Clin Soc Work J (2009) 37:234–247
DOI 10.1007/s10615-009-0207-3

ORIGINAL PAPER

The Therapeutic Palette: A Guide to Choice Points in Integrative Couple Therapy

Peter Fraenkel

Published online: 7 May 2009

Abstract This article describes the Therapeutic Palette approach to couple therapy. The Palette is organized in terms of three domains: Time Frame (past vs. present vs. future), Degree of Directiveness, and Change Entry Point (emotions, thoughts, behavior, physiology), and assists clinicians to draw from different schools of therapy in a flexible and purposeful way. In contrast to more structured, sequential approaches to integrative therapy, the Therapeutic Palette is designed to allow shifts among different theories and practices within one session. A detailed case vignette illustrates the approach.

Keywords Integrative couple therapy · Marital therapy

Introduction

Faced with the inevitable deluge of the couple's behaviors, words, emotions, conflicting accounts of problems and differing preferences for solutions, the couple therapist can feel overwhelmed with choices about what to focus on at any particular moment of a session, across the whole session, and in the course of a therapy over time. The contemporary couple therapist must choose among a wide range of theories and associated practices within the couple therapy literature, with a simultaneous awareness of other types of psychotherapy (individual, group), other forms of treatment such as psychopharmacology, and the holistic body-mind approaches such as EMDR, somatic experiencing, and mindfulness practices.

During the fertile period of the 1960s through the early 1980s, many therapists aligned themselves with one or another school based on allegiances to how, and with whom, they were trained (Fraenkel 2005). However, contemporary therapists must reckon with the postmodern premise (Gergen 2002) that all theories are partial constructions and no one school of thought can have a superior fix on the "reality" of a couple's problems and solutions. This premise makes it more difficult to align oneself confidently with only one approach. Several therapists have proposed ways to integrate thoughtfully multiple approaches to couple therapy (see also Gurman and Fraenkel 2002 for review; Gurman 2005; Pinsof 1995; Scheinkman 2008).

This article presents an approach to drawing flexibly and purposefully among different schools of couple therapy, through the utilization of a Therapeutic Palette (hereafter referred to as TP; Fraenkel 1997; Fraenkel and Pinsof 2001). The TP is a heuristic metaphor selected to emphasize the need for a disciplined, yet flexibly creative clinical process, much like a skilled painter who draws from a palette of colors to create a unique piece of art. The painter is able to use accumulated knowledge of the history of painting, and yet is able to respond to current inspirations from among a varied set of refined techniques.

Rationale for a Flexible Integrated Approach to Couple Therapy

The first premise supporting an integrative approach is that "nothing always works" (Pinsof 1995). Couple therapy outcome research has not yet provided a definitive guide for selecting one approach over another. Several of the

P. Fraenkel (✉)
Department of Psychology, The City College of New York, Room 7/120, North Academic Center, 138th Street and Convent Avenue, New York, NY 10031, USA
e-mail: fraenkelorama@gmail.com

approaches that have garnered clinical, anecdotal support such as Bowenian, strategic and narrative therapies, have not been tested through empirical inquiry. Meta-analyses of couple therapy outcome studies repeatedly find that approximately two-thirds of couples in treatment improve, regardless of treatment model (Gollan and Jacobson 2002). The ecological validity of many family therapy studies has been critiqued because outcome studies carried out in a controlled academic context may not be applicable or relevant to practice that takes place in outpatient clinics or private practice (Wright et al. 2006).

While some conclude that couples (and therapists) must lower their expectations for change (Baucom et al. 2005), others argue that "pure-form" (single theory) approaches to couple therapy are not sufficient to meet the range of problems presented within particular couples or across the population of couples seeking treatment. Indeed, emerging research indicates that approaches integrating practices based on different theoretical perspectives show superior effectiveness (Baucom et al. 2005; Gollan and Jacobson 2002). Other research posits that the most potent change occurs during the micro moments between therapist and client, regardless of therapy model. Pinsof (1995; Pinsof and Wynne 2000) proposes research that tracks process-outcome links in integrated problem-centered therapy as a more productive focus for clinical research.

The second premise supporting an integrative approach is that couples often have their own theories about what will prove most helpful to them, as well as previous experiences in therapy that they wish to repeat or avoid. Couples who have been in or are presently in individual psychotherapy may have specific requests regarding the focus on past vs. present issues—some may want the couple therapy to take an approach similar to their individual therapy, and others want the couple therapy to take a different approach. Preferences for how to approach problems in therapy may also be linked to the couple's culturally-based beliefs about change, and the conditions under which they seek therapy. For example, Boyd-Franklin (2003), Falicov (1998), and Lee (1997) have, respectively, noted that, due to the continued stigma for African-Americans, Latinos, and Asian-Americans of seeking therapy and concerns about sharing private aspects of couple and family life with strangers, therapy may only be sought when there are action-oriented problems to solve. A therapist may incur a great deal of "resistance" or lose the couple altogether by forging ahead with an approach that the couple has explicitly requested not to engage in, such as in-depth exploration of feelings and family history, when they are requesting assistance with problematic communication; or, conversely, offering CBT communication skills to a couple that has asked for a more intergenerational/psychodynamic approach. Ultimately, the therapist's attentiveness and flexibility in response to the couple's demonstrated or described inclinations and preferences for taking particular therapeutic approaches may greatly affect the quality of the therapeutic alliance, which, in turn may affect psychotherapy outcome far more than the specific techniques utilized (Hubble et al. 1999).

In an era in which collaborative relationships between therapists and the persons seeking therapy are increasingly valued, the clients' knowledge about their problems, needs, solutions, and preferences for change processes are viewed as equally valid to those of the therapist (Fraenkel 1997; Gurman and Fraenkel 2002; Sheinberg and Fraenkel 2001). A truly consistent interpretation of the postmodern, collaborative ethic (Anderson 1995; Freedman and Combs 1996) would be to honor clients' requests for any therapeutic approach in order to create a collaborative relationship. The couple is invited to provide ideas, requests, and ongoing evaluative feedback to the therapist, who attempts to honor these by engaging all of the therapeutic resources at his or her disposal; who engages the couple in decisions about when to suspend one approach and take another; and who makes a conscientious referral to colleagues if necessary. Pinsof (Fraenkel and Pinsof 2001) notes that in drawing flexibly and thoughtfully on various approaches, the therapist models effective collaborative problem-solving.

The third premise of a flexible integrative approach is that multiple causes of distress require multiple, overlapping approaches to change. Pinsof's (1995) integrative problem-centered therapy, Scheinkman's (2008) multilevel couple therapy and the TP approach recognize the multiple levels of context, from intimate relationships to extended family, community, society, and environment.

Furthermore, successful treatment must respect partners' respective nexus of cultural and social locations affording them resilience, power, and privilege, or vulnerability, powerlessness, and marginalization (Boyd-Franklin 2003; Falicov 1995); their place in the life cycle and in their individually preferred plans for the future (Fraenkel 1994); life experiences such as significant stressors or traumata that highlight the salience of particular aspects of internal life and social context; individual biologically- and possibly genetically-based temperament, emotion regulation abilities, cognitive strengths and limitations, spiritual resources, physical health; and the degree of similarity or difference on all these sensitizing factors between partners. A critical area for ongoing assessment in all couples is power differences between partners, based (especially in heterosexual couples) on participation in larger societal narratives of gender roles (Goldner 1988; Goldner et al. (1990), but also based on differences in gender roles in gay and lesbian couples, or on class, income, education, race, immigration status, disability, and other dimensions of difference (see chapters in McGoldrick and Hardy 2008).

