Indira Gandhi
National Open University
National Centre for Disability Studies

# MCFTE-001
## Marital and Family Therapy and Counselling

Block

# 2
# MARITAL THERAPY

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***Acknowledgement:***

We acknowledge our thanks to Prof. Omprakash Mishra, Former PVC, IGNOU; Prof. C.G. Naidu, Former Director (I/c) P&DD and Head, Nodal Unit; Dr. Hemlata, Former Director (I/c) NCDS; and Dr. Arun Banik, Director, NCDS, for facilitating the development of the programme of study.

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***Course editing by the programme coordinators involved content editing, language editing, unit formatting and transformation of the units.***

***Acknowledgement:***

We express our thanks to the writers of Units for providing the artwork included in their respective units.

We would like to acknowledge the various authors, books, journals and websites from which matter related to this course was researched; though they have been duly acknowledged in the relevant Units, but might have inadvertently been missed.

Concept for Cover Design : Prof. Neerja Chadha & Dr. Amiteshwar Ratra
Preparation of Cover Design : Mr. Haldar, Pink Chilli Communication, Dwarka

June, 2011



ISBN:



*Further information on Indira Gandhi National Open University courses may be obtained from the University's office at Maidan Garhi, New Delhi- 110 068 or the official website of IGNOU at www.ignou.ac.in.*

Printed and published on behalf of Indira Gandhi National Open University by Registrar, MPDD.

Laser Composed by: Rajshree Computers, V-166A, Bhagwati Vihar, (Near Sector-2, Dwarka), Uttam Nagar, New Delhi-110059

Printed by:

# BLOCK 2 MARITAL THERAPY

In the previous Block of the Course 'Marital and Family Therapy and Counselling' you studied about the various assessment methods used in marital and family therapy and counselling practice. The different methods about which you learnt in the previous Block were interview methods, self report scales, research tools and essential skills for therapy. In this Block we will read about different therapeutic interventions used in marital and family therapy and counselling along with some illustrations using therapeutic interventions. There are five Units in this Block.

*Unit 5* is entitled '*Emotion Focused Couples Therapy*'. The Unit gives theoretical foundations of emotion focussed therapy. The principles and processes of the therapy are described. Tasks and specific intervention techniques of emotion focused couples therapy have been explained. Contraindications for emotion focused family therapy with couples has also been discussed.

*Unit 6* is '*Cognitive Behavioural Sex Therapy*'. This Unit explains the therapeutic intervention of cognitive behavioural sex therapy for premature ejaculation and vaginismus. A case illustration is used to explain this theory in detail. Precautions to be taken in using sex therapy have been outlined.

*Unit 7* is on '*Marital Enrichment Techniques*'. In this Unit meaning of marital enrichment has been outlined and the need for marital enrichment in the society has been discussed. Guidelines for conducting marital enrichment are described. The common areas of marital enrichment and guidelines for counsellor for marital enrichment have been outlined in the Unit.

*Unit 8* is focuses on '*Interviewing Skill and Circular Questioning in Assessment — A Case Study*'. This Unit explains interviewing skills and circular questioning; an important technique, with the help of a case illustration. This Unit outlines in detail the process and how the method has to be used.

# UNIT 5 EMOTION FOCUSED COUPLES THERAPY

## Structure



## 5.1 INTRODUCTION

Emotions are essential aspects of human nature. For human beings the need to belong, affiliate and relate to others is a basic need that lasts a lifetime. According to Frijda (1986), any emotion is a complex information processing system; it integrates innate, biological and psychological needs with past experience, present perceptions and anticipated interpersonal consequences. They thus help individuals adapt to the social environment, and sustain and enhance relationships.

**Objectives**

After studying this Unit, you will be able to:

- Describe the role of emotions in couple's therapy;
- Delineate theoretical foundations of emotion focussed therapy; and
- Understand the process of emotion focussed therapy with couples.

## 5.2 DYADIC NATURE OF EMOTIONS

Considerable attention has been given to the role of emotions in psychotherapy, and emotions are of particular importance in couples therapy. Greenberg and Johnson (1986) note that the problems couples bring to therapy are predominantly emotional in nature; many couples seek help because they experience emotional distress.

Whatever school of therapy adopted, much of therapy consists of helping couples identify what they are feeling, understand the origins of their feelings, tolerate the intense emotional states better and minimize the tendency to exclude these states from conscious awareness. Further, success of a therapy is also evaluated in terms of improvement in relationship (emotional) dimensions of satisfaction, intimacy and affection.

Given this importance of emotions, advancements in the field of marital therapy have led to the development of specific theoretical perspectives and interventions where emotions occupy a central place. Emotion Focused Therapy is one such perspective.

During any interpersonal interaction, emotions guide us and orient us towards the action we need to take. In a relationship, emotions experienced and expressed by one partner influence and transform emotions experienced and expressed by the other partner. This is a very important characteristic of close relationships. Fosha (2001) suggested that when partners are in an emotionally connected relationship based on support and empathy, it enhances their capacity to feel. Under these conditions, each partner is open and communicates to the other, who responds openly in turn. Partners are hence able to communicate even in face of discord. Thus, this dyadic nature of emotions not only guides interactions and allows partners to connect to each other, it also enhances closeness.

## 5.3 THEORETICAL FOUNDATIONS OF EMOTION FOCUSED THERAPY

Emotion Focused Therapy (EFT) is an approach that combines the systemic, attachment theory and humanistic-experiential perspectives. It lays emphasis on acceptance and expression of unacknowledged feelings and relationship needs. It postulates that the emotional experience of each partner guides their relationship behaviour; it influences display of behaviours like care, affection, comfort and support. EFT views emotions as allies in therapeutic change. According to EFT, in marital conflict at least one person feels that their partner is closed off to them and is emotionally unresponsive.

### 5.3.1 Attachment Theory Foundations of EFT

The EFT therapist perceives symptoms of marital distress as distorted expressions of normal attachment related emotions. Attachment theory postulates that marital distress occurs when the attachment bond is threatened. Attachment bond refers to an emotional tie; a set of attachment behaviours to create and manage closeness to the attachment figure and regulate emotion. Accessibility and responsiveness of the attachment figure is essential for a feeling of personal security. In attachment context, a couple that is fiercely

fighting, is in reality fighting for a sense of safety and security with each other.

Partners with a secure attachment, openly communicate their core emotional needs (e.g.: need for care, love, comfort, support) to each other. They are confident and secure about their relationship, and are comfortable reaching out to each other for fulfillment of these core needs. The fears and anxieties experienced are adequately and appropriately dealt with. For example, the anxiety in the experience "when you don't take my call, I feel alone, rejected and uncared for" is soothed and nullified as "when you don't take my call, I know it's because you are busy and you will get back to me when you can".

In anxious attachment, partners find it difficult to soothe own and each other's anxieties. Any threat to the attachment bond leads to distress and results in clinging behaviour to get a comforting response from the partner. For example, "why didn't you take my call, you never listen to me, you know I get anxious, can't you just speak to me for one minute".

In avoidant attachment, partners do not know how to engage without letting their anxieties overwhelm them. Hence they deactivate the attachment system (Johnson et al., 2005, pg 15), suppress their core needs, withdraw and reduce verbal and nonverbal interaction. Attempts to engage with the partner cause distress. For example, efforts made to hug and comfort partner for not taking the call is met with withdrawal, no reciprocal affection and decision not to call partner again at work.

In disorganized or fearful avoidant attachment style, the partner is simultaneously a source of and solution to the attachment fear. For example, one wants the partner to call and likes this caring behaviour. However, when answering these calls is anxious, uncomfortable with strong positive emotions aroused, one tries to keep partner away by cutting short these calls or talking about superficial, inane things.

### 5.3.2 Experiential Humanistic Foundations of EFT

The experiential approach views people as oriented towards growth with healthy needs and desires. Further, emotions are seen as relational action tendencies that form the basis of social connectedness and constantly give us signals about the nature of our social bonds. Emotions orient partners towards their own needs, organize responses and attachment behaviours, and activate core cognitions concerning self, other and the nature of the relationship. Disowning of emotions and needs is seen as problematic. The experiential root of EFT emphasizes clients to experience, become aware of, and process their emotions.

### 5.3.3 Systemic Foundations of EFT

EFT is systemic in the sense that is emphasizes the power of present interactions. The behaviour of each person is understood in the context in which it occurs and causality is circular. Systems theory postulates that each couple over a period of time develops and maintains characteristic sequences (or patterns) of interaction. These patterns become rigid, stable and predictable with time. Here behaviour of each partner directs and prohibits certain behaviours of the spouse through the mechanism of feedback loops.

Adding to the systemic perspective, EFT views emotions as a primary signaling system that organizes key interaction patterns.

### 5.3.4 Types of Emotions

EFT categorizes emotions as Primary, Secondary and Instrumental.

- **Primary Emotions**

Primary emotions are defined as people's core gut responses to situations. These are the very first feelings in response to a situation (Greenberg, 2002). Examples of some maladaptive primary emotions are: anger at violation, feeling wronged or disrespected; sadness at loss, loneliness or deprivation; shame of feeling unloved, worthless or no good and anxiety of feeling inadequate or insecure. Awareness of primary emotions helps access one's core needs and guides subsequent behaviour.

People usually regret these emotions and the way they express them. These emotions are also usually the ones in which partners get stuck and they underlie stable dysfunctional interactional patterns. Thus, awareness, reorganization and resolution of primary emotions are important therapy tasks.

- **Secondary Emotions**

Secondary emotions are readily available defensive coping strategies against the primary emotions that hide what people are feeling deep down. For example, anger hiding primary feelings of sadness, aloofness hiding fear, and depression hiding anger. Secondary emotions are much easier to express than primary emotions. Secondary emotions are symptoms of the core feelings; people find these troublesome and want to get rid of it (Greenberg, 2002). In a couple's relationship, secondary emotions perpetuate negative interaction patterns and distress by clouding primary emotions and keeping core needs buried. The therapist empathically explores secondary feelings to access primary emotions.

- **Instrumental Emotions**

Instrumental emotions are emotions which when expressed help the person get what they want. They are expressed to achieve an interpersonal goal and influence the responses of others. For example, a person learns that getting angry is likely to intimidate people or crying is likely to elicit sympathy and concern. Instrumental emotions are general emotional styles that over time become a part of personality (Greenberg, 2002). The therapist helps the client become aware of the effects and intentions of their emotional expressions. Further, clients are helped to find direct ways of expressing themselves and stating their needs.

### 5.3.5 Goals of EFT

Couples experiencing distress have rigid, maladaptive interaction cycles. These patterns become self-reinforcing and maintain distress. EFT for couples aims at reduction of distress experienced by partners by creating safer and more secure attachment bonds between them. The goal of EFT is to — access the emotional responses that underlie negative couple interaction, heighten emotional experience, restructure interactions between partners, make partners more accessible and responsive to each other, help the couple develop more

adaptive ways of relating to each other, and foster positive cycles of comfort and caring.

## 5.4 PROCESS OF THERAPY

### 5.4.1 Principles of Change in EFT

The work with emotions in therapy utilizes three principles of change. The *first principle* refers to increasing emotional awareness. Awareness of emotions in words helps clients reflect on their experience, create new meanings, and helps people develop new narratives to explain their experience. Techniques like refocusing on inner experience, analyzing expression and intensifying experience are used. The *second principle* of change addresses emotional arousal and its regulation through the use of techniques like distancing, self-acceptance and self-soothing. By learning emotional awareness and emotion regulation and giving way to experiencing healthy primary emotions, change in the distressing emotional experience can be brought about. The *third and most fundamental change principle* involves changing emotion with emotion, and modifying maladaptive emotional responses. *Emotional intervention* includes evocation and intensification of emotions to motivate new behavioural responses; emotional restructuring (evoking the network underlying problematic responses in order to restructure the network), and accessing state-dependent core beliefs (Greenberg, 2002; Greenberg & Safran, 1984b; Greenberg & Safran, 1989).

The focus of EFT is in the here and now; the therapist evokes the partner's emotions in the session, deepens the emotional experience and uses that "present" context to shape changes in the interaction between partners. These moment to moment changes that happen in the emotions of the partners allow for examination of their inner realities, which in turn impacts reconstruction of interaction patterns. As interaction patterns change, they modify the inner realities of each partner as well.

### 5.4.2 Nine Steps of EFT

***Step 1: Formation of therapeutic alliance and begin identification of relationship needs and attachment insecurities that underlie the conflict.***

The first task of therapy is to create and maintain a collaborative therapeutic alliance; an alliance in which each spouse's experience is sensitively listened to, empathized with, not blamed and accepted. Unless the therapist is able to create a safe space in therapy, partners are unlikely to feel secure enough to explore their feelings. Empathy, genuineness, warmth, validation, a nonjudgemental stance and verbal and nonverbal communication skills that help the therapist connect with the experience of each spouse, facilitate alliance formation. Techniques of paraphrasing, reflecting and clarification are adopted by the therapist. For example, when a statement like "talking to him is useless" expressed by the wife causes husband to cross his arms and look away from her, and in turn further increases the wife's anger, the therapist may make the following statements – "I am wondering what you are feeling right now"; "can you help me understand what you feel when you hear her say this?"; "what did you feel when he looked away from you?"; "it seems that

you move away from her when she is angry"; "it is like you cannot reach out to him".

Therapist explores how the problematic behaviours, or the emotions from which they arise, occur in the context of the relationship. Therapist understands that the partner's maladaptive behaviours make sense as they are efforts to connect with the partner. For example, a therapist may say "for you, it is like, I want him to turn and talk to me, and at that time crying seems the only way to get him to do that. Is that how it may happen?"; "you turn away from her and walk out because it seems the only way to deal with the fear of being hurt". This communicates acceptance, validates couple's experience and removes the possibility of either partner feeling blamed for their ongoing distress. As each partner feels accepted, they are more willing to trust the therapist.

Couple is also assessed for any contraindications such as ongoing violence and abuse.

***Step 2: Identify the negative interaction cycles that maintain attachment insecurity and distress.***

Therapist helps the couple slow down and recognize their interactional patterns. The therapist may do this by focusing on a recent argument and re-entering the negative interactional cycle. Each spouse gives a re-enactment and therapist reflects it back to check with each spouse. The therapist puts the cycle into an attachment context by reflecting how each spouse ends up in separation distress, becomes absorbed in angry protest and feelings of helplessness and isolation (reference). The relationship needs of each partner that underlie the negative interaction cycle are also assessed. Techniques of tracking and enactment are used and an attachment (interactional) hypothesis is formulated.

