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COUPLE THERAPY FROM THE PERSPECTIVE OF SELF PSYCHOLOGY AND INTERSUBJECTIVITY THEORY

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Central tenets of self-psychology and intersubjective systems theory (e.g., Stolorow & Atwood, 1992) are applied to the understanding and treatment of couple. The concepts of selfobject needs, unconscious organizing principles, and learned relational patterns are used to conceptualize common couples difficulties. A treatment approach is outlined, involving: (1) listening from within each partner's subjective perspective; (2) establishing a therapeutic dialogue through which each partner's selfobject needs, ways of organizing experience, and patterns of relating can gradually be empathically illuminated and transformed; and (3) facilitating new relational experiences with the couples therapist and eventually between the partners. Four concepts of self psychology that are particularly useful with some of the most challenging aspects of couples work are then discussed. Finally, the judicious use of directive interventions with couples is discussed as consistent with this perspective. A case example is used throughout the paper to illustrate key points.

Keywords: couple therapy, self psychology, intersubjectivity

Couple therapy is hard. It is hard enough to immerse yourself in and make sense of the internal world of one person, let alone two. Moreover, the couples therapist endeavors to track not only each partner's subjective experience, but also the process and quality of interactions between the partners, those between herself and each partner, and her own internal experience. She attempts to respond in an attuned manner to each partner's needs, while trying to keep the two traumatically injuring each other in the very setting that is supposed to be bringing them closer. As Livingston (1995) has aptly described, the couples therapist leaves behind the relatively ordered world of individual treatment and

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falls "down the rabbit hole" to the world of couple therapy, where "chaos and a recurrent dread of retraumatization reign" (Livingston, 1995, p. 248).

This form of treatment is difficult regardless of theoretical model, but a clear theoretical understanding of the reasons for couples' difficulties and of ways to facilitate change can structure and "hold" the couples therapist so she can better hold and respond to even the most difficult couples.

A contemporary self-psychological, intersubjective psychoanalytic framework offers a wealth of concepts that are particularly applicable to the unique challenges of couples work. The concepts of selfobject experience, unconscious organizing principles, and learned relational patterns; an emphasis on listening from within the patient's perspective; and the model's approach to defensiveness and aggression, in particular, make it extremely useful for understanding and intervening with troubled couples. This framework differs from the classical and object relations approaches to couples treatment (e.g., Dicks, 1967; Scharff & Scharff, 1991) in a number of important ways, and thus offers an alternative psychoanalytic approach to this challenging but often powerful and rewarding form of treatment.

Literature Review

Solomon (1985, 1988a, 1988b, 1989) was among the first to note the implications of Kohut's work (Kohut, 1971, 1977, 1984) for the treatment of couples. She focused on the model's usefulness in the treatment of particularly narcissistically vulnerable partners. Schwartzman (1984) also discussed narcissistic transferences between partners.

A number of authors later addressed the application of intersubjectivity theory (Stolorow, Brandshaft, & Atwood, 1987), later known as intersubjective systems theory (Stolorow & Atwood, 1992), to couple therapy. Ringstrom (1994) proposed a six-step model that emphasizes the validity of each partner's subjective perspective, the selfobject needs underlying their complaints, and the tendency to reenact the past to maintain a sense of self-organization. Trop (1994) focused more narrowly on the influence of each partner's unconscious organizing principles on their experience of each other, and discussed countertransference in couples work from an intersubjective perspective (Trop, 1997). Incorporating concepts from nonlinear dynamic systems theory, Shaddock (1998, 2000, 2002) has offered illustrations of his intersubjective approach and the possibilities for facilitating deep individual change within a couples treatment context. Livingston has contributed a series of papers applying the concepts of transference and countertransference (Livingston, 1995), conflict and aggression (Livingston, 1998), "vulnerable moments" and vulnerability (Livingston, 2001), and working with dreams (Livingston, 2001) to couple therapy.

Most recently, Rubalcava and Waldman (2004) and Howard (2004) have discussed work with intercultural couples. The former paper emphasizes the difficulties in mutual selfobject responsiveness that can arise secondary to different "cultural organizing principles" (Rubalcava & Waldman, 2004, p. 134), while the latter incorporates concepts from attachment theory into an overarching self-psychological, intersubjective approach.

Together, this body of work offers a wealth of thoughtful theoretical ideas and clinical material that can be enormously useful to clinicians struggling with the many challenges involved in treating couples. The present paper will highlight, illustrate, and extend this previous work in an effort to offer an integrated summary of a self-psychological, intersubjective approach to couple therapy.

Selfobject Experience and Selfobject Failure in Couples' Relationships

The concept of selfobject experience, as originally proposed by Kohut (1971, 1977, 1984) and revised and extended by others (Stolorow, Brandshaft, & Atwood, 1987), captures much of what people are generally looking for in couples' relationships: experiences that help them consolidate and maintain a positive, cohesive sense of self. More simply, people want a partner who makes them feel better, not worse. This generally means someone understanding, positive, and affirming; someone they can look up to, admire, and lean on in times of stress, who helps with the experience, modulation and integration of affect; and someone with whom they feel a sense of essential likeness and belonging—in other words, someone who functions as a reliable source of selfobject experience.

Troubled, conflictual couples are not reliably able to provide these experiences for each other. A lack of needed selfobject experience underlies most or all couples' presenting problems, whether the problems involve conflict or disengagement, and whether overtly about sex, money, housework, parenting, in-laws, or whatever.

For example, conflicts about money often involve one partner's need for the selfobject experience of safety and security provided by saving versus the other's need to feel affirmed, stimulated, soothed, or otherwise enhanced by buying or spending. Conflicts about in-laws are often about mutual needs for affirmation and validation. One partner needs to feel his or her family of origin is seen positively and valued (or at least understood in context), whereas the other needs the affirmation of feeling that he or she is now central in the partner's life, and that any hurtful experiences with the in-laws are empathically understood and responded to. Each of the other common couples' issues listed above can be similarly translated into the language of underlying selfobject needs and failures, as the following case illustrates.

Case Example

Mike and Ann fight constantly about household tasks. "How can you not hear that cat meowing with hunger, not see the wilting, unwatered plants, not worry about those unpaid bills? Grow up!" she screams at him, literally and figuratively. "Take care of stuff! Don't leave me feeling like the only adult here! How did I end up—once again—back in a relationship where I am always the caretaker, the driver, the more competent one—just as I was as a child?"

