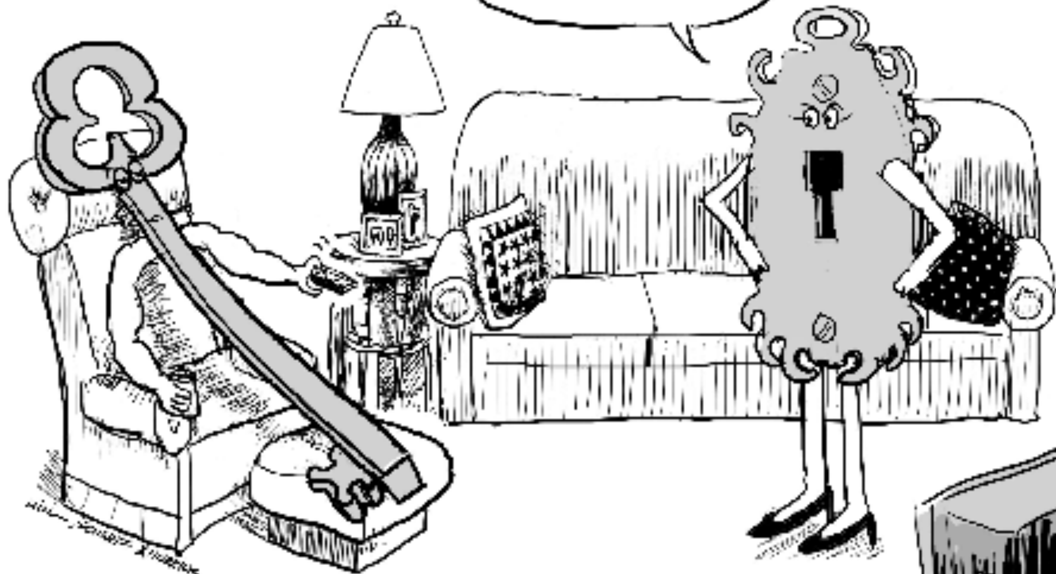
When Love Locks Fail: Understanding How Couples Fit Together

is Key to Helping Them Come Apart

AGENDA

9:00 – 9:10	Introduction and overview of the program
9:10 – 9:20	Fishbowl demonstration and Discussion
9:20 – 10:30	Discussion: The nature of couple relationships:
	Why we come together and why we come apart.
10:30 – 10:40	Break
10:40 – 11:00	Exercise: Observations and experience of relationship patterns.
11:00 – 11:15	Whole group debrief of exercise.
11:15 – 11:45	Discussion: The Power of Holding Both.
11:45 – 12:10	Fishbowl Demo: Putting the learning to practice
12:10 – 12:15	Wrap Up and Conclusions.


I HAVE NO IDEA
WHAT I EVER
SAW IN YOU.

From Navigating Emotional Currents in Collaborative Divorce: A Guide to Enlightened Team Practice, Scharff and Herrick, 2010.

CONCEPT OF THE "LOCK AND KEY" DYNAMIC BETWEEN COUPLES

The concept of the "Lock and Key" dynamic between couples is rooted in theories discussed and published over decades by various psychological writers explaining how people choose their partners, and how the patterns between partners evolve over time – to strengthen the relationships or create tensions and fissures.

In the book Navigating Emotional Currents in Collaborative Divorce: A Guide to Enlightened Team Practice, Scharff and Herrick repurposed these original theoretical writings to help Collaborative professionals of all disciplines understand their divorcing clients, and how important is can be to understand their historic couple dynamics and patterns.

The core idea of the "Lock and Key" is that we all choose our long term, most intimate partners for both conscious and unconscious reasons. We choose them because they are sexy, because they are smart, because they make us laugh, because they love to play tennis as much as we do, because they also want children – or don't. These are the conscious reasons we are aware of and can explain.

However, when we choose a long -term partner, unconscious – or just semi-conscious – reasons are at work as well. Therapists know well that many people who end up married to heavy drinkers grew up with a parent who suffered from an alcohol disorder or addiction. Sometimes we choose a partner who is spontaneous, and even a bit "wild" after growing up in a home in which everything is rigidly scheduled. Or we find a partner who has rigid expectations after growing up with rigid expectations.

What is happening here? How does our history influence our choice of partner? And why do we often find the very trait we loved at first so irritating – even crazy making – after we are partnered for a few years?

There are a few different psychological drives that can play out in our long term, intimate partnership.

One example is our seeking a partner who behaves in ways, or has needs, that are familiar to us. We feel that our relationship "fits us like a glove" – because we grew up in a family, or with a parent, or a sibling who behaves in just that way, and had very similar needs. Perhaps we grew up with a special needs sibling and were in a caretaking role from an early age, to help overwhelmed parents. Perhaps we gravitate to partners who need caretaking, and who are particularly dependent. While we may have chosen (unconsciously) a partner in part because of this familiar pattern, over time we may become frustrated, and disappointed in our partner

because of that very dependence that seemed so comfortingly familiar at first. We no longer need to replicate our early pattern – and now that pattern does not fit. It rubs and irks.

Another example is seeking a partner who possesses a trait, or ability that we lack – perhaps because we grew up in a family that frowned upon or criticized that trait. We might have grown up in a family that did not "allow" expressions of anger. A message of "be nice, and don't have ugly feelings" may have been unspoken by parents, but powerful in its impact. We may unconsciously be drawn to a partner who feels free to be angry and express that, so that our partner can, in effect, "carry the angry feelings for us." Over time, this dynamic may cease to work for us, without our understanding why. We may tire of our partner's short temper and yearn for someone steady and calm because we have grown more comfortable with modest expressions of anger in ourselves.

A third example is being driven to choose a partner whom we – perhaps with minimal self-awareness – see as the opposite of someone we struggled with when we were young. The person who grew up with a rageful parent might choose a partner who is above all else quiet and contained. Yet this partnership may falter over time as that calm quiet becomes dull or feels disengaged and indifferent as we are no longer needing to push away from our origins.

A final example is an unconscious drive to master some reality that we suffered from during childhood. That person who marries a heavy drinker, and grew up with an alcoholic parent, may be driven to try to finally heal the person who self-medicates. Without being aware of the drive, this person may forgive, or even ignore the heavy drinking behavior during courtship, unconsciously believing that "I will make him/her so happy, that they won't want to drink so much when we are settled down. This time, I will help my loved one stop drinking." When that effort fails, the relationship can weaken.

No matter what our individual drive(s) are when we choose our partners, the relationship can deteriorate unless we are ultimately able to examine, discuss, understand, and perhaps even shift the dynamics that have become the "lock and key" patterns that do not work for us. When an unhappy couple fails to seek therapy, or when therapy fails, these folks end up in our offices – seeking separation or divorce.

The important learning for us, based on the Lock and Key concept, is that much individual unhappiness in a marriage stems from the historical patterns in the relationship – that were often formed by the partners themselves, when they chose each other, and chose to stay with each other while the distress intensified. There is often no "good guy" and "bad guy" in a marriage – only people who chose one another for unconscious reasons that played out in unexpected ways – and were never fully understood by both partners.

Seeing in a Couple in Three Dimensions: The Benefits of Learning the Other Side of the Story

Here are a few benefits of taking the time to identify a couple's lock and key patterns, and how they came to be.

- It helps you to empathize with the other client and their professional team and avoid seeing one client as "the bad guy" and the other as "victim".
- It helps you avoid getting caught in adversarial positions that arise from missing the complexity of the couple's relationship and seeing clients in dichotomous ways.
- It helps you to realistically assess the validity of your client's perspectives and sometimes to be able to offer your client a broader view of what is occurring between them and their spouse.
- It helps the professionals remain cohesive, if everyone is able to understand the couple's dynamics as historic, repetitive, and as "no one's fault" – these folks chose one another for complex reasons, and we can have empathy for them both.

COMMON LOCK AND KEY COMBINATIONS

Note: These are unconscious aspects of the relationship. Many of these could also be conscious. What gets folks in trouble are the unmetabolized unconscious aspects of their relationship. Here are some examples:

emotionally deprived marries nurturer
emotionally deprived marries smothering care-giver

emotionally abused marries gentle care-taker
emotionally abused marries abuser

disorganized marries organizer
disorganized marries conrol freak

creative free spirit marries conservative intellectual
creative free spirit marries emotionally contstricted obsessive

What is Imago?

What is Imago Relationship Therapy?

Developed by Dr. Harville Hendrix and Dr. Helen LaKelly Hunt in 1980, Imago Relationship Therapy is a form of relationship and couples therapy that focuses on relational counseling to transform any conflict between couples into opportunities for healing and growth.

The Latin word "imago"—meaning "image"—refers to the "unconscious image of familiar love." What we find is that there is frequently a connection between frustrations in adult relationships and early childhood experiences. As an example, individuals frequently criticized as a child will likely be highly sensitive to their partner's criticism. Childhood feelings of abandonment, suppression or neglect will often arise in a marriage or committed relationship.

When such “core issues” repeatedly come up with a partner, they can overshadow all that is good in a relationship and leave one to wonder whether he or she has chosen the right mate.

Through Imago Relationship Therapy, couples can learn to understand each other’s feelings and “childhood wounds” more empathically, allowing them to heal themselves and their relationships so they can move toward a more “Conscious Relationship.”

As illustrated in Dr. Hendrix’s *New York Times* bestselling book, **Getting the Love You Want: A Guide for Couples**, learning and teaching the “Imago Dialogue” allows couples to move from blame and reactivity, to understanding and empathy, so they can create a deeper and loving connection with each other.

From conflict to hope

At some point in their relationship, couples often find themselves struggling with anger and shock, despair and sadness. Some are newlyweds, and can’t understand how they have plummeted from the heights of love and glory into a swamp of hopelessness and conflict. Others have been married for many years, and though they have been slogging along – in calm or storm – their days of wine and roses are a dim memory. Even if life at home is relatively peaceful, couples lament that they have “nothing in common anymore.” And so they lead a disappointed or angry co-existence, each with their own friends and interests, in a marriage of convenience, or an arrangement they endure “for the sake of the children.”

Shattered dreams, whatever form they take, are painful. But there is hope. In fact, the pain and conflict of committed relationships arise not out of lack of love for our partners, but from a misunderstanding of what love relationships are about. Your conflict can be the very fuel for the fulfillment you seek.

Why do we fall in love?

What is really happening when we fall in–and out of–love?
What's really going on when couples fight?

To gain insight into the hidden agenda of a relationship, we need to look at the complex process of human growth and development, and at how we human beings fit into the larger scheme of things.

We believe that we are creatures of nature, with the evolutionary program of our species encoded in our genes, and that we all begin life in a state of relaxed and joyful bliss. If our caretakers are attuned to our wants and needs, ready and able to provide warmth safety and sustenance, our feelings of aliveness and well-being are sustained. We remain whole.

But even in the best of circumstances, our parents are not able to maintain perfect standards, to be available every minute, to always understand exactly what is needed or to meet every demand. Tired, angry, depressed, busy, ill, distracted, afraid–our parents fail to sustain our feelings of security and comfort.

Every unmet need causes fear and pain and, in our infantile ignorance, we have no idea how to stop it and restore our feeling of safety. As a response, we adopt primitive coping mechanisms ranging from constant crying to get attention to withdrawing inward and denying that we even have needs. Meanwhile, throughout our childhood, we are also being socialized, molded by our caretakers and communities to fit into society. Observant and malleable, we learn what to do to gain love and acceptance. We repress or disown parts of ourselves that society finds unacceptable or unlovable. Our sense of "allrightness" diminishes, and we end up as shadows of our whole, true selves.

Most of us had “good enough” caretakers; we do all right. Some of us didn’t fare so well, and our lives are handicapped by deep hurts. All of us were wounded in childhood to some extent. We are now coping as well as we can with the world and our relationships, but parts of our true nature were suppressed in the unconscious. We look grown up–we have jobs and responsibilities–but we are walking wounded, trying to live life fully while unconsciously hoping to somehow restore the sense of joyful aliveness we began with.

When we fall in love, we believe we’ve found that sense of joyful aliveness! Suddenly, we see life in technicolor. We nibble each others’ ears and tell each other everything; our limitations and rigidities melt away. We’re sexier, smarter, funnier, more giving. We feel whole, we feel like ourselves. Finally we feel safe, and breathe a sigh of relieved deliverance. It looks like everything is going to turn out all right, after all.

Why does falling in love go wrong?

But inevitably–often when we marry or move in together–things just start to go wrong. In some cases, all hell breaks loose. The veil of illusion falls away, and it seems that our partners are different than we thought they were. It turns out they have qualities that we can’t bear. Even qualities we once admired grate on us. Old hurts are reactivated as we realize that our partners cannot or will not love and care for us as they promised. Our dream shatters.

Disillusionment turns to anger, fueled by fear that we won’t survive without the love and safety that was within our grasp. Since our partner is no longer willingly giving us what we need, we change tactics, trying to maneuver our partners into caring–through anger, crying, withdrawal, shame, intimidation, criticism–whatever works. We will make them love us. Or we may negotiate for time, love, chores, gifts.

The power struggle has begun, and may go on for many years, until we split. Or we settle into an uneasy truce.

What is going on here? Apparently you have found an Imago partner. Someone, I'm afraid, who is uniquely unqualified (at the moment), to give you the love you want.

Furthermore, this is what's supposed to happen!

Let me explain. We all think that we have freedom of choice when it comes to selecting our partners. But regardless of what it is we think we're looking for in a mate, our unconscious has its own agenda.

Our primitive "old" brain has a compelling, non-negotiable drive to restore the feeling of aliveness and wholeness that we came into the world with. To accomplish that, it must repair the damage done in childhood as a result of unmet needs, and the way it does that is to find a partner who can give us what our caretakers failed to provide.

You'd think, then, that we would choose someone who has what our caretakers lacked. If only that were so! But the old brain has a mind of its own, with its own checklist of desired qualities. It is carrying around its own image of the perfect partner, a complex synthesis of qualities formed in reaction to the way our caretakers responded to our needs. Every pleasure or pain, every transaction of childhood, has left its mark on us, and these collective impressions form an unconscious picture we're always trying to replicate as we scan our environment for a suitable mate.

This image of "the person who can make me whole again" I call the Imago.

Though we consciously seek only the positive traits, the negative traits of our caretakers are more indelibly imprinted in our Imago picture, because those are the traits which

caused the painful experiences we now seek to heal. Our unconscious need is to have our feelings of aliveness and wholeness restored by someone who reminds us of our caretakers. In other words, we look for someone with the same deficits of care and attention that hurt us in the first place.

So when we fall in love, when bells ring and the world seems altogether a better place, our old brain is telling us that we've found someone with whom we can finally get our needs met. Unfortunately, since we don't understand what's going on, we're shocked when the awful truth of our beloved surfaces, and our first impulse is to run screaming in the opposite direction.

But that's not all the bad news. Another powerful component of our Imago is that we seek the qualities missing in ourselves that got lost in the shuffle of socialization. If we are shy, we seek someone outgoing; if we're disorganized, we're attracted to someone cool and rational. But eventually, when our own feelings—our repressed exuberance or anger—are stirred, we are uncomfortable, and criticize our partners for being too outgoing, too coldly rational, to temperamental.

Why is conflict good!?

Being aware of ourselves is the key; it changes everything.

When we understand that we have chosen our partners to heal certain painful experiences, and that the healing of those experiences is the key to the end of longing, we have taken the first step on the journey to real love.

What we need to understand and accept is that conflict is supposed to happen. This is as nature intended it: Everything in nature is in conflict. Conflict is a sign that the psyche is

trying to survive, to get its needs met and become whole. It's only without this knowledge that conflict is destructive.

Divorce does not solve the problems of relationship. We may get rid of our partners, but we keep our problems, carting them into the next relationship. Divorce is incompatible with the intentions of nature.

Romantic love is supposed to end. It is the glue that initially bonds two incompatible people together so that they will do what needs to be done to heal themselves.

The good news is that although many couples become hopelessly locked in the power struggle, it too is supposed to end.

Regardless of what we may believe, relationships are not born of love, but of need; real love is born in relationships, as a result of understanding what they are about and doing what is necessary to have them.

You may already be with your dream partner, but at the moment, he or she is in disguise– and, like you, in pain. A Conscious Relationship itself is the practice you need to restore your sense of aliveness. The goal of Imago Practice is to change the power struggle and set you on the path of real love.

How to make conflict bring us closer

Many couples' problems are rooted in misunderstood, manipulated, or avoided communications. To correct this, we have created the Imago Dialogue, the core skill of Imago Practice.

Using this effective communications technique, you can restructure the way you talk to each other, so that what you say to each other is mirrored back to you, is validated, and empathized with. You can use the Imago Dialogue to tell each other all about your childhoods, to state your frustrations clearly, and to articulate exactly what you need from each other in order to heal.

Clear communication is a window into the world of your partner; truly being heard is a powerful aphrodisiac.

Over time, we move from a staring at exteriors to a sharing of interiors, as we learn to participate in the emotional realm of the other, while holding onto our own, separate experience.

Initially, Dialogue may feel artificial. With practice, it will become seamless and connecting.

In the Dialogue, both partners cross a bridge into each other's worlds, motivated not only by the Receiver's desire to be "hear and understand" but also to meet the Sender's need to be "heard and understood." The Dialogue fosters intentionality, a commitment to slow down our lives and devote specific uninterrupted time to our relationships. The Dialogue ultimately says to the other, "I respect your otherness; I want to learn from it. And I want to share mine with you."

One of the greatest learnings of Dialogue is the discovery of two distinct worlds. Whenever two people are involved, there are always two realities. These realities will always be different in small and large ways, no matter what. And the reality of the other person can be understood, accepted, valued, and even loved but not made to be identical to our own.

Finding true love

The Dialogue must also be turned into action: we give our partners what they need, and not just what is easy to give. Now we come to the heart of the matter: in a Conscious relationship we agree to change in order to give our partner what s/he needs. This is a radical idea. Conventional wisdom says that people don't change, that we should simply learn to accept each other as we are. But without change, there is no growth; we are confined to the fate, to remaining stuck in our unhappiness.

Change is the catalyst for healing. In changing to give our partners what they need, we heal our own painful experiences. Our own behavior was born in response to our particular deprivations; it is our adaptation to loss. In giving our partners what is hardest for us to give, we have to bring our hidden selves out into the light, owning and enlivening parts of ourselves. When we change our behavior in response to our mate, we heal our partner and ourselves.

I call the process by which we alter our entrenched behaviors to give our partners what they need stretching, for it requires that we conquer our fears and do what comes unnaturally. Our resistance reflects our defenses. Often we may feel that we're losing ourselves but we are not ourselves now; it is in the crucible of change that we regain ourselves.

Over the course of time, as our partners demonstrate their love for us, as they learn about and accept our hidden selves, and as we stretch to love our partners, our pain and self-absorption diminishes. We restore our empathic feelings for our partners, and our feelings of connection to the other that were lost in the pain of our childhood. Finally we learn to see our partners for themselves, with their own private world of personal meaning, their own ideas and dreams, and not merely as extensions of ourselves, or as we wish they were. We no longer say, "You liked that awful movie?", but rather "Tell me why you liked that movie. I want to know how you think."

