psychology and therapy*. Homewood IL: Dorsey.
- Bednar, R.L., Burlingame, G.M., & Masters, K.S. (1988). Systems of family treatment: Substance or semantics? *Annual Review of Psychology* 39: 401–434.
- Beels, C.C., & Ferber, A. (1969). Family therapy: A view. *Family Process* 8: 280–318.
- Berger, R., & Hannah, M. (1999). *Handbook of preventive approaches in couple therapy*. New York: Brunner/Mazel.
- Bergin, A.E. (1963). The effects of psychotherapy: Negative results revisited. *Journal of Counseling Psychology* 10: 244–250.
- Bergin, A.E., & Garfield, S.L. (eds.). (1994). *Handbook of psychotherapy and behavior change: An empirical analysis* (4th ed.). New York: John Wiley & Sons.
- Berman, E.B., Lief, H., & Williams, A.M. (1981). A model of marital integration (pp. 3–34). In G.P. Sholevar (ed.), *The handbook of marriage and marital therapy*. New York: Spectrum.
- Black, L.W. (2000). Therapy with African American couples (pp. 205–221). In P. Papp (ed.), *Couples on the fault line: New directions for therapists*. New York: Guilford Press.
- Bloom, B. (1992). *Planned short-term psychotherapy: A clinical handbook*. Boston: Allyn & Bacon.
- Bloom, B., Asher, S., & White, S. (1978). Marital disruption as a stressor: A review and analysis. *Psychological Bulletin* 85: 867–894.

- Bogdan, J. (1984). Doctor Pangloss as family therapist. *The Family Therapy Networker* 8(2): 19–20.
- Bowen, M. (1976). Principles and techniques of multiple family therapy (pp. 388–404). In P.J. Guerin, Jr. (ed.), *Family therapy: Theory and practice*. New York: Gardner Press.
- Bowen, M. (1978). *Family therapy in clinical practice*. New York: Jason Aronson.
- Boyd-Franklin, N. (1989). *Black families in therapy: A multisystems approach*. New York: Guilford Press.
- Boyd-Franklin, N. (1993). Race, class and poverty (pp. 361–376). In F. Walsh (ed.), *Normal family processes* (2nd ed.). New York: Guilford Press.
- Bradbury, T.N., & Fincham, F.D. (1990). Preventing marital dysfunction: Review and analysis (pp. 375–401). In D. Frank, F.D. Fincham, & T.N. Bradbury (eds.), *The psychology of marriage: Basic issues and applications*. New York: Guilford Press.
- Bray, J.H., & Jouriles, E.N. (1995). Treatment of marital conflict and prevention of divorce. *Journal of Marital and Family Therapy* 21: 461–473.
- Broderick, C.B., & Schrader, S.S. (1981). The history of professional marriage and family therapy (pp. 3–35). In A.S. Gurman & D.P. Kniskern (eds.), *Handbook of family therapy*. New York: Brunner/Mazel.
- Broderick, C.B., & Schrader, S.S. (1991). The history of professional marriage and family therapy (pp. 3–40). In A.S. Gurman & D.P. Kniskern (eds.), *Handbook of family therapy* (Vol. 2). New York: Brunner/Mazel.
- Budman, S.H., & Gurman, A.S. (1988). *The theory and practice of brief therapy*. New York: Guilford Press.
- Burman, B., & Margolin, G. (1992). Analysis of the association between marital relationships and health problems: An interactional perspective. *Psychological Bulletin* 112: 39–63.
- Catherall, D.R. (1992). Working with projective identification in couples. *Family Process* 31: 355–367.
- Christensen, A., & Heavey, C.L. (1999). Interventions for couples. *Annual Review of Psychology* 50: 165–190.
- Christensen, A., Jacobson, N.S., & Babcock, J.C. (1995). Integrative behavioral couple Therapy (pp. 31–64). In N.S. Jacobson & A.S. Gurman (eds.), *Clinical handbook of couple therapy* (2nd ed.). New York: Guilford Press.
- Coie, J., Watt, N., West, S., Hawkins, J., Asarnow, J., Markman, H., Ramey, S., Shure, S., & Long, B. (1993). The science of prevention: A conceptual framework and some directions for a national research program. *American Psychologist* 48: 1013–1022.
- Cordova, J.V., Jacobson, N.S., & Christensen, A. (1998). Acceptance versus change interventions in behavioral couple therapy: Impact on couples' in-session communication. *Journal of Marital and Family Therapy* 24: 437–455.
- Cummings, N., & Sayama, M. (1995). *Focused psychotherapy: A casebook of brief, intermittent psychotherapy throughout the life cycle*. New York: Brunner/Mazel.
- Daiuto, A.D., Baucom, D.H., Epstein, N., & Dutton, S.S. (1998). The application of behavioral couples therapy to the assessment and treatment of agoraphobia: Implications of empirical research. *Clinical Psychology Review* 18: 663–687.
- Dattilio, F.M., & Bevilacqua, L. (eds.). (2000). *Comparative treatments for relationship dysfunction*. New York: Springer Publishing Company.
- Dicks, H.V. (1967). *Marital tensions*. New York: Basic Books.
- Doherty, W.J., & Simmons, D.S. (1996). Clinical practice patterns of marriage and family therapists: A national survey of therapists and their clients. *Journal of Marital and Family Therapy* 22: 9–25.
- Donovan, J. (ed.). (1999). *Short-term couple therapy*. New York: Guilford Press.
- Duhl, B.S., & Duhl, F.J. (1981). Integrative family therapy (pp. 483–513). In A.S. Gurman & D.P. Kniskern (eds.), *Handbook of family therapy*. New York: Brunner/Mazel.
- Dunn, R.L., & Schwebel, A.I. (1995). Meta-analytic review of marital therapy outcome research. *Journal of Family Psychology* 9: 58–68.
- Efron, D., & Veenendaal, K. (1993). Suppose a miracle doesn't happen: The non-miracle option. *Journal of Systemic Therapies* 12: 11–18.