Mike, for his part, feels overloaded, worried about work, unappreciated for what he does do, and constantly criticized and sexually rejected by his wife. "Nothing I do is ever enough," he says. "I'm always in the doghouse, just like I was growing up." He has married another version of his critical mother and grandmother, the last thing he wanted to do or thought he was doing. He vacillates between trying to please Ann ("Just tell me what to do and I'll do it") and withdrawing into work or TV, an option which leaves him even less aware of Ann and her needs.

Ann and Mike's overt complaints and conflicts about housework, criticism, and sex are understood in this model as expressions of unmet selfobject needs. Ann needs the house neat and the bills paid on time to relax and feel soothed (to counter a sense of inner disorganization), and to feel she's with a competent and capable man who can take care of her. An orderly home is also a source of pride and self-esteem for her.

In contrast, Mike feels more relaxed and soothed when he doesn't worry about staying on top of things, when home does not become yet another place of demands and tasks—even if that means the place is messy or bills get paid late sometimes. For him, a more

casual attitude toward these things means he's not in his tense, uptight childhood home, but in a haven where he is accepted and affirmed as he is, messy and all.

Differing needs regarding housekeeping are only the beginning for this couple. Ann also needs closeness to relax and feel soothed, while Mike needs more distance for the same purpose. She finds going out to the theater, symphony, or dinners with friends stimulating and enlivening, whereas Mike finds these only occasionally pleasurable and not nearly as much of a source of selfobject experience. He is hurt by Ann's disdain for people who don't value these experiences as much as she does. Finally yet importantly, sex is an important source of selfobject experience for Mike, the best way he knows to feel desirable, affirmed, and potent, as well as soothed and nurtured. Not surprisingly, for Ann it feels more affirming and reassuring when Mike wants to be with her without sex, because sex is not a primary source of soothing or affirmation for her.

This example illustrates how common complaints and sources of conflict between partners reflect unmet selfobject needs, especially when one person's need for a particular experience is directly at odds with the other's equally legitimate need for the opposite experience. These competing selfobject needs occur in both happy and unhappy relationships, although certainly some couples, like Ann and Mike, are more exquisitely mismatched than others. The extent of the differences in needs matters less than how the couple experiences and responds to the inevitable empathic ruptures they cause.

The case also illustrates that despite people's best efforts to find a relationship that will repair old wounds, they so often end up in yet another one that seems to repeat early or previous selfobject failures. Relationships that once held such great promise, like Ann and Mike's did not so long ago, seem to turn, almost inexorably, into painful repetitions of previous selfobject failures.[1]

How and why does this happen so often, and how can we help couples out of these painful, destructive situations? From this perspective, the answers lie in each partner's self-organization, internal capacities, and selfobject needs, in the ways each has come to organize the experience of others, and in their resulting interactional patterns.

State of the Self of Each Partner

Couples' relationships are highly influenced by the extent to which each partner has developed a positive, cohesive sense of self and the ability to articulate, regulate, and integrate affect. People who have not done so are more dependent on others to provide self-functions, such as affirmation or soothing. They are more reactive to injuries or selfobject failures, and either too overwhelmed by their own affective experience (like Ann) or too affectively deadened (like Mike) to empathically grasp and respond to the experience of others. These deficits thus leave them with more intense needs for responsiveness, yet less capacity to be responsive.

Both Ann and Mike have significant deficits in self-esteem and affect regulation, which helps explain why they have had so much trouble consistently meeting each other's

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[1] When one member of a couple like this enters individual therapy or analysis, the individual therapist/analytst understandably often concludes that the individual work should help the patient get out of this obviously destructive and painful relationship. This certainly may be the best option in some cases, but as I hope to show in this paper, for many others it is by staying in and examining the relationship in depth that unconscious organizing templates and patterns of relating become clearer, often clearer than is possible in individual modalities.

selfobject needs. Although they present quite differently (Mike is more conscious of his anxiety and self-doubt and lets it show, whereas Ann appears more confident and keeps her conscious focus on what she likes about herself), both can feel damaged, different or inadequate. In addition, when injured or disappointed Ann can easily become flooded by overwhelming, intense affects, like rage or depression, whereas Mike becomes "numb" or paralyzed and often doesn't know what he's feeling.

Because of these deficits, Ann has intense reactions to seemingly minor disappointments by Mike, and has trouble remaining calm and discussing her strong feelings in a manner Mike can respond to (i.e., without attacks, contempt, or righteous indignation). Mike's difficulty with emotional experience makes it difficult for him to attune to and understand Ann's emotional experience, and to identify and convey his own needs. Criticism or negative feedback also triggers each partner's negative self-experience and is thus very hurtful and upsetting, which also makes it difficult for them to discuss differences productively.

Each Partner's Organization of Experience

Couples' relationships are also influenced by the particular ways partners experience each other and their interactions. According to intersubjectivity theory, people experience the world through the lens of their particular organizing frameworks– unique unconscious organizing principles or templates–that formed based on early relational experiences (Stolorow, Brandshaft, & Atwood, 1987). This is a contemporary definition of transference, which differs from previous views of transference as distortion, projection, and so forth. These unconscious organizing processes influence what partners expect and fear in relationships, what they notice or attend to, the psychic "meaning" of interactions, and their emotional and behavioral responses to others.

For example, based on her experience growing up in a disengaged, alcoholic family, Ann developed an organizing framework of others as poor caretakers and of herself as brighter and more competent than most others. Thus, she came into the relationship with Mike– before he'd ever forgotten or neglected one thing–with a preexisting tendency to experience others as incompetent, not understanding her and not taking good care of her. At the same time, she deeply hoped and yearned to finally find someone who would understand and take care of her in all the ways her family (and previous men) had not. Mike's obliviousness, forgetfulness, and lack of emotional availability were therefore extremely important and painful disappointments for Ann and only heightened her fear that she would never get the attention and care-taking she so desperately needed.

