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The Difficult Couple

by Steven A. Foreman

What makes the difficult couple difficult? As therapists, we describe couples as “difficult” based on the troubled feelings we are left with—uninspired, bored, mournful, or horrified— when treating or even thinking about such a couple. Our countertransference is the first identifying signal.

What experience triggers such an internal reaction? Usually it’s when the couple refuses to get better. The partners fail to solve the problems with which they came into therapy. They suffer and struggle terribly but seem to drag each other down like drowning victims with their arms around each others’ necks. The therapist feels he is watching or participating in the tragedy, like a third member pulled into the morass.

The therapist can feel victimized and unfairly attacked when difficult patients blame, criticize, or yell. Or she can feel responsible and guilty for failing to alleviate the suffering of one or both partners. With difficult couples, the therapist invariably gets drawn into the drama, facing the pain, despair, and sense of no way out that grips the couple.

This chapter will highlight some of the reasons that these couples are so difficult to treat and thereby shed light on strategies we can use to extricate ourselves and our clients from these apparently impossible messes. Difficult patients seem to weave “spells” that paralyze and torment each other and the therapist. I’ll outline the origins and mechanisms of these spells by illustrating how couples reenact pathological relationships from their past and how they engage each other and the therapist in dramas which reflect how little they feel they deserve in their lives. This chapter will establish how to identify difficult patients and what techniques are most useful in their treatment. Understanding the nature of their distorted beliefs and resisting the pernicious power of their spells can help the therapist forge an inspired treatment plan.

Identifying Difficult Couples

In addition to using the barometer of our own countertransference, we can identify difficult couples by several factors:

- 1) Their interpersonal behaviors are more disturbed both inside and outside the therapy, characterized by abuse and self destructiveness.
- 2) Their childhood experiences are more disturbed and their histories are often marked by severe psychological trauma such as parental loss, abuse or neglect.
- 3) There is often concomitant psychiatric illness such as major depression, serious substance abuse, or even psychosis.

The couple’s disturbed current behavior and disturbed childhood experiences are directly related. Each partner reenacts pathological relationship patterns from his family of origin. The partners play different roles including: how each acted as a child, how the parents acted toward them, and how the parents treated each other. Reenactments in relationships are fairly universal and are often healthy since they’re one of the ways people face and reexamine the normally painful experiences and parental mistakes they endured growing up. These reenactments are part of the growing process that relationships offer in life.

But sometimes people get stuck in their reenactments. Instead of breaking out of old patterns with a new relationship, a person can drag the new relationship into old patterns. This happens when both members' psychological issues intersect in ways that make it impossible to help each other and actually intensify or aggravate each person's pathological behaviors. Even though there are two dramas being reenacted (one from each family of origin), each person is only aware of the one in which he is consumed. In these intractable conflicts, two people are usually under the illusion they are fighting about the same thing. In reality, each partner is working on an individual issue, which is different than the partner's issue, even though both issues are occurring simultaneously.

So, difficult couples are stuck in unhappy repetitions of past family relationships. They are usually unaware that their current problems have any relation to the unresolved conflicts from their families of origin. They are also completely absorbed in their current despair and desperation. Almost all couples who seek therapy feel somewhat stuck. But difficult couples are more stuck. Their pathological families of origins resulted in more pathological reenactments in their adult relationship.

Such difficult couples often have an underlying belief that they have no hope and no right to solve their mess. This hopeless feeling is driven by lifelong experiences of interpersonal failure first as children and then as adults. The despair is also driven by an overwhelming feeling of guilt and self blame which is often unconscious.

As children in dysfunctional families they felt responsible, however irrationally, for their parent's failures and family suffering. Subsequently, they often feel very guilty trying to solve their relationship problems (which they desperately want to do) because they feel if they get their needs met, they'll damage the other person in the relationship, just as they believed as children. Their exaggerated worries are reinforced, moreover, by watching their partners suffer following their repetitive painful interactions. This guilt about damaging others becomes more intense because they choose partners who, like their parents and siblings, are more psychologically fragile.