- Emmelkamp, P.M.G., & Gerlsma, C. (1994).

- Marital functioning and the anxiety disorders. *Behavior Therapy* 25: 407–429.
- Epstein, E.E., & McCrady, B.S. (1998). Behavioral couples treatment of alcohol and drug use disorders: Current status and innovations. *Clinical Psychology Review* 18: 689–711.
- Falicov, C.J. (1983). *Cultural perspectives in family therapy*. Rockville, MD: Aspen Systems.
- Falicov, C.J. (1988). *Latino families in therapy: A guide to multicultural practice*. New York: Guilford Press.
- Falicov, C.J. (1995). Training to think culturally: A multidimensional comparative framework. *Family Process* 34: 373–388.
- Feldman, L.B. (1979). Marital conflict and marital intimacy: An integrative psychodynamic-behavioral-systemic model. *Family Process* 18: 69–78.
- Feldman, L.B. (1985). Integrative multi-level therapy: A comprehensive interpersonal and intrapsychiatric approach. *Journal of Marital and Family Therapy* 11: 357–372.
- Feldman, L.B. (1992). *Integrating individual and family therapy*. New York: Brunner/Mazel.
- Floyd, F.J., Markman, H.J., Kelly, S., Blumberg, S.L., & Stanley, S.M. (1995). Preventative intervention and relationship enhancement (pp. 212–226). In N.S. Jacobson & A.S. Gurman (eds.), *Clinical handbook of couple therapy* (2nd ed.), New York: Guilford Press.
- Fraenkel, P. (1995). The nomothetic-ideographic debate in family therapy. *Family Process* 34: 113–121.
- Fraenkel, P. (1997). Systems approaches to couple therapy (pp. 379–414). In W.K. Halford & H.J. Markman (eds.), *Clinical handbook of marriage and couples interventions*. New York: John Wiley & Sons.
- Fraenkel, P. (1999). “. . . and liberty and relationship strengthening programs for all (who want them).” *American Family Therapy Academy Newsletter* 78: 43–45.
- Fraenkel, P., Markman, H., & Stanely, S. (1997). The prevention approach to relationship problems. *Sexual and Marital Therapy* 12: 249–258.
- Fraenkel, P., & Pinsof, W. (2001). Teaching family therapy-centered integration: Assimilation and beyond. *Journal of Psychotherapy Integration* 11: 59–85.
- Fraenkel, P., & Wilson, S. (2000). Clocks, calendars, and couples: Time and the rhythms of relationships (pp. 63–103). In P. Papp (ed.), *Couples on the fault line: New directions for therapists*. New York: Guilford Press.
- Framo, J.L. (1965). Rationale and techniques of intensive family therapy (pp. 143–212). In I. Boszormenyi-Nagy & J.L. Framo (eds.), *Intensive family therapy*. New York: Harper & Row.
- Framo, J.L. (1976). Family of origin as a therapeutic resource for adults in marital and family therapy: You can and should go home again. *Family Process* 15: 193–210.
- Framo, J.L. (1981). The integration of marital therapy with sessions with family of origin (pp. 133–158). In A.S. Gurman & D.P. Kniskern (eds.), *Handbook of family therapy*. New York: Brunner/Mazel.
- Framo, J.L. (1989). How AFTA got started. *American Family Therapy Association Newsletter* 37: 10–15.
- Framo, J.L. (1996). A personal retrospective of the family therapy field: Then and now. *Journal of Marital and Family Therapy* 22: 289–316.
- Franks, C.M. (ed.). (1969). *Behavior therapy: Appraisal and status*. New York: McGraw-Hill.
- Freedman, J., & Combs, G. (1996a). Gender stories. *Journal of Systemic Therapies* 15(1): 31–46.
- Freedman, J., & Combs, G. (1996b). *Narrative therapy*. New York: W.W. Norton.
- Freedman, J., & Combs, G. (2000). Narrative therapy with couples (pp. 342–361). In F.M. Dattilio & L.J. Bevilacqua (eds.), *Comparative treatments for relationship dysfunction*. New York: Springer Publishing Company.
- Friedlander, M.L., Wildman, J., Heatherington, L., & Skowson, E.A. (1994). What we do and don't know about the process of family therapy. *Journal of Family Psychology* 8: 390–416.
- Friedman, E.H. (1985). *Generation to generation: Family process in church and synagogue*. New York: Guilford Press.
- Furman, B., & Ahola, T. (1992). *Solution talk:*

- Hosting therapeutic conversations.* New York: W.W. Norton.
- Garfield, S.L. (1994). Research on client variables in psychotherapy (pp. 190–228). In A.E. Bergin & S.L. Garfield (eds.), *Handbook of psychotherapy and behavior change* (4th ed.). New York: John Wiley & Sons.
- Gerson, R., Hoffman, S., Sauls, M., & Ulrici, D. (1993). Family-of-origin frames in couples therapy. *Journal of Marital and Family Therapy* 19: 341–354.
- Giblin, P., Sprenkle, D.H., & Sheehan, R. (1985). Enrichment outcome research: A meta-analysis of premarital, marital, and family interventions. *Journal of Marital and Family Therapy* 11: 257–271.
- Goldner, V. (1985a). Feminism and family therapy. *Family Process* 24: 31–47.
- Goldner, V. (1985b). Warning: Family therapy may be hazardous to your health. *The Family Therapy Networker* 9(6): 18–23.
- Goldner, V. (1988). Generation and gender: Normative and covert hierarchies. *Family Process* 27: 17–31.
- Goldner, V. (1998). The treatment of violence and victimization in intimate relationships. *Family Process* 37: 263–286.
- Goldner, V. (1999). Morality and multiplicity: Perspectives on the treatment of violence in intimate life. *Journal of Marital and Family Therapy* 25: 325–336.
- Goldner, V., Penn, P., Sheinberg, M., & Walker, G. (1990). Love and violence: Gender paradoxes in volatile attachments. *Family Process* 29: 343–364.
