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Brief Relational Couple Therapy

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In keeping with other brief therapy models – including MRI (developed by the clinicians at the Mental Research Institute, e.g., Watzlawick et al. 1974), Strategic Therapy (Haley 1987), Solution-Focused Brief Therapy (SFBT) (e.g., de Shazer 1985), and the Milan Associates (e.g., Boscolo et al. 1987) – Brief Relational Couple Therapy (BRCT) is a systemic approach significantly influenced by Gregory Bateson's revolutionary systemic ideas (Bateson 2000) and Milton Erickson's innovative hypnotherapy and psychotherapy methods (Erickson 1980; Flemons 2002; Flemons and Green 2007, 2018; Haley 1986).

Introduction

As brief therapists, BRCT clinicians are committed to working as efficiently as possible (Fisch et al. 1982). Aware that both therapist- and client-expectancy contribute significantly to therapeutic outcome (Kirsch 1999), they are careful not to assume that long-standing and/or particularly distressing problems necessarily require longer durations of treatment (O'Hanlon and Wilk 1987). They search for and highlight the strengths and resources of couples – noting their areas of expertise and any previous successes in solving problems – and they offer possible understandings (or framings – see below) of the problem for clients to consider. They acknowledge their own expertise in helping couples change, but they make clear that they don't have privileged access to a "correct" view of the clients' situation. This nonnormative stance means the therapists never take a position on what the clients "should" do, and they don't advocate for "better" or more "open" communication. Any ideas the therapists offer are posed tentatively and are qualified as provisional.

BRCT therapists make suggestions for experiments the clients might undertake (either in the session or back at home) to gather information about consistencies and variations in the problem the clients have identified. However, they avoid offering "first-order" solutions (Watzlawick et al. 1974), that is, ideas for interventions that don't differ significantly from what the couple has already tried or what others (whether friends, family members, or other therapists) have already suggested. As MRI theorists pointed out long ago, problems are generated and maintained by ineffective solution attempts applied to life difficulties (Watzlawick et al.).

Committed to developing an insider's appreciation of the pattern, the "logic," of the couple's interaction, BRCT therapists concur with the MRI emphasis on "speaking the client's language" and

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attending to the client's beliefs, values, and priorities (Fisch et al. 1982). Their goal is to make "contextual sense" of the couple's fights but also of the stubborn commitments of each partner. Rather than attempting to correctly diagnose pathology in how people think and/or what they do, BRCT therapists go in search of the legitimacy of each partner's positions and actions, as well as the legitimacy of the couple's interactive pattern of relating. The therapists operate from the assumption that the fighting and the suffering reflect both partners' fundamental need for safety and their willingness to do whatever it takes, regardless of the consequences, to protect themselves. One or the other (or both) may also feel the need to protect the children, the other person, and/or the relationship.

This assumption of the therapists about the necessity of safety is an example of *reframing*, a therapeutic technique derived from Bateson's (2000) recognition that the way an item of perception or experience is contextualized or categorized (i.e., "framed") is integral to its meaning. When the context or category (the frame) is changed, the meaning changes, and this in turn changes the experience itself. For example, when clients' intransigence on an issue is framed (by themselves, by their partner, and/or by a professional) as petty stubbornness, they can't change their mind without losing face, without admitting, if only tacitly, that they have been inappropriately and unnecessarily resistant. However, if the importance of safety is underscored and their behavior is reframed as *one of many* ways of ensuring this safety, then a change of mind is not an admission of blame and it doesn't have to entail a loss of face. In this way, clients are provided the freedom to safely change from *this* way of feeling protected to *that* way.

BRCT therapists work to create the conditions for clients to safely experience the vulnerability of interpersonal intimacy. Such intimacy – first, perhaps, with the therapist and then with the partner – is engendered through conversations organized by the therapists' commitment to *empathic knowing*. Contrary to what is commonly understood, empathy does *not* involve therapists asserting that they understand what the clients are describing:

> Joanne: I can't take it anymore. I'm ready to leave. If I'm not screaming at Tony, I'm screaming in my head: Enough! Enough already!!
>
> Therapist: I hear what you're saying. I get that you're upset.

