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Acceptance, Mindfulness, and Change in Couple Therapy

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Pat and Sam are both unhappy in their relationship. Pat complains that Sam does not give much in the relationship, is uncommunicative, and withdrawn. Pat claims, "Sam just isn't ever there for me." Sam counters that Pat is constantly criticizing and accusing, and is always on Sam's case. Sam claims, "I tune Pat out because it's all the same. In Pat's eyes, I do nothing right. So why even try?"

Pat and Sam have repeated arguments that consist, literally and figuratively, of some variation of the following interaction:

PAT: I need more from you.

SAM: I am trying to please you.

PAT: You are not doing a very good job.

SAM: Yes, I am.

PAT: No, you are not.

SAM: OK, well then, I won't even try.

PAT: Now, you are really doing a bad job.

SAM: I don't care. I quit.

PAT: You don't love me.

SAM: You don't appreciate me.

These complaints are familiar to couple therapists. We have created Pat and Sam from the stories of many couples and given them unisex names so as to avoid both gender stereotyping and a heterosexist bias. One can easily imagine them as a gay couple, a lesbian couple, or a heterosexual couple, in which either partner might be the male or the female.

We use Pat and Sam as our example couple as we try to explain the therapeutic approach of integrative behavioral couple therapy (IBCT). Developed by Andrew Christensen and the late Neil S. Jacobson (Christensen & Jacobson, 2000; Jacobson & Christensen, 1998), IBCT is one of the new behavior therapies. Like other therapies discussed in this book, it emphasizes acceptance and mindfulness, but it does so within the context of a close relationship. To understand IBCT and what is new about it, it is useful to compare it to what we call traditional behavioral couple therapy (TBCT—often referred to as behavioral marital therapy or behavioral couple therapy in earlier writings; Jacobson & Margolin, 1979). At times, we also compare IBCT to traditional cognitive-behavioral couple therapy[1] (CBCT; Baucom & Epstein, 1990). As we discuss the differences between IBCT and TBCT, we use Pat and Sam as our example couple, showing how they might be treated with the different approaches. No matter how intriguing the differences in the conceptualization of a couple's problems, the changes that it seeks in the couple, and the methods for inducing change, however, the most important issue is whether the two treatments lead to different outcomes. Thus, we look briefly at some of the empirical data on these treatments.

CONCEPTUALIZATION OF COUPLE PROBLEMS

TBCT conceptualizes a couple's problems in terms of specific, target behaviors. Often, partners come into therapy with vague complaints about each other, such as "She is selfish," "He is not supportive," and "She can't communicate well." The TBCT therapist tries to pinpoint the specific behaviors that each partner would like changed. By turning vague, general complaints into specific target behaviors, the therapist helps the couple define its problems clearly. These definitions then pave the way for behavior change efforts that follow. For example, a TBCT therapist working with Pat and Sam would try to make Pat's general complaint that "Sam isn't there for

[1] There is a newer, "enhanced" version of cognitive-behavioral couple therapy (see Epstein & Baucom, 2002) that overcomes some of the limitations of traditional CBCT that we describe.

me and Sam's complaint that "Pat is always on my case" more specific and behavioral. In working with Pat's complaint, the therapist might discover that Pat means, in part, that Sam does not initiate conversation with Pat, such as asking about his or her day. Sam's complaint may mean, in part, that Pat criticizes Sam frequently about not making the relationship a priority.

A therapist who is more cognitively oriented might also attempt to identify some problematic cognitions associated with the problematic behaviors. For example, such a therapist would note the overgeneralized, "all-or-nothing" thinking that characterizes Pat, as in Pat's claim that Sam is "never there for me." A cognitively oriented therapist might suggest that Sam maintains the erroneous cognition that "avoidance solves problems."

IBCT focuses on a broader unit of analysis than TBCT or CBCT. Although it also seeks specific examples, it looks for the broad response class that characterizes each partner's complaints. For example, many of Pat's complaints concern the amount of closeness Pat gets from Sam, such as Sam's attention to Pat, interest in doing things with Pat, and responsiveness to Pat's desires. The term "closeness" could be the broader response class in which most of Pat's complaints fall. Furthermore, IBCT identifies the broad relationship theme in the struggle that characterizes a particular couple. This theme usually centers around a difference between partners on some fundamental dimension of relationship functioning. For example, Pat is extroverted and emotional, while Sam is shy and reticent. Pat does indeed want Sam to initiate more conversation, but Pat also wants Sam to initiate physical affection and sex, and to be more responsive when Pat initiates conversation, affection, or sex. In general, Pat wants an animated, emotional, energetic connection with Sam. On the other hand, Sam wants more time alone, more contact with friends, and more privacy. Although Sam does indeed also want fewer criticisms from Pat, this request seems like a reaction to their current struggle. In considering the broad response class of what each partner wants, the IBCT therapist might decide that the theme of "closeness versus independence" characterizes Pat and Sam's struggle. Pat wants a fundamentally closer relationship than Sam, who wants more individual independence than Pat.

Not only do TBCT and IBCT differ in the level of analysis with which they conceptualize the presenting problems of a couple but they also differ in how they conceptualize the reasons for the couple's struggle. TBCT may focus on the reciprocal interplay between problem behaviors, the way in which one problem behavior elicits another. For example, the TBCT therapist might suggest that Sam gets criticized because he or she does not ask about Pat's day, but Sam does not ask about Pat's day because he or she gets criticized so often. The TBCT therapist might further suggest that each partner is in a similar position of "I won't give because I am not being given to." A CBCT therapist would additionally propose that faulty thinking leads to these offending behaviors. Pat criticizes Sam so much, because Pat sees Sam in an extreme, all-or-nothing way ("Sam never shows any interest in me"). Similarly, Sam rarely initiates conversation, because Sam also sees Pat in overgeneralized terms ("Pat is always on my case").