Similarly, Mike's early history of criticism and lack of affirmation by his family resulted in his unconscious expectation that others would similarly undervalue him. Although Ann was often critical of him, Mike frequently experienced her as even more critical and devaluing than she felt. He often interpreted Ann's anger and depression as indications that she was not attracted to him or didn't love him, or as the result of his own "incompetence in relationships," rather than as stemming primarily from Ann's own dynamics and prior experiences.

Unconscious organizing principles or frameworks help explain how and why people so often end up with partners who are so tragically similar to early figures, despite having consciously intended to find someone very different. How did Ann, an intensely needy, emotional woman who clearly needed an attentive, idealizable, emotionally available caretaker, choose a preoccupied, forgetful, emotionally distant man? Why did Mike, who

so needed affirmation, love, and acceptance, marry an angry, critical woman so much like his mother and grandmother?

The concepts of the selfobject and repetitive dimensions of experience (Stolorow, Brandshaft, & Atwood, 1987), thought to exist in a figure-ground relationship to each other, help shed light on these questions. In the early part of a relationship, the selfobject dimension of experience is generally in the foreground. Each person views the other primarily through the organizing lens of the viewer's selfobject needs and longings–as a potential source of needed selfobject experience. Through this lens, the ways the other person meets (or seems to meet) the viewer's selfobject needs are in clearest focus, whereas the ways they do not are seemingly not noticed or attended to. This is the wonderful, exhilarating, blissful part of the relationship, before the new partners have ever experienced each other through the lens of the repetitive dimension of experience.

For example, during their courtship, Ann was most aware of Mike's intellect, professional accomplishments, and intense adoring interest in her, whereas Mike saw Ann mainly as a woman who was emotional in a way he longed to be, who had an appealing, well-rounded life outside of work, and who made him feel needed and important. He "knew she could be difficult," as he said much later, but felt he was up to the challenge. The idea of succeeding at a relationship with her where other men had failed was a potential source of pride for him.

At some point during this "honeymoon" or selfobject dimension phase, a selfobject failure or empathic rupture triggers the emergence of the repetitive dimension of experience. One partner then shifts to experiencing the other primarily through the lens of previous negative relational experiences. At this point, the partner's similarities to previous disappointing others are most noticed and attended to.

For example, when Mike let her down, Ann would suddenly see him mainly in terms of his deficits and alarming similarities to her family. His lack of emotional attunement to her, as well as his forgetfulness, insecurity, and so on, would suddenly be glaringly obvious to her. As illustrated in the case vignette detailed below, at these times Ann would completely lose touch with any sense of Mike as a source of selfobject experience and would wonder in painful bewilderment how she could ever have seen anything positive in him.

A final point about how partners end up with someone so painfully similar to early figures: people do not fall for just anyone who offers the missing selfobject experiences they need. Ann was not attracted to every man she met who was bright and found her intriguing, for example. Rather, we are particularly attracted to those who offer important selfobject experiences *and* seem (consciously or unconsciously) similar to early figures in important ways. The similarities feel familiar and offer the potentially more powerful corrective experience of getting the needed responses from someone very similar to the parents or caretakers–perhaps the next best thing to getting such responses from them directly. Unfortunately, of course, the similarities set the stage for terrible repetitions of previous disappointments as well.

Relational Patterns Between Partners

Self-capacities and organizing frameworks, discussed in the previous two sections, influence the way people behave in relationships. They affect how we typically cue others to our needs and feelings, what we do when we are hurt, disappointed or angry, how sexual

feelings and needs are expressed, and so on. These patterns are internalized based on the interactional patterns the developing child witnessed and was part of.[2]

For example, Mike learned early to keep his distance from others to protect himself. When his parents were angry with him, he was better off making himself scarce and staying out of their way until their anger blew over. Now, in his adult relationships, he has difficulty staying present and connected when others are angry. In contrast, Ann learned early that the squeaky wheel got the grease, or that the best thing to do when disappointed or upset is to go on the offensive like her family did with each other and with her. Neither can recall any instances in which negotiating, compromising, or apologizing occurred in their families, so it is not surprising that they have such difficulty doing these things with each other.

Couple Therapy: Improving Selfobject Responsiveness Between Partners

In this model, the essential goal of treatment is to help partners to become more able to function as a source of selfobject experiences for each other in a reliable, reciprocal manner. Doing so involves the ability to communicate needs clearly, grasp each other's selfobject needs and notice each other's cues, understand each other's experience and behaviors, tolerate occasional empathic failures without experiencing them as threatening to the self, and repair empathic ruptures quickly. These abilities are related to the three areas discussed above: the state of the self, the organization of the experience of others (transference), and learned relational patterns.

Self-deficits are addressed by focusing on the self-experience and selfobject needs of each partner, such that the therapist becomes a source of selfobject experience for each. The goal is to facilitate the development of a more positive, cohesive sense of self, and the ability to experience and regulate affect adaptively. This process was originally conceptualized as the gradual internalization of functions initially provided by the therapist (Kohut, 1971, 1977) and later as a gradual reorganization of the experience of the self (Stolorow, Brandshaft, & Atwood, 1987). It occurs through a process of empathic immersion into the subjective inner world of each partner and the establishment of a therapeutic dialogue with each partner. Through this dialogue, each patient's selfobject needs can be met his or her and self-experience illuminated, understood, and gradually transformed.

The dialogue also turns partners' attention toward understanding how they came to experience themselves, others, and their current relationship as they do. The underlying meanings of each partner's complaints are understood and illuminated, especially as they reflect unmet selfobject needs from early relationships and the influence of the repetitive dimension of experience.

The therapist and partners gradually identify and examine relationship behaviors or patterns in terms of how they developed historically and the purposes (such as defensive

[2] The concept of learned relational patterns as I use it here is generally consistent with the work of Stolorow and his colleagues, discussed above, as well as with the concepts of implicit relational knowing or implicit relational procedures as discussed by the Boston Process of Change group (Lyons-Ruth, 1997), Herzog's "relational templates" (Herzog, 2004), Beebe and Lachmann's patterns of self and mutual regulation (Beebe & Lachmann, 2002), and the work of Mitchell and other relational theorists on relational patterns (e.g., Mitchell, 1988, 1997). For the purposes of this paper, the nuances of the distinctions between these concepts are not relevant.

or protective) they are currently serving. The therapeutic relationship and the couple's relationship serve to illuminate these old relational patterns and offer the opportunity to develop new relationships through which these old patterns and templates can be transformed.