Rather than *claiming* to understand, BRCT therapists *demonstrate* it by offering back empathy-informed descriptions of, and hunches about, what they have distilled from the clients' stories.

> Joanne: I can't take it anymore. I'm ready to leave. If I'm not screaming at Tony, I'm screaming in my head: Enough! Enough already!!
>
> Therapist: You're at your wits' end! And there's no respite. Screaming inside, screaming outside – you must be exhausted.
>
> Joanne: Yes, but I'm too wired to feel the exhaustion.
>
> Therapist: So stressed. Kind of like feeling perpetually charged with an electric current?
>
> Joanne: So much. And I'm afraid of a spike taking me out.

Attending carefully to both the content and the emotional complexities of the stories, therapists offer their emerging empathic grasp of what the clients are saying. As clients listen and respond to these comments, agreeing with some and disagreeing with or correcting others, therapists use the feedback to adjust what they are understanding (and thus saying). Through such recursive dialogue, therapists derive a more accurate grasp of the clients' experience, and clients feel better heard and understood, allowing them to relax into trusting someone who is essentially a stranger.

This interactive unfolding of empathic knowing is particularly important when working with couples, as conflict is common. Rather than trying to maintain a neutral position that neither partner would take issue with, BRCT therapists adopt Anderson and Goolishian's (1986) commitment to "multi-partiality" with couples who are holding divergent views and are telling demonstrably different versions of fights and disagreements. The therapist stays actively engaged at all times, making empathic statements that the one partner can agree with, acknowledging that the other partner views the situation fundamentally differently,

empathizing with the second partner's view and experience, going back and doing the same with the first partner, and so on:

Joanne: I race home as soon as I can, but it is often after six. By then Tony, who isn't working and has no other responsibilities, should at least have dinner on, if not have the girls fed. But nine times out of ten, he hasn't even figured out what he's going to cook. Is he at least helping them with their homework? No! He's in his room on his iPad, drinking his first glass of wine for the evening.

Therapist: You arrive home frazzled and exhausted, and it seems only reasonable that Tony would show appreciation for all you do by helping with the kids – with cooking and homework. It sounds like you experience his being in his room as an affront.

Joanne: I do! Why is it up to me, the one working her butt off and paying the bills, to also have to make dinner?! If he doesn't care about me, well, whatever, but at least he could do it for the girls – they need to eat!

Therapist: It seems to you like a no-brainer. If only for the kids!

Joanne: Yes. Exactly.

Therapist: (turns to Tony) Do you agree with Joanne that most nights when she gets home she is the one to start in on making dinner?

Tony: Such a heroic figure. Fighting the good fight all day at work, only to arrive home and start dishing it out as she walks in the front door.

Therapist: Comes in like she's spoiling for a fight? You must have to gird yourself for her arrival.

Tony: You said it!

Therapist: I imagine the wine helps with that.

Tony: Oh yeah. I hear the car door, and I know the fireworks are about to begin.

Therapist: Feels safer in your room?

Tony: Let's just say there's no "Hello, how was your day?" No "How'd the writing go?" No "How are the girls?"

Therapist: You'd like to feel Joanne's interest in you and the girls be more important than her concern about whether you're fulfilling your assigned duties.

Tony: Yes!

Therapist: You want to feel like her husband and co-parent, not her employee.

Tony: Exactly.

Therapist: And Joanne, I imagine you'd love to walk in the door and encounter a husband who is happy you're home and invites you to join him in sharing some wine and finishing off dinner preparations.

Joanne: That would be wonderful.

Therapist: You don't want to be in the position of assigning duties.

Joanne: Not at all. But he doesn't step up, so what I'm supposed to do?

Therapist: It has felt like you've had no choice.

Joanne: Right.