***Step 3: Access the primary emotions underlying each partner's interactional position.***

In the beginning of the therapy, partners usually express secondary reactive emotions (such as anger and frustration) as they talk about what has been happening in their marriage. These are reflected and validated not emphasized. A therapist has to get through these secondary emotions to get to the primary emotion. The underlying primary or more vulnerable emotions like sadness, fear and shame are identified and emphasized in therapist reflections. For example, as a husband talks of withdrawing from his wife, the therapist reflects his secondary anger. When the therapist helps husband identify that he moves away from wife as he feels "overwhelmed", this is reflected with emphasis. The therapist then moves into accessing the primary emotion underlying the feeling of being overwhelmed by saying "help me understand what it is like for you when you feel overwhelmed, when you feel that that there is no way out, when you want it to just stop?" This may help the husband access primary feeling of helplessness or failure.

***Step 4: Reframe the problem in terms of circular causality so that the cycle is viewed as the key relationship problem.***

After the therapist has identified the primary emotions of both partners, he/she repeatedly reframes distress in terms of the negative interaction cycle.

Therapist reflects how the secondary emotions maintain this cycle, and what primary emotions and unmet attachment needs are hidden by these secondary emotions. Therapist reflects how this negative cycle leaves them distressed, disconnected and actually increases insecurity. Reflection on the negative cycle helps remove blame from one partner; they now begin to see that the cause of distress is not their partner, but this cycle that they both are perpetuating. This helps reduce blame and move towards partners working together to change this cycle.

Steps 1-4 of EFT lead to cycle de-escalation, the first important change event in EFT. De-escalation must happen before moving to steps 5-7. Couples, who are able to de-escalate, fight less often, end fights sooner, have less reactive secondary feelings, and more positive feelings.

***Step 5: Experiential identification of disowned attachment needs, fears and aspects of self.***

This is a more individually oriented step. The therapist now explores in more detail the experience of the feelings elicited in earlier steps. Therapist explores what that feeling implies, what needs and fears are associated with it, what are the beliefs about self that arise from these feelings and what it informs about the relationship.

This step is begun first with the withdrawing partner and not the attacking partner. For example, the therapist begins to explore feelings of helplessness and failure of the withdrawing partner. For example, husband may feel that he has failed in his marriage and feels sad that he is not the husband he or the wife wanted. When this primary emotion of sadness is further processed, husband is able to access and express a deep sense of inadequacy. This exploration also helps him access his need for a more secure connection with his partner. Further, this exploration can access husband's view of self; his view of self as incompetent. Therapist then consolidates husband's awareness of his fears and needs, helps him assert his needs, and change his behaviour with his partner from a withdrawing to a more engaging one.

***Step 6: Promote acceptance by each partner of the other's emerging experience.***

The therapist now processes the above therapy event with the partner. Therapist uses reframes, reflections and evocative questions such as, "what is it like sitting here right now hearing from your husband that he feels like he is failing?" Reframing husband's actions in terms of underlying vulnerable emotions elicits wife's attempts to connect and comfort. The therapist also helps the wife reflect on and express her own emerging primary emotions she experienced when the husband spoke of his needs and fears in step 5. This prepares the wife to offer comfort in step 7, where the withdrawing partner is asked to risk and reach for acceptance and comfort.

***Step 7: Facilitate the expression of needs and wants to restructure the interaction, based on new understandings, and create bonding events.***

This is the most crucial step of EFT. Continuing with the above example, in this step the therapist helps the withdrawing partner re-engage. The therapist initiates enactment in which the husband now clearly expresses his desire

for a new kind of connection and security. This helps the husband articulate his attachment hurts and fears from a deeper level. Hence he is now able to make statements like –"I hate it when we fight. I want to keep that connection with you"; "I need you to move away from your anger. I need you to give me a chance"; "I don't want to feel scared anymore"; "I am still fearful, but less than before. I know that she will get angry, but I also know that underneath that anger, she is really hurt". The enactment in this phase is characterized by greater attentiveness to affect, focus on attachment needs and wants, mutual responsiveness and empathy, with therapist mainly as observer and consultant.

After the withdrawing partner is re-engaged, the next step is to complete step 5-7 with the other partner. As the therapist explores wife's anger (secondary emotion), the wife is able to access her feelings of being hurt. Exploring these feelings of hurt the wife is able to access her deep feelings of shame and her fears of being abandoned (primary emotion). The therapist empathized with, reflected and heightened this sense of loneliness and shame, and helped wife to share with her husband how sad, afraid and ashamed she feels when she is unable to meet her own need of being perfect. Wife's view of self was that she is imperfect and flawed. Husband felt sad for her and expressed that it just helped him see her as more human and vulnerable like him; that this part of her does not intimidate him. Rather, he accepts her and wants to comfort her. Therapist highlights this and helps the partners begin to change their stance and behaviour towards each other. Questions like "He wants to comfort you. Can you let him? Can you tell him now how afraid you are to show this part to him? Can you begin to ask him for acceptance, for reassurance right now?" help bring about a change in the interaction cycle.

The above example highlights the blamer-softening event; the task in step 7 is to complete the blamer-softening event. A softening event happens when a previously hostile/critical spouse asks from a position of vulnerability for reassurance, comfort and some other attachment need to be met. The blaming spouse is able to disclose vulnerable aspects of self, and the withdrawn partner responds accordingly. A softening represents a shift in the negative interaction cycle towards increased acceptability and responsiveness. Occurrence of softening event is essential for therapeutic and relationship change.

***Step 8: Facilitate the emergence of new solutions to old problems.***

***Step 9: Consolidate new positions and cycles of attachment behaviour.***

Therapist in these two Steps 8 and 9 reviews accomplishments of the couple by highlighting the initial negative interaction cycle and contrasting it with the new positive interactional cycle. Therapist uses examples of recent interactions to highlight this change. Positive changes in each spouse are recognized and reinforced by the therapist in a way that helps them see how they are re-strengthening the bond. Therapist continues to reflect each partner's behaviour in attachment terms of mutual accessibility and responsiveness. This helps in the consolidation of the developing secure base.

To summarize, at the end of therapy the partners have:

- Greater awareness of their emotional patterns of relating to one another

- Awareness of emotional needs
- Awareness and understanding of how their own emotional needs interact with their partner's emotional needs to create negative interaction cycles that cause distress and weaken the attachment bond
- Ways to maintain emotional engagement by developing soothing and calming interactions that facilitate creation of a safe space, encourage engagement, and develop and maintain positive attachment behaviours.

**Check Your Progress Exercise 1**

***Note :*** a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1. Discuss the use of emotions in EFT.

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## 5.5 TASKS AND SPECIFIC INTERVENTION TECHNIQUES OF EFT

### 5.5.1 Process of Accessing and Reformulating Emotions

How does a therapist bring the focus on emotions in the EFT session? A safe therapeutic space allows for partners' emotions to be expanded and deepened. Nonverbal parameters like the stance, tone of voice and eye contact of the therapist help clients feel safe, develop a strong alliance and engage with their experience at a much deeper level. This allows the clients look at even the difficult emotions in a therapeutically helpful way.

Some techniques that therapists' use for getting the partners to engage with emotions are as follows:

- **RISSSC**

When the therapist wishes clients to contact and engage with difficult emotions, the following RISSSC acronym is useful (Johnson, 2004). This includes:

- REPEAT – It is important to repeat key words and phrases a number of times to emphasize the emotional experience. For example, "So you feel empty inside, and that feeling is unbearable. It is hard to live with that emptiness".
- IMAGE – Use of images to capture and focus deeply on a emotion. For example – "So you wait for him to respond, to say something, but it is like you are facing a wall; a thick, high wall, that does not let you reach him. How does it feel to be facing this wall? What does it do to you?"

- SIMPLE – It is essential to keep words and phrases simple and concise. For example – "So what you want at that time is for her to talk calmly".
- SLOW - The therapist slows the pace of his/her speech and of the session so that the client can engage with the emotional experience and it can be deepened. For example – "Hmm (pause)…. And that is very lonely place for you…. (pause)".
- SOFT – A soft voice soothes and encourages deeper experiencing and risk taking. It helps the clients absorb their emotions.
- CLIENT'S WORDS – The EFT therapist notes and adopts the client's words and phrases in a collaborative and validating way. For example, "Its like when he says no, it's a punch in the gut and you are reeling from it. You feel rejected and it hurts".

- **Validation**

This is particularly crucial in the first few sessions. It communicates to each partner that their emotions and responses are genuine and understandable, and that their responses are the best solutions they could find in the light of each partner's experience of the relationship. Validation normalizes actions, behaviours and emotions, decreases defensiveness, and helps establish alliance. For example, "I think I understand your withdrawal …you feel so hurt, so devastated, that you find it easier to deal with your hurt in this way, it is your way of protecting yourself".

- **Evocative Responding**

Often clients talk about external events or report on events that progressed during the couple's last fight. The therapist bypasses this more superficial content and focuses on the tentative, unclear or emerging emotion in their experience. Often evocative imagery is used to explore and enhance the experience of the client. Reflections are often used; for example – "When you say that, there is a catch in your voice, like it hurts to even put into words that you may not be what she needs". Further, questions like "What happens to you when you see her turn away from you like that?''; ''How do you feel as you listen to him saying that he feels afraid of opening up to you?''; ''What is it like for you right now to hear him compare you with his mother?''; ''How does it feel when you hear him say that he is not important for you?''; "Your fingers are rolled up in a fist, but you are also crying, am wondering what is going on for you right now?" are helpful. These reflections and questions are offered tentatively, allowing the client to explore, absorb or change the understanding of their experience. These help clients formulate and symbolize their experience. 'Why' questions are to be avoided in this process because they do not facilitate deepening of the emotional experience.

- **Heightening**

Once the emotion has been evoked in the session, the therapist tries to heighten and intensify specific responses and interactions. These responses and interactions are often those that maintain the negative interaction cycle. Additionally, whenever positive or new healthy interactions occur, they are also heightened. Once the clients experience the depth of the primary emotion

that is the time the therapist can facilitate new interaction patterns between partners. For this purpose, imagery, metaphors, repetition and enactments may be used. For example, "Can you tell *him* that… that I would feel better if you just reassured me that you love me?", "I find it difficult to tell you this because I don't want you to think that I am crazy or a very needy person"; "You can say that to her, it's hard for me to open up..I can't make myself do that, I have to keep you out…it's like if I don't keep you out ..if I don't build this wall, I am going to be run over,.. that I am not ready to connect with you".

- **Empathic Conjectures and Interpretations**

Conjectures refer to propositions that are not proven, but appear correct and have not yet been disproven. The goal here is to facilitate more intense experiencing that spontaneously leads to emergence of new meanings. These inferences may be about defensive strategies, attachment needs and core attachment fears and fantasies. Therapists use this technique to reach the primary emotion or the core need of the client when the client is talking about secondary emotions or about the external events. It brings new meaning to the existent interaction patterns between the partners. It also helps the partner understand the reason why they find it difficult to relate or engage with each other; what obstructs the path to a secure attachment between partners. For example, "What I hear you saying is that for you, there is a sense of powerlessness in this situation. Does it match with what you experience?'', ''So it is like you are trying to tell her that you feel that you have lost face and feel ashamed when she keeps pointing out your faults…" (conjecture about primary emotion). For example, "It's like, when you feel hurt, you pursue him more… like you need that connection with him at that time. Does this go with your experience?'' (conjecture about interaction pattern). For example,"You feel confused because it is like, I can't make sense of what is happening…you are anxious.. wary.., it is difficult for you to trust him because it's been hard for you to predict his behaviour in the past (conjecture about attachment fears)." For example, "So you could never tell him that you felt ashamed when he criticized you about your weight. It made you question your value. What you wanted was acceptance" (conjecture about core needs).

### 5.5.2 Process of Restructuring Interactions Between Partners

Once the partners are more aware of their emotions, the meanings and significance of their emotions, how these emotions influence their behaviour and maintain negative interaction cycles, the next step is for the therapist to restructure the negative interaction patterns (Johnson et al., 2005). ***The therapist uses the emotional material to help the partners show their vulnerability/needs to each other and not just talk about their vulnerabilities***. The therapist helps the partners experience new emotions; these are used to create a new dialogue, restructure their interactions, thereby creating more positive interactions that help partners develop more secure attachment.

The therapist uses the following strategies to facilitate restructuring of interactions (Johnson, 2004):

1. Tracking and reflecting interactions
2. Reframing
3. Use of enactments

- **Tracking and Reflecting Interactions**

Tracking of interactions starts from the therapist's observation of in-session interaction sequences. The therapist describes the structure and process (i.e. the sequence) of the interaction explicitly to increase awareness. The technique allows the partners to distance themselves and examine the cycle. Partners become aware of what each of them does to create and maintain this cycle, a cycle that is recurring. They not only see the role they play in perpetuating the cycle but also how they get affected by it; that the partners are both unwitting creators and victims of this negative interaction cycle. It alters the belief that the defect lies within the either partner; this reduces blaming the partner for relationship distress. It helps each partner take the responsibility for the way the relationship has evolved, while blaming the cycle for the distress. The therapist reflects that it is this cycle that does not let the partners develop a secure, caring relationship.

The therapist tracks interactions by asking the partners to narrate a recent incident or uses the interaction within the sessions. For example, "(to the husband) When you start getting annoyed, you walk out of the room, and you (turning to the wife) go after him, shouting more." For example, "What happened during the fight on Friday, when you went for dinner to your mother-in-law's house?". For example, "Hold on, what just happened here? You rolled your eyes and frowned as he spoke about how hurt he feels when you do not listen to him. Help me understand what you felt right now when you heard him say this."

