

From

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## **Chapter 1**

### **An Overview of Psychodynamic Couple Therapy**

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#### **Introduction**

Psychodynamic couple therapy is an application of psychoanalytic theory. It draws on the psychotherapist's experience of dealing with relationships in individual, group, and family therapy. Psychodynamic couple therapists relate in depth and get firsthand exposure to couples' defenses and anxieties, which they interpret to foster change. The most complete version of psychodynamic therapy is object relations couple therapy based on the use of transference and countertransference as central guidance mechanisms. Then the couple therapist is interpreting on the basis of emotional connection and not from a purely intellectual stance. Object relations couple therapy enables psychodynamic therapists to join with couples at the level of resonating unconscious processes to provide emotional holding and containment, with which the couple identifies. In this way they enhance the therapeutic potential of the couple. From inside shared experience, the object relations couple therapist interprets

anxiety that has previously overwhelmed the couple, and so unblocks partners' capacity for generative coupling.

## **The Development of Couple Therapy**

Couple therapy developed predominantly from psychoanalysis in Great Britain and from family systems theory in the United States. At first the limitations of classical psychoanalytic theory and technique inhibited psychoanalysts from thinking about a couple as a treatment unit. In reaction to that inadequacy for dealing with more than one person at a time, family systems research developed. However, many of the early systems theorists were also analytically trained or had been analyzed, and so psychoanalysis had an influence on systems theory contributions to family therapy, and its extension to couple therapy in the United States (J. Scharff 1995). But it was not until object relations theory enriched the field of psychoanalysis in Great Britain that a form of psychoanalysis readily applicable to couples emerged.

Until then, psychoanalytic theory had stressed the innate drives of sexuality and aggression (Freud 1905). Freud made little reference to the effect of the actual behaviors of parents on children's development, unless abuse had occurred (Breuer and Freud 1893-1895). True, Freud's later structural theory dealt with the role of identification with selected aspects of each parent in psychic structure formation, but these identifications were seen as resulting from the child's fantasy of family romance and aggression towards the rival, not from the parents' characters and parenting styles (Freud 1923). It was as though children normally grow up uninfluenced by those they depend on until the Oedipus complex develops. Even then, the psychoanalytic focus was squarely on the inner life of the individual.

In the United States, family systems theorists understood that spouses became part of an interpersonal system, and then devised ways of changing the system. However, without an understanding of unconscious influence on behavior they could not address the irrational forces driving that system. In addition, they remained more interested in family systems than in couple systems for many years.

### **In Great Britain**

Object relations theory emerging in Great Britain was also an individual psychology, but since it was being developed to address the vicissitudes of the analyst-analysand relationship, it lent itself well to thinking about couples, as shown by Enid Balint and her colleagues and students at the Family Discussion Bureau of the Tavistock Centre. As object relations theory continued to develop in Great Britain, it provided the theoretical foundation needed for the psychodynamic exploration of marital dynamics being explored at the Tavistock Institute of Marital Studies in the 1950s and 1960 (Pincus 1955). Then in 1957, it was the publication of Henry Dicks (1967) landmark text, Marital Tensions, integrating Fairbairn's theory of endopsychic structure and Klein's concept of projective identification that gave the crucial boost to the development of a clinically useful couple therapy. At that time, two therapists treated husband and wife separately, and reported on their sessions at a shared meeting with a consultant. The team could then see how the individual psychic structures of marital partners affect one another. This observation led Dicks to realize that the psychic structures interact at conscious and unconscious levels through the central mechanism of projective identification to form a "joint marital personality," different from, and greater than, the personality of either spouse. In this way, partners rediscover lost aspects of themselves through the relationship with the other. Later, Dicks and his

colleagues realized that it was more efficient for a single therapist to experience the couple's interaction first-hand, and couple therapy as we know it today had arrived (Dicks, personal communication).

### **In America**

The next boost to couple therapy came from psychoanalysis in South America where modern concepts of transference and countertransference were being analyzed in detail. Racker (1968) thought that countertransference was the analysts' unconscious reception of a transference communication from the patient through projective identification. He said that this countertransference might be of two types, concordant or complementary. The concordant identification is one in which the analyst resonates with a part of the patient's ego or object. The complementary identification is one in which the analyst resonates with a part of the patient's object. Let's say that the patient who was abused by his father feels easily humiliated by aggressive men in authority positions. He feels like a worm in front of the analyst whom he glorifies, and he defends against this feeling of weakness and insignificance by boasting about his income. If the analyst feels envious and impoverished in comparison, he is identifying with the patient's ego (concordant identification). If the analyst responds by puncturing the boastful claims, he is identifying with the patient's object derived from his experience with his father (complementary identification). After Racker, analysts could understand their shifting countertransference responses as a reflection not just of the transference, but of the specific ego or object pole of the internal object relationship.

This insight from psychoanalysis deepened appreciation for the way that a relationship is constructed, each partner to the relationship resonating with aspects of projective identifications to a greater or lesser degree. Applying this insight to the couple relationship between intimate partners, couple therapists could better understand how partners treated one another. They also had a way of

using their unique responses to each couple to understand how the partners connected with their therapist.

In North America in the 1960s, Zinner and Shapiro (1972) went against the systems theory mainstream to study the family systems of troubled adolescents in relation to their individual psychic structures, using Dicks's ideas as the explanatory linking concept. Focusing on the parents as a couple Zinner (1976) extended Dicks's ideas on marital interaction to explore marital issues as a source of disruption to adolescent development. Their research findings provided further support for the value of couple therapy. Another boost came in the 1970s from developments in the understanding and treatment of sexuality (Masters and Johnson 1970, Kaplan 1974, D. Scharff 1982). Object relations theory of couple therapy now included an object relations approach to sexual intimacy (Scharff and Scharff 1991). And in the 1990s, research on attachment processes stemming from the pioneering work of Bowlby, revealed that early infant attachment bonds influence the attachment patterns of adults, which has a profound effect on the life of couples and on the attachment styles of their children. Several clinicians and researchers have applied infant and adult attachment concepts to study the complex attachment of couples (Clulow 2000, Bartholomew, Henderson and Dutton 2000, Fisher and Crandall 2000).