In contrast, IBCT focuses on a broader, multilayered contextual framework for understanding interpersonal problems. IBCT looks at partners' individual histories, as well as their interactional history with each other, that may make them vulnerable to differences from their partner. Relevant history usually includes experiences in their family of origin, particularly relationships with their parents, and romantic history in previous close relationships. For example, Pat, an only child, was doted on by well-to-do parents, was used to lots of attention, and easily felt neglected if little attention was forthcoming. In contrast, Sam was from a lower socioeconomic class family with three children, in which both parents worked hard just to make ends meet. Because his or her siblings tended to do better in school, Sam often felt "less than" them. In fact, Sam generally felt inferior to others and was sensitive to criticism. A painful breakup with a partner that was more educated also contributed to Sam's sense of inferiority. Thus, Pat's history led him or her to be sensitive to any indication of neglect by Sam. On the other hand, Sam's history led him or her to be sensitive to comments, such as criticism, from Pat that might make him or her feel inferior.

In attempting to understand couples, IBCT therapists also focus on what attracts partners to each other. Sometimes these features are related to the very qualities that later lead to problems. Early in their relationship, Pat's and Sam's differences provided a positive connection between them. Pat's effusive style was great for Sam: It made Sam feel admired and appreciated in ways that Sam had never felt before. Also, Pat could be center stage with Sam, who was quite happy to give Pat plenty of attention and accommodate Pat's many needs and desires. At best, Pat was the "life of the party," a delightfully "over-the-top" person. On the other hand, Sam was reserved and quiet, but basked in Pat's reflected light and effusive praise. Pat could bring Sam out somewhat; Sam could meet Pat's needs.

As Pat and Sam each got involved with work and raising their two children, Sam became less attentive to Pat and less accommodating to Pat's needs. Pat became less praising of Sam. To cope with the loss of attention from Sam, Pat became critical and demanding of Sam. Pat told Sam what was wrong and what would make it right, but often in very angry and attacking ways. When threatened, Pat felt defensive and went on the attack. To cope with the loss of praise and increase in criticism from Pat, Sam became withdrawn. Withdrawal would at least end the criticism temporarily. When threatened, Sam retreated. Although, early on in the relationship, Pat provided the kind of positive reinforcement and validation that Sam sorely needed, now Pat provided the kind of criticism that raised Sam's old fears of being inferior. Although, early on, Sam had provided the kind of atten-

tion that Pat needed, now Sam withdrew in ways that made the relationship seem empty to Pat. Each of their ways of coping with the changes in their relationship stimulated even more of those negative changes. The more Sam withdrew, the more Pat criticized and demanded; the more Pat criticized and demanded, the more Sam withdrew. They were in a common but vicious cycle of demand–withdraw interaction (Eldridge & Christensen, 2002), and they both felt frustrated and hopeless to alter it.

This conceptualization of a couple's problems—a formulation in IBCT—consists of several components. First, there is the central theme of the couple's struggle—the difference or seeming incompatibility between partners. In the case of Pat and Sam, that theme is closeness–independence. Second, vulnerabilities in one or both partners that arise from some combination of their genes and history provide emotional fuel for their current differences. Pat's sensitivity to inattention and neglect, and Sam's sensitivity to criticism are examples. Third, each partner tries to cope with these differences in ways that seem reasonable to him or her but often unintentionally exacerbates the stress and polarizes their differences. Sam's effort to withdraw from Pat in order to achieve a level of desired independence increases Pat's anxiety, so that Pat pursues, criticizes, and makes demands on Sam, who then withdraws further from Pat. A vicious cycle of withdrawing and demanding then develops between the two of them. As they become polarized in their conflicting positions, each begins to vilify the other in his or her thinking—believing the other does not really love him or her, concluding that the other is "always" this (something bad) or "never" that (something good). Finally, the two may experience a variety of negative emotions that lead them to feeling "stuck" and "trapped." The harder they try, the worse the problem gets. They feel desperate but hopeless to change the situation.

In the first three sessions, IBCT therapists gather information necessary to create a formulation by interviewing the partners together (first session) and each partner alone (second and third sessions). In the fourth session of IBCT, the feedback session, the therapist shares the formulation with the couple. This sharing is done in a collaborative way, so that the partners can elaborate the formulation, amplify parts of the formulation, or alter parts that seem incorrect. If the therapist has really listened to both partners and incorporated their experience into the formulation, the couple usually accepts it as an accurate "story" about their problem.

The formulation guides the subsequent treatment sessions. The content of the treatment usually concerns recent, emotionally salient incidents, both positive and negative, that are reflective of the formulation. A example of a positive incident would be an occasion where Sam was able to respond to Pat's need for attention; a negative incident would be an occasion where Sam felt particularly hurt because of criticism by Pat and withdrew. Upcoming events that are of concern or broader issues of current concern are

also common topics. An upcoming weekend away where Pat is concerned that Sam will get involved with shopping and be inattentive would be worthy of discussion, as would some general discussion of their differing expectations of how they spend the weekend together. Each of these incidents and issues is good material for therapy, because it is directly or indirectly related to the formulation. An effort is made to avoid dealing with tangential problems that may arise in the course of treatment. If, for example, Pat and Sam came late to a session, annoyed at each other because of some miscommunication about where they were to meet beforehand, the therapist might give limited focus to that event, if it seemed largely irrelevant to their ongoing problematic concerns—that is to say, the formulation. However, the formulation is not a static conceptual framework for viewing the couple. As the therapist and the couple work together and get increasingly greater understanding of their issues, they may alter and enrich their formulation or the "story" of their concerns.

