UNIT 3 PSYCHODYNAMIC COUPLE THERAPY

Structure

3.0 INTRODUCTION

The emergence of conflict in a marriage or serious relationship does not necessarily signal disaster ahead. In fact, it might lead to a great opportunity for couples to work with a marriage and family therapist to strengthen the love relationship, restore trust in the relationship, and increase the possibilities for true intimacy.

Relationship problems are far more likely to develop during times of transition for couples and their families, such as when starting a new relationship, bringing a child into the family, dealing with a grandparent's death, or ending a relationship. Whether you hope to save a marriage, plan for a divorce, or sort out all the territory in between, a marriage and family therapist can be an objective source of support and information about love relationships. In this unit we will be dealing with nature and definition of couples therapy and follow it up with approaches to couples therapy. Under this we will discuss the psychodynamic approach, client centered approach, behavioural approach etc. Then we deal with psychodynamic couples therapy and discuss the use of transference in couples therapy.

3.1 OBJECTIVES

After completing this unit, you will be able to:

- Define and describe the nature and definition of couples therapy;
- Approaches to couples therapy;
- Explain psychodynamic theory to couple counselling with case illustration;
- Process of psychodynamic couple therapy;
- Framework of object relations approach; and
- Discuss the use of transference in couple's therapy.

3.2 NATURE AND DEFINITION OF COUPLES THERAPY

The terms couples therapy, marriage counseling and marital therapy are all used interchangeably. These different names have been used to describe the same process, with the difference often based on which psychotherapy theory is favoured by the psychologist.

Couples therapy focuses on the problems existing in the relationship between two people. But, these relationship problems always involve individual symptoms and problems, as well as the relationship conflicts. For example, if you are constantly arguing with your spouse, you will probably also be chronically anxious, angry or depressed (or all three). Or, if you have difficulty controlling your temper, you will have more arguments with your partner.

In couples therapy, the psychologist will help you and your partner identify the conflict issues within your relationship, and will help you decide what changes are needed in the relationship and in the behaviour of each partner, for both of you to feel satisfied with the relationship.

These changes may be different ways of interacting within the relationship or they may be individual changes related to personal psychological problems. Couples therapy involves learning how to communicate more effectively, and how to listen more closely. Couples must learn how to avoid competing with each other, and need to identify common life goals and how to share responsibilities within their relationship. Sometimes the process is very similar to individual psychotherapy, sometimes it is more like mediation, and sometimes it is educational. The combination of these three components makes it effective.

3.3 APPROACHES TO COUPLES THERAPY

There are many different approaches to couples therapy, which may be used alone or combined with other methods by the therapist. Among the oldest is the psychodynamic approach, which attributes problems within a marriage to the unresolved conflicts and needs of each spouse. Each client's personal history and underlying motivations are central to this mode of therapy. Therapists using this approach apply the principles of psychoanalysis in their treatment; they may either treat both marriage partners individually, or treat one spouse in collaboration with another therapist who treats the other.

3.3.1 Psychodynamic Therapy and Couples Counseling

As the oldest of the modern therapies, psychodynamic therapy is based in a highly developed and multifaceted theory of human development and interaction. Psychodynamic therapy is an insight oriented approach that focuses on unconscious emotions that manifest in behaviour.

This approach is well suited for working with couples counseling because it works to identify emotions that manifest in behaviour, it allows the focus of the sessions to be on the unique situation of each individual client, and it takes into account how past relationship experiences affect current relationships.

One of the main goals of psychodynamic therapy is client self-awareness and understanding of how the past can influence present behaviour. It can help settle past conflicts as well as issues arising from past dysfunctional relationships. It is derived from the psychoanalytical method that Sigmund Freud researched. Freud felt that the human mind or psyche was made up of several different levels and that it is the unconscious mind which contains events from our past. He felt that forgotten experiences can still affect our present behaviour. In order to treat this, Freud developed a method by which memories and associations could be brought to the surface and examined in order to modify our current behaviour.

The therapeutic relationship in psychodynamic counseling is based on acceptance, empathy and understanding, with an emphasis on developing a good working alliance that fosters trusts. This relationship creates a safe environment that promotes healing.

3.3.2 Systems Approach and Couples Counseling

Marriage counseling that follows a systems approach stresses the interaction between partners as the origin of marital difficulties, rather than their actions or personality. Behaviour and communication patterns are analysed as well as the interlocking roles portrayed by the couple or members of the family. Family members may be conditioned to consistently play “the strong one” or “the weak one,” or such other roles as “scapegoat,” “caretaker,” or “clown.” Although initially it may seem that only one member of a family system is troubled, on closer inspection his or her difficulties are often found to be symptomatic of an unhealthy pattern in which all the members play an active part.

Systems theory is actually an umbrella term for a range of therapies, and systems-oriented counseling may take a variety of forms, including both short- and long-term therapy.

3.3.3 Client Centered Therapy

A popular individual treatment approach also used in marriage counseling is Rogerian or client-centered therapy, also referred to as humanistic therapy. Here, the emphasis is on communication and the open sharing of feelings. Through specially formulated exercises, couples work on improving their speaking and listening skills and enhancing their capacity for emotional honesty.

