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Couples Counseling in Alzheimer's Disease: Additional Clinical Findings from a Novel Intervention Study

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Abstract

This article describes the clinical findings of a study designed to assess the benefit of counseling for couples, one of whom is in the early stage of Alzheimer's disease (AD). We previously reported our findings based on the first 12 couples that enrolled in the study. Based on the treatment of 30 additional couples, we have refined our treatment strategy to include concepts of Gestalt Therapy and Transactional Analysis and identified prevalent issues of concern to this cohort. The study design has remained as described in the earlier article (Epstein et al., 2006), and has proven to be appropriate to meet the goals of this intervention as indicated by our clinical experience and feedback from the participating couples. Case vignettes demonstrate how to conduct the sessions so that the experience of each member of the dyad is validated, while acknowledging the differential impact of the disease on them.

Keywords

Alzheimer's disease; couples counseling; randomized wait-list control design

INTRODUCTION

This is the second of an anticipated series of articles describing the clinical findings of a counseling intervention for couples, one of whom has been diagnosed with early-stage Alzheimer's disease (AD). In a previous article (Epstein, et al., 2006), initial findings based on a sample of 12 couples were discussed, using two case studies. This article reflects our evolving perception of the impact of AD on the marital relationship, and a subsequent fine tuning of the therapeutic approach based on working with 30 additional couples.

Our approach is to focus simultaneously on two individuals and their diverging, converging and changing emotions and needs. The clinician seeks to create a setting where both partners are invited to participate as equals, while acknowledging that one of them suffers from cognitive decline.

RATIONALE

As previously described (Epstein et al., 2006), the purpose of the intervention remains to preserve the integrity of the relationship and the sense of self of each partner when one of them is diagnosed with Alzheimer's disease. "Marriage represents the single most influential and sustained relationship in the lives of many elderly spouse caregivers" (Rankin, Haut, and

Keefover, 2001). Our intervention is based on the premise that the marital relationship remains essential to the afflicted spouse as well. "Awareness and sense of subjective self for the person with dementia is co-constructed within the spousal marital relationship," a concept expressed by Hellstrom & Lundh (2005). How the person with dementia treats his or her partner and is treated in return can have implications for the unfolding of the illness and the strategies used to manage its impact (O'Connor, 2007).

Since our first article on the study was published, there have been increased efforts to understand the impact of dementia on the person with the disease, as well as on the spousal relationship. Some articles looked at the quality of the marital relationship (Karney et al., 1995; Lewis, 2000) and others at the impact of the disclosure of a diagnosis of MCI or AD on the couples and their planning for the future (Husband, 2000; Blieszner et al., 2007). Adams et al., (2008) shifted the focus from caregiver stress and burden to grief and loss, though they do not discuss the losses of the person with dementia. There have also been interventions designed to address the needs of the caregiver and treatment planning. Whitlatch (2006) developed a dyadic intervention which included spouses with dementia, but the primary focus was on care planning.

We are encouraged that there appears to be a trend toward more inclusion of and attention to the psychological processes of the person with dementia (Zarit, 2004; O'Connor et al., 2007; Menne et al., 2008). Nevertheless, these approaches differ qualitatively and conceptually from ours. We thus continue on our own journey and present the therapeutic method that emerged intuitively from our experience. We are confident that treating a couple faced with AD as a unit is an effective modality. Looking at the members of a couple as equal players in the marital drama offers an affirming view of their relationship and its capacity to embrace change.

STUDY DESIGN

This study employed a randomized wait-list control design. Evaluations were conducted at baseline and 2 and 4 months later. Those in the immediate treatment group received six counseling sessions within 2 months of baseline. Those in the wait-list control group were evaluated on the same schedule as the immediate treatment group and offered the same intervention beginning after the 4-month follow-up. The content of the intervention was individualized to the needs of each couple shaped by the changes in the relationship that had occurred since the onset of AD. We offered all participants brief telephone counseling upon request (*ad hoc* counseling) from the time of enrollment through the last follow-up assessment. Intake and follow-up assessments consisted of structured written questionnaires administered to each member of the couple separately in person to both treatment and wait-list control participants by an independent rater, who recorded their responses. The quantitative results will be the subject of another article. Here we describe the qualitative outcomes and the clinical experience of the counseling sessions.