## **Theoretical Basis of Psychodynamic Couple Therapy**

### **Fairbairn's model of psychic structure**

Fairbairn held that the individual is organized by the fundamental need for relationship throughout life. The infant seeks relationship with the mother (or primary caretakers) but inevitably meets with some disappointment, as when the mother cannot be available at all times or when the infant's distress is too great to be managed. The mother who is beckoning without being overly seductive, and who can set limits without being persecuting or overly rejecting infuses the infant's self with feelings of safety, plenty, love, and satisfaction. The mother who is tantalizing, overfeeding, anxiously hovering, excessively care taking, or sexually seductive is exciting but overwhelming to the infant, who then feels anxious, needy, and longing for relief. The mother who is too depressed, exhausted, and angry to respond to her infant's needs has an infant who feels rejected, angry, and abandoned. The mother who gets it more or less right, has an infant who feels relaxed, satisfied and loved.

When a frustrating experience occurs, the infant takes into the mind, or introjects, the image of the mother as a somewhat unsatisfying internal object, whether of an exciting or rejecting sort. The infant's next response is to split off the unbearably unsatisfying aspects from the core of this rejecting internal object and repress them because they are too painful to be kept in consciousness. However, whenever a part of an object is split and repressed, a part of the ego or self that relates to it is also split off from the main core of the ego along with the object. This now repressed relationship between part of the ego and an internal object is characterized by an affect. The rejecting object is connected to affects of sadness and anger. The exciting object is connected to affects of longing and craving. Remaining in consciousness connected to the central ego is the ideal object characterized by affects of satisfaction.

This produces three tiers of three-part structures in the self: central, rejecting and exciting internal object relationships in the ego, and within each internal object relationship, a part of the ego, the object, and the affect that binds them.

In health, these elements of object relations organization are in internal dynamic flux, but in pathologically limited states, one or another element takes over at the expense of others in a relatively fixed way. So one person can be frozen into an angry rejecting stance towards others if dominated by rejecting object qualities; another can be fixed in an excited, seductive and sexualized way of relating. In some trigger situations, one of these ordinarily buried ways of relating can take over in an automatic and repetitious way.

**Figure 1:** Fairbairn's model of psychic organization. The central ego in relation to the ideal object is in conscious interaction with the caretaker. The central ego represses the split-off libidinal and anti-libidinal aspects of its experience along with corresponding parts of the ego and relevant affects that remain unconscious. The libidinal system is further repressed by the anti-libidinal system when anger predominates over longing as shown here, but the situation can reverse so that the libidinal system can act to further repress the anti-libidinal system when an excess of clinging serves to cover anger and rejection. (Copyright David Scharff reproduced courtesy of Jason Aronson.)

### **Klein and Bion's theory of projective and introjective identification**

Klein proposed that people relate unconsciously and wordlessly by putting parts of themselves that feel dangerous or endangered into another person by projection. This unconscious mechanism characterizes all intimate relationships beginning with the infant-parent relationship and continuing throughout life. Through facial gesture, vocal inflection, expressions of the eyes, and minute changes in

body posture each of us continuously communicates subtle unconscious affective messages even while communicating a different message consciously, rationally, verbally. These affective messages are communicated from the right frontal lobe of the brain of one person to the right brain of another below the level of consciousness, but they fundamentally color the reception of all communications (Schoore 2001). They transmit parts of oneself to the interior of the other person where they resonate with the recipient's unconscious organization (a projective identification) and may evoke identification with the qualities of the projector. The recipient of a projective identification takes in aspects of the other person through introjective identification.

For instance, a child who fears his own anger will place it in his mother, identify her with his own anger, and then feel as afraid of her as he felt of his own temper. Or a weak wife who longs for strength, but also fears it, chooses a tyrannical husband whose power she regards with a mixture of fear and awe. A husband who is afraid that being sympathetic implies weakness locates tenderness in his wife or children, where he both demeans it and treasures it.

Bion (1967) described the continuous cycle of projective and introjective identification that occurs mutually between mother and infant. He studied the maternal process of containment, in which the parent's mind receives the unstructured anxieties of the child where they unconsciously resonate with the parent's mental structure, and the parent then feeds back more structured, detoxified understanding that in turn structures the child's mind. In this way, the child's growing mind is a product of affective and cognitive interaction with the parents. The same thing happens in couples: continuous feedback through cycles of projective and introjective identification is the mechanism for normal unconscious communication that is the basis for deep primary relationships. Bion (1961) also described valency, the spontaneous emotional clicking of strangers in a group setting, governed by fit between their unconscious needs. A couple is a special, small group of two who click as strangers and choose to become intimate, based on their unconscious needs.



## Dicks

Dicks (1967) built his theory of marriage by integrating these elements from Fairbairn and Klein (to which we later added the contributions from Bion on valency and containment). Marriage is a state of continuous mutual projective identification. Interactions of couples can be understood both in terms of the conscious needs of each partner and in terms of shared unconscious assumptions and working agreements. Cultural elements are the most obvious determinants of marital choice -- the sharing of backgrounds or values that are part of conscious mate selection -- but Dicks's research showed that the long-term quality of a marriage is primarily determined by unconscious fit between the internal object relations sets of each partner.

### Figure 2 Projective and introjective identification in a marriage

Let's read this diagram of a couple relationship from the husband's point of view. A husband craves affection from an attractive but busy wife. He hopes she will long for him as he longs for her, but she is preoccupied and pushes him away. Her responds by rejecting her before she can

reject him and he squashes his feelings of love for her. To put this in technical terms, his exciting object relationship seeks to return from repression by projective identification with his wife's exciting object relationship. Instead, it is further repressed by her rejecting object relationship with which he identifies in self-defense. His rejecting object relationship is reinforced as a result and so increases the unconscious secondary repression of his exciting object relationship. His rejecting object is enhanced and his exciting object is crushed. In the marriage with healthy unconscious fit, his rejecting and exciting objects would have been modified and reintegrated into the central ego.