3.3.4 Behavioural Approach

Another widely employed mode of marriage counselling is based on a behavioural approach, in which marital problems are treated as dysfunctional behaviours

that can be observed and modified. Couples are made aware of destructive behaviour patterns, often by systematically recording their behaviour until certain patterns emerge. The therapist then coaches them in various modifying strategies with the goal of achieving positive, mutually reinforcing interactions.

Behaviour oriented therapy also focuses on improving a couple's problem-solving and conflict-resolution skills. Marriage counsellors may conduct therapy sessions with both spouses, treating one as the primary client and the other one only occasionally, while another therapist treats the other spouse. An increasing number of therapists counsel couples in pairs, with married therapists sometimes working together as a team. Theoretically, the relationship between the co-therapists is supposed to serve as a model for their clients. Marriage counselling in groups, which is becoming increasingly common, offers clients some of the same advantages that group therapy offers individuals.

Self Assessment Questions

1) Define couple therapy.

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2) Describe the nature of couple's therapy.

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3) Discuss the different approaches to couples counselling.

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4) Elucidate psychodynamic approach to couples counselling.

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5) What is systems approach to couple counselling?

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6) Discuss the application of behavioural approach in couples counselling.

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3.4 PSYCHODYNAMIC COUPLES THERAPY: AN OBJECT RELATIONS APPROACH

Object relations couples therapy is a psychoanalytically based method of couple treatment that integrates past with present, conscious with unconscious, and the intrapsychic with the interpersonal. The object relations approach helps couples discern how past life experiences as individuals can limit their possibilities in the present as a couple. It clarifies how unconscious processes can promote conflict and disappointment. It helps partners take ownership for how their individual perceptions, fears, and motivations may be shaping their interactions as a couple.

The most difficult aspect in couple's therapy is the observation of partners blaming each other. It is also a common observation that polarisations within the session in which each partner clings to an unambivalent point of view that is in exact opposition to that of the other.

In the following example from a marital session, I examine how our psychoanalytic approach informs a particular understanding of and intervention in such an argument.

3.4.1 Clinical Illustration and Analysis: Conflict as a Safe Haven

For Anitha and Vikram, after years of emotional distancing and conflict, a more friendly relation had gradually evolved during 1½ years of marital therapy. Physical intimacy, however, remained a remote and improbable goal. On the surface, Vikram appeared to be the spouse who sought a sexual connection whereas Anitha disavowed any desire. She blamed her lack of interest on the many ways she felt that Vikram disappointed her. He attributed his lack of sexual initiative to her episodes of hostility.

In the session, the couple opened with what appeared to be a regressive, angry argument, recalling to me the early months of our work. All the old familiar bones of contention were resurrected. Anitha "ragged" on Vikram for his failure to take good care of her by seeking out a higher-paying job. Vikram criticized Anitha for neglecting the needs of the children and letting the housekeeping go. The therapist discovered that the weekend before this fight began the couple had had "good family-together time," and that, more precisely, the retrograde conflict began shortly after the couple had "cuddled in bed." Vikram had drawn close to Anitha and she had responded. This degree of physical closeness had not occurred in ages. As the discussion deepened, therapist learned that, Anitha liked this "cuddling . . . but it also made me mad" because Vikram, she thought, would wrongly conclude she had forgiven him for all his transgressions. Internalising more and more, Anitha revealed that she had recently experienced an awakening sexual desire for Vikram and had asked him to "kiss and hug." She joked that she was afraid to have sex because she would have to talk about it in couples therapy. Anitha said she was reluctant to relinquish her "survival mode"—that is, her determination to depend only on herself and not to allow herself to rely on and come close to Vikram.

For Vikram's part, he admitted that he felt anxious when the couple hugged and kissed at Anitha 's request. She perceived this as a subtle sense of his distancing after their physical contact. Vikram then associated to his fear of being dependent on Anitha and to the death of both his parents when he was quite young.

These seemingly warring adversaries are sharing a common internal ambivalence over closeness, dependency, and intimacy. Their ordinary, consistent way of relating involves maintaining a distance, often hostile, which keeps at bay, for each of them, the anxieties that, would emerge from a more intimate connection. When they "cuddled in bed," Vikram was aware of anxiety, whereas Anitha found herself getting angry at him. With their usual equilibrium destabilised by the sexual contact, shared anxiety led them to dig up the familiar bones of contention and to restore, through arguing, their costly but safer distance.

The object relations couples therapist looks beyond the manifest content of an argument to understand the unconscious factors that may have triggered the conflict in the couples. Every marriage or intimate couple relationship is likely to have significant unresolved issues, bones of contention, which may be managed by compromise or simply tolerated and accepted as a difference, as in "we agreed to disagree." When these "bones" suddenly get reactivated in the relationship, we look for the possible triggers of this current conflict and focus on developing understanding of the underlying issues. This approach is quite different from those couples's therapies that focus entirely on the manifest content of the conflict—for example, with Anitha and Vikram, the therapist attending to complaints about poor housekeeping or not seeking more financial security with a higher-paying job.