The couple therapist focuses on developing a selfobject relationship with both partners and facilitating selfobject experience between them. She listens carefully to each partner from within that partner's own subjective perspective and attempts to respond in an attuned manner to each partner's selfobject needs of the moment. She attends carefully to the state of the self of each and makes every effort to make the sessions a safe place where narcissistic injury is minimized and empathic ruptures are quickly explored and repaired. The focus is on both promoting insight and understanding and on helping partners develop new relationship behaviors. Thus, interventions include empathic reflections and interpretations, setting empathic limits when needed, and directive or coaching interventions when these facilitate selfobject experience between the partners.

Self Psychological Concepts and Common Difficulties in Couple Therapy

Several aspects of self-psychology theory are particularly relevant to difficulties that commonly arise in the treatment of couples. These difficulties include cases in which the therapist understands one partner more easily than the other; those in which one or both partners are easily narcissistically injured, defensive, or resistant; and partners who are blaming, hostile, and/or aggressive. Self-psychological concepts most useful when dealing with these difficulties will be discussed in turn.

Equal Empathic Immersion

The concept of listening from within the patient's own subjective perspective is a major contribution to individual treatment, yet is perhaps even more crucial in couple work where there is another perspective to listen within. An emphasis on understanding each patient from within his or her own subjective perspective can help therapists avoid a classic pitfall of couple work: the tendency to identify with or understand one partner more easily than the other and to intentionally or unintentionally side with one against the other.

With Mike and Ann, I often found myself internally "siding" more with one or the other. Because I, too, had been the brunt of Ann's contempt, hostility, and disgust, I often found it easier to be empathic with Mike's experience of being victimized and mistreated than with Ann's outraged indignation. I would then feel tempted to point out to Ann that Mike was right, she was being abusive, rather than exploring and understanding why she was behaving as she was. On the other hand, having been a parentified child myself, I easily could understand Ann's need for a competent caretaker and her frustration with always being "the driver." I would then be tempted to emphasize to Mike the importance of taking charge more often, rather than focusing on understanding his experience and the understandable reasons he did not do so. I sometimes gave in to these temptations or pulls, but consistently lived to regret doing so, as that kind of assertion or confrontation was rarely helpful and often injurious to one or both.

Rather, at such times, I have found it more helpful to pay close attention to my listening stance or vantage point and try to deliberately shift it whenever I notice that I am not equally empathically in touch with both partners. In general, whenever one partner's view has seemed more correct, valid, or reasonable than the other's, I have found that I

am not listening to the less-valid-seeming partner from within that person's own subjective perspective.

Ringstrom (1994) presented a compelling example of a couple in which the husband initially seemed to the therapist to be much more disturbed than the wife, just as the wife contended. However, when the man's odd and alarming behaviors were explored and understood in depth from within his own perspective, what initially looked "crazy" to both the wife and therapist became much more understandable. I have had similar, though less dramatic, experiences on many occasions with couples.

Of course, deliberately shifting one's listening stance is more easily said than done. Couple work often leads to intense emotional reactions in the therapist that can interfere with the smooth shifting of listening stances and achievement of the goal of equal empathic immersion. This work often involves sitting with partners who are intensely angry, hurt, or miserable, who are actively hurting each other before our eyes, and/or who are terribly stuck - unable to make their relationship work yet unable to get out of it. It can thus be very stressful and painful for the couples therapist, especially when we can particularly relate to the pain of one or both partners because of some aspect of our own history (e.g., our experience of being in various couples ourselves, our experience of other important couples such as our parents, and so on). These experiences can be usefully explored and understood in terms of what they mean about both therapist and patients, a process that involves a return to empathic immersion and inquiry into the subjective experience of each partner.

Narcissistic Injury and the Rupture and Repair Sequence

The risk of narcissistic injury seems to me to be even higher in couple work than in individual treatment modalities. Partners frequently injure each other during couple sessions, and empathic ruptures between therapist and patients are also more frequent because the therapist's attention is divided. Thus, an understanding of narcissistic vulnerability and an emphasis on the repair of empathic ruptures are particularly important in couple work.

With this in mind, when working with couples I experience myself as vigilantly, constantly monitoring the state of the self of each partner and their moment to moment sense of injury as it is conveyed verbally and nonverbally. Although I certainly watch for and process empathic ruptures in individual work as well, I am less vigilant since injuries occur less often. With couples, I scrutinize each partner for signs of injury, "sniff it out," and intervene quickly in an effort to reduce, recognize, and repair injuries. This can involve anything from a glance that conveys "Ouch, I know that hurt" to empathic limits on hurtful, abusive behavior, to seeing partners separately in certain circumstances if they cannot avoid traumatically injuring each other when seen together.

As I have discussed in more detail elsewhere (Leone, 2001), one of my guidelines for determining when to see partners (or family members) together versus separately is the degree to which they are able to be in the same room without constant traumatic narcissistic injuries to each other. A full discussion of the advantages and disadvantages of seeing partners separately is beyond the scope of this paper, but protecting each from further traumatic injury is an important factor to be considered when making this decision.

When partners are seen together, it is important that the therapist help them convey their unmet needs and complaints in a manner that is sensitive to the narcissistic needs of the partner who is the target of the complaints. The goal is to make the sessions a place

where selfobject experience can occur, not selfobject injury. This may require the therapist to take an active role in empathically setting limits or containing patients who are intentionally or inadvertently hurting each other.

As will be discussed in the following section on dealing with aggression, every effort should be made to limit the injurious behavior without shaming or narcissistically injuring the person being limited or contained. For example, the therapist might say, "I understand how furious you are and how much you need to say this, but I want to help you say it in a way that increases the likelihood you can get the response you need." The goal is to help partners take much better care of the other's narcissistic needs while also conveying their own needs and complaints.

Whenever possible, the therapist can also point out and affirm any "forward edge" or growth-promoting aspects of a particular behavior or comment, whereas also noting its problematic or "trailing edge" aspects (Tolpin, 2002). For example, Ann's hostile, critical, obnoxious demeanor often contained the forward edge tendril of an effort to seek out and access desperately needed selfobject responses. I tried to remember to recognize and affirm her healthy, growth-promoting desire to finally have her needs met, even as I also tried to help her see how her hostility repeated the ways her parents had spoken to her and how it had developed in reaction to their lack of responsiveness. Partners are often more able to hear a limit or suggestion that a behavior needs to change without severe narcissistic injury when any positive aspects of the behavior are also recognized.