This comprehensive contextual perspective on couples requires a comprehensive approach to assessment, and several systemically-oriented texts have attempted to diagram such an approach (Snyder et al. 2002). However, few have incorporated the concept of the partners' "stories" or narrative accounts (White 1991). Ultimately, how partners view themselves in relationships, and how they view that relationship in the multiple contexts of their world, affects what they do and how they feel in relationships. Thus, in assessing couples, it is important over time to ascertain their experiences at all levels of context as well as how they narrate and otherwise represent their experiences and views of themselves in all these levels of context. The TP attempts to incorporate the concept of narrative through an expanded understanding of "representation," which has the added benefit of allowing an integrative link to contemporary psychodynamic theory and the social/relational development of the brain (Jurist et al. 2008; Siegel 1999). See Fig. 1.

Elements of the Therapeutic Palette

The Therapeutic Palette (TP) is a heuristic metaphor designed to guide therapists in flexibly selecting among different theoretical perspectives and their associated practices to best meet the unique needs of each couple in each session and over the course of therapy. Before proceeding to the elements of the TP, it is important to note that, far from being simply purely poetic, aesthetic expressions, metaphors are integral, practical aspects of theory utilized in all sciences (Lakoff 1993). Metaphors have a long history as useful tools in family therapy training (Duhl 1983). Although explicit, step-by-step treatment manuals have the advantage of concretely specifying therapeutic practices, researchers have noted that it is often difficult for therapists to adhere to such specificity without a high degree of external monitoring, a condition that is unlikely to prevail outside of carefully controlled studies conducted in university settings (Gollan and Jacobson 2002; Wright et al. 2006). In contrast, metaphors, if linked to a set of clear treatment selection principles, provide a broader, overarching sense of direction in making these choices. As noted earlier, at the current stage of research on moment-to-moment choice points, organizing metaphors may provide a more ready form of guidance than do manuals for the integrative couple therapist.

Fig. 1 Levels of context and representation of selves in relationship

Just as the artist draws from three primary colors, the TP categorizes three organizing themes: Time Frame, Degree of Directiveness, and Change Entry Point. Time frame refers to whether the focus is on the couple's *present* patterns of interaction, thoughts, emotions, and aspects of context (both challenges and resources); on the link between the present and *past* experiences (both in the couple's history as well as in partners' past relationship histories and their respective families and cultures of origin); or on the couple's plans and visions for the *future*. For instance, behavioral and cognitive-behavioral, strategic, structural, experiential, and emotionally focused couple therapies all focus primarily on the here-and-now of the couple's experience; Bowenian and other intergenerational approaches, insight-oriented marital therapy (Snyder 2002), and object relations couple therapy highlight the link between past and present; and solution-focused approaches focus on the future. Narrative couple therapy (Zimmerman and Dickerson 1993) bridges all three temporal frames. These different schools of couple therapy are organized by time frame in Table 1.

Degree of Directiveness clusters interventions contained within the variety of specific approaches along the continuum of the degree to which the therapist takes the role of facilitating a couple's existing strengths and resources, on one hand, versus the role of teaching or structuring, on the other. For instance, on the less directive end of the continuum are practices such as encouraging self reflection, or highlighting and encouraging exceptions and new narratives. Mid-range practices include pointing out or interpreting links between family-of-origin experiences and present patterns of experience and action. Practices on the high end of the directiveness continuum highlight the active role of the therapist as expert in providing psycho

education about particular psychiatric conditions, teaching communication and problem-solving skills, or taking firm positions about interrupting cycles of intimate violence. Table 2 clusters a number of common therapeutic techniques in terms of level of directiveness.

Change Entry Point centers on the relative focus on thoughts, emotions, behaviors, and physiology. For example, structural, strategic, and cognitive-behavioral approaches initiate change largely through the "portal" of behaviors. On the other hand, experiential and emotionally focused therapy highlight emotions, while intergenerational, narrative, and solution-focused approaches focus initially on beliefs. Therapies that begin with mindfulness practices engage partners first in relaxation and breathing exercises designed to reduce sympathetic (fight or flight) and increase parasympathetic (calming, soothing) nervous system response (Layton 2008). These different foci are presented in Table 1.

Three overarching principles guide which time frame, level of directiveness, and change entry point to select at any particular juncture of the therapy. Principle 1 is the Health/Resource Perspective: the assumption that couples have existing strengths, capacities, and skills that have been submerged by their sense of hopelessness in the face of their problem patterns, and therapy should first attempt to mobilize these strengths prior to taking a more directive, instructive approach. However, because couples often feel stuck in problem patterns by the time they seek therapy, the therapist should be prepared to be a bit more directive/instructive initially, and to move to less directive approaches once the couple has gained a greater sense of resourcefulness and hope.

Table 1 Therapeutic Palette: taxonomy of couple therapies by time frame/focus and change entry point

Time frame/focus	Change entry point[a]
Present-oriented approaches	
Cognitive-behavioral	B
Structural	B
Strategic	B
Milan strategic	C
Emotionally focused	E/B
Satirian	E/B
MRI	B
Mindfulness/breathwork	P
Past-to-present approaches	
Intergenerational/Bowenian	C
Milan systemic	C
Contextual	C
Psychodynamic	C/E
Narrative	C
Future-oriented approaches	
Solution-focused	C
Solution-oriented	C
Narrative	C

Adapted and updated from Fraenkel, P., & Pinsof, W. M. (2001). Teaching family therapy-centered integration: Assimilation and beyond. *Journal of Psychotherapy Integration, 11*, 59–85

[a] *B* behavior, *C* cognition, *E* emotion, *P* physiology

In addition to guiding decisions about degree of directiveness, the health/resource principle guides the therapist to focus on a particular time frame so as to encourage the couple to explore untapped resources. For instance, if they have a good sense of humor, or relatively easy access to their shared sensuality or sense of exploration, or have good communication aside from current conflicts, the therapist can suggest that the couple utilize these "present-tense" resources either in session or in activities between sessions. A couple that is blocked in current interactions but reports skill demonstrated in their individual and shared history, might be guided to revisit past successes in order to re-inforce a sense of competence and coherence.

Principle 2 is to Balance Support of the Existing System with the Need to Introduce Novelty. At the simplest level, this principle suggests that the therapist establish with the couple what is working for them in their relationship, and determine what they have tried in attempting to address their difficulties, before introducing new ideas and practices. On a more subtle level, this principle also guides the therapist to listen carefully to verbal and nonverbal signals indicating what time frame, level of directiveness, and change entry point is most available to focus on and utilize at any given moment. For instance, if in the course of describing a difficult interaction about money, one partner makes reference to how his or her parents seemed never to agree about money, the therapist has an easily accessible entry to the past, and what each partner witnessed in their parents' relationships. Or, if one partner comments that conflicts about money make her worry that they will have no viable future, the therapist might choose to explore each partner's vision of the future (Fraenkel 1994, 2001).

The key to this flexible, non-threatening approach of inviting novelty is to be sensitive to spontaneous openings presented in the in-session interactive process. This approach differs from more structured approaches to assessment that systematically and sequentially probe the partners' present interactions and backgrounds (Scheinkman 2008; Snyder et al. 1995), but shares with these approaches the need to be aware of multiple domains of influence on couple experience and interaction.