3.4.2 Projective Identification

Interpersonal conflict reflects the transposition of intrapsychic conflict within each partner on to the couple relationship. The mental mechanism that is

responsible for this transformation is *projective identification,* the core concept of the object relations approach.

Melanie Klein (1946) defined projective identification as "a combination of splitting off parts of the self and projecting them onto another person," later describing it as "the feeling of identification with other people because one has attributed qualities or attributes of one's own to them". Klein saw this as a defensive mode evolving from an early infantile developmental stage in which anxiety is warded off by experiencing intolerable affects, especially aggression, as if they resided in a space external to the self. This defensive "splitting" thereby creates the first *"me–not me boundary."* As the infant matures, and a self–object boundary develops, the preobject *"not me"* realm fuses with the object world, and what is projected is now directed into the mental image of the other. However, what is projected, is not only the disavowed aspects of the self but also those aspects that are cherished.

Much before Klien, Sigmund Freud (1921) provided an example of projective identification in characterising the *"falsification of judgment"* that accompanies the idealisation of loved objects, what we refer to as falling "*head over heels"* in love. The tendency that falsifies judgment in this respect is that of idealisation, but now it is easier for us to find our bearings. We see that the object is being treated in the same way as our own ego, so that when we are in love a considerable amount of narcissistic libido overflows onto the object. It is even obvious, in many forms of love choice, that the object serves as a substitute for some unattained ego ideal of our own ego, and which we should now like to procure in this roundabout way as a means of satisfying our narcissism.

In a more modern and comprehensive view (Zinner 2001), we can say that projective identification is our universal way of perceiving and comprehending others. When we are interacting with another person, our behaviour toward that other is determined by our mental image of him or her. Our consequent behaviour impinges on and affects that other person, but the person we are relating to exists only within our mind as a construct. This created mental image of the other is built from sensory stimuli coming from the outside that are then processed by our own mental apparatus.

We never truly know the other person and what he or she feels. We can only approximate the actuality and subjectivity of the external object by drawing on our own experience and attempting to match it with what our senses are receiving from the outside. We unconsciously regard the actual object as the embodiment of our mental construct and treat him or her accordingly. This unconscious recognition of a projected aspect of our self in the object is the identification process in the mechanism of projective identification. Thus, in this definition, both projection *and* identification occur within the mind of one person, the subject. There appears to be, perhaps, a wired-in propensity to distance oneself from emotional pain by placing its source outside of the self, a generic process we refer to as *externalisation.* When our effort to form a realistic picture of the other is burdened by a simultaneous need to expel a part of our self, the image of the other is thus tainted and distorted by our own defensive or empathic functions.

3.4.3 Empathy

It is a form of projective identification that includes an explicit or implicit ongoing examination in an effort to approximate the actuality of the other. Empathy

involves openness and curiosity about the nature and subjectivity of the other as well as a willingness to alter one's perceptions depending on fresh impressions communicated by the other. One hallmark of defensive projective identification is the sense of certainty that the subject has of the nature of the other and the inflexibility of the subject's perceptions regardless of what the other may be communicating that may differ from these perceptions. Thus, in our understanding of the interaction of the couple, we ask ourselves not *whether* projective identification is occurring but rather to what degree it is serving defensive or empathic functions.

In intimate relationships, behaviour generated by projective identification may have a coercive quality that is very likely to evoke in the recipient an experience of himself or herself that resonates with the way the projecting spouse is behaving toward him or her. A loving glance can evoke in the partner a feeling of being lovable. Conversely, a contemptuous sneer from a husband, one of a pattern of such behaviours, is likely to evoke in the wife a sense of being disgusting and contemptible. Because both partners are viewing each other through the filter of projective identification, we can view the entire relationship as a nexus of interlocking projective identifications generated by both partners, in which the experience of the self is strongly affected by the way one is perceived and treated.

Participants in close relationships are often in collusion to sustain their mutual projections—that is, to support each other's defensive operations and to provide experiences through which the other can participate vicariously. It is the subject's unconscious identification with the recipient of his or her projections that allows for this vicarious experience of living through the other. For projective identification to function effectively as a defense, the true nature of the relationship between the self and its projected part must remain unconscious, although the individual may feel an ill-defined bond or kinship with the recipient of his or her projections. The disinheriting of the projected part is not so complete that the subject loses his or her capacity to experience vicariously a wide range of the object's feelings, including those which the subject has himself or herself evoked. These vicarious experiences contain features associated not only with gratification but with punishment and deprivation as well.

In the case of Anitha and Vikram, each experienced considerable unconscious inner conflict over sexual intimacy and its threatening consequence of emotional dependency. As a way of warding off anxiety, both partners colluded in parceling out the elements of their own ambivalence into roles each would assume. Thus, Vikram spoke in behalf of their shared desire for sex, whereas Anitha represented their fear of physical intimacy. In this manner, the intrapsychic conflict of each was transformed into interpersonal conflict within their relationship. It does appear that conflict between partners is often more bearable than conflict within oneself. When Anitha reversed roles with Vikram and initiated sexual contact, their distant but stable equilibrium dissolved. Each became anxious and managed to restore the sexual distance by regenerating conflict in digging up the familiar bones of contention.