- Goodman, E.S. (1973). Marriage counseling as science: Some research considerations. *The Family Coordinator* 22: 111–116.
- Gottman, J.M. (1991). Predicting the longitudinal courses of marriage. *Journal of Marital and Family Therapy* 17: 3–7.
- Gottman, J.M. (1994a). *What predicts divorce?* Hillsdale NJ: Lawrence Erlbaum Associates.
- Gottman, J.M. (1994b). *Why marriages succeed or fail.* New York: Simon and Schuster.
- Gottman, J.M. (1999). *The marriage clinic: A scientifically based marital therapy.* New York: W.W. Norton.
- Gottman, J.M., Coan, J., Carrère, S., & Swanson, C. (1998). Predicting marital happiness and stability from newlywed interaction. *Journal of Marriage and the Family* 60: 5–22.
- Greenberg, L.S., & Johnson, S.M. (1986). Emotionally focused couples therapy (pp. 253–278). In N.S. Jacobson & A.S. Gurman (eds.), *Clinical handbook of marital therapy.* New York: Guilford Press.
- Greenberg, L.S., & Johnson, S.M. (1988). *Emotionally focused couple therapy.* New York: Guilford Press.
- Greene, B.L. (ed.). (1965a). *The psychotherapies of marital disharmony.* New York: The Free Press.
- Greene, B.L. (1965b). Introduction: A multi-operational approach to marital problems (pp. 1–14). In B.L. Greene (ed.), *The psychotherapies of marital disharmony.* New York: The Free Press.
- Grych, J., & Fincham, F. (1990). Marital conflict and children's adjustment. *Psychological Bulletin* 108: 267–290.
- Guerin, P.J., Jr. (1976). Family therapy: The first twenty five years (pp. 2–22). In P.J. Guerin, Jr. (ed.), *Family therapy and practice.* New York: Gardner Press.
- Guerin, P.J., Jr., Fay, L.F., Burden, S.L., & Kautto, J.G. (1987). *The evaluation and treatment of marital conflict: A four-stage approach.* New York: Basic Books.
- Guerney, B.G. (1977). *Relationship enhancement.* San Francisco: Jossey-Bass.
- Guerney, B., Brock, G., & Coufal, J. (1986). Integrating marital therapy and enrichment: The Relationship Enhancement approach (pp. 151–172). In N.S. Jacobson & A.S. Gurman (eds.), *Clinical handbook of marital therapy.* New York: Guilford Press.
- Guerney, B., & Maxson, P. (1990). Marital and family enrichment research: A decade review and look ahead. *Journal of Marriage and the Family* 52: 1127–1135.
- Gurin, E., Veroff, J., & Feld, S. (1960). *Americans view their mental health.* New York: Basic Books.
- Gurman, A.S. (1971). Group marital therapy: Clinical and empirical implications for outcome research. *International Journal of Group Psychotherapy* 21: 174–189.
- Gurman, A.S. (1973a). Marital therapy: Emerging trends in research and practice. *Family Process* 12: 45–54.
- Gurman, A.S. (1973b). The effects and effec-

- tiveness of marital therapy: A review of outcome research. *Family Process* 12: 145–170.
- Gurman, A.S. (1978). Contemporary marital therapies: A critique and comparative analysis of psychoanalytic, behavioral and systems theory approaches (pp. 445–566). In T. Paolino & B. McCrady (eds.), *Marriage and marital therapy*. New York: Brunner/Mazel.
- Gurman, A.S. (1979). Dimensions of marital therapy: A comparative analysis. *Journal of Marital and Family Therapy* 5: 5–16.
- Gurman, A.S. (1981). Integrative marital therapy: Toward the development of an interpersonal approach (pp. 415–462). In S.H. Budman (ed.), *Forms of brief therapy*. New York: Guilford Press.
- Gurman, A.S. (1982). Changing collusive patterns in marital therapy. *American Journal of Family Therapy* 10: 71–73.
- Gurman, A.S. (1983). Family therapy research and the “New Epistemology.” *Journal of Marital and Family Therapy* 9: 227–234.
- Gurman, A.S. (1990). Integrating the life of an integrative family psychologist (pp. 250–266). In F. Kaslow (ed.), *Voices in family psychology* (Vol. 2). Newbury Park CA: Sage Publications.
- Gurman, A.S. (1992). Integrative marital therapy: A time-sensitive model for working with couples (pp. 186–203). In S. Budman, M. Hoyt, & S. Friedman (eds.), *The first session in brief therapy*. New York: Guilford Press.
- Gurman, A.S. (2001). Brief therapy and family/couple therapy: An essential redundancy. *Clinical Psychology: Science and Practice* 8: 51–65.
- Gurman, A.S. (2002). Brief integrative marital therapy: A depth-behavioral approach (pp. 180–220). In A.S. Gurman & N.S. Jacobson (eds.), *Clinical handbook of couple therapy* (3rd ed.). New York: Guilford Press.
- Gurman, A.S., & Jacobson, N.S. (1995). Therapy with couples: A coming of age (pp. 1–6). In N.S. Jacobson & A.S. Gurman (eds.), *Clinical handbook of couple therapy* (2nd ed.). New York: Guilford Press.
- Gurman, A.S., & Jacobson, N.S. (eds.). (2002). *Clinical handbook of couple therapy* (3rd ed.). New York: Guilford Press.
- Gurman, A.S., & Kniskern, D.P. (1977). Enriching research on marital enrichment programs. *Journal of Marriage and Family Counseling* 3: 3–11.
- Gurman, A.S., & Kniskern, D.P. (1978a). Deterioration in marital and family therapy: Empirical, clinical and conceptual issues. *Family Process* 17: 3–20.
- Gurman, A.S., & Kniskern, D.P. (1978b). Research on marital and family therapy: Progress, perspective, and prospect (pp. 817–901). In S.L. Garfield & A.E. Bergin (eds.), *Handbook of psychotherapy and behavior change* (2nd ed.). New York: John Wiley & Sons.