Examples of Simple reflections of interaction sequences:

- "he doesn't talk, and you also move away"
- "when he criticizes you, you see him as…."
- "when he does ..... you respond by..... "
- "you feel alone, unsupported when he doesn't listen to you"
- "so this is what the cycle looks like: the more she tries to come close to you, the more you move away..so she pursues and you withdraw"

- **Reframing Problems in Terms of Cycles and Interaction Processes**

As a result of tracking, the therapist now places each partner's behaviour in the context of the other's response. Some of the reframes used are as under:

- *The negative cycle is the enemy:* The therapist reframes the negative interaction cycle as an enemy; it's the cycle that causes distress. This externalizes the problem, lifting the "blame" from either partner. This encourages the partners to team up, and "fight" against a common enemy.
- *Fight for a secure attachment:* The problems of the couple are reframed as a struggle for secure attachment. The behaviours and feelings

of each partner are reframed in the context of underlying attachment vulnerabilities and core emotional needs.

- *Protecting the relationship*: Interactional responses are framed as underlying vulnerabilities and attachment processes. Interactional patterns that emerge between partners are seen as efforts to maintain the relationship. However, this comes at the cost of great emotional distress. Typically, patterns such as "Pursuer-Withdrawer" are attempts of one partner to protect the relationship by pursuing the other. The withdrawer is trying to regulate attachment fears and anxieties, so that the conflict doesn't escalate and the relationship is protected. The pursuer is being critical; the signal sent to the partner being, "you are unavailable". The pursuer is trying to save the relationship by fighting for a connection. Further, withdrawal is also reframed as a response to how crucial this attachment is to the person (rather than indifference; Johnson et al., 2005).

- *Reframing behaviours and needs:* For example, a desperate desire of the pursuer to connect is not seen as a deficit in the spouse (she is too needy) or in terms of her family of origin (she is reacting to her partner as if he were her ungiving father). Rather, it is seen in terms of the present relationship. The pursuing behaviour is seen in terms of the distant position he takes and her subsequent deprivation. His withdrawal is framed as self-protection in face of angry pursuit, rather than a reflection of indifference (Johnson, 2004).

- *Showing what secure attachment will look like:* The therapist shows what it would be like to have secure attachment with the partner, what the partners will be able to ask of each other, how they can seek safety with each other. For example, "So what I hear both of you say is that last night's fight was about feeling alone and unsupported. While talking about finances, Ajay, you just wanted Aruna to acknowledge and appreciate the efforts you make to earn money, and support the family. You wanted validation. But what you saw was that Aruna was getting angry. You felt hurt, like you were struggling with this alone, by yourself. You reacted by withdrawing and going off to bed. And Aruna, you wanted acknowledgment of the efforts you make in managing the home, and keep it running on a budget. But you did not get that validation. This made you feel angry. Did I get that right? But, you know, the relationship can be a safe space where you ***could*** reach out to each other for that support. That is what both of you would like, or are struggling for, but are finding it difficult to do."

- **Use of Enactments**

Enactments are the most directive part of EFT. The therapist asks partners to make direct contact with the other, and gives specific directions for what is to be said. The therapist directs one partner to respond to the other in a specific way, encourages the expression of new emotional experience to the other, or supports each to state needs and wants directly. Therapist guides the dialogue and helps the couple process their experience of this enactment. The therapist asks the partners to enact the negative interaction cycle or specific parts of the cycle.

In this process, negative interactions are deflected, and attachment enhancing interactions are encouraged. Repeated small enactments shape more secure bonds between partners. The therapist may say, “Ahmed, can you tell Nazia what it is like for you when this sea of work, children, demands of other family members keeps you away from her?” This is simple request to make contact. Once the enactment is initiated, the therapist has to take care that it continues till reframing happens and there is no early exit or going back to the old negative pattern.

For enactments, a context is created, intensity is built up and sometimes, the therapist has to paint a picture of what the contact may look like. For example, “So, Sudha, when Harish came home late from work again, you felt sad, like you don’t matter to him. Or that you are not important to him. Can you tell him right now what it is like for you to feel rejected like that?” The therapist then goes onto heighten the intensity of the interaction. “It must be hard for you, Sudha to feel that you do not matter to him, to feel rejected. Can you tell Harish what it is like for you to feel that you don’t matter?” The contact is anticipated; “Sudha, have you wondered what it maybe like, to tell Harish that you feel rejected? To say to him that Harish, when you don’t spend time with me, I feel that I don’t matter to you…that my presence or absence doesn’t mean anything to you. What would it be like to tell him that?”.

Enactments work in two ways: one, they allow for one partner to show their vulnerability to the other (take the risk of sharing in the safety of the therapist’s presence). Second, in turn, they give the other partner opportunity to experience empathy and compassion for the first one. And it is in this moment that a new connection in the relationship is forged. Continuing with the above example, the therapist may say, “Harish, what was it like for you to hear Sudha say that she feels she doesn’t matter to you? Can you tell her that?” Harish may say, “I didn’t know she felt rejected. When I heard you Sudha, I felt for you. I never thought it was like that for you. You mean a lot to me Sudha. You are very important to me.” Therapist: “Can you tell her that once more, and say it slowly”. Harish tells Sudha again. The therapist then turns to Sudha and says, “What is it like to hear Harish say that?” Sudha: “It feels nice Harish. You haven’t said this before. It makes me feel good.” Therapist: “As both of you talked to each other, what I saw was compassion, and a lot of concern”.

## 5.6 CONTRAINDICATIONS FOR EFT WITH COUPLES

Since EFT is process of increasing intimacy and bonding between partners through explorations of emotions and vulnerabilities, it is contraindicated under following conditions:

- When there is ongoing violence & aggression between partners
- Severe psychiatric conditions such as psychosis or suicide attempts in one partner
- Couples who are aiming at dissolution of the relationship
- High level of mistrust
- High degree of alienation (or emotional distance) from each other

## 5.7 LET US SUM UP

In this Unit, we have learnt that EFT is a therapeutic intervention for distressed couples, that aims at helping couples have more soothing interactions, and facilitates the development of a secure attachment between them. It is a focused therapy approach based on the attachment theory, humanistic-experiential and systems perspectives. By creating a safe, secure space, the therapist facilitates the exploration of emotions and helps the partners share their core needs and vulnerabilities with each other. As they share this experience, new connections between partners emerge, which allow for a more secure bond to form. The process of EFT requires a good therapeutic alliance to help the couple access primary emotions and restructure their interactions, so that they can reach out to each other in times of distress and seek support.

## 5.8 GLOSSARY

**Attachment** : The innate drive in humans to seek and maintain contact with others.

**Anxious attachment** : An attachment style characterized by extreme distress associated with separation from a loved one and difficulty in having soothing, calming interactions.

**Avoidant attachment** : An attachment style characterized by suppression of manifestation of emotional display in times of distress, and focus on external tasks.

**Primary emotions** : Emotions experienced in direct response to the immediate situation.

**Secondary emotions** : Emotions which help the person cope with the primary emotions.

**Secure attachment** : An attachment style where partners are confident about their connection with each other, and are comfortable in expressing their attachment needs.

**Instrumental emotions** : Emotional expressions aimed at influencing others.

## 5.8 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

**Check Your Progress Exercise 1**

1. Emotional experiences of each partner shape their relationship. During any interpersonal interaction, emotions guide us; or rather orient us towards the next action we have/need to take. In EFT, emotions are used to change emotions.

   The emotional style one partner uses to get the needs fulfilled evokes the emotional vulnerability of the other partner. S/he reacts or behaves in keeping with this vulnerability. This evokes a further response from

the first partner. Thus there is a feedback loop within the couple system which maintains the distress or the negative interaction patterns.

## 5.9 UNIT END QUESTIONS

1. How are emotions and attachment related?
2. From an EFT perspective how is couple distress conceptualised?
3. What are the steps in EFT?
4. What are the contra-indicators for EFT?

## 5.10 FURTHER READINGS AND REFERENCES

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# UNIT 6 COGNITIVE BEHAVIOURAL SEX THERAPY

**Structure**



## 6.1 INTRODUCTION

Sexual functioning is one of the important basic aspects of human life and any problem in this area can lead to significant personal distress, conflicts in the relationship, and emotional problems. In this Unit, we will discuss types of sexual dysfunctions and use of sex therapy to resolve the issues.

**Objectives**

After studying this Unit, you will be able to:

- Get knowledge about the kinds of sexual dysfunctions and the psychological factors contributing to the same;
- Understand the management techniques and their application; and
- Be able to formulate cases and solve such problems.

## 6.2 SEXUAL DYSFUNCTIONS

Sexual functioning also has impact on one's self esteem and quality of life (Chevret et al., 2004; Rosen et al., 2004). Sexual dysfunctions are categorized based on the stages of sexual response cycle. The dysfunctions are thus related to desire, excitement, plateau, orgasm and resolution phases of sexual response cycle (Masters and Johnson, 1966).

According to the Diagnostic and Statistical Manual (DSM-IV TR), there are six female sexual disorders: hypoactive sexual desire disorder, aversion disorder, sexual arousal disorder, female orgasmic disorder, vaginismus, and dyspareunia.

Similarly, the male sexual dysfunctions can be classified as desire disorders which includes hypoactive sexual desire disorder and sexual aversion disorder (16%); disorders related to excitement which includes erectile dysfunction (20%); orgasm disorders which includes premature ejaculation (35%) and disorders related to resolution, Post-coital dysphoria and Post-coital headache (5 -10%) (Heiman, 2002).

Sexual experience is always a synergy of biological, psychological and social factors. Therefore, it is important to assess all these areas while taking sexual history, and the management is multidisciplinary in nature. Similarly, it is important to understand the subjective meaning of sexuality and partnership within the intimate relationship and tailormake the intervention (Rosing et al., 2009).

**The psychological factors that contribute to sexual dysfunctions can be categorized under the following headings:**

- *Predisposing Factors:* These include restrictive upbringing, inadequate sexual information, disturbed family relationships, traumatic early sexual experiences which damage the self-concept, early insecurity in psychosexual role which may include attitude towards own body, about sexual thoughts and urges, maturity etc. and guilt about earlier sexual relationships.
- *Precipitating Factors:* Random failure resulting in anticipatory anxiety, child birth, discord in the general relationship, infidelity, unreasonable expectations, dysfunctions in the partner, reaction to organic factors, ageing, depression and anxiety, traumatic sexual experience and hesitant sexual experiences.
- *Maintaining Factors:* Performance anxiety and anticipation of failure resulting in avoidance and playing spectators' role in turn can lead to failure. Other factors include guilt, loss of attraction between partners, poor communication between partners, discord in relationship, fear of intimacy, impaired self-image, inadequate sexual information, sexual myths, restricted foreplay, psychiatric disorder in any of the partners and negative cognitions.

Sex therapy generally refers to the techniques given by Masters and Johnson (1970). 'Sensate focus' is a common component used for all kinds of sexual problems in addition to the specific techniques. The common goals of the sex therapy are information and education, attitude change, taking mutual responsibility, eliminating performance anxiety, improving communication and applying different sexual techniques, changing life styles and sex roles and prescribing changes in behaviour. Modifications are made depending on the conditions such as availability of the partner, kind of the dysfunction, the socio-cultural factors, and presence of other co-morbid psychiatric and physical conditions. On the part of the therapist willingness to address the issue with frankness and authenticity and ability to handle one's own sexuality is crucial (Manjula et al., 2003; Rosing et al., 2009).

In this Unit two sexual dysfunctions (one male and one female) commonly present have been elaborated in terms of the dysfunction and therapy, with help of a case illustration.

## 6.3 COGNITIVE BEHAVIOUR SEX THERAPY

Cognitive-behavioural model of sexual dysfunction deals with the complex interaction of cognition (thoughts), behaviour, biology, and interpersonal functioning

central to the understanding of sexual dysfunction. Negative thoughts that adversely affect sexual function often involve worry about performance, which can distract from erotic cues and reduce sexual responding and pleasure and increase negative emotions such as anxiety, fear, despair and can lead to avoidance. For example, "I should be able to reach orgasm during every sexual encounter", may be an unrealistic expectation by women. Similarly, attitudes like "women should not enjoy sex, and if she does, it reflects a bad character", "man is responsible for giving pleasure to woman", "a man should get erection at will and should maintain as long as the partner wishes" etc. can also contribute to sexual dysfunction.

Cognitive-behavioural sex therapy consists of several treatment components focusing on changing maladaptive sexual thoughts and behaviours. Treatment is conducted in individual or couple format. Treatment plans are individually constructed to meet the specific needs of the patient, and specific methods are used to treat different problems. Interventions include:

1) Psycho-education to correct the common myths and misinformation about sex.

2) Sexual communication training, planning and making time for intimacy, expanding the sexual repertoire by increasing the interest and changing the sexual situations.

3) Desensitization based treatments including series of specific behavioural strategies are carried out to reduce anxiety, increase pleasure and intimacy.

4) Cognitive restructuring to challenge negative thoughts, beliefs and misconceptions associated with sex.

5) Lifestyle interventions such as exercise and sleep hygiene that may contribute to sexual response.

6) Marital therapy to resolve interpersonal conflict and enhance intimacy and individual therapy to address the individual factors contributing to sexual functioning such as depression, anxiety, personality traits etc.

**Sensate Focus** is a behavioural programme given by Masters and Johnson (1970) which involves a couple completing homework assignments in the form of structured touching. The basic goals of sensate focus exercises, are to improve communication between the couple, to reduce the performance anxiety, to know each other's erogenous zones, and to take mutual responsibility. The series of specific exercises for couples encourage each partner to take turns paying increased attention to their own senses.

The first step is called *non genital sensate focus* which involves exploring the pleasure areas of the partner, communicating the likes and dislikes and to become comfortable with each other's body and taking responsibility and pleasure giving. During this phase breast, pelvic area and genitals are not to be touched. The next step is *genital sensate focus***;** here the pleasuring exercises include the breast, pelvic area and genital area. The third step is called *vaginal containment***;** this step involves insertion without any thrusting movements. This enables the male to become acquainted with intravaginal sensations in a non-demanding environment. The last step is *vaginal containment with thrusting* to ejaculation. The steps can be done over few days to weeks till the partners are comfortable. This basic technique is used in most of the sexual dysfunctions with addition of

specific techniques for the different problems. Similarly, the positions are also advised based on the kind of the difficulty. Female superior position is suggested in conditions like erectile dysfunction and premature ejaculation.

Other therapies include Helen Kaplan's (1974) *New sex therapy* which is a combination of behavioural and analytical strategies, addressing the dysfunction and the relationship conflicts, and *PLISSIT model* (Annon, 1976) which includes tailoring the treatment plan according to the needs of the patients and the problems. The various levels at which the interventions are provided can be elaborated as permission, limited information, specific instructions and intensive therapy.