3.4.4 Transference

It is one form of projective identification, as it appears in the psychotherapeutic setting. The term, however, has been expanded to be almost synonymous with *projective identification* by including many situations in which *" a normal*

person's perceptions and affective responses vis-à-vis the self and others are heavily influenced by the activation of significant relationship representations from the past" (Gerber and Peterson 2006).

The operation of projective identification within marriage, however, is more than a matter of externalisation of disavowed or cherished traits. We find that in the defensive mode, the contents of the projected material contain highly conflicted elements of the spouse's object relationships with his or her own family of origin. Although it is commonplace to think of a husband selecting a mate who is "just like the girl who married dear old dad," we are here referring to the unconscious striving to re enact conflictful parent child relations through such an object choice. Highly fluid role attributions occur in which a husband, for example, may parentify his spouse, or, on the other hand, infantilise her by experiencing the wife as the child he once was.

The externalisation of aspects of old nuclear relationships may serve not only a defensive need but also a restorative one, to bring back to life, in the form of the spouse, the individual's lost infantile objects, both good and bad. The perception of the partner coloured by the image of a beloved deceased parent may be salutary, heightening affection for the spouse. On the other hand, it may also be constraining on the object of the perception insofar as it detracts from her individuality and may lead to conflict when she does not conform to the parental image. Thus, recognising the restorative function of these projective identifications may lead the therapist to fruitful exploration of unresolved grief over the death of the parent or other important person.

Our understanding of the impact of projective identification on couple relationships has profound implications for our therapeutic approach. For working with couples, many therapists utilise some form of a focal problem solving approach, often cognitive behavioural in style, with a primary focus on the manifest content of the conflict and perhaps an elaboration of dynamic patterns across conflicts. According to these methods, a couple enters therapy with its disputes, and the therapist seeks to resolve the conflict through identifying strengths, making behavioural contracts, conducting conflict resolution, assigning paradoxical interventions, or promoting fair fighting techniques, among other similar interventions. When a couple's conflict, however, is deeply anchored in interlocking processes of mutual projective identification, it can be very difficult, if not impossible, to make progress with most problem-solving strategies. This follows from our understanding that in these situations, interpersonal conflict is serving the intrapsychic defense of each partner so that there is a strong unconscious motivation for sustaining the couple's disharmony in order to preserve each partner's internal equanimity.

The object relations therapeutic approach is indicated for just these kinds of refractory couple discord. Our theory informs us that the manifest conflict and anger are not the primary targets of our efforts, but rather we seek to uncover the sources of pain within both partners that have caused them to use the relationship as a repository for disavowed aspects of their own selves.

When successful, our exploration of the underpinnings of the manifest conflict reveals a more poignant subtext in which each partner is able to become aware of the emotional pain that led to the expulsion of the distress, appearing as anger, into the interpersonal space. Insofar as the therapist's efforts lead to a shift from

blame to internalisation of conflict within the individual partners, there is a diminution of anger and an increased capacity for empathy, compassion, and respect for one another that was not possible when each spouse was the target or perpetrator of criticism and rage.

The following description of a marital therapy session with Anand and Jaya illustrates the ebb and flow of externalising and internalising processes in the relationship, with concomitant shifts between anger and sadness.

3.4.5 Clinical Illustration and Case Analysis

Conflict as a Defense against Fear of Loss

When therapist again reminded Jaya that he could not schedule their sessions to an earlier time, She quipped, "Don't *any* of your patients get better?" This response reflected her sense of continued bickering with her husband Anand recently, although not at the level of several weeks ago.

They described a typical fight in which the two of them ended up snapping at each other in front of Rajani (their 3-year-old daughter) after the child fell and hurt herself. Each blamed the other for not keeping a watchful eye on the little girl as she was playing on their bed. This is a typical instance of their taking out their shared anxiety on one another and polarizing over who would bear all the worry.

One scene during this altercation involved Jaya panicking when she noticed some blood in Rajani's mouth and then shouting at Anand to "get off the fucking phone" while he was taking his time, casually conversing with his son. *She* had actually handed the phone to Anand earlier when he had followed the crying Rajani into the room. Jaya commented that after this blowup, both felt "heartsick" at the way they had dealt with Rajani's injury.

They reported several other bickers during which Jaya was nagging Anand while he was dragging his feet on a project because he felt again that giving in to Jaya was being "euchred," which is his expression for being "led by the nose." Their fight seemed to be over the proper height of the wall they were building in the basement. Jaya wanted a higher wall than Anand, and they couldn't agree. The therapist commented that in recent weeks they have been erecting a wall between them such that they're not pulling together as a team under stress and, as Jaya put it earlier, "It's like we're having all our old fights all over again."

Therapist inquired about the deeper layer of concern underlying the wall, and Jaya teared up, saying, "It's because when I need him he's not there. I can't count on him being here." Hearing the reference to Anand's absence, therapist asked Jaya if she had been concerned about Anand's health lately. Anand is considerably older than her and not scrupulous about his health habits. At this she nodded affirmatively and began to cry. The conflict seemed to start while he was away so much recently working so hard on a contract that he, incidentally, just informed me he had successfully completed. She felt like a "single parent" then and imagined him dying and how much worse it would be if he did. She worried about his knees, his hearing, and, above all, about his weight and his drinking. She revealed she carries a fantasy that at any time he could have a heart attack and die. Then she would be all alone with Rajani and unable to remain in their house, because she couldn't afford it even for 6 months. In this recent concern

she pleaded to Anand to draw up an accounting of how much she would be left with, and he did. Of course, he was unaware of the poignant aspect of her request and how frightened she was at the prospect of losing him.

