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Clinical Processes in Behavioral Couples Therapy

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Abstract

Behavioral couples therapy is a broad term for couples therapies that use behavioral techniques based on principles of operant conditioning, such as reinforcement. Behavioral shaping and rehearsal and acceptance are clinical processes found across contemporary behavioral couples therapies. These clinical processes are useful for assessment and case formulation, as well as teaching couples new methods of conflict resolution. Although these clinical processes assist therapists in achieving efficient and effective therapeutic change with distressed couples by rapidly stemming couples' corrosive affective exchanges, they also address the thoughts, emotions, and issues of trust and intimacy that are important aspects of the human experience in the context of a couple. Vignettes are provided to illustrate the clinical processes described.

Keywords

behavioral couples therapy; behavior observation; behavior shaping; acceptance

Behavioral couples therapy (BCT) is a broad term for couples therapies that use behavioral techniques based on principles of operant conditioning, such as reinforcement (Gurman, 2008). Whereas all couples therapies are focused on reducing relationship distress, we argue that BCTs such as traditional behavioral couple therapy (TBCT; Jacobson & Margolin, 1979), integrative couple behavioral therapy (IBCT; Jacobson & Christensen, 1996), and the program developed by John M. Gottman (1999) use the common clinical processes of behavioral shaping and rehearsal as well as acceptance to increase reinforcing interactions and rapidly and efficiently stem the negative and corrosive interactions frequently seen in couples presenting for therapy.

The Process of Behavioral Shaping and Rehearsal

The process of behavioral shaping and rehearsal begins with behavioral observation by the clinician. Observing the interactions of the partners plays an important role in assessment, case conceptualization, and determining which interpersonal behaviors will require shaping and rehearsal. Whether using a formal behavioral coding system, such as the Specific Affect

Coding System (Coan & Gottman, 2007), or more global classes of couple behavior, such as negativity, positivity, and withdrawal, the clinician is looking for behaviors that have been shown to distinguish distressed couples from satisfied couples (Gottman & Notarius, 2000). Distressed couples have been found to exhibit more negative affect, such as criticism, defensiveness, contempt, stonewalling, and belligerence, in dyadic interactions, and show more rapid and longer-lasting hostility responses (Gottman, 1999; Carrere & Gottman, 1999; Gottman & Notarius, 2000). Distressed couples also frequently fail at repairing conflict (Gottman & Notarius, 2000). Although satisfied couples will also show some negative affect, they exhibit positive affect, such as interest, validation, affection, and surprise or joy, at a ratio of 5:1 to negative affect (Gottman, 1999).

Once the clinician has observed the behavioral interactions of the couple and determined the behavior (e.g., target behavior) to be changed, the clinician will begin by modeling desired behaviors for the couple, and then shaping the couples' displays and providing feedback as they practice the more positive exchanges. This stage of the process allows the therapist to act as an educator, coach, and commentator, and will slow the escalation of conflict, making conflict repairs easier for the couple. Behavior shaping follows from the assumption that couples experience conflict and distress because the couples lack the skills to communicate functionally (Epstein & Baucom, 2002; Geiss & O'Leary, 1981). Behavior shaping has been found to be superior to traditional communication training (e.g., reflective listening; Baucom, Sayers, & Sher, 1990; Cornelius & Alessi, 2007; Halford, Sanders, & Behrens, 1993) because the collaborative nature of behavior shaping produces long-lasting changes in communication patterns (Baucom & Hoffman, 1986; Wheeler, Christensen, & Jacobson, 2001). Each approach may differ in the exact form of the clinician shaping. For example, TBCT takes a more rule-governed approach to communication training (Sevier, Eldridge, Jones, Doss, & Christensen, 2008), setting rules for how couples should interact and reinforcing approximations toward the goal. IBCT, on the other hand, dictates a more contingency-shaped approach to communication training, in which the clinician explores partners' reactions to messages and shapes more effective communication. Comparisons between the TBCT and the IBCT approach have found that the TBCT approach leads to a more rapid decrease in the amount of negativity expressed by partners, but IBCT engenders more long-term changes in relationship functioning (Baucom, Sevier, Eldridge, Doss, & Christensen, 2011; Sevier et al., 2008). The best of both worlds may be the use of both rule-governed and contingency-shaped changes to communicating. For example, encouraging the couple to avoid using specific behaviors that are corrosive to relationships and to practice behaviors that predict future satisfaction and stability, thus allowing the reinforcing properties of the improved interactions to potentiate future positive exchanges. In its most specific form, this process can include educating couples about such behaviors through modeling and then skillfully shaping couple interactions to exhibit behaviors such as interest, validation, affection, and surprise or joy and pure anger, and avoid exhibiting behaviors such as contempt, belligerence defensiveness, or criticism (Gottman, 1999; Gottman, Coan, Carrere, & Swanson, 1998).