- Gurman, A.S., & Kniskern, D.P. (1979). Marriage therapy and/or family therapy: What’s in a name? *American Association for Marriage and Family Therapy Newsletter* 10(3): 1, 5–8.
- Gurman, A.S., & Kniskern, D.P. (1981a). Family therapy outcome research: Knowns and unknowns (pp. 742–775). In A.S. Gurman & D.P. Kniskern (eds.), *Handbook of family therapy*. New York: Brunner/Mazel.
- Gurman, A.S., & Kniskern, D.P. (eds.). (1981b). *Handbook of family therapy*. New York: Brunner/Mazel.
- Gurman, A.S., & Kniskern, D.P. (1986). Commentary: Individual marital therapy—Have reports of your death been somewhat exaggerated? *Family Process* 25: 51–62.
- Gurman, A.S., & Kniskern, D.P. (1992). The future of marital and family therapy. *Psychotherapy: Theory, Research, & Practice* 29: 65–71.
- Gurman, A.S., Kniskern, D.P., & Pinsof, W.M. (1986). Process and outcome research in family and marital therapy (pp. 565–624). In A. Bergin & S. Garfield (eds.), *Handbook of psychotherapy and behavioral change* (3rd ed.). New York: John Wiley & Sons.
- Gurman, A.S., & Knudson, R.M. (1978). Behavioral marriage therapy I: A psychodynamic-systems analysis and critique. *Family Process* 17: 121–138.
- Gurman, A.S., & Razin, A.M. (1977). *Effective psychotherapy: A handbook of research*. New York: Pergamon Press.
- Hahlweg, K., & Klann, N. (1997). The effectiveness of marital counseling in Germany: A contribution to health services research. *Journal of Family Psychology* 11: 410–421.
- Hahlweg, K., & Markman, H.J. (1988). Effec-

- tiveness of behavioral marital therapy: Empirical status of behavioral techniques in preventing and alleviating distress. *Journal of Consulting and Clinical Psychology* 56: 440–447.
- Haley, J. (1963). Marriage therapy. *Archives of General Psychiatry* 8: 213–234.
- Haley, J. (1976). *Problem-solving therapy*. San Francisco: Jossey-Bass.
- Haley, J. (1984). Marriage or family therapy. *American Journal of Family Therapy* 12: 3–14.
- Halford, W.K. (1998). The ongoing evolution of behavioral couples therapy: Retrospect and prospect. *Clinical Psychology Review* 18: 613–633.
- Halford, W.K., & Markman, H.J. (eds.). (1997). *Clinical handbook of marriage and couples intervention*. New York: John Wiley & Sons.
- Halford, W.K., Sanders, M.R., & Behrens, B.C. (1994). Self-regulation in behavioral couples therapy. *Behavior Therapy* 25: 431–452.
- Hamburg, S. (1996). Review of Jacobson & Gurman's *Clinical handbook of couple therapy* (2nd ed.). *Child and Family Behavior Therapy* 18: 55–60.
- Hardy, K.V. (1991). The theoretical myth of sameness: A critical issue in family therapy training and treatment (pp. 74–93). In G.W. Saba, B.M. Karrer, & K.W. Hardy (eds.), *Minorities and family therapy*. New York: Haworth Press.
- Hare-Mustin, R.T. (1978). A feminist approach to family therapy. *Family Process* 17: 181–194.
- Hare-Mustin, R.T. (1987). The problem of gender in family therapy theory. *Family Process* 26: 15–27.
- Hare-Mustin, R.T., & Marecek, J. (1994). Feminism & postmodernism: Dilemmas and points of resistance. *Dulwich Centre Newsletter* 4: 13–19.
- Heiman, J., & LoPiccolo, J. (1988). *Becoming orgasmic*. New York: Prentice-Hall.
- Hoffman, L. (1990). Constructing realities: An art of lenses. *Family Process* 29: 1–12.
- Hudson, P., & O'Hanlon, W.H. (1992). *Rewriting love stories: Brief marital therapy*. New York: W.W. Norton.
- Jackson, D.D. (1959). Family interaction, family homeostasis and some implications for conjoint family psychotherapy (pp. 122–141). In J. Masserman (ed.), *Individual and family dynamics*. New York: Grune & Stratton.
- Jackson, D.D. (1965a). Family rules: The marital quid pro quo. *Archives of General Psychiatry* 12: 589–594.
- Jackson, D.D. (1965b). The study of the family. *Family Process* 4: 1–20.
- Jacobson, N.S., & Addis, M.E. (1993). Research on couples and couples therapy: What do we know? Where are we going? *Journal of Consulting and Clinical Psychology* 61: 85–93.
- Jacobson, N.S., & Christensen, A. (1996). *Integrative behavioral couple therapy*. New York: W.W. Norton.
- Jacobson, N.S., & Gurman, A.S. (eds.). (1986). *Clinical handbook of marital therapy*. New York: Guilford Press.
- Jacobson, N.S., & Gurman, A.S. (eds.). (1995). *Clinical handbook of couple therapy* (2nd ed.). New York: Guilford Press.
- Jacobson, N.S., & Margolin, G. (1979). *Marital therapy: Strategies based on social learning and behavior exchange principles*. New York: Brunner/Mazel.
- Jacobson, N.S., & Martin, B. (1976). Behavioral marriage therapy: Current status. *Psychological Bulletin* 83: 540–566.
- Jacobson, N.S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology* 58: 12–19.
- James, K., & MacKinnon, L. (1990). The “incestuous” family revisited: A critical analysis of family therapy myths. *Journal of Marital and Family Therapy* 16: 71–88.
- James, K., & McIntyre, D. (1983). The reproduction of families: The social role of family therapy. *Journal of Marital and Family Therapy* 9: 119–129.
- Johnson, S. (1986). Bonds or bargains: Relationship paradigms and their significance for marital therapy. *Journal of Marital and Family Therapy* 12: 259–267.
- Johnson, S. (1996). *The practice of emotionally focused marital therapy*. New York: Brunner/Mazel.