In the TP approach to integration, the three primary colors of therapy are used to gradually "fill in" the initial "sketch" presented by the couple. Over time, the "sketchy" initial understanding is enriched with color and texture in a kind of "paint-by-numbers" drawing. Rather than

Table 2 Couple therapy interventions by degree of directiveness

Couple therapy approach	Low directiveness	Medium directiveness	High directiveness
Structural-strategic	Tracking, joining, mimesis	Positive reframes and enactments; assigning straightforward intersession tasks	Unbalancing, ordeals and paradoxical directives, use of self to build intensity
Intergenerational	Constructing genograms	Engaging one partner to speak while the other listens; noticing intergenerational themes	Coaching in approaching and differentiating from family of origin members
Narrative	Highlighting subordinated narratives and strengths	Externalizing conversations	Vigorous deconstruction of problem narratives
Cognitive-behavioral	Recording antecedents and consequences surrounding problem interactions; identifying expectations and hidden issues	Reinforcing spontaneous in-session positive interactions; suggesting more balanced initiation of couple behaviors (housework, sexual intimacy)	Teaching communication and problem-solving skills; sharing research findings about particular disorders (psychoeducation)
Solution-focused	Highlighting exceptions, scaling	Miracle question, eliciting images and conversations about preferred futures	Firmly blocking or attenuating couple's repeated description of problem pattern, redirecting toward preferred solutions
Emotionally focused	Reflecting emotional experience, validation, tracking, reflecting, and replaying interactions	Evocative responding, heightening, empathic conjecture and interpretation, reframing patterns in terms of attachment processes	Restructuring and shaping interactions
Mindfulness	Noticing and encouraging spontaneous deep breathing and focus	Teaching specific meditation and mindfulness practices	Teaching Beginning Anew or other Buddhist-based relationship healing practices
General couple therapy practices	Inviting each partner to express his/her feelings and perspective; offering support and validation to both partners; encouraging self-observation/reflection on problem patterns	Pointing out problematic styles of interaction occurring in session and setting guidelines for in-session interaction	Emergency procedures for managing violence against self or others; engaging legal, medical, and other agencies

completing one section of the "painting" (for instance, the couple's current problematic interaction patterns) before moving on to another section (for instance, their respective family- and culture-of-origin backgrounds), the therapist follows the lead of the couple as partners move among different concerns and demonstrate certain aspects of their experience. Furthermore, increased understanding and the interventions used to stimulate novelty and change occur simultaneously. For example, if newly acquired communication skills lower the level of mutual animosity, a couple may be better able to access, explore, and describe painful experiences in their families of origin.

This flexible approach is based on the belief that the flow of couples' experiences within and between sessions, and the events that make one or more aspects of experience, vulnerability, resource, and context more salient, do not adhere neatly to a precise therapeutic plan. In this respect, the approach represented by the TP differs from more structured, sequential approaches proposed by Pinsof (1995) and more recently, Scheinkman (2008). The TP suggests that several foci may occur within one session. Any intervention may support several different theoretical perspectives simultaneously, like overlapping lenses that create a kind of "convergent validity." This is similar to anthropologist Clifford Geertz's (1973) concept of "thick description," as an intervention that is supported by two or more theories simultaneously gains a kind of "thick support" or "thickened value and intentionality." For instance, teaching (or at least encouraging) a couple to use more equitable, non-aggressive communication is simultaneously supported by a cognitive-behavioral theory promoting acquisition of skill; by a feminist couple approach that seeks to promote greater equality and less intimidation between partners; by a structural couple therapy that promotes increased closeness between partners; by emotionally focused couple therapy that values the opportunities for couples to express deeply held, vulnerable emotions; by a psychodynamically-informed couple therapy focused on increasing each partner's capacity to reflect on the mind of the other; by an attachment-based therapy seeking to improve neuro-physiologically determined emotional regulation (Atkinson 2005); by a family-of-origin approach seeking to interrupt inherited distance-promoting interactions; and by narrative couple therapy that values opportunities for each partner to share their respective perspectives in order to attain a more "preferred story."

Rather than attempting to master each of the distinct therapy approaches, it may be sufficient to develop basic mastery in one approach, and to assimilate new ideas and practices into existing therapeutic skills (Fraenkel and Pinsof 2001). Although each approach to couple therapy utilizes specific theoretical constructs and refined interventions, the TP provides a rationale to weave diverse interventions into a cohesive, integrative couple therapy. A comparative analysis of the different therapy models indicate that all engage in some version of observing, summarizing, empathizing, and suggesting. The TP draws from the collective set of possibilities in order to create a therapy that is most sensitive and responsive to the couple's strengths and needs at any particular moment.

As noted earlier, an integrative therapy approach requires a comprehensive yet simple guide to assessment. Figure 2 presents a simple and useful integrative visual map that summarizes the large amount of information obtained while assessing couple difficulties and desired change. A great deal of research in social, clinical, and personality psychology has identified two fundamental, orthogonal (independent) dimensions of relationships in general: on the horizontal axis, degree of closeness/connectedness/involvement, from high to low, and on the vertical axis, degree of symmetry in power or influence, from highly symmetrical to asymmetrical. Couples can be mapped in any one of the four quadrants created by these intersecting dimensions, either in terms of particular interactions or for their relationship overall: high closeness/high power symmetry, high closeness/low power symmetry, low closeness/high power symmetry, low closeness/low power symmetry. In addition, three variables should be considered: each partner's respective *perceptions* of their degree of closeness and power symmetry; each partner's respective *preferences* for degree of closeness and power symmetry; and the *therapist's perceptions* of the couple's placement on these dimensions as indicated by their verbal and nonverbal behaviors.

In line with the flexible, client-determined agenda advocated by the TP, the therapist's understanding of the nature and sources of couple difficulty and resources accumulates over time as the couple guides the therapist towards the salient as well as unspoken aspects of their experience.

Case Vignette

The following detailed description of a session illustrates the use of the TP to negotiate a juncture in the therapy in which a couple was considering prematurely terminating. Rob 36, and Jill, 32, a middle-class white heterosexual, Jewish-American (nonreligious) couple living in an "artsy" section of downtown New York City, had been together 5 years, and married for one and a half years. Jill was an associate director for a non-profit arts organization; Rob was a professional musician. In the initial phone call, Jill said they sought therapy because of frequent arguments. On a few recent occasions, these had escalated to the point where Rob threw dishes and punched the wall. He had never directly struck Jill or threatened to do so; but his behavior left her intimidated and "uneasy."

In the first session, the couple reported that many of their arguments centered on Jill's concern that she was providing most of the couple's income; Rob did not have steady paying work as a musician, and refused to get a non-music "day gig." He spent much of his time on recording projects that did not have immediate prospects of earning money; so while he was busy, he was not earning much. Rob acknowledged that he was "sensitive" to moments when Jill was not "fully supportive" of his pursuing his musical career. Jill noted that, coming from a family that declined from middle to lower-middle class when she was a teenager, she had worked since age 13 to provide herself a financial base. She worried that with Rob she had ended up with a man like her father who would not contribute adequately to their financial resources. On the other hand, she acknowledged his talent as a drummer and wanted to see him "go for his dreams."

Jill reported feeling "unsafe to communicate my truth in the marriage." The couple described a classic symmetrical pattern in which Jill would tentatively voice her upset about the "work situation," Rob would become defensive, Jill would get more vocal but also more anxious, Rob would become increasingly belligerent, until Jill "gave up." Following these arguments, they often would go for days without speaking with each other. The last 2 weeks were characterized by almost complete distance and silence between them. As a result of these conflicts, their sex life and general enjoyment of time together had markedly declined.