Partners in difficult couples feel guilty doing better than their parents and siblings which is why they tend to repeat such pathological relationships so faithfully, unconsciously, and tenaciously. They actively undermine themselves and each other in their efforts to solve their problems. In therapy, they don't get better, or they get better then slip backwards.

As these couples falter, the therapist feels anxious, deflated, and helpless. The couple repeats their parents' pathologic behavior and they unconsciously place the therapist in the same position they were in as children. The therapist ends up watching the couple fail and flounder, feeling the same helplessness and guilt each partner felt watching their parents.

In the treatment of almost all couples, blame plays a central role. Most partners in conflict feel blamed and then blame one another. But difficult couples have a more exquisite sensitivity to blame. This is because they feel intolerably guilty and externalize blame more than most. They also have grown up with more blame so they feel it and sling it more readily.

Many people in relationships have a hard time asserting their needs which leads to unhappiness and problems in communication. Partners in difficult couples have even less ability to assert their needs. There are many reasons for this inability including cognitive and emotional deficits which inhibit awareness or expression of feelings. Much of this inability to express needs comes from the partners' profound lack of a sense of appropriate entitlement which is based on their childhood histories of abuse or neglect. Consciously, these unhappy people feel greedy for wanting too much and guilty if they get what they need.

The Case of Sam and Jody

I'd like to illustrate some of these general principles with a clinical case description of a very difficult couple, Sam and Jody, who were in their late forties. This couple came for treatment following a recurrent incident where Sam abusively humiliated Jody.

It was the second marriage for each. They both drank alcohol although Jody's dependence was more severe. Sam was a corporate executive who was domineering and controlling. Jody retreated and withdrew when he got angry which only provoked him to be more aggressively intrusive. Her alcohol use and smoking cigarettes worried Sam. Then she would lie to him, hide bottles and pretend she wasn't smoking which worried and infuriated him more. He would chase her down and force her to listen to him. He became physically violent three or four times in the marriage, slapping her.

Sam's father died when Sam was 21 years old of an alcohol related illness. Sam described his mother as intrusive and abusive. She would chase him around the house, yelling at him, complaining, and invading his privacy.

Jody's family had attended a fundamentalist church where if you didn't conform to the edicts of the church, you would be cast out of the congregation and the family. Though not alcoholic, her parents were physically out of control and verbally abusive to her as a child.

The current relationship of this couple repeated several pathological aspects of their families of origin. Sam was "sensitive" about his wife's alcohol use because it reminded him of his father's alcohol related death. When he worried about her, he acted just like his mother treated him: intrusive, aggressive, and abusive. He didn't realize at first that his behavior was a reenactment of his mother's style, but thought he needed to be "in control all the time". In his first session, he reported, "I inflict emotional pain. The more I do, the less I get. I'm not smart enough to control that." Later he said, "I've worn her down, broken her spirit. It's the opposite of what I want... The last thing I want is to hurt her."

Jody was also repeating several patterns from her childhood. She was acting like a "bad" child by smoking and drinking, just as she did in her family of origin. They were always threatening to reject or punish her because of her rebellious behavior. She reenacted this relationship with her husband whom she invited to punish or reject her. And just as she did with her parents, Jody felt responsible for her husband getting wildly out of control when provoked. In addition, her drinking was a form of acting out of control, a way of identifying with her parents. Sam, likewise, identified with his parents, particularly his mother, by acting out of control. Neither could stop his behavior nor influence the other's behavior. Indeed, each only seemed to make the other worse.

This case illustrates how Jody and Sam's individual issues were simultaneously operating without either one of them being aware of it. Jody wanted to be accepted and treated with respect to overcome her childhood belief she had no right to that. Just as she provoked her parents in the unconscious hope of obtaining help and not rejection, she tested Sam with her "bad" behavior. In doing so, she inadvertently collided with Sam's issue of worry which triggered his excessive controlling and abusive behavior.