In IBCT, the formulation is a kind of conceptual scaffold upon which greater relationship mindfulness can be built. During the course of treatment, the couple becomes more aware of the interconnection between seemingly disparate events. Pat's harsh accusation that Sam has a "dwarf libido," and Pat's vigorous entreaty that they spend the day together, may be driven by similar motivations. If treatment is successful in IBCT, partners become attuned to each other's emotional responses. Pat begins to see Sam's withdrawal as defensive—an effort to protect rather than an effort to neglect. They become more mindful of the events in their relationship and the emotional impact of these events, and can thus respond to them differently.

EMOTIONAL ACCEPTANCE, BEHAVIORAL CHANGE, AND COGNITIVE CHANGE AS GOALS IN COUPLE THERAPY

In TBCT, the primary goal of treatment is behavioral change. As documented by extensive research (Weiss & Heyman, 1997), partners in distressed couples display relatively more negative behaviors and fewer positive behaviors toward each other than do their nondistressed counterparts. TBCT tries to alter that balance by increasing the frequency, duration, and intensity of positive behaviors and reducing the frequency, duration, and intensity of negative behaviors. If Pat makes statements that "Sam never listens to me" or "always withdraws during a disagreement," TBCT might teach Pat to use a more modulated style of description and avoid extreme terms such as "always" and "never." The assumption in TBCT is that a change in behaviors will lead to a change in cognitions and emotions.

In traditional CBCT, the focus is less on changing behavior than on changing or "restructuring" cognitions that may drive behavior. CBCT

therapists focus on cognitive processing, such as selective attention and "all-or-nothing" thinking, and cognitive factors such as attributions, which refer to partners' explanations of events in their relationship, and assumptions, which refer to partners' beliefs about marriage, men and women, and their partner, such as a belief that disagreement is bad for marriage. In dealing with Pat's "always" and "never" statements, a CBCT therapist might focus on Pat's tendency to attend selectively to Sam's negative behavior and the tendency toward "all-or-nothing" thinking about Sam. The assumption in CBCT is that a change in thinking will lead to changes in behavior and emotion.

In contrast to these approaches, the emphasis in IBCT is on emotional acceptance, the affective response that each partner has to the other. An IBCT therapist would explore each partner's emotional reactions, the conditions that elicit them, and the impact that they have. For example, in dealing with the issue of Pat's use of "always" and "never," the IBCT therapist would explore the conditions that elicit that response in Pat. At times, Pat gets so frustrated with Sam's lack of response that Pat, at the moment, feels like Sam is "never" there when needed. At other times, it is less a response to frustration than an attempt to goad Sam into action. In general, the use of extreme language is part of Pat's characteristic style of presentation: Pat can describe Sam as an "awesome lover" and as "having never really cared" over the course of the same day. In exploring Sam's response to Pat's use of language, the IBCT therapist might discover that, in emotional moments, Sam is angered and hurt by Pat's comments, feeling that nothing will ever please Pat, and vowing not to even try. Often, Sam feels "off center" with Pat, pulled reluctantly into Pat's emotional highs and lows, but sometimes enjoying the ride. IBCT assumes that when these emotional reactions are discussed in a nonjudgemental, empathic way, both partners, over time, become more mindful of each other's reactions and less negatively reactive to them. IBCT further assumes that these discussions create changes in partners' cognitive interpretations of each other's actions and changes in those actions themselves. Over time, Sam may view Pat's actions as less directed at Sam and more a reflection of Pat's mercurial moods. Pat may alter the frequency or intensity with which he or she makes "always" or "never" comments, or both may be able to recover more quickly from an incident in which such a comment disrupts their relationship.

In IBCT, interventions designed to foster emotional acceptance are applicable to a wide array of generally legal and moral behavior, but behavior that is often troublesome and emotionally upsetting. Acceptance interventions are appropriate to everyday behavior that leads to slights, annoyances, and hurts: a partner's outspokenness, a tendency to withdraw when stressed, preoccupation with work, pessimistic views, emotionality, flirtatiousness, and the like. However, dangerous and destructive behavior, such as physical violence and substance abuse, should *not* be the focus of acceptance interventions. Particular instances of these behaviors might be forgiven, but they should never be accepted. However, even within the broad array of behaviors that could be acceptable, IBCT provides no list of what specific behaviors should be accepted. IBCT generally accepts the values of each couple and each partner, as long as they do not promote destructive actions. Therefore, any list of acceptable actions would of necessity be individual. For most couples, sexual infidelity is unacceptable, but other couples find sexual infidelity, under certain conditions, acceptable. Likewise, particular individuals might find unacceptable a relationship with someone who did not want children, someone who was not of a particular religious faith, or a person who smoked. IBCT does, however, seek to lift the curtain of acceptability on a broader array of possible behaviors. When couples end IBCT, they are likely to be more mindful of their partners' actions and reactions, and more accepting of them.

In IBCT, acceptance does not mean submission, nor does it imply a lack of assertion. A focus on acceptance does not mean that IBCT attempts to communicate that partners should or must stay together. With the exception of illegal and destructive behavior, such as violence and substance abuse, IBCT therapists communicate no "should" messages.

At its most fundamental level, IBCT promotes acceptance of the following ideas: Each partner has feelings that are understandable; each partner has a story that makes sense; each partner has hold of some truth about the relationship; and each partner has a position on the problem that is worthy of attention and consideration. When there is little or no acceptance, the feelings may seem outrageous, the story may not make sense—it may seem to contain no truth, and the position itself may inspire ridicule. Out of this fundamental acceptance and the conversations that ensue from it, acceptance of more specific negative behaviors may emerge, such as greater acceptance of a partner's anger, or a greater acceptance of a partner's shyness about initiating sex.