Jill and Rob met in an inpatient drug and alcohol rehabilitation facility; neither had used substances since that time. Both had a fair amount of previous experience with therapy—group therapy while in rehab and six (Jill) to eight (Rob) years each of individual, psychodynamically informed therapy. They both attended Alcoholics Anonymous, and Rob also attended Narcotics Anonymous. Over the past year, Jill had been prescribed and was taking antidepressants. In the first session, we also briefly explored their family-of-origin histories, and I learned that both came from families in which there was a fair amount of verbal and physical aggression. Jill had felt frightened and oppressed both by her father's verbal abusiveness towards her mother, and by her mother's frequent humiliating treatment of her. Rob's father had beaten him frequently, and Rob ran away from home at age 16. Rob also shared with me that he was deeply immersed in the literature of the men's movement—Robert Bly, Joseph Campbell, and mythological models of male relationships and power.

Rob was clear from the beginning of the first session that he did not see their problems as requiring therapy, but was willing to try it. He felt Jill unduly "shamed" him about his level of contribution to their finances. Based on his involvement in men's groups and his reading of the men's movement literature, he believed that part of the problem was "Jill's fear of archetypal male power." He clarified that he did not condone violence, but felt Jill was too sensitive to the times when he insisted on doing things his way. Again, Jill reiterated that she was torn: on the one hand, she was supportive of Rob pursuing music and his education (he had recently enrolled in a GED program to complete high school)—"I don't want to put out your flame or tread on your creativity"—on the other, she wanted to be "with a man who's self-supporting and helps me support myself." She hoped that therapy would help them find a compromise, and he agreed that he needed to do more to "build the third entity—us."

Thinking about this couple in terms of the dimensions and perceptions of power symmetry and closeness diagrammed in Fig. 2, it seemed each perceived the other at times to disrupt their balance of power: Rob felt Jill used her steady job and higher income to set terms for what he could or could not do with his career; and Jill felt intimidated by Rob's defensive responses. I observed Rob speaking and acting in ways that intimidated and constrained Jill, whereas Jill seemed repeatedly to back down and placate rather than exert power over Rob. This power struggle greatly disrupted their sense of closeness and connection, which at other times was quite strong.

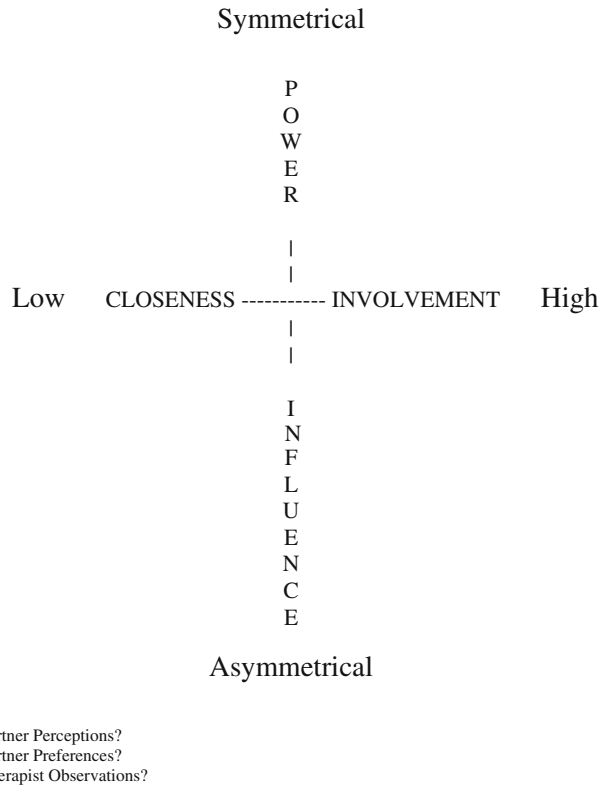

Fig. 2 Map for assessing power and closeness in couple relationships

Having spent most of the first session learning from the couple about their challenges and goals, I then described to them my approach to couple therapy as a combination of "action and insight." I explained that I work with couples to increase insight by exploring partners' beliefs and feelings about one another, and the influence of experiences in their families of origin in shaping these beliefs, feelings, and sensitivities; and that I also work with couples to develop new, preferable ways to interact with one another. I invited them to tell me how they thought we should begin—exploring their experiences in their families, or working on communication and other aspects of their interaction. Both partners felt they did not want to begin by talking in detail about their families of origin, having done a lot of that in their individual therapies. Given the painful intensity of their conflicts, they agreed to focus first on changing their interaction patterns.

Based on the TP's health/resource principle, I always try first to take a less directive approach that builds on the couple's existing capacities. I explored their existing communication resources; yet even with encouragement to locate positive exceptions, they could not recall a time when they had communicated well about problems. Nor did they believe their parents provided useful models for couple communication. Therefore, they agreed to have me teach them the communication and problem-solving skills from PREP® (Fraenkel and Markman 2002; Markman et al. 2001), which I did in the following three sessions. PREP® involves providing research-based information about communication patterns associated with relationship distress and dissolution, followed by coaching the couple in the Speaker-Listener Technique, a version of "active listening" in which each partner has the opportunity to be the speaker and the listener several times over the course of a conversation. When in the role of speaker, the partner speaks for 10–15 seconds using "I statements" and the listener "paraphrases," repeating back what she/he heard, and being corrected by the speaker for accuracy as necessary.

After a first week of introducing this material and a short practice session, and a second week focused on coaching in the technique, I then taught the couple PREP's structured problem-solving format, as well as an approach to identifying the "hidden issues" around closeness, power, and respect that underlie persistent arguments. The couple learned the skills readily, and both agreed that despite it feeling a bit "artificial" and "stilted" to communicate in this manner, they could see the benefit of this approach over their highly conflicted style. Jill seemed more enthusiastic about the skills than did Rob, who focused a bit

more on the artificial quality. Indeed, at the outset of the following session—the focus of this detailed integrative process case study—Jill notes that Rob told her he wants to end the therapy.

It is the therapist's capacity to "inhabit" or keep in mind the three primary colors of the TP—the time frames of past, present, future, the range of possible levels of directiveness, and the entry points of emotion, thought, behavior, and physiology—that attunes her/him to potential openings offered by the couple's ongoing verbal and nonverbal expressions. In the present session, I engaged theories and practices from across the range of each of the primary colors of the Therapeutic Palette: cognitive-behavioral, collaborative, strategic, structural, attachment and emotionally focused, and narrative.

Because the usefulness of the TP is best revealed at the micro, moment-to-moment level of therapy process, I will present and then comment upon (in italics) verbatim segments of this session and how I reflected upon and negotiated the choice points using the TP.

Jill: Can I talk? (chuckles)
Rob: No way! (joking tone)
Jill: Rob was thinking about …
Therapist: Great Start!

Rob is poking fun at the egalitarian aspect of the Speaker-Listener Technique. From a feminist structural family therapy perspective, I wonder if something about using the technique has disrupted their imbalance of power, leading him to feel threatened by Jill's increased opportunity to be heard. As part of ongoing joining, and to strengthen my relationship with Rob, whom I already knew was a bit less enthusiastic about the therapy in general and the communication skills in specific, I decide to join in the banter and tease him back.