PARTICIPANTS

Participants diagnosed at the Alzheimer's Disease Center (ADC) who met study criteria described below were told about the study and were invited to participate. Other couples were referred by community agencies or learned about the study from the media, flyers disseminated at conferences and workshops, or by word of mouth. A total of 42 couples enrolled in the study. We began the study by pilot testing the intervention with 3 couples. Subsequently, 39 couples were randomly assigned by lottery to the treatment or control group. Eight couples who were randomized to the wait-list control condition never received the counseling due to ill health or their disappointment at having to wait for treatment. One couple in the treatment group also

did not complete the sessions due to ill health of one of the spouses. The remaining couples completed all six sessions.

Participant Eligibility and Screening

One member of the couple had to have received a diagnosis of AD and be in the early stage, and both needed to be willing to take part in the counseling program. An initial screening questionnaire determined probable eligibility for the study. Prior to enrollment, the couple was invited to an in-person screening session with both clinicians to confirm eligibility. Since the inception of the study, we have become more alert to possible rule-out circumstances such as medical and psychological conditions that may compromise the couple's ability to utilize this intervention and to tolerate being randomized to the delayed-entry arm of the study. These include the immediate need of treatment for psychosis, intense anxiety or severe depression, abuse, neglect, and suspicion of violence, either expressed by the couple or assessed by the clinician. In addition, we have found that couples counseling, which is based on verbal expression and exchange, may be contraindicated if the afflicted spouse suffers from moderate to severe receptive or expressive language difficulties (aphasia) or either spouse has severe uncorrected hearing loss.

CHOICE OF CLINICIAN

The clinician needs to be interested in counseling elderly couples confronting AD and other serious illnesses and have the necessary skills and stamina to tolerate the intense emotions and the poignancy of the couple's circumstances. Furthermore, we (the two clinicians) have found it helpful to share our own feelings and reactions to the work with each other, and to get feedback from the other professionals on our team. The curiosity and courage to explore personal responses to the work in a mutually supportive supervisory setting is analogous to the experience we ask of the couple in their therapy and enhances the ability of the clinician to perform the tasks required.

CLINICAL TASKS

In observing our own process we have come to realize how important it is for the clinician to:

1. Be sensitive and alert to the effects of the cultural, ethnic, and religious background of both members of the couple on their attitudes and behavior and to ask about their meaning rather than making assumptions.
2. Assess whether the couple is: (a) in a crisis and requires immediate intervention, (b) needs a supportive approach, or (c) can tolerate and appreciate more insight-oriented work.
3. Address the issues arising from the diagnosis of AD, each partner's individual reaction to it, and its impact on the couple. Their current coping style is considered in the context of the couple's established patterns of dealing with adversity.
4. Evaluate how much of the therapeutic work should focus on educational, practical, and emotional issues.
5. Consider the degree to which the couple's history together and dynamics might interfere with or support their ability to cope with the new situation.
6. Be aware that issues of commitment and disappointment can be particularly acute when a couple has been together for a comparatively short time such as in a second marriage. The role of adult children of either spouse can further complicate the situation.

7. Be able to track the fluctuations in the couple's reaction to an illness, which in itself fluctuates.
8. Modulate the level of emotional intensity in the session so that the couple is not overwhelmed.
9. Convey the idea that some issues can be put back 'under the rug,' or not taken out from under it, if this is what the couple chooses to do.

In summary, the clinician has to communicate to the couples (many of whom are of a generation not inclined to use psychotherapy) that expressing feelings, such as anger, sadness, resentment, as well as joy and appreciation, can be helpful to both partners and will increase their ability to handle the future challenges of aging and AD.

The clinician needs to be open and non-judgmental of whatever path the couple follows. One couple chose to marry to formalize their relationship after many years of being together. It is also possible that couples might choose to separate, although this has not happened in our study sample.

THEORETICAL UNDERPINNINGS

Our clinical approach is present-oriented and addresses long-established dynamics only when they interfere with mastering current challenges. In addition to our backgrounds in psychodynamic and Gestalt therapies, we have found theoretical support and useful conceptual formulations from Transactional Analysis (Harris, 1969; Ernst, 1971; Berne, 1961) and from writings by Winnicott (1971).