- Johnson, S.M. (1999). Emotionally focused couple therapy (pp. 13–41). In J. Donovan

- (ed.), *Short-term couple therapy*. New York: Guilford Press.
- Johnson, S.M., & Greenberg, L.S. (1995). The emotionally focused approach to problems in adult attachment (pp. 121–146). In N.S. Jacobson & A.S. Gurman (eds.), *Clinical handbook of couple therapy* (2nd ed.). New York: Guilford Press.
- Johnson, S.M., Hunsely, J., Greenberg, L., & Schindler, D. (1999). Emotionally focused couples therapy: Status and challenges. *Clinical Psychology: Science and Practice* 6: 67–79.
- Johnson, S., & Lebow, J. (2000). The “coming of age” of couple therapy: A decade review. *Journal of Marital and Family Therapy* 26: 23–38.
- Kanfer, F.H., & Phillips, J.S. (1970). *Learning foundations of behavior therapy*. New York: John Wiley & Sons.
- Kaplan, H.S. (1974). *The new sex therapy*. New York: Brunner/Mazel.
- Kaplan, H.S. (1983). *The evaluation of sexual disorders*. New York: Brunner/Mazel.
- Kerr, M., & Bowen, M. (1988). *Family evaluation*. New York: W.W. Norton.
- Kiecolt-Glaser, J.K., Fisher, L.D., Ogrocki, P., Stout, J.C., & Speicher, C.E. (1987). Marital quality, marital disruptions and immune function. *Psychosomatic Medicine* 49: 13–34.
- L’Abate, L., & McHenry, S. (eds.). (1983). *Handbook of marital interventions*. New York: Grune & Stratton.
- Laidlaw, R.W. (1957). The psychiatrist as marriage counselor (pp. 52–61). In C.E. Vincent (ed.), *Readings in marriage counseling*. New York: Crowell.
- Laird, J. (1999). The politics of “smart marriage.” *American Family Therapy Academy Newsletter* 77(Fall): 43–45.
- Laird, J., & Green, R.J. (eds.). (1996). *Lesbians and gays in couples and families: A handbook for therapists*. San Francisco: Jossey-Bass.
- Lambert, M.J., & Bergin, A.E. (1994). The effectiveness of psychotherapy (pp. 143–189). In A.E. Bergin & S.L. Garfield (eds.), *Handbook of psychotherapy and behavior change* (4th ed.). New York: John Wiley & Sons.
- Lazloff, T.A., & Hardy, K.V. (2000). Uncommon strategies for a common problem: Addressing racism in family therapy. *Family Process* 39: 35–50.
- Lebow, J.L. (1984). On the value of integrating approaches to family therapy. *Journal of Marital and Family Therapy* 20: 127–138.
- Lebow, J. (1997). The integrative revolution in couple and family therapy. *Family Process* 36: 1–17.
- Lebow, J.L., & Gurman, A.S. (1995). Research assessing couple and family therapy. *Annual Review of Psychology* 46: 27–57.
- Lebow, J.L., & Gurman, A.S. (1998). Family systems and family psychology (pp. 473–496). In A.S. Bellak & M. Hersen (eds.), *Comprehensive clinical psychology* (Vol. 1). New York: Pergamon Press.
- Lederer, W., & Jackson, D.D. (1968). *The mirages of marriage*. New York: W.W. Norton.
- Leiblum, S., & Rosen, R. (eds.). (1989). *Principles and practices of sex therapy* (2nd ed.). New York: Guilford Press.
- Leslie, G.R. (1964). Conjoint therapy in marriage counseling. *Journal of Marriage and the Family* 26: 65–71.
- Lewis, J.M., & Gossett, J.T. (2000). *Disarming the past: How an intimate relationship can heal old wounds*. Phoenix, AZ: Zeig, Tucker & Co.
- Libow, J. A., Raskin, P.A., & Caust, B.L. (1982). Feminist and family systems therapy: Are they irreconcilable? *The American Journal of Family Therapy* 10: 3–12.
- Luborsky, L., Singer, B., & Luborsky, L. (1975). Comparative studies of psychotherapies: Is it true that “Everybody has won and all must have prizes?” *Archives of General Psychiatry* 32: 995–1000.
- Madanes, C. (1980). Marital therapy when a symptom is presented by a spouse. *International Journal of Family Therapy* 2: 120–136.
- Manus, G.I. (1966). Marriage counseling: A technique in search of a theory. *Journal of Marriage and the Family* 28: 449–453.
- Markman, H.J. (2000). Personal communication.
- Markman, H.J., Floyd, F.J., Stanley, S.M., & Storaasli, R.D. (1988). Prevention of marital distress: A longitudinal investigation. *Journal of Consulting and Clinical Psychology* 56: 210–217.
- Markman, H.J., Renick, M.J., Floyd, F.J.,

- Stanley, S.M., & Clements, M. (1993). Preventing marital distress through communication and conflict management training: A four and five year follow-up. *Journal of Consulting and Clinical Psychology* 62: 70–77.
- Markman, H., Stanley, S., & Blumberg, S.L. (1994). *Fighting for your marriage*. San Francisco: Jossey-Bass.
- Markowitz, L.M. (1994). The cross-currents of multiculturalism. *The Family Therapy Networker* 18: 27.
- Martin, P.A. (1965). Treatment of marital disharmony by collaborative therapy (pp. 83–102). In B.L. Greene (ed.), *The psychotherapies of marital disharmony*. New York: The Free Press.
- Martin, P.A. (1976). *A marital therapy manual*. New York: Brunner/Mazel.
- McCarthy, B.W. (2002). Sexuality, sexual dysfunction, and couple therapy (pp. 629–652). In A.S. Gurman & N.S. Jacobson (eds.), *Clinical handbook of couple therapy* (3rd ed.). New York: Guilford Press.
- McGoldrick, M. (1993). Ethnicity, cultural diversity, and normality (pp. 331–360). In F. Walsh (ed.), *Normal family processes* (2nd ed.). New York: Guilford Press.