The night before, Jaya arrived home late from work to find Anand devouring a 12-ounce steak. This upset her considerably although she did not mention it to Anand. To her this was an example of his self-neglect. Ordinarily, when she is home and cooking dinner, she prepares meals that are suitable for a man with heart disease, such as beans and rice. She was angry at him in the session for his "not letting yourself use me as a resource," because she is able to prepare for him foods that are tasty and healthful. "Instead, you act like I'm your enemy," she says when she admonishes him for eating foods that are unhealthful for him.

Reflecting on this session, we see that this couple has recently been bickering again as Jaya said, "It's like we're having all our old fights all over again." She is referring to the bones of contention—"our old fights"—unique to this couple. Her guilty perception of their backsliding into conflict is transformed into a wisecracked projective identification in which she blames therapist, in the transference, for not getting "*any* of patients . . . better." Rather than eliciting the manifest content of their recent bickering, there is need to search for the precipitant of this current round of conflict.

Hearing her critical reference to Anand —"I can't count on him being here"—therapist associates to the possibility of her losing him and ask if she is concerned about his health. This question reveals the source of their recent tensions, as Jaya begins to cry and tell how, in the face of Anand's recent prolonged absence, she worries that he might die and leave her and their daughter, Rajani. In their relationship, the fear of death and loss is parceled out by projective identification. Anand is cavalier in his dismissal of the dangers to his health from his very casual attitudes about his eating, drinking, and lack of exercise. Jaya, on the other hand, carries all the worry for the couple about the consequences of his health habits. Because he does not internalise his own concern about dying prematurely, Anand runs the risk of fulfilling that grim prophecy by, for example, gorging on a 12-ounce steak the night before the session. Interestingly, this behaviour may be his way of expressing his own feeling of abandonment by Jaya, who came home too late to cook a healthful dinner for him.

These interactions illustrate a fundamental consequence when a couple uses their relationship as a repository of disavowed and devalued projections. They are unable to work as a team because their polarisation causes them to pull in opposite directions. In distinction, when each partner in a couple is able to internalise intrapsychic conflict and tolerate anxiety, ambiguity, or sadness, the pair can function as a team and benefit from its joint and collaborative efforts. In this connection, Jaya lamented to Anand that "You are not letting me use you as a resource."

Their failure to share anxiety and guilt following Rajani's fall is another example of how defensive projective identification leads to couple conflict and dysfunction. The role of the worrier switched during the interaction so that at first, Aanand was moaning "Oh my gosh! Oh my gosh!" while Jaya handed him the phone so that he could speak with his son, a nonurgent matter. He was bearing the anxiety for both of them. Spotting a small amount of blood in Rajani's mouth, Jaya

panicked, as the defense against her anxiety crumbled. At that point *she* became the worrier and raged at Anand for being on the very phone she had handed him moments before. Because of the work that they had previously done in therapy about their flawed handling of anxiety connected with Rajani, both recognised their return to an old pattern of blaming and felt "heartsick" about what they had allowed to happen.

During their conflict over Rajani's fall, however, what remained constant was the polarisation of attitudes.

Another important feature of object relations couples therapy is to listen for the symbolic and metaphoric quality of the content of marital conflict. In the session with Anand and Jaya, a significant and emotionally charged argument persists over how high to build a wall within their basement. When such an intensity of feeling arises over what would appear to be a manageable difference of opinion, therapists should look for the metaphoric meaning of what is contested. In this case, in recent weeks a "wall" was being erected as the couple distanced itself through "having all of our old fights" after Anand's return from his travels.

A primary goal of object relations couples therapy is to help each partner reinternalise what he or she has projected into the interpersonal sphere in a way that has burdened the relationship. The conflicted internal relationships can only be resolved intrapsychically. When such reinternalisation occurs, there is a striking shift from anger and polarisation within the couple toward sadness, tenderness, and poignancy in each partner. This transition is evident in the session with Anand and Jaya as they finally share the "heartsick" feeling at how they divided and fought over Rajani's fall. Similarly, their arguments over the wall and their old fights are ameliorated when they become aware of their concerns about abandonment and death.

Following the successful reinternalisation of projected elements, there can be considerable individual intrapsychic work done in the course of the couple sessions. What often does occur, however, is that the partners seek out individual psychotherapy with a different therapist as a complement to the couple treatment? Both Anand and Jaya had been in individual therapy before the couples work began and continued with that synergistic combination.

Self Assessment Questions

1) Discuss psychodynamic couple's therapy as an object relations approach.

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2) What is projective identification?

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3) Discuss empathy and transference in psychodynamic couple's therapy.