### 6.2.1 Cognitive Behaviour Therapy for Premature Ejaculation (PE)

Premature ejaculation (PE) is the most prevalent male sexual dysfunction which is estimated to affect 1 in 3 men (20 - 30%) in the age range of 18 - 59 years. It can be primary or secondary. For the primary PE the causes may be organic largely than psychological. The organic causes include: hypersensitivity of the penis, reduction of ejaculatory threshold, prostatitis and urethritis. Medical conditions like diabetes and hypertension can also contribute to PE. The psychological causes that are responsible for PE are performance anxiety, stress related disorders and depression (14 - 58%) (Kennedy & Rizvi, 2009).

However, only 50% report that it bothers them and only 10% seek help, the reason for the same being embarrassment, stigma, lack of knowledge about treatment, lack of reliable treatment options and thinking of it as transient problem. The condition is largely considered as psychological either a learned behaviour or a response to a meaningful event/interaction or sexual anxiety. The partner may be upset with the rapid emotional change, or the outcome of the sexual encounter. In an episode of PE, the intimacy shared with a partner suddenly comes to a quick end. One might feel angry, ashamed, guilty and frustrated and turn away from the partner. It impacts the relationship and the interactions between the couple. The female usually feels disregarded, used and not loved. Persons with PE usually do not come within a year of the marriage, consultation commonly happens 5-20 yrs after the marriage. Problem increases after all the children are born and reached some level of independence (Laumann et al., 2005; Metz et al., 1997).

The American Urological Association (2004) considers that diagnosis of PE should be based solely upon sexual history and shortened intravaginal ejaculatory latency time (IELT). The 3 key factors necessary for diagnosis of PE are — (i) patient reports of reduced control over ejaculation, (ii) patient (and/or partner) reports of reduced satisfaction with sexual intercourse, and (iii) patient (and/or partner) distress over the condition.

Other psychological factors are interpersonal conflicts with partner, sexual guilt, perfectionism or unrealistic expectations about sexual performance, negative cultural conditioning like early sexual contacts with commercial sex workers who demand the act to be done quickly, situations where there is fear of being found may cause the individual to become conditioned to achieve orgasm rapidly (Palmer & Stuckey, 2008). Similarly, excessive excitement in earlier experiences, sexual abstinence, new partner, new settings, surroundings, extremely responsive and assertive partner, and teenage sex play results in conditioning to that pattern

of sexual functioning (cars, parking, parks etc.). Once it is developed in the above said situation there is anxiety in the next encounters about the performance which can result in playing spectator's role and losing confidence, and one can develop secondary erectile dysfunction. The maintaining factors are: stress, depression, marital disharmony and hostility towards partner, 'Don't touch' approach to genitalia, avoidance of sexual intercourse, nagging by female partner etc. Distraction procedures like thinking about non-sexual material, work, family budget, counting backwards, biting lips, contracting rectal sphincter, pinching self, pulling hair, alcohol use, sedatives, anaesthetic ointments, masturbating 1-4 hrs before coitus reduce sensate input during coital process but are not successful in learning to tolerate the sensations and delay the ejaculation (Masters & Johnson, 1970; Porst et al., 2007).

**There are a number of techniques that are used in combination and isolation to treat the PE:**

- ***Stop-Start Technique:*** In 1956, Semans described the basic procedure for the stop-start technique. In this method, a man is repeatedly brought to high levels of arousal and then stimulation is stopped just before ejaculatory phase begins (ejaculatory inevitability), repeated for 3-4 times before allowing to ejaculate.

- ***Squeeze Technique:*** Subsequently, Masters and Johnson (1970) adapted this technique to a start-stop-squeeze sequence in which the penis is squeezed proximal to the frenulum, by the man or his partner for 15-20 seconds, immediately upon stopping of stimulation. After applying squeeze for 3-4 times the man is allowed to ejaculate. Both techniques are usually employed in a graduated fashion, starting with partner manual stimulation, vaginal containment without thrusting, and ultimately, active thrusting intercourse.

Pulling down on the scrotum is another technique. In addition, other areas of the individual are also addressed to facilitate the sexual functioning such as behaviour, affect, genital sensation, imagery, cognition, interpersonal relationship, and use of drugs. The combined use of psychosexual-behavioural therapy and pharmacological agents has also been advocated for the difficult-to-treat cases in some studies. In addition, the use of pelvic-floor muscle rehabilitation with exercise training, electro stimulation, and biofeedback to help patients gain control of ejaculatory latency has also been advocated (Kaplan, 1994; La Pera & Nicastro, 1996).

The common components that are found to be effective in treatment of PE are communication skills, sexual skills, lowering performance anxiety and sexual anxiety (McCabe, 2001). Combination of drug therapy followed by behaviour therapy is found to help in maintaining the improvement for longer periods and also help in improvement in the couple's sexual relationship and renewal of intimacy (Steggall et al. 2008). With behavioural therapy of about 12-18 sessions the improvements were basically seen in latency period, satisfaction, decreased anxiety and difficulty in retarding ejaculation (Chen et al., 2009).

### 6.2.2 Cognitive Behaviour Therapy for Vaginismus

Vaginismus is a sexual pain disorder, in which there is involuntary spasm of the muscles around the lower one third of the vagina causing pain on any attempts of penetration. Primary vaginismus is diagnosed in women who have never

experienced vaginal penetration, while secondary vaginismus denotes prior successful vaginal penetration. For some women, vaginal tightening occurs in all situations where vaginal penetration is attempted (generalized type). 12-17% of the women who report to the sex therapy clinics complain of vaginismus (Spector & Carey, 1990).

The three most common contributing factors to vaginismus are fear of painful sex; the belief that sex is wrong or shameful (often the case with patients who had a strict religious upbringing); and traumatic early childhood experiences. Other causes may be sexual abuse, frightening childhood medical procedures, painful first intercourse, relationship problems, sexual inhibition or fear of pregnancy. The severity of pain can be mild to severe. The women with severe vaginismus avoid all kinds of sexual touching or intimacy and often do not cooperate for gynaecological examination.

**The cognitive behaviour therapy in Vaginismus includes various components such as:**

- ***Sex Education:*** This can be done using the relevant scientific literature on the anatomy, physiology of the vagina, the functioning and mechanism of sexual activity. Depending on the requirement, the clients can be suggested to read selected literature, watch relevant material.
- ***Self-exploration of Sexual Anatomy:*** This can be done using a hand mirror and exploring the organ by one's own fingers. This method would help in understanding the anatomy and also exploring the pleasure associated with the same.
- ***Desensitization:*** When the woman exhibits fear of the sexual intimacy and intercourse, she is exposed to situations that create a mild sense of psychological discomfort or anxiety. Once these situations are conquered, the patient is exposed to sexual situations that they find more threatening, until coitus is eventually achieved without difficulty.
- ***Graduated Insertion Under Relaxation:*** It is aimed at decreasing avoidance behaviour and penetration fear. The client is trained with relaxation to begin with. Once she is able to relax, one might commence with the tip of a cotton bud, or the tip of the patient's little finger, followed by the gradual insertion of two or more fingers, internal sanitary pads, various lubricated cylinders, and eventually by the gradual insertion of the penis.
- ***Insertion of Penis with the Woman in Control:*** This is done in female superior position, so that the woman can have control over the insertion and the movements culminating with vigorous coital movement.
- ***Transferring Control of Insertion of Penis to Partner:*** The final step in the treatment would be to allow the partner to insert without anxiety and avoidance on the part of the woman (Butcher, 1999).

Other techniques that are used along with the above are cognitive therapy aiming at correction of faulty attitudes and irrational beliefs and sensate focus to increase the pleasure of sexual intercourse and to defocus from the performance.

The success of the therapy ranges from 60-90% for a maximum of 1 year follow-up (Van Lankveld et al., 2006; Jeng et al., 2006).

**Check Your Progress Exercise 1**

***Note :*** a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. What are the uses of sensate focus in sex therapy?

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2. Outline the management of premature ejaculation.

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3. Enumerate the treatment of vaginismus.

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## 6.4 A CASE ILLUSTRATION

*Mr. P, 32 years married male, educated up to Diploma in Engineering and working as an assistant engineer, hailing from middle class socio-economic status and urban back ground, reports with the complaints of difficulty in maintaining erection, since one year; decreased frequency of intercourse, and complaints of pain during the intercourse in the wife since 3 years.*

History of the problem revealed that from the time of marriage the wife has never allowed the husband for the intercourse, though she was comfortable with the foreplay. When the husband would approach her for insertion, she would shout and scream and push the husband away. However, the husband kept trying, though not successful. Wife reported that she used to have shivering in the thighs and pain in the vagina during the act. Though every day she would think of cooperating and to bear the pain, she could not do so when the time came. The frequency of their sexual activity came down to once in one or two weeks. The husband noticed that after a year or so he used to ejaculate as he tried to penetrate. Wife started blaming him for not being able to do the intercourse successfully. She would blame him saying that "since he is a male he should do it even if she screams, that is how the other husbands do". She would also tell him that it is his responsibility to somehow force her and have intercourse. Once he started having the premature ejaculation the blaming increased all the more. Apart from this the couple did not have any major differences in their relationships and there were no other conflicts. Only two of them lived and there were no

issues with the other members of the extended family. However, her sisters and relatives started asking her as to why they are not planning for children, this used to bother her and she would put more pressure on the husband. Husband never blamed her, would think that something might be wrong with him. They consulted a gynaecologist following which he came to know that she has a problem. Wife also got an idea about the problem.

Both of them came from conservative middle class families, belonged to same township. It was an arranged marriage with the consent of both of them. The wife was educated up to bachelor's degree and was working for a company, after the marriage. The wife quit the job to take treatment. Husband also consulted an urologist and was referred from there.

There was no history of any childhood abuse, extramarital affairs or premarital sexual relationships in both the couple. The sexual knowledge was obtained through the magazines, movies and novels. The wife seemed to have learnt that intercourse is painful in the beginning from friends who were married; however they had also informed her of the fact that later encounters are not painful and only the initial or first one being painful. The couple had not discussed any of these problems with their respective family members and felt that they should find out the solution. The main reason for coming for consultation was to have a child.

- **Analysis of the Problem**

The assessment in sexual dysfunctions is done using various methods. One important among them is the case history. The history is often taken from both the couple, individually as well as together. The aim of taking a detailed history is to identify the precise nature and development of the problem which includes nature, frequency, severity, distress, duration, factors contribute to improving or worsening, cognitions, method of coping, beliefs and attempts to treat. To get an understanding about each partner's background, information about sexual development and attitudes towards sexuality is needed. This would help in understanding the causes of the problem. It is also important to understand the attitude towards the problem, expectations from the treatment and how much of responsibility the partners take and what is the reason for seeking the treatment now.

The suitability for sex therapy is determined by the nature of sexual problem — primary /secondary, medical /psychological factors. If the problem is secondary and psychological in nature, it is amenable for therapy. Similarly, if partners are motivated to get treated and willing to cooperate, there are no major problems in the general relationship, there is absence of physical or psychiatric illness then the treatment progress is better. During the pregnancy usually the sex therapy is not recommended. Though for each kind of the disorder specific questions have to be asked, there are certain general areas that have to be covered in all patients.

*The general guidelines in taking history are*: begin with relatively non embarrassing questions before going into sexually explicit questions, start with open ended questions and then proceed to closed ended questions, do not use the colloquial terms it can be imprecise and uncomfortable and it is better to use the common vocabulary after discussing with the clients.

*The general areas to be assessed are:* the details of the presenting problems, relationship quality, personal history of sexual development and experiences,

family environment, early childhood experiences, body image and self esteem, present relationship with the partner, current practices and preferences and fantasy. In addition to the history, the measures to assess depression, anxiety, sexual knowledge and misconceptions, dysfunctions and attitude towards sexual practices can be used.

- **Formulation of the Case for Therapy**

After getting information from all the sources (history, assessments, physical and medical examinations) the case is formulated for therapy. The formulation provides understanding of the difficulties and rational basis for the treatment approach.The formulation is generally based on three main categories of information; the predisposing, precipitating and maintaining factors. In the present case, the predisposing factors for both the client and the wife include restrictive upbringing wherein the sexual matters are not discussed openly. Inadequate sexual information wherein the wife has got information that it is painful and she has developed a phobia towards the intercourse, also beliefs such as it is the responsibility of the man to make the intercourse successful and he should be able to penetrate under any kind of situation. The husband believes that it is his responsibility to perform the sexual activity. He has also developed performance anxiety and experiences feeling of inadequacy and guilt for not able to have successful intercourse. Precipitating factors for the premature ejaculation in the husband were, non-cooperation, shouting and screaming of the wife and blaming by her for not being able to penetrate which would have made him anxious and play spectators role along with feelings of inadequacy. The unreasonable expectations of the wife have also put a pressure on his performance leading to enhanced anxiety.

The maintaining factors are performance anxiety leading to anticipation of failure and avoidance and playing spectators role during the sexual intercourse. Also associated guilt for not being able to perform and inadequate sexual knowledge and myths about the sexual functioning gives rise to negative automatic thoughts during the intercourse such as “whether I will be able to penetrate successfully?”, “what if I fail”, “my wife would think that I am sexually inadequate”. Similarly, the wife’s unreasonable expectation, fear about not been able to conceive, fear of pain contribute to the dysfunction. Some of the cognitions related to pain are “what if it hurts and there is damage to the vagina?”, “I cannot tolerate the pain” and “my vagina cannot accommodate the size of the penis”. These behavioural and cognitive factors maintain the cycle of the sexual dysfunction.

- **Cognitive Behaviour Therapy in the Case**

The therapy in this case started with psycho-education to the couple to educate them about the nature of the problem, the factors maintaining the problem, clarification of their misconceptions and information on the anatomy and physiology of the sexual functioning in simple language.

The next set of sessions focused on introducing the Cognitive Behaviour Therapy (CBT) model and do’s and don’ts in the therapy (ban on sexual performance and initiation of sensate focus). Both the partners were trained in Jacobson’s progressive muscular relaxation, to reduce the anxiety levels. Each step of the sensate focus was carried out for about 2-3 weeks each.