- McGoldrick, M., Pearce, J.K., & Giordano, J. (eds.). (1982). *Ethnicity and family therapy*. New York: Guilford Press.
- Meissner, W.W. (1978). The conceptualization of marriage and family dynamics from a psychoanalytic perspective (pp. 25–88). In T. Paolino & B. McCrady (eds.), *Marriage and marital therapy*. New York: Brunner/Mazel.
- Messer, S.B., & Warren, C.S. (1995). *Models of brief psychodynamic therapy: A comparative approach*. New York: Guilford Press.
- Michaelson, R. (1963). An analysis of the changing focus of marriage counseling. Unpublished Doctoral Dissertation, University of Southern California.
- Minuchin, S. (1998). Where is the family in narrative family therapy? *Journal of Marital and Family Therapy* 24: 397–403.
- Mittelman, B. (1948). The concurrent analysis of married couples. *Psychiatric Quarterly* 17: 182–197.
- Mohr, R. (2000). Reflections on Golden Pond (pp. 312–334). In P. Papp (ed.), *Couples on the fault line: New directions for therapists*. New York: Guilford Press.
- Mudd, E.H. (1957). Knowns and unknowns in marriage counseling research. *Marriage and Family Living* 19: 75–81.
- Nadelson, C.C. (1978). Marital therapy from a psychoanalytic perspective (pp. 89–164). In T. Paolino & B. McCrady (eds.), *Marriage and marital therapy*. New York: Brunner/Mazel.
- Neal, J., Zimmerman, J.L., & Dickerson, V.C. (1999). Couples, culture, and discourse: A narrative approach (pp. 360–400). In J. Donovan (ed.), *Short-term couple therapy*. New York: Guilford Press.
- Nerin, W.F. (1986). *Family reconstruction: Long day's journey into light*. New York: W.W. Norton.
- Nichols, M.P. (1987). *The self in the system*. New York: Brunner/Mazel.
- Nichols, M.P., & Schwartz, R.C. (1998). *Family therapy: Concepts and methods*. Boston: Allyn & Bacon.
- Nichols, W.C. (1973). The field of marriage counseling: A brief overview. *The Family Coordinator* 22: 3–13.
- Nichols, W.C. (1988). *Marital therapy: An integrated approach*. New York: Guilford Press.
- Norcross, J.C., & Goldfried, M.R. (eds.). (1992). *Handbook of psychotherapy integration*. New York: Basic Books.
- Oberndorf, C.P. (1931). Psychoanalysis of married couples. Paper presented at the American Psychiatric Association.
- Oberndorf, C.P. (1934). Folie à deux. *International Journal of Psychoanalysis* 15: 14–24.
- Oberndorf, C.P. (1938). Psychoanalysis of married couples. *Psychoanalytic Review* 25: 453–475.
- Olson, D.H. (1970). Marital and family therapy: Integrative review and critique. *Journal of Marriage and the Family* 32: 501–538.
- Olson, D.H. (1990). Marriage in perspective (pp. 402–419). In F.D. Fincham & T.N. Bradbury (eds.), *The psychology of marriage: Basic issues and applications*. New York: Guilford Press.
- Olson, D.H., Russell, R.C.S., & Sprenkle, D.H. (1980). Marital and family therapy: A decade review. *Journal of Marriage and the Family* 42: 973–992.
- Olson, D.H.L., & Sprenkle, D.H. (1976). Emerging trends in treating relationships.

- Journal of Marriage and Family Counseling* 2: 317–329.
- Paolino, T., & McCrady, B. (eds.). (1978). *Marriage and marital therapy*. New York: Brunner/Mazel.
- Papero, D. (1995). Bowen family systems and marriage (pp. 11–30). In N.S. Jacobson & A.S. Gurman (eds.), *Clinical handbook of couple therapy* (2nd ed.). New York: Guilford Press.
- Papero, D.V. (2000). Bowen's systems theory (pp. 25–44). In F.M. Dattilio & L.J. Bevilacqua (eds.), *Comparative treatments for relationship dysfunction*. New York: Springer Publishing Company.
- Papp, P. (1988). Couples (pp. 200–250). In M. Walters, B. Carter, P. Papp, & O. Silverstein (eds.), *The invisible web: Gender patterns in family relationships*. New York: Guilford Press.
- Papp, P. (2000). Gender differences in depression: His or her depression (pp. 130–151). In P. Papp (ed.), *Couples on the fault line: New directions for therapists*. New York: Guilford Press.
- Paul, N. (1969). The role of mourning and empathy in conjoint marital therapy (pp. 186–205). In G. Zuk & I. Boszormenyi-Nagy (eds.), *Family therapy and disturbed families*. Palo Alto CA: Science & Behavior Books.
- Paul, N., & Paul, B. (1975). *A marital puzzle*. New York: W.W. Norton.
- Perel, E. (2000). A tourist's view of marriage: Cross-cultural couples—challenges, choices and implications for therapy (pp. 178–204). In P. Papp (ed.), *Couples on the fault line: New directions for therapists*. New York: Guilford Press.
- Pinderhughes, E. (1989). *Understanding race, ethnicity, and power: The key to efficacy in clinical practice*. New York: The Free Press.
- Pinsof, W.M. (1981). Family therapy process research (pp. 699–741). In A.S. Gurman & D.P. Kniskern (eds.), *Handbook of family therapy*. New York: Brunner/Mazel.
- Pinsof, W.M. (1983). Integrative problem-centered therapy: Toward the synthesis of family and individual psychotherapies. *Journal of Marital and Family Therapy* 9: 19–35.
- Pinsof, W.M. (1995). *Integrative problem-centered therapy*. New York: Basic Books.
- Pinsof, W.M. (1999). Building love and transforming conflict in couples therapy. Workshop presented at the Annual Conference of the American Association for Marital and Family Therapy, Chicago, October.