Finally, we can relax; everything is all right.

A conscious relationship is a spiritual path which leads us home again, to joy and aliveness, to the feeling of oneness we started out with. All through the course of Imago Practice, we learn to express love as a behavior daily, in large and small ways: in other words, in stretching to give our partner what they need, we learn to love. The transformation of our relationships may not be accomplished easily or quickly; we are setting off on a lifelong journey.

Take the next step:

1. Read a copy of the *New York Times* bestseller, **Getting the Love You Want**

2. Attend an **Getting the Love You Want workshop by Harville and Helen** .

3. **Find a trained Imago Therapist or a workshop by a Certified Workshop Presenter** in your area.

The Essentials of Imago Theory and Practice: a paper on basic definitions

Bruce Crapuchettes, Ph.D.
May 23, 2005
(This is a paper written while being dean of the faculty for the two years of 2003/4 as an attempt to clarify various issues and get consensus among the faculty)

Introduction

History of the Imago International Institute

I will start by using the history in the 2005 Catalog of the Institute (pages 3-4):

Harville Hendrix, Ph.D. and Helen LaKelly Hunt, Ph.D. founded The Institute for Imago Relationship Therapy (IIRT) in 1984. It thrived for many years offering face-to-face learning opportunities and products that teach the dynamics of the committed relationship in achieving personal growth. This included national and international workshops and seminars for couples and singles, as well as training programs for qualified therapists in the theory and practice of Imago Relationship Therapy.

In 2001, Harville Hendrix and Helen LaKelly Hunt along with a Founding Board of Imago Therapists, transformed the Institute For Imago Relationship Therapy (IIRT) into a non-profit organization called Imago Relationships International, Inc. (IRI) which supports Imago therapists worldwide. This new non-profit organization, IRI, succeeded IIRT and gives it continuity to serve the larger international community even better. The Imago International Institute (III) is the education and training division of IRI and is supervised by the Board of IRI. Tim Atkinson is the president of the Imago International Institute and is responsible to the Board of IRI of which he is the Executive Director. About two thousand Certified Imago Therapists, one hundred and sixty Workshop Presenters and an Institute Faculty of twenty Clinical Instructors offer therapy, workshops, training courses and conduct ongoing research of significant relationships for the purpose of enhancing the systematic theory of Imago Relationship Therapy.

Imago Relationship Therapy, originating in the partnership of Harville and Helen, integrates the seminal interpersonal insights of major Western psychological systems, behavioral sciences, and spiritual disciplines into a uniquely comprehensive theory of primary love relationships. Developed from the exclusive study of couples, it presents an approach that builds on and extends previous efforts.

The “imago” is a theoretical construct, a composite image in the unconscious of the significant character traits and behaviors of childhood primary caretakers, both positive and negative. By pairing us with an “Imago Match” - an individual who is like our caretakers in emotionally significant ways - our unconscious drives us to re-create our childhood psychological dynamics in an attempt to heal the central wounds we carry. The process of Imago Relationship Therapy is

aimed at using this context to transform relationships into a therapeutic encounter and fuel for each partner's psychological and spiritual self-completion.

Imago Relationship Therapy utilizes a variety of clinical procedures to teach couples, and individuals desiring an intimate union, to identify their defenses against intimacy and to understand the unconscious forces that influence partner selection and contribute toward flawed relationships. Goals of the therapy include: constructively using the energy of relational frustrations rooted in primitive and illusionary ideation of one's love partner; recognizing the failure of archaic behavior to gratify needs and achieve self-completion; and perceiving one's partner realistically without the encumbrance of one's own unconscious projections. Other aspects of the Imago process involve learning new skills and changing hurtful behavior, in the course of which partners consciously aim to meet one another's needs and thereby restore the lost and denied parts of themselves. A core skill is a three-part dialogue that breaks couples out of defensive and symbiotic relating and promotes differentiation and compassion for the other. Eventually, each partner becomes skilled at containing the other's pain and reactivity. The Imago process is a transformative journey, and when applied consistently, promotes mutual healing and maturity.

History of the need for present definitional clarification

For the first 11 years of the Institute, Harville Hendrix focused on establishing the Institute and developing Imago theory and practice through teaching and writing. He trained and certified a dozen faculty members and certified five master trainers by 1995. The master trainers met regularly to help administrate the institute, train advanced Imago clinicians, and to continue developing the theory and practice along with Harville.

Harville, being a theoretician rather than an administrator, stayed with writing and speaking, while faculty volunteers helped lead the Institute. Since the faculty, including the master trainers, were all entrepreneurs, they were strong leaders in their own right, and lacking solid "deanship" leadership, Imago theory and practice evolved in a non-structured manner. There was good camaraderie among the faculty and they always tried to remain a "dialogical community," but not having strong leadership from a dean, the theory and practice became somewhat individualized over the next seven years. Imago was expanding worldwide, and creative leadership emerged here and there where the energy and resources were available.

By the end of 2002, Harville was concerned about the "loose" direction of the development of theory and practice. It has always been a vision of Harville's that the trainings and workshops be standardized enough so that couples attending a workshop in New York, Los Angeles, Auckland, Jerusalem, or Vienna, would all be getting the same workshop. His dream had also been that our Basic Clinical Training be standardized enough so that anyone around the world receiving Imago Therapy from a Certified Imago Therapist will be getting the same therapy. Another big hope of the whole Imago community is that more published research be done on Imago therapy so that it can become more known in the larger professional community and be a part of standard curricula in graduate schools. The problem with researching Imago therapy is that practice and implementation are not very precise making it difficult to research in a scientific manner.

Harville therefore spearheaded hiring me as the first paid part-time dean of the Institute from January 1, 2003, through January 31, 2005. My experience of being dean of the faculty the first year was like herding cats. The faculty, all being entrepreneurs, were each heading in their own direction. I first needed to build better connections between faculty members, make sure faculty meetings were substantive, and gradually bring the focus onto definitions of Imago theory and practice. Hopefully, the next step will be to gradually standardize the trainings and workshops enough so that Harville's dream of having a network of therapists worldwide who all teach and practice the same theory will be realized.

Having considered this task of definition for a long time and calling on others in the faculty to send me their ideas and papers on this topic, I will now pencil out a first draft of what Imago theory and practice looks like. Hopefully, this will be a good basis for discussion among the faculty and among the larger Imago community.

Obviously, I do not take credit for the contents of this paper. It is a compilation of the thinking of Harville Hendrix/Helen LaKelly Hunt, the faculty, and Imago therapists around the world.

The Essentials of Imago Theory

A. Cosmology

1. We are made up of neutral, pulsating energy.

2. Our essential state is that of relaxed joyfulness and empathic connection.

3. Because we are all from a common source and all part of the same web of the universe, as we participate in nature's healing plan for ourselves, we contribute not only to our own healing, but to the healing of our planet.

B. Evolution

1. Imago theory seeks to make sense of the nature of adult committed relationships.

2. When we suffer pain in our childhood experiences, we protect ourselves with maximizing and/or minimizing defenses and also block the expression of our basic functioning (thinking, feeling, sensing, and acting). These defenses disrupt the flow of our pulsating energy and disrupt our essential state of relaxation, joy, full aliveness, and connectedness. These maximizing and minimizing defenses are called our "denied self" because it is difficult to see ourselves clearly. The blockage of our four basic functions is called the "lost self." Other defenses develop what we call the "missing selves" such as the "hidden self," the "disowned self," the "presentational self," the "personal self" and the "social self."

3. Our wounding and defenses have been developed through both nature and nurture.

    a. Nature

Whereas we are part of the evolution of the animal kingdom, we inherit some qualities through our DNA and hormones. For example, tigers defend themselves primarily through the expansion of energy (scare or kill the enemy), while deer defend themselves through minimizing their energy (stand still or disappear). Common language calls this “fight or flight”. We have a mandate from nature: stay alive at all costs and even more, feel fully alive.

b. Nurture
In response to, or modeling ourselves after our parents, we learn during the early years of our lives (in combination with our innate tendencies, such as DNA) how to defend ourselves successfully enough to stay alive.

4. Nature has designed a program of self repair through the process of romantic attraction. Couplehood becomes the primary crucible for growth and healing because while couples are roughly equally wounded, their adaptation to their wounds are opposite and complementary.

C. The Relational Model

Imago therapy is making a shift from the **Individual Model** of psychotherapy to the **Relational Model** of psychotherapy. Even as physics now realizes that an electron can only be studied in its context, and when the context changes, the properties of the electron changes, so also in psychotherapy, we have come to realize that people must be understood within their context. Human beings are born into relationships, wounded in relationships, and heal in the context of relationships. Therefore, Imago therapists professionally see individuals in the context of group therapy and see those in committed, intimate relationships with their partners.

D. The Imago idea

The Imago idea has three parts:

1. Falling in love is a selection process at an unconscious level.
Couples choose their partners based on an unconscious image developed in childhood which is called the “Imago”. It is a composite image of both the positive and negative traits of one’s childhood caretakers. The negative traits have the strongest draw because it is the negative traits that indicate our unfinished business. We thus fall in love with what we call an “Imago Match”. We all have a yearning to become whole and complete. We therefore fall in love with someone who has the unique capacity to re-activate childhood wounds and who can be the best catalyst for that maturing and healing process we long for.

When we connect with this person, we will consciously feel an attraction, but we won’t know why. Since we have fallen in love with a person that has the negative characteristics of our early caretakers, they will be constitutionally incapable of giving us what we need, and we will be unable to give them what they need. They also will be wounded in about the same developmental stage but will defend themselves in the opposite manner from us, and they will have held onto functions

that we have lost. Through the power of romantic love and the chemicals that fuel it, we will become bonded. Because these chemicals make us feel so wonderful, we drop our defenses and get a taste of our full aliveness which is our birth right. When we fall in love, we are really falling in love with our anticipated wholeness, but we think we have fallen in love with the other person.

2. **The purpose of the attraction is to finish childhood.**
   Everyone has a deep longing to complete the unfinished business of childhood, a longing to finally grow up and become mature. "Marriage" or "the committed intimate relationship" is "finishing school." It gives us a second change to "grow up" and finally mature. The purpose of the connection is NOT to "feel happy". As we mature, we WILL feel happy. Growing up always entails some pain.

3. **Therefore, our task is to align our conscious mind with our unconscious agenda.**
   a. The agenda of the conscious mind is to feel good. We drink coffee or wine to feel good. We workout to feel good. We have sex to feel good. The conscious mind has a "feel good" agenda.

   b. The agenda of the unconscious mind is to grow and heal, to reach completion and wholeness. The unconscious mind does not really care if we feel good or not. In our deepest places, we yearn to move toward maturity which often entails pain. "No pain, no gain." This is why after marriage (or full commitment) couples move into the stage called the "power struggle".

E. Character Structure

1. Character Structure is what we develop to protect ourselves from the pain received in childhood. We either maximize or minimize our energies to protect ourselves from danger. For example, when sensing danger and wanting to protect ourselves, we might pursue while in relationship, or conversely, we might distance ourselves to feel safer.

2. When we are in pain, we become self absorbed and lose our sense of empathic connection. We become symbiotic, meaning that each of us only see the world one way, "my way." "You and I are one, and I'm the one." One of the primary goals of Imago therapy is to break the emotional symbiosis. (This is different from biological symbiosis where two organisms work together to enhance each other's lives.)

   Empathy is the cure for symbiosis. The Imago Dialogue is the structure through which we learn empathy.

F. Developmental Stages

1. As children grow up in their families of origin, they go through stages of development. The first four stages, attachment, exploration, identity, and competence, are the most important and last about 2 years each. All children are wounded to a certain degree in childhood in all stages of development. But most of

us have a primary wound in one of these stages. We select a partner through the process of Romantic Love who is also wounded in the same or an adjacent stage, but has developed the opposite defense to that wound.

2. All adult intimate relationships go through stages that will include the unconscious stages of romantic love and the power struggle. These are called unconscious stages because they are driven by reactivity. In the "romantic love stage" the couple is reactively nice. In the "power struggle stage" the couple is reactively nasty. If a couple is willing to discover the possibilities inherent in having a conscious relationship (meaning, a relationship driven by intentionality rather than reactivity) there will be four more stages to go through, that of re-commitment, doing the work, awakening and real love. These are cyclical and spiral upward. The relationship is never static. The "journey toward consciousness" remains a journey and never "arrives." As a couple reaches "real love" for a while, they then recycle through re-commitment, doing the work, awakening, and real love again and again, ever circling higher. At any point, a couple may fall into a very dark valley, but if they continue to desire to move toward consciousness, they can always re-commit themselves to the growth and healing process.

G. Growth

Growth is modifying character structure (our defensive system) which served us well in childhood but is blocking intimacy in adult relationships. This growth (modification of character structure) is necessary to be able to meet our partner's needs, thus bringing them healing. We have developed characterologically in such a manner that we are fundamentally defended against meeting our partner's needs. We call meeting our partner's needs stretching. Without stretching there is no growth and no healing. Imago says, "My partner's needs are the blue print for my growth."

H. Healing

Healing is getting our needs met that were not met in childhood. As children, we were wounded by the intimate other (our parents). When we left home, our parents stopped being the intimate other, and we found an intimate other that has the negative character traits of our parents in order to finish childhood and become healed and mature. As adults, our actual parents no longer have healing power because they cease to be the intimate other. Now the partner, who carries the traits of our parents, becomes the intimate other who has the potential to bring us healing (and the potential to would us all over again, even worse that during childhood). I like the movie title, "Sleeping With The Enemy.")

I. Self Hatred

Deep unconscious self hatred coming from not getting our needs met in childhood prevent clients from receiving the love that is given to them. During childhood we suppressed our needs because it was our needs that caused parental worry and anxiety. For example, during the exploration stage of development, we touched and tasted things and walked in places that made our parents anxious. In the identity stage of development, we tried on life characters (cops and robbers, nurse and doctor) that made

our parents feel squeamish. We suppressed our needs as children, not only wanting to "take care of" our parents, but also because we felt we were the problem in their lives, we made them anxious. Therefore, as adults, we are not in touch with our (hated) needs, and when our partner is willing to "stretch" and grow to meet our needs, we feel unworthy and uncomfortable and push the gift away. This unconscious "self hatred" is then acted out in the relationship through the defense of projection. We project onto our partners what we dislike and hate in ourselves and then criticize them for it.

Needing to "stretch and grow" in a relationship and "pushing healing gifts away" are the two main blocks for reaching human maturity.

J. Therefore, we see the following in couples:

1. The difficulties/conflicts that arise in intimate partnerships are rooted in childhood pain. These conflicts are essential if the couple is going to mature. "Conflict is growth trying to happen."

2. In an intimate relationship, both partners contribute equally to the conflict. The relationship exists in a balanced system. This is often very difficult to see.
   a. Both are equally wounded.
   b. Both are equally intelligent.
   c. Both are equally interested in growing and healing.

3. Since the roots of the power struggle lies in childhood woundedness, the solution is not in terms of problem solving, but in terms of healing. "Relationship problems are not solvable, they are only healable."

4. Healing and growth can happen in all relationships. But the greater the degree of commitment and intimacy in the relationship, the greater the potential for healing and growth. Therefore, the committed, intimate partnership is the place where deepest growth and healing can take place. Friendships can bring some healing, but only to the extent of commitment and intimacy.

5. The growth/healing process happens over time and will require that each transcend their own reactivity and replace it with intentional behaviors. Thus the healing journey is from reactivity to intentionality. This is what we call "becoming conscious."

The Essentials of Imago Practice

A. The practice of Imago therapy

We think that all couples desire safety and passion.

1. Safety

Couples need physical and emotional safety so that they can be vulnerable enough to "do the work." Imago practice is designed to develop safety between couples so that the embedded potential for healing and growth will emerge. Only in safety will the healing life force arise and the energy for personal growth be unleashed. In addition to the goal of healing and growth, Imago practice brings about connection and differentiation. Safety is brought about through the use of structure. Structure is at the heart of Imago work. The less safe a couple feels, that is more conflict and chaos, the more structure is needed. Imago therapists do not allow couples to discuss, chat, talk, or negotiate their problems during sessions. All Imago work is done through structured dialogues. The therapist/coach is responsible to shift the energy out of criticism, blame or shame into self-disclosure.

2. Passion

   All couples want passion. They want to be in touch with the life force that is their birth-right. They want to feel that "you and I make a great team." They want to feel sexually alive. They want to feel effective and energized in the world. We see passion as a function of safety. As "the work" is done, passion emerges. Therefore, Imago therapists do not focus at first on passion. The focus of the work is developing safety. Passion work, or "re-romanticizing" work, is done when enough safety has first been established.

The practice of Imago therapy contains the following:

1. Couples face each other and are coached to dialogue with each other. The way the office is set up is important. If the couple sits on a couch facing the therapist, it is as if the healing power comes from the therapist, "the doctor." Imago therapists see themselves as "coaches" rather than "doctors." They are coaches of process. The healing power lies between the couple who face each other and talk to each other, not to the therapist.

   Dialogue consists of:
   a. Mirroring
   b. Validation
   c. Empathy
   d. Response

2. There is very little teaching or counseling in an Imago session. It mostly consists of the facilitator holding the couple in dialogue with each other. Theory itself holds no healing power. Couples often want to intellectualize by asking many questions about the theory. We feel it is important to not get pulled into discussing Imago or doing paper/pencil exercises. This is left to the Imago Workshops (for couples or for individuals). I have had some couples in therapy for several sessions before they ever discover that the therapy is based on "Imago Theory." I suggest that Imago therapists recommend their clients to take Harville's workshops, either "Getting…" or "Keeping…", in order to get the theory.

3. The presenting "problem" is seen as only the tip of the iceberg which is not solvable but only healable as the couple is coached deeper through the use of dialogue into the dynamics that lie behind "the problem". The conflict and ensuing power struggle in a relationship is only a bubbling up of the unfinished business from childhood. The goal of the facilitator is to deepen the couple into the unfinished business rather than trying to solve the presenting problem.

4. The practice of Imago Relationship Therapy consists of:
    a. The Imago Dialogue (or The Formal Dialogue): The flesh and blood of Imago therapy. Through the Imago Dialogue, a sacred space can be created between a couple that will allow them to more clearly understand the unconscious agenda hidden in their power struggle and find the roadmap for growth and healing that will restore safety and passion. The equalization of power in the couple is key to Imago therapy. As children we often felt powerless. As adults we want equality.
        i. The Imago Dialogue is to bring about re-connection
            -done through mirroring, validation, and empathy.
        ii. The Imago Dialogue is to break the symbiosis and develop differentiation
            -done through mirroring, validation, and empathy.