The wife was told to explore her body and genitals which she had not done till then, to become comfortable with her own body. In the subsequent sessions, she

was asked to insert the tip of her little finger and explore the vagina. The couple was told to involve in sexual foreplay before this. In the next sessions, the husband was also asked to insert his little finger after the foreplay, once they became comfortable with this step the wife was told to try with two fingers and to insert little deeper.

By this stage, the anxiety in the couple had reduced significantly, she was not resisting touching of her genitals, there was no shivering of the thighs and pain in the vagina reduced. Husband reported reduction in the anticipatory anxiety about the sexual interaction and pleasure during their intimacy. At this stage, husband was told to practice start-stop technique and wife was told to help him in that. By the end of two months the wife was comfortable with insertion of larger dilators and showed interest to proceed with the insertion of penis. The female superior position was suggested. Though in the beginning she experienced difficulty in insertion later on she could do it and she experienced minimum pain.

**Check Your Progress Exercise 2**

***Note :*** a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this unit.

Answer with reference to the case study reported.

1. What are the misconceptions that the couple seems to have?

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2. What are the predisposing, precipitating and maintaining factors for the target problems?

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3. What are the negative cognitions reported in the couple?

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## 6.5 PRECAUTIONS TO BE TAKEN IN SEX THERAPY

- One should take the cultural factors into consideration while doing the sex therapy such as advising nudity when it is not acceptable to either of the partners.
- The language therapist uses should be in agreement with that of the client, colloquial language which may not communicate what one wants to communicate and may also cause discomfort either in patient or therapist should be avoided.
- Very deeply ingrained gender issues which may result in negative feelings in the patient need not be challenged.
- Not to hurry the therapy when the previous step in the therapy is not achieved.
- When there are relationship problems between the couple severe enough to account for sexual problems, the relationship problem needs to be addressed first.
- To ensure the feasibility of sex therapy in terms of space, time, privacy, work pressure, interference by other family members etc.
- Make sure that elaborate sexual history is taken from both the partners separately covering the predisposing, precipitating and maintaining factors.

## 6.6 LET US SUM UP

Sexual dysfunction is the most common health problem seen in both men and women, however the amount of interest given to this area seems to be very minimal. There is lot of secrecy and lack of knowledge in this area leading to more problems. The psychological factors play crucial role in predisposing individual to develop problems, in precipitating and maintaining the dysfunctions. The psychological therapies play an important role in the treatment of secondary sexual dysfunctions.

The sex therapies mainly based on cognitive and behavioural principles are found to be effective in the treatment of both male and female dysfunctions. The main components of these therapies include improving knowledge, mutual responsibility, facilitating attitude change, eliminating performance anxiety, improving communication and sexual techniques, changing life styles and sex roles and prescribing changes in behaviour. In addition, there are specific techniques to address different kinds of dysfunction. The psychological interventions also seem to help in maintenance of the treatment gains and improve the quality of marital life in the couple.

## 6.7 GLOSSARY

**Desensitization** : A type of behavioural therapy based on the principle of reciprocal inhibition wherein the individual is trained to approach the feared stimuli gradually in a state of relaxation.

**Performance Anxiety** : Fear of performance is a common sexual problem in which anxiety about engaging in sexual activity becomes an overriding block to the spontaneous flow of sexual feelings and thoughts.

**PLISSIT** : The PLISSIT Model (Permission, Limited Information, Specific Suggestions, and Intensive Therapy) is one of the most commonly used and effective models used for intervention for sexual problems, developed by Anon (1976).

**Sensate Focus** : A set of specific sexual exercises for couples or for individuals aimed at increasing personal and interpersonal awareness of sensory experience.

**Spectator Role** : Preoccupation with the sexual arousal and need to be good in sexual responsiveness leading to excessive focusing on each detail of the lovemaking resulting in loss of arousal.

## 6.8 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

**Check Your Progress Exercise 1**

1. It is useful in enhancing the sensual experiences though focus on pleasurable sensations and exploration of pleasurable areas. It helps to defocus attention from performance; improving communication between the couple and facilitates mutual responsibility of sexual interaction.

2. Sensate focus and relaxation training can be used to reduce the performance anxiety. Specific techniques like squeeze and start-stop technique can be used to prolong the ejaculatory latency.

3. To begin with relaxation training helps in reducing the anxiety associated with sexual intercourse. The fear can be addressed through desensitization techniques followed by gradual insertion (aiming at dilation of vagina) of the objects to achieve the vaginal flexibility. In addition misconceptions related to pain have to be addressed.

**Check Your Progress Exercise 2**

1. The wife seems to believe that “males should get erection on their will and should maintain as long as it is required”, “man is responsible for penetration and intercourse”, “sexual intercourse is highly painful and some damage may occur to her vagina during the intercourse”. The man seems to believe that “he should be able to penetrate, otherwise he may be having some problem”, and “he is inadequate as a man because he is not able to hold the erection”.

2. The predisposing factors in both of them are restrictive upbringing and lack of adequate knowledge leading to misconceptions about sexual performance. Repeated failures to insert have led to performance anxiety and secondary erectile dysfunction in the man. For the woman, the fear that it is going to be painful has led to development of vaginismus in the first attempt.

3. Negative cognitions in the man are "whether I will be able to penetrate successfully?", 'what if I fail", 'my wife would think that I am sexually inadequate". Similarly, wife seems to have cognitions related to pain such as "what if it hurts and there is damage to the vagina?", "I cannot tolerate the pain", "my vagina cannot accommodate the size of the penis", and "I cannot conceive if I continue to have pain".

## 6.9 UNIT END QUESTIONS

1. What are the kinds of sexual dysfunctions seen in men and women?
2. What are the psychological factors implicated in sexual dysfunctions?
3. What are the components of history taking in sexual dysfunctions?
4. Outline the management of premature ejaculation and vaginismus.
5. What are the prerequisites for sex therapy?

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# UNIT 7 MARITAL ENRICHMENT TECHNIQUES

## Structure



## 7.1 INTRODUCTION

Marriage as a socio-cultural institution has undergone tremendous change in South-Asia and recent trends show an increase in marital distress. Marriages are sources of satisfaction and discontentment and marital expectations are often implicitly implied. With the breakdown of the joint family system and increasing urbanization, couples learn to rely on each other to fulfill all their needs and expectations, within an environment of dual-income earners and long working hours. Paucity of communication and low positivity in marriage are common complaints of couples in the recent years. While South Asian spouses make individual attempts to improve marital happiness and view their marital relationships as important, marital therapy is still viewed as 'taboo'. For instance, Indian society does not approve of help seeking for family matters (Bhatti & Sobhana, 2000). Hence, these distressed spouses/ couples often rely extensively on family members and friends for advice, which may be beneficial albeit biased.

Seeds of marital distress can be traced back to the initial stages of marriage and the formation of maladaptive interactional patterns. This implies the need to prevent these early dysfunctional patterns from becoming habitual. Marital enrichment offers the opportunity for less distressed spouses/ couples to correct these dysfunctional patterns and improve marital happiness. While this form of psychological intervention can be carried out during any stage of marriage, marital enrichment is ideal when the couple is in the initial years of marriage or in a transitional phase in the family lifecycle stages (for example, transition to parenthood).

Marital counsellors and family therapists must be trained in a basic understanding of marital enrichment and its techniques. This allows the counsellor/therapist to determine whether marital therapy or marital enrichment would be beneficial to the couple, depending on the couple's marital issue and needs.

**Objectives**

After studying this Unit, you will be able to:

- Facilitate an understanding of the need for marital enrichment;
- Determine the contexts wherein marital enrichment can be beneficial; and
- Develop behavioural skills for providing marital enrichment in 3-7 sessions individually or in groups of married persons.

## 7.2 NEED FOR MARITAL ENRICHMENT

The three crucial tasks of marital life involve the formation of a healthy marital subsystem; the healthy separation and negotiation of altered relationships with the spouses' respective families of origin; and a spousal agreement about extra-familial arrangements such as work—leisure time and social life. Couples face difficulties in adjusting to each other and developing a shared philosophy of life within the first few years of marriage, whether in an arranged marital context or in an inter-caste and inter-religious context. (Christensen & Heavey, 1999; Olson & DeFrain, 1994; Harway, 2005). However, pressures of long working hours and work stress lower the frequency of spousal discussions and lead to misunderstandings and disagreements.

### 7.2.1 Marital Difficulties of Asian Couples

Traditionally, South-Asian marriages were based on the spiritual unification of a couple with three basic aims: *dharma* (rights and responsibilities), *praja* (progeny), and *rati* (libidinal satisfaction) (Bhatti, 1993). Although Indian families demonstrate limited closeness, occasional family loyalty and emotional separateness; cohesion among other dimensions of family functioning has undergone a change since the past decade (Bhatti, Shah, & Udayakumar, 1998). Murthy (2003) highlights the effect of recent social cultural changes and the increasing influence of mass media on the aspirations of individual and family life. These recent socio-cultural changes and media emphasize values of companionship, intimacy, marital happiness, independence, initiative and self-determination. This complicates South-Asian marriages, by resulting in a contradictory mixture of traditional and modern features. For example, marriage is perceived from the traditionalist perspective of social status and security as well as from the modern view of marriage as an opportunity to facilitate personal and marital growth. Although stereotyped gender roles are reducing (Isaac & Shah, 2004) and a large proportion of South Asian couples earn dual incomes, the process of decision-making still remains with the husband and his parents. Further, the wife is expected to promote the traditions and values of her husband's family and be answerable to them, whilst residing in a nuclear family and managing work and family duties. For example, the wife may be an independently earning member of the family but is often expected to hand over her income to her husband's parents or to indicate to them as to how the income was spent. These differing values and patterns lead to marital conflict and distress among young South-Asian couples. In the last two decades particularly, rates of marital distress

and divorce have significantly increased in South-Asia and the West (TISS, 1991; Desai, 1994). Relationship difficulties are also recognized as dominant themes in the session process of individual, couple and family therapy in India (Shah & Isaac, 2005). These evidences indicate the need for marital enrichment as a preventive paradigm especially in South Asia.

The process of spouse selection has also changed in South Asia. Individual selection takes prominence and people often meet their spouses through common friends, school and work campus and social-networking internet sites, rather than through parental selection. This offers both partners the chances to get to know each other and develop a close relationship. Assistance provided by the spouses' families of origin during the marital ceremony and early marital years becomes a protective factor. Difficulties arise when families of origin become unwilling to accommodate the new family member, frequently criticize, and refuse to communicate with the new family member, thus also adversely affecting the marital bond between the spouses. Failure of spouses to communicate about these family-of-origin issues creates a marital divide, susceptible to unreasonable expectations and erroneous rationalizations.

***Common areas of marital difficulties are:***

*Communication:* Communication styles are a major factor in the success of marital relationships. Effective marital communication includes affective and non-affective communication, with spousal freedom in expressing thoughts, doubts, and worries in an atmosphere of trust. Spousal difficulties in communication typically arise from a fear that his/her communication will be misunderstood, discarded, or invalidated by the other spouse. Other faulty communication practices include mind reading, communication of only negative feelings and blame, a belief that problems will resolve without being communicated, and 'silent treatment' methods. These communication patterns become more rigid over time, if not addressed, and can eventuate into only need-based communication between spouses. This minimal communication style lowers overall marital quality and paves the way for marital disruption and divorce.

*Conflict Resolution:* Conflicts can arise over an exchange on daily events, ideas, feelings, decisions and in methods used to solve problems. Couples with high marital difficulties either use conflict-avoidant strategies or escalate their discussions to arguments and threats, which are both detrimental to marital success. Another common conflict resolution style involves one spouse constantly bringing up a topic for discussion and the other spouse physically or psychologically withdrawing from the same with a fear that the discussion will escalate into an argument. This keeps the issue unresolved and becomes a source of frustration and resentment between the spouses. Common areas of conflict among couples are finance, child-rearing practices, and family of origin issues, intimacy and decision-making. Incompatibility in expectations and functioning styles about these aspects causes conflicts to remain unresolved and manifest in other domains of marital life. For example, a spouse's resentment about how the other spouse parent's did child rearing may become a source of tension and other unresolved differences between the spouses (such as time spent together) will result in an argument till this initial issue of parenting is resolved.

*Intimacy:* Initial conflicts about intimacy between young South-Asian spouses often centre over the difference in levels of intimacy prior to and post marriage. The media influences and Westernization values helps create an image of marriage as a source of high couple intimacy and couples tend to expect that level of

intimacy without spending the time to nurture it. Successful marital relationships involve a high level of intimacy and self-disclosure. Couples with high levels of intimacy tend to segregate couple time. This time is also protected from conflictual discussions. Hence, these couples preserve their levels of intimacy despite arguments/ conflicts and avoid using the argument to influence all their time together. By doing so, these couples are able to encapsulate the issue of argument and effectively deal with it in problem solving mode, and simultaneously feel connected to each other. Intimacy also exists in different forms from physical intimacy to emotional intimacy (that can arise from conversations).This recognition of diverse forms of intimacy and varying levels of intimacy helps to strengthen the marital bond.

*Expectations:* Unmet expectations often occur because spouses do not express their expectations to each other or expect the other person to already know their expectations. While some expectations may be at a conscious level, spouses may also show certain behaviours and desires without a clear awareness of the expectations from which they stem. Expectations also tend to bias communication styles between spouses.

As expectations develop from an individual's background, experiences and perception, it is imperative that spouses discuss their uniquely different expectations. Spouses should create shared expectations at three levels: for themselves, their marriage, and their future. This spousal communication and mutual understanding about their expectations helps to strengthen the marital bond and enhance marital communication.

With the increase in marital distress in South-Asian marriages, efforts to ameliorate the same should become the task of a responsible marital counsellor. The marital counsellor has the option of choosing marital therapy for couples with higher levels of distress and marital enrichment for those with milder difficulties. As opposed to marital therapy, marital enrichment programmes seek to address potential issues before they become problems and to equip couples with necessary skills and insights to handle future difficulties. Hence, marital enrichment is often regarded as preventive in nature, while marital therapy falls under the purview of psychological remediation. However, in the recent decades, there has been a gradual blurring of these preventive and remedial interventions (Berger & Hannah, 1999). The awareness of both forms of counselling helps the counsellor therapist make the appropriate choice based on the couples' levels of distress and ensures that married individuals and couples with a varying range of marital issues can be assisted.