Jill & Rob: (laughs) Yeah
Rob: I heard you say "Can I start?"
Jill: Yeah, you're correct, I did say can we start. See? We've been practicing our exercises.
Rob: Is that an accurate paraphrase? (smirking slightly)
Jill: Rob brought up the fact that he wanted to come and close out, because he felt like we could do this on our own, and buy a book and look at a book and do exercises, and he'd be committed to doing it out of the book, and I said hmm, you know, I'm not ready to do that, but I'll think about that. And then I thought, hmm, well maybe he's right, because that's what I do—I don't think and I turn it over to Rob, I turn it over to the man in the relationship. And the different thing I did this time was to talk to other people who had been to therapy. And talking and thinking for myself. What I feel good about is in these sessions, I feel more comfortable and at ease bringing up topics that I don't really feel comfortable discussing with Rob alone. And I think also what has helped me in these sessions is that you have a third eye into the relationship, a third more, you know, not as biased or judgmental, and I think when I get with Rob, I get into Rob's shit, and I'm not focused on my own stuff. And I don't feel as able to communicate as easily, and I've seen the benefit of the few sessions we've had so far. I mean, this weekend, I want to say I was out of the depression, finally, because I had energy, I wanted to do things; I wanted to communicate with Rob more than just the surface, superficial level. You know, really let him know what's going on in my mind. (Rob leans over and takes a sip of his drink; Jill pauses abruptly for a moment, as if on alert, then continues as Rob sits back in his chair.) I think, Monday night or Tuesday night, we brought up the work issue again, and it got pretty spicy; I mean, the good thing was I can talk about, you know, here's how I feel about your work issue. And he talked, and we got this anger out and then we were friends again, so it didn't just like… there wasn't this low-grade fever or tension underneath the relationship. So that's been what's up for me. I'm committed to being here, and this process, because that's how it benefits me.

I sense that in this session, I will need to enable Rob to feel more in control but without silencing Jill. To achieve this using the TP, I decide to shift my Degree of Directiveness, moving from the directive activity of teaching them skills, to a less directive stance in which I am focused on listening to their feelings and supporting their existing strengths and perspectives.

Therapist: (turns to Rob) And how about you?
Rob: (slouching back in his chair, as if to show disengagement). Um, Yeah, my feeling after last week was that I sort of sensed that the reason we had come was that the stress on our relationship had to do with money and my work, and us not spending time together, and it seems like when we spend a lot of time separately, demons sort of appear that, it's really easy to take, for me, it's really easy to take Jill's negative inventory as long as I'm not in daily contact with her, like if I'm not in daily contact with her, the demons appear saying…you know, taking her negative inventory in some way. And so, things have felt a lot better since July began, and I also sensed that we weren't doing anything in here that we couldn't do on our own, given the time to sit down and communicate. I think we also have real good recovery relationship skills, communication skills, already, and I sensed that we were really starting here from, and I need to preface that with perhaps that's how this process works, but we were starting with very basic building blocks, and you were getting to know us, and

saying, well, why don't you try communicating this way, and it seemed very kindergarten-relationship therapy for people who were having real communication problems, or real uncommunicated stuff, which I don't think we have a lot of uncommunicated stuff at all, only because we're both in recovery processes, where we've both been in therapy, and we go to 12-step meetings and have networks of people who share their feelings and keep stuff on the table, and we're constantly working on ourselves, so it's a little … it's different than a couple that have friends who don't do anything like that, nothing at all, so a lot of things go uncommunicated. But I wanted to give the benefit of the doubt to actually this process, because I mean we just warmed up and you're just getting to know us, and I don't really know what this style… I've actually never been to couples therapy, so I don't know what it is, although I've been in the deep water with other kinds of therapy, so there was that, and I want to give the benefit of the doubt to the process, and also Jill seems to desire to continue just to see out of curiosity, I mean I don't see any deep dark stuff that we're not communicating, but like she said, she feels a little safer with a third party, just by, in some ritual sense perhaps, that we're witnessed in communication, and maybe there's some benefit in that, and so if she feels safer, I'm not under extreme protest, but under slight misgivings, I'm showing up. I'm willing to extend myself.

Therapist: That's good.

Jill: And now I feel totally patronized, like I'm taking this out, like I feel patronized like you're just coming here because I want to be here and this will help me because I'm the (Jill quotes with her hands) "sick" one, and I have this whole scenario with me being the "sick" one. Sometimes, Rob, I get really angry and resentful of you because it sort of sounds like you're not a part of this at all, and you've been as quiet as I have these last few months, not addressing any of the issues, sort of letting them lie and like, waiting until we talk about it. That's how I project them anyway. That's my projection.

Rob (sitting up more now) I don't get that, and I just want to put on the floor that I'm not here being a martyr, and I'm not here just patronizing you saying (in a mock dejected voice) "you're unhappy and I'll go along with it if it will make you happy." (Jill nods in understanding and approval) I did say that I see that the process, I don't claim to know what the process is, and I want to give it the benefit of the doubt. I did state that I had doubts, and I would like to give it the benefit of the doubt.

This conversation presented an opportunity to establish a collaborative stance that encourages participants to be active in shaping their own therapy. It furthermore overlapped with my early training in strategic family therapy, in which "resistance" is handled through positive connotation and prescribing it (*Haley* 1987)*, as follows:*

Therapist: And I want to say something about those doubts; I think that's terrific, and I want to say also that it's really useful for at least one person in a couple to have some doubts about the process, because what that does is keep us sharp, and keeps us really energetic and focusing on what's going on, and then keeping in mind what shouldn't go on.

Rob: I agree, and in the therapeutic process it's always good that we don't have a belly-up client who will come forever, and think you come in, and the therapist is like "We'll go on forever."

Therapist: (Pointing to myself), Not this one, though (smiling).

Jill & Rob: (laughs) Okay, good.

Therapist: Not this guy (jokingly, in the kind of "hipster" style that the couple uses when joking around; couple laughs loudly, with apparent relief. Then I shift to a sincere tone), So, just to highlight this, keep being skeptical (looking at Rob), as long as you feel you want to take that role, and maybe at some point (I turn to Jill) you may want to be skeptical. Because that keeps us jumping and it keeps me alert to the idea that you want to move to independence from therapy as soon as you can, and that's great.

Rob: Yeah, (looking engaged now) and to complete that, I think it's two-fold, I have a skepticism or doubt, I'm knowledgeable, and it's an informed skepticism; I've been in therapeutic processes a lot, so I know how it works, however, I am also skeptical or suspicious of my own denial. (Jill nods and gives an agreeing response) And that's why I show up, because denial for me is so insidious that I'm never sure what I am hiding, so in that sense I want to say that I want to reiterate, or further confirm that I'm not showing up to patronize you (directed to Jill), but I know I have plenty of denial in my life. If I can discover that and uncover some stuff here that's great.

Jill: That's really good to hear, that feels really good, and I think also that for me as a patient, I feel like I have a responsibility when something that's not working in this process, I can say "Hey that's not working for me", and that's OK to say in this process, and also if I want to do something specific (Jill seems to become a bit more relaxed: she uncrosses her legs, readjusts pant leg, and recrosses her legs, and leans toward Rob a bit), I don't know, role play or something, or whatever I want to do, then I can suggest that.

Therapist: Absolutely.