        Through the use of the Imago Dialogue, couples learn to become curious about and honor the other person's perspective and realize that the other perspective is just as valid as theirs.
    b. Behavior Change Request Dialogue: This Dialogue is the backbone of Imago therapy because no relationship can mature without changes of behaviors.
        i. To use the energy of frustration to transform the relationship from criticisms to asking directly and positively to have your needs met by:
            1. coaching the sender to feel the pain behind the frustration
            2. coaching the sender to get in touch with the childhood wound that lies underneath the present pain
            3. coaching the sender to get in touch with the sadness underneath the childhood wound
            4. coaching the sender to re-experience the sadness behind the unmet needs as a child in the home of origin
        ii. To bring about healing by:
            1. coaching the sender to transform their broad unmet needs in positive, concrete and behaviorally measurable requests
            2. coaching the sender to make their requests small and time limited
        iii. To bring about growth by:
            1. coaching the receiver to stretch and modify their character structure that has limited their ability to give healing gifts
            2. coaching the receiver into making a decision to become their partner's healer (the stand-in for the parent who gave the original wound) through the granting of requests and to view them as gifts

c. Parent/Child Dialogue
   - to get in touch with the childhood wound and the sadness behind it
   - to help the receiver gain empathy for the sender

d. Holding Exercise
   - to get in touch with pain from outside the relationship
   - to help the receiver gain empathy for the sender

e. Positive Container Exercise
   - to tap into the healing potential of joy energy

f. Flooding of Admiration
   - to get in touch with the positive elements of the relationship and feel romantically connected

g. Develop a positive relationship vision
   - to catch a vision of where the couple is going and letting that vision "pull" them in that direction

4. Much emphasis above is put on "coaching." The word is repeated frequently so that the reader will get the importance of deepening the work through coaching. The coach is in charge of whatever happens in the room. An interesting paradox is that the coach is fully in charge, but not controlling. Advanced skills in Imago therapy is learning how to coach couples to go deeper and get in touch with their emotions, their pain, their sadness. Questions, or talking to the client encourages the client to intellectualize. Coaching is done by talking <u>through</u> the client (not to the client), giving them words to say to their partner, words that accurately reflect their inner world. This requires good tracking.

   Coaching to go deeper is done by the use of:

   a. Lead lines

      This is when the coach gives an incomplete sentence leading to feelings.
      "When you distance yourself from me, I feel . . ."
      "What I'm afraid of is . . ."

   b. Doubling

      This is when the coach gives a complete sentence that includes a feeling word that is thought to be at the tip of the sender's tongue. It is always held lightly and easily changed.
      "I feel lonely."
      "I feel sad."

   c. Instructions

      These instructions are very short. (Do not "teach" here.)
      "Mirror that back."
      "Tell him more about that."

      Most instructions can be eliminated through the use of lead lines. For example, rather than say, "Mirror that back," the coach can say, "So what

you're saying is . . ." Or, rather than "Now, I would like you to empathize," the coach can say, "I imagine you are feeling . . ."

B. The essentials of the Imago Dialogue

1. An appointment is made.
2. The couple speaks to each other.
3. First, there is a listening phase where the receiver mirrors the sender.
   The receiver mirrors accurately containing their own emotions. I recommend word for word mirroring in this section.
4. Second, there is a validation phase
   a. The first step is a summary mirror.
      One may be able to mirror each segment accurately without "getting" the meaning of the send. A summary is the first step of validation because it lets the sender know that s/he has been logically "followed, and has gotten the essence of the send."
   b. Validating sentences are:
      "I follow what you are saying."
      "Your perspective is valuable and important to me."
      "You make sense."
5. Third, there is an empathy phase.
   a. Guesses are made by the receiver as to what the sender might be feeling.
   b. These guesses are checked out and validated.
6. Forth, there is a receiver phase which includes mirroring, validation and empathy.
   a. The receiver says, "I would like to respond."
   b. The receiver responds to the topic chosen by the sender. There is only one topic per dialogue. Imago Dialogues always have a response, otherwise it is a monologue. Being able to handle a response is the only way to break the symbiosis. It is important to keep in mind that the Imago Dialogue is not designed to "feel good." Usually differentiation does not feel good. The Imago Dialogue is designed both for connection **and** differentiation.
7. It is the responsibility of the therapist to coach the sender out of criticism and blame into self disclosure.

C. The essentials of the Behavior Change Request Dialogue (BCR Dialogue)

1. An appointment is made.
2. The couple speaks to each other.
3. Active, step-by-step preparation of the receiver
4. A frustration send
   a. Coaching helps the sender use the energy of **frustration** to get in touch with and **name the pain** behind the frustration (ie: I feel unimportant and abandoned). Coaching moves the sender into self-revelation and vulnerability.
   b. There is only one summary mirror at the end of the send so that the "affective flow" is not broken (No word for word mirroring here). The coach does not ask questions nor allows multiple mirrors. There is no check for accuracy from the receiver. The coach is the check for accuracy and will double to help the receiver mirror accurately. The goal is to keep the sender in an affective state.

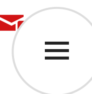
   c. There is no validation or empathy as separate sections of this dialogue because it will break the **affective flow** which is all important. The coach makes sure the mirror is warm and connecting as much as possible.
5. The coach has the receiver say a transition sentence that picks up one or two "pain words" from the frustration send.
   For example:
   "When you feel **unimportant** and **abandoned** by me, what does that remind you of in childhood?"
   "When you feel **blamed** and **criticized** by me, what does that remind you of in childhood?"
6. A childhood wound send
   a. Coaching moves the sender from the **wound** to the **sadness** underneath the wound
   b. There is only one summary mirror at the end of the send (not word for word) so that the "affective flow" is not broken. The coach does not ask questions nor allows multiple mirrors.
   c. Once in childhood, the coach makes sure the sender stays in childhood so that the receiver does not lose their growing empathy.
7. A short statement of need. It is a broad, general need tied to the unmet need of childhood that is positively stated. For example, "I need to feel connected to you."
8. Three positive SMART requests:
   SMART =
   S - Specific (a behavior)
   M - Measurable (frequency)
   A - Achievable (a small step)
   R - Relevant (relevant to either the frustration or the need)
   T - Time limited (two weeks)
9. Requests are mirrored
10. All three requests are written down, and at least one is granted. The others are excellent topics for Imago Dialogues later.

D. The essentials of the Parent/Child Dialogue

1. The couple speaks to each other.
2. An appointment is not necessary since it springs from work being done in the Imago session. The coach my say, "Since you are talking about your mother, I would like you to do a role play and actually talk to your mother in the present tense. Would you be willing to do that?" And to the receiver, "Would you be willing to role play being the mother?"
3. The dialogue is a role play.
4. The sender is the child and chooses an early age to speak from.
5. The send is in the present tense from the chosen age.
6. The coach has the "as if good parent" lead the dialogue by asking the following questions and then mirrors each response in summary form only. The receiver does **not** coach the sender.
   a. "What is it like living with me?"
   b. "What is your deepest hurt with me?"
   c. "What do you need from me?"

   d. The coach does **not** have the receiver ask, "What did you do to protect yourself as a child?" This breaks the affective flow and forces the child to become cognitive and come back to adult thinking. While this is theoretically interesting, it is clinically disruptive during this dialogue.
7. The receiver, the "as if good parent," only mirrors in summary form after each segment of the send so that the affective flow is not broken (as in the BCR Dialogue above). There is no validation or empathy as separate sections of this dialogue because it will break the **affective flow** which is all important. The coach makes sure the mirror is warm and connecting as much a possible.
8. The couple now de-roles.
9. The receiver, now as spouse, becomes the sender and says something like the following:
   a. "As Bob/Nancy, I heard that you were wounded by . . . (feeling lonely and disconnected) in childhood."
   b. "I want to learn how to heal these wounds . . . (of loneliness and disconnection) in our present relationship."
   c. "You deserve it!"

   The former "child" now the current partner mirrors each send and says, "Thank you."



HARVARD UNIVERSITY
The Graduate School of Arts and Sciences

FEBRUARY 14, 2017

BLOG

Love, Actually: The science behind lust, attraction, and companionship

by Katherine Wu
figures by Tito Adhikary

In 1993, Haddaway asked the world, "**What is Love?**" I'm not sure if he ever got his answer – but today, you can have yours.

Haddaway - What Is Love [Official]

Sort of.

Scientists in fields ranging from anthropology to neuroscience have been asking this same question (albeit less eloquently) for decades. It turns out the science behind love is both simpler and more complex than we might think.

Google the phrase "biology of love" and you'll get answers that run the gamut of accuracy. Needless to say, the scientific basis of love is often sensationalized, and as with most science, we don't know enough to draw firm conclusions about every piece of the puzzle. What we do know, however, is that much of love *can* be explained by chemistry. So, if there's really a "formula" for love, what is it, and what does it mean?

Total Eclipse of the Brain

Think of the last time you ran into someone you find attractive. You may have stammered, your palms may have sweated; you may have said something incredibly asinine and tripped spectacularly while trying to saunter away (or is that just me?). And chances are, your heart was thudding in your chest. It's no surprise that, for centuries, people thought love (and most other emotions, for that matter) arose from the heart. As it turns out, love is all about the brain – which, in turn, makes the rest of your body go haywire.

According to a team of scientists led by Dr. Helen Fisher at Rutgers, romantic love can be broken down into **three categories**: lust, attraction, and attachment. Each category is characterized by its own set of hormones stemming from the brain (Table 1).

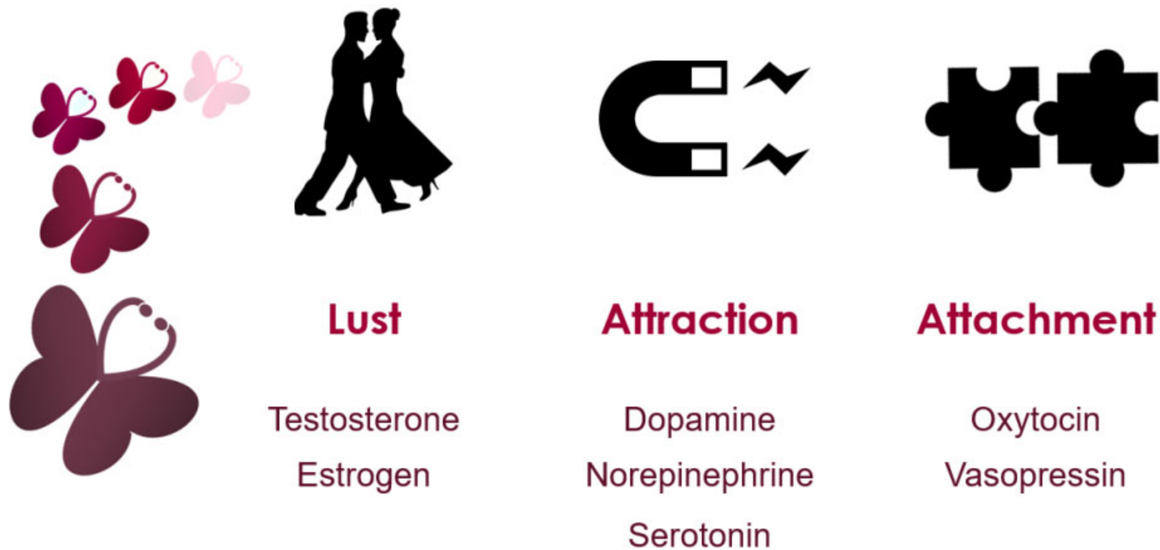


Table 1: Love can be distilled into three categories: lust, attraction, and attachment. Though there are overlaps and subtleties to each, each type is characterized by its own set of hormones. Testosterone and estrogen drive lust; dopamine, norepinephrine, and serotonin create attraction; and oxytocin and vasopressin mediate attachment.

Let's Get Chemical

Lust is driven by the desire for sexual gratification. The evolutionary basis for this stems from our need to reproduce, a need shared among all living things. Through reproduction, organisms pass on their genes, and thus contribute to the perpetuation of their species.

The hypothalamus of the brain plays a big role in this, stimulating the production of the sex hormones **testosterone** and **estrogen** from the testes and ovaries (Figure 1). While these chemicals are often stereotyped as being "male" and "female," respectively, both play a role in men and women. As it turns out, testosterone increases libido in just about everyone. The effects are less pronounced with estrogen, but some women report being more sexually motivated around the time they ovulate, when estrogen levels are highest.

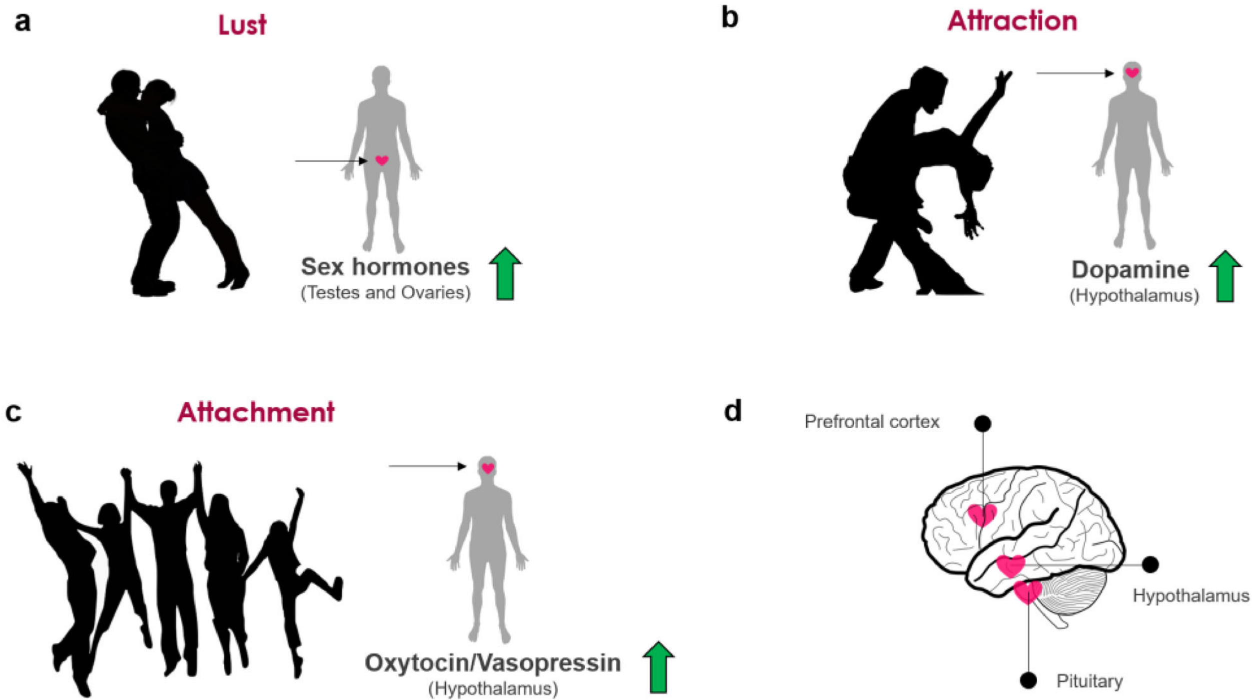


Figure 1: A: The testes and ovaries secrete the sex hormones testosterone and estrogen, driving sexual desire. B and C: Dopamine, oxytocin, and vasopressin are all made in the hypothalamus, a region of the brain that controls many vital functions as well as emotion. D: Several of the regions of the brain that affect love. Lust and attraction shut off the prefrontal cortex of the brain, which includes rational behavior.

Love is its Own Reward

Meanwhile, **attraction** seems to be a distinct, though closely related, phenomenon. While we can certainly lust for someone we are attracted to, and vice versa, one can happen without the other. Attraction involves the brain pathways that control "reward" behavior (Figure 1), which partly explains why the first few weeks or months of a relationship can be so exhilarating and even all-consuming.

Dopamine, produced by the hypothalamus, is a particularly well-publicized player in the brain's reward pathway – it's released when we do things that feel good to us. In this case, these things include spending time with loved ones and having sex. High levels of dopamine and a related hormone, **norepinephrine**, are released during attraction. These chemicals make us giddy, energetic, and euphoric, even leading to decreased appetite and insomnia – which means you actually can be so "in love" that you can't eat and can't sleep. In fact, norepinephrine, also known as noradrenalin, may sound familiar because it plays a large role in the **fight or flight** response, which kicks into high gear when we're stressed and keeps us alert. Brain scans of people in love have actually shown that the primary "reward" centers of the brain, including the ventral

tegmental area and the caudate nucleus, **fire like crazy** when people are shown a photo of someone they are intensely attracted to, compared to when they are shown someone they feel neutral towards (like an old high school acquaintance).

Finally, attraction seems to lead to a reduction in **serotonin**, a hormone that's known to be involved in appetite and mood. Interestingly, people who suffer from obsessive-compulsive disorder also have low levels of serotonin, leading scientists to speculate that this is what underlies the overpowering infatuation that characterizes the beginning stages of love.

The Friend Zone

Last but not least, **attachment** is the predominant factor in long-term relationships. While lust and attraction are pretty much exclusive to romantic entanglements, attachment mediates friendships, parent-infant bonding, social cordiality, and many other intimacies as well. The two primary hormones here appear to be **oxytocin** and **vasopressin** (Figure 1).

Oxytocin is often nicknamed "cuddle hormone" for this reason. Like dopamine, oxytocin is produced by the hypothalamus and released in large quantities during sex, breastfeeding, and childbirth. This may seem like a very strange assortment of activities – not all of which are necessarily enjoyable – but the common factor here is that all of these events are precursors to bonding. It also makes it pretty clear why having separate areas for attachment, lust, and attraction is important: we are attached to our immediate family, but those other emotions have no business there (and let's just say people who have muddled this up **don't have the best track record**).

Love Hurts

This all paints quite the rosy picture of love: hormones are released, making us feel good, rewarded, and close to our romantic partners. But that can't be the whole story: love is often accompanied by jealousy, erratic behavior, and irrationality, along with a host of other less-than-positive emotions and moods. It seems that our friendly cohort of hormones is also responsible for the downsides of love.

Dopamine, for instance, is the hormone responsible for the vast majority of the brain's reward pathway – and that means controlling both the good and the bad. We experience surges of dopamine for our virtues *and* our vices. In fact, the dopamine pathway is particularly well studied when it comes to addiction. The same regions that light up when we're feeling attraction

light up when drug addicts take cocaine and when we binge eat sweets. For example, cocaine **maintains dopamine signaling** for much longer than usual, leading to a temporary "high." In a way, attraction is much like an addiction to another human being. Similarly, the same brain regions light up when we become addicted to material goods as when we become emotionally dependent on our partners (Figure 2). And addicts going into withdrawal are not unlike love-struck people craving the company of someone they cannot see.