Therapist: Man, it would feel so much better to not feel compelled to ride him.

Joanne: You can't imagine the relief.

Therapist: Let's talk about what the first step in that direction might look like.

Such empathy-infused conversations help each partner to feel understood, and they can facilitate descriptions in positive terms of what each person needs and what he or she might be willing and able to do differently in the service of making change possible. The conversations also provide a foundation for the therapist to introduce subtle shifts in how the problem is understood. The therapist framed Tony's drinking of wine and retreating to his bedroom as methods of protection or coping. Such characterizations are supportive rather than critical, and, as such, they make it possible for Tony to make different choices in the future without losing face. Implied in the therapist's comments is the idea that if Tony has been protecting himself from Joanne in *these* ways, perhaps he could find *other* ways of feeling safe. Perhaps he could shift from protecting himself *from* her to protecting himself *with* her. The therapist also described Joanne *feeling* like she had no other choice than to tell Tony what he needed to do. This is different from describing her as *actually* not having any other choice. The description implies that there is flexibility available; she just hasn't recognized it, yet. Thus, the conversation has brought the couple to a place where they can safely explore other possibilities.

The *relational* orientation of BRCT therapists is grounded in Bateson's (1991) recognition that we "live in a world that's only made of relationships" (p. 287). Information, the "stuff" of mind, is composed not of *things* but of *differences* or *distinctions* (Bateson 2000; Flemons 1991), and a difference is nothing (a no-thing) other than a relationship – a boundary that separates (and thus identifies) an object from what it isn't. According to Bateson (2000), *mind* is not synonymous with *brain* but is, rather, a system-emergent phenomenon, formed and maintained in communicational loops within and between

brain and body, and within and between perceiving organisms in an ecosystem: "The individual mind is immanent but not only in the body. It is immanent also in pathways and messages outside the body; and there is a larger Mind of which the individual mind is only a sub-system" (2000, p. 467).

For BRCT therapists, the relevant loops of this larger mind are those within and between partners and among the partners and the therapist. The information shared along these circuits is sometimes *rational*, but it is always *relational*. Both partners are communicating back and forth – or, more accurately, round and round – within themselves (between brain and body) and with each other, responding to each other's responses to each other's responses. It doesn't take long, particularly at times of high stress, for the communications to become fraught – knotted in a way that feels difficult if not impossible to untangle.

BRCT therapists thus conceive of themselves as disentanglement consultants. This is an important distinction: When couples localize a problem (usually each partner locates it inside the *other* person – "We'd be fine if only it weren't for my partner's pathology"), they typically come to therapy with a request to have the problem controlled, contained, or cured. But such goals are unattainable, and they lead to solution behaviors that tend to exacerbate the suffering (Watzlawick et al. 1974). All problematic solution attempts stem from a desire to distance from whatever is deemed undesirable; treating the problem as *other*, clients want to be rid of it. Paying heed to Milton Erickson's admonition (in Rossi and Ryan 1986) that the clinician's task is "*that of altering, not abolishing*" (p. 104; italics in the original), BRCT therapists shift the clients' goal from wanting to be free *of* the problem to finding freedom *in relation to* it. Problems are altered when the clients' experience has changed – when they are able to do something different in the relationship and in relation to the problem, which then allows them to view the relationship and the problem differently, or when they come to a different view of their partner and the struggle they've been having together and this shift in perspective frees them up to engage differently.

BRCT therapists have no interest in couples achieving "insight." This would imply that there exists one "right" understanding of the clients' situation and their participation in it, and that finding and embracing this understanding would itself be somehow therapeutic. Instead, the focus is on the clients finding it possible to orient differently to themselves and each other, allowing for a shift in their pattern of interaction and/or in the discovery of exceptions to their problem.

Case Study

A BRCT therapist began seeing Stephen, a 50-year-old physician, after Stephen's wife, Rachel, also a doctor, discovered his 4-year affair with a drug rep, Sandra, who still often visited his practice. Rachel worked at a hospital serviced by a different rep, so she didn't know Sandra personally, but when she discovered the texts and emails that confirmed the betrayal, she was able to use social media to familiarize herself with a woman she considered her nemesis.