Sam's behavior provoked Jody to continue her pattern and her behavior provoked him to continue his. His behavior confirmed her belief that she deserved to live her life acting and being treated like a despicable creature.

Both saw the other's behavior through the lens of their individual experiences. For Sam, Jody's behavior was irresponsible and only served to torture him. For Jody, Sam was just another person abusing her because she was such a bad person. She could not see how truly worried he was about her, because his abusive behavior seemed inconsistent with such feelings.

Treatment

The treatment of the difficult couple begins like the treatment of any couple, by supporting both partners, by finding out where each person wants to go, and by stopping the cycle of blame. The therapist can wade into the fight and try to solve it. In so doing, the therapist can "translate" for each partner what the other is saying and then interpret how each misunderstands the other and inadvertently pushes each other's buttons. The therapist can encourage each partner to elucidate more clearly her needs as part of practical problem solving as well as part of a campaign to disabuse each partner of mistaken ideas about

what the other really wants. In the course of trying to solve the couple's problem, the therapist can note what is getting in the way of the solution when initial problem solving doesn't work.

But it's usually the case with difficult couples that clarification of issues and rational problem solving will not be enough to resolve the couple's problem. The difficult couple does not get better in the same way as "other" couples. This chapter will outline a step by step process for effective treatment. It will discuss developing an appropriate attitude or therapeutic stance in which the therapist masters her own countertransference feelings and simultaneously helps break the spell which binds the couple.

Taking Both Sides

In any treatment, it is crucial for the therapist to approach the couple in the role of a resource and an ally to both members. This position cannot be sustained if the therapist takes one side against the other or falls into the invitation to blame either of them. The therapist has to be alert to the couple's sensitivity and avoid tactless communications which might be misperceived as blame. By mastering this, the therapist also serves as a model for the couple to be able to talk more clearly to each other without getting sidetracked. With difficult patients, who are hypersensitive to blame and quite blaming themselves, this issue often presents quite early in the therapy.

For example, in the first session of another case, when Julie yelled and snarled at her husband Bob for having an affair with another woman, he responded by being inarticulate and confused. Bob was so paralyzed, he couldn't think clearly or present his side. Julie was so hurt and angry, she did little more than yell and blame. This pattern of communication was ineffective and exemplified long standing problems in their relationship. Julie tended to suffer, blame and not listen to Bob while Bob tended to get confused, quietly withdraw, and avoid Julie.

As the therapist, I felt frustrated and a little irritated by each partner's obvious self-centeredness and insensitivity to the other. Julie's relentless complaining was grating while Bob's passivity and marital betrayal was disappointing. Neither seemed motivated to change his repetitive interactional style even though it was damaging. If I was looking for an excuse to blame someone, both partners presented themselves as inviting candidates.

Any couples therapist knows that once you take sides with one partner against the other, the therapy will fail. I could have sided with Bob that Julie was miserable to live with or I could have sided with Julie as the rightfully angry victim of a deceitful and psychologically paralyzed husband. Some therapists try to remedy this dilemma by blaming both partners equally, attempting to appear at least evenhanded. My experience has been that when therapists tell patients how awful they are, this does not lead to new insights and growth but instead confirms the patients' underlying beliefs that they are bad and undeserving, which intensifies their maladaptive behaviors.

Difficult patients are like other patients in that they test the therapist from the first day to see if she will be judgmental or rejecting. But the tests are more exaggerated and more compelling. The therapist feels intensely drawn to believe the patient's presentation of herself as blameworthy and rejectable. This is the "spell" the difficult patient weaves, convincing the people in his life, i.e. the partner, the therapist, and others, of the veracity of his distorted beliefs about himself and provoking them to respond negatively.

The therapist's strategy should be to avoid falling for the invitation to judge and blame. This may sound easy but the therapist may often feel like Odysseus bound to the mast, trying to resist the Siren call. Even though we are intellectually committed to being nonjudgmental, sometimes therapists underestimate the patient's power to convince us of his monstrous self-image and to provoke us to judge or dismiss him based on that.