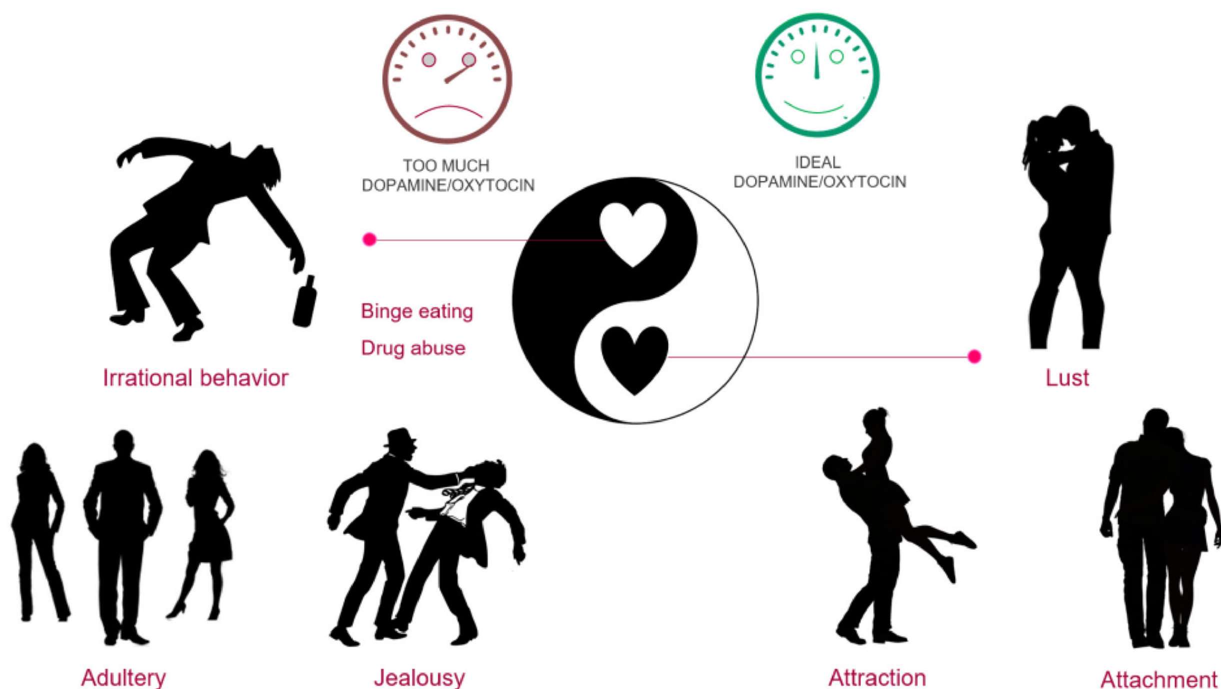


Figure 2: Dopamine, which runs the reward pathways in our brain, is great in moderate doses, helping us enjoy food, exciting events, and relationships. However, we can push the dopamine pathway too far when we become addicted to food or drugs. Similarly, too much dopamine in a relationship can underlie unhealthy emotional dependence on our partners. And while healthy levels of oxytocin help us bond and feel warm and fuzzy towards our companions, elevated oxytocin can also fuel prejudice.

The story is somewhat similar for oxytocin: too much of a good thing can be bad. Recent studies on party drugs such as MDMA and GHB shows that oxytocin may be the hormone behind the **feel-good, sociable effects** these chemicals produce. These positive feelings are taken to an extreme in this case, causing the user to dissociate from his or her environment and act wildly and recklessly. Furthermore, oxytocin's role as a "bonding" hormone appears to **help reinforce the positive feelings** we already feel towards the people we love. That is, as we become more attached to our families, friends, and significant others, oxytocin is working in the background, reminding us why we like these people and increasing our affection for them. While this may be a good things for monogamy, such associations are not always positive. For example, oxytocin has also been suggested to play a role in ethnocentrism, increasing our love for people in our

already-established cultural groups and making those unlike us seem more foreign (Figure 2). Thus, like dopamine, oxytocin can be a bit of a double-edged sword.

And finally, what would love be without embarrassment? Sexual arousal (but not necessarily attachment) appears to **turn off** regions in our brain that regulate critical thinking, self-awareness, and rational behavior, including parts of the prefrontal cortex (Figure 2). In short, love makes us dumb. Have you ever done something when you were in love that you later regretted? Maybe not. I'd ask a certain star-crossed **Shakespearean couple**, but it's a little late for them.

So, in short, there is sort of a "formula" for love. However, it's a work in progress, and there are many questions left unanswered. And, as we've realized by now, it's not just the hormone side of the equation that's complicated. Love can be both the best and worst thing for you – it can be the thing that gets us up in the morning, or what makes us never want to wake up again. I'm not sure I could define "love" for you if I kept you here for another ten thousand pages.

In the end, everyone is capable of defining love for themselves. And, for better or for worse, if it's all hormones, maybe each of us can have "chemistry" with just about anyone. But whether or not it goes further is still up to the rest of you.

Happy Valentine's Day!

Katherine Wu is a third-year graduate student at Harvard University. She loves science with all of her brain.

Further Reading

1. For a long-form human interest story on love, see National Geographic's coverage of **"True Love"**
2. For a very in-depth (and well-done!) introduction to the brain and its many, many chemicals, check out the **NIH's Brain Basics page**
3. For the New York Times' take on falling in love with anyone, ask these **36 questions**

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203 thoughts on "Love, Actually: The science behind lust, attraction, and companionship"

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Randomized Controlled Trial of Imago Relationship Therapy: Exploring Statistical and Clinical Significance

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Randomized Controlled Trial of Imago Relationship Therapy: Exploring Statistical and Clinical Significance

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ABSTRACT

For decades, couples around the world have used Imago relationship therapy (IRT) to improve their relationships. While anecdotal success stories abound, no randomized controlled trial of IRT's impact has been accomplished until now. The authors review the results of a randomized controlled trial of distressed, treatment-seeking couples who completed 12 sessions of IRT and the impact their involvement had on their marital satisfaction. Results showed that (a) individuals in the treatment condition experienced statistically significant increases in marital satisfaction, while couples in the control group did not; (b) levels of marital satisfaction did decrease significantly from posttreatment to follow-up but remained significantly higher than at pretreatment; (c) though statistically significant, the improvements experienced by the treatment group were not clinically significant improvements; and (d) while approximately one-third of participants achieved recovery during treatment, at the dyad level, only one couple achieved recovery. Further analysis and recommendations for future research are discussed.

KEYWORDS

Imago relationship therapy; couples counseling; clinical significance; randomized controlled trial

Committed romantic relationships have a significant impact on an individual's psychological and physical well-being, and it is commonly accepted that personal happiness is highly associated with the type of relationship one has with one's intimate partner (Dyrdal, Roysamb, Nes, & Vitterso, 2011; Headey, Veenhoven, & Wearing, 1991). A positive romantic relationship can buffer against mental health issues (Seikkula, Aaltonen, Kalla, Saarinen, & Tolvanen, 2013) and a significant body of scholarship has demonstrated that couples therapy is an effective method for reducing both relational distress and individual psychological symptoms (Beach, Dreifuss, Franklin, Klamen, & Gabriel, 2008; Snyder, Castellani, & Whisman, 2006; Snyder & Halford, 2012).

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There are a number of approaches to couples counseling that are currently being used by therapists. Two of these approaches, behavioral couples therapy and emotion-focused couples therapy, have received the widest attention in the research literature, having been evaluated through multiple clinical trials and having been found to be effective in producing clinically and statistically significant reductions in relationship distress (Lebow, Chambers, Christensen, & Johnson, 2012; Snyder et al., 2006). Other approaches to couples therapy, such as interpersonal, cognitive-systemic, and communication-focused therapies, are currently building a research base (Snyder & Halford, 2012). However, some approaches that are experiencing widespread domestic and international use have yet to be rigorously examined.

The present randomized controlled trial seeks to bring comprehensive empirical attention to Imago relationship therapy (IRT; Hendrix, 2008), an integrative approach to couples therapy that has been practiced extensively for more than 30 years. IRT is a theoretical and applied methodology for working with couples in committed relationships. While preliminary research has been conducted on IRT, no randomized controlled trial has been completed until now. For couples and for the field of mental health, there is a critical need and great utility in evaluating the effectiveness of interventions already in broad use (Stratton, 2011). Taking into account IRT's widespread attention and use, Lazarus (2000) highlighted the need to move beyond IRT's foundation of "charisma, conjecture, anecdotes, and untestable theories" (p. 224). Additionally, Berger (1997) challenged the Imago community to conduct robust research that would include control groups, randomization, objective measures, and posttreatment follow-up.

Couple Distress

As stated previously, romantic relationships impact individual well-being both psychologically and physically (Synder & Halford, 2012). Positive couple relationships can be a source of support to manage stress and can positively impact personal happiness (Hilpert, Bodenmann, Nussbeck, & Bradbury, 2012). The vast majority of people around the world continue to choose to marry (United Nations Social Affairs Population Division, 2003), despite falling marriage rates in recent decades and the belief of 39% of Americans that marriage is becoming obsolete (Pew Research Center, 2010). Perhaps the most relevant indicator of relational distress is the 40% to 50% divorce rate (Snyder & Halford, 2012; Stanley, 2007).

Distress in romantic relationships is itself strongly associated with mental health problems such as depression, anxiety, and substance abuse (Whisman, 2007). Such distress is also associated with poor physical health (Kiecolt-Glaser & Newton, 2001). Additionally, parents in distressed relationships are more likely to use negative parenting techniques with their children, leading to a host of potential problems, such as having a higher risk for poor mental health and lower academic achievement (Afifi, Boman, Fleisher, & Sareen, 2009; Krishnakumar & Buehler, 2000; Potter, 2010).

Couples Therapy

Couple communication styles are directly associated with marital satisfaction (Heyman, 2001; Walitzer, Dermen, Shyhalla, & Kubiak, 2013), and negative communication patterns are a strong predictor of marital dissatisfaction and marital dissolution (Kiecolt-Glaser, Bane, Glaser, & Malarkey, 2003). Therefore, most approaches to couples therapy focus on enhancing communication and cultivating the couple's emotional bond (Reibstein & Burbach, 2013).

The evidence for the efficacy of couples counseling continues to grow. In the United States, the National Registry of Evidence-based Programs and Practices, part of the United States' Substance Abuse and Mental Health Services Administration, includes several forms of couples therapy and programs for marriage enrichment (NREPP, 2015). The proliferation of evidence-based couples counseling underscores the ultimate need for therapeutic modalities to demonstrate their clinical efficacy and serves as a justification for the present study.

Imago Relationship Therapy

Harville Hendrix and Helen LaKelly Hunt developed IRT in 1980 as a theoretical and applied methodology for working with couples in committed relationships (Martin & Bielawski, 2011). Today, there are more than 1000 certified Imago therapists in more than 30 countries (Imago Relationships International [IRI], n.d.). IRT integrates psychodynamic approaches (e.g., ego psychology, attachment theory, and object-relations psychology), transactional analysis, and cognitive-behavioral approaches and hypothesizes that unconscious factors play a significant role in mate selection and the development of conflict in romantic relationships (Zielinski, 1999). Unconscious partner selection creates an opportunity to heal a connection that was lost in childhood by increasing empathy, understanding, and communication with one's adult romantic partner (Love & Shulkin, 2001). In healing childhood wounds, IRT emphasizes growth within a relational paradigm by focusing on the self-in-relation rather than the self-as-independent. Growth is seen as occurring through relationships, as opposed to through individuation and separateness, which is often touted as the pinnacle of personality development (Banks, 2011).

The self-in-relation first occurs in infancy between child and caretaker. Within this first intimate relationship, the child learns to define the self through actions and words that receive either validation or neglect from early caretakers. These interactions, in turn, facilitate a growth process that can build connection and empathy or foster defensive disconnection (Jordan, 1995). If an individual experiences ongoing violations in close relationships, then self-protection is learned and implemented (Jordan, 1995). IRT seeks to correct developmental stumbling blocks and childhood wounds by restoring the connection between partners.

IRT Interventions

Imago therapists actively help couples learn and apply connection-building skills though a number of specific interventions, such as the couples dialogue, parent–child dialogue, behavior change request dialogue, and Imago workup. The following paragraphs summarize these interventions and are drawn from the *Imago Training Manual* (IRI, 2014), part of the educational materials used by the therapists in the present study during their training.

The Couples Dialogue

Imago therapy is perhaps best recognized by the use of the couples' dialogue. The couple learns to effectively communicate by taking turns as the "sender" or the "receiver." By using a three-step process of mirroring, validating concerns, and expressing empathy, couples practice paraphrasing, interpreting content and meaning, and asking for clarification. Couples learn to express genuine care for each other and are curious about each other's views, which creates feelings of safety, even in times of disagreement.

The Parent–Child Dialogue

This dialogue takes the sender back to their experiences in childhood, allowing the sender to identify his or her thoughts and feelings associated with a childhood caretaker and then direct them towards his or her current romantic partner. The dialogue is designed to enable the receiver to experience empathy for the sender's unmet childhood needs and understand how they relate to present needs in the relationship.

The Behavior Change Request Dialogue

This process is a formal expression from the sender that allows the receiver to hear and empathize with a present frustration in the relationship and how it relates to an unmet childhood need. At the end of the dialogue, the sender requests three specific, small behavior changes that relate to the frustration (e.g., "I request that you make dinner for me once during the next week"). The receiver then chooses to try one of the requested behavior changes. The couple is taught specific goal-setting techniques to meet the expressed needs and encouraged to display gratitude for the vulnerable expression of personal needs.

The Imago Workup

The Imago workup is a psychoeducational exercise that encourages individuals to identify positive and negative traits in their partner that are similar to those of an early childhood caretaker (e.g., available, energetic, short-tempered, or overbearing). This helps the couple understand the similarities between their romantic partner and childhood caretakers and how these similarities can contribute to relationship frustrations.

Imago Research

Several nonrandomized, noncontrolled preliminary research studies have been conducted that lend some validity to the efficacy of IRT (aHannah, Luquet, & McCormick, 1997; Hannah et al., 1997b; Luquet & Hannah, 1996). IRT is usually delivered through either traditional in-office therapy or through the Getting the Love You Want Workshop (GTLYW Workshop), a manualized, 2-day psychoeducational workshop conducted by certified presenters. Studies have been conducted in both settings (Pitner & Bailey, 1998; Weigle, 2006). We present here a review of research on the use of IRT in clinical settings. For a review of preliminary studies on the GTLYW workshop, see Hogan, Hunt, Emerson, Hayes, and Ketterer (1996) and Schmidt, Luquet, and Gehlert (2015).

Luquet and Hannah (1996) hypothesized that IRT would have a positive effect on communication skills and specifically that IRT would promote empathy, intimacy, and conflict resolution in couples' relationships. The researchers administered the Marital Satisfaction Inventory (Snyder, Wills, & Keiser, 1981) to analyze couples' progress. Upon completing a manualized six-session course of IRT, the nine couples showed significant improvement on the subscales of Global Distress, Affective Communication, and Problem Solving Communication. In a further examination of data analyzed by Luquet and Hannah (1996), Hannah et al. (1997b) assessed participants' functioning in the life areas of family, health, intimacy, social life, and work. In the same sample, there were significant changes on the Well-Being, Symptoms, and Life-Functioning subscales.

Both of these studies were limited by their extremely small sample size; use of a mostly Caucasian, middle-class, and middle-aged sample; and reliance on only correlational analyses when examining associations between the outcome measures. The Hannah et al. (1997b) study was limited by its reliance on data collected using COMPASS, which has been only nominally examined in the research literature.

Hannah et al. (1997a) investigated the association between short-term IRT and outcomes of health and psychosocial wellness, narcissism, relationship maturity, didactic adjustment, and the use of Imago skills. In 21 couples, results revealed statistically significant changes from pretreatment to posttreatment on indices of dyadic adjustment, commitment, relationship maturity, and the use of Imago skills. There was also a statistically significant increase in participants' scores on the Well-Being COMPASS scale; scores on Life Functioning were not significantly higher posttreatment.

As in the aforementioned studies, the research by Hannah et al. (1997b) was limited in the use of a similarly nondiverse sample and reliance on COMPASS. Further, the study lacked *a priori* hypotheses and neglected to examine the relationships among the various outcome measures. All these studies were limited by the lack of control group data. The absence of control and randomization make it difficult, if not impossible, for researchers to determine if an intervention is responsible for change (Schulz, Chalmers, Hayes, & Altman, 1995). As stated by Hannah et al. (1997b), the data collected for these studies "can best be described as pilot data" (p. 87).

The Present Study

In response to the existence of only preliminary research on the efficacy of IRT and the relative widespread use of Imago among clinicians globally, the present randomized controlled trial sought to examine the efficacy of a 12-session course of IRT treatment with couples experiencing distress in their relationships. The independent variables were treatment condition (i.e., treatment or control group) and time in treatment. The dependent variable was relationship satisfaction. We hypothesized that:

H1: Subsequent to treatment, there would be a main effect for time in treatment; averaging across treatment condition, the mean of the participant's relationship satisfaction scores would increase over time.

H2: Subsequent to treatment, there would be a treatment condition by time interaction. We expected to find that over time we would find differences in mean levels of relationship satisfaction between the treatment and control groups.

H3: Only the treatment group would experience a statistically significant increase in marital satisfaction scores over time.

H4: At the 12-week follow-up, the treatment group would not exhibit a decrease in level of relationship satisfaction.

H5: There would be a clinically significant increase in the level of relationship satisfaction in the treatment group.

The final hypothesis about clinically significant change was a major focus of the present study. Unlike statistical significance, clinical significance refers to the importance of determining if a change makes a real difference in the individual's life (Kazdin, 2003). For our purposes, we wanted to know not only if participants would experience statistically significant increases in relationship satisfaction, but, more importantly, if improvements would move participants from relationship discord to satisfaction (i.e., recovery). This study was the first study of IRT to examine clinically significant change.

In our analysis of clinically significant change, we would use Jacobson and Truax's (JT; 1991) method for calculating clinical significance. In the JT approach, clinically significant change is indicated when the level of functioning on an assessment post-treatment places the individual closer to the mean of the well-adjusted population than it does to the mean of the maladjusted population. Jacobson and Truax present two other measures of clinical significance but argue for the use of this least-arbitrary measure when population norms are available. Moreover, in a comparative analysis of multiple approaches to measuring clinical significance, Bauer, Lambert, and Nielsen (2004) support the JT method because it is widely-used and balances the benefits and drawbacks of other methods.

Our analysis of significant change would also include a *post hoc* analysis to determine the rate of improvement and recovery for participants in the treatment group.

We used a reliable change index (RC), which was developed by Jacobson, Follette, and Revenstorf (1984) and later amended by Christensen and Mendoza (1986):

$$RC = \frac{X_2 - X_1}{S_{diff}}$$

where X_1 represents the participant's pretreatment score, X_2 represents the posttreatment score, and S_{diff} is the standard error of difference between the two scores. A posttreatment RC larger than 1.96 is likely to occur only when the participant has experienced real change.