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3.5 USE OF TRANSFERENCE IN COUPLES THERAPY

According to the object relations approach, the world of internalised object relationships is transposed onto the world of actual interpersonal relations through the mechanism of projective identification. This transposition occurs in a variety of spheres, not just within the couple relationship. Interactions with children, friends, employers, colleagues, and others are governed by the same psychological mechanism. Transference is the form of projective identification that occurs in the therapeutic relationship.

In couple's therapy, transference feelings and marital issues are often inextricably interwoven threads of the same interpersonal fabric. Because the couple's therapy is a three-person relationship, there is an increase in the permutations; the forms of this transference may take in contrast with individual psychotherapy.

First, as in individual work, there is the focused transference that each partner feels toward the therapist based on that partner's internal object world.

Second, there is a very common triangular transference configuration in which each partner is seeking to be the one preferred by the therapist at the expense of the other.

This three some interaction often re enacts sibling experiences in competition for the favour of their parent.

More often than not, each partner enters couple treatment with the fantasy hope that the therapist will validate his or her point of view and work to change his or her partner's wrongful attitudes and behaviour.

Many of the early efforts by the therapist are devoted to helping the couple understand that each partner is contributing to the problematic interactions in

their relationship. This requires that the therapist actually be able to rise above, in attitude and behaviour, the drumbeat of blaming and fault finding that so frequently take place in an adversarial couple situation. Even handedness and neutrality in the therapist are greatly aided by his or her understanding of the complex and complementary interplay of the internal object world of the partners as it is transposed onto their current relationship.

Third, there is a complex transference that encompasses the experience of the entire three-person group in interaction. One such instance is the *shared fantasy* within the couple that the couple treatment is in itself a danger to the integrity of the relationship and the safety of individual members, rather than a resource for help, healing, and growth.

Especially where words have been used as instruments of aggression rather than of understanding and support, there may be a great fear of becoming open and vulnerable in the session, with a consequent constriction of communication and a perception of the therapist as an agent of harm. It is therefore an early priority that the therapist recognise and explore this shared fantasy that talking is dangerous because language, the very vehicle for healing in therapy, is seen paradoxically as the greatest threat to the safety and security of the couple.

Because of the emotional power inherent in a group, strong counter transference experiences are to be expected in couples therapy, and it is often a challenge to convert these feelings into stimuli for constructive therapeutic reflection and intervention, in contrast to internalising them so that they colour the therapist's self experience in a way that helps no one in the threesome.

This attitude that the treatment situation is one of harm rather than of help is often discovered through the therapist's own counter transference experiences in a variety of ways. For example, the therapist may find himself or herself, in the face of the couple's silence and constricted communication, feeling the need to energise the interaction with frequent superficial interventions.

In the absence of the therapist's forced efforts the group feels lifeless and defeated, and the therapist's sense of himself or herself as helpful and competent may suffer. It is useful for the therapist to be aware of such personal reactions because they serve as a signal that there is some problematic fantasy operating within the threesome that requires explicit exploration. In this instance, the therapist can use his or her sense of ineffectiveness to ask directly about the couple's experience of the therapy and the therapist, and what their fears are of saying what is on their mind in the session.

The elucidation of transference by the therapist offers the valuable opportunity to examine the marital relationship in the here and now of the session. This in-the-moment examination is often more highly affectively charged than the couple's rehearsing of the more remote then-and there events of the previous week. Working in the here and now is especially helpful to the therapist, as he or she has the opportunity to experience and learn from his or her counter transference reactions as the drama unfolds in the session. It is also necessary to address problematic negative transference issues that might lead to acting out or an interruption of treatment if ignored.

3.5.1 Clinical Illustration and Case Analysis

Work in the transference is illustrated in the couple treatment of Thrivedi and Tulasi. The session occurs soon after a difficult interruption, involving a lengthy unanticipated absence by the female therapist and the death of Thrivedi's mother. The hour opens with an extended silence and downcast expressions:

> Tulasi: I feel so bad. Everything's falling apart. I'm too angry, hurting.
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> Therapist: Your relationship is falling apart?
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> Tulasi: Yeah, and between me and myself.
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> Thrivedi: It's also a hard time for me. I'm feeling very alone. I'm not through feeling the loss of my mother. I'm feeling alone with Tulasi, too, feeling there's not much room for me. I'm not sure what to do about that.
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> Therapist: You look quite sad.
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> Thrivedi: I've had pretty sad days. I wrote all the thank-you notes for people who helped a lot. I'm feeling pretty bad, pretty sad. Yesterday, I spent time going back through things . . . greeting cards . . . business stuff. I felt pretty sad, pretty alone.
>
> Therapist: You feel alone in your grieving or without your mother?
>
> Thrivedi: Both . . . [Thrivedi *recounts how he called his uncle and aunt, who were close to his mother*] . . . it's a sad thing.
>
> Therapist: Right now you seem very closed in, inside your grief.
>
> Thrivedi: Yeah.
>
> Therapist: Is your grief complicated? I had the impression your relationship with your mother was not satisfying for you, which would complicate your grief.
>
> Thrivedi: The last few years she tried to reach out and we worked through a lot of stuff. She was a critical person, not easy to talk to. I was always feeling I'd be criticized.