As therapy began, Stephen was still very much involved with Sandra and reluctant to end it, although Rachel was demanding that he do so. The couple had played mixed-doubles tennis for many years, successfully competing nationally when they were younger and, until recently, still actively involved in senior competitions. The revelation of the affair had rocked this world, where both were minor celebrities, as well as the local medical community, where they were respected as a successful dual-career couple.

The therapist saw Stephen alone for several sessions as he oscillated between guilt over hurting Rachel and a desperate desire to continue seeing Sandra. After a number of weeks, Stephen announced that he wanted to fix his marriage, and he asked Rachel to join the therapy. They began working towards rebuilding their fractured relationship, but the progress was touch-and-go. Despite his reassurance to Rachel that he would end the affair, Stephen held back from cutting off all contact with Sandra, and, he said, he could do nothing about the fact that his office was still part of her drug-rep responsibilities; he couldn't stop

her from dropping off samples and requesting time with the docs. This devastated Rachel, who would threaten to leave, but she didn't follow through, as she truly wanted to save the marriage.

Rather than urging Stephen to end all contact with Sandra and reclaim his marriage, and rather than urging Rachel to fight harder for her husband or make good on her threats, the therapist, eschewing any position of authority from which to tell them what they should do, instead maintained a stance of deep empathy for both partners.

> Therapist: Rachel, this is such familiar territory for you, and yet you never give up hope. Even in the midst of your devastation, you reach out to Stephen.
>
> Rachel (crying): I hate that I still love him. If I could leave him and tell him to go to hell I would. But I still love him. I want this marriage.
>
> Therapist: You feel so caught, wanting, but so far unable, to cast him aside. The connection is strong. You just want to be rid of him *and* you just want him.
>
> Rachel: (quietly) Yes, both.
>
> Therapist: And (turns to Stephen) as hard as it is to imagine ending your relationship with Sandra, here you are with Rachel, receiving her pain and anger, accepting it.
>
> Stephen: I *hate* hurting you, Rachel. I'm truly sorry. I just can't promise you right now that I will never see her again. She's not a bad person. I don't want to devastate her.
>
> Rachel: (yelling) But you're devastating *me!*
>
> Therapist: (to Stephen) You don't want to hurt either of them.
>
> Stephen: No, I don't.
>
> Therapist: (to Rachel) And you're caught by the irony that Stephen's commitment not to be hurtful wounds you to your core.
>
> Rachel: It stabs me in my heart.
>
> Therapist: . . . So very, very painful. And no easy answers. Rachel, what do you know about yourself, and about Stephen, that gives you hope you can recover from this betrayal, whether or not the marriage itself survives?
>
> Rachel: I don't know (more crying); I am just not willing to give up. Not yet, not after 20 years. I still love the bastard, stupid as that sounds.

While Stephen remained stuck, not knowing how or whether to end his relationship with Sandra or to divorce his wife, the therapist saw Rachel for several sessions, helping her to find her way through the anger and confusion she was experiencing. She remained unconvinced that she and Stephen could ever make the progress necessary to reconcile and rebuild their relationship, and the therapist respected this questioning. Blind-sided by the affair and publically humiliated when it had become known to both the professional and tennis communities, she had, she said, "gone underground," losing her voice and becoming an invisible passenger in a relationship that felt out of control. Normally a strong and productive person, Rachel felt she had lost her balance, resulting in her acting in ways that she didn't recognize or respect. She wanted to stop alternating between berating Stephen about the affair and begging him to end it.

> Therapist: It makes sense to me that you would be out of touch with your usual mojo – you are accustomed to being a vibrant part of a dynamic, and very public, relationship. So who is Rachel outside of the Rachel-and-Stephen duo?
>
> Rachel: Exactly! I hate it; I feel invisible, and then I hate him. And I have no voice! No vote! The son of a bitch does exactly as he pleases, and I have to accept the fallout. He just gets away with it!