Transactional analysis (TA), is based on the theory that there are four existential life positions, and identifies them as, "I am not ok, you're ok; I am not ok, you're not ok; I am ok, you're not ok; I am ok, you're ok" (Ernst, 1971). Transactional analysis further posits that people under stress tend to blame others for their distress. Depending on life circumstances, individuals will use one of these positions as a starting point from which they interact with others or may return temporarily to what Berne calls the "child ego state," replaying scenes from their childhood when they lack the resources to maintain an adult ego state.

Identifying where, in Ernst's "Okay corral," the members of the couple were located helped structure the work. Put simply, the goal of the treatment for the couple is to arrive at the "We're both okay" position.

Referring to these formulations can bring the couples' present life positions into the open, thereby encouraging their examination and the reduction of blame and negative judgment. This approach avoids the common pitfall of assigning the "one down" role of identified patient to the person with dementia and the "one up" positioning of the well spouse, which would be consistent with a medical model. Instead we are guided by the notion: 'No one is to blame; what matters is how we go forward and figure things out.'

We discovered that the couples could shift toward mutual acceptance when a safe environment, much like the holding environment described by Winnicott, was created in the session. Winnicott's definition of psychotherapy as an activity where two (or three) people play together is a useful construct. According to Winnicott (1971), it is the task of the clinician to help create the environment where this play is possible.

Looking at what one does, at how one feels, without immediately judging it as good/bad/right/wrong was initially unfamiliar to the couples but opened up a space for curiosity and engagement, which is the playfulness described by Winnicott. In this 'blame free' zone the

couple could ‘play with’ the issues they were confronting, and feelings could be examined, moved around, looked at from different angles.

In our work, the clinician shifts back and forth between the members of the couple, holding the reality of each with equal attention, offering them the opportunity to consider the validity of each other’s experience without judgment. The clinician has to be mindful of the non-afflicted spouse’s tendency to seek an alliance with the clinician in which the ill spouse becomes the object of scrutiny. Consequently, the well spouse may be taken aback in the first session, while the ill partner lights up and sits a little straighter as a result of the shift in perspective.

CLINICAL CASE EXAMPLES

Case vignettes will illustrate our approach and describe common reaction patterns of couples confronted with AD (the couples’ names have been changed as have elements of the scenarios to protect confidentiality).

Previously Unexpressed Resentments

The following is an example of the shifts that can take place in a relationship when the ‘unspeakable’ can be spoken, with the encouragement and support of the clinician. The counseling invites both spouses to give up the irrational and unrealistic expectations of the idealized perfect union and to live more realistically together after having expressed their truths to each other. The couple is no longer stuck in their old standoff, but may be able to adapt more flexibly to the new situation.

When the reality of the progressive nature of the illness seeps into the awareness of the well spouse, feelings of resentment may emerge because any hopes for future satisfaction of deferred needs are dashed. The well spouse becomes aware that relying on the sustaining comfort of looking forward to better times and a ‘better’ spouse who turns from frog to prince and becomes the ideal companion who is appreciative and emotionally available, is no longer realistic, and confronts the realization that this cannot happen, because of the relentless progression of the illness.

Now the well spouse has to accept responsibility for the decisions and choices that brought him or her to this place. The expected compensations no longer assuage the suppressed needs and desires. Regrets about paths not taken that might have rescued the spouse from the current situation and are no longer imaginable, such as divorce (“I should have left after his/her affair”), unexpressed resentments, or opportunities not pursued, can come roiling forth in rage, hatred, or depression.

Case vignette 1—The Lees—This couple has been married for 40 years, has two daughters, and is financially comfortable. Mrs. Lee had been an actress who gave up her career aspirations to get married. She felt that she was plain looking and could not afford to turn down what she feared would be her only marriage proposal. Mr. Lee had been a business man. He is very aware of his failing memory, and writes lists to navigate through daily life.

In their first session the couple appeared ‘dug in,’ like two fighters in their corners in the ring, mostly too tired to move or fight much, but also unwilling to leave their long held positions, the wife’s of hurt and disappointment and the husband’s of ignoring her feelings.

Mr. Lee came to the sessions with a list of his concerns, which dealt mostly with his wife’s physical health, her weight, her drinking and her general passivity. He wanted her to exercise and stay healthy so that she could take care of him and “push my wheelchair.”