Jill: I mean as far as the exercise thing (referring to the Speaker-Listener), it's pretty hard for me not to joke with Rob about it (because of its artificial quality), but then we talked on the phone a lot so there was this one time that it was a real issue that we got to use that whole play out. And it worked great.
Therapist: (To Rob) Do you agree?
Rob: Uh huh, it did yeah.
(long, thoughtful pause)
Rob: That technique seems to, for me, open up communication that normally wouldn't be open so directly. So that you get to confirm what you're trying to say, slowly if necessary, and be heard and confirmed that you're being heard. And, thereby avoiding or sidestepping any possible hurtful or damaging miscommunications…But it was good, I mean, it was good when we did, it was good just to…
Jill: And knowing that they're those tools I think I feel safer to, like I did on Monday night to say what I was thinking about your work stuff that night.
Rob: I think I must have some sort of desire, maybe it's a male thing (laughs), I want the heavy machinery (Jill laughs), I don't want you to give me a spade, I want a back hoe, you know.
Jill: (laughing) He's not kidding, that plays itself out literally.
Rob: (laughing) It does.
Therapist: Well, what would look like heavy machinery to you?
Jill: At least a weed-whacker, Honey.
(all still laughing)
Therapist: Because that's important, maybe there's something that you've got in mind that I need to know about.
Rob: I don't know, teach us how to do a Spock Mind Meld
(everyone laughs)

In applying the TP, several interpretations and possible responses came to mind. In a dramatic turnaround, Rob has acknowledged that the communication skills he had mockingly characterized as "kindergarten therapy" have been useful to them, and in a humorous way, states that the couple's difficulties may require more intensive assistance than the techniques being offered thus far. Interestingly, although he's suggesting that he still wants direction/instruction, he seems to be implying metaphorically that he'd like more of a focus on emotions than on communication behavior. This is an important shift, from initially minimizing the severity of their difficulties, to overtly recognizing that there are significant issues facing them. His humorous request to learn the Mind Meld technique used by the alien Mr. Spock in Star Trek suggests a number of related themes: that Rob wants to become emotionally closer with Jill, possibly revealing that he has a more anxious-ambivalent insecure attachment style than would be surmised given his more frequently-expressed, more avoidant, or pseudo-secure "take it or leave it" stance; that he wants a quick way to achieve this closeness that is under his control and that doesn't require the complexity of having to recognize and hold in mind her perspective and desires when they contrast with his own (in Star Trek, the Mind Meld technique allows the "melder" to know and fuse with the other's mind without allowing access to his own mind); and that he would like to be able to control Jill's mind better, or even eliminate her mind as separate from his—as the Mind Meld can be used to take control of an enemy. I use this information to sketch an important area of inquiry that will need to be filled in at an appropriate opportunity. In terms of the Change Entry Point, I realize that the therapy needs to shift from a relative focus on behavior change to a greater focus on emotions (Woolley and Johnson 2005).

Jill: A lot of times I just project onto Rob that he's this sort of omnipotent force in the relationship and that it's my duty to go along with what he says, and then I end up really resenting it, and that's definitely my stuff. And it's also manipulation; he pointed it out just with the Japanese food suggestion, (Rob: Yeah) I mean you know, he wanted to go for Japanese food, and I didn't, and that was a way for me to get more power and more fuel for the anger and rage against him, just to, you know, to go along with it and say 'fine' and smile when I really didn't want to go for Japanese food.

It seems that the couple is strongly tied to the "addiction/co-dependency" themes that are popular in recovery communities, but I am also focusing on the power dimension. From a feminist perspective, Jill's formulation seems to me overly complicated and obscures Rob's real assumption of gender-based power and his tendency to force Jill to do what he wants through persistence and threat. I decide to clarify their belief as a first step towards challenging it.

Therapist: Let me clarify something. The manipulation is what?
Jill: There's a manipulation so I can get more rage and fuel my anger by not speaking up for what I want and going along with him, and getting even more pissed off at him because he's such a jerk.
Rob: It's set up to build, (to Jill) let me interpret from yours, I think it's a set up to build herself up by giving me ammunition to put me down. In other words (Jill: Yeah) I'm ok, because you're an asshole. There are times where you will assert yourself, and I go into my manipulative child trying get what I want. You know, "I want ice cream," and using every, you know, every form

that I can, any kind of sweetness or whining to get my way, even when once you've asserted yourself, I'll go after you to try and break you down.
Jill: Can you give me an example within our relationship that happened recently?
Rob: I know that my will (looks to therapist) and I'm incredibly willful, meaning how I go about getting the things I want, it doesn't matter, I'll try any form of manipulation if I decide I want something, if I decide I want to go to (Jill: the auction) the auction in town, I'll try any which way, "we're going to the auction, first of all, we're going to the auction", and I'll try and break you down, you don't want to go, and I'll work on it. You know go to the lake instead. Is that a good example?
Jill: Yeah

The couple enters a spontaneous role play of a recent time at their small country house where they each had a different idea about where to go swimming, and through interruption, whining, persistence, and threat (to take their dog with him, leaving Jill alone) Rob got Jill to go along with his wishes.

Rob: (finishing the role play): Go ahead…just come to the lake with me. Come on.
Jill: (to therapist) See and now I don't know how to get out of this. At this point, I have no patience, I'm frustrated, "fine I'll go to the lake with you," that's it. And then I'm in the truck on the way to the lake, staring out the window (brings leg up to chest), just staring, just totally out, I might as well be on the roof looking down. I'm not in my body.
Rob: And you go into the water, trying to like it.
Jill: Yeah
Therapist: So do you know that she's in this state?
Rob: Yeah!
Jill: I spend a lot of time in that kind of state, too.
Therapist: (To Rob), So, that's kind of funny, you don't like when she's in that state.
Rob: It feeds my shame.
Therapist: It does?
Rob: Oh absolutely, as a shame-based person, I seek a shamer, I seek a damager.

The couple continues to employ recovery concepts that have been helpful in ending their addictions. I am aware that this was the physical and psychological space in which they met and fell in love, but wish to expand the level of awareness that they operate within. The couple's creative utilization of metaphor and their capacity for humor and role play, support my shift to a narrative perspective to assist them in speaking more directly about emotions. I choose to offer an externalizing intervention.

Therapist: I just was wondering if this is the shame saying…
Rob: (nodding in agreement) I set it up.
Therapist: (continuing in a slightly humorous masked voice…) I'm going to create her being down and angry, and I'm going to feel bad about it, so we can go off to the swimming hole and she's depressed, and I'm a jerk, and everything's fine.
Rob: Exactly! (laughs)
Therapist: So these are, this is the shamer taking charge of you (points to Rob), and having a very powerful impact on you (to Jill), with you helping out the shamer in him. (Rob sits back in his chair, looking reflective)
Jill: What I don't understand is how this changes.

In confirming the couple's readiness to work from this perspective, I return to my earlier invitation to have both partners join me in critically evaluating how we work together, and confirm the usefulness of shifting from one therapeutic approach (cognitive-behavioral) to a combination of narrative and emotion-focused.

Therapist: (Rob leans forward, towards therapist) Would it be possible for you (to Rob) to take an even more active role in labeling the shamer with a name? There's a way in which labeling these processes in ourselves can sometimes really help put them outside, and then you can be watching how that voice comes in and starts taking over, and starts running your emotional-relationship life. You said there's a way in which you create a situation that's dependent on making you feel bad. Do you have another name you want to give it? I know it may sound like "kindergarten therapy"….
Rob: (shakes his head to signal "No" in response to my comment that this might seem too "kindergarten" for him, and continues addressing my suggestion about naming the shame): It doesn't feel so (pause), at this moment and generally in my life, it doesn't feel like I'm separate from it. That I can separate. At least lately it's been, I mean I've been pretty depressed too, I'm identifying with it as me, not as a part of me or separate from me, so it's not easy to just give it a name.
Therapist: Oh it won't be easy, necessarily, or then again you might have a moment of inspiration.
Rob: So we're trying to name the demon.
(Therapist: Yeah)
Rob: And so we're going to personify it somewhat.
Therapist: So it really captures what it does to you or what it appears like. So that when you start getting into the process we can start talking about it say, well there goes…
Jill: (with an expression of excitement at getting the idea) And replace it with something else!
Therapist: Yes, and take action against it. Do you see that?