Despite these efforts, narcissistic injuries will inevitably occur, of course. Such injuries offer an opportunity to help couples learn how to recognize and repair them, first by watching the therapist process and repair any ruptures between herself and either or both partners. During my work with Ann and Mike, Ann was frequently angry with me. She complained that Mike wasn't getting better fast enough, that I was too committed to my "nicey-nicey" demeanor to confront him more sternly, and so on. After she and I developed a pattern of repairing these ruptures, we could then compare our pattern with what she and Mike did when the ruptures occurred between them.

Many couples, including Ann and Mike, report having left previous couple treatments after one or both partners felt too injured by the therapist or each other. I believe this model's vigilant attention to narcissistic needs and injuries–and to empathic ruptures and their repair–often allows narcissistically vulnerable couples to stay in treatment longer than they might in treatments informed by other theoretical models.

Defensiveness and Resistance as Self-Protection

Self psychology's view of defensiveness and resistance as "obligatory measures of self-protection" (Wolf, 1984) is an important contribution to individual treatment, but is perhaps even more important in couple work where partners are often more defensive and resistant than they are in the safety and security of the individual analytic hour. For example, couple therapists frequently struggle with couples in which one or both partners firmly believe the difficulties in the relationship are caused solely or primarily by the other person. Other examples include partners who argue with or reject any critical feedback they receive and couples in which one or both partners are extremely resistant to engaging in couple treatment despite clear relationship difficulties. In such cases, a focus on listening from within each partner's own subjective perspective (which can be imagined, in the case of a spouse who is not present) and on understanding the self-protective function of the defensive behavior can be extremely useful.

In this model, the focus is not on confronting the defensiveness or overcoming the resistance but on understanding how such behaviors serve to protect a vulnerable self. So rather than trying to convince Ann that she, too, contributed to the relationship problems when I experienced her as blaming everything on Mike, I tried to focus instead on strengthening the self through the selfobject bond with me so that she could eventually see her contribution without traumatic injury to the self. Although it was often difficult when I became frustrated with Ann, whenever possible I tried to empathically appreciate her experience of Mike as the problem and affirm her strengths, while also gradually exploring how "her part" of things, such as her hostility, had understandably developed in the context of her early experiences.

Partners can also be helped to understand the function of defensiveness in themselves and each other. For example, those who are struggling with their partner's refusal to enter couple treatment can be helped to see the partner's reluctance to do so as natural and understandable given that person's fears or previous experiences. I have often found that when one partner tells me the other will "never, ever, under any circumstances" agree to couple therapy, that person frequently understands very little about the reluctant partner's reasons for refusing. When the willing partner is finally able to be empathic and responsive to the many legitimate reasons the reluctant partner has for refusing (fear of embarrassment, of being ganged up on, of retraumatization, or of loss; discomfort with a process that is not a social norm, and so on), the reluctant partner is often more amenable to reconsidering his or her decision.

Similarly, when Mike became injured by her hostility and criticisms, Ann was initially unable to appreciate his experience. She would frequently complain, "This is hopeless, we can't get anywhere if he's going to get defensive every time I bring anything up!" I tried to empathically appreciate her experience while also gently introducing a new point of view, as in, "I see your point, Ann–if you can't even talk about the problems, of course we can't get anywhere! You do have to be able to tell him what you need that you aren't getting, I agree–and yet, defensiveness is natural. We all feel we have to object when something just doesn't seem true or when we feel attacked or portrayed inaccurately. What we need to understand is what's making him feel that way and why." There were times when Ann could not hear this, of course ("I couldn't care less why he's feeling that way!"), but over time, the idea did sink in. The response also protected Mike a bit and legitimized his experience while also encouraging him to reflect on the reasons for his experience and defensive reactions. Again, the focus is on understanding the reasons for the defensiveness or resistance and on the legitimate need for comfort and reassurance.

Aggression and Hostility as Expressions of Narcissistic Injury

Lastly, yelling, threatening, and aggressive words or even actions can be difficult enough to deal with in individual treatment, but when multiplied times two (or three, when the therapist gets angry, as well) they can be overwhelming. Self psychology's conceptualization of anger and aggression as secondary to narcissistic injury or perceived threat to the self (Kohut, 1972) can help therapists stay grounded in the face of chaos and respond in ways that are most likely to help people move into a more vulnerable, less hostile place.

Aggressive behaviors, including verbal aggression, can be understood as efforts to do one or more of the following: communicate the experience of injury or threat and put a stop to the injurious behavior, demand or otherwise elicit desperately needed selfobject responses, and restore or shore up the self. Anger, especially outrage and righteous indignation, can be energizing and vitalizing (Lachmann, 2000). These feelings "pump us

up," restore a sense of power and potency, and protect us from more vulnerable feelings such as hurt, sadness, or shame (Livingston, 1998). Aggressive ways of responding to disappointment or pain and of expressing angry feelings developed through the partners' repeated early experiences of the ways these feelings were expressed and dealt with in their families.

With these concepts in mind, the therapist can respond to anger and aggression by empathically appreciating and legitimizing the angry person's experience while also limiting its inappropriate expression. This involves first matching the angry person's affective tone and summarizing his or her position in an emotionally intense manner that captures the person's experience as closely as possible. Hearing one's angry feelings accurately and powerfully articulated can have an immediately calming effect: people don't feel as great a need to continue ranting or building a case once it is clear that their position has been accurately understood in depth. On the (all too infrequent) occasions when Ann had this experience with me, she would roll her eyes and sigh, "Exactly," in a tone implying, "Finally, you get it–it's about time!" but would settle down immediately. In the first vignette detailed below, an example of this occurred when I said, "This just isn't working for you" in a tone matching Ann's flat, bitter one at the beginning of the session.