Mrs. Lee acknowledged that she resented his demands, and declared she had no intention of exercising, losing weight, or quitting drinking.

The clinician noticed that the couple never looked at each other during the first two sessions and was struck by a sense of this being ‘pay back time,’ but what for was unclear.

In the third session the clinician asked Mr. Lee if he knew what his wife was angry about. He shrugged his shoulders.

Clinician:	“Have you ever thought of asking? You could ask right now”.
Mr. L.:	“There are a few things I know she was not happy about ...” (trails off)
Clinician:	“You want to list them yourself or ask her right now?”
Mr. L.:	“Okay, so what are you angry about?” (Mrs. L. had started to cry while this exchange was going on.)
Mrs. L.:	“I don’t know what this is supposed to do. There is nothing that can be done now and I wouldn’t know where to start ...”
Mr. L.:	“See?”
	Clinician to Mrs. L. “Hold on for a minute here. Just start somewhere and we’ll take it step by step (turns to Mr. L). “Right?” (He nods bravely)
Mrs. L.:	“Well, he knows.” (Cries harder) “I am not even angry about your affair and I knew you didn’t come back because you loved me. You came back because you missed the kids, having a family. It sounds like I am competing with my own child but I am not! What I cannot forget is what you said when Barbara was born, ‘Until now I did not know what love was.’ I should have left right then instead of living with someone who could or would not love me, but I was too scared,” (blows her nose) “and now you only care about me so that I can take care of you and I won’t do it!”
Clinician:	“Do what exactly?”
Mrs. L.:	“Well, you heard him, push him in the wheel-chair; change his diapers ...”
Clinician:	“Wow! Hold it right here.” (turns to husband). “You have mentioned that you want your wife to be fit enough to take care of you, right?” (He nods.) “So what would you do if she can’t move around anymore and you would have to push her in a wheelchair or change her diapers? Would you do that?”
Mr. L.:	(totally matter of fact): “Me? Of course not!”
Clinician:	“So, what we have here are two people who tell each other that they would not change each other’s diapers, which might have to be dealt with in the future, but right now you are both diaper free, right?” (Both smile and nod)...
Clinician (to Mr. L.):	“Did you know that Elise never felt loved by you?”
Mr. L.:	“I think I love her, maybe not enough, I never felt loved by my mother.” (Wife interjects: “They had a terrible relationship.”), “and I am used to Elise, her quirks, and she is really smart and we enjoy the theater ... and I trust her ...”
Clinician (to Mrs. L.):	“How does that sound to you?” She shrugs and blows her nose....

At the next session the Lees appeared as if a weight has been lifted from each of them, looking at ease with each other. Mrs. L. started by saying that Willie is the only person she can be herself with, that she is a very private person, uncomfortable with most people, but not with him. This was the first time she spoke of herself as an individual with her own personality and not only as an unloved wife. Having expressed her pain, she appeared to have gained access to other feelings and was able to see some benefit in having Willie as a partner. In the space that was created by the reduction in acrimony, Elise and Willie spent the final two sessions planning for the future.

III Spouse’s Denial that Behavior Could be Disease-Related

Although study participants initially acknowledge the diagnosis of AD, it is common that specific instances of forgetting or confusion are denied or rationalized. The well spouse then may press the ill spouse to admit the lapses, provoking a defensive response. This is illustrated in the following vignette:

Case vignette 2—The Allens—Mr. and Mrs. A. have been married for 10 years. It is the second marriage for both. One of the pleasures they share is going on ocean cruises.

Mrs. A. exhibited characteristic symptoms of early stage AD, such as difficulty organizing and planning, and finding her way in new surroundings. Shortly before entering the study they had returned from a lengthy cruise and were considering future trips.

The following is an exchange that occurred as Mr. A. expressed his concerns about his wife's ability to find her way around the ship.

Mr. A.:	"I am not sure that we can continue to go on these cruises since my wife can't be trusted to find her way back to our cabin and I don't want to always be worried about her."
Mrs. A.:	"What are you talking about? I never had any problem. I always found my way back."
Mr. A.:	"But you had to ask someone."
Mrs. A.:	"No I didn't."
Mr. A.:	"Yes you did."
Clinician:	"Let's stop for a moment. Let's figure out what is going on." (Clinician leans forward and looks at the couple with curiosity. This slows down the process.)
Clinician (to Mrs. A.):	"This must be so upsetting. You sound like you feel accused" ...
Clinician (to Mr. A.):	"You must be so frustrated to hear her denying what you say when you feel that you are right. Let's look at this again."
Clinician (to Mrs. A.):	"You both agreed to meet with me so we can look at how your memory problems affect how the two of you are with each other."
Mrs. A.:	"But they are not as bad as he says."
Clinician:	"Your husband may be exaggerating or overly protective and you might be forgetting some details. What we are trying to figure out is how the two of you can deal with this."