To see the power and the limitations of acceptance, consider the distinction between an "initial problem" and a "reactive problem" (Christensen & Jacobson, 2000). The initial problem is the specific problem that the partners initially face. For example, Pat is more interested in sex than is Sam. The reactive problem emerges from the couple's attempts to deal with the initial problem. Pat and Sam argue about how often they should have sex. Pat accuses Sam of not having a healthy libido. Sam counters that Pat is oversexed. Sam's level of interest in sex is reduced due to the pressure to produce more, and Pat's level of interest in sex is increased because of deprivation. An emotional acceptance by each of the other's level of sexual interest would not solve the initial problem (the difference in sexual interest), but it would reduce all the reactive problems (the arguments, the accusations, and the reactive polarization of interests). Furthermore, acceptance may open up some possibilities for satisfying Pat's sexual needs that the

couple did not seriously consider before—such as masturbatory actions by Pat alone, or by Sam for Pat.

There is an important link between the IBCT notion of emotional acceptance of partner and the notion of individual acceptance that is dealt with elsewhere in this book. To accept the experience and behavior of a partner means that one must come to terms with—accept—one's own strong emotional reactions, such as feelings of anger, anxiety, and disappointment. These are the kind of strong feelings that lead one to attack, minimize, ridicule, avoid, or withdraw from the partner. If one accepts these personal feelings rather than acting upon them in these problem-enhancing ways, then one can accept the partner. Thus, acceptance of partner and acceptance of one's own upsetting feelings and thoughts go hand in hand. To truly accept the partner gives little room for experiential avoidance of one's own feelings. Consider, for example, Pat's negative feelings for Sam's mother, Betty. Sam had wanted so much for Pat to share the strong connection that Sam felt with Betty. For Sam to hear Pat's feelings about Betty, and Pat's desire to avoid Betty, arouses strong feelings of anger and disappointment. Sam has urges to attack Pat and to reject Pat just as Pat has rejected Betty, in order to quell Sam's strong emotions. To truly listen to Pat, Sam must accept his or her own feelings. Often, there is no more powerful stimulus for our own emotions than the feelings, experiences, and views of our partner.

METHODS FOR INDUCING CHANGE

Two Types of Change Strategies

The most common way that people deliberately induce behavior change in others is through instruction and training. Instruction usually includes the rationale for the desired behavior and a description of it. Training involves modeling of the desired behavior, practice or rehearsal of it, and corrective feedback. The parent instructs a child to cook on the stove by telling the child about cooking and providing rules about what to do and what not to do. The parent may then model the appropriate behaviors for the child, watch the child practice the behaviors, and provide corrective feedback.

TBCT therapists have adopted these strategies to train couples in better communication and problem solving. The therapist instructs the couple in the purpose and value of specific communication strategies, such as "I statements," "paraphrasing," and "problem definition." The therapist may demonstrate these behaviors for the couple, and then have the partners practice them in the session. Then, the therapist provides corrective feedback about their performance of these skills.

Instruction and training is not required for many behaviors that a therapist may want to induce in clients, because the necessary behaviors are already in their repertoire. Simple requests, encouragement, or demands, perhaps buttressed with appropriate explanations, are all that is necessary. A parent asks the child to cook the dinner tonight, knowing the child has the requisite skills.

TBCT adopted this simple approach of requests and encouragement to elicit positive interaction between partners. In the strategy of behavioral exchange, therapists encourage partners to develop lists of positive actions they could do for each other, then ask them to engage in "caring days" (Jacobson & Margolin, 1979), when they will do a number of these positive acts. In a less formal way, therapists may encourage the couple to have a "date night," to go away on a weekend, or to spend some special time alone with each other every evening. These strategies of direct request are hardly unique to TBCT and find their way into a variety of approaches. Solution-focused therapy (Hoyt, 2002) is almost exclusively based on the identification and encouragement of positive actions by the couple.

These strategies of instruction, training, and direct requests are effective methods of behavior change when the person being changed wants to learn or engage in the behaviors. However, they are not very effective if the person to be changed is not interested, is motivated to do something else, or is disrupted by the presence of strong emotions. For example, telling people the value of eating less food overall and more healthy food in particular has been rather dramatically unsuccessful, even though most people believe in the validity of the message. Despite the public health message, Americans keep putting on weight, simply because unhealthy food is rewarding to eat. Similarly, training people in appropriate exercise regimens has often proven ineffective. Despite widespread information on exercise, most Americans remain physically unfit—because exercise requires consistent effort and is often unrewarding.

Distressed couples present a serious challenge to these methods of inducing behavior change through instruction, training, and direct requests. When talking about an emotional problem, they may be highly motivated to say an accusatory "you" statement, despite their training in "I" statements. Although they may be encouraged to engage in positive activities by the therapist, they may be unwilling to do so when feeling angry and resentful. Even though they have practiced reflective listening, their nonverbal behavior to their partner's provocative communication may indicate anything but understanding. They may summarize their partner's position in a tone that ridicules that position.

To understand the methods of IBCT, and to differentiate them from those of TBCT, a distinction by Skinner (1966) between rule-governed behavior and contingency-shaped behavior is helpful. In the former, behavior is under the control of an explicit rule generated through training or explicit suggestions (e.g., "Do aerobic exercises at least 3 times a week for a half a hour"). Reinforcement occurs because of compliance with the rule.

For example, the exercise trainer rewards the performance of the aerobic exercise or the individual person rewards him- or herself ("It feels good that I did something for my health"). In contrast, contingency-shaped behavior comes about as the natural stimuli and reinforcers in the situation guide relevant behavior. For example, a group begins playing basketball together. They find it enjoyable and join a local league; they end up practicing a couple times a week and playing a game once a week. Their behavior is shaped by the contingencies generated by the group (the pressure to participate and not let the group down, the reinforcement generated when any member plays well, when they win, and when they go for drinks afterward and debrief the game). Their behavior happens to meet the aerobic rule, but only coincidentally; the rule has little or no control over their behavior.