Rachel had been closely monitoring Stephen's computer and cell-phone communications with Sandra, focusing on that to the exclusion of most everything else, save for her patients. She and the therapist explored expanding the scope of her interests to include activities of her own she cared about.

> Therapist: Certainly, right now Stephen is calling the shots on what happens with this other relationship. What parts of your life are still yours? What matters to you now in the areas of your life that you are in charge of?
>
> Rachel: I'm still a doctor, and I'm still an athlete. I have a professional identity separate from him, but we've been tennis partners for forever. I haven't played singles for as long as I can remember, and I don't remember the last time I competed with a different partner.

The therapist acknowledged how difficult it would be for Rachel to find anything as arresting as the status of Stephen's relationship with Sandra; nevertheless, they explored the possibility, however slim, of her experimenting with reclaiming a life that didn't have Stephen at the center. When she returned a few weeks later, Rachel described an experience much different from what she would have predicted. She'd started thinking a lot about personal agency, and

she'd decided to do something about it. She moved fulltime into a nearby condo that she and Stephen owned on the beach, she started playing women's doubles tennis, and she blocked both Stephen and Sandra on Facebook. She and Stephen had gone to dinner twice, but only when it was convenient for her; a few other times when he'd suggested they meet, she'd been too busy with work or other involvements to agree. She said she'd become much less reactive to him – her anger had transported her into living rather than stewing.

The couple came in together to the next appointment 3 weeks later. They had spent two weekends together, talking intensely about issues they had not discussed in many years, and Stephen said he had not been in touch with Sandra for several weeks. During this session, the couple described an ongoing challenge that Stephen considered a catalyst for his affair. For several years, sex with Rachel had felt like "an obligation," and at some point along the way, he'd found himself unable to maintain an erection during intercourse. He'd started avoiding sex with her altogether, and they'd become "like roommates," and this had compromised not only their physical closeness but also their emotional connection. With Sandra, he'd had "no problems in the penis department." This had been both exciting and relieving for him, proving that he didn't have a physical problem.

Now that they were having unprecedented intense, intimate dialogues, this topic was on the front burner, and they were concerned it could be a deal breaker, even as they both gained confidence that they could save their marriage. Rachel was not the least bit interested, she said, in staying in a sexless marriage. Turning to Stephen, she was clear and forceful: "You can take your obligation and shove it up your ass!" She was no longer concerned, she said, about whether he considered her sexy enough; she found *herself* sexually attractive and, if he didn't, she knew she would find someone else who would. Rachel had found her voice, her strength, and her independence. She was clear that she wouldn't tolerate any communication between Stephen and his lover, but she also said that she was firing herself as a "private investigator." If Stephen chose to be with her, he had to be all-in; if he waffled, or if she discovered he was lying, she'd immediately file for divorce. If he wanted to work towards rebuilding trust and to risk reigniting their sexual relationship, she would consider it; otherwise, she was moving forward on her own. Stephen found the difference in Rachel both intriguing and terrifying.

> Therapist: (to Stephen) What's it like to have these conversations with Rachel now, and to anticipate being sexual with her?
>
> Stephen: Talking to her is incredibly arousing; she's strong and demanding and sexy. I've never been so attracted to her, intellectually. But I don't trust that's going to make the difference for me physically. And the thing is, I know there is nothing wrong with me physically. I can perform, believe me!
>
> Rachel: Well, imagine how terrifying that is for me, Stephen! How can I risk making myself vulnerable to you, knowing that if I'm not sexy enough, you'll just go back to her!

These significant changes in their ways of relating to each other, and in Rachel's ways of relating to Stephen, to his affair, and to her own sexuality, opened the door to different ways of conceptualizing their past struggles. The therapist acknowledged the differences and offered a reframe of Stephen's past difficulty in maintaining an erection with Rachel.