At this point the couple faces a task together. For the moment, they are on the same page, rather than each looking to justify and to defend his or her view.

The clinician's response joins the couple together in their mutual distress. The clinician speaks the reality that each seeks to deny or avoid, which grounds the work by taking it out of the blaming game and releasing the fears and anxiety it conceals.

Well Spouse's Denial that a Behavior may be Disease-Related

Although less common, the well spouse may deny that some behaviors of the ill spouse are symptoms of AD. The following vignette illustrates this:

Case vignette 3—The Greens—Mr. and Mrs. G. have been married for 5 years. Mrs. G. works part time in sales and Mr. G., the person with dementia, sells candy at a kiosk in an office building.

Mrs. G. declares that she will not tolerate her husband's failure to support her need to maintain an active life apart from him and his fearful reactions when she is a few minutes late. She insists that he can change his reaction and behavior and threatens to leave if he fails to do so. Mrs. G. does not accept that these are additional symptoms of the illness that go beyond poor memory, such as anxiety, fearfulness, confusion, and lack of emotional containment and responsiveness to her needs. Instead, she surmises that he uses the illness to cover up the fact that he never liked her to go out without him. This disagreement has a long history, but in the past Mr. G. was apparently better able to control his reactions, and Mrs. G. continues to believe that he should be able to do so now. Mrs. G. was annoyed with some of her husband's behaviors even before they married but had assumed that she would be able to change them after they married. She now struggles not to give up her belief that she can turn him into the husband she wants him to be.

Mrs. G.:	"We had a terrible week. On Monday I came home a few minutes late and there he was, yelling."
Mr. G.:	"But hon, I don't yell. Did I really yell?"
Mrs. G.:	"You went like this." (Spreading her arms to imitate his gestures, shouting) "'Where were you?' And you had called all over to find out where I was, and I was just two minutes late." (Mr. G. sits and stares. The clinician looks at him and he makes a gesture of 'What can I do?')

Clinician to Mr. G.: "Well it sounds to me like you were scared. You didn't know where your wife was."
 Mrs. G. interrupts: "He knew, he knew, I wrote him a note when I would be home."
 Clinician: "Did you have the note when you got worried?" (Mr. G. nods his assent.)
 Clinician: "It sounds like the two minutes were too long for you."
 Mrs. G.: "His kids tell me that he was always like that. Maybe it has something to do with losing his first two wives and his mother."
 Clinician: "That sounds like a lot of losses. What about your mother?"
 Mr. G.: "I was seven when she died."
 Clinician: "This is so touching. You might feel like a seven-year-old when you watch the clock, waiting for your wife to come home and not being sure that she will return."
 Mr. G. (very animated): "She might be in an accident, in the hospital, under a bus. And in my head I know I am overreacting, but down here (points to his chest) I can't help it"
 Mrs. G.: "He's not worried for me. He's worried for himself."
 Clinician (turns to Mrs. G.): "Well, if you feel like a seven-year-old, of course you are worried for yourself, because you cannot survive without an adult." (Silence, they both look at each other).
 Mrs. G.: "In my head I understand he might feel like the seven-year-old, but here I don't (pointing to her chest), I get so angry and just want to run."
 Clinician: "So you have that in common; you understand each other in your heads, but your guts give you a different message and you don't feel compassion for each other...."

When the distressing behavior of the person with dementia is familiar, in that it is an exaggeration of a behavior that occurred prior to the illness, it is more difficult for the well spouse to accept it as a symptom of AD. In the above vignette the well spouse had always experienced her husband's tendency to insist on punctuality as an attempt to control her, and had hoped that her threats to leave him would motivate him to change. Now she might need to consider that her husband's behavior is and may always have been an expression of what TA calls a "child ego state" that is now exacerbated by his illness. Her husband's fearful behavior may similarly trigger Mrs. G's own regression, which Berne calls contamination of the "adult ego state," preventing her from recognizing the impact of the illness and leaving her anchored to her anger and denial.