In the following vignette, names and details of individuals have been changed to protect confidentiality, but the partners are in their mid-20s, have been married 5 years, and have an 18-month-old child. They are presenting for treatment with complaints of escalating conflict

and multiple life stressors. The couple has a history of infidelity early in the relationship and issues of honesty and trust continue to create distress. The Dyadic Adjustment Scale (DAS; Spanier, 1976) was used at intake to measure relationship satisfaction. Scores of 97 or greater on the DAS indicated good relationship satisfaction. Individual scores for the husband and wife indicated that both were experiencing distress, scoring 93 and 83, respectively. After several months of treatment, the husband and wife's scores on the DAS had improved to 107 and 95, respectively.

In the following vignette, the clinician, acting as an educator, has modeled the desired behavior for the couple and, acting as a coach, provided feedback on what was observed; and shaping the display of behaviors that predict satisfaction and stability by suggesting alternatives when appropriate.

Therapist: Let's discuss a conflict that has caused tension in your relationship. I'd like you to practice is using the positive behaviors we talked about. Remember, they are sadness, anger, interest, affection, validation, and surprise, or joy. Also, avoid using the negative behaviors that we discussed: contempt, defensiveness, criticism, belligerence, and stonewalling. I will be your coach throughout the discussion. I may stop the conversation to give suggestions along the way. Are you ready?

Patty: I think so. Can we talk about chores around the house?

Travis: (Smiling) This should be interesting.

Patty: Well, I know it has caused a few arguments over the past week.

Travis: Yeah.

Patty: And I get mad when you say you'll do something—like the dishes—but you don't. Or you say, "Yeah, I'll get to that when I'm done with this email," but then it never happens.

Therapist: Travis, take care in not shutting the conversation down with sarcasm. Patty, can you be a little more specific? I think you are making a specific complaint, but it was couched in terms of always and never.

Patty: Okay. Travis, take last night. I was trying to get our daughter to sleep, and the dishes were in the sink, and I asked you to help with them and you said you would. I got busy and forgot about it, but later that night I went to get some water from the sink it was still full of dishes!

Travis: Yeah, I didn't get around to it. I got sucked into work and lost track of time.

Patty: But that's how it always goes!

Therapist: Okay, let me step in here because I heard some criticism and defensiveness. How might the two of you respond differently? Maybe with validation?

Patty: Let me try again. Travis, I was angry when I saw that the dishes weren't done. I know that you are busy with those online courses and that it takes a lot of your time. I know how important it is for you and for our family, but sometimes I need help around the house. It hurts when I can't trust you to follow through; I mean last night it did.

Travis: Last night I got caught up in my work. And I know that it wasn't just last night, but that it happens a lot. I want to do better, but I don't know how when we argue.

In the previous vignette, the husband displays contempt through sarcasm in his statement, "*This should be interesting,*" defensiveness (excuse making) later in the exchange, and the wife displays criticism in her use of "never" and "always" when expressing displeasure at what her husband has done and later when she states that she "can't trust" him. The clinician attempts to shape more desired displays on two occasions. In the first instance, the clinician stops the couple, asking the husband to reduce his displays of contempt (sarcasm) and defensiveness, and asking the wife to reduce her display of criticism by asking her to be more specific and avoid using statements that include "always" and "never." The clinician then allows the discussion to continue and waits to see if the couple will spontaneously display the desired behavior. When this does not happen, the clinician then prompts the couple to use validation in the continuation of the discussion. Because the clinician does not want the displays of the desired and more productive behavior to be contingent on his reinforcement, the clinician allows the experience of being heard and understood through the use of validation to reinforce the future displays of such behavior.