### **Winnicott's theory of the parent-infant relationship**

To the foundation found in Dicks's integration of theories of Fairbairn and Klein, we have added other aspects. First, we have drawn from Winnicott's (1960) study of the infant-mother relationship (see Figure 2.) He described three basic elements, the environmental mother, the object mother, and the psychosomatic partnership. The environmental mother offers an "arms around" holding within which she positions the baby, providing a context for safety, security, a sense of well being, and growth. Within this "arms around" envelope, the object mother offers herself as a direct object for use by the baby in a "focused" relationship in which each incorporates the other as an internal object. There is a transitional zone between the contextual and the focused aspects of the infant-mother relationship. The psychosomatic partnership between parent and infant begins in pregnancy as a primarily somatic connection with minor psychological aspects based on the parents' fantasies of their unborn child and their imagined roles as parents. As the infant develops and becomes known as a person, the somatic element is subsumed in a psychological connection, which however, always retains vestiges of the

original somatic one, and which therefore can lead to the somatizing of psychological conflict. In later life the original psychosomatic partnership is the foundation of adolescent and adult sexual relationships (Scharff and Scharff 1991; D. Scharff 1982). In safety and intimacy enjoyed in the context of a committed sexual relationship, the partners experience a focused interpenetration of mind and body. They become each other's internal objects, drawing from internal object relationships that preceded their finding each other, and then modifying them in the light of new experience so as to build new internal organizations.

**Figure 2.** Winnicott's conception of the mother-infant relationship showing contextual holding, transitional space, and focused relating. Focused (or centered or I-to-I) relating occurs in and across the transitional space. Transitional space is in contact with both contextual (or arms-around) relating and focused relating, and is also the zone that blends the two. Transitional space is also the space between inside and outside world for the mother and for the infant, and the space of exchange between their individual inner worlds. Copyright David and Jill Scharff.

**Attachment theory and couple therapy**

Bowlby (1969, 1973, 1980) took an ethological approach to explore Fairbairn's proposition that relationships are the driving force in human motivation. Reviewing studies of mother-infant behavior across many animal species, he found that all primate infants show instinctual behaviors – rooting, sucking, clinging, crying, and smiling – and that these behaviors had nothing to do with aggression release or sexual pleasure. In Bowlby's theory, these instinctual patterns had to do with ensuring protection, proximity, and emotional connectedness, and that when these needs for proximity were not met, pathology resulted. Bowlby's theory came to be called Attachment Theory.

Ainsworth and her colleagues developed a research model for use with humans to explore and refine this early attachment theory. They designed a test called the "Strange Situation" in which mother and baby are subjected to brief separations with and without a stranger present, and then study, score, and categorize the baby's reactions on reunion with the mother (Ainsworth, Blehar, Waters, and Wall 1978). Infants attachment style at a year can be classified into four groups: Secure, anxious-insecure, avoidant-insecure, and disorganized/disoriented. If the baby treats the returning mother directly and confidently – even if the baby expresses angry protest at her absence – the attachment bond is coded as secure. If the baby clings, protests, and resists separating again, the coding is anxious-insecure; if the baby turns away and more or less shuns the mother, the coding is anxious-avoidant. If the infant moves away and then towards the mother, darts glances at her while avoiding her, and shows a chaotically rapid alternation of fear and need, the coding is disorganized/disoriented. This disorganized/disoriented group is associated with trauma and aggression perpetrated on the infant by the parent, or communicated to the infant unconsciously. It is of particular interest that an infant develops an attachment bond that is specific to each parent or caretaker. For instance, an infant can be securely attached with the mother and disorganized with the father.

Fonagy and colleagues (Fonagy, Gergely, Jurist and Target 2003) argued that attachment is not an end in itself but a context in which the self develops out of its relationships to others, a point of view

similar to Sutherland (1990). They held that, within those relationships, an important variable is the mother's capacity to mirror her child's feelings and yet mark them as belonging to the child and not to herself. Her capacity to reflect upon and mentalize her infants' experience helps the child to read the feelings and intentions of others, discover and regulate affect experienced in interaction, and develop a sense of personal agency and selfhood.

Recently Main has developed a way of coding attachment styles in adults through analysis of their verbal narrative coherence as they describe their own histories (Main 1995, Main and Solomon 1987). Whether the content of these histories is secure or insecure is not the point. It is the style of the telling that determines the coding. An adult's attachment classification predicts the infant's attachment bond to that adult with a high degree of accuracy, even before the birth of the child.

Following these developments, researchers have begun to apply attachment theory to the study of couple dynamics. Clulow and his colleagues at the Tavistock Marital Studies Institute have described complex attachments between couples (Clulow 2000, Fisher and Crandall 2000). Each partner provides an attachment object for the other while needing to be attached to the other. These patterns change with time and circumstance for a couple. Bartholomew and her colleagues have described various attachment patterns that correlate with healthy relationships and with those that are at risk for abuse or violence. For instance, a couple in which both parties code for secure attachment is at least risk, while a couple in which both partners show insecure, preoccupied and anxious attachments is at greater risk, and the risk level is magnified when there are disorganized and fearful patterns (Bartholomew, Henderson and Dutton 2000).

Couples often experience distance or argument as a rejection that is analogous to the emotional separation that an infant feels. Similarly, they experience the interval between therapy sessions as a separation and reunion. This experience of the episodic nature of treatment mirrors the couple's own

history of loss and reunion, and drives issues into the transference. This concurrence is then employed to advantage in couple therapy, as therapists interpret reactions to the frame of treatment in the light of the couple's previous experience.