Although rule-governed and contingency-shaped behavior can generate behaviors that look, at first glance, to be virtually identical, they create a different feel. Rule-governed behavior is likely to feel more effortful; contingency-shaped behavior more spontaneous and natural. Contingency-shaped behavior may be more likely to persist, as long as the contingencies remain in place.

With its emphasis on behavior exchange, and communication and problem-solving training, TBCT seeks to induce change through rule-governed behavior. Similarly, traditional cognitive-behavioral approaches seek to alter thinking through rule-governed approaches. The therapist asks clients to track their cognitions about the relationship and trains clients to actively refute any dysfunctional cognitions. For example, if the client identifies a thought that the partner is not loving enough, the client is asked to analyze the evidence for and against that notion, looking in particular for evidence that would constitute an exception to that notion.

In contrast to both TBCT and cognitive approaches, IBCT attempts to induce change through contingency-shaped strategies. Rather than encouraging clients to engage in different behaviors, IBCT therapists call attention to overlooked actions, thoughts, and feelings; they highlight specific actions, thoughts, and feelings that may be glossed over, and they elicit new reactions in each partner. Consider how an IBCT therapist might work with Pat and Sam's pattern of accusation and withdrawal.

PAT: (*to Sam*) I don't know what goes on with you. You just don't engage in the relationship at all. You are completely passive, out to lunch.

THERAPIST: (*to Pat*) You mentioned not knowing what goes on with Sam. You are kind of confused by Sam.

PAT: Yes.

THERAPIST: (*to Sam*) I noticed that when Pat started talking to you, you kind of turned down, and there was a look on your face . . .

SAM: When Pat gets on my case like that, I just tune out.

THERAPIST: For you, it's same old, same old.

SAM: Yes, completely.

PAT: (*agitated*) So you turn off no matter what I say. You can't handle anything I might have to say.

THERAPIST: I think you put your finger on a real bind you are in, Pat. You have something important to say to Sam, something very important, but you don't know if there is any way that you can say it that will get heard. So you end up having no voice in this relationship.

PAT: That's right. And me without a voice is not me. (*smiles; half-chuckles*)

THERAPIST: (*to Sam*) I think that, for very different reasons, you are, oddly enough, in a very similar bind. You have things to say also, but you are so often taken with protecting yourself, taking cover, from what comes across to you as Pat's accusations, that you don't get a chance to focus on what you want to say.

SAM: I hadn't thought of it that way, but it might be true.

In this short exchange, the therapist does not suggest any rules for the couple or correct Pat and Sam for not following rules, such as the rule about "I statements," or the rule about listening by paraphrasing. Instead, the therapist repeatedly refocuses the conversation and highlights less obvious aspects of it. For example, the therapist focuses on the confusion in Pat's accusation (that Pat is confused about what is going on with Sam). The therapist calls attention to Sam's nonverbal withdrawal and reinforces Sam for discussing the withdrawal. It is more productive to discuss withdrawal, which is not withdrawing, than to withdraw. At that point, Pat gets agitated and goes on the attack, but the therapist focuses on the bind Pat is in and suggests that Pat has no voice. Pat smiles at the irony—that a talker such as he or she is would have no voice—but sees the truth in it. Then, the therapist links Pat's predicament to that of Sam. It is a new idea to Sam that neither has any effective voice in the relationship, but Sam considers the notion tentatively. In each of these interventions, the therapist seeks to change the adversarial context of accusing and withdrawing to a more collaborative context, in which each partner has difficulty voicing his or her concerns about the relationship. Also, the therapist may shift Pat's and Sam's views of each other. For Sam, there may be a tiny shift from "Pat is attacking me" to "Pat is attacking me because he or she is confused about what is going on with me." For Pat, there may be a tiny shift from "Sam always withdraws from me" to "Sam withdraws from me but has things to say to me." Certainly, many conversations, much more extended than the one just described, will be required to achieve the kind of contingency-shaped changes that are the goal of IBCT. Yet even in this short exchange, the therapist shapes a new, more productive conversation by shifting the stimuli to

which each partner responds and finding ways in which each partner can be reinforced for expressing, or having expressed, his or her experience in the relationship.

Contingency-Shaped Strategies to Promote Acceptance

Having made this essential distinction between two different kinds of change strategies, we can now consider the three specific strategies that IBCT uses to promote acceptance: empathic joining around the problem, unified detachment from the problem, and tolerance building. All three rely on contingency-shaped strategies of change. IBCT does not tell clients that they should be more accepting, or tell them what they should accept. Rather, it tries to create conditions under which partners will naturally increase in their emotional acceptance of each other.

Empathic Joining

In this strategy, IBCT therapists suggest or elicit feelings associated with the couple's problem that are not commonly expressed. These feelings may be unexpressed because they are embarrassing or vulnerable, or because the partner is only dimly aware of them. These emotions, once voiced by one partner, may then elicit more constructive and sympathetic responses in the other. In this way, IBCT therapists attempt to generate an empathic connection between partners around the very issues that drive them apart.

Partners are liable to first discuss their problems by expressing "hard" feelings and thoughts that present the self as strong and point an accusing finger at the other. For example, Pat frequently expresses anger and frustration at Sam and catalogues Sam's inadequacies. These expressions typically lead to defensiveness, counterattack, and withdrawal. IBCT therapists look for the "softer," more vulnerable feelings and thoughts that may also exist alongside the harder feelings and thoughts. IBCT therapists may probe for feelings of disappointment, neglect, and hurt, or feelings that suggest uncertainty, confusion, and doubt. However, even these softer feelings and thoughts may be presented in an accusatory way. Pat may acknowledge feelings of hurt or neglect but voice them as attacks ("You always hurt me"), or admit to confusion and uncertainty about Sam's intentions, but in a manner that leaves little doubt about fault or responsibility ("You would confuse anyone with your lack of response"). So it is a challenge for the therapist to create a therapeutic environment where partners feel safe to express soft feelings and thoughts that portray their raw vulnerability to the other.