Not only should the therapist avoid blame, but it is helpful to be positive and supportive of both partners, not against each other but toward attaining their individual goals. For example, Jody tried to overcome her belief she was bad and deserving of abuse while Sam tried to overcome his conviction he was responsible for other people's pathology. They both wanted to overcome their compulsions to act out of

control like their parents. Consequently, I allied myself with each person's strivings, respected them, helped them, and at the same time, assessed whether there was anything essentially incompatible about their needs in the relationship.

Determining Each Partner's Direction

Helping each person identify and achieve personal goals is the other side of not falling for the invitation to judge and blame because it requires taking each person seriously. This is problematic with difficult patients because they invite you to not take them seriously. They look like they enjoy their hellish relationships and seem to have no interest in healthy goals. My strong assumption is that this is an illusion, a "spell" that the therapist should resist. Rather we should actively reframe the difficult patients' behavior in a way that challenges their distorted beliefs about themselves and also helps shed light on what is adaptive about what they're trying to do.

For example, in the case of Sam and Jody, some therapists might have formulated that Sam sadistically enjoyed tormenting Jody and that Jody really wanted to suffer masochistically as a passive aggressive way to torment Sam. This formulation seems consistent with their behavior. However, I didn't believe that suffering and tormenting each other truly reflected what they wanted. I aligned myself with the part of Sam who said he didn't want to hurt Jody and the part of Jody who said she didn't want to be treated badly by Sam.

Early in therapy, I asked both of them about their individual goals to see if there were any areas of common ground. It turned out there was considerable overlap—including their commitment to the marriage, their respect for each other, and their sexual interests—which instilled some hope. Then I encouraged both partners to spell out their side of the intense provocative cycle enabling them to hear each other more clearly. It was at this point that Jody heard for the first time how worried Sam was about her and Sam heard how Jody really feared rejection. This allowed them to experience one another as real people rather than as ghosts from the past. Once it was clear to me what dramas each was reenacting, I could elucidate them, facilitating their disengagement from each others' repetitions. Even though people are compulsively drawn to repeat their troubled pasts, my assumption is that they actually want to be free not to repeat but to achieve some degree of intimacy and mutuality in their relationship.

Eventually, I told them that Jody repeated with Sam what she did with her parents: she acted like a "bad" kid and provoked Sam to be punitive like her parents. Similarly, I told them that Sam was repeating his mother's behavior by acting overbearing and abusive toward Jody, not because he liked it or wanted to but out of unconscious loyalty to his mother. I told him that he really wanted a different relationship with Jody than his mother had with him and that's why they were entering therapy to change these repetitive patterns.

Stopping the Cycle of Blame

Supporting both members and reframing the conflict psychologically are instrumental in stopping the partners from blaming each other. It is helpful for the therapist to address the cycle of blame directly: "No wonder you don't trust each other. You're in the middle of a battle. Blame is in the air. You can't really hear each other because you're both very sensitive to being blamed. When one of you rightfully defends yourself, the other one feels blamed and blames back. There is an illusion that what you both want is incompatible but I don't think that's true based on what I hear you saying."

An example which illustrates stopping the blame cycle was the case of Betty, a 40 year old woman who complained of recurrent health concerns, and her husband, Jack, who regularly dismissed and criticized her for being a "hypochondriac." Betty had a breast lump and wanted to be able to talk about her fears about breast cancer while the couple was waiting for the results of the biopsy. Jack didn't want to entertain speculations about cancer before the results of the biopsy were in. He encouraged her to take one step at a

time and not to worry unnecessarily until they actually had a confirmed diagnosis. Betty felt dismissed and rejected by Jack's refusal to talk.

This interchange was upsetting to both of them. There had been other health scares including an episode of rectal bleeding and recurrent abdominal pains. During each episode, Betty wanted support from Jack but was bitterly disappointed and angry when she felt shut out. Jack was fearful of getting swallowed up in Betty's "hysteria". He thought she enjoyed being in crisis and felt she perversely wanted to drag him down with her. He became resentful and avoided her when she was having her health crisis "of the week" as he called them. He derided and blamed her for creating problems unnecessarily.