### **Theory of transference and countertransference in couple therapy**

Transference and countertransference are as central to psychodynamic couple therapy as they are to individual analytic therapy. To understand them, we refer to Winnicott's description of the environmental mother responsible for securing the context for safety and growth, and the object mother available to be used as the material for the child's world of inner objects. In the contextual transference a patient treats the therapist as a good understanding parent if the transference is positive, and as a misunderstanding, mismanaging parent if negative. In the contextual countertransference, the therapist feels taken for granted as a trusted benign parental object when things are going well, and treated with dismissal, suspicion or seduction if negative. In the focused transference a patient may treat her therapist as a critical mother, a cherished sibling or a seductive father – projections of discrete inner objects to which the patient's self relates. Or she may deal with her therapist as an ignorant child, greedy baby or irresponsible adolescent – hateful or craving parts of her self that she puts into the therapist. In the focused countertransference, the therapist feels treated in a certain specific way – hated, desired, attacked or shunned – depending on the discrete ego or object pole of the inner object relationship being lived out through projective identification (Scharff and Scharff 1991).

In individual therapy, in the early phase as the patient negotiates entry into the therapeutic space and establishes whether it is safe and secure, the contextual transference is central. As therapy evolves, and with increasing trust in the contextual transference, discrete focused transferences emerge. The therapist receives these discrete object transferences and resonates with them, the

resulting countertransference providing access to the internal organization of the patient and becoming the vehicle for their resolution (J. Scharff 1992).

Similarly, in couple therapy, the contextual transference is important from the beginning, but it emanates not only from each partner individually, but more importantly from their holding of each other – that is from their shared environmental holding. Because the partners have a problem that leads to seeking help, by their own definition their shared holding has been insufficient. This deficit is further communicated to the therapist through their contextual transference. Figure 3 shows the transference situation and its origins in the contextual holding (which we sense in their joint marital personality) and through their centered holding (which is the sum of their patterned mutual projective identifications and use of each other as internal objects.) Together they project aspects of their separate and shared unconscious life into the therapist, who receives them as countertransference. While individual transferences certainly occur in couple therapy, we understand these principally as compensations for what each partner misses in the couple relationship. In treating couples, we use countertransference to understand deficits in the couple's shared holding that make it difficult for them to provide safety, meet each other's needs and contain anxiety (see below, example of evaluating a couple).

**Figure 3.**

**Caption: Transference and Countertransference in Couple Therapy.**

While focused transferences emanate from the individual partners, the most important source of couple transference is the shared contextual transference that conveys strengths and deficits

in their shared holding capacity. Couple therapists' countertransference is most usefully interpreted as resonating with this area of transference. Copyright Jill and David Scharff.

The internal couple is an unconscious psychic structure consisting of two internal objects in relationship. It represents each person's accumulated experience and fantasies about couples – loving couples, hateful couples, couples with the impossibility of linking, couples who cannot differentiate, sexual and asexual couples. Each therapist carries an internal couple, a constellation comprising the sum of his or her experiences growing up with couples, and an essential determinant of the therapist's countertransference to a couple. Any couple in therapy resonates unconsciously with a facet of the therapist's internal couple, and this is unique to that couple and that therapist.

## **Technique in Couple Assessment and Therapy**

### **The frame**

In assessment and in subsequent therapy, couple therapists begin by setting a firm, but flexible frame bounded by frequency and length of sessions for an agreed-upon fee and maintained by a professional attitude that guarantees the couple confidentiality, respects ethical boundaries between therapist and couple, shows concern, interest, tact and good timing. Couples' attempts to alter the frame are understood as communications about the holding provided by their couple relationship and their individual psychic structures in the present, and in their family of origin in the past.



### **Holding and containment**

Couple therapists maintain a position of involved impartiality while creating a psychological space for work in which to offer safety and security (therapeutic holding) and begin the process of containment (mental receptivity, digestion, and unconscious resonance).

### **Following affect, gathering history, working with the unconscious**

They look for aspects of object relations history, not by getting a preprogrammed history or a genogram, but by asking for history at moments of heightened affect so as to understand the here-and-now expression of early experience. In this way, history provides the context and language for understanding inner object relations and their effect on current interactions, both in therapy and in the couple's life. Couple therapists track affect in the session because it reveals split off object relations that are problematic for the couple.

### **Working with countertransference**

Couple therapists use countertransference to detect transference that drives these core-affective moments. They analyze the feelings that are stirred in them by the couple they are treating and look for a match between their own responses and reactions the partners have now or in their families of origin. Responding to one member of the couple, the therapist arrived from inside his own experience at an idea of how that person's partner might be feeling. Resonating variously with a projected part of the ego or the object of one or another internal object relationship in wife or husband, over time therapists figure out the object relations set of each of member of the couple by receiving mirror images in their own object relations set.

### **Working with dreams and fantasies**

Work with dreams and fantasy is another avenue through which therapists reach the unconscious levels of the couple relationship. If a partner reports a fantasy, the therapist asks more about it and helps the partner share reactions and other fantasies. When a partner tells a dream in couple therapy, it is regarded as a communication from both partners, both of whose associations to the dream are valued. All elements are combined in arriving at understanding conveyed through tactful interpretation of defense, anxiety and inner object relations.

### **In assessment**

In assessment, interpretations are tried out at several levels -- from making links between memory and current experience, which the couple has kept apart, to making deeper interpretations about the defensive aspects of mutual unconscious projective identifications or the persistence of childhood patterns of interaction. This tests the couple's defenses and their capacity for therapy. A formulation is then given to support the therapy recommendations. Enough must be said so that the couple can get a taste of therapy and decide if it will be helpful, but it is too soon to know much, and too soon to say all that is apparent in case it might be overwhelming

### **In therapy**

In ongoing therapy, couple therapists continue their efforts to understand and interpret at moments of readiness. They offer continuing psychological holding and containment in a shared collaborative effort to promote growth and healing through understanding. Interpretation of conflict,

defense and understanding of basic anxieties take center stage. Working through the issues over and over in different guises takes the couple into the late phase of therapy. By the time the couple is able to support each other, identify issues, share feelings, dreams, and fantasies, detect the unconscious factors that are interfering, and maintain an intimate bond, they are ready to terminate, equipped with skills for dealing with the developmental challenges that may come their way.