In addition to an accurate empathic encapsulation of the angry partner's experience, the therapist may need to set empathic limits on the expression of anger to keep the session safe and to help structure and contain an out-of-control person. As discussed in the last section, the therapist should be careful to avoid using an authoritarian or reprimanding tone and should instead emphasize her empathic understanding of the reasons for the behavior, or its forward edge aspects, if any, whereas also gently limiting it. "I can see how that would have made you furious, how it would have hurt you and provoked you. And I think it's very healthy for you to find a way to say, 'no, I won't be hurt in that old way anymore,' but in order for that to happen, we've got to help you do this differently," the therapist might say.

In extreme or unsafe situations, the therapist may separate the couple temporarily. On several occasions, I asked Mike to wait out in the waiting room while Ann and I processed her rage without him, even though this was not her preference. A milder version of this is to encourage or direct the angry person to talk to the therapist instead of the partner, although the partner remains in the room. The partner is then being talked about, not directly attacked, which can be less provocative and less injurious. The angry person is also more likely to connect with the therapist and settle down, and less likely to be provoked or reactivated by the partner when engaging in a dyadic manner with the therapist (McCormack, 2000).

Finally, once the angry person feels thoroughly understood and is in a calmer, more reflective place, the therapist can begin to focus on exploring and making sense of the anger in terms of the concepts just discussed. Rage can be translated into the language of unmet needs and injuries, old injuries that were repeated or reactivated by the current precipitant can be identified, and the influence of the patient's particular ways of organizing experience can be explored. The energizing, restorative, or protective functions of the anger or outrage and the influence of each partner's early experiences of anger can be identified and understood.

The following vignette from a treatment session with Mike and Ann (that occurred about 8 months into a 3-year treatment) illustrates many of the concepts discussed in the previous two sections.

Clinical Vignette #1

Ann comes in a rage shortly after returning from a trip she'd taken without Mike. I take one look at her face as she stalks into my office and think, "Uh oh–here we go." "I'm done," Ann announces flatly before Mike has even been seated, glaring at me. "I'm just finished."

I know she means done with Mike, not me–this time, anyway. I meet her eyes, hold her gaze a minute, my expression serious and concerned, inviting her to tell me more. I then meet Mike's for a moment, trying to convey nonverbally my concern for him and my awareness of how what Ann is saying must be hurting him. He looks tired and defeated.

"This is just not working for you," I say to Ann firmly, matching her flat, bitter tone, shaking my head. I am trying to capture her feelings, nonverbally as well as verbally, without taking on the issue of whether she is really ending the relationship. I also want to engage her in dyadic interaction with me and discourage her from talking to Mike at this point.

"That's right, it isn't," she agrees, settling down a little. She launches into a description of how she'd returned from the trip to find Mike had "completely fallen apart" and had not done many household tasks he'd agreed to do. In particular, he had not watered her vegetable garden during a heat wave and her beloved tomato and bean plants had all died. (One of Ann's few positive childhood memories was of working in the backyard garden with her grandfather.) When she'd returned, gotten upset, and directed things, they had completed all the tasks together in about 2 hours and had even gone out and bought more vegetable flats and planted them. She is contemptuous and derisive of Mike's apparent difficulty doing these things without her direction. "I need a partner, an adult, not some little boy who doesn't even know plants need to be watered. . ."

Mike interrupts here to say in a weary tone that of course he knows they do, he just hadn't realized how quickly plants can die. He'd gotten caught up with work, forgotten about the watering, and had readily apologized. Ann cuts him off rudely, "Yeah, right, I've heard it all before. Don't give me that crap. And anyway, it's not just the garden, it's the whole thing. . ."

I interrupt her here, seeing an opportunity to get a word in and try to shift things a bit. "All right, Ann, Ann, wait. You're right, it is about more than just the garden," I say. "A lot more. Of course to Mike it's just an oversight, the kind of thing that can happen when you're preoccupied with work. I can see how that could happen," I tell Mike, trying to respond empathically to both of them. "But to you (back to Ann) it's much more, it's another example of his obliviousness, his not taking care of things, and of how you end up back in that old driver role again."

"Yes," she agrees, "I am in that role with him–a lot–and I've had it. I'm sick of it!"

"I know you are," I say, speaking more softly now, holding her gaze intently, trying to slow things down and change the mood to a more reflective instead of reactive one. "Very sick of it. You've been in it for such a long time now."

She agrees, softens a bit, begins tearing up. "Yes I have. And he knows that now–after this (the therapy)–and yet he still lets this happen! For someone who wants to get out of that role, I sure picked the wrong guy."

I again make eye contact with Mike, trying to convey my concern, my awareness of how that statement must have hurt. I nod and lift a finger, telling Mike nonverbally, "I'm sorry, I'm coming to you in a minute." I then tell Ann, "Well, you did pick someone for whom the kind of noticing, and neatness, and on-top-of-things-ness that you need does not come easily. For a lot of important reasons, those are just not Mike's style. He feels better when he doesn't worry about that stuff too much–and yet you need it so desperately. Of course you wonder if you made a bad choice– he's not good at something you really need."

She nods, meets my gaze, surprised that I am agreeing with her on this.

"You need to be watered, given extra care in the heat, or you start to wither too," I continue. Again, I am trying to translate her rage into the language of unmet needs and promote more vulnerable emotion. Ann rolls her eyes briefly and I know she thinks I am overdoing the metaphor a bit, something she has said "you shrinks love to do," but she doesn't argue. I feel like we both know the metaphor fits. She is listening, not arguing, so I go on. "And maybe it seems like– here's this person who lets tomatoes die, what about when it comes to you?" (She nods) "And once he's let you down like others have– once history has repeated itself–then you're so flooded with the disappointment, and all the old pain it stirs up, that it takes you over. Then all you can see then are the ways he disappoints you, like they did so often. And it starts to feel like that's all there is."

Ann nods, settling way down, seemingly lulled by my soothing voice as much as anything I have said. "That's true, that's exactly what happens. I can't think of one positive thing, even though I know I have felt them. I can't even remember them, or they seem minor compared to the bad. All I can see are his flaws and that's all that matters." She glances at Mike for the first time–almost, but not quite–apologetically.

I say something like, "Right, you can't remember any of the ways you've told me in the past that he's an excellent match for you. When all you can see are the similarities with your childhood, the only options you can see are either to stay miserable in that old place or to get out. If those are your only two options, I can certainly see why you would think of the second one. What we're trying to do here is give you another option." Ann nods, still wary, but settled for the moment.