Betty was quite hurt by Jack's anger and apparent indifference. She was convinced Jack didn't care about her since he was so hurtful when she felt vulnerable. She felt her needs to be cared for, loved, and listened to were a burden to him. In her anger she fought back by blaming her husband for being insensitive and uncaring.

On his side, Jack felt overwhelmed by what he saw as Betty's endless physical problems and emotional needs. He felt responsible to solve her problems and suffered enormous guilt because he was unable to relieve her anxiety and physical discomfort. His guilt led him to blame Betty.

Their individual childhood experiences fanned their marital difficulties. Betty's mother was very depressed, needy, self-centered and an inadequate caregiver. Betty came to believe that her own needs were burdensome to her mother and to everyone else, including Jack.

Jack's mother died of cancer when he was six years old and his heightened sense of responsibility and failure to help Betty presumably derived from that experience. Betty's possible illness and emotional distress made him feel so threatened and helpless that he was unable to respond or even listen to her.

Betty's assumption that her fundamental needs for love and attention tormented her husband was reinforced by Jack's exaggerated painful responses to her. In fact, Jack was tormented, not by her needs, but by his guilt that he was not able to help her more. His suffering only increased her guilt so that both came to believe that they were responsible for the other's suffering. Jack blamed Betty for being too needy and she blamed him for not helping her enough, confirming each of their worst fears.

To stop the cycle of blame, I pointed out that Jack was really very worried about Betty's physical complaints and felt to blame for not being more effective in helping her. I noted that since Jack felt so much self-blame for failing to be more helpful, he felt compelled to blame her for being too needy. I also pointed out that Betty felt very much to blame for having so many problems and burdening her husband. In order to counter her self-blame, she blamed him for being insensitive.

In order for Jack to stop blaming Betty for being too needy, I told them he needed to relax his expectations of himself to solve all her problems. I basically gave him permission to do much less than Jack thought he needed to. Instead of solving all her problems, he just had to listen and not attack her.

In order for Betty to stop blaming Jack for being too insensitive, I bolstered her sense of appropriate entitlement and said she should get more emotional support from him. Instead of retreating in shame from his accusations that she was too needy, I encouraged her to clearly ask for the time and attention she needed.

I was very concrete in facilitating negotiations to solve this problem. After ascertaining that Jack thought Betty needed 24 hours a day of handholding, I asked Betty if anything less than that would be sufficient for her needs. She said she needed some time from Jack she could count on because he always put her off and ended up giving her nothing. I asked her if 15 or 20 minutes of time to talk would be enough. He sneered that would never be enough for her. She said that would actually be fine if he really did it but she was sure he'd have no interest in giving her that much time.

Betty was suspicious when he said that was acceptable. She said she was sure he would let her down and not follow through. We agreed if it was inconvenient for him to talk at a particular time, he would suggest a specific later time. I helped them to negotiate a plan which included 15-20 minutes of time daily for Betty to talk about her physical complaints and for Jack to listen without trying to help too much and without being critical.

They were surprised to find out their worst fears did not come true: she was not a bottomless pit and he was not completely uncaring. By encouraging both to articulate concretely what they wanted, their misconceptions were relieved about what they thought each other wanted. He was relieved to find out he could help her a lot by doing much less work. She was relieved to find out he actually cared about her and was willing to give her time and attention. He began to realize he was not as omnipotently responsible for her as he had felt. She began to realize that her needs were not as excessive and toxic as she had thought.

When Solving the Fight Doesn't Work

In the therapy with Sam and Jody, I tried to help solve their conflicts as described earlier, by 1) identifying what each person was fighting about, 2) identifying hot buttons, and 3) identifying misunderstandings. Early on, we attempted to solve conflicts concretely by devising plans which addressed both of their needs.