Although soft, vulnerable feelings are often the focus in empathic joining, it is important to note that it is the function of the behavior, not its topography, that matters. If one member of a couple commonly expresses soft, vulnerable feelings that the other regularly ignores, IBCT would not target repetitive expression of these feelings as a goal. The therapist would want to find out how these expressions are being received by the ignoring partner, and how the expressing partner reacts to the reception. This exploration might elicit hard feelings and thoughts in the expressing partner that probably exist alongside the frequently voiced but regularly ignored expressions of vulnerability. These are the kind of emotions that, in this case, might command the attention of the partner and elicit a more engaged response.

Similarly, in working with a withdrawn partner such as Sam, the IBCT therapist might try to elicit any response whatsoever, even a hard expression. Any engagement, unless it is actively destructive, may be a good first step for a withdrawn partner and may function to interrupt the engaged partner's domination of air time between them. In the earlier example, the therapist reinforced Sam's initial response that "Pat gets on my case." Of course, the goal is not to turn an "attack–withdraw" pattern into a "mutual attack" pattern, but there are often a number of steps, many of them faltering, in shifting the context between partners from adversaries to sympathetic partners.

Unified Detachment

In contrast to the emotional focus of empathic joining, the emphasis in unified detachment is on creating objective, intellectual distance from the problem. In empathic joining, IBCT therapists alter an ongoing battle between partners by getting them to notice and attend to each other's wounds. In unified detachment, IBCT therapists ask couples to move to a better vantage point, use their binoculars, and observe their ongoing battle.

In unified detachment, IBCT therapists often engage the couple in a descriptive analysis of the sequence of behavior that makes up a particular problematic interaction. For example, suppose Pat and Sam had a difficult evening out at dinner. At the following session, the therapist might enlist the partners' assistance, as relationship detectives, to discover the triggering events that led their interaction astray. Together, they would describe and explore the sequence of events: At first they were doing fine, but the initial triggering event occurred when Pat talked about a problem at work and did not think Sam, examining the menu, was appropriately attentive. Annoyed, Pat made a sarcastic comment about Sam memorizing the menu, which was a triggering event for Sam, who then actively ignored Pat. And the two of them were off and running. The therapist might link this incident to the formulation and characterize it as a case of lack of attention leading to accusation, leading to withdrawal, leading to further accusation.

IBCT therapists also engage couples in comparative analyses of individual incidents. For example, suppose Pat and Sam had another evening

out to dinner the following week that went well. The therapist might inquire whether there were any potential problems that they had to navigate. If there were, the therapist would help the partners identify specific actions, however subtle, that each took that enabled him or her to recover. Perhaps Pat, despite annoyance at Sam for inattention, repeated his or her comments, albeit with some tension in his or her voice. Sam suppressed the urge to withdraw from the accusatory tension in Pat's voice, and they were able to recover from a potentially disruptive experience.

Using metaphors, giving problems names, and invoking humor are also ways of creating distance from a problem. For example, depending on their sensibilities, Pat and Sam might respond to names such as "Mount Vesuvius" for Pat and the "cave dweller" for Sam. Mount Vesuvius erupts regularly, but the cave dweller always has available protection. However, the therapist must be careful that the humor does not deride either partner, or that names and metaphors are not used as weapons.

In general, the strategies of unified detachment serve to treat the problem the couple faces as an "it" rather than a "you." Sometimes IBCT therapists use props to objectify the problem and place it outside the relationship. For example, the therapist might suggest that the partners put their problem on an empty chair in the therapist's office and discuss the problem, or express their frustration with it, as "it" is sitting there. The therapist might also suggest that the partners have a chair for the therapist in their home, where they can go to and complain about the problem. Although these particular actions can come across as "gimmicky," their usefulness with a particular couple is judged by whether they achieve their function of detaching the couple from the problem. Because therapists have only limited knowledge of partners' unique histories, there is always some trial and error in finding out which particular types of unified detachment or empathic joining strategies will work.

Promoting emotional acceptance through unified detachment and empathic joining is conceptually distinct. The former is focused on objective analysis of a problem, while the latter is focused on an emotional exploration of the problem. However, in practice, the two strategies are often used together. For example, in debriefing an incident, the IBCT therapist may not only help the partners articulate the important behaviors that unfolded in the sequence of their interaction, and how these behaviors are similar to or different from their usual pattern (unified detachment), but also explore the emotional reactions that each experienced at different points in the sequence (empathic joining). Both strategies lead to what we might call greater "relationship mindfulness," a nonjudgmental awareness of negative relationship roles and interaction patterns, without as much emotional participation in the roles or patterns. That is to say, both strategies make partners more aware of what is happening within themselves and within the other as they go through a problematic sequence of interaction. As one is more aware of the complex stimuli that constitute a situation, he or she may respond less negatively. One has a greater number of response options to the situation.

Tolerance Building

An important assumption of IBCT is that many important differences between partners, and the problems those differences create, will never be completely erased. Barring major head trauma or psychosurgery, Pat will always be more opinionated, more vocal, and more desirous of attention and contact than Sam. Similarly, Sam will always be more self-conscious, more deliberate, and more desiring of privacy than Pat. So the demons that Pat and Sam have, and the demons that most couples have, can never be destroyed. But they can be tamed. The intensity of a couple's problems can diminish. The power these problems have over the emotional climate of the relationship can be undermined.