Jill: Yeah, it reminds me of an exercise we did in rehab one time…
Rob: The image that surfaced first is, what movie was it? *The Fisher King*, did you ever see that movie? The dark knight, with the horse and big things flowing everywhere and this fierce thick wood thing coming after him… Some sort of dark knight…
Therapist: Keep going, because I think you're on to something here.
Rob: Yeah, I'm trying to think of some old English name, because it keeps it from being superficial…I want to give it something that's separate from everyday English, so it can have more majesty. Ha ha, "Your Majesty," because I definitely pray to that throne. That Dark Knight. (long pause, looking thoughtful) something demonic and Old English…(pause) and it starts with a "V."
Therapist: Yeah, definitely. (To Jill) Does that image conjure up something for you?
Jill: I'm thinking about how his intellectual abilities and his ability to manipulate, I immediately think that I'm the dumber one, that I'm the dumb one. And my mother and father, that's their relationship.
Rob: So you've got your own private demon working on you. (Jill nods)
Jill: Yeah, he's the one that's more intelligent of the two of us, and I'm *really dumb*.
Therapist: That's what you think.
Jill: That I'm really dumb. So I shouldn't even play this game, just give it to him.
Therapist: It may be that that voice and that message in you deserves also…
Jill: That's my shame?
Therapist: Well, I don't know if it's a shamer, if it feels that way, you haven't talked about it as shame, maybe it has a different quality. Maybe for him, he's talking about shame, and for you, you're talking about something else.
Jill: It's "Rotunda," that's what I call it.
Therapist: You have a name for it already?
Jill: Yeah, Rotunda.
Therapist: Rotunda. What is that?
Jill: Yeah, this fat thing, which also goes back with my mom. Yeah, Rotunda. That's what it is.
Rob: It sits on you.
Jill: Yeah, it squashes me. It squelches me. I just came up with it now, that's what it is.
Therapist: That's interesting, this is good. (To Rob) you're getting very close, you've got an image and a beginning name "V" the Dark Knight, and an approach to finding a name for this thing. (To Jill) And you've got a name for it and an image.
Jill: Which just came out here, I mean it came out of nowhere. Which is cool. And it fits.
Rob: (To Jill) And I want to say that I totally identify with you sitting there. There was an interview that I have on tape you can watch of …
Jill: Charlie Rose?
Rob: That girl that, what's her name…Sarah Jessica Parker. And in this interview, I was watching her thinking the same thing.
Jill: That you are more intelligent?
Rob: No, that she's really intelligent. And I'm dumb, I'm never going to be intelligent like her.
Rob: Her and Matthew Broderick, they're a couple and they're both really intelligent and well read, and come from very schooled, nurturing families, and I'm damaged goods (Jill nods empathically, as if to say, "That's how I feel about myself"), and I'll never be smart like …I'm the dumb one. I'm a member of the mediocrity. I just wanted to say that I *totally* …that's exactly, when you were talking about it sitting and looking at me, I was like, "boy, I do that." (Now reflecting again on his externalization of shame): Or it's that dark thing ….that Dark Knight. He has a coat of arms. I just got a view of it.
Therapist: Part of what may be hard for you both that doubles the difficulty you have, as Rob said, is that the two of you share at least in a schematic way some similar kinds of experiences in your life, of a feeling like family was a very difficult place where you got put down, and (looking at Jill), I would guess that you sense that in him, that you (looking at Rob) feel that way, too, more than sense that, know it, and that may make it harder at times for you (looking again at Jill) to stand up for yourself.
Jill: Because I'm trying to protect his feelings and that's a biggie for him already.

The couple's engagement of the narrative practices I introduced facilitated their experience and expression of vulnerable emotions, which in turn broadened the Time Frame Focus of the therapy from a focus on the Present (*power inequities played out in communication*) *to the link between these behavioral patterns, their emotions, and their respective traumatic family-of-origin experiences.*

Therapist: I think if each of you can think of steps, small things like little micro moments that start to loosen up the grip for you of Rotunda, and you, the Dark Knight, that's where you can start to loosen up this part and start reducing it's effect on your life. One thing you could do is, if you (Jill) feel Rob is starting to push you into decisions you're not happy with, you might say, "I feel the presence of the Dark Knight." And then Rob, you could stop pushing and shift into a more open conversation. And if you (looking at Rob) sense that Jill is starting to get quiet and back down in response to you,

you might say, "I feel the presence of Rotunda," and again, move into a more open way of deciding whatever it is you're deciding.

Jill: I hope that during the week while we're away we can start talking this through because I need some more clarity, it's a really important piece.

Rob: Yeah, wow. (pause, looking thoughtful)

Therapist: You said "Wow."

Rob: I've never put shame as an intelligent opponent with a will that desires to see me destroyed. I just actually had a visualization of it, of the same exact thing, of me there, and him coming with his lance and (sound effect) takes me out like that. It gave me the feeling instantly of sadness and compassion for me, which I generally don't have.

Summary

In the remaining sessions, the couple continued to examine the concepts and perspectives opened up in this session. Sharing vulnerabilities allowed them to refine new-found, more collaborative and respectful ways of talking about problems. In describing themselves and their relationship, the couple shifted away from the language of the recovery community and the tropes of the men's movement, into a language that allowed them to name vulnerable emotions (anxiety, fear, frustration, sadness, loneliness). Each became better able to note moments when they felt the other was trying too hard to exert control or get their way, and instead, to see the other more compassionately and respond more kindly.

In refining the couple's understanding of the link between shame and power, it was important to return to their respective, traumatic experiences in their families of origin. Each came to recognize how their sense of each other as "damaged persons" formed a core of their initial bond. They shifted to a perspective that would allow them to support each other as resilient survivors of abuse, and challenge interactions that were built on old "damage" narratives.

The organizing metaphor of the TP and its three "primary colors" of Time Frame Focus, Level of Directiveness, and Change Entry Point, along with the two principles of Health/Resource and Balancing Support of the Existing System with the Need to Introduce Novelty, provided a parsimonious framework that enhanced my ability to track the flow of the couple's process, to conceptualize and release points of resistance, to locate openings, and to select flexibly and deliberately from several different schools of therapy often viewed as incompatible, including cognitive-behavioral, feminist, narrative, solution-oriented, emotion focused, family of origin, and structural-strategic. Utilizing the full Therapeutic Palette equipped me to work collaboratively with the couple to fill in the initial "sketch" of their difficulties, and to "paint" with them as co-artists a preferred present that equipped them for a better future.

References

Anderson, H. D. (1995). Collaborative language systems: Toward a postmodern therapy. In R. H. Mikesell, D. D. Lusterman, & S. H. McDaniel (Eds.), *Integrating family therapy: Handbook of family psychology and systems theory* (pp. 27–44). Washington DC: American Psychological Association.

Atkinson, B. J. (2005). *Emotional intelligence in couples therapy: Advances in neurobiology and the science of intimate relationships*. New York: W. W. Norton & Company, Inc.

Baucom, B., Christensen, A., & Yi, J. C. (2005). Integrative behavioral couple therapy. In J. L. Lebow (Ed.), *Handbook of clinical family therapy* (pp. 329–352). Hoboken, NJ: Wiley.

Boyd-Franklin, N. (2003). *Black families in therapy: Understanding the African American experience* (2nd ed.). New York: The Guilford Press.

Duhl, B. S. (1983). *From the inside out and other metaphors: Creative and integrative approaches to training in systems thinking*. New York: Brunner/Mazel.