- Pinsof, W.M., & Wynne, L.C. (1995). The efficacy of marital and family therapy: An empirical overview, conclusions, and recommendations. *Journal of Marital and Family Therapy* 21: 585–613.
- Pittman, F. (1989). Remembering Virginia. *The Family Therapy Networker* 13(1): 34–35.
- Raffa, H., Sypek, J., & Vogel, W. (1990). Commentary on reviews of "outcome" studies of family and marital psychotherapy. *Contemporary Family Therapy* 12: 65–73.
- Rait, D. (1988). Survey results. *The Family Therapy Networker* 12(1): 52–56.
- Roberto-Forman, L. (2002). Transgenerational marriage therapy (pp. 118–147). In A.S. Gurman & N.S. Jacobson (eds.), *Clinical handbook of couple therapy*. New York: Guilford Press.
- Sager, C.J. (1966). The development of marriage therapy: An historical review. *American Journal of Orthopsychiatry* 36: 458–467.
- Sager, C.J. (1967a). The conjoint session in marriage therapy. *American Journal of Psychoanalysis* 27: 139–146.
- Sager, C.J. (1967b). Transference in conjoint treatment of married couples. *Archives of General Psychiatry* 16: 185–193.
- Sager, C.J. (1976). *Marriage contracts and couple therapy*. New York: Brunner/Mazel.
- Sager, C.J. (1981). Couples therapy and marriage contracts (pp. 85–130). In A.S. Gurman & D.P. Kniskern (eds.), *Handbook of family therapy*. New York: Brunner/Mazel.
- Sager, C.J., Kaplan, H.S., Gundlach, R.H., Kremer, M., Lenz, R., & Royce, J.R. (1971). The marriage contract. *Family Process* 10: 311–326.
- Sander, F.M. (1979). *Individual and family therapy: Toward an integration*. New York: Jason Aronson.
- Sanders, G. (2000). Men together: Working with gay couples in contemporary times (pp. 222–256). In P. Papp (ed.), *Couples on the fault line: New directions for therapists*. New York: Guilford Press.

- Satir, V. (1964). *Conjoint family therapy*. Palo Alto: Science and Behavior Books.
- Satir, V.M. (1965). Conjoint marital therapy (pp. 121–133). In B.L. Greene (ed.), *The psychotherapies of marital disharmony*. New York: The Free Press.
- Satir, V. (1972). *Peoplemaking*. Palo Alto, CA: Science and Behavior Books.
- Scharff, J.S. (1995). Psychoanalytic marital therapy (pp. 164–193). In N.S. Jacobson & A.S. Gurman (eds.), *Clinical handbook of couple therapy* (2nd ed.). New York: Guilford Press.
- Scharff, J.S., & Bagnini, C. (2002). Object relations couple therapy (pp. 59–85). In A.S. Gurman & N.S. Jacobson (eds.), *Clinical handbook of couple therapy* (3rd ed.). New York: Guilford Press.
- Scharff, D.E., & Scharff, J.S. (1991). *Object relations couple therapy*. New York: Jason Aronson.
- Schnarch, D. (1991). *Constructing the sexual crucible*. New York: W.W. Norton.
- Schnarch, D. (2001). The therapist in the crucible: Early developments in a new paradigm of sexual and marital therapy (pp. 43–56). In S. McDaniel, D. Lusterman, & C. Philpot (eds.), *Casebook for integrating family therapy*. Washington DC: American Psychological Association.
- Schwartz, R.C. (1995). *Internal family systems therapy*. New York: Guilford Press.
- Schwartz, R.C., & Johnson, S.M. (2000). Commentary: Does couple and family therapy have emotional intelligence? *Family Process* 39: 29–33.
- Segal, L. (1991). Brief therapy: The MRI approach (pp. 171–199). In A.S. Gurman & D.P. Kniskern (eds.), *Handbook of family therapy* (Vol. 2). New York: Brunner/Mazel.
- Segraves, R.T. (1978). Conjoint marital therapy: A cognitive behavioral model. *Archives of General Psychiatry* 35: 450–455.
- Segraves, R.T. (1982). *Marital therapy: A combined psychodynamic behavioral approach*. New York: Plenum Press.
- Shadish, W.R., Montgomery, L.M., Wilson, P., Wilson, M.R., Bright, I., & Okwumabua, T. (1993). Effects of family and marital psychotherapies: A meta-analysis. *Journal of Consulting and Clinical Psychology* 61: 992–1002.
- Shadish, W.R., Ragsdale, R., Glaser, R.R., & Montgomery, L.M. (1995). The efficacy and effectiveness of marital and family therapy: A perspective from meta-analysis. *Journal of Marital and Family Therapy* 21: 345–360.
- Shields, C.G., Wynne, L.C., McDaniel, S.H., & Gawinski, B.A. (1994). The marginalization of family therapy: A historical and continuing problem. *Journal of Marital and Family Therapy* 20: 117–138.
- Sholevar, G.P. (ed.). (1981). *The handbook of marriage and marital therapy*. New York: Spectrum.
- Siegel, J. (1992). *Repairing intimacy: An object relations approach to couples therapy*. Northvale NJ: Jason Aronson.
- Simmons, D.S., & Doherty, W.J. (1995). Defining who we are and what we do: Clinical practice patterns of marriage and family therapists in Minnesota. *Journal of Marital and Family Therapy* 21: 3–16.
- Skygger, A.C.R. (1976). *Systems of family and marital psychotherapy*. New York: Brunner/Mazel.
- Skygger, A.C.R. (1980). Recent developments in marital therapy. *Journal of Family Therapy* 2: 271–296.
- Skygger, A.C.R. (1981). An open-systems, group analytic approach to family therapy (pp. 39–84). In A.S. Gurman & D.P. Kniskern (eds.), *Handbook of family therapy*. New York: Brunner/Mazel.
- Slater, S. (1995). Persistent stressors in lesbian couples' lives (pp. 37–62). In *The lesbian family life cycle*. New York: The Free Press.