When a client is not able to put his or her reactions into the "play space" and to consider their multiple meanings and functions, the clinician can only observe to the couple how important it now seems for them to hold on to their beliefs and to suggest that they may not always feel this way. Whether a belief functions as a protection or a weapon, it will not be relinquished without a satisfactory alternative. Our research has shown that counseling can alter a caregiver's negative appraisal of a dementia-related behavior (Mittelman, et al., 2004). Negative appraisal on the part of the caregiver can render the person with dementia at higher risk for nursing home placement (Mittelman, et al., 2006). However, the intention is not just to shift the appraisal from negative to positive, but to a more realistic one that can be a resource for coping (McNulty 2008).

Coming Through the Fog—I Am Still Here, Sometimes

In the supportive atmosphere of the sessions the ill spouse can often become engaged in dialogue much as he/she had prior to the illness. The ill spouse is energized and mobilizes still available inner resources to respond to the invitation to be a full participant in the sessions. This experience can be challenging to the well spouse who has to accommodate to the "continuation or periodic reappearance of the 'former self' of the person with dementia" (Robinson et al., 2005), and to shift from the more emotionally removed caregiver role back to that of spouse. In the following vignette we see such a resurfacing.

Case vignette 4—The Grays—Mr. and Mrs. Gray have been married for over 20 years in second marriages for both. The husband, who has dementia, is 93 years old, but looks like 78. Mrs. Gr. is 78, and also looks much younger than her age.

Mrs. Gr. starts the final session: "Things are going so much better...."
 Clinician: "How come?"
 Mr. Gr.: "Well, it's you, you did it." (pointing to the clinician). (Mrs. Gr. nods in agreement).
 Clinician: "What did I do?"

Mr. Gr.: "You made Natalie less upset and you helped me get out of myself."
 Mrs. Gr.: "I have to say that Jim tries to be more considerate, he jokes less in that nasty way."
 Mr. Gr.: "Really? I am not aware of that."
 Mrs. Gr.: "Yes, and also, I take all of this less personally. It's not in any way easier, but you helped me see that he can't help it. It's not to hurt me...." (pauses) "In a way it is very sad because it has very little to do with me...."
 Mr. Gr.: "And now she only wakes me up once, and not with that exasperated tone."
 Mrs. Gr. (interrupts): "And you get up."
 Mr. Gr.: "Yes, I don't have to fight you."
 Clinician: "Jim, you said earlier that I get you out of yourself. What did you mean by that? Could Natalie do that and would you want her to?"
 Mr. Gr.: "Most of the time I feel so foggy in my head, you know, my mind is going, it's so hard to concentrate, to be interested. Things I used to do automatically, I have to concentrate really hard on."
 Clinician: "Are you saying I am getting through your fog?"
 Mr. Gr.: "Yes, you make me be interested in myself again, make me try to participate."
 Mrs. Gr.: "I have to admit that I have not tried that with you in a long time and when I am here I see the old Jim. It's just so hard to make that extra effort."

This last session renewed this couple's desire to be more caring and present with each other and motivated the well spouse to encourage her husband to make an effort and connect with his 'old self' when possible.

The Role of Humor

In the previous vignette the wife noted that the husband no longer uses "nasty humor," a device which is frequently employed by husbands with AD, usually to the distress of the wife. Rarely is the humor and joking experienced as funny, but rather as a persistent and dissonant note that becomes a further thorn in the side of the wife. The clinician also found herself the object of the husband's 'humorous' barbs, but she understood that they had multiple functions—as a communication tool, which can be used as a weapon, but also as a means to lighten uncomfortable and embarrassing situations. It is interesting to note that among the couples in our study, we did not see wives with dementia utilize this coping strategy.

The following vignette, where the wife has lost her benevolent attitude toward her husband's struggle to feel good about himself, is another example of the changing dynamic in a marriage. She now openly expresses her disgust and impatience with his humorous attempts to assert a "one up" position.