Method

The Sample

Participants were recruited via convenience and snowball sampling. Recruitment was managed by the researchers in a city that was not one of the cities where participants were being recruited. This allowed us to do our best to standardize recruitment in all geographic locations. Using the Internet, we identified civic organizations, graduate-level mental health programs, houses of worship, and mental health professional organizations in the geographic areas we were targeting and contacted them via e-mail requesting that our solicitation for participants be distributed to their members and contacts. We also posted solicitations on online professional and community listservs and forums. The solicitations provided a link to the study website where they could read more about the study and initiate the screening process. The primary benefit described to participants was the possibility of improving the quality of their relationship. The primary risk we described was the possibility of their relationship satisfaction decreasing and that this would be more likely to happen through participation in the control group. All participants were adults in heterosexual relationships that resided in eight metropolitan cities in the United States as well as one in Canada. The inclusion criteria consisted of the following: be cohabitating for a minimum of 1 year, have no immediate plans to terminate the relationship, have received no psychiatric treatment within the last 2 years, be free of alcohol or drug problems and primary sexual dysfunction, have no evidence of active partner abuse, not be presently involved in other psychologically oriented treatment, not be incarcerated, and be experiencing distress in their relationship. Distress was assessed using the Marital Adjustment Test (MAT; Locke & Wallace, 1959), and at least one partner was required to have a score below 100 on the assessment; there were exclusion criteria involving exceptionally low MAT scores. If couples were eligible to participate, then they were randomly placed into either the treatment or control group using an online random number generator.

Three-hundred forty individuals completed the initial online screening. Of these, 62 were individuals whose partner did not complete the screening, so they were disqualified from participating. Of the remaining 278 individuals (139 couples), 104 couples were not enrolled because one or both of them did not meet the following

inclusion criteria: 33 did not meet distress criteria; 17 qualified, but did not respond to our communications about next steps for enrollment; 17 were not available during hours when treatment would be provided in intervention condition; 11 were geographically too distant from treating therapists; 2 had previous exposure to IRT treatment or literature; and 24 for miscellaneous reasons (e.g., being on medication, currently receiving treatment, abuse, etc.).

Nineteen couples were initially enrolled in the control group. One of these couples withdrew from the study after completing the first assessment and two more did not complete the final assessment. In the treatment group, 16 couples were enrolled and two couples dropped out. One stopped attending treatment and the other did not complete assessments at the final two data collection time points. A Mann–Whitney *U* test comparing means on MAT did not reveal a significant difference between participants who did and did not complete the study. Subsequently, the sample for the present study was composed of 32 participants (16 couples) in the control group and 28 participants (14 couples) in the treatment group.

The mean age for the sample was 45 years, and ages ranged from 25 to 70 years with the majority of participants being in their 30 s (32%) or 40 s (32%). The length of the couple relationships ranged from 2 to 45 years with most of the couples having been together for 5 to 10 years (30%). Ninety-five percent of the sample completed at least some college, with 35% having completed a bachelor's degree and 37% having completed additional graduate or professional studies. Forty-seven percent reported a combined household income up to $100,000 and 42% reported making between $100,000 and $200,000. Fifty percent of the couples made between $60,000 and $140,000. The participants were 81% white, 17% black, and 2% of Asian descent. Thirty percent of the participants had engaged in couples therapy at some point during the past 5 years and 22% had engaged in either individual or group therapy.

The pretreatment mean score on the MAT (Locke & Wallace, 1959) was 73.45 ($SD = 23.85$), indicating that the sample was indeed experiencing marital distress. The MAT, in part, assesses disagreement in several domains related to romantic relationships on a 6-point Likert-type scale ranging from always agree to always disagree. We conceptualize a high level of disagreement as either frequently disagree, almost always disagree, and always disagree. High levels of disagreement were experienced in our sample in the following domains: 52% sex relations, 44% demonstration of affection, 40% handling finances, 36% matters of recreation, 26% conventionality (right good, proper conduct), 23% dealing with in-laws, and 20% friends. Based on a frequency analysis of presenting problems covered in the screening assessment, there were no observable differences in presenting problems between the intervention and control groups. Further, 55% of participants indicated that they were less than happy with their relationship and 60% reported that they at least occasionally wished they were not in the relationship. There were no significant differences between the treatment and the control groups with respect to MAT scores. There

were also no significant group differences on characteristics such as age, length of relationship, or level of education.

Procedures and Measures

Data for this study were collected online using PsychData. Initial enrollment screening was conducted online to determine if prospective participants met the eligibility requirements. Participants completed an informed consent and the screening questions separately from their partner at a time of their choosing. The informed consent included information on the funders of the study. The participants were not paid for participating in the study.

Participating couples in the treatment group committed to completing 12 treatment sessions, 90 minutes in length each, at no cost. The 12 sessions had to occur within a timeframe of 18 weeks and the interval between sessions could not exceed 2 weeks. They also committed to not engaging in treatment during the follow-up period. Given the lack of clinical evidence supporting IRT, the length of treatment for the study was somewhat arbitrary. A review of couples therapy research literature indicated that 12 sessions was the mode number of sessions for couples (Fals-Stewart, Birchler, & O'Farrell, 1996; Greenberg, Warwar, & Malcolm, 2010; Schade et al., 2014; Tilden, Gude, Sexton, Finset, & Hoffart, 2009; Trudel et al., 2008). This was a number also frequently suggested by IRT therapists with whom we consulted and fit within our research budget.

We assessed couples pretreatment, mid treatment, and posttreatment, which was also common practice in the literature we reviewed. We did not find a clear best-practice for length of assessment follow-up posttreatment, so we selected a 12-week follow-up to roughly mirror the length of treatment. The treatment group was assessed before the first counseling session (T_1), after the sixth session (T_2), after the twelfth (i.e., final) session (T_3), and 12 weeks after the final session (T_4). Participants in the control group were assessed on the same schedule as those in the treatment group: at study enrollment (T_1), 6 weeks later (T_2), and again 12 weeks after enrollment (T_3). Control group participants in all cities were offered free admission to a GTLYW Workshop after they completed the 12-week assessment. The workshop was intended to serve as an incentive for participating in the control group. Because of the option to participate in the workshop immediately after treatment, control group participants were not assessed at a 12-week follow-up. We were unable to manipulate the offering of the workshop to fall after a 12-week period. Over the course of 12 weeks, the control group participants read *You Just Don't Understand: Women and Men in Conversation* (Tannen, 2007). They received no other interventions, and compliance with the reading exercise was not assessed.

The clinicians administering treatment were certified Imago relationship therapists who were also either Imago faculty or Imago consultants (i.e., the highest level of training possible as an Imago clinician). They were recruited by e-mailing Imago faculty and consultants and requesting their participation. Some were recruited by in-person or phone requests. The therapists were all licensed in their respective

fields (e.g., counseling, social work, and psychology) within the state they currently practice. They volunteered to participate in the study after being solicited to participate by IRI. The therapists were all offered payment of $100 per session. Several therapists volunteered their time and opted not to receive payment. There were one or two therapists in each of the eight cities where we collected data, and each therapist agreed to treat one or two couples. None of the therapists were authors of this study.

To ensure treatment fidelity, all sessions were video-recorded and evaluated using reactive observation (Bernard, 2012). Participants were made aware of and agreed to having their session recorded when they completed informed consent. No research tool existed for assessing fidelity of IRT treatment. Thus, the variables and behavioral indicators under observation were based off the Scoring System for Imago Therapy Certification (SSITC; IRI, 2014), which is the standardized evaluation tool for therapists becoming certified in IRT. The SSITC was adjusted for research purposes (several written-feedback items were removed) and renamed SSITC-R. The SSITC-R includes 14 Likert-type items that assess the use of IRT techniques, ability of the therapist to move the couple into deep behavior- and feeling-targeted conversation, and inclusion of psychoeducational content related to IRT principals. The rating scale was as follows: 1 = present in the video; 2 = not present in the video but not necessary given the content of the segment; 3 = not present in the video but necessary. The SSIRTC-R consists of three separate sections: Section A includes establishing and maintaining the structure of the IRT dialogue; Section B includes the therapist's facilitation of "deepening" techniques; Section C evaluates the inclusion of Imago psychoeducation. Total scores on the SSITC-R range from 14 to 42. A perfect score of 14 signifies the use of all major Imago principles and techniques, while a score of 42 indicates a complete lack of Imago principles and techniques. Scores lower than 23 indicate fidelity with IRT best practices.

The four raters who participated in the video reviews were recruited using the same procedure that was used to recruit the clinicians for the study. They were all certified IRT faculty or consultants who were not participating in the study as clinicians; they volunteered their time and were not compensated. Before beginning the rating process for the research study, all raters participated in practice reviews using the SSITC-R and video segments of couples receiving IRT (these videos were of couples outside the research study). After the first practice review was completed, the raters and researchers discussed areas of disagreement or confusion in utilizing the SSITC-R and it was adjusted as needed. The final version of the SSITC-R was established and three additional videos were rated to ensure reliability before beginning the rating process with the videos from the study participants.

Twenty-minute-long video clips were selected from the midpoint of each therapist's fifth and ninth session with a couple and rated by the reviewers using the SSITC-R. Segments were reviewed by more than one rater. The mean of the reviewed videos was 20.8, indicating that therapists in the study were delivering treatment at or above the level that is required for certification as an IRT clinician.

Table 1. Mean MAT scores across time.

	T_1		T_2		T_3		T_4[a]	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Control group								
Raw scores	75.22	24.94	75.08	25.36	74.19	23.95		
Adjusted scores[b]	0.00	1.00	−0.01	1.02	−0.04	0.96		
Treatment group								
Raw scores	71.43	22.83	79.27	28.09	91.32	24.42	88.14	20.60
Adjusted scores	0.00	1.00	0.34	1.23	0.87	1.07	0.73	0.90

Note. MAT is Marital Adjustment Test (Locke & Wallace, 1959). T_1 is study enrollment, T_2 is week 6, T_3 is week 12 (posttreatment for treatment group), and T_4 is 12-week follow-up.
[a]Only data for the 20 participants (10 couples) who completed the T_4 are presented here.
[b]The raw MAT scores at each time point were converted to z-scores using the T_1 mean and standard deviation for each group.

Marital Adjustment Test

The MAT (Locke & Wallace, 1959) is a 15-item self-report questionnaire that is one of the most frequently used measures of relationship satisfaction. Kazak, Jarmas, and Snitzer (1988) described it as the "grandparent" of marital satisfaction measures. The scale focuses on issues such as involvement in joint activities, demonstration of affection, frequency of marital complaints, level of loneliness and well-being, and partner agreement on significant issues. Scores on the scale are calculated by summing numerical weights that correspond to each item. Higher MAT scores indicate higher levels of overall marital satisfaction. Chronbach's α in data from the present study was .72 for T_1, .79 for T_2, .77 for T_3, and .67 for T_4. The test-retest reliability, as measured in data from the control group between T_1 and T_3, was .84.

Results

Results were calculated using IBM SPSS Statistics Version 20. Table 1 presents the mean MAT scores in the treatment and control groups longitudinally across the study. The control group exhibited slightly decreasing MAT scores, while the treatment group exhibited rising scores to T_3 and then a decline in the final MAT score at T_4. Despite the random assignment to treatment condition, there were differences between the T_1 MAT scores (control group $M = 75.22$, treatment group $M = 71.43$). To account for this variability in the dependent variable and potential variability across time, we employed Robert's z-score method of adjustment, which is described in Hamilton et al. (1954). Separately for each group (i.e., control and treatment), the raw MAT scores at each time point were converted to z-scores using the T_1 mean and standard deviation for that group. In other words, the z-scores were scaled to T_1 scores. The adjusted scores are also presented in Table 1. Figure 1 illustrates the change in the adjusted MAT scores in both groups' scores across time. The MAT scores for the control group declined slightly, while the MAT scores for the treatment group increased appreciably.

Treatment Effects

Using the adjusted z-scores, we conducted a repeated-measures MANOVA to test for main effects and interactions for time and treatment condition (i.e., treatment

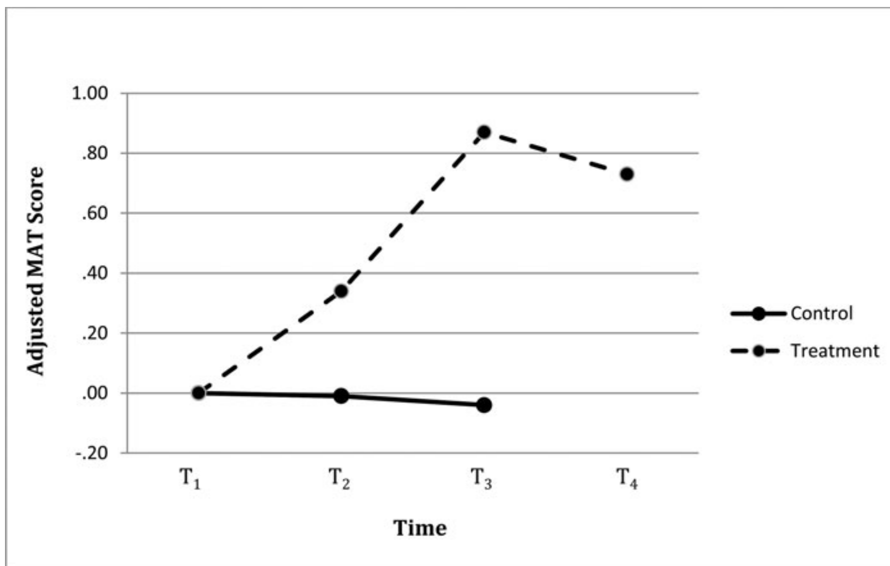

Figure 1. Mean adjusted scores on the Marital Adjustment Test (MAT; Locke & Wallace, 1959) across time.

or control). This analysis yielded a significant multivariate main effect for time, $F(2,116) = 11.91$, $p < .001$, $d = .45$. A significant main effect for time means that when ignoring the effect of treatment condition, the average of all participants' scores on the MAT increased over time. The power to detect the effect, as calculated using G*Power, was 1.00. There was no significant main effect for treatment condition, $F(1, 58) = 2.79$, $p = .100$, meaning that when we ignore the effect of time, treatment condition alone did produce differences in participant's level of marital satisfaction. Further, we also found a significant interaction between time and treatment condition, $F(2, 116) = 14.48$, $p < 001$. The significant interaction means that, in describing the main effect for time (i.e., that time has an effect on MAT), the main effect must be qualified by stating that the effect depends on treatment condition. In other words, the effect of time on MAT depends on condition. We can make the causal inference that the treatment group's MAT levels improved because they were in the treatment condition. Subsequently, hypotheses H1 and H2 were confirmed.

Increases in MAT Scores

Next, we conducted paired sample *t*-tests to determine whether the changes in MAT scores across time were significant. As can be seen in Table 2, the mean MAT score in the control group did not change significantly between any time points. Conversely, the mean MAT scores in the treatment group did significantly increase over the course of treatment from T_1 to T_3. Furthermore, in the treatment group, there was not significant change between T_1 to T_2, but there was significant improvement from T_2 to T_3. So, only the treatment group exhibited a statistically significant increase in mean MAT scores during the treatment period. H3 was confirmed.

Table 2. Paired sample *t*-tests of mean MAT scores across time.

Treatment Condition	Mean Comparison	*t*	*df*	*p*	Cohen's *d*
Control	T_1 and T_2	0.06	31	.956	.01
	T_2 and T_3	0.84	31	.406	.03
	T_1 and T_3	0.42	31	.681	.04
Treatment	T_1 and T_2	−1.81	27	.810	−.30
	T_2 and T_3	−5.35	27	.001*	−.46
	T_1 and T_3	−5.23	27	.001*	−.84
	T_3 and T_4[a]	2.27	19	.035**	.31
	T_1 and T_4	−4.15	19	.001*	−.59

Note. MAT is Marital Adjustment Test (Locke & Wallace, 1959). T_1 is study enrollment, T_2 is week 6, T_3 is week 12 (posttreatment for treatment group), and T_4 is 12-week follow-up.
[a]Only data for the 20 participants (10 couples) who completed the T_4 assessment were used in the *t*-tests involving T_4 data.
*$p < .001$, **$p < .05$.

Our final paired sample *t*-test checked for change in mean MAT scores for the 20 participants who completed the assessment at the 12-week follow-up. As can be seen in Table 2, there was a significant decrease from T_3 to T_4. The treatment group did exhibit a statistically significant change in mean MAT scores posttreatment. Hypothesis H_4 was rejected. However, the T_4 mean score for these individuals remained significantly higher ($SD = .90$) than at T_1.

To shed light on the practical significance and magnitude of change between time points, Table 2 also presents effect sizes. Regarding the statistically significant differences in the treatment group, the differences range in magnitude from medium (T_2 to T_3; $d = -.46$) to large (T_1 to T_3; $d = -.84$) (Cohen, 1988).

Clinically Significant Change

Figure 2 illustrates the JT approach to calculating clinically significant change with the data in the present study. In Locke and Wallace's (1959) normative data, the mean MAT score for well-adjusted couples was 135.90. In the present study, the mean MAT score at T_1 for all participants in our sample was 73.45. These are the two means against which a participant's posttreatment MAT score was compared. The midpoint between these scores is 104.68, a number that serves as the cutoff point past which a participant's MAT score must improve in order to indicate clinically significant change. In other words, a MAT score below 104.68 would suggest an individual to be a member of the population of individuals maladjusted in their romantic relationship. A score above 104.68 would likely place that individual in the population of well-adjusted individuals. As Figure 2 illustrates, the treatment group's T_3 mean MAT score of 91.32 is below this cutoff point, indicating that the treatment group did not experience a clinically significant improvement in marital adjustment. Subsequently, H5 was not supported.

Rates of Improvement and Recovery

Our final analysis was the analysis to determine the rate of improvement and recovery for participants in the treatment group. Table 3 shows the pretreatment and

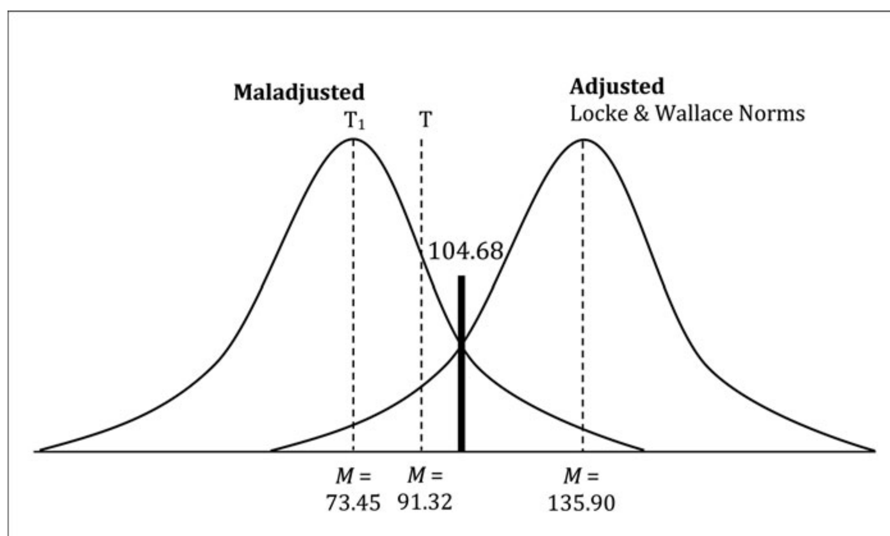

Figure 2. Mean scores on the Marital Adjustment Test (MAT) at pretreatment (T_1) compared with mean scores of adjusted individuals from Locke & Wallace's (1959) normative data; 104.68 is the cutoff point between the two means. T_3 is the mean score of the treatment group subsequent to treatment.