- Snyder, D.K. (1999). Affective reconstruction in the context of a pluralistic approach to couple therapy. *Clinical Psychology: Science and Practice* 6: 348–365.
- Snyder, D.K., & Wills, R.M. (1989). Behavioral versus insight-oriented marital therapy: Effects on individual and interspousal functioning. *Journal of Consulting and Clinical Psychology* 57: 39–46.
- Snyder, D.K., Wills, R.M., & Grady-Fletcher, A. (1991). Long-term effectiveness of behavioral versus insight-oriented marital therapy: A four-year follow-up study. *Journal of Consulting and Clinical Psychology* 59: 138–144.

- Solomon, M.F. (1989). *Narcissism and intimacy*. New York: W.W. Norton.
- Sprenkle, D.H., & Storm, C.L. (1983). Divorce therapy outcome research: A substantive and methodological review. *Journal of Marital and Family Therapy* 9: 239–258.
- Stanley, S.M., Blumberg, S.L., & Markman, H.J. (1999). Helping couples fight for their marriages: The PREP approach (pp. 74–89). In R. Berger & M. Hannah (eds.), *Handbook of preventive approaches in couple therapy*. New York: Brunner/Mazel.
- Stanley, S.M., Bradbury, T.N., & Markman, H.J. (2000). Structural flaws in the bridge from basic research on marriage to interventions for couples. *Journal of Marriage and the Family* 62: 256–264.
- Stanley, S.M., Markman, H.J., St. Peters, M., & Leber, D. (1995). Strengthening marriages and preventing divorce: New directions in prevention research. *Family Relations* 44: 392–401.
- Stricker, G. (1994). Reflections on psychotherapy integration. *Clinical Psychology: Science and Practice* 1: 3–12.
- Stricker, G., & Gold, J.R. (eds.). (1993). *Comprehensive handbook of psychotherapy integration*. New York: Plenum Press.
- Stuart, R.B. (1969). Operant-interpersonal treatment of marital discord. *Journal of Consulting and Clinical Psychology* 33: 675–682.
- Stuart, R.B. (1980). *Helping couples change: A social learning approach to marital therapy*. New York: Guilford Press.
- Thoreson, C.E., & Mahoney, M.J. (eds.). (1974). *Behavioral self-control*. New York: Holt, Rinehart & Winston.
- Walters, M., Carter, B., Papp, P., & Silverstein, O. (1988). *The invisible web: Gender patterns in family relationships*. New York: Guilford Press.
- Watson, A.S. (1963). The conjoint psychotherapy of married partners. *American Journal of Orthopsychiatry* 33: 912–922.
- Watson, D.C., & Tharp, R.G. (1972). *Self-directed behavior: Self-modification for personal adjustment*. Monterey CA: Brooks/Cole.
- Watzlawick, P. (ed.). (1984). *The invented reality: How do we know what we believe we know?* New York: W.W. Norton.
- Weeks, G., & Hof, L. (1987). *Integrating sex and marital therapy*. New York: Brunner/Mazel.
- Weiner-Davis, M. (1992). *Divorce-busting*. New York: Summit Books.
- Weiss, R.L., Birchler, G.R., & Vincent, J.P. (1974). Contractual models for negotiation training in dyads. *Journal of Marriage and Family* 36: 321–330.
- Wells, R.A., & Gianetti, V.J. (1986a). Individual marital therapy: A critical reappraisal. *Family Process* 25: 43–51.
- Wells, R.A., & Gianetti, V.J. (1986b). Rejoinder: Whither marital therapy? *Family Process* 25: 62–65.
- Whisman, M.A., Dixon, A.E., & Johnson, B. (1997). Therapists' perspectives of couple problems and treatment issues in couple therapy. *Journal of Family Psychology* 11: 361–366.
- Whisman, M.A., & Snyder, D.K. (1997). Evaluating and improving the efficacy of conjoint couple therapy (pp. 679–693). In W.K. Halford & H.J. Markman (eds.), *Handbook of marriage and couples intervention*. New York: John Wiley & Sons.
- White, M. (1986/1987). Couple therapy: 'Urgency for sameness or appreciation of difference.' *Dulwich Centre Review/Summer*: 11–13.
- White, M. (1988). The externalizing of the problem and the re-authoring of lives and relationships. *Dulwich Centre Newsletter/Summer*: 3–21.
- White, M. (1991). Deconstruction and therapy. *Dulwich Centre Newsletter* 3: 21–40.
- White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: W.W. Norton.
- Wile, D.B. (1981). *Couples therapy: A nontraditional approach*. New York: John Wiley & Sons.
- Willi, J. (1982). *Couples in collusion*. Claremont CA: Hunter, House.
- Wills, R.M., Faltler, S.L., & Snyder, D.K. (1987). Distinctiveness of behavioral versus insight-oriented marital therapy: An empirical analysis. *Journal of Consulting and Clinical Psychology* 55: 685–690.
- Wincze, J., & Barlow, D. (1996). *Enhancing sexuality: Client workbook*. New York: Gray Wind Publications.

- Wynne, L.C. (1983). Family research and family therapy: A reunion? *Journal of Marital and Family Therapy* 9: 113–117.
- Young, J.E. (1994). *Cognitive therapy for personality disorders: A schema-focused approach*. Sarasota FL: Professional Resource Press.
- Zimmerman, J.L., & Dickerson, V.C. (1993a). Bringing forth the restraining influence of pattern in couples therapy (pp. 194–215). In S. Gilligan & R. Price (eds.), *Therapeutic conversations*. New York: W.W. Norton.
- Zimmerman, J.L., & Dickerson, V.C. (1993b). Separating couples from restraining patterns and the relationship discourse that supports them. *Journal of Marital and Family Therapy* 19: 403–413.
- Zimmerman, J.L., & Dickerson, V.C. (1994). Using a narrative metaphor: Implications for theory and clinical practice. *Family Process* 33: 233–245.

Manuscript received August 16, 2000; final revision submitted January 7, 2002; accepted January 10, 2002.