Maintain the frame

Hold attitude of involved impartiality

Track the affect

Take object relations history at core affective moments

Assess attachment style

Assess projective identificatory system

Use countertransference to detect transference

Integrate sex therapy

Work with dreams and fantasies

Interpret defensive patterns and sub-groupings

Understand basic anxieties

#### **Figure 4 Techniques of Couple Therapy**

#### **Example of Assessment with a Couple**

The following vignette illustrates the assessment process with a couple, in this case meeting with us as a co-therapy assessment team. A therapist working alone is equally likely to be effective, but

for teaching purposes we have chosen a co-therapy example because it readily shows the effects of transference.

### **Assessing the couple's attachment style**

Michelle and Lenny sought consultation because he wanted to get married and she wanted to break up. Their demeanor in the session was teasing, perverse, flippant, seductive, and yet highly entertaining. Michelle was taunting of Lenny, who appeared to delight in her no matter how she demeaned him. They explained that she was cruel only to him, and their friends did not enjoy their act, but as she said, 'He does bring it out in me.' When David Scharff asked why they were still together, Lenny, answered, "I'm the rock in the river, and I stay there while she runs up and down the river." He thought of himself as being steadfast like a rock, but she accused him of being immovable as a rock. Michelle claimed to have all the vitality for the couple, and while Lenny agreed that he got liveliness from her, he also saw her as flighty.

Michelle had an avoidant attachment style, while Lenny had an anxiously clinging one. Their projective identificatory system was stuck in a pattern in which he idealized her vitality and his steadfastness, while she held him in contempt for being stubbornly passive and for idealizing her. Despite her contempt for his adoration, she desperately needed him to idealize her (since she did not love herself) and he needed her to bring him life.

### **Noting the projective identificatory system of the couple**

Michelle's flamboyantly bright blue shirt with red, green and yellow leaves met an echo in Lenny's blue polo shirt with faint yellow and green stripes and a touch of red. David Scharff, struck by the similarity and difference in their dress, asked about the shirts.

Michelle burst out laughing at the ridiculousness of his comment. She said, "It's a total coincidence! I bought that shirt for him. He would never buy it. It's not his personality; it's mine."

However Lenny said, "I like it, even 'tho I would probably buy the solids."

The shirts gave a vivid image of their system of mutual projective identification. Lenny had the more solid version of the colorful personality that he took in from the relationship with Michelle. She got stability from him even although she denigrated it as immovability. He got vitality from her, and tolerated her scorn as the price. Michelle said he came from an indulgent family that did not challenge him, while she came from a disorganized, intellectual family that felt special. Lenny added that in his family, he learned from his mother and sisters that men weren't good to women. He had grown up dedicated to setting that right.

### **Using transference and countertransference**

As the session evolved, the therapists used the transference-countertransference exchange to understand and speak more effectively to the perverse quality of their relationship.

Jill Scharff noted aloud that David Scharff had grown uncharacteristically quiet and seemed sleepy in comparison to her, much as Lenny seemed quiet compared to Michelle. She presumed that this difference between her and him was a countertransference response to the interior of the couple's relationship. She said aloud that she noticed that while she was quick to pick up on what was being said, he seemed uncharacteristically sleepy, perhaps responding to what was not being said. She said that she expected that his state of mind could be understood in a way that would allow more understanding of Michelle and Lenny's situation. That allowed David Scharff to shake himself back to a state of awareness and say what he had felt. He said

that together Michelle's contradictions of his observations and Lenny's tolerance of her verbal abuse had defeated him -- put him psychologically out of commission. Now, with Jill Scharff's supportive prompting, he was able to make this unconscious defeat conscious, and to say that Michelle's upbeat tone seemed to be the wrong music for the words she spoke about the death of the relationship. Michelle was quick to laugh off his comment that her words sounded like a dirge, but Lenny responded seriously. He said, "It's like the jazz bands at a New Orleans funeral."

Lenny's capacity to respond with another rich metaphor like this showed the emotional attunement and strength that must have been part of his appeal for Michelle, and encouraged us to predict a good capacity for work in ongoing therapy.

#### **Asking about the couple's sexual intimacy**

We asked directly about the couple's sexual life.

Michelle, nonplussed for the first time, said, "You talk about it, honey!"

It quickly emerged that Michelle hated sex because she hated her body, but Lenny's steadfast caring and careful handling had enabled her to tolerate intercourse for the first time in her life, while enjoying other aspects of sex. Her tone changed instantly as she described the situation: she still had vaginismus -- tightness of the pelvic musculature that produced pain on penetration -- and she was not orgasmic in intercourse, but she had learned to have orgasms in the shared situation. Gratefully and straightforwardly, she gave Lenny credit in this area.

This discussion filled in another piece of the puzzle. Sex secured their attachment. In this area, Lenny was a good enough object (like a rock) who could modify Michelle's rejection of sexual experience

(like water running past it) so that sex could be a pleasure for both of them. We recommended an extended evaluation for understanding the dynamic of their pursuit and avoidance at the surface and their unconscious connectedness at emotional depth with a view to helping them decide whether to pursue couple therapy.

## **Integration of Sex therapy Techniques in Couple Therapy**

Frank discussion of sexual functioning should be part of every couple evaluation. Matter-of-fact queries about sex from the beginning open a space for the frank discussion of sexual material as the therapeutic relationship deepens. Couples may accept superficially reassuring information about their sexual life at first, but later convey disappointment. They need their couple therapist to have a working knowledge of sexuality. Couple therapists must be fully informed on sexual development and dysfunction, sex research advances, and contemporary clinical approaches to extend those formulated by Masters and Johnson (1970), such as Kaplan's (1974) integration of behavioral sex therapy and psychodynamic couple therapy, and Scharff's (1982) developmental object relations approach to sexuality, sexual dysfunction, and sexual dysjunction on a couple's intimacy.