> Therapist: How very difficult for both of you to imagine enjoying sexual encounters together while worrying that if Stephen can't get it up, this would mean the end of your relationship. These are incredibly high stakes, and a lot of pressure to put on one organ and one experience. Stephen, I have a question for you.
>
> Stephen: Shoot.
>
> Therapist: You said before that sex with Rachel had starting feeling like an obligation.
>
> Stephen: That's right.
>
> Therapist: And then at some point after that, you started having erection difficulties during intercourse.
>
> Stephen: Yes.
>
> Therapist: Do you remember when that started?
>
> Rachel: It didn't happen all of a sudden, but it got pretty quickly to where it was happening a lot, and then he just avoided sex altogether.
>
> Therapist: That sound about right to you, Stephen?
>
> Stephen: Pretty close, yeah.
>
> Therapist: And when did that start?
>
> Rachel: Must have been about four years ago.
>
> Therapist: Makes sense. About the time the affair started.

Rachel: Son of a bitch!

Therapist: Sure, but this is what I'm thinking. It seems to me, Stephen, that while you were involved with Sandra, being sexual with Rachel felt to your penis like "cheating" on Sandra. While obviously disturbing to you both, the one thing your lack of an erection accomplished during your relationship with Sandra was to keep you from betraying her, or from giving false hope to Rachel. Perhaps there was some wisdom in the choice your penis was making at the time. *You* weren't being monogamous, but *it* was. Now, however, much has changed between you two, and, Rachel, you now have begun to embrace your own sexual identity apart from Stephen. I'm wondering how your body may respond differently now, Stephen, given that you would no longer be "cheating" when being sexual with Rachel.

Rachel: Sweet. My philandering husband has a monogamous dick. Who knew?

By reframing Stephen's erection difficulties as a sign of his faithfulness, if only to his lover, the therapist offered Stephen and Rachel (and Stephen's mindful body) a way forward. Given the intimacy and vulnerability generated by their new conversations, and given Stephen's commitment to direct his faithfulness towards his wife, they could expect his "monogamous penis," not weighted down by guilt, to rise to the occasion.

Therapist: So, what incredible risks you are both taking – finding the freedom to talk about sex when it has been a taboo topic – and act! – for so many years.

Rachel: Yes, it's terrifying, but I'm not going to go back underground. This is our only chance.

Therapist: There is tremendous risk for both of you, but what I notice is that you are each finding the strength to embrace risk in new ways. I wonder how you will find desire in that risk, and where that desire will take you both.

The couple continued to attend therapy, sometimes weekly, sometimes sporadically, for the next 3 months. Rachel stayed in the condo until she decided it was emotionally safe to move home, and they started playing tennis together again, though with a different set of interpersonal rules. Stephen had always been a fierce competitor; when one of them would make a mistake, he'd be quick to anger and unrestrained in voicing his criticism. He wouldn't hold onto his rancor, but his words and tone of voice would ring in Rachel's ears, and she was no longer willing to be subjected to his temper. She agreed to play again with him in competition, but only if he approached winning – and losing – with more acceptance and kindness. He took up her challenge and worked, mostly successfully, with the therapist on altering his orientation to the game.

They also ventured into a sexual relationship, full of apprehension and anticipation, facing their greatest fear – that Stephen would not be able to be fully sexual with Rachel. The results were often wonderful, sometimes disappointing, and at one point devastating, but the act of taking the risks *together* allowed them to find mutual respect and desire, both of which had been absent from their relationship for many years. In their final session, they described their evolving sexual connection, their commitment to saving their marriage, and their success on the courts. The yelling was absent, and, continuing to untangle themselves from the effects of the affair, they were finding joy and rhythm in all facets of their partnership.

Cross-References

- Brief Strategic Couple Therapy
- Collaborative Couple Therapy
- Couple Therapy
- Empathy in Couple and Family Therapy
- Neutrality of Therapist in Couple and Family Therapy
- Reframing in Couple and Family Therapy

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