For example, I worked with the couple about rules for arguing. They seemed to argue at any time about any subject. Jody complained that she was constantly criticized, so I suggested a 15 minute moratorium on criticism about any subject when Sam first came home from work. I worked with them to keep their arguments simple and to limit the duration.

Even though Sam and Jody seemed articulate, motivated, and capable of addressing the issues, they would go home and repeat the cycle with renewed vehemence. In the third session, they made an agreement to stop their intense fighting. In the fourth session, Jody reported, "Things aren't going well. He said I should be slapped around for lying."

I interpreted that both Sam and Jody were taking too much responsibility for the other's behavior. I suggested that when Jody drinks, Sam should not stop caring, but he should stop harassing her. I suggested that when Sam worries about her, Jody should not take it to heart and assume that she is a terrible person. This seemed to be helpful because Jody then recalled from her childhood that in her family's church, she had to go along with authority or be cast out. Sam said, "I didn't know that. I won't cast you out."

Their relationship seemed to improve. Their fights temporarily lessened. Sam liked that she stopped taking his criticisms so much to heart. We talked about Sam's concern about her cigarette smoking. I observed that Jody was playing the role of a rebellious teenager and Sam was playing the punitive parent. This allowed them to relax and feel closer.

In the following session, they reported that everything fell apart again. They had another fight at home. Sam was critical. She withdrew. He attacked her more fervently. She threatened to leave. They stopped the fight for about an hour and then resumed antagonisms again. I observed that this was still an improvement that they were able to avoid slipping into the fight so easily and then they were able to stop fighting for an hour. I worked with them to reconstruct how and why each of them slipped back into this old pattern.

After three months of therapy, Jody offered to stop drinking. Sam said it wasn't necessary. He said she should only cut back. I had spelled out how destructive alcohol was to both of them and that they might have to stop completely. I now used this opportunity to encourage complete abstinence from alcohol for both of them. In the next session, Sam said, "We're not going anywhere. Drinking is still going on." Jody said, "That's not true. I stopped. I just drank once when you unfairly accused me of drinking." He said, "I can't trust you," at which point she got up and left the office despite my asking her to stay.

After she left, I spoke to Sam about the necessity for both of them to stop drinking, and for Sam to stop worrying, berating, and treating her like a child. I encouraged him to pursue individual therapy in addition to the couples work. Jody came back in the next session and apologized for walking out but reaffirmed her right to protect herself against Sam's criticisms. In the discussions of abstaining from alcohol over the next month, Jody did not agree to stop but only said she wanted to cut back, a reversal of

her previous position. Sam agreed with that plan but I strongly recommended she stop drinking and contact Alcoholics Anonymous.

A Turning Point

After five months of therapy, the couple had a session in which they continued to fight about the same issues: Sam's criticizing and Jody's drinking. They appeared to make no real progress resolving this repetitive painful interaction despite their mutual sincere efforts. At that moment I realized for the first time that neither partner was going to let himself gain control of his behavior while the other was out of control.

I interpreted this to them, saying, in effect, that each felt guilty outdoing the other. It created a self-perpetuating system since each was waiting for the other to be in control before she would allow herself to gain control. Jody agreed enthusiastically to the interpretation.

This was a turning point in the therapy. In the next session, Sam came alone because Jody had checked herself into a thirty day inpatient alcohol program. Sam said, "I took to heart the discussion last week," following which he described acting differently in response to Jody's provocations. He didn't "bite" and he didn't really get angry. He offered her the telephone number of the inpatient alcohol program and she threw it out. Later she asked for it again and he gave it to her. They had both shifted in their behavior.

In that session, Sam spontaneously explored his past for the first time. His history and dynamics seemed clearer to both of us. Jody played his father's role. Sam remembered that once before, when Jody was drunk, she wanted to go into an alcohol program, but he opposed it, saying he wanted her to take care of herself. I interpreted that he felt pulled to reexperience and even maintain the same alcoholic tensions with Jody that his mother had with his father because he felt badly his parents never solved that issue and he wouldn't let himself gain control of a problem that they couldn't.