### 7.2.2 Field of Marital Enrichment

The marital enrichment field is still young and owes its origin to David Mace who established the first Marriage Guidance Council in England in 1938. Mace proposed that marital enrichment programmes should keep couples and families out of trouble through enabling them to develop their own resources. These programmes provide couples with tools designed to enhance their marital relationship.

Several marital enrichment programmes have been developed by marital therapists, researchers, lay counsellors and religious groups; and focus on various themes of communication, conflict resolution, and intimacy. Some of the common marital enrichment programmes are the Association for Couples in Marriage Enrichment (ACME), Marriage Encounter, Couple Communication, Practical

Application of Intimate Relationship Skills (PAIRS) and Prevention and Relationship Enhancement Programme (PREP). Each marital enrichment programme follows its own protocol and basis. For example, the Practical Application of Intimate Relationship Skills (PAIRS) programme focuses largely on strengthening marital intimacy and derives itself from a humanistic perspective. Conversely, the Prevention and Relationship Enhancement Programme (PREP) comes from the cognitive-behavioural tradition and emphasises on improving communication and conflict resolution styles. Most marital enrichment programmes focus on key areas of marital life such as communication. However, these programmes can also be generalist in approach and target overall marital quality. Hickmon, Protinsky and Singh (1997) describe an adventure-based marital enrichment programme which had the specific target of enhancement of marital intimacy. Despite these differences in the target skills and delivery style, all marital enrichment programmes centre on the dual purposes of promotion of positive marital health and prevention of marital distress. Marital enrichment typically works on modifying the key marital aspects identified through research on successful marriages and families. Hence, the marital domains of communication, intimacy and conflict resolution are common targets for marital enrichment.

Marital enrichment is providing a spouse/couple information about their marriage and relevant research findings that can help them enhance their marriage. Hence, rather than focusing on only the aspects the client brings as important or distressing in a marital therapy situation, the marital enrichment counsellor will provide the couple with information and techniques related to common marital areas (even if these areas are currently unrelated to the couple's presenting complaint) that the couple can use to strengthen their marriage.

### 7.2.3 Marital Enrichment and Prevention

Marital enrichment comes under the purview of prevention science, as it seeks to reduce risk factors and raise protective factors in order to disrupt the processes that contribute to marital dysfunction. Primary prevention aims at the eradication of stressful agents and the reduction of stress. Secondary prevention, defined as early identification and prompt treatment, has the goal of reducing the prevalence of the dysfunction. Tertiary prevention focuses on the reduction of residual deficits and disabilities.

Marital enrichment is similar to primary and secondary interventions as it can be used with non-distressed, mildly or moderately distressed couples to reduce marital risk factors like negative interaction patterns and dysfunctional relationship beliefs; and to raise marital protective factors of friendship, interpersonal support, and mutual dedication.

Though couples therapy is largely based on the medical model and focuses on couple pathology, preventive efforts lie within the purview of positive marital health and promote constructive and mutually satisfying patterns in communication, conflict resolution and intimacy. Preventive approaches are geared toward relatively functional couples who may not have yet experienced significant relationship problems, whereas remedial interventions or couple therapy models target dysfunctional couples that have already experienced interactional problems and have low relationship satisfaction, low relationship stability or both.



As marital enrichment comes under the purview of prevention, it is used with the 'normal' rather than the 'patient' population, wherein levels of marital distress

are lower and spouses may only present with sub-clinical issues (for example: a spouse may have a risk for developing depression or indicate a few depressive symptoms but may not meet criteria for a depressive disorder). Typically, marital enrichment sessions should be spaced out in weekly or fortnightly session formats to allow spouses/ couples to attempt the enrichment suggestions in their marital lives and come for the next session with feedback. Due to the prevention format and the fact that distress levels are not so marked, improvements in marital satisfaction will be minor and will augment over the years. Preventive programmes typically use a period of two years to show maximal efforts and marital enrichment programmes are not exempt from this guideline. Counsellors should expect this slow and gradual change but also attempt to obtain long-term feedback from spouse/ couples who attended marital enrichment sessions to determine its true effects.

**Check Your Progress Exercise 1**

***Note*** **:** a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this unit.

1. List common areas of marital difficulties.

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## 7.3 CONDUCTING MARITAL ENRICHMENT

Marital enrichment is a complementary adjunct to marital therapy. Often, techniques used in marital enrichment and marital therapy are similar and focus on common areas of communication, conflict resolutions and intimacy. The difference between these forms of counselling lies in determining the context wherein marital enrichment forms the preferred choice of treatment. Marital enrichment is typically the preferred choice of intervention when marital distress is lower, the couple is more amenable to seek help, both spouses are younger and also less rigid in their patterns of interactions, and motivated to learn new ways of marital interaction and improve marital satisfaction. These conditions facilitate an active spousal participation in the sessions and an immediate transfer of learning of behavioural skills and insights from the session context to their marital reality.

### 7.3.1 Guidelines for Conducting Marital Enrichment

Marital enrichment programmes should ideally be provided at the best cost-effective time like the first few years of marriage among couples of younger age and lower marital problems. This allows the spouses to provide reflection about common marital difficulties without resentment and blame as well as motivate them to engage effectively in the session and implement the suggestions provided in their marital life. Marital enrichment can also be provided at important transitions in a couple's life such as shifting from one family lifecycle stage to the next and/ or if they change their type of living arrangements. For example, it can be

provided when a couple becomes parents or if the couple moves from a nuclear living arrangement to a joint household.

Marital enrichment can be provided in individual, conjoint, or even group sessions. It is important that the marital counsellor presents common marital concerns and asks the spouses for their daily experiences related to that marital area. Both spouses should be asked to present their experiences and views about this in order to facilitate deeper understanding about each other. This enables the counsellor to clarify for the couple their existing marital strengths (areas wherein they currently do not have difficulties) and their marital weaknesses that they can ameliorate. For example, the counsellor can list common areas of marital enrichment such as communication, intimacy, conflict resolution and so on and the spouse/ couple can be asked to elaborate on this aspect with reference to their marital life. Strengths and difficulties that couples have with each area can be outlined. Based on this discussion, feedback can be provided to the couple about their current marital status, strengths and lacunae. The marital enrichment sessions could be then tuned to enhance marital strengths and reduce their marital difficulties, with insights and behavioural strategies.

Typically, marital enrichment is carried out in the initial stages of marital life to equip the couples with skills to handle future marital difficulties. In addition, the initial adjustments and realization of marital difficulties often occur in the first year of marriage and can exacerbate if not addressed. Typical patterns of relating and interacting with each other develop and become stable over time. Hence, marital enrichment can act like a 'safety-valve' for marital distress by providing an opportunity for couples to tackle their marital difficulties before it becomes too late and results in marital discord.

While there are no clear contra-indicators for marital enrichment, the counsellor must use his/her discretion to determine whether marital enrichment is the optimal treatment. In the case of domestic abuse, extramarital relationships in either spouse, marital therapy should be the preferred mode of treatment. Marital enrichment can be used later to supplement the earlier marital therapy sessions. In the case wherein one spouse has a severe psychiatric disorder such as schizophrenia, psycho education of the illness with family members will be more relevant than marital enrichment. Marital enrichment may also be contra-indicated when one spouse has antisocial personality traits or has substance abuse, as these formats may require a specialized form of marital therapy to deal with these issues.

## 7.3.2 Common Areas of Marital Enrichment

Marital enrichment focuses on exploration and skill training through reflective spousal and couple-based exercises. Marital satisfaction is linked to early interactional patterns and hence, these marital enrichment programmes focus on changing the communication practices, conflict resolution styles and intimacy patterns adopted by the couple. The information about constructive and destructive marital patterns is shared with the couples in the marital enrichment programme in order to produce desired changes in their relationship functioning.

***The marital areas addressed in a marital enrichment session are outlined below:***

*Communication:* The marital enrichment counsellor should indicate faulty communication practices such as mind reading, escalation, and avoidance and

ask the couple for the frequency of these patterns in their marital life. The counsellor then should encourage the couple to lower these patterns and teach the couple to use 'I- statements'. As opposed to 'you -statements', the use of 'I-statements' encourages individual responsibility without displacement of blame.

For example, a statement such as 'You never listen to me' can be rephrased as 'I feel hurt when I say something important and it seems like you may be not attending to what I say'. Similar, couples can be taught to avoid the use of threats and absolute words such as 'always' and 'never'. Awareness about these faulty practices enables spouses to recognize and ameliorate their communication patterns.

Maintaining eye contact, giving verbatim feedback, and not answering the complaint or interjecting defensiveness helps couples stay connected and avoid misunderstandings. The couples can be taught how to segregate time to confide in each other regularly with emotional openness and empathic listening, without allowing their listening to be hindered by their biases.

*Conflict resolution:* The couple is taught to resolve differences and conflicts by seeking to learn from each other rather than to win the argument. The couple can be taught to express their 'wants' rather than 'needs' and state these requests clearly and directly. Spouses can learn how to stay focused on the present issue in a calm manner and avoid past references so that the issue reaches a state of resolution. Techniques to solve a problem by examining the advantages and disadvantages of different options can help them reach a feasible solution. The counsellor should de-emphasise the couples' use of 'silent treatment', avoidance of conflictual discussions, and blame. The couple should be encouraged to 'agree to disagree' and be accommodative and collaborative in their negotiations.

For example, If a couple is complaining about how decision-making is carried out in their marriage, the counsellor must help them understand both perspectives. The counsellor can also aid the discussion by presenting a neutral understanding of the couple's dilemma. The spouses can then be helped to examine the pros and cons of each spouse's decision making capacity and process style and then adopt a more collaborative stance. Practice with effective conflict resolution practices will help couples to generalize this learnt skill to other conflictual areas and reduce marital tension.

*Intimacy:* To strengthen intimacy, the spouses can be taught to provide daily appreciation and praise to each other, and try actively to reduce the frequency of negative emotions and blame. The counsellor can also ask the couple to create intentional activities that strengthen their couple relationship and create a 'we-based' couple identity. The counsellor should emphasise the need for the couple to maintain active connections with their extended family members. The counsellor should also emphasise the need for each spouse to demarcate individual space and activities from conjoint activities and clarify the importance of individual and couple goals. This allows for growth at both personal and relationship levels.

Intimacy is an important cause for marital disharmony and is not just restricted to sexual intimacy. Couples must learn how they can be intimate with each other, physically and verbally. The marital enrichment counsellor should help spouses/ couples understand these different behavioural expressions for themselves and their spouses, and convey their expectations and desires explicitly in the context of intimacy.

*Commitment:* The couple should be strengthened to increase their commitment for each other and to their marriage. The spouses can be encouraged to share their individual expectations to each other and discuss ways to meet each other's expectations. Couples should be encouraged to let go of minor grudges in order to remain committed to the relationship. Techniques to maintain an effective work-life balance and invest time and energy into couple and familial activities become an important way for South-Asian couples to show their commitment to each other.

For example, spouses often believe that marital commitment is a natural process in marriage. However, several couples currently complain about being unsure about their commitment to each other and to the marital relationship. Spouses can be taught to define their concept of marital commitment and express that to each other in their daily lives. This builds up their level of commitment in the relationship and increases overall marital satisfaction.

### 7.3.3 Counsellor Guidelines for Marital Enrichment

As marital enrichment differs from marital therapy in its approach, the counsellor must also adopt a different stance whilst conducting marital enrichment. A marital enrichment counsellor must be facilitative and offer reflections, rather than prescriptions or directions. The marital counsellor must also regularly assess the spouses for signs of mental illness. During the course of a marital enrichment session, the marital counsellor may discover the presence of higher marital distress, mental illness and/or deep-seated psychological conflicts. In that case, the counsellor should let the couple know that a different intervention for the same will be required and appropriately refer the couple to a trained mental health professional.

The counsellor must be able to convert daily marital issues provided by the couple into a framework of marital strengths and weaknesses and be motivated to help the couple overcome their weaknesses. The counsellor must be curious about individual and couple differences that have resulted in their lower levels of marital distress and reinforce the couple for this. The counsellor must be optimistic and avoid pathologising the marital situation. The marital counsellor should be careful to maintain neutrality towards both spouses in sessions, and avoid prejudice and a judgemental attitude. Role-plays of good communication and conflict resolution styles may be integral to enable the couple to transfer learning to their marital life.

**Check Your Progress Exercise 2**

***Note :*** a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1. Explain why marital enrichment is typically conducted for couples in the initial stages of marital life.

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## 7.4 LET US SUM UP

In this Unit, we have learnt that marital enrichment is an alternative format of counselling for younger couples with milder levels of marital distress. The incidence of marital distress and divorce is steadily increasing in South Asia and marital therapy may not be the only solution to resolve marital difficulties. The marital counsellor should be trained in both marital therapy and marital enrichment and use the format that is appropriate to the couples' marital context. Conducting marital enrichment with young couples can be beneficial as young couples may have lower marital distress, be more willing to change and engaged in the session. In addition, marital patterns in the earlier years of marriage may be more conducive to change as compared to the later years of marriage.

Marital counsellor can focus on providing information on constructive and destructive marital patterns in a marital enrichment session. In these time-limited sessions, the counsellor can focus on common marital areas such as communication, conflict resolution, and intimacy. Suggestions to improve the same can be provided and in the case of a more serious marital difficulty, the couple can be referred to a trained mental health professional. The counsellor must play a facilitative role in marital enrichment sessions rather than a directive therapist stance.

## 7.5 GLOSSARY

**Cohesion** : Level of connectedness and 'we-feeling' that spouses experience toward the couple unit

**Commitment** : Extent to which spouses value the marital relationship and their intentions and actions pertaining to its' maintenance and continuation

**Communication** : The spousal exchange of information that should result in increased understanding and awareness about each other

**Conflict Resolution** : Ability to recognize and deal with marital disagreements and hurts that are inevitable in any intimate and lasting relationship

**Intimacy** : Verbal and/or nonverbal expressions of closeness, care and affection that are shared by spouses

**Marital Difficulties** : Marital distress reflected from the incompatible needs and wishes of the spouses

**Marital Enrichment** : Form of counselling wherein the therapist addresses potential marital issues before they become problems and helps to equip the couple with necessary skills and insights to handle future difficulties

**Preventive Interventions** : Couple-based interventions aimed at reducing marital risk factors and reinforcing marital protective factors in order to prevent marital distress and discord

## 7.6 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

**Check Your Progress Exercise 1**

1. Common areas of marital difficulties are poor communication, issues related to families of origin, poor conflict resolution, low intimacy, and high expectations.