Case vignette 5—The Bergers—The Bs., a couple married for 5 years in a second marriage for both, could be heard in the hallway before entering the office. Mrs. B. was yelling at her husband, "Why don't you shut up once in a while! That was not funny and you embarrassed me and that woman! She did not want to talk to you!" In response, Mr. B. looked a little sheepish, but lightened up the minute he saw the clinician, greeting her with a big smile and a loud hello.

Clinician: "What was that all about?"
 Mr. B.: "What do you mean?"
 Mrs. B.: "Don't pretend you don't know!"
 Mr. B.: (with a chuckle) "I forgot."
 Mrs. B.: "See, here he goes again," (turns to him). "It's not funny and you know it drives me crazy!"
 Mr. B. (to clinician): "I bet you don't yell at your husband when he drives you crazy. You do have a husband, right? You are much too nice not to have one."
 Mrs. B.: "I can't do this anymore, and he thinks this is funny and it was never funny, but now it's unbearable."
 Mr. B.: "I am just trying to make conversation, I don't mean no harm."
 Clinician: "Your wife feels harmed" (turning to wife), "Right?" (Mrs. B. nods).
 Mr. B.: "That's because she never had a sense of humor"
 Mrs. B.: "Certainly not your sense of humor!"
 Clinician: "Would you say that since you were diagnosed with AD you have more fights over what is 'funny'?"
 Mrs. B.: "Well, before we got married we could have a conversation now and then. Now it's only these stupid jokes. Also, I was not always with him and did not see how he behaved."
 Clinician to Mr. B.: "What do you think?"
 Mr. B.: "I try to please everybody, make things better, and she only yells at me."

Clinician:

"It must be hurtful to you too then, you're trying so hard and your wife only feels hurt and angry. Actually, you are both hurt and angry."

The remainder of the session was spent exploring the issue of disappointment, which loomed large with this couple. Mrs. B. admitted that she never found her husband's jokes funny, but grinned and bore them since he had other wonderful qualities. Again, this is a common feature with many married couples: The wife smiles and rolls her eyes while the husband is joking with the receptionist, waitress, *etc.* Mr. B., in turn, senses that his wife does not find his jokes funny (anymore) and increases his efforts, unable to change the script. The clinician needs to be mindful not to identify with the wife's exasperation and to bring this dynamic to the couple's attention.

While most attempts by husbands with early AD to utilize humor have not had the desired outcome, we had one striking example in which the husband's sense of humor continues to enrich the couple's connection.

Having known each other for over 30 years, Mr. Brown finally proposed to marry his partner when he realized that her ability to take care of him would be hampered by her lack of legal status. Mr. Brown's sophisticated, wry, and offbeat sense of humor remains largely intact in spite of his condition. His type of humor has been characterized by Stocking and Zillmann (1976), as absurd, typified by word plays and clowning. Mrs. Brown enjoys her husband's humor, and is not put off by its sometimes unpredictable turns. For instance, at a visit to the urologist, as the doctor tried gently to prepare him for an upcoming rectal exam, Mr. Brown said, "I know what to do" and opened his mouth wide. The doctor stared at him, perplexed. The wife explained her husband's joke by adding, "You should see what he does at the dentist," and all laughed.

On another occasion, Mrs. Brown, by chance, met her husband with his aide on the bus (he was coming from a day program) and offered her seat to him, since his balance had become quite unsteady. He responded in a loud voice, "Oh thank you so much, will you marry me?" The whole bus fell quiet. The passengers at first did not know how to react, then broke into laughter.

Unlike the unsuccessful use of humor to minimize stress and or to maintain status, Mr. Brown does not put others down. Instead he invites others to play along.

CONCLUSION

Our study has shown that it is possible and worthwhile to offer counseling to couples when one member is in the early stage of AD, and that our clinical approach is suitable for *both* members of the dyad. Six sessions proved sufficient to shift the couples into a mode in which they could face the future together more optimistically and collaboratively. When each member of the couple is able to take the other's behavior less personally, and assume an accepting, non-judgmental, non blaming attitude, the relationship stands on a firmer footing. All couples could probably benefit from developing these relationship muscles, but those coping with a disability may derive even greater benefit from interventions such as this one.

Alzheimer's disease is a progressive chronic disease, which makes it difficult to predict the long term benefits of this intervention. Nevertheless, we feel it is important to recognize and support the ongoing connection between the members of the couple. It is our hope that our intervention will be replicated and expanded upon in the future.

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