Because of this notion that each couple has a perpetual problem with enduring dynamics (Huston, Niehuis, & Smith, 2001), IBCT emphasizes the management of problems rather than their elimination, and emphasizes recovery from problems rather than their prevention. The several strategies of tolerance building assume that problems will reappear but focus on ways to manage them better or recover from them more quickly. Thus, tolerance building is based on an acceptance of the continued existence of a problem.

One important strategy for tolerance building is to have couples enact negative behavior in the session. In this strategy, IBCT therapists instruct partners to deliberately enact clearly defined, negative behaviors that are part of their perpetual problem. For example, a therapist might ask Pat and Sam to enact a typical problematic episode in which Pat is critical and Sam is defensive. The therapist would not do this when Pat is, in fact, feeling critical and Sam is feeling defensive. Rather, it is important to enact the episode when neither partner is feeling the requisite emotions. Why? When the only instigation of a negative episode is the therapist's instructions, the couple will experience the episode very differently. Partners will likely see their own and their partner's behaviors more clearly and thus increase their mindfulness of their problematic pattern. Because the pattern is not provoked, they will probably experience less intense and different emotional reactions than usual. They may see that it is possible to respond in ways other than their usual response. They may experience some desensitization to the usual provocative behavior.

Couples sometimes have a difficult time enacting negative behavior. They may make such a poor attempt at imitating themselves that they smile, giggle, or laugh at the results. This kind of reaction is hardly viewed as a failure. In fact, it provides an excellent occasion for unified detach-

ment. The therapist can join in and promote their view of their problem from a humorous vantage point.

Sometimes individuals can enact negative behavior in such a way that it does trigger emotional reactions in the partner. Most of the time, these emotional reactions are smaller versions of the usual reaction. The therapist can use whatever emotional reactions are generated as an occasion for empathic joining. Because the reactions are not as strong as usual, it may make the exploration and elaboration of emotional responding easier for the therapist to conduct and easier for the partner to empathize with, hear, and understand.

The therapist can follow an enactment of problematic behavior with an enactment of appropriate problem management. For example, the therapist may encourage Pat to enact criticism but encourage Sam to respond to it differently, or ask Sam to respond defensively with Pat and ask Pat to respond differently to Sam's defensiveness. It is, of course, easier to manage difficult behavior when one is not upset, so when the couple is able to manage problematic behavior well in the session, the therapist notes that partners may not be able to do so as easily when their emotions are triggered.

The therapist may also follow the in-session enactment with an assignment to enact a problematic interaction at home, when partners are not actually upset. For example, Pat might be asked to initiate criticism of Sam when he or she is not feeling particularly critical. Pat can therefore observe Sam's reaction more clearly and objectively. Pat is to reveal the ruse immediately, so that a true problematic interaction is not generated by a staged one. Sam is present when the therapist gives the assignment, so Sam's automatic reaction to Pat's criticism may be disrupted. After all, maybe it is not "real."

There are other strategies in tolerance building. The therapist may engage the couple in an analysis of the positive benefits that result from the differences that partners normally experience as negative. At the very least, differences between partners serve a kind of balancing function (e.g., the optimism of one is balanced by the pessimism of the other). Often, the differences are part of a central attraction between the couple. For example, Pat's sociability, particularly his or her generosity with praise, made Sam feel appreciated. Sam's reticence made it easy for Pat to be center stage. Another strategy is to look for alternate sources to fill needs that the partner has difficulty in meeting. Pat certainly needs other friends to fill the need for social contact.

Each of these "tolerance building" interventions communicates to the partners that their problem will reappear but can be managed. These interventions serve a kind of relapse prevention function in couple therapy. They prepare the partners for the inevitable reappearance of some of the problems that brought them to therapy in the first place.

Deliberate Change Strategies in IBCT

Although the focus of IBCT is on building emotional acceptance, with the assumption that emotional acceptance often brings about important behavior changes, IBCT also employs the traditional change strategies of TBCT: behavior exchange, communication training, and problem-solving training. Usually, the IBCT therapist starts out with acceptance strategies, but if a couple's initial presentation suggests that traditional change strategies would solve the problem and that the couple would be responsive to these strategies, then the therapist should start with change. For example, if a couple presents with a specific problem and is not in an adversarial role vis-à-vis each other, then the therapist might begin treatment with problem solving. However, the more frequent sequence is that IBCT begins with acceptance strategies, then shifts to change strategies when partners are more collaborative with each other but need to increase their positive interaction, improve communication, or negotiate differences.

When traditional change strategies are conducted in IBCT, they are usually implemented in a more individualized, less formal, and less rule-governed way. To make the change interventions more individualized, IBCT therapists would use the formulation of the couple's problem to inform behavior exchange, communication training, and problem solving. By using the formulation as a basis for these traditional interventions, the IBCT therapist may increase partners' mindfulness of their common patterns and alternatives to those patterns. For example, based on the formulation for Pat and Sam, the IBCT therapist would know that any initiation of contact by Sam toward Pat would likely be reinforcing for Pat. So behavioral exchange exercises that led to those kind of initiations would be encouraged.

To make change strategies less formal and less rule-governed, IBCT therapists often reduce the number of rules for change strategies, move toward more general principles, and modify rules according to what will help the couple most. For example, rather than teach couples to use specific "I statements" or to use the *XYZ* formula ("When you do *X* in situation *Y*, then I feel *Z*), the therapist might simply encourage partners to talk more about themselves and their own emotions when discussing problems. For example, the therapist might say to Pat, "Sam needs to hear more about you and your feelings, rather than your thoughts or opinions of him or her." Traditional problem solving is guided by a number of rules, such as "Start off the discussion with a positive statement about your partner relevant to the discussion" and "Don't move on to the solution phase until you have clearly defined the problem." IBCT therapists should only incorporate rules if they are essential to success for a particular couple. For example, if Pat and Sam mix the consideration of solutions with the definition of the problem, but this mix usually does not derail the discussion, then the thera-

...wise to leave the rule in the rule book. Sometimes a consideration of possible solutions helps define what the real problem is.