Sam's identification with his mother became clearer. He began to see how he harassed Jody like his mother harassed his father. I pointed out that the purpose of acting like his mother was to keep from being aware how unpleasant and pathetic she was. Acting like her served to justify her behavior to himself and to protect her from his disappointment and scorn. This line of interpretation allowed Sam to disconnect from his compulsive critical behavior towards Jody. Sam eventually entered his own therapy and developed a more pleasant demeanor even at work where he had been a tyrannical boss.

Jody became more self confident and happier in her relationship with Sam. Jody had quit her therapy with her previous therapist and started working with an alcohol counselor. When I asked whether she was getting enough therapeutic support, Jody replied she felt "greedy" if she let herself get too much. She had several relapses requiring hospitalization during our couples therapy and continued to test whether Sam would ultimately reject her.

The therapy lasted a total of 19 months. Jody continued to relapse in her drinking. Sam worried he'd slip backward to become critical again. As the therapy came to a close, they dealt with the ability to ask for things from each other, saying "no", and many other issues, from fights about how each did the checkbook differently to pursuing a more satisfying sex life. Significantly, they agreed to move from an "open" to a monogamous sexual arrangement in their marriage.

In a follow up contact 20 months after the therapy ended, the therapist learned that the couple was still together, though Jody was still struggling with alcoholism. Sam was not sure if they were going to stay together. However, the miserable cycle of blame and provocation had been broken. Both partners were dealing with their considerable issues from a different vantage point, no longer locked in their previous patterns.

The Therapist's Stance

The therapist's role is not simply one of diagnostician and interpreter. We are inevitably drawn into the psychology and experience of the couple as a member of the system. The therapist's countertransference, besides being an initial diagnostic indicator, is an opportunity to empathize with each partner's feelings about the other. When Jody relapsed in her drinking, I felt worried and frustrated like Sam. When Jody reported Sam was still verbally abusing and threatening her, I felt angry and considered giving up on him like Jody.

Countertransference is also a window into the past to see how each partner felt experiencing a version of this drama as children. When Jody repeatedly acted irresponsibly self destructive, I felt worried and disdainful, a paler version of the way she felt towards her severely dysfunctional parents as a child. When Sam repeatedly attacked Jody, I felt disappointed and irritated towards him, which paralleled how he felt as a child when his mother attacked his father. When Sam couldn't change his behavior despite my best efforts, I felt frustrated just as Sam felt as a child when his father continued to drink and his mother continued to be inappropriate no matter what he did. My experience of anger, helplessness, and despair in response to Sam and Jody's behavior, was a cognitive and emotional glimpse into their experience as children.

The therapist, unwittingly and painfully pulled into the maelstrom, is thereby positioned to help the couple find the way out. He can take stock of his own feelings and understand what the couple feels. The therapist is depressed and despairing. The therapist feels responsible for helping the couple and is poignantly aware he is failing to do so. The therapist is angry at people who seem miserable and bent on self destruction. Then he feels guilty for having such feelings for people he is supposed to be helping. All of which directly repeat the feelings each partner has for each other and are the same feelings each partner had for her parents during childhood.

Consequently, the therapist's emotional and behavioral response can be powerfully therapeutic to each member of the couple. These patients are intensely interested in how the therapist manages his internal state, struggling with despair, blame, guilt, and omnipotent responsibility, which can serve as a new model with which each partner can identify. If the therapist's behavior is different from each partner and different from each partner's parents in the past, it can challenge each person's convictions that they have to be miserable and treat each other badly.

If the therapist resists the invitation to believe what the couple believes, to feel guilty and miserable, to feel paralyzed, to get confused and blame irrationally, the couple can take heart. Jody may have an intractable drinking problem, but I don't have to panic and attack. Sam may be impossibly critical but I don't have to get depressed and develop a drinking problem. Just maintaining a thoughtful, helpful demeanor in the face of this drama is an immense achievement that no one in the family has been able to achieve so far.