Thrivedi and the therapist engage in a discussion in which the therapist especially questions him about his relationship with his mother. Throughout, Tulasi remains utterly silent, often staring out into space. Thrivedi is responsive to the therapist's interventions. He begins to cry, concluding, "No matter how bad things were, she loved me and now she's gone."

> Thrivedi: All these feelings are overwhelming. I don't know how to be with Tulasi when she's having all these feelings, too. Somehow it feels like it has to be either her or me. I don't know how to work it so that we can both be depressed or sad or both be mourning.
>
> Therapist: You have the idea that Tulasi is feeling cut out because I'm talking to you and drawing you out?
>
> Thrivedi: Yeah, I do. And feeling she's resenting it a lot . . . [*silence*] . . . I know part of the problem is I want somebody to take care of me . . . to be kind . . . and I know that's not fair . . . to expect . . . of her. It took me a lot to get to the point where I could recognise that. I just don't know how things are supposed to be anymore.

During the course of the session thus far, the therapist has been acutely aware of Tulasi's conspicuous silence and lack of involvement. The therapist found herself irritated at Tulasi and was determined to keep the channel of communication open with Thrivedi by ignoring Tulasi's efforts to undermine it. This counter transference experience was familiar to her in working with this couple. She had frequently felt as if she were compelled to make a choice between devoting attention to one spouse or the other. The partner not receiving the therapist's attention at the moment would remain silent and sullen. Thus, the interaction had a quality of taking turns rather than of give and take. Aware that she was acting out her own counter transference irritation, the therapist decided to shift to interpretation.

Thrivedi: I've been feeling I have to have something to help me get through this. I don't have Tulasi. I just don't know how to get to her . . . without her feeling resentful. It's like I have to totally be on my own or I have to rely on Tulasi —those two things—the dependency I want isn't good, isn't healthy, but I still want it . . . and I feel like there must be some appropriate halfway point, but I don't know how to get there.

Therapist: You do both look as though if either of you were to want anything from the other you'd be very disappointed. Is that what breaks down so fast, Tulasi? Fall apart very quickly, you said. [*Silence.*]

Tulasi: Sitting here while you've been talking to Thrivedi has been very difficult. I find myself resenting a couple of things you said. I resent the time you're spending with him—I feel very small.

Therapist: When I'm talking to Thrivedi it doesn't feel like you're both getting something because if he's getting something, then you're not.

Tulasi: Yeah.

Therapist: That makes you feel very small.

Tulasi: Well, he's got this enormous grief to deal with and he needs a lot. I shouldn't get mad when you're helping him.

Therapist: It's such a deep loss and both of you have a need for an abiding presence that's just for you. That need is very strong. You're both talking about how you're struggling with the fact that it's not there—a very reliable, immediate, understanding presence—how much you each need it and how much it's not there either from each other or from anyone, really.

Tulasi: That's a lot of what happens to me. It's not there. I don't think I ever really had it. Sometimes I feel I have it, but then I lose it, which I do, then I can't . . . I can get through a session with my individual therapist, and then I can do what I need to do with Thrivedi, except then when something comes up between us, then I can't hold on to it. If I don't have it, then I don't want to deal with all his stuff. But I can't adjust. If I can't have it, then I'm through. . . . Sometimes it feels really good, but there's an awful lot of pain with it, all that pain around therapy this summer, I can't get away from it.

Therapist: You mean my absence and the effect it had on everything?

Tulasi: Yeah. I was afraid, really afraid. I felt badly. I was a little weird. I didn't notice it was a pattern. When I was supposed to see you and I didn't, I'd get weird, but I didn't connect it.

Therapist: Maybe now with things settling down, seeing me for a couple of weeks, maybe now it will be possible to understand these feelings, not just to have to endure them.

Tulasi: Yeah.

This excerpt reveals a highly interwoven blend of transference, countertransference, and marital issues. A triangular configuration is evident, but it is, however, a pre-oedipal, or oral, triangle in which there is a competition not for a sexual relationship with the parent of the opposite sex but rather for the basic supplies of emotional survival. The raw data for the therapist's grasp of the marital unconscious assumption come from several sources. She reflects on the manifest behaviour in the session, which is characterised by the lack of give and take, and the sullen silence of each spouse when the therapist is attending to the other.

She contemplates the manifest verbal content—for example, Thrivedi's regret that "It has to be her or me" but not both who can be sad or mourning. The therapist includes in her consideration Thrivedi's story of a mother who was not warm, but a "critical person, not easy to talk to." A crucial part of the mix is the tension within the therapist over the competition for her attention and her own irritated determination to defy Tulasi's envy to the point of ignoring her. Out of her experience in the here and now, the therapist is able to formulate for herself an unconscious assumption governing the marital relationship. That is, those resources for a basic sense of worth and for psychological survival are limited and only sufficient for one partner. Whatever sustenance is received from the good object, couple, or individual therapist is ephemeral. There is a tenuous capacity for one spouse to give to the other without experiencing envy for what the other is getting and rage at what one is giving up. The couple *shares* this fantasy and, in the session, the transference vision of the therapist as the central source of sustenance.