Couples' sexual difficulties derive from several areas: deficits in learning about sexual function – often because of cultural or family strictures concerning sex; problems in individual emotional development of one or both partners that produce difficulty in the sexual arena; and marital strain that takes its toll on a couple's sexual function. Life events and transitions – the moment of commitment or marriage, the birth of a first child or a child of one particular gender, adolescents leaving home, job loss or the onset of menopause – may trigger anxieties that impinge on sexual function. Finally, physiologic factors interfere with sexual function: age, disease, or medication – especially psychotropic medications.

Any of these factors that introduce difficulty in sex usually produce repercussions on the couple's overall relationship.

When sexual difficulty is the most significant feature of a couple's problem, or when it runs in parallel with overall difficulty and has not yielded to couple therapy, the couple therapist needs to use behavioral sex therapy techniques, integrated into the overall psychodynamic approach (Kaplan 1974, Scharff and Scharff 1991). The couple agrees to limit their sexual interaction to a graded series of exercises conducted in private. Exercises begin with nude massages, excluding breasts and genitals. Each session is reviewed with the therapist who looks for patterns of difficulty that provide an opportunity to work psychodynamically. Linking small failures in the exercises to the couple's overall difficulties and histories, the therapist interprets the underlying unconscious individual and couple issues, and integrates them in the subsequent assignments. Couples gradually move along the gradations of sexual exchange until they are ready for intercourse. Complete sexual function now has embedded in it both the therapist's contextual support and the therapist's collaborative effort to interpret themes that have precluded or inhibited sexual passion.

### **Working with Dreams in Couple Therapy**

Dreams offer partners a unique opportunity for working on unconscious communication inside the self and the couple's system. Dreams inform couples about the partners' internal self-and-object relations at the same time that they give important clues about the way each spouse uses the other as an external object. A dream from only one spouse obviously reflects the inner object relations of that one person, but told in couple therapy, that dream is regarded as a communication on behalf of the couple, and so it often leads to exploration of issues in both partners. When both partners report dreams, a richly interlocking texture of conscious and unconscious understanding is possible.



### **A clinical example of dream analysis in sex therapy**

The following example illustrates both the course of sex therapy and the crucial role of dreams in helping a couple to move beyond therapeutic impasse. When working with dreams, couple therapists elicit the associations of both the dreamer and the partner and connect the elements of the dream to affect, personal history, sexual desire, and the intimate relationship.

Dr. and Mrs. T, both 35, were referred to me (DES) after adopting an infant girl. Trying unsuccessfully to conceive during the preceding infertility evaluation, Dr. T had experienced impotence occasionally. The couple's shared low sexual desire had become apparent to the social worker during the subsequent adoption evaluation. Dr. T mentioned two events that he had found traumatic: He had been involved in boarding school homosexual encounters; and his father had suddenly left his mother seven years previously. Mrs. T, who had older brothers, was pushed to be as athletic as the boys, which left her feeling shaky as a woman. In an individual session, I encouraged Dr. T to tell his wife about his performance anxiety and erectile difficulty. Seeing them in a couple session, I said that they shared an avoidance of sexuality because of uneasiness about themselves as sexual people. I described how shared low sexual desire derived from their internal couples – his of a warring couple, and hers of a family repressing feminine sexuality. They agreed to my recommendation for psychodynamic sex therapy to treat the sexual difficulty itself and to explore and resolve their emotional distance.

Insecure and avoidant aspects of the couple's attachment had been projected into their sexual bond. Both of them were open and trusting. I felt good about them and I was hopeful for their

progress. It was not long before I recognized that my hope for them was my countertransference to an excited object transference, and it would soon meet the usual fate of disappointment.

My bubble burst when Dr. T found obstacles to scheduling our work. Frustrated, I confronted Dr. T more insistently than Mrs. T had done. He finally changed his schedule, and reported with a sense of relief that he had passed a crisis of commitment. He felt for the first time different from his father.

The early exercises went well as the couple relaxed into them. They felt a new investment in each other. But when genital stimulation was prescribed, Dr. T continually reported feeling no arousal, and drew a blank. To help the couple move past the impasse, I looked to their unconscious. I asked Dr. T if he had had any dreams. He promptly obliged:

“I dreamt that a teacher I hardly knew at medical school came over and sat next to me. He was too arrogant to do that in real life. Last week I read that he had killed himself. We used to worry about suicide when my wife’s brother was depressed but he didn’t die. We also worried that her brother had organic causes for depression, just as I worry my impotence is organic.”

I said that since Dr. T could masturbate normally, his erectile function was not organically impaired. So we should look to the dream for understanding the source of his impotence.

Mrs. T. said, “I worry he doesn’t find me attractive. I never feel sexy like a real woman. I was a runner who developed late and didn’t menstruate until I was 23. I think I got stuck at age 16.”

I said that they both felt deficiencies about their bodies like most adolescents do, and that the dream showed that it felt like a life-or-death matter to them. The dream also suggested that they felt I was like an arrogant, unavailable medical school teacher, and could therefore not be trusted to be on their side.

The following exercise sessions were no different. Dr. T. felt no arousal even with genital stimulation, and actually lost arousal in masturbation exercises. I was losing hope for them. I thought, 'Perhaps they were not treatable after all!' To put this in technical terms, I absorbed their doubts in my countertransference through my introjective identification, and so began to feel my hope for them "killed off." I now experienced them as a failed exciting internal couple. It crossed my mind that if they left treatment without improvement, I would be relieved. To use language identified with their metaphors, I felt "sick of treating them" and "had lost my desire" to help. Here, in resonance with my internal couple was a replay in my countertransference of their unconscious problem. I felt seduced by them as exciting objects, and then let down by the failure they also feared.