Table 3. Individual MAT scores, improvement, and recovery.

Participant	Couple	T_1 MAT	T_3 MAT[a]	RC[b]	Improved but not recovered	Recovered
1	A	103	**115**	0.93	N	Y
2	A	94	102	0.62	N	N
3	B	95	**109**	1.08	N	Y
4	B	50	70	1.55	N	N
5	C	70	70	0.00	N	N
6	C	53	76	1.78	N	N
7	D	72	**130**	**4.49**	N	Y
8	D	78	**105**	**2.09**	N	Y
9	E	37	87	**3.88**	Y	N
10	E	72	93	1.63	N	N
11	F	65	84	1.46	N	N
12	F	93	**106**	1.01	N	Y
13	G	78	99	1.63	N	N
14	G	106	**116**	0.77	N	Y
15	H	44	32	−0.93	N	N
16	H	31	35	0.31	N	N
17	I	60	92	**2.48**	Y	N
18	I	44	72	**2.21**	Y	N
19	J	90	103	1.01	N	N
20	J	77	**113**	**2.79**	N	Y
21	K	36	**121**	**6.58**	N	Y
22	K	68	75	0.53	N	N
23	L	75	103	**2.17**	Y	N
24	L	110	**120**	0.77	N	Y
25	M	70	84	1.08	N	N
26	M	105	91	−1.08	N	N
27	N	46	54	0.58	N	N
28	N	78	100	1.70	N	N

Note. MAT is Marital Adjustment Test (Locke & Wallace, 1959). T_1 is study enrollment and T_3 is posttreatment at week 12. RC, Reliable Change Index; Y, yes; N, no.
[a]Bold text represents recovery. [b]Bold text indicates improvement (RC > 1.96).

posttreatment scores for each participant, as well as their corresponding RC. Participants are also classified as improved (RC > 1.96) or recovered (on the basis of the 104.68 cutoff point from the clinical significance analysis). Fourteen percent of the sample experienced some improvement, while 32% experienced improvements at the level of recovery. Table 3 also shows the couples and the partners in each couple are represented by the same letter in the Couple column. It is also important to consider recovery at the dyad level, which we define as both partners experiencing recovery. By this definition, only one couple, couple D, recovered, while couples A, G, J, and L were all close to recovery.

Discussion

The main purpose of this study was to assess marital satisfaction outcomes following a 12-week course of IRT. The results showed that (a) individuals in the treatment condition experienced statistically significant increases in marital satisfaction, while couples in the control group did not; (b) levels of marital satisfaction did decrease significantly posttreatment but remained significantly higher than at pretreatment; (c) though statistically significant, the improvements experienced by the treatment group were not clinically significant improvements; and (d) while approximately one-third of participants achieved recovery during treatment, at the dyad level, only one couple achieved recovery.

The need for more robust empirical examination of IRT has been great, especially given the widespread global use of IRT and the nearly-two-decade period since the last study of IRT in a clinical setting. Our findings, which are the first to be based on treatment and control data, lend additional support to the possible efficacy of IRT as a treatment modality that benefits couples experiencing distress in their relationships. Importantly, because randomized controlled trials give researchers the ability to make casual inferences, they can provide the strongest evidence of a treatment's efficacy. This evidence is important because it is imperative for mental health practitioners to use forms of treatment with evidence to suggest that they provide the greatest chance of clinical improvement (Hunsley, Dobson, Johnston, & Mikail, 1999). While we did exclude participants with some severe presenting problems, research by Miller, Yorgason, Sandberg, and White (2003) and Whisman, Dixon, and Johnson (1997) indicates that our criteria did not exclude the majority of presenting issues that couples bring to treatment. Our research design was also strengthened by our use of multiple therapists in multiple cities across North America. Our findings represent an initial step in forming a base of evidence on which IRT clinicians can make decisions about the care of clients. As community providers and funders demand more accountability from clinicians, they will require even more evidence that builds on our findings.

Importantly, for this sample of distressed couples, significant change was not detectible at the midpoint of treatment and was only expressed after 12 sessions of treatment. This finding is inconsistent with the findings of Luquet and

Hannah (1996) and Hannah et al. (1997a, 1997b). Those authors found that a 6-week course of treatment in IRT was associated with improvements in marital functioning. An explanation for these differing outcomes may be the result of the assessments used in the various studies. The Narcissistic Personality Inventory, COMPASS, and Relationship Maturity Index are measures of various aspects of individual and relational functioning, rather than measures of relationship satisfaction. Further, COMPASS was designed to measure progress in individual therapy (Lueger, 2012). Luquet and Hannah (1996) did use the robust Marital Satisfaction Inventory but assessed only functioning on three of 11 subscales, making it difficult to grasp a true picture of relationship well-being. The only previous research of IRT to use a robust, well-validated assessment was the work of Hannah et al. (1997b), who used the Dyadic Adjustment Scale. However, the pretreatment mean score on the DAS ($M = 103.00$, $SD = 22$) in their sample was so close to the mean of well-adjusted individuals ($\bar{M} = 114.80$, $SD = 17.80$; Spanier, 1976) that they were likely sampling from the population of well-adjusted adults. Using a robust measure of relationship satisfaction and sampling from the population of distressed couples, we found that 12 sessions of treatment were necessary to produce gains in dyadic adjustment.

While statistical indications of a treatment outcome are important, they have little to do with the size, quality, or clinical significance of change. Statistical analyses shed little light on the actual efficacy of treatment. The testing of clinical significance is a critical advancement in the evaluation of interventions (Kazdin, 2003). According to Kazdin,

> clinical significance refers to the practical or applied value or importance of the effect of an intervention, that is, whether the intervention makes a real (e.g., genuine, palpable, practical, noticeable) difference in everyday life to the clients or to others with whom the client interacts. (2003, p. 691)

Calculating effect sizes, such as Cohen's *d*, sheds some light on the magnitude of treatment effects but is limited in that the result is still a statistic that is not based on standards of efficacy that are set by consumers, clinicians, and researchers (Jacobson & Truax, 1991).

What does this mean in relation to our results? The treatment group's improvements in relationship satisfaction were detectible through our statistical analyses. The magnitude of change between T_1 and T_3, as denoted by Cohen's *d*, could even be classified as large. But much like the shrinking of a tumor during chemotherapy, change, even great change, does not necessarily equate to recovery. To determine the meaningfulness of treatment, we employed a measure of clinical significance based on norms of well-adjusted individuals and found that the treatment group did not experience gains that would number them among the well-adjusted population. In other words, their improvements in relationship satisfaction would likely not have practical effects on their everyday lives. Importantly, these improvements did deteriorate significantly during the 12-week follow-up. This is unsurprising, given that recovery was not realized for so many.

Our findings suggest that 12 sessions are insufficient to produce meaningful change for most couples, though it was enough for one-third of the participants. However, at the dyad level, it was sufficient for only one couple. The fact that four other couples, 29% of the treatment group, were so close to recovery enables us to speculate that just a few more sessions were needed for a large portion of the sample. But without additional data, we can only conclude that the IRT intervention did not produce meaningful change for most couples.

Our findings also illustrate the limitation of examining statistical significance and effect sizes. In considering only those statistics, our results look quite positive. However, examining clinical significance and practical value of change provided a more nuanced and precise interpretation of these data. We acknowledge, too, that when considering clinical significance, the results are also less optimistic.

Limitations and Recommendations for Future Research

There are several important limitations of this study. First, while our sample size was typical of research on couples counseling, by statistical standards, it was still small. Because we did not employ an intent-to-treat analysis, the few dropouts in our small sample could have increased the chance of Type 1 error.

Second, in IRT, couples are often encouraged to attend the GTLYW Workshop as an adjunct to treatment. Hypothetically, this provides an initial, large dose of treatment and aids recovery. We did not include the workshop in our protocol primarily because of budget constraints. Several of the clinicians in our study reported that the participants they were treating would have benefitted greatly from attending the workshop. Future randomized controlled trials of IRT could include a third treatment condition where participants would experience in-office treatment and the workshop. Given the prevalence of referring couples to the workshop, the relationship of the workshop to therapy should be investigated.

Given the upward slope of the MAT scores for participants in the treatment group, the number of couples who were close to recovery, and the declines during the follow-up period, we could hypothesize that the treatment was effective but the dosage was not sufficient for recovery. Therefore, the length of treatment in the present study was possibly a third limiting factor. Given that recovery is the goal of treatment, future research could examine longer courses of treatment. This would shed light on this potential limiting factor and the competing possibility that IRT is an ineffective treatment.

Fourth, our findings shed light on the possible efficacy of a course of IRT treatment, but do not illuminate the efficacy of specific interventions within therapy. Future research could investigate how specific interventions contribute to outcomes.

Fifth, our inclusion criteria would be expected to influence our findings. We had restrictive inclusion criteria for participants in this study. Certainly many couples present for treatment with plans to terminate the relationship or with co-occurring psychiatric, substance abuse, sexual dysfunction issues. Further, our

sample was homogenous demographically. All participants were heterosexual and most were Caucasian, college educated, and high earners. Our use of online recruitment and computer screening required computer access and literacy; these requirements may have excluded participants with lower socioeconomic status. Our findings should be generalized only tentatively to other populations; further research with diverse populations is warranted. Our inclusion criteria permitted the participation of individuals who had received counseling in the past 5 years, a potential confounding variable. Thus, the present treatment could have served as a refresher for some participants, rather than an independent clinical experience. Additionally, some of our participant's T_1 MAT scores were near our exclusion cutoff point of 100. It is debatable whether or no these couples were truly distressed.

Sixth, as in many studies of marital satisfaction, the present study relied solely on self-report data. Our data are potentially biased in that there was no check on the accuracy of the self-report assessments. Ideally, participants would be interviewed or observed by a rater who was blind to treatment condition.

Seventh, despite its age, we relied on a statistic for well-adjusted couples that Locke and Wallace (1959) acquired by identifying participants "judged to be exceptionally well-adjusted in marriage by friends who knew them well" (p. 254). Marriage has certainly changed in the last half decade. Other, more current, researchers have attained samples of well-adjusted couples by sampling from the general population with the assumption that non–treatment-seeking couples are well adjusted. These samples have mean levels of marital adjustment that are lower than Locke and Wallace's (1959) statistic. Given that we focused our investigation on clinically significant change, we opted for a more rigorous cutoff point that would indicate a greater likelihood that participants passing it in treatment would indeed be recovered (i.e., well adjusted) and not simply out of the clinical population.

Finally, the community of IRT therapists and educators should put every effort into recruiting and supporting scholars among its ranks. The dearth of research and contemporaneous focus on intervention and program development over the past decades contradict the movement toward evidence-based practice. Ideally, theoretical scholarship and program development should stem from systematic research, allowing clinicians to integrate their clinical expertise with the best external evidence (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996).

Despite the limitations discussed here, this study contributes to the field of couples therapy in important ways. There is consensus that couples therapy has positive impacts on psychological and the physical health. Nevertheless, no approach has been shown to be more effective than others (Snyder & Halford, 2012; Snyder et al., 2006). Therefore, it is vital to examine all approaches in broad use. While widespread in practice, IRT has endured despite lack of empirical validation. Our findings underscore the possible validity of IRT treatment and provide a basis for researchers to continue to evaluate the efficacy of IRT.

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References

Afifi, T. O., Boman, J., Fleisher, W., & Sareen, J. (2009). The relationship between child abuse, parental divorce, and lifetime mental disorders and suicidality in a nationally representative adult sample. *Child Abuse & Neglect*, *33*, 139–147.

Banks, A. (2011). The mythic reality of the autonomous individual: Developing the capacity to connect. *Zygon*, *46*, 168–182.

Bauer, S., Lambert, M. J., & Nielsen, S. L. (2004). Clinical significance methods: A comparison of statistical techniques. *Journal of Personality Assessment*, *82*(2), 60–70.

Beach, S. R. H., Dreifuss, J. A., Franklin, K. J., Klamen, C., & Gabriel, B. (2008). Couples therapy and the treatment of depression. In A. S. Gurman (Ed.), *Clinical handbook of couples therapy* (4th ed., pp. 545–566). New York, NY: Guilford Press.

Berger, R. (1997). What can clinicians learn from research? *The Journal of Imago Relationship Therapy*, *2*(1), 71–80.

Bernard, H. R. (2012). *Social research methods: Qualitative and quantitative approaches*. New York, NY: Sage.

Christensen, L., & Mendoza, J. L. (1986). A method of assessing change in a single subject: An alteration of the RC index. *Behavior Therapy*, *17*, 305–308.

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Erlbaum.

Dyrdal, G. M., Roysamb, E., Nes, R. B., & Vitterso, J. (2011). Can a happy relationship predict a happy life? A population-based study of maternal well-being during the life transition of pregnancy, infancy, and toddlerhood. *Journal of Happiness Studies*, *12*, 947–962. doi:10.1007/s10902-010-9238-2

Fals-Stewart, W., Birchler, G. R., & O'farrell, T. J. (1996). Behavioral couples therapy for male substance-abusing patients: Effects on relationship adjustment and drug-using behavior. *Journal of Consulting and Clinical Psychology*, *64*(5), 959–972. doi:10.1037//0022-006x.64.5.959

Fradenburg, L. A., Harrison, R. I., & Baer, D. M. (1995). The effect of some environmental factors on interobserver agreement. *Research in Developmental Disabilities*, *16*(6), 425–437.

Greenberg, L., Warwar, S., & Malcolm, W. (2010). Emotion-focused couples therapy and the Facilitation of forgiveness. *Journal of Marital and Family Therapy*, *36*(1), 28–42. doi:10.1111/j.1752-0606.2009.00185.x

Hamilton, M., Pickering, G. W., Roberts, J. A. F., & Sowry, G. S. C. (1954). The aetiology of essential hypertension : The arterial pressure in the general population. *Clinical Science*, *13*(1), 11–35.

Hannah, M. T., Luquet, W., & McCormick, J. (1997a). COMPASS as a measure of the efficacy of couples' therapy. *American Journal of Family Therapy*, *25*, 76–91.

Hannah, M. T., Luquet, W., McCormick, J., Galvin, K., Ketterer, K., May, K., … Kot, L. A. (1997b). Short-term Imago therapy and changed in personal distress. *The Journal of Imago Relationship Therapy*, *2*(2), 55–65.

Haynes, S. N., Follingstad, D. R., & Sullivan, J. C. (1979). Assessment of marital satisfaction and interaction. *Journal of Consulting and Clinical Psychology*, *47*, 789–791. doi:10.1037//0022-006X.47.4.789

Headey, B., Veenhoven, R., & Wearing, A. (1991). Top-down versus bottom-up theories of subjective well-being. *Social Indicator Research*, *24*, 81–100. doi:10.1007/BF00292652

Hendrix, H. (2008). *Getting the love you want: A guide for couples*. New York, NY: Owl Books.
Heyman, R. E. (2001). Observation of couple conflicts: Clinical assessment applications, stubborn truths, and shaky foundations. *Psychological Assessment*, *13*(1), 5.
Hilpert, P., Bodenmann, G., Nussbeck, F., & Bradbury, T. N. (2012). Predicting relationship satisfaction: A matter of conflict, positivity, or support? *Family Science*, *4*, 110–120. doi:10.1080/19424620.2013.830633
Hogan, T., Hunt, R., Emmerson, D., Hays, R., & Ketterer, K. (1996). An evaluation of satisfaction with "Getting the Love You Want" weekend workshop. *Journal of Imago Relationship Therapy*, *1*, 67–75.
Hunsley, J., Dobson, K. S., Johnston, C., & Mikhail, S. F. (1999). The science and practice of empirically supported treatments. *Canadian Psychology/Psychologie Canadienne*, *40*(4), 316–319. doi:10.1037/h0086849
Imago Relationships International. (2014). *Clinical training in Imago relationship therapy: Training manual text*. Lexington, KY: Author.
Imago Relationships International. (n.d.). Imago around the world. Retrieved from http://pro.imagorelationships.org/ABOUT/ImagoWorldwide.aspx
Jacobson, N. S., Follette, W. C., & Revenstorf, D. (1984). Psychotherapy outcome research: Methods for reporting variability and evaluating clinical significance. *Behavior Therapy*, *15*, 336–352.
Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology*, *59*(1), 12–19.
Jordan, J. V. (1995). *Relational awareness: Transforming disconnections*. Work in progress, No. 76. Stone Center for Developmental Services and Studies, Wellesley, MA.
Kazak, A. E., Jarmas, A., & Snitzer, L. (1988). The assessment of marital satisfaction: An evaluation of the Dyadic Adjustment Scale. *Journal of Family Psychology*, *2*(1), 82–91. doi:10.1037/h0080475
Kazdin, A. E. (2003). Clinical significance: Measuring whether interventions make a difference. In A. E. Kazdin (Ed.), *Methodological issues and strategies in clinical research* (pp. 691–710). Washington, DC: American Psychological Association.
Kiecolt-Glaser, J. K., Bane, C., Glaser, R., & Malarkey, W. B. (2003). Love, marriage, and divorce: Newlyweds' stress hormones foreshadow relationship changes. *Journal of Consulting and Clinical Psychology*, *71*, 176–188.
Kiecolt-Glaser, J. K., & Newton, T. L. (2001). Marriage and health: His and hers. *Psychological Bulletin*, *127*, 472–503.
Krishnakumar, A., & Buehler, C. (2000). Interparental conflict and parenting behaviors: A meta-analytic review. *Family Relations*, *49*, 25–44.
Lazarus, A. (2000). Working effectively and efficiently with couples. *The Family Journal*, *8*, 222–228.
Lebow, J. L., Chambers, A. L., Christensen, A., & Johnson, S. M. (2012). Research on the treatment of couple distress. *Journal of Marital and Family Therapy*, *38*, 145–168.
Locke, H. J., & Wallace, K. M. (1959). Short marital adjustment and prediction tests: Their reliability and validity. *Marriage and Family Living*, *21*, 251–255.doi:10.2307/348022
Losada, J. L., & Manolov, R. (2015). The process of basic training, applied training, maintaining the performance of an observer. *Quality & Quantity*, *49*(1), 339–347.
Love, P., & Shulkin, S. (2001). Imago theory and the psychology of attraction. *The Family Journal*, *9*, 246–249. doi:10.1177/1066480701093002
Lueger, R. J. (2012). The Integra/COMPASS tracking assessment system. *Integra Science and Practice*, *2*, 20–30.
Luquet, W., & Hannah, M. T. (1996). The efficacy of brief Imago therapy: Preliminary findings. *Journal of Imago Relationship Therapy*, *1*, 67–75.

Martin, T. L., & Bielawski, D. M. (2011). What is the African American's experience following Imago education? *Journal of Humanistic Psychology*, *51*, 216—228. doi:10.1177/0022167809352379

Miller, R. B. M., Yorgason, J. B., Sandberg, J. G., & White, M. B. (2003). Problems that couples bring to therapy: A view across the family life cycle. *The American Journal of Family Therapy*, *31*, 395–407.