**Check Your Progress Exercise 2**

1. Marital enrichment should be provided in the initial years of marriage so that the couple is able to know their strenghts and weaknesses and hence improve their marital relationship. Conducting marital enrichment with young couples can be beneficial as young couples may have lower marital distress, be more willing to change and engaged in the session. In addition, marital patterns in the earlier years of marriage may be more conducive to change as compared to the later years of marriage.

## 7.7 UNIT END QUESTIONS

1. Mention some common communication difficulties faced by a couple.
2. Elucidate the reasons for marital difficulties among South-Asian couples.
3. Explain how marital enrichment is considered as a preventive programme. What are the indications and contra-indications for marital enrichment?
4. List four marital enrichment techniques. Elucidate the common areas of marital enrichment.

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# UNIT 8 INTERVIEWING SKILLS AND CIRCULAR QUESTIONING IN ASSESSMENT – A CASE STUDY

## Structure



## 8.1 INTRODUCTION

When the couple comes for couple therapy, the therapist aims to understand their current difficulties and current interaction pattern, evolution of their problems and what maintains their interactional difficulties. Through the assessment process and the style of asking questions, the therapist helps the couple see how the quality of the relationship is a function of the interaction between them (circularity). Using good clinical skills in the assessment (circular questions, therapist neutrality, eliciting positives about the relationship, avoiding linear questions), to elicit responses about the quality of relationships, further aids the formulation of a hypothesis of what maintains the couple's current problems. It also helps the couple see that both partners have a role in improving the relationship.

**Objectives**

After studying this Unit, you will be able to:

- Understand how assessment phase in couple therapy can be carried out; and
- Use and apply circular questionsing.

## 8.2 THE CASE STUDY

### 8.2.1 Background Information of the Couple

Anju and Suresh, 26/F and 27/M, respectively were both engineers, working currently in the Information Technology, IT sector, from middle socio-economic status. Both are Hindus and share a common cultural background of being from Madhya Pradesh. The couple had a love marriage, and had been married for

eight months now. The couple presented with complaints of having very frequent quarrels and a feeling that the love between them was lost. Anju felt that Suresh did not support her in anything, and Suresh felt that Anju behaved immaturely. They had tried to work out their differences, on their own and with the help of common friends, but could not reach a resolution. They were referred for couple therapy by one of their friends.

### 8.2.2 The Intake

When the couple presented to the family therapy centre, the therapist had an initial intake session with them. As explained in previous Units, the process of assessment starts from the time the couple or the family make the first contact with the therapist. Some sections of the intake interview are produced below to show the beginning of the assessment of the couple.

*(The therapist, T began the intake by introducing herself and asking the couple to share basic details of their socio-demographic backgrounds. She then asked them the reason for seeking help from a marital therapist.)*

T: Anju and Suresh, could you tell me the reason for coming to the family therapy centre?

(Suresh, S is looking out of the window; Anju, A has a look of exasperation on her face)

A: See, let me give you a background; we got married eight months back. Things were fine till then…

S: (Cuts in, doesn't let Anju complete her sentence and says) Things were not all fine Anju. We were having problems before also…

A: (cuts in, doesn't let Suresh complete his sentence and says) Okay fine, we were having problems before, but not so many as we are having now.

T: What is the nature of the difficulties both of you are facing as couple now?

S: We are just unable to get along. We are constantly fighting; we never seem to agree on anything. It's a mess.

A: Like, small things become big issues for us. And our fights go on for days. There is no end to it. On the face of it, we do things together…. We go for parties, functions and *pujas*, but scratch the surface and things are not working out so smoothly.

T: Both of you feel that there are many disagreements between you and once these start, they don't get resolved?

A and S: (both nod their heads) Uh-hmm.

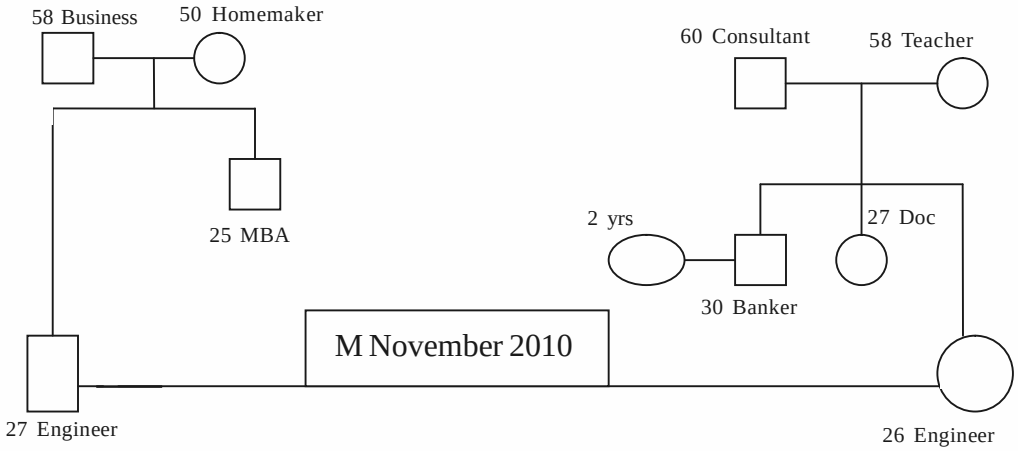
The therapist made a note that the partners did not allow each other to complete their sentences and interrupted each other. She inferred that the couple may be having problems in the area of communicating with each other. The therapist continued with the intake.

As the intake was concluded, the couple was socialized into couple therapy. It was planned in therapy to start formal assessment of the Genogram, each partner's family of origin (FOO), the courtship period and of the first life cycle stage

(married couple without children). The relevant information obtained is shared below.

## 8.2.3 Assessment Phase

- **The Genogram**




- **Wife's Family of Origin**

Anju was the last born of three siblings, born of a non-consanguineous union. Her father was 60 years old, working as a consultant in a law firm. Her mother was 58 years old, and had retired as a high school teacher three months ago. Anju's elder brother was 30 years old, a banker and married for two years. He lived separately with his wife. Anju's elder sister was 27 years old. She was a doctor and doing her post graduation. The family was a liberal, cosmopolitan one. Everyone was encouraged to get good education and become independent. Anju was closer to her father, though she got along well with her mother as well. She looked up to her father and admired him for his values of equality, tolerance. Her brother was very close to the mother. The parents would have frequent quarrels regarding parenting of the children, with the father being close to Anju's paternal grandmother, which Anju's mother did not like. Anju and her siblings would be frequent witnesses to these fights. Leadership of the family was shared by both parents; day to day decisions about running of the household were taken by the mother; larger decisions were taken by parents, and the children were never involved in them. Financial decisions were managed and executed by the father. Both parents were working and earning members of the family. The father was liberal with the children, trying to discipline them through reasoning. The mother was more critical and sometimes used punitive methods of disciplining the children. The children's main task was to study; they did not have any household responsibilities. The communication between parents was direct and the noise levels were high. The children had open communication with both parents and with each other. There was verbal and non-verbal communication of welfare and emergency feelings within the family. Anju reported that though she felt that her parents cared about each other and did things which demonstrated that, she never saw how they actually resolved a fight. The parents reinforced all the three children for their efforts and achievements, and encouraged them to follow their ambition and dreams. They had good relations with and support from the extended family.

- **Husband's Family of Origin**

Suresh was first born of two siblings, born of a non-consanguineous union. His father was 58 years old, and ran a construction business. His mother was 50 years old, and a homemaker. The family was conservative and largely traditional. Suresh's younger brother was 25 years old, had completed his MBA and was now working with his father in the family business. Suresh reported that in his family, relationships were cordial between his parents. He did not observe any overt fights or quarrels between them. One reason, he said was that his mother never went against his father's word. Both children were close to their mother and shared their feelings with her. Since the father was involved in running the business, he could not spend much time at home. The children, however, did respect and care for their father, and understood the demands of his work. The father did not share much about his business with the children while they were growing up, but this changed when both the children became young adults. Father was the nominal and the functional leader of the house. He took all major decisions in the family, though the day to day running of the house was left to the mother. Even when Suresh and his brother grew up, they usually deferred to their father's wishes/ decisions. The mother's role was to take care of the children and their emotional needs. Father was the earning member of the family. The children sometimes helped their mother in household chores, and as they grew up, they would help out with getting the outside work done for her. Communication in the family was direct between the mother and children. She would however, had to mediate between them and the father. This was especially significant when Suresh said that he wanted to do engineering and become a professional (he was not inclined to get into the family business). He communicated the same to his mother, and she told the father. Father was not happy because he wanted Suresh to become a part of the business. After much tussle and negotiating, Suresh's father relented. This left a deep impact on Suresh, and he reported he started feeling greatly indebted to his father from then on. Thereafter, he wanted to do everything else as per his father's wish. Father's worries about the business became less when Suresh's younger brother showed interest in joining it. Reinforcement in the family was rarely verbally demonstrated. It was understood that everyone was doing their duties/ chores and there was no special need to acknowledge them specifically. The family was cohesive. They had good relationships with the extended family. In times of personal and financial needs, the family could rely on Suresh's paternal and maternal uncles. Problems within the family were usually sorted out by Suresh's father, and his word was the final word.

- **Courtship Period**

Suresh and Anju met when he was 24 years old and she was 23 years. They were working in the same IT Company. They soon became friends and spent a lot of time together. Suresh reported that he liked Anju's independence, her ability to think on her own and take decisions, that she was ambitious, "and was not a damsel in distress". She reported that what she liked about Suresh was his work ethic, professionalism, and strivings to "make it on his own, and not depend on his father's money". They shared common interests such as reading, travelling. Both reported that they could rely on each other during times of difficulties at work, especially. Each found the other to be caring, and supportive. Their friendship soon evolved into an intimate relationship. The couple spent most of their free time together, going for movies, plays, and parties. They would also have disagreements/ fights if Suresh took on more work at the office and

got less time to spend with Anju. Following this, Suresh reminded Anju that she would also spend a lot of time at work. Two years later they decided to get married. The relationship was approved by Anju's parents, as she had shared with them about it. They had even met Suresh a few times. Suresh's family did not know that he was in a relationship with Anju. He disclosed about this first to his mother, and she reported about this to the father, because he wasn't sure how his father would react. After finding out more about Anju's family, cultural and social background, Suresh's father agreed to the alliance. Thus the engagement was fixed and the couple got married six months later. The marriage process went off smoothly and both sets of in-laws seemed to be able get along cordially with each other.

***Given below is a session transcript that reflects the process of assessment of the courtship period. Here, the therapist explores some aspects of the development of the couple relationship.***

S: We met in the cafeteria. My classmate Manoj was working in the same department as her. So we used to all have lunch together.

A: And coffee together. Now he is too busy for all these things.

S: After Manoj left we started to take our coffee break together.

T: Um-hmm.

A: He was very stressed out… and we used to spend a lot of time talking about it.

T: *So you would discuss what concerned him and what he was stressed about… could you tell me a bit more about that? What was the stress about? (problem definition question, past)*

A: Because of the pressure from his home.

S: I would tell her about my parents. You see papa wanted me to join the business even when I had started my work here and I was confused.

T: Um-hm

S: She was supportive at that time. She encouraged me to follow my heart. (Suresh pauses)

T: Anju was there for you at that time. (*Therapist highlights positives and conveys understanding to the clients*)

S: Yes… We used to also talk about difficulties we had at work.

A: Yes. I used to crib about my boss and Lakshmi.

S: Lakshmi was her co-worker.

A: We started to go for movies together, and we took our day off together. We even went for plays.

S: I used to get bored of them.

A: Yes, even then half the time you had to work after hours.

S: I was building my career. It's because of that work that I am where I am today. You also used to spend lots of time at work.

A: Not to that extent. You told me that I also needed to work on my career. When it suits you I should work on my career, now my career isn't important.

T: Anju, Suresh, you both were saying that you used to go out for movies, take time off together... (*therapist tries to highlight the positive interaction pattern present earlier in the relationship*).

A: We also had fights because he wanted to spend too much time at work which wasn't required.

S: We just had one fight.

A: We had one major fight. I used to tell you so many times that there was no need to check for office work on your day off, remember?

S: At that time I was very worried about setting up my career. I reduced that. Anyway, we used to enjoy going for movies. Both of us love horror movies, you know.

A: It was fun.

T: You both enjoyed your time together.

(*The therapist observes that the couple, while starting to talk about their shared interests or positives, veers off to criticizing and pointing faults in each other. Thus the therapist makes a deliberate decision to explore positive interaction patterns that existed at the beginning of their relationship and what attracted them to each other*)

A: Yes.

T: What did you like about him?

A: He was focused, and wanted to stand on his own feet. He wasn't afraid of hard work. He had family values. I liked him.

T: What made you decide to marry him?

A: Well, he was.., is a nice man (laughs), and he asked me to marry him. (Pause)

T: (Nods)

A: We became close. It seemed like a good idea. My father also liked him a lot.

T: How did you feel about him?

A: I also liked him.

T: (To Suresh). What did you like about her?

S: She is pretty. (Laughs)

A: (Laughs)

T: (Smiles). What made you to ask her to marry you?

S: She was independent. She understood me.

A: I used to make him laugh. (Turns to Suresh) You said that you married me because I could make you laugh after any meeting.

S: Yes, she has this ability. When I would tell her about my meetings, any meeting, the way she would imitate others! It would make things less serious. Actually I tend to take things too seriously at times. She just used to make it lighter.

A: I also liked that he used to encourage me always.

S: I told my mother about us first. She told my father.

T: She was supportive?

S: Yes. She was a bit unsure, but she knew how I felt about Anju, so she convinced papa.

(*Here, the therapist chooses to explore how Suresh and Anju's parents responded to their relationship*)

T: (To Anju) What about your parents? You were saying that your father liked Suresh.

A: I had taken him home a few times, and they knew I liked him. My father also liked his independence. He felt Suresh would be able to look after me well. Mom was not so happy, but Dad was on our side.

T: What was she unhappy with?

A: She was worried about what relatives may say about a love marriage, but actually we are from the same community and no one said anything bad, so she was also O.K with it.

T: Uh-hmm.

It can be seen in the above transcript that the therapist used circular questions, conveyed empathy, and ensured that the perspectives of both the partners were brought out in the session.