Then Dr. T brought a second dream, assuring me it was unrelated to therapy:

"I was standing with some people in a large room with our backs to the wall. We were going to be executed one by one. At first, I felt defeatist. I took off my jacket just as I did a moment ago here. I thought, "I hope they'll hurry." Then I thought, "I don't want to die. So, fight!" They were demonstrating killing us with carbon monoxide on a bed – which is how my old teacher killed himself. I asked to use the telephone and called my mother. There was no answer, but I just walked out the door of the room. I took off my shirt because it was a giveaway. It was 2 a.m. I began to run through a strip mall. A motorcycle cop caught up with me, but just then a bad guy came out and shot at him. The cop chased him and I got away.

Dr. T's associations to the dream showed that the execution or asphyxiation that he feared was connected to the smothering anxiety of the sexual exercises that I assigned, for which he stripped, and which he carried out on a bed. When I said that the cop and the teacher he feared were standing for me, he said, "No doubt about that! I am beginning to realize I am afraid of being controlled by you and by my wife if she controls my penis." He said that the building in which he faced execution was like the boarding school he attended, leading us to talk about his pain on leaving home in adolescence. He explained that he had wanted away from his mother, but once he got to school he missed her and felt unprotected from the sexual teasing of older boys. He remembered that, as he left home, he suddenly realized that his parents had a sexual life.

In the dream, Dr. T called his mother as he had done then when threatened by loneliness and homosexual seduction at boarding school. I realized that his resistance to therapy was a fearful reaction to me as a potentially seductive older boy and as a mother he might need too much.

Responding to Dr. T's realization that his parents had a sex life, Mrs. T now said, "Well, they did have another child after you left, your sister, and we named our daughter after her. When I realized that my husband was afraid of me suffocating him in bed if I became sexual, I kept sex under wraps, which suited me anyway because I was so frightened of it. He would treat me as though I were a cop like his mother. We are both afraid of being sexual, and so we've been afraid of you, or rather of what we asked you to do for us. But I think I can stand my fright if my husband will try to stand his."

Mrs. T's reluctance to engage sexually stemmed from her fear that being sexual would make her become a rejecting mother. Like her husband she was afraid of a controlling woman who emasculates her incompetent husband. Therapy addressed this shared internal couple and the unconscious fear it evoked.

In the exercises following this session, Dr. T was easily aroused for the first time, and the treatment followed a rapidly successful course, to sexual satisfaction, and eventually to a much-desired pregnancy.

What broke the logjam? Dr. and Mrs. T recognized the dovetailing of their projective identifications. They revisited their adolescent anxieties about becoming sexual beings. They each found a critical parent in the transference and worked on it. They discovered that they were in the grip of a paralyzed internal couple. Dr. T allowed the image of his parents as a sexual couple to resurface, which gave him permission to be a sexual person and reassure his wife that she was desirable. The recovery of an unconscious sexual internal couple facilitated the actual couple's re-entry into the intimate life of the marriage. Given enough time, commitment, and a willingness to work with dreams and fantasies, many couples respond as well.

## **Challenges to the Couple Therapist**

### **Working with trauma in couple therapy**

Childhood physical abuse, sexual abuse, and traumatic medical intervention at a young age, significantly affect individual development by creating traumatic nuclei and gaps in the psyche. Adult survivors of trauma may visit trauma on their partners or avoid anything that might cause it recurrence. Sexual abuse will often – but not always – show up as sexual symptomatology in the couple, even if they have been able to have a relatively normal sexual life before marriage or early in the marriage (Scharff and Scharff, 1994). Adult trauma, too, will handicap couples, especially if it reawakens memories of childhood injury. Adults who were traumatized in childhood are at increased risk for adult trauma.

Tony and Theresa came to therapy after Tony lost his right arm and shoulder to amputation to abort a life-threatening infection in the upper arm following an injection there for asthma. Although his employer offered to support physical therapy and the fitting of a prosthetic arm, Tony resisted rehabilitation and became immobilized with depression. Theresa and he grew increasingly angry at each other over the next year. Exploring their anger, the therapist learned that in growing up, they had suffered physical violence. Each had taken the role of defending their siblings from physical attacks from their parents, and been hit frequently in the process. When they married, they had vowed never to fight, and now would go so far as to punch the wall and break their fists rather than strike each other. They would break a bone, or break up as a couple, rather than risk expressing anger directly, lest they lose all control and hurt each other.

The trauma experienced in adulthood brought this couple's shared history of childhood physical abuse to the forefront. Early in their marriage, their adult attachment seemed secure, but now trauma threatened to overwhelm their current recovery and brought out the old insecurity. Trauma to one partner can overwhelm the couple's holding and containment for one another. A therapist must spend

time as witness to the trauma before it is possible to help the couple work in a symbolic, reparative way. (Scharff and Scharff 1994, D Scharff 2002).

### **Working with the difficult couple**

The difficult couple is the one that the therapist dreads seeing. A therapist may be unable to tolerate silence, another cannot stand relentless fighting, yet another may be allergic to sweetness that masks hostility. Another type of difficult couple is the one in which one of the partners is sure that the other is being sided with by the therapist. The therapist who is committed to involved impartiality may feel extremely upset by accusations of unfairness and fail to interpret the sibling rivalries being fought out, probably because of painful feelings towards her parents over sibling issues of her own. Whatever specific form it takes, the difficult couple gets to the therapist's internal parental couple and stirs unease and sometimes despair (J. Scharff, 1992). The therapist's capacity for holding and containment is stretched to the limit. Only when the therapist is open to experiencing fully in the countertransference the hopelessness that underlies the couple's defense of being difficult is there some hope of recovery (D. Scharff and J. Scharff, 1991). On the other hand, sometimes the best course is to acknowledge a lack of fit and refer the couple. What may present a problem for one therapist may be easier for another. On the other hand the difficult couple may dump all their negativity with one therapist and appear to do well with the next one but in fact the partners have not developed the capacity to integrate good and bad objects.