National Registry of Evidence-based Programs and Practices (NREPP). (2015). Retrieved from http://www.nrepp.samhsa.gov/SearchResultsNew.aspx?s=b&q=marriage

Pershing, J. (Ed.). (2006). *Handbook of human performance technology: Principles, practices, and potential* (3rd ed.). San Francisco, CA: Pfeiffer.

Pew Research Center. (2010). *The decline of marriage and rise of new families*. Retrieved from http://pewresearch.org/pubs/1802/decline-marriage-rise-new-families

Pitner, G. D., & Bailey, W. R. (1998). The getting the love you want workshop, marital satisfaction and relationship quality. *The Journal of Imago Relationship Therapy*, *3*(1), 35–48.

Potter, D. (2010). Psychosocial well-being and the relationship between divorce and children's academic achievement. *Journal of Marriage and Family*, *72*, 933–946.

Reibstein, J., & Burbach, F. (2013). An increasingly convincing case for couples therapy. *Journal of Family Therapy*, *35*, 225–228. doi:10.1111/1467-6427.12019

Sackett, D. L., Rosenberg, W. M. C., Gray, J. A. M., Haynes, R. B., & Richardson, W. S. (1996). Evidence-based medicine: What it is and what it isn't; it's about integrating individual clinical expertise and the best external evidence. *British Medical Journal*, *312*, 71–72.

Schade, L. C., Sandberg, J. G., Bradford, A., Harper, J. M., Holt-Lunstad, J., & Miller, R. B. (2014). A longitudinal view of the association between therapist warmth and couples' in-session process: An observational pilot study of emotionally focused couples therapy. *Journal of Marital and Family Therapy*, *41*(3), 292–307. doi:10.1111/jmft.12076

Schmidt, C. D., Luquet, W., & Gehlert, N. C. (2015). Evaluating the impact of the imago couples workshop on relational adjustment and communication patterns. *Journal of Couple and Relationship Therapy*. doi:10.1080/15332691.2014.978061

Schulz, K. F., Chalmers, I., Hayes, R. J., & Altman, D. G. (1995). Empirical evidence of bias: Dimensions of methodological quality associated with estimates of treatment effects in controlled trials. *Journal of the American Medical Association*, *273*, 408–412.

Seikkula, J., Aaltonen, J., Kalla, O., Saarinen, P., & Tolvanen, A. (2013). Couples therapy for depression in a naturalistic setting in Finland: A 2-source randomized trial. *Journal of Family Therapy*, *35*, 281–302. doi:10.1111/j.1467-6427.2012.00592.x

Snyder, D. K., & Halford, W. K. (2012). Evidence-based couples therapy. *Journal of Family Therapy*, *34*, 229–249. doi:10.1111/j.1467-6427.2012.00599.x

Snyder, D. K., Castellani, A. M., & Whisman, M. A. (2006). Current status and future directions in couples therapy. *Annual Review of Psychology*, *57*, 317–344.

Snyder, D. K., Wills, R. M., & Keiser, T. W. (1981). Empirical validation of the Marital Satisfaction Inventory: An actuarial approach. *Journal of Consulting and Clinical Psychology*, *49*(2), 262.

Spanier, G. B. (1976). Measuring dyadic adjustment: New scales for assessing the quality of marriage and similar dyads. *Journal of Marriage and Family*, *38*, 15–28.

Stanley, S. M. (2007). What really is the divorce rate? Retrieved from https://www.prepinc.com/docs/content/articles/what_is_divorce_rate_8-3-2007.pdf

Stratton, P. (2011). *The evidence base of systemic family and couples therapies*. Warrington, UK: Association for Family Therapy.

Tannen, D. (2007). *You just don't understand: Women and men in conversation*. NY: William Morrow Paperbacks.

Tilden, T., Gude, T., Sexton, H., Finset, A., & Hoffart, A. (2009). The associations between intensive residential couple therapy and change in a three-source follow-up period. *Contemporary Family Therapy*, *32*(1), 69–85. doi:10.1007/s10591-009-9104-8

Trudel, G., Boyer, R., Villeneuve, V., Anderson, A., Pilon, G., & Bounader, J. (2008). The marital life and aging well program: Effects of a group preventive intervention on the marital and sexual functioning of retired couples. *Sexual and Relationship Therapy*, *23*(1), 5–23. doi:10.1080/14681990701635061

United Nations Economic and Social Affairs Population Division. (2003). *World fertility report*. New York, NY: United Nations.

Walitzer, K., Dermen, K., Shyhalla, K., & Kubiak, A. (2013). Couple communication among problem drinking males and their spouses: A randomized controlled trial. *Journal of Family Therapy*, *35*, 229–251. doi:10.1111/j.1467-6427.2013.00615

Weigle, J. B. (2006). *The impact of participating in an Imago therapy workshop on marital satisfaction*. (Unpublished doctoral dissertation). Walden University, Minnesota.

Whisman, M. A. (2007). Marital distress and DSM-IV psychiatric disorders in a population-based national survey. *Journal of Abnormal Psychology*, *116*, 638–643.

Whisman, M. A., Dixon, A. E., & Johnson, B. (1997). Therapists' perspectives of couple problems and treatment issues in couple therapy. *Journal of Family Psychology*, *11*, 361–366. doi:10.1037/0893-3200.11.3.361

Zielinski, J. J. (1999). Discovering Imago relationship therapy. *Psychotherapy*, *36*(1), 91–101.

SUBSCRIBER-ONLY NEWSLETTER

Well

Fighting With Your Partner? Use These 4 Phrases.

Brevity is key, experts say.

By Jancee Dunn

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You're reading the Well newsletter, for Times subscribers only. Essential news and guidance to live your healthiest life. Get it in your inbox.

Last weekend, as I was cleaning up a mess in the kitchen, my husband was parked in the living room, absorbed in his phone.

I asked him for help. Silence. I asked again. Nothing. As I shoved plates and bowls into the dishwasher, I slipped into an old habit: I imagined a thought bubble above his head.

"Life is good," it said. "I'm kicking back while my wife does everything! My time is more valuable than hers!"

This relationship-sabotaging practice is known by many names: Some call it "the story I am making up," or "the story I am telling myself right now." Terrence Real, a family therapist and the author of "Us: Getting Past You and Me to Build a More Loving Relationship," calls it "unconscious storytelling" — and it happens when you imagine what your partner is thinking or feeling.

Making these assumptions can escalate an argument and distort the issue, Real said. Instead, he counsels people to share perceived slights using a therapeutic tool known as "the feedback wheel." This simple, four-sentence method — adapted, he said, from the work of the therapist Janet Hurley — helps loved ones share grievances in ways that speed the repair process.

When you find yourself in a storytelling spiral, pause and remind yourself that you care about the person who has upset you, Real said. Then ask if it's a good time to talk.

If they're open to hearing about your frustrations, use these four statements:

1. "This is what I saw or heard."

Describe what happened in one sentence, Real said. "Share only the facts — ones a camera could record," he said. The key to this statement, and the feedback wheel overall, is its brevity, Real said.

2. "This is what I made up about it."

Explaining your personal point of view "acts as a circuit breaker," said Alexandra Solomon, a professor of psychology at Northwestern University and the author of "Loving Bravely." Not only does this take the heat off the other person, she said, but it compels you to examine your own emotions. "The stories we tell ourselves are informed by our internal landscape of wounds and tender spots and traumas and patterns," she said.

Using this phrase helps acknowledge that your perception might be inaccurate. "It's taking responsibility that this is your construction," Real said.

3. "This is how I felt."

Take a moment to focus on your emotions. Then describe them, concisely, to your partner, Real said. You might say that you're scared, hurt or angry, he explained. "Feelings only," he said, "not thoughts or beliefs." Sharing your feelings helps you move from the "reactive parts of your brain," Real said, and into what he calls "the wise adult."

4. "This is what would help me feel better."

This final statement, Real said, is one that most people leave out. But making your needs clear is a necessary step because "you can't complain about not getting what you never asked for," he said.

By sharing the story you made up, your feelings and your needs, Real said, you're shifting from anger to vulnerability. You "say what needs to be said," Real added, but it's done with respect.

Ideally, Dr. Solomon added, "the other person responds feeling grateful for their partner's vulnerability rather than guilt-tripped or defensive."

Using these statements with my husband has been a game-changer: Sometimes my interpretations of his behavior are so off base that when I tell him, we laugh — and the tension is broken.

In the case of the dishes, I eventually stormed into the living room and told my husband that I'd concocted a story that involved him deliberately ignoring me and prioritizing his leisure time over mine.

"I'm sorry, what?" he said, taking out his earbuds.

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Jancee Dunn is the columnist for Well's subscriber-only newsletter. More about Jancee Dunn

A version of this article appears in print on , Section A, Page 3 of the New York edition with the headline: Here to Help; Fighting With Your Partner? Use These 4 Phrases.

Hierarchy of Techniques

Navigating the Tension Between Tending and Moving:
A Hierarchy of General Techniques to Use in Fraught Moments

In order to make it easier to think about (and choose between) the myriad ways we can help clients to navigate fraught moments in our work, we've created a four-part continuum of types of interventions. There are infinite ways of putting these techniques into action. Every professional develops his or her own style and voice for implementing these techniques with particular clients. But here we offer a conceptual framework. As you read, note that the list of techniques begins by keeping reactions *within* the mind of the professional (technique #1), then moves outward with increasingly interpersonal activity—first toward "tending" or "opening up" emotion (techniques #2 and #3), then toward "moving," or containing emotion while sticking close to the task (technique #4).

1. **Note the emotion/s that you are having and/or that the others appear to be having, but choose not to address them openly**

   In this technique you note and mentally file the emotions away and use them a) to develop hypotheses about yourself, your clients, and yourself, and b) to later reflect on whether the emotion is being evoked in you by the client/situation or comes more from your own idiosyncratic experience and needs to be managed separately.

   > *Example: During a team meeting your client looks out the window, apparently not paying attention to the discussion. Perceive your client as being overwhelmed by the content of the conversation. You are aware of some anxiety in yourself, a pressure to comfort and re-engage them. But you carry on as you were, without changing anything about your tone or pacing, and you make no comment.*

2. **Acknowledge emotions non-verbally**

   There are a number of ways to acknowledge the emotional experience of others without words. Non-verbal interactions make-up about 90% of our interpersonal communication, and are crucial tools. There are a number of ways to acknowledge the emotional experience of others without words.

Examples:

- Seek out eye contact with client/s or colleague/s- note their responses and attempt to have a "silent conversation"
- Convey interest, concern and empathy through subtle adjustments of facial expression and/or posture while remaining silent or continuing the current line of discussion
- Use physical touch – e.g. a pat on the shoulder
- Make a connecting gesture- e.g. pass a tissue box to a client who is tearing up
- Scan the room- make eye contact with each person with a facial expression that conveys authentic curiosity and creates a sense of connection
- Use your body to create space without using words- e.g. raise a finger in a gesture indicating "Let's keep quiet for a bit folks" when one client or colleague is struggling to find words or to maintain composure

3. **Verbally acknowledge emotions by asking open-ended questions that invite clients to lean further into their feelings, explore their meanings, and share with others**

Examples:

- "I see that you're tearing up a bit. What just happened that triggered you?"
- "I just saw a shift in your facial expression – not sure how to read it, but I'm interested to know what may have just happened for you." (Consider complementing your words with inviting non-verbal techniques-- such as a quizzical look or an open-palm gesture-- that are authentically *yours*)
- "You've mentioned many times that this topic makes you anxious. Please tell me if I've got it wrong, but from the look on your face I'm guessing you're having one of *thos*e moments. Let's just push "pause" for a 'sec so we can talk a bit and see how you're doing with this."

4. **Verbally acknowledge emotions briefly and with limits, and return quickly to focusing on the task**

Example:
"This is tough stuff. I can see you're struggling. But I know you wanted to get this issue resolved today…are you ok to keep going?"

Toolbox of Collaborative Techniques and Skills

PUTTING THE TENDING-MOVING CONTINUUM INTO ACTION: THE ESSENTIAL SPECIAL OPS COLLABORATIVE TOOLBOX

Now that you're familiar with our continuum of general techniques for navigating emotion in a fraught moment, you'll be asking "But what does that look like? What should I do or say?" Over time, each of us will develop our own personal style of working and will bring our own personality into our work. But there are many specific technical skills that every professional should master. Here's our list- it's not exhaustive, but it's a good start.

I. TECHNIQUES THAT ARE USEFUL AND EFFECTIVE WITH EVERY CLIENT

#1 Staying in role

Because clients come to us in a fragile and often emotionally needy state, they are never going to get quite as much *of* us or *from* us as they want. And actually, it's important that they don't. Our capacity to empathize with our clients in helpful ways that foster growth depends on our maintaining a crucial increment of professional distance (rather than over-identifying or merging with our clients). A state of empathic connectedness requires each person in the interaction to retain a separate "self." As helping professionals, we need a "transitional space," a neutral zone between us across which we can reach when we need to regulate our clients' anxiety up our down, introduce a new idea, or lend our clients some of our own confidence. Setting firm, predictable (but not punitive or inflexible) boundaries from which we depart only after thoughtful consideration, and maintaining our professional stance-- these techniques make it possible for us to invite clients out of fixed positions so they can achieve their own highest transformative potential.

The more traumatized or anxious a client, the more likely it is that he or she will push at our boundaries. Healthier clients (who have developed a measure of basic trust in the world and in their own capacities to tolerate painful feelings) may express frustration withour professional limits, but are likely to respect (or at least accept) them. But think about the clients who pressure us to return their calls on Sunday, to depart from our ordinary billing protocols, or to engage in social relationships with them. Especially those of us who are vulnerable to over-functioning (or over-functioning with respect to certain character types) may find ourselves temporarily pulled out of our own professional orbit and tempted to make unusual or inappropriate concessions. If you've ever found yourself scheduling a meeting with a client outside of your own office hours without asking yourself why are making the accommodation and if the client really needs it, than you know what we mean. Maintaining sturdy Micro-and Macrocontainers requires that when we alter our ordinary way of working we do so only after thoughtful consideration and self -reflection. Holding to well-defined, predictable, reliable

boundaries and resisting the urge to move to quickly to accommodate or gratify reinforces the crucial notion that you are a safe base who not only empathizes with your client but has faith in their capacity to tolerate anxiety long enough for both of you to understand and make meaning of it.

Maintaining our professional stance (our clients are not our friends!) also mitigates against professional burnout. Holding to your boundaries minimizes the risk that you will feel frustrated, exploited, or worn-out by your client. This is important. If you become resentful, you'll begin (without meaning to) to send signals that there are cracks in your empathy. In that way, your client will have succeeded in creating exactly what he or she feared and expected- another person who has let them down.

#2 Minimizing small talk

Remember that our clients are often suffering. And we are are, for this period in their lives, centrally important figures in the central drama of their lives. In fact, because they rely on us for so much, we tend to be idealized or devalued in ways and with intensities of which we are not aware. Bear in mind that our clients carry us in their minds when they are not with us, listen for our internalized voices when they feel unmoored, and often scan our faces with the anxious intensity of a cancer patient analyzing their oncologist for clues about the outcome of their latest CAT scan.

How we conduct ourselves and what we talk about in the presence of our clients matter. A lot. Follow your clients. Cues as to what they need from you are embedded in the nature of their moods (which will likely vary from meeting to meeting). If they feel like chatting about their vacation, let them. But don't walk into the room exchanging news about your grandchildren with your co-counsel or announce to the room that you had a fabulous vacation. Even when our clients joke, it's often a way of managing more painful feelings. Ours is a serious business, and should be treated as such.

Small talk that is not initiated by our clients is also disrespectful of their time, effort, and money.

#3 Not acting celebratory

When we work with colleagues of whom we are fond or in a process we feel passionately about, it is easy to put a happy spin on things. But statements like "I'm so glad you chose a Collaborative Divorce," or "Congratulations for choosing mediation" can often be upsetting or offensive to clients who, while putting on a brave face, feel their world is collapsing around them. Divorce is not a cause for celebration. Especially at the beginning (before you and your client know each other well), find a way to support your client's higher order choices without do any emotional high-fives.

#4 Non-judgmental listening

The psychoanalyst Wilfred Bion described a state of being “without memory or desire”- in other words, meeting each new client fresh and taking in their story without imposing our own assumptions, biases or agendas. Especially if you’ve been practicing your profession for many years, it’s impossible not to recognize certain character types or project the trajectory of a given case. But that type of professional shorthand can get in our ways. We may be very technically talented, but until our clients feel deeply understood and accepted—not as we wish our imagine them to be, but as they are—nothing else we do will matter. Our job to accept the whole person- quite a different process from attempting to like everything about them or agreeing with their positions. Effective listening involves keeping steady eye contact, maintaining an open, caring expression that reacts appropriately but does not reflect surprise or exaggerated emotion (positive or negative), an emotional (or actual) “leaning in” posture, and restraint in allowing the client plenty of time to talk, reflect, and allow his or her narrative to unfold organically. At the same time, we do need to respond and to ask questions of our own- but how much or about what should fit the needs of the client and the moment.

#5 Asking curious questions*

Authentically curious questions are non-rhetorical and not rote. They carry no assumptions, biases, and judgment. They convey a genuine interest in the reply, even if the reply may contain painful truths. An authentically curious question is crafted and conveyed in a way that opens a safe, space for a new paradigm of communication. It is non-shaming and invites vulnerability- the path to new ideas and to intimacy. In order to be effective, a curious question needs to convey the sense that the speaker can be trusted, so one’s words, tone, and non-verbal behavior must contain a sensitivity to the receiver’s own style of communication and emotional state in the moment. And often, a curious question requires us to move invite our conversation partner’s aggression towards us, rather than deflecting, countering with aggression of our own, or fleeing into another topic.

Examples:

#1

"I can hear in your voice that you're frustrated with me, but I'm not sure why. Can you help me understand?"

#2
"My bookkeeper let me know today that you are several months behind. I'm interested to know if there's anything on your end that might be making it difficult to stay up to date, or if you have any questions or concerns about my bill that we haven't discussed?"

*If you haven't yet read Sharon Ellison's book "Taking the War Out of Words: The Power of Non-Defensive Communication," we highly recommend it!

#6 Employing Empathy vs. Sympathy

You've probably noticed in your own life that the phrase, "That must have been so terrible for you," can sometimes make you feel worse and sometimes make you feel better. Assuming the speaker is someone whose good intention you are inclined to trust, what accounts for the difference?

Any words offered to you in a moment of powerful feeling that do not give you a sense that the person speaking has a true grasp of your emotional experience will fall flat. On the other hand, those same words, spoken from a place of deep understanding and emotional connection, can have the power to sustain you through your darkest moments.

Sympathetic words are not only generally unhelpful, they can be destructive. These words are spoken from a position of distance. They are often self-referential ("Sorry you're sick! I hope you don't have what I had last week! Gosh, it was the worst.") or are born out of an anxiety in the speaker that conveys that they are overwhelmed by your experience ("I'm sure you're biopsy will come back negative. I just have a feeling."). Some of the most problematic sympathetic responses involve the speaker moving too quickly to advice or action ("I'm so sorry you got laid off. I know a great vocational coach- I'll email you his contact info right away!") or dismissing the importance of a loss ("Sucks that she broke up with you! She didn't deserve you anyway!").