I take this opportunity to finally shift to Mike. I have left him longer than I usually do in joint sessions, but in this case, I know from experience that he can tolerate it without an empathic rupture. "You need another option, too, right Mike?" I begin. We explore Mike's experience of the incident, including both what is repeated for him when Ann is attacking, hostile, and contemptuous, and what was going on that caused him to be so misattuned to her regarding the garden and other tasks.

We identify once again how easy it is for him to slip into an old pattern of focusing on work and his own internal world and not being as in touch with the world around him. "When Ann's here, she keeps me outer-focused," he acknowledges. "When she left I just kind of did what I always used to do: got lost in my own world, immersed myself in work, and forgot everything else." We also talk again about how nice and relaxing it is for him to let things get messy and not worry about tasks getting done because that feels so different from his childhood home. Ann listens, rolling her eyes and looking skeptical at times, but taking in much of it.

Later, Mike is able to apologize to Ann again, differently this time. His previous apology appeared to have been a rather rote one for having overlooked a minor task, made in an aggrieved, weary tone that implied, "What's the big deal?!" He now conveys a more heart-felt sorrow for how their differing interpersonal patterns and opposite needs so tragically repeat each other's past pain. Ann is not yet able to do the same, but is no longer talking about ending the relationship.

This session illustrates the therapist's efforts to empathically appreciate both partners' experience, and to help them move from rage and resignation to an examination of how they came to feel and act as they do. The presenting complaint (i.e., "he's incompetent and let my tomatoes die") was translated into the more vulnerable language of selfobject needs and longings (for "watering," care-taking, and so on), and the repetitive dimension of experience was interpreted and examined. Throughout this process the therapist also

provided selfobject experiences of validating, organizing, and soothing, which were strengthening to the self of each.

Directive Interventions as Selfobject Experiences

Although understanding and explaining were the only intervention options for classical self psychologists, more recently noninterpretive interventions have been viewed as appropriate when they are experienced by the patient as a selfobject response (e.g., Bacal, 1990). For example, a number of authors have advocated a more intersubjective relatedness (Shane, Shane, & Gales, 1995) or subject-to-subject relatedness (Jacobs, 1995) between therapist and patient, when this form of relating is judged to be optimal for the patient. In this section, I suggest that directive, educating, or behavioral techniques can also be experienced as optimally responsive by some patients.

Consistent with this view, Connors (2001) recently discussed the role of active, symptom-focused techniques in the self psychologically informed treatment of anxiety disorders and behavior disorders. I agree with her assertion that "reduction of symptomatic problems strengthens the self and facilitates deeper levels of self-exploration and therapeutic involvement" (Connors, 2001, p. 74). This framework is consistent with the work of Basch (1988) regarding the "spiral" relationship between behavior change and self-esteem and his use of directive, advice-giving interventions in certain cases. It is also consistent with the work of those calling for an integration of psychoanalytic and behavioral or directive approaches (Bader, 1994; Wachtel, 1994).

The use of directive, educating or advice-giving interventions can be particularly important in the treatment of relationships, where the goal is not only self-development, but also interpersonal behavior change. Helping partners become more attuned and responsive to each other may require a more psychoeducational or directive approach at times, such as when trying to help partners learn how to comfort each other, seduce each other, express anger adaptively, or otherwise understand and respond differently to each other.

Livingston (2001) has discussed the "educating" aspects of couple therapy, particularly regarding the need to actively encourage partners to express more vulnerable affects like pain and longing. "Stay there a little longer," he encourages his patients (Livingston, 2002) when they allow themselves a more vulnerable, less defended moment. This kind of coaching or directing helps patients learn to recognize when they are being more vulnerable and when they are instead shifting to a more defended, less open mode of relating.

Shaddock (2002) has also discussed the role of behavior change in couples work, viewing new behaviors by partners as ways to perturb an existing dynamic system. He advocates encouraging partners to "try on" new behaviors, even if the behavior has a rote or forced feel initially, arguing that one partner's different behavior can create a new relationship context and eventually alter organizing principles.

Other couple therapists have advocated the use of directive or behavioral interventions with couples, within the context of an overarching psychodynamic or psychoanalytic framework (Kaplan, 1974, 1995; Pinsof, 1995; Pizer & Pizer, 2002). However, these authors appear to advocate using these techniques with most or all couples, at least initially, and do not think in terms of the couple's particular selfobject needs in determining when and whether to use them. For example, Kaplan's approach to sex therapy and Pinsof's integrative model both suggest routinely beginning with more behavioral or directive techniques and moving to a more interpretive focus only if the directive approach is unsuccessful.

In contrast, I advocate the use of directive techniques when (and only when) they are experienced by one or both partners as a needed selfobject response or when they facilitate a selfobject experience between the partners. Thus, they may be used at any point in the treatment after the therapist has developed some empathic appreciation for each partner's selfobject needs and a sense of how each might experience more directive interventions.

From a self psychological perspective, directions, advice, exercises, and the like can be understood as idealizing selfobject functions, in which the therapist is experienced as someone who can be looked up to as a source of wisdom, care taking, and so on. Thus, they are most appropriate in the context of an idealizing transference from both partners, or when both seem to need structuring, containing or guidance.[3] They may be especially important with patients who did not experience their parents as providing these things.

It is important to note that I use directive techniques infrequently. I believe many people who would benefit from such techniques do not end up in my office, but meet their need for structure or direction in other ways: by seeking advice from friends or family members, reading self-help books or magazine articles about relationships, watching "Dr. Phil," and so on. On occasion, however, I find that the use of an exercise, assignment, or direction can be an optimal selfobject response (Bacal, 1990) that furthers the treatment, as the following examples illustrate.

Clinical Vignette #2 and Additional Examples

In one session, Ann was finally able to access and express the more vulnerable feelings under her rage. She talked about how desperately lonely she felt at times, even when Mike was home, and described how empty she felt. She was crying softly and for the first time acknowledged that her emptiness was not just Mike's fault, that she'd actually felt it all her life. It was a powerful and poignant moment, and both Mike and I were moved. I then became aware of wishing that Mike would reach out to Ann in some way, to comfort her. He made no move to do so, and instead sat back in his corner of the couch, watching, moved and touched but seemingly feeling this was my territory to handle. I got the feeling he just wanted to stay out of the way and not do anything to disrupt the process or reactivate Ann's wrath.