Falicov, C. J. (1995). Training to think culturally: A multidimensional comparative framework. *Family Process, 34*, 373–388. doi:10.1111/j.1545-5300.1995.00373.x.

Falicov, C. J. (1998). *Latino families in therapy: A guide to multicultural practice*. New York: Guilford.

Fraenkel, P. (1994). Time and rhythm in couples. *Family Process, 33*, 37–51. doi:10.1111/j.1545-5300.1994.00037.x.

Fraenkel, P. (1997). Systems approaches to couple therapy. In W. K. Halford & H. Markman (Eds.), *Clinical handbook of marriage and couples interventions* (pp. 379–413). London: Wiley.

Fraenkel, P. (2001). The place of time in couple and family therapy. In K. J. Daly (Ed.), *Minding the time in family experience: Emerging perspectives and issues* (pp. 283–310). London: JAI.

Fraenkel, P. (2005). Whatever happened to family therapy? It may be in better shape than you think. *Psychotherapy Networker, 29*, 30–39. See also p. 70.

Fraenkel, P., & Markman, H. J. (2002). Prevention of marital disorders. In D. S. Glenwick & L. A. Jason (Eds.), *Innovative strategies for promoting health and mental health across the life span* (pp. 245–271). New York: Springer.

Fraenkel, P., & Pinsof, W. M. (2001). Teaching family therapy-centered integration: Assimilation and beyond. *Journal of Psychotherapy Integration, 11*, 59–85. doi:10.1023/A:1026629024866.

Freedman, J., & Combs, G. (1996). *Narrative therapy: The social construction of preferred realities*. New York: W. W. Norton & Company.

Geertz, C. (1973). *The interpretation of cultures*. New York: Basic Books.

Gergen, K. J. (2002). Psychological science in a postmodern context. *The American Psychologist, 56*, 803–819. doi:10.1037/0003-066X.56.10.803.

Goldner, V. (1988). Generation and gender: Normative and covert hierarchies. *Family Process, 27*, 17–31. doi:10.1111/j.1545-5300.1988.00017.x.

Goldner, V., Penn, P., Sheinberg, M., & Walker, G. (1990). Love and violence: Gender paradoxes in volatile attachments. *Family Process, 29*, 343–364. doi:10.1111/j.1545-5300.1990.00343.x.

Gollan, J. K., & Jacobson, N. S. (2002). Developments in couple therapy research. In H. A. Liddle, D. A. Santisteban, R. F. Levant, & J. H. Bray (Eds.), *Family psychology: Science-based interventions* (pp. 105–122). Washington, DC: American Psychological Association.

Gurman, A. S. (2005). Brief integrative marital therapy: An interpersonal-intrapsychic approach. In J. L. Lebow (Ed.), *Handbook of clinical family therapy* (pp. 353–383). Hoboken, NJ: Wiley.

Gurman, A., & Fraenkel, P. (2002). The history of couple therapy: A millennial review. *Family Process, 41*, 199–260. doi: 10.1111/j.1545-5300.2002.41204.x.

Haley, J. (1987). *Problem-solving therapy* (2nd ed.). San Francisco: Jossey-Bass.

Hubble, M., Duncan, B., & Miller, S. (1999). *The heart and soul of change*. Washington, DC: American Psychological Association.

Jurist, E. L., Slade, A., & Bergner, S. (Eds.). (2008). *Mind to mind: Infant research, neuroscience, and psychoanalysis*. New York: Karnac Press.

Lakoff, G. (1993). The contemporary theory of metaphor. In A. Ortony (Ed.), *Metaphor and thought* (2nd ed.). New York: Columbia University Press.

Layton, M. (2008). The soul of relationship: Where self and other meet. *Psychotherapy Networker, 32*, 34–39. See also p. 56.

Lee, E. (Ed.). (1997). *Working with Asian-Americans: A guide for clinicians*. New York: Guilford Press.

Markman, H. J., Stanley, S. M., & Blumberg, S. L. (2001). *Fighting for your marriage* (2nd ed.). San Francisco: Jossey-Bass.

McGoldrick, M., & Hardy, K. (Eds.). (2008). *Revisioning family therapy: Race, class, culture, and gender in clinical practice* (2nd ed.). New York: Guilford Press.

Pinsof, W. M. (1995). *Integrative problem-centered therapy*. New York: Basic Books.

Pinsof, W. M., & Wynne, L. C. (2000). Toward progress research: Closing the gap between family therapy practice and research. *Journal of Marital and Family Therapy, 26*, 1–8. doi: 10.1111/j.1752-0606.2000.tb00270.x.

Scheinkman, M. (2008). The multi-level approach: A road map for couple therapy. *Family Process, 47*, 197–213. doi:10.1111/j.1545-5300.2008.00248.x.

Sheinberg, M., & Fraenkel, P. (2001). *The relational trauma of incest: A family-based approach to treatment*. New York: Guilford Press.

Siegel, D. J. (1999). *The developing mind: How relationships and the brain interact to shape who we are*. New York: The Guilford Press.

Snyder, D. K. (2002). Integrating insight-oriented techniques into couple therapy. In J. H. Harvey & A. Wentzel (Eds.), *A clinician's guide to maintaining and enhancing close relationships* (pp. 259–275). Mahwah, NJ: Lawrence Erlbaum Associates Publishers.

Snyder, D. K., Cavell, T. A., Heffer, R. W., & Mangrum, L. F. (1995). Marital and family assessment: A multifaceted, multilevel approach. In R. H. Mikesell, D. D. Lusterman, & S. H. McDaniel (Eds.), *Integrating family therapy: Handbook of family psychology and systems theory* (pp. 163–182). Washington, DC: American Psychological Association.

Snyder, D. K., Cozzi, J. J., & Mangrum, L. F. (2002). Conceptual issues in assessing couples and families. In H. A. Liddle, D. A. Santisteban, R. F. Levant, & J. H. Bray (Eds.), *Family psychology: Science-based interventions* (pp. 69–88). Washington, DC: American Psychological Association.

White, M. (1991). Deconstruction and therapy. *Dulwich Centre Newsletter, 3*, 21–40.

Woolley, S. R., & Johnson, S. M. (2005). Creating secure connections: Emotionally focused couples therapy. In J. L. Lebow (Ed.), *Handbook of clinical family therapy* (pp. 384–405). New York: John Wiley & Sons, Inc.

Wright, J., Sabourin, S., Mondor, J., McDuff, P., & Mamodhoussen, S. (2006). The clinical representativeness of couple therapy outcome research. *Family Process, 46*, 301–316. doi:10.1111/j.1545-5300.2007.00213.x.

Zimmerman, J. L., & Dickerson, V. (1993). Separating couples from restraining patterns and the relationship discourse that supports them. *Journal of Marital and Family Therapy, 19*, 403–413. doi: 10.1111/j.1752-0606.1993.tb01002.x.

Author Biography

Peter Fraenkel, PhD is Associate Professor of Psychology, Doctoral Subprogram in Clinical Psychology at The City College of New York; Director, Ackerman Institute's Center for Work and Family, and former Director of The Prevention and Relationship Enhancement Program for Couples (PREP®) at the New York University Child Study Center. He's co-author of *The Relational Trauma of Incest: A Family-Based Approach to Treatment*, and author of numerous publications on time, work, and family, and integrative couple therapy. He was co-recipient of the 2004 American Family Therapy Academy's Award for Significant Contribution to Family Therapy Theory and Practice. He is also in private practice in New York City.