Empathic responses require restraint, self-management and the ability to tolerate painful feelings without trying to discharge them in any of the ways described above. Consider the way a good parent focuses on her baby's cry and movements without becoming to anxious, takes them inside herself, and lets them resonate within her until she develops an understanding of the problem and can offer the right solution. This can be tough; listening to a baby's cry is painful, and not rushing in to quickly to "solve" the problem requires emotional maturity and restraint. An empathic listener doesn't rush to fill silence with platitudes. He or she sits in silence until they have a sense that they should speak. If the moment is right, he or she asks as many curious questions as it

takes for them to learn enough about the speaker's experience that they can feel it on a gut level. While one person can never fully know what it's like to be another person (and, as we described, is most helpful when they can maintain some emotional distance), the e most powerfully therapeutic tool we have available to us, the one thing that everyone craves, is the experience of feeling profoundly understood. True expression of empathy is the emotional equivalent of saying "I can't know everything about what it's like to be you, and though I can't take your pain away I am right here with you. I understood what it's like to walk in your shoes. And if the most helpful thing is for us to simply *be* together, that's what we'll do.

#7 Framing the issue

To frame an issue is to pull the core meaning of the current discussion, dilemma or task from the chaos of a moment and to articulate it in a way that facilitates understanding. Framing the issue might involve clarifying which topic should be the focus of discussion vs. simply a re-hashing of an old dynamic that lead you into the weeds. Framing might also take the form of summarizing a dilemma and challenges you face in navigating it. The more clearly we are able to frame the issue, the more likely we, our clients and our colleagues will be able to move efficiently forward in the process.

Examples:

#1
"I think this discussion is not so much about length of spousal support and more about when Lynn will be able to go back to work. Lynn - Can we talk about your plans and what a realistic time frame might be for getting your degree, and finding your first job?"

#2
"We've spend almost an hour talking about how the two of you are going to spend time with your kids over winter break this year, even though you both came in today saying you wanted to work efficiently. I think we're up against the understandable problem that on the one hand you want to move forward with your parenting plan, and on the other hand it's painful and difficult to imagine losing time with your kids, especially during special holidays."

#8 Paraphrasing

Paraphrasing is the verbal equivalent of standing very close to a client – as close as we can without being literally in their shoes. Repeating something someone says, sticking close his or her own words without sounding (or feeling) like a parrot, is the goal of this technique. Leading into a paraphrase with a comment like, "Just to make sure I am tracking you…." can be helpful. It can be useful to summarize a bit (since that requires

you to organize and condense your clients' thought—itself a helpful technique. But be sure to let your client know you're keenly aware you may get it wrong and are open to feedback ("Let me know if I'm off base, but I think the heart of what you're saying is…"). The more fragile or rigid client your client, the less deviation from their original phrasing they'll be able to tolerate. Paraphrasing is one of the building blocks of conveying empathy. So it has to be authentic, and it has to be accurate. Don't worry about sounding pat. If you feel the truth of what you are saying it will "*go in,*" if you don't, it won't. Better to be silent than to talk simply because you think it's your turn.

Example:

CLIENT: "My husband's house is such a mess I'm worried the kids will flunk out of school if they have to study there. No way are they staying with him during school weeks!"

PROFESSIONAL:
"Wow, so you're saying Karl's house is so chaotic and messy the kids won't be able to work there – which should have an impact on what schedule will be good for them."

#9 Limit setting

As we've pointed out, some clients come in to the process insecure, and have great difficulty building trust. It may be counter-intuitive, but more fragile clients need clearer limits and boundaries because those limits represent reliability and predictability and are the lynchpins of a good holding environment. Even if they rail against you, rigid clients will experience your calm resolve as a sign that you can be trusted and are strong enough to withstand their aggression (a indication that you can help).

Pushing limits might take the form of disrespecting protocols, refusing to do homework, or behaving toward you or your colleagues in a blatantly inappropriate way. But being firm is not the same as being punitive- so tread carefully. Don't retaliate or become patronizing. Be respectful, but don't apologize- stay the course.

Examples:

#1
CLIENT: "I know we're supposed to stop at noon, but I have just a couple more things I need to talk about – can we go until 12:30?"

PROFESSIONAL: "I do need to stop at noon. But let's set up a time to talk tomorrow so we can run through those other issues – does that work?"

#2

CLIENT: "I'm firing my divorce coach – can you give me the names of other coaches I can call?"
PROFESSIONAL: "Wow – sounds like we have a lot to talk about. I want to understand your concerns about her. Have you talked with your coach about this?"

CLIENT: "No – I'll tell her later, after I retain someone new. I've made up my mind. Done deal. It's my divorce. Move on."

PROFESSIONAL: "You really must have had a negative experience; I want to hear about it. Maybe replacing will turn out to be the right decision, I don't know. But this is an important crossroad in your process, and we both care about your success. Tell me more about why you feel the way you do. Then let's talk about what makes the most sense as next steps."

#3
CLIENT: (Yelling and rising from his chair) "I'm really pissed at you! You're not advocating for me!

PROFESSIONAL: (Seated, using a calmly firm tone and gesturing to the client's chair) "I want to hear what I've done to upset you, Jon, but I can't listen while you're yelling. Please have a seat and talk to me about this. "

#10 Taking a break

When one or more clients or professionals are emotionally overwhelmed, the authors do not recommend that a professional jump immediately to suggesting they "take a break" (e.g. take a short walk, sit in another office for awhile, use the restroom). We favor staying put long enough to determine if the holding and containment we provide can help clients to stay with us, so that we can make meaning from and work through their experience. But there are times when the intensity becomes counterproductive it makes sense to take a break.

Examples:

- Two or more professionals or clients are incapable (at least in that moment) of not fighting. The hope is the parties involved will calm down and be able to return to the work in more reasonable frames of mind.
- An overwhelmed, flooded client is unable to recover in our presence (or the presence of others in the room)
- An overwhelmed client feels humiliated that his or her emotions are so starkly in evidence.

#11 Caucusing

There are times when breaking up larger meetings into smaller caucusing groups can be helpful, particularly for moving past impasse.

Examples:

- A client is really ready to relinquish a position but feels too humiliated to do so in the presence of their partner.
- One or more clients need to "reset" within the safer, more intimate Microcontainer provided by their own professional/s.

II. TECHNIQUES THAT ARE USEFUL AND EFFECTIVE ONLY WITH CLIENTS WHO ARE LESS RIGID AND/OR HAVE COME TO VIEW YOU AS A TRUSTWORTHY SAFE BASE

#1 Reframing

If paraphrasing is standing right with a client, reframing is a stretch. It is the verbal equivalent of taking one time step forward, in a direction that we hope will help the client move ahead just a bit, toward change, compromise, clarity or acceptance. The trick to a good reframe is that it is different enough from what the client has just expressed to stretch the client in a helpful direction, but not so different that it elicits anxiety or annoyance in the client. Attempting a reframe is risky when a client is in an highly agitated state, since they are likely flooded, unable to process new information, and vulnerable to feeling emotionally "dropped" by you. Reframing works best when a client is calm enough to be receptive (which, depending on your client, may be possible even when they are also significantly anxious). Reframing is effective only if and when your client already trusts that you are on their side and that you understand and accept the complexity of their often conflicting feelings. A badly timed reframe can at best fall flat and at worst cause a rupture in your relationship with your client.

Example:

CLIENT: "My husband's house is such a mess I'm worried the kids will flunk out of school if they have to study there. No way are they staying with him during school weeks!"

PROFESSIONAL:

“Yeah I get it – you have a lot of concerns about the kids, including their ability to stay organized and do well in school when they have to go back and forth. It’s hard to imagine that Bob is ever going to get it together, or that the kids could ever adjust.”

#2 Reality testing

Like every other “stretching’ technique, use this one only if when you know your client well and you have a strong working alliance. The first piece of this technique involves conveying your sense of respect for your client’s feelings and opinions *as expressed*. The second piece is involves you (gently) offering a new perspective – offered in a spirit of non-judgmental caring and a desire to be helpful. Before offering reality testing, be sure to reassure your client – especially if they look worried – that you are not feeling critical. Find a way to share your confidence that your client is ready to be challenged a bit. Then share your opinion, perception or new perspective. Reality testing is an offer to expand your client’s worldview in a way that will expand their possibilities.

Example:

CLIENT: *“My husband’s house is such a mess I’m worried the kids will flunk out of school if they have to study there. No way are they staying with him during school weeks!”*

PROFESSIONAL:
“ I know how worried you have been about Karl’s failure to organize his home. I can see how chaotic his life is sometimes – it’s pretty apparent to me. I wonder if you would be interested, though, in hearing a slightly different take on the situation that I’ve been thinking about. I know you want to find a way forward in sharing parenting time with him…I have a perspective that might help us move forward – but it does contrast a bit with your perceptions of him.”

CLIENT: “…yeah, I do want to hear your thoughts. But I want you to know how worried this makes me. It’s a big deal.”

PROFESSIONAL: “It IS a big deal. Your children’s adjustment is a HUGE deal. But here’s the thing I’ve been thinking. You’ve told me how much Karl loves the kids – and how much the boys miss him when they don’t see him. Right?”

CLIENT: ‘Yeah. True.”

PROFESSIONAL: “So, I’ve just been thinking about what a learning curve Karl has. He has lived for ten years as part of a couple, and you were really the one who kept the trains running on time. You were the one who thought ahead, and who made sure the boys had clean soccer uniforms. Karl is a slob. But….I think he might be trying to get better at day- to-day organization. I think he is motivated to learn how to do some of the things

you have always done so well. Do you think it's possible that he could get better at this, that he could learn to create enough of a clean home that the boys could spend some time with him during school nights and still be ok – if we give Karl time to practice and [here with bit of a wry smile] maybe the name of a great house cleaner?"

#3 Making links

Making a link is a more advanced version of reframing. When we make a link we are exerting more force-- we draw the client yet further from their safe ways of seeing things. When we link (or draw a connection between) a client's current experience and past experience, we can help them develop new insights, relinquish long-held positions, and experience real transformation. Since making a link is another "stretching" technique – so it will backfire or cause injury if push it before our clients are emotionally ready.

Example:

CLIENT: "My husband's house is such a mess I'm worried the kids will flunk out of school if they have to study there. No way are they staying with him during school weeks!"

PROFESSIONAL:
"I understand your worry – especially because you grew up with a mom who was a hoarder – right? Didn't you tell me that? So no wonder a messy house at Karl's would freak you out. It makes sense that you'd feel particularly protective of your kids when it comes to chaos. It's probably worth our thinking a bit, though, about how much of your concern is based in your experience with you mom, and how much of it is really about Karl. Your mom was incurably chaotic. The question is, could Karl benefit from some time to learn new organizational skills?"

#4 Using tropes

As we get to know our clients over time, we inevitably develop an awareness of unhelpful, idiosyncratic patterns in their ways of relating to us, to their future ex, and to their divorce process. Often these patterns reveal themselves most strongly when our client is under stress. The patterns sometimes reflect stale, repetitive coping mechanisms that echo dynamics from their family of origin and/or their failed marriage. Healthier clients can usually be helped to see these patterns fairly quickly. More rigid clients may be able to see the patterns when you point them out, but have great difficulty modifying their behavior. One of the most useful tools for helping clients at all points on the Rigidity/Flexibility Continuum (healthy clients who are temporarily struggling; rigid clients who are stuck) is the co-construction between you and your client of something we call "tropes". A trope is a well-developed metaphor- a simple way of representing a complicated pattern or idea. It's a recurring, condensed set of ideas represented by a symbolic thought that is a shorthand for a commonly recurring

theme. It can be a word, an expression or even a sound or an image. For our purposes, we're talking about the development of a secret language shared with your client. This language is an outgrowth of your special alliance and creates a sense of a special connection.

Think of how much fun it is to have "in jokes" with your friends, or sing a spoof at an office party that is hilarious to the group but would mean nothing to people outside the firm. There is something exhilarating a shared complex knowledge that can be expressed simply and that can be understood only by a select few.

A trope serves another crucial function. Think of way that a beloved object- a teddy bear or security blanket- represents to a child the safeness and nurturance of their parents and home. It is a metaphor so powerful that, when stuffed into a backpack and carried along, can make it possible for a child to go alone to their first sleepover. In our context, a trope is an adult version of a security blanket- another kind of transitional object for our clients. A trope comes to represent *you and the containing function that you provide.* The use of the trope, whether it takes the form of a verbal exchange that is actually occurring in the moment, or rather is an idea your client can hold in mind and conjure up as needed, is like an icon in a computer. As our client's minds click on the trope, it expands and allows our client emotional access the to the holding experience that you provide. A trope is a soothing agent. The use of tropes can obviate the necessity for long conversation or between-meeting real-time communication.

Example:

Years ago, Kate worked with a client we'll call Millie. Millie had an ongoing habit of ranting without about the evils of her soon-to-be ex-husband. Her rants derailed meetings as well as her ability to concentrate and complete tasks (including divorce-related. Her ruminations caused her to cancel and be late for meetings, and inhibited her ability think clearly at the Collaborative table. Her undermined her own efforts to protect her children from her bitterness about the divorce. One day, Kate asked Millie if she remembered the song from Sesame Street, "Put Down the Ducky." It was a song Bert - and an entire cast of stars – sang to Ernie when he wanted to learn to play the saxophone but wouldn't put down his rubber ducky. It was a song about managing anxiety in the service of positive change!

Millie recalled the song and was intrigued by Kate asking her about it. Kate suggested that whenever Millie began feeling overwhelmed, she could imagine herself putting "putting down the ducky." So that she could "learn to play the saxophone" – in other words, so she could recover from her divorce and move on in life the way she wanted to.

Millie loved the idea (she had a good sense of humor.) From then on, whenever Millie started ramping up about her husband's flaws, Kate would whisper something like, "Put that ducky, down, babe" or perhaps, simply mouth the word "ducky." These interventions were highly effective: In one meeting, as Millie's voice started to rise in response to a perceived provocation by her husband, Kate quickly and surreptitiously mimed playing a sax. Millie laughed, and calmed down. Occasionally, Millie sent Kate text messages along the lines of, "Having a rough night. Trying to peel my white knuckled fingers off the ducky." This represented light years of progress, since up then Millie had had a regular habit of inundating Kate with "urgent" calls and emails to which she expected speedy responses but from which she took little comfort

When Millie's case reached settlement, and she had her last meeting with Kate, she gave he a gift-wrapped package inside of Kate found…. a rubber ducky, of course.

#5 Articulating polarities

In our context, a polarity is the dynamic tension between two opposite or contradictory wishes, thoughts, opinions, or tendencies that coexist within one individual or within a couple. Our work is replete with polarities. As a matter of fact, navigating them is exactly what we are doing in the ongoing balancing act of "tending and moving." Noticing and articulating a polarity with compassion and empathy is an important element in helping a client, colleague or couple to resolve the polarity (by relinquishing positions) and choose a path forward.

As with all of these techniques, speaking thoughtfully and carefully and using non-critical or judgmental words and phrases is key.

Examples:

> *#1*
> *CLIENT: "I have to move out of this damn house, but I'm so afraid of moving into a new place. I'm going in circles."*
>
> *PROFESSIONAL: "Clearly you are torn. You're so ready for a change – to get on with your life, but it's terrifying to take the next leap! Why don't we talk about both sides…what would it be like to postpone the move, and then what might it feel like to explore nearby apartments?"*
>
> *#2*
> *CLIENT: I hate the idea of needing him and his money! I'm the original feminist! But I just don't know how I'm going to get back into the work force. I don't know if I can support myself at this age.*

PROFESSIONAL: You are in a tough spot. I can hear you rebelling against the notion of continuing to lean on Barry for financial support – you are fiercely independent. But the reality is you may need to lean on him for a few years, until you get back into teaching. It's hard to be up against two things that might be true – but are sort of in opposition to each other.

#6 Articulating our own uncertainty

There are many moments in our work when we have no idea where to go next. We simply don't know what to do or so. Perhaps we are triggered emotionally, and can't think. Perhaps we are lost in the content of the discussion, or can't track our client- emotionally, cognitively, or both.
Taking time to sort out the source of our confusion not only helps us figure out the most helpful way to intervene, it also sends powerful messages about our trust in the team, our trust in the process, our willingness to be vulnerable, and our belief that meaning can be made from chaotic experience.

Examples:

#1
PROFESSIONAL (To a client): "I'm having a hard time reading you…I'm not sure what might be most helpful right now."

#2
PROFESSIONAL: (To colleagues and clients in the room.) "So we all went from talking about one thing to talking about a totally different thing. I'm wondering if I'm the only person who is having trouble tracking. Can we push pause for a 'sec to figure out where we are?"

#3
PROFESSIONAL: (To another professional in the room) "I'm not sure how to be most helpful right now. Do you have any thoughts about what we should do with our last fifteen minutes?"

#7 Use of silence

Allowing space for our clients to think, react – to fill the space in any way they wish – is sometimes hard for professionals. But allowing silence to build is one of our most powerful tools. Remaining quiet following a particularly anguished moment can convey respect for the profound feelings in the room – feelings that cannot easily be addressed with words. Restraint from speaking when clients are struggling to find their way forward leaves space for them to master a task and experience the resultant satisfaction- a transformative experience. Remaining silent also leaves room for others in the room who may process at varying speeds but have something important to contribute. On the other hand, it is important to remember that fragile, and highly anxious clients may have a tough time tolerating silence, and may even interpret it as indifference. Silence, like any particularly powerful tool, has to be used carefully, and with thought.

By the way, don't make the mistake of confusing silence with inaction. Sitting still while remaining emotionally attuned is one of the most active (and often difficult) techniques of all.

When Love Locks Fail: Understanding How Couples Fit Together is Key to Helping Them Come Apart

RESOURCES AND MATERIALS

Dr. Helen Fisher, Biological Anthropologist Answers Love Questions From Twitter, https://www.youtube.com/watch?v=6DYgImG1CKo

Harville Hendrix, PhD and Helen LaKelly Hunt, PhD, website: https://harvilleandhelen.com/initiatives/what-is-imago/

Getting the Love you Want: A Guide for Couples, Harville Hendrix, PhD and Hellen LaKelly Hunt, PhD

Blog, https://sitn.hms.harvard.edu/flash/2017/love-actually-science-behind-lust-attraction-companionship/

Gehlert, Nathan C., "Randomized Controlled Trial of Imago Relationship Therapy: Exploring Statistical and Clinical Significance" (2017). 2017 Faculty Bibliography. 12. https://collected.jcu.edu/fac_bib_2017/12

Scharff, Kate and Herrick, Lisa, Navigating Emotional Currents in Collaborative Divorce: A Guide to Enlightened Team Practice (ABA 2011)

Scharff, Kate and Herrick, Lisa, Mastering Crucial Moments in Separation and Divorce: A Multidisciplinary Guide to Excellence in Practice and Outcome (ABA 2017)