Trying not to disrupt Ann's experience, I softly asked Mike how he was feeling. He conveyed that he was moved, sorry for Ann, and wished he could help her, then added, "But I guess there's nothing I can do. All I can do is love her and hope that's enough."

I nodded, then caught Ann's eye, knowing that she would probably have at best mixed reactions to that comment. It looked like she was shifting out of her more vulnerable tearful state and was gearing up to tell Mike for the millionth time that of course love was not enough, that if he still thought that then he was an idiot and things were really hopeless, and so on. I nodded very slightly, holding her gaze intently, trying to convey, "I know, I've got it." I lifted the fingers of one hand slightly, trying to signal her, "Hold on, stay where you were, I'll do it for you." Probably partly because she was so drained by her crying, she dropped her eyes in apparent, although clearly temporary, acquiescence. In this brief "eye dialogue," we see Ann's developing ability to trust me, to allow me to

[3] This may explain why behavioral and cognitive behavioral couple therapy has consistently been found to be effective for some, but not all, patients who utilize it: it may be effective for the percentage of patients with these particular idealizing selfobject needs, but less effective for the rest of the sample.

provide a selfobject function for her, and her newly emerging ability to stop herself from reverting to a more typical interactional pattern.

This having occurred in the span of a few seconds, I gently told Mike that love was a lot, and did have an important effect on Ann, but that she also needed more from him, just as he had needed more from his parents as a child. I asked if he had any thoughts about what Ann might be needing at that moment. He looked taken aback, as though her needing something from him hadn't occurred to him. He thought a minute, then said he'd like to hold Ann but didn't know if she'd want him to. I met Ann's eyes, questioningly, and she half-shrugged in acquiescence. I then nodded to Mike, and motioned for him to move over on the couch. He leaned toward Ann a bit, tentatively. "Go ahead," I encouraged him. "You can skooch over a little more if you want," I directed, motioning to him with my hand like a traffic cop. He slid over, more assertively pulled Ann to him, and she cuddled against him and continued crying. They stayed that way for quite awhile, during which she said her main feeling was "Where've you been all this time?"

When this "vulnerable moment" (Livingston, 2001) or heightened affective moment (Beebe & Lachmann, 2002) had passed, we talked about my direction or encouragement to Mike. Ann said it was one of the first helpful things I'd done in the 18-month treatment ("Finally!"). Mike acknowledged that if I directed him like that too frequently he might start to feel controlled and dominated by me as he did with Ann. However, he said that in this case he had appreciated the direction, especially because it was a suggestion, not an order. He also described a mixed experience of feeling embarrassed that I'd have to tell him something he "should have known," but also pleased or flattered that I'd seen him as capable of doing it. He had imagined I'd be thinking, "This is important stuff. I'd better handle this, Mike will screw it up!" We explored extensively Mike's sense of himself as "not good at these things," and related it to the fact that no one had comforted him or helped him learn how to comfort someone else.

I made a number of other specific suggestions over the course of Ann and Mike's treatment. After much internal debate, I suggested they attend a weekend workshop for couples run by colleagues of mine with a different theoretical approach (Hendrix's Imago Therapy, see Hendrix, 2001), but one that I consider to be consistent with many aspects of self psychology. They did so with generally positive results. Mike felt he'd accessed more intense or vulnerable emotion than he had been able to in our work together and was also impressed by the model of a sensitive and attuned man he found in the male co-leader. Ann said she had primarily learned that she that she didn't want to be empathic to Mike, she just wanted him to listen empathically to her (i.e., she was much more comfortable being the "sender" than the "receiver" in active listening dialogues). This recognition led to a productive exploration of this preference and a discussion of whether or not this was a problem for her or for the couple.

In response to Ann's seeming need for more active structuring and her tendency to flood with affect between sessions, I suggested John Gottman's book "Seven Principles of a Happy Marriage" (Gottman & Silver, 2000),[4] which Ann and Mike both liked. Ann especially liked the chapter advising that husbands defer to their wives more! Our

[4] Gottman's empirical studies of couples (Gottman, 1999) have led to a number of findings I see as consistent with the tenets of self psychology. For example, "repair attempts" (efforts to repair empathic ruptures, in self-psychological language) and the ability to defer to each other (translation: respond to the partner's selfobject needs) were associated with positive outcomes. Disdain, contempt and "stonewalling," (or selfobject failure, shame, narcissistic injury in this model) were highly predictive of divorce or marital dissatisfaction (Gottman, 1999).

discussion of this chapter led to important insights about Ann's family. Interactions had seemingly been viewed as a battle between winners and losers, an organizing framework Ann acknowledged still having.

Lastly, because the couple routinely returned from vacations having had a miserable time together, I suggested they ask each other the following question on each morning of their up-coming vacation: "What would make this a good day for you?" They were then to do at least one thing on each person's list. They reported finding this quite effective and returned from their trip having had a better time. They noted with surprise having been unaware that they had not been previously checking in with each other in this rather obvious way. We agreed that this was not as surprising given that apparently their parents had not checked in with them in this manner, nor had they witnessed other family members doing so with each other.

I would like to emphasize that I did not make such suggestions whenever a potentially helpful recommendation crossed my mind, but only when I felt such a suggestion was the most empathically attuned response to one or both partners' needs. Their experience of these suggestions was usually, but not always, explored in detail. I believe these more directive interventions were an important part of what helped this couple improve, but I doubt they would have been effective outside the context of an idealizing selfobject transference.

Conclusion

Self-psychology and intersubjectivity theory can be very helpful to clinicians struggling with the challenges involved in treating couples. Understanding and reframing conflicts in terms of underlying selfobject needs, the influence of unconscious organizing frameworks and learned patterns of relating help couples become better able to meet each other's selfobject needs. Basic tenets of self psychology, including listening from within the patient's perspective, careful attention to narcissistic vulnerability, and an understanding of the functions of defense, resistance and aggression can be particularly useful in avoiding common pitfalls of couple work. Finally, directive interventions can be useful when they are experienced by the couple as responsive to a selfobject need or as facilitating selfobject experience between them.

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