The specific transference feeling of each spouse toward the therapist at any given moment is different, determined by whether the therapist is seen as attending to or ignoring Thrivedi or Tulasi. In this excerpt, the therapist's capacity to grasp the here-and-now situation inclusive of both transference *and* marital dynamics allows her to focus her intervention on the issue that carries the highest affective charge of the moment. Therapeutic interventions are most effective when directed toward issues linked to strong affects. In the absence of an affectively toned area, interpretations are received with intellectualisation and little emotional impact. In couples therapy, we see this latter phenomenon in the all-too-frequent retrospective bland analyses of the marital fight of the previous week.

3.5.2 The Frame of Object Relations Couples Therapy

The frame of the couples treatment and the nature of the therapist's activity follow from the object relations theory. Sessions are held once or more times weekly at a set time. The length of treatment is open-ended, and termination evolves naturally out of completion of the task. Meetings take place only when both partners are able to be present and begin when both have arrived.

Concurrent individual psychotherapy can act in synergy with the couples work, in which the partners each have their own individual therapist who is not also the couples therapist. It is advisable that the couple's therapist not do both forms of treatment. When one partner meets with the couples therapist in the absence of the other partner, there is the risk that the therapist will learn something that would disturb the absent mate should he or she become aware of this information. Thus, the therapist is left with the dilemma of having to protect the confidentiality of the spouse with whom he or she met alone and therefore having to hold a

secret that cannot be shared with the absent partner. This is an untenable position for the therapist, whose responsibility is to the couple as a whole and not to only one spouse. In addition, when the therapist wears both hats in doing the individual and couples work, jealousy and destructive competition can arise, and this only serves to compound the adversarial relationship that existed in the first place.

With separate individual and couples therapists, either the patient can transmit understanding gained across the boundary of the two therapies, or both therapists can confer as needed with permission. The couples therapist's responsibility is to the couple as a unit, and his or her stance should be one of evenhandedness in the presence of conflict. Primarily, the therapist serves as an observer, listener, active formulator, and interpreter of the forces that shape the couple's interaction.

Active behavioural interventions mainly involve encouraging the partners to use direct and attentive communication with each other in the session rather than to speak to each other through the therapist by referring to the spouse as "he" or "she." Homework, such as experimentation with physical intimacy, is a creative product of the couple's imagination rather than a generic exercise determined by the therapist.

Object relations couples therapy attends to both the interpersonal and the intrapsychic simultaneously. It is a flexible approach tailored to the nature of the relational difficulty and to the developmental level of each partner. Thus, the treatment is an approach to formulating and intervening rather than a prescription of specific interventions and tasks that could apply to all couples. What is constant, however, in the object relations approach is the attention to the way in which the world of early internalised relationships has unconsciously come to life again in the current life of the couple.

Self Assessment Questions

1) In couples therapy how are transference feelings and marital issues inter related?

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2) What is three person group interactions in couples therapy?

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3) Discuss counter transference experience in couple's therapy.

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4) Discuss active behavioural interventions in couple therapy.

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5) Discuss object relations couples therapy.

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3.6 LET US SUM UP

Relationship problems are far more likely to develop during times of transition for couples and their families, such as when starting a new relationship, bringing a child into the family, dealing with a grandparent's death, or ending a relationship. There are different approaches to couples therapy like systems approach, behavioural approach, client – centred therapy and psychodynamic approach.

The central concept of object relations couples therapy is the transposition of the internalised object world of each partner into the interpersonal sphere of the relationship. The mental mechanism that transforms the intrapsychic into the interpersonal is projective identification. Unconscious forces are paramount in choosing intimate partners as well as in guiding the interaction of the couple. The relationship of the couple, in its most refined form, can make possible empathic and collaborative efforts in which the whole is greater than the sum of its parts. In contrast, for defensive purposes, the couple relationship may become the repository of devalued aspects of each partner, leading to conflict, polarisation, and dysfunction. Interpersonal conflict may be more tolerable than intrapsychic distress, leading partners to resist efforts to reduce the level of interpersonal conflict.

The primary goal of object relations couples therapy is to foster reinternalisation of projected devalued aspects of each partner, leading to a reduction in couple

conflict, enhanced empathy, but an increase in individual emotional pain. Those devalued aspects of the self that have become reinternalised are now available for intrapsychic resolution, which may take place as part of the couples therapy as well as in concurrent individual therapy with another therapist.

The couple's therapist seeks the underlying issues that precipitate conflict rather than focusing on resolving the manifest content of the conflict. Anger is seen as reactive to hurt and emotional pain within the individual partners. Use of transference–counter transference phenomena in the here and now of the couple session may provide access to affectively charged and workable dynamics that are central to the couple relationship itself.

3.7 UNIT END QUESTIONS

1) Discuss the nature and definition of couples therapy.
2) Discuss the different approaches to couple therapy.
3) Explain the psychodynamic approach to couples counselling.
4) What is systems approach to couple counselling?
5) Discuss the psychodynamic couples therapy as an object relations approach.
6) How is transference used in couple counselling?

3.8 SUGGESTED READINGS

Framo, J.L. (1970). *Symptoms from a Family Transactional Viewpoint. In Family Therapy in Transition.* Edited by Ackerman. NW. Boston, MA, Little, Brown, 1970, pp 125–171.

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