The Process of Acceptance

Acceptance, a core component of many BCTs and particularly central to IBCT (Gurman, 2008), is a process incorporated into contemporary versions of BCT to improve the weaknesses of TBCT. Although initial research found that TBCT was effective in improving marital satisfaction, subsequent investigations found that a majority of TBCT couples had relapsed shortly after the termination of therapy (Wheeler, Christensen, & Jacobson, 2001). To address this shortcoming in TBCT, Jacobson and Christensen proposed a reconceptualization of BCT that encouraged couples to accept those aspects of a partner that cannot be changed and commit to changing those aspects of themselves that can (Dimidjian, Martell, & Christensen, 2002). In IBCT, acceptance is considered a central process of change and is not meant as a resignation or defeat, but as an acknowledgment of the inherent realities within a relationship. What matters is not solving the unsolvable problem, but changing the affective displays exhibited when these conflicts are discussed. Through this process, couples are encouraged to show compassion toward and empathic understanding of their partners, and accept ongoing conflicts as opportunities to work together as a way of building intimacy through shared struggle. These ideas proposed by Jacobson and Christensen in IBCT are similar to those proposed by Gottman (1999) in his "Building the Sound Marital House" treatment approach, in which he discusses research findings that the majority of couples (69%) experience ongoing problems that have no solution. Gottman (1999) suggests focusing therapeutic attention on the affect displayed and the manner in which these problems are discussed rather than trying to solve the problems themselves.

The use of acceptance within BCT has been a subtle, but significant, shift in treatment that has resulted in striking influences on treatment efficacy. For example, compared with TBCT, couples who received acceptance-focused IBCT demonstrated greater improvements in marital satisfaction and overall functioning, were less blaming, and used more soft emotions and less harsh emotions when discussing conflict (Cordova, Jacobson, & Christensen, 1998; Jacobson, Christensen, Prince, Cordova, & Eldridge, 2000). More recent investigations of acceptance as a mechanism of change within TBCT and IBCT have also found that increases in the acceptance of partner target behaviors (behaviors in which the other partner desires change) were related to increases in relationship satisfaction for the couple. Additionally, even though couples in both treatments experienced a significant relapse in target behaviors in the second half of therapy, the relapse was more harmful to the relationship satisfaction of TBCT than of IBCT (Doss, Thum, Sevier, Atkins, & Christensen, 2005). These findings suggest that acceptance may also provide a sort of “inoculation” affect against declines in satisfaction that may accompany the natural ups-and-downs that occur over the course of a long-term intimate relationship. In addition, just as in a wide variety of individual therapies in which acceptance of the client is a necessary component for change to occur (Gilbert & Leahy, 2007; Miller & Rollnick, 2013), acceptance appears to function similarly for couples. Acceptance in one partner has been shown to mediate the behavior change in the other partner (Dimidjian, Martell, & Christensen, 2002; South, Doss, & Christensen, 2010). It appears that as partners decrease their efforts to change each other, they become less emotionally reactive, thereby increasing the likelihood of behavior change.

In the following vignette, Travis and Patty are encouraged to identify those conflicts that are not likely to change, and rather than trying to solve the problem, approach the conflict as an opportunity to join together and take each other’s perspective.

Therapist: When you think about issues that often become conflicts for the two of you, are any of those things that you don’t ever seem to solve?

Travis: Yes. As you know, we’ve had to deal with the fallout from my past infidelity. I was wrong to cheat on Patty, and I’ve tried to make amends. We’ve worked hard on this and it hasn’t been easy. It just feels like there is still a distance between us.

Therapist: Patty, what are your thoughts on this?