IBCT therapists are not as optimistic as TBCT therapists that couples can make many changes in their behavior and that these changes will persist. Therefore, IBCT therapists attempt to make only those deliberate changes in behavior that are essential for constructive functioning in a particular couple. Rather than a position of changing as much as can be changed, IBCT therapists change as little as is needed. In that way, IBCT therapists hope that a few important changes may persist.

Finally, IBCT therapists often return to acceptance strategies when change strategies stimulate strong emotions or elicit patterns of polarized interaction. Empathic joining, unified detachment, and tolerance building may therefore be mixed in with the change process. IBCT assumes that both acceptance and change will be required to alter most of the presenting problems that trouble couples. The preference in IBCT is that greater emotional acceptance will lead to unstructured, "spontaneous" change in couples as a result of different experiences of the partners. However, IBCT does incorporate efforts toward deliberate, structured change in therapy, but often these efforts involve an integration of acceptance and change strategies, much like the integration of acceptance and change that is the solution to couples' presenting problems.

EVIDENCE FOR THE EFFECTIVENESS OF INTEGRATIVE BEHAVIORAL COUPLE THERAPY

IBCT was developed in part because of the limited outcome results from TBCT. There is more evidence on TBCT than on any other couple treatment. TBCT has consistently performed better than control groups, and, by American Psychological Association Division 12 standards, TBCT has reached the highest level of empirical support, that of an "efficacious and specific treatment" (Baucom, Shoham, Meuser, Daiuto, & Stickle, 1998; Shambless & Hollon, 1998). However, despite this positive support, the evidence indicates that only a bare majority of couples make reliable improvements during therapy, and only about one third recover at the end of treatment, that is to say, look more like normal than distressed couples (Jacobson et al., 1984). Furthermore, the evidence indicates poor maintenance over long-term follow-up (Jacobson, Schmaling, & Holtzworth-Munroe, 1987; Snyder, Wills, & Grady-Fletcher, 1991).

Also damaging to TBCT is some of the evidence on therapy process. Although changes in communication are the presumed mechanism for improved satisfaction in TBCT, research has shown that changes in communication are inconsistently related to improvements in satisfaction (e.g., Baucom & Mehlman, 1984). Also, couples often do not continue using the skills they learned in therapy (Jacobson et al., 1987).

IBCT was developed with the prediction that it would be at least as powerful as TBCT in the short-term and more powerful than TBCT in the long-term (Jacobson & Christensen, 1998). There have been three studies of IBCT that provide support for that prediction. In a dissertation, Wimberly (1997) showed that an IBCT group treatment for couples was superior to a wait-list control group. In a preliminary study Jacobson, Christensen, Prince, Cordova, and Eldridge (2000) showed that experienced clinicians could deliver both TBCT and IBCT to couples, that TBCT generated levels of reliable improvement consistent with previous research, but that IBCT generated somewhat higher levels of improvement in satisfaction (80% of couples in IBCT and 64% of couples in TBCT demonstrated clinically significant change). A major, two-site clinical trial is currently under way (Christensen et al., 2004) that examines treatment response in a sample of chronically and seriously distressed couples. Immediate posttreatment results indicate that IBCT and TBCT couples showed substantial improvements in relationship satisfaction during treatment, that IBCT couples improved steadily over treatment but that TBCT couples improved more quickly early in treatment but then leveled off later in treatment, and that IBCT couples showed a nonsignificantly higher level of reliable improvement in satisfaction than TBCT couples (71% of couples in IBCT vs. 59% of couples in TBCT). Couples are assessed every 6 months for 2 years following treatment. Although all couples have not yet reached the 2-year follow-up, a majority have. Analysis of the available data indicates that IBCT couples maintain and improve their satisfaction over 2 years significantly more so than do TBCT couples. In addition to this outcome data, studies of the process of change in therapy, not yet completed, will address the mechanisms by which both TBCT and IBCT improve relationship satisfaction. Although there are much more data to come, the evidence so far is extremely promising in its support of IBCT.

CONCLUSIONS

In this chapter, we have described IBCT (Christensen & Jacobson, 2000; Jacobson & Christensen, 1998) by comparing it to TBCT (Jacobson & Margolin, 1979) and to a lesser extent, traditional CBCT (Baucom & Epstein, 1990). IBCT differs from other behavioral couple therapies in its focus on broad response classes versus narrow target behaviors, its focus on emotional acceptance over direct behavioral change, and its emphasis on contingency-shaped versus rule-governed change strategies. IBCT is similar to many of the individual therapies described in this book because of its

focus on emotional acceptance and mindfulness, although in IBCT, the focus of acceptance and mindfulness is the relationship. When IBCT is successful, partners become more emotionally accepting of each other, although this acceptance often requires an acceptance of strong emotions within themselves. Similarly, partners become more mindful of the contingencies that exist within their own relationships and are thus able to respond in more diverse, flexible, and constructive ways in their relationships. Currently available data provide promising support for the ability of IBCT to improve functioning in distressed couples.

In the course of this chapter, we followed Pat and Sam as they may have experienced IBCT. At the conclusion of therapy, Pat was effusive in praise of the therapist and therapy, emphasizing, of course, the benefit that both had had on Sam. In contrast, Sam gave a more muted reaction to therapy but did acknowledge that it had been helpful, and gave the therapist a warm handshake at the end.

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