- **First Life Cycle Stage: Married Couple Without Children**

The couple got married and left for their honeymoon for two weeks. Their problems began soon after they came back. One of the major difficulties was that Anju had wanted to live with Suresh in a separate house, and not with his parents. Though they had tried to discuss this earlier, they had not been able to reach any decision. Suresh's mother wanted Anju to take on a more active role in the management of the home. Anju was not keen on this and her work hours left her with little time to participate in household chores. Anju expected Suresh to tell his mother to not nag her. Suresh felt that given his parents had agreed to both of his major demands, he was obliged to give in to their demands and expectations. He felt that now since Anju was a part of the family, she should take on responsibilities at home also. He also felt upset that he was being expected to choose between his mother and his wife. He found it difficult to balance between them both. Further, he did not feel Anju made any efforts to improve her relationship with his parents. They found their sexual relationship dissatisfying.

***The following transcript reflects assessment of the couple's current problems and tracking the sequence of interaction during a fight.***

T: Since when have you noticed these difficulties in your relationship? *(Sequence of interaction)*

S: We did have problems and fights before marriage as well, but I thought they were normal, a part of any relationship.

T: Uh-hmm.

S: Yes, but since we got married things have been really different.

T: What have you seen or experienced which is different? *(Problem Definition Question)*

S: See things change when you get married… people change, and we also want that our partners should become better, or grow for the better. That's what I was trying to help out Anju with…

A: I don't think I need help in growing up.

T: (To Anju) Let us allow Suresh to complete what he has to say, and then you could give us your point. Suresh, you were saying that you were trying to help Anju with?

S: See, even the therapist is asking you to keep quiet. You always do this; you never listen to what I have to say.

T: Let me clarify what I meant. *We had discussed earlier about some ground rules for the sessions. Each of you will get your turn to speak.* Suresh, you were sharing your observations about the changes in your relationship with Anju after marriage.

S: Yes, we spend less time together; I have to constantly try to mediate between Mom and Anju. It is very demanding. I mean it was never like this earlier. Even Anju, I felt, was more receptive to what I had to say before marriage. Now if I tell her something, she just will not even listen to me. She cuts into my sentences. I never get to say anything.

T: Hmm. Can you tell me Suresh, what you meant when you said that you have to mediate between your mother and Anju?

S: See, I owe my parents a lot. They have agreed to two most important things I have wanted… first was to do engineering and then was to marry Anju. I just feel now I have to do my bit and make them happy, do what they expect me and now us to do. My Mom does expect Anju to do more work at home, and sort of do things the way Mom has been doing them. And Anju doesn't want to do it. She is not interested. Anju then comes and tells me to tell Mom not to tell Anju to do this and that at home… to give her more "space". See I know how Anju feels and how Mom feels. I try to reason with Anju how she needs to accommodate with my family.

T: *Then what do you do Suresh, when Anju tells you to tell your mother?(tracking sequence of interaction)*

S: I now actually don't tell my mother anything. In the beginning I wasn't sure how to tell mom, but I tried. I told her to give Anju more time, to warm up. Mom didn't like that I was taking Anju's side. When I told Anju to be more flexible, she wouldn't listen to me. She tells me I am trying to control her.

T: You have tried to talk to both of them, but it hasn't been useful; and you also feel that you aren't being heard by Anju.

S: Yes.

(*The therapist at this point, prioritises tracking the couple's interaction, while making a mental note of what Suresh said about his mother's reactions.*)

T: Anju, what are your concerns about your relationship with Suresh right now? (*Clarification question, present*)

A: Like I said earlier, we fight too much. And once we start, each fight just goes on and on. I also think that we spend very little time "being" with each other. We have little time, and even in that we keep fighting. It appears so meaningless…. to be like this.

T: No fight gets resolved or closed then and there.

A: It drags on.

T: What do you think are the reasons for that? *(Problem definition: explanation)*

A: Let me give you an example. His mother asked me to come back early from office one day. I had a conference call in the evening that day, so I said I am not sure. She got upset and complained to Suresh. Then Suresh told me to prioritize things in my life. And I am like, if there is work, I cannot get out of it saying my mother-in-law wants me to come back home early. Secondly, my commitment to my work was something that he liked about me in the beginning, and now the same thing has become an eye-sore. Why can't he stand up for me, in front of his mother? And I am an adult; I would like to do things the way they make sense to me.

T: Then what happened? *(Tracking sequence of interactions)*

A: Then he said that things change after marriage, and I should be ready to make compromises and adjustments.

T: Uh-hmm.

A: And then I said that why should I be the one to make all compromises, I already did, about staying with his parents.

T: Then what happened?

A: Then he said that I was being rigid and immature. I felt angry and I said he should stop controlling me. And he left the room.

T: So the argument didn't get resolved.

A: It didn't. This is our usual pattern. We start a fight, and one of us walks out. When we went out the day after, we got into a fight about eating out. I didn't want to go, we had not been speaking properly after the fight and he kept insisting.

T: What happened after he had left the room? *(Therapist brings back the Anju's attention to the current discussion)*

A: I went to the kitchen and I washed the vessels.

T: Uh-hmm. So after the argument you'll left the (pause).

S: Bedroom

T: Right, you left the bedroom and went to the sitting room? And she went to the kitchen.

S: Yes, I thought I would get on line and get some work done instead of wasting my time trying to explain to her. She was banging everything in the kitchen. I could hear it in the sitting room.

T: So you went to the sitting room and Anju went to the kitchen to wash the vessels (pause). Is that what you'll usually do at this time? (Brief pause). Or?

A: If we fight when I get home, then he just starts his work. Usually I wash the vessels and help my mother-in-law in the kitchen while he watches T.V with my father-in-law.

S: Usually by the time she comes back mom has already prepared dinner, so the only things she does in term of house work is washing up the vessels used to prepare dinner, and the plates after we eat.

A: She also leaves afternoon vessels and plates for me.

T: Uh-hmm… What do your parents do when you both fight? *(Tracking sequence of interaction)*

A: My father-in-law will know that we are having a fight from our faces. Then he will ask Suresh what happened and they will start talking about it.

T: (To Suresh) Can you tell me what happens?

S: He asks me, and then what am I to do? I cannot ignore him. I just tell him very briefly.

A: (To S), Yes, you have brief conversations of 45 minutes. Don't worry; your mother can hear you in the kitchen.

S: (To T) That's why, to stop that, I start to work online at that time, but even then she has a problem.

T: (To S) So after the fight, you went to the sitting room and what you were saying could be heard in the kitchen (looking at Anju)

A: No, he stopped doing that; he just works on the laptop.

T: Then what happened?

A: Then they had dinner, and we went to sleep.

T: Um-hmm.

S: She had dinner in the kitchen.

T: Um Hmm. Did you both talk about it then?

S: No. I knew there was no point. When I went near her, she got up and went to the bedroom, so after that I just kept my distance.

T: Um-hmm, and then you'll go to sleep (pauses) . . .

A: (Laughs) Then I went and slept next to him.

S: (Smiles)

T: (Smiles), But you didn't talk. . .

S: (Laughs) No.

T: And the next morning?

A: The morning is anyway rushed.

S: That evening I asked her to come out for dinner.

T: (To S) How do you feel Anju responded to the idea of eating out?

S: She said she wasn't interested in going out for dinner with me. I was trying, you know, but that doesn't make any difference to her.

T: (To S) You were trying to work on things after the fight and make things better, and (to A) you were hurt by what happened the day before so you weren't comfortable going out for dinner. *(Therapist demonstrating neutrality and empathy towards both)*

A: Yes Anyway he thinks I'm immature. If so much is wrong with me why should he go out to dinner with me? We can sit at home with his parents.

S: (To A) It's not like that.

A: (To S) Then what? I'm rigid and immature, right?

S: (To A) There is no point in talking to you. You take everything I say in the opposite way. (To T) She is very immature. She cannot understand anything.

A: (Interrupts by shouting at S). You are a control freak. The only reason you want to take me for dinner is that you want to have sex.

S: (Shouting back) You only think like that. There is no point in opening my mouth. I will just sit here quietly. You can say whatever you want. You don't have any brains.

T: (To S and A) One minute, (pauses). (To A) You both had a fight the day before, which didn't get resolved. The next day evening when you went out (pauses).

From the above section of the transcript, the therapist identifies that –

1. The couple doesn't close arguments
2. When the husband tries to reconcile with the wife, she thinks he has an alternate agenda
3. She reacts with anger; and then he resorts to name calling, and withdrawal.

***The following transcript highlights use of circular questions to help the couple understand how both of their behaviours' contribute to the relationship difficulties. This section of the transcript was taken from the third assessment session. It picks up at a point in the session where Suresh and Anju use labels to indicate some behaviour which contribute to the dysfunctional interaction patterns between them.***

S: (In an exasperated tone) I am telling you, Ma'am, she does this all the time. She will be totally immature.

T: *What does Anju "do" that "shows" you that she is immature?*

S: She is like that only.

T: Let me clarify. She would be doing something from which you infer that she is "immature"? (*In a gentle tone*)

S: Yes.

T: S*o what would those behaviours be?*

S: She does not want to listen to what I have to say, she doesn't incorporate my suggestions for improving the relationship between her and my mother, she cries at the drop of the hat.

T: *When does she show you this behaviour? Can you give me some examples?*

S: Yeah… I told her once that she can make the food the way my mother likes to have it prepared. Then she asked me why she should do things that way. She was rigid and said that she had no value in the house, that she is like a puppet which has to do things as per others' wishes. She just went off-tangent! I didn't understand where that line came from. She makes a mountain out of a molehill! My reason for telling her to listen to my mother was that if my mother saw that Anju was making efforts to adjust, then I could have also told my mother later to back off a little bit, and do things as per Anju's wishes. But that just won't happen!

T: Suresh, did you tell Anju the reason you wished she would do things the way your mother likes them?

S: What is there to tell, anyone can understand that.

A: Ma'am, can I say something here?

T: Sure, Anju.

A: See I didn't know till now, as to why he kept asking me to do things as per his mother's wishes. He never told me that clearly. What he did tell me was that I should make adjustments, and that adjustments are needed after marriage! That did not make any sense to me!

T: Uh-hmm

A: (Turns to Suresh) Okay, if I knew what your point was, I would have taken it. But anyway, (turns to therapist and says) when he speaks like that, ordering me around, I just feel like I don't have to listen to this nonsense!

T: *Anju, when Suresh said to you to make the food the way his mother likes to have it prepared, what did it mean to you?*

A: It meant to me that he is ordering me around. It makes me feel as if he thinks that I don't have my own brain. I feel pushed to the corner and then the only thing I can think of doing is to stick to my point. I don't want to listen to him or his point at all. I feel controlled. Then I won't listen to him. Or I cry because I feel as if he is ganging up with his mother against me. I feel alone. So uncaring!

T: *What does Suresh do to show that he is uncaring?*

A: Earlier, if I got upset and cried, related to anything, he would be supportive. He listened to what I had to say. He then gave me a correct perspective. If I was right he would say that. If I was wrong, that also he told me, and I appreciated that. You should have someone in your life who is not afraid of

telling you truth, or correct you if you are going wrong. But since we got married, it has been like he can only point out what is wrong, nothing I do is right for him. When I cry, he just calls me names and walks off… doesn't even want to try to console me! That's what he does… walks off, calls me names. And that's when I feel he is uncaring. Then I just don't ever want to listen to him. I need to protect myself.

T: So let me get that: Suresh you request Anju to listen to your mother, because you think it will give you some grounds to ask your mother to accommodate Anju's perspective. Anju, you do not know what his intention is, and you feel that Suresh is not appreciative of you, and think that he is controlling you. You then stick to your position or cry. Suresh you then feel that Anju is not being flexible. You leave the place. Anju, you do not like that, believe that Suresh is being uncaring. And the position you take for the next interaction is like that you need to protect yourself. *(The therapist reflects to the couple the circularity of their interaction).*

**Check Your Progress Exercise 1**

***Note :*** a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. Give some examples of circular questions that you can ask a couple during assessment.

   .....

   .....

   .....

2. What are the two main difficulties the couple in the given case study is having in managing their conflict?

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## 8.3 LET US SUM UP

This Unit highlights, with the help of session transcripts, the therapist's use of interviewing couples in assessment phase. Asking circular questions such as tracking interaction, problem definition, clarification questions about the past and present, conveying empathy, setting limits, and prioritising which material to discuss in detail in the current session can help in understanding the couple's problems and conflicts. Through responding to circular questions and experiencing the therapist's neutrality, the partners begin to develop a new understanding of each other's perspectives. This enables them to appreciate the physical and emotional context in which their behaviours occur. Thus the manner, in which the assessment phase is conducted, sets the stage for the intervention phase in couple's therapy. The experience of the assessment conducted in this manner tells the couple that both partners will have a role to play in improving the quality of the relationship. It also helps the therapist remain neutral, and indicate that he or she is interested in listening to and understanding the couple.

## 8.4 GLOSSARY

**Circular questions** : Questions which draw connections and differences between family members, and imply that behaviour of one person is related to the behaviour of another person in a circular way rather than in a linear way (Brown, 1997)

**Problem definition questions** : Questions which ask for description of the specific behaviours which are perceived to be problematic

**Sequence of interaction questions** : Questions which track sequences of behaviours between family members

## 8.5 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

**Check Your Progress Exercise 1**

1) Examples of circular questions that can be asked during assessment are:
   - What is the main concern of the family now?
   - What does this behaviour mean to you?
   - What was the problem at that time (that is, in the past)?
   - What is your explanation for that?
   - When this (a particular behaviour/event or situation), what does she do?
   - Then what does he do?
   - How does she respond?
   - What solutions have you both tried earlier?
   - Was it (a particular behaviour) more (or less) then (that is, in the past), or is it now (in the present)?
2. The couple is having difficulties in clear communication and resolving conflicts.

## 8.6 UNIT END QUESTIONS

1. What is the relevance of therapist's maintaining neutrality in the session?
2. In the case described in the Unit, in what ways did the therapist demonstrate neutrality?
3. How can the use of circular questions facilitate assessment process in couple or family therapy?

## 8.7 FURTHER READINGS AND REFERENCES

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# MCFTE-001 MARITAL AND FAMILY THERAPY AND COUNSELLING

***OPTIONAL PAPER 1***