### **Managing resistance to couple therapy**

Sometimes one member of a couple does not want therapy, but it is usually possible to get the couple in for a single consultation session in which to work on the reasons for refusing treatment. The psychodynamic couple therapist does not use persuasion or paradoxical prescription to get the couple into treatment, but accepts that there must be a good reason for the resistance and tries to make it conscious and understandable so

as to free the couple to make a choice based on a good experience of the value of reflection. Once a couple therapy contract is made, couple therapists work with the couple, not with the individual partners. They establish that way of working and hold to it as a standard from which to negotiate frequency, experiment with requests for individual sessions, and learn.

### **Working with the couple when there is an affair**

The couple dealing with infidelity is filled with disappointment, envy, rage, and sadness. The first task of the couple therapist is to hold all the feelings that the marriage could not. Then she wants to know details of the affair because the attraction of the lover and the keeping of a secret contain important information about repressed object relations that cannot be expressed and contained within the marriage. Splitting good and bad objects between spouse and someone else is a major defense, and it does not stop with the end of the affair. Some couple therapists insist that the affair be stopped, on the grounds that they do not want to sanction a duplicitous life, but most therapists accept the marriage and its infidelity as the patient. They work to see whether the marriage is to continue, at which point the lover must indeed be renounced. Intimate partners cannot work on their relationship while one of them has another intimate partner. Even though the affair is a betrayal and a threat to the marriage, it is also an attempt to maintain the marriage by getting needs met elsewhere. Sometimes a partner reveals the secret to the therapist on the phone or in an individual session to which both partners have agreed. In this case it is best to acknowledge that a problem has arisen, and ask for more individual sessions to work it through. The therapist does not want to force a confession, but if the marriage is to continue in couple therapy, she learns about the meaning of the affair and the need for secrecy in individual terms, and works towards a planned revelation in the couple setting. Individual work like this may result in ending the couple therapy, or it may become a prelude to it.

### **Handling acute couple distress**

Acute distress arises for instance when there is a sudden revelation of an affair, death of a newborn, suicide threat, acute psychotic reaction, and acute intoxication from substance abuse. Acute distress calls upon the couple therapist for an emergency appointment of sufficient length to assess the situation, give the couple



time to express their distress, and let the therapist develop the necessary holding capacity and make the necessary arrangements -- or refer to a colleague who can do so. Medication, removal of a violent member from the home, emergency care, and couple consultation may work together to avoid a hospitalization. Speed is essential for taking advantage of the healing potential of the crisis in the system. Enough time is essential for demonstrating the possibility of understanding their overwhelming emotion. And a second appointment within the week should be confirmed before the couple leaves the session.

## Termination

The therapeutic space has been internalized as a reasonably secure holding capacity.
Unconscious projective identifications have been recognized, owned and taken back
The capacity to work together as life partners is restored.
Intimacy and sex is mutually gratifying.
The holding environment extends to the family
The needs of each partner are separate and distinct
Or, the loss of the marriage is accepted, understood, and mourned

**Table 1. Criteria for Termination**

The couple in therapy has had some rehearsal for termination when ending each time-limited session and facing breaks in treatment due to illness, business commitments, or vacations. Couple therapists work with the couple's habitual way of dealing with separations in preparation for the final parting, for which they will be ready when the above goals have been met. The couple relives issues from earlier phases of the treatment, now with a greater capacity for expressing feelings, allowing

difference, recovering from difficult moments, dealing with loss, respectfully confronting and understanding defensive positions, and mastering anxiety.

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From Couple Therapy 1.0 to a Comprehensive Model: A Roadmap for Sequencing and Integrating Systemic, Psychodynamic, and Behavioral Approaches in Couple Therapy. Article. Jun 2017. Fam Process. Arthur C. Nielsen. Couple therapy is a complex undertaking that proceeds best by integrating various schools of thought. Grounded in an in-depth review of the clinical and research literature, and drawing on the author's 40-plus years of experience, this paper presents a comprehensive, flexible, and user-friendly roadmap for conducting couple therapy. It begins by describing "Couple Therapy 1.0 Psychodynamic therapy is a talking therapy. This means that it is based on the concept that talking about problems can help people learn and develop the skills they need to address them. It is an approach that embraces the multifaceted aspects of an individual's life. It provides a container in which people can gain insights into themselves, their pasts, and their feelings. They can develop a better understanding of how they see the world and the ways in which all these factors affect their experiences. With the help of a therapist, people undergoing psychodynamic therapy will work to understand their feelings, beliefs, and childhood experiences. The goal is to help people recognize self-defeating patterns, explore new ways of being in the world, and help people feel better. Family Theory and Therapy: An Overview 5. The development of the field of family therapy was facilitated by a number of movements in the field of mental health in general. Wynne and his colleagues' investigation of psychodynamic aspects of schizophrenia attempted to identify the characteristic structure and roles in families that produce schizophrenia (Ryckoff et al. 1959; Wynne et al. 1958). Wynne's work is premised on the concept that all humans experience both a fundamental need to relate to others and a lifelong striving to develop a sense of personal identity. Psychodynamic therapy is the oldest of the modern therapies. Psychodynamic therapy grew out of the theories and practices of Freudian psychoanalysis. It is one of the three main types of therapy used to treat depression. Psychodynamic therapy is a long-term form of psychotherapy that recognizes negative patterns of behavior and feelings that are usually rooted in the past and resolving them. Psychodynamic therapy can be used for individuals, couples, families, or groups. Psychodynamic therapy works well with other types of therapies as well as medications. Psychodynamic therapy is a form of therapy with a focus on a holistic perspective of the client. It aims to explore the client's needs, urges, and desires. While psychodynamic therapy is still applied in many situations, its popularity has lagged behind these other types of therapy in the last few decades. However, it is still the most recognizable form to those inexperienced in the theory and application of therapy, and it is still a worthwhile goal to understand the basics of psychodynamic therapy. Read on to learn about the theory behind this seemingly simple question to psychodynamic therapy. Before you read on, we thought you might like to download our 3 Positive CBT Exercises for free.