Patty: Travis knows how I feel. When it happened, it shattered my trust in him and although I’ve been able to regain trust in Travis, it isn’t like it used to be. I’m committed to this relationship, but I know that I carry the scars from what happened.

Therapist: I see. Although you both want to make this relationship work, there is some hurt that still surrounds the past infidelity. It sounds like it may never go away. In spite of your best efforts, the emotional pain from the betrayal is still a part of your relationship. How do you experience those emotions?

Patty: It mostly happens when I find myself questioning if Travis is being honest with me. Like when he says he will do something, and he doesn’t follow through, or when he comes

home late from work. I find myself questioning if he is lying to me again. It leaves me feeling suspicious and lonely.

Therapist: And how do you end up acting toward Travis in these moments?

Patty: I guess I pull away from him and become a bit more distant.

Travis: I know what Patty is talking about. I can tell when she is feeling that way. Even though she's in the room with me, it's like all of a sudden I'm sitting with a stranger and not my wife. I feel like I've done something wrong, but I don't know what.

Therapist: How do the two of you usually deal with these emotional situations?

Travis: We don't deal with them very well. I've tried to change the mood by acting sweet or funny, but it doesn't help. Sometimes I get angry. Mostly I just wait it out.

Therapist: I wonder what it would feel like to talk about the emotions instead of trying to change how you feel. Patty, you could tell Travis when you feel hurt or distrustful; and Travis, you could tell Patty when you feel distanced from her. Each of you can try to understand where the other is coming from. It is awful hard to change our emotions, but we can change how we act when they occur. I wonder if turning toward each other for support might allow these events to play out differently.

Patty: We could try it.

Therapist: Okay. Let's practice with a role play once and get an idea of how it might feel to have such a conversation.

Travis: Okay. I'll start. Patty, you've gotten quiet all of a sudden. Are you feeling hurt and worried?

Patty: Yes. You didn't call before you left work like you said you would and it made me worry about what is going on.

Travis: I am sorry to make you worry again. I'm sorry that this has happened to you and to us, and that you continue to have fears. I am completely committed to you, our relationship, and to making it better for us. I will continue to work on following through better.

Patty: Thank you.

Therapist: How did that feel for the two of you? Patty?

Patty: I felt less abandoned because he noticed how I was feeling and reached out to me.

Therapist: Travis, how about you?

Travis: I was nervous at first about talking to her about it; like I'd get blasted in bringing it up. In the end, though, I'm glad I did. I feel closer to Patty.

In the previous vignette, the couple has chosen an ongoing area of difficulty to learn about the practice of acceptance. The therapist begins this discussion by modeling acceptance through expressing empathy for the couple in acknowledging that there is still pain surrounding the past infidelity and that they both want the relationship to work. The effect of this on the couple is quickly evident, in that the tone of the conversation softens and they begin to see the problem as belonging to “them” rather than something that either one of them is doing. This change is exemplified by the husband’s interest in the reason his wife became quiet and validation of the wife’s worry. An unanticipated bonus in this exchange was the reinforcement the wife offered her husband for reaching out to her, both in not reacting negatively to his query, and in thanking him for his efforts to reach out to her.

Summary and Conclusion

The techniques of behavior observation, behavior shaping and rehearsal, and acceptance are elements of the clinical process in BCT that, when used in combination, create effective and efficient change in distressed couples by rapidly stemming the negative and corrosive behaviors often exhibited by couples presenting for therapy. These process techniques are useful within specific stages of treatment: the behavior observation portion of behavior shaping can be used in the service of assessment and case conceptualization, behavior shaping can be used as an intervention for communication skills training, and acceptance can be used as an intervention for some chronic conflicts. Additionally, they can also be used more generally throughout therapy to address conflicts and issues as they arise. We also believe, as demonstrated through the included vignettes, that a behavioral approach to couples therapy adequately addresses not only core issues within a relationship, such as communication and conflict resolution, but also the thoughts, emotions, and issues of trust and intimacy that are important aspects of the human experience (Epstein & Baucom, 2002).

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