The content of the therapist's interpretations may be useful and structuring to the couple, but the process is equally powerful. In the case of Sam and Jody, the line of interpretation was accurate and probably helpful, but it was not enough. The couple was stuck. The fights were repetitive and ugly despite months of therapeutic work. I felt silly and worthless at times but didn't give in to that feeling and kept trying to find the cutting edge of the therapeutic work. I was daunted but not crippled by the dynamics. The partners could each take heart and identify with my capacities for energy and ingenuity in the face of their painful intransigence in order to "break the spell" they had woven.

Remembering that patients repeat miserable relationships is the most orienting asset in the therapist's possession. Naive therapists and patients automatically jump to the conclusion that the patient's behavior directly reflects their underlying capacities. This leads to the therapist accepting the patient's own distorted self concept. The patient may believe she is defective, immoral, or monstrous and then initially act that way to see if the therapist believes it too. Often, therapists prematurely diagnose their patients as defective or empty based on their initial compelling presentation.

Difficult patients almost always believe this about themselves. A patient once described himself as a Dr. Jekyll and Mr. Hyde because he found that as he pulled up his driveway to his home, he felt himself transform into an abusive nasty stepfather to his wife's teenage sons. He confided in me that since his mother was of German extraction, he believed he had "Nazi genes". This patient acted tyrannical with his subordinates at work and was challenging and critical to me in therapy. When I challenged his view that he was genetically defective and strongly suggested his behavior represented repetitions of the way his father treated him, he eventually changed his behavior with his subordinates and slowly shed his self image as a monster.

Omnipotence and Guilt

The process of doing therapy with difficult patients often revolves around the experience of omnipotent responsibility, worry, and guilt. This is a universal experience for people who witness or experience gut wrenching trauma. It is at the heart of the "spell" which binds difficult couples and which ensnares the therapist. For the therapist to deal with this omnipotence requires establishing an appropriate therapeutic distance. Difficult patients invite the therapist to take exaggerated, polarized positions, either to run screaming from the room or to jump into the enmeshed system and drown in an attempt to save everyone. The therapist has to find a way to stay emotionally connected, yet not overwhelmed by her own feelings of compassion and longing to help.

The experience of omnipotent responsibility for the therapist is triggered most powerfully by the experience of patients not improving. The therapist has to maintain a balance between helping and not helping. The therapist can't force the couple out of its pathologic pattern nor should she turn her back on a couple who seem impossible to help, two clear impulses engendered by the difficult couple.

A powerful alternative approach is for the therapist to invite the couple out of their pathological repetitive behaviors. Such an approach demonstrates clarity of thought, affective attunement, caring, and a lack of being overwhelmed. The therapist plays the role of caring, expert consultant, with great influence but not total control. He doesn't act out of panic or guilt, but out of thoughtful understanding of what the members of the couple are trying to do and what obstructions are getting in their way. This is a capacity which a difficult couple doesn't usually have but can gain by paying close attention to the therapist and identifying with his demeanor.

Feelings of omnipotence can distort the therapist's assessment of how to conceptualize goals for treatment. It's important for the therapist to have a rational method for assessing goals for couples therapy. Some therapists invariably try to save the relationship as their primary goal. Others try to ascertain if the relationship is troubled, and if it is, try to "save" one or the other partner by convincing her to leave the relationship. Both of these automatic strategies are problematic.

In my opinion, the therapist should always try to assess what are the psychological goals of each member of the relationship and then assess what role or potential role the relationship plays in attaining those goals. When couples come into therapy, the therapist should not assume that the relationship should be saved no matter what. It is possible one or both members really needs to leave the relationship in order to attain his life goals but can't. Similarly, if the couple comes in miserably stuck in an unhappy marriage, the therapist shouldn't conclude the relationship should end. It is possible the partners are very invested in working on their individual issues in the context of that miserable relationship. Ending the relationship might not be useful because each partner might go out and repeat the same dynamics in the next relationship. The therapist needs to meet each partner where he is, help him discover where he wants to go, then help each either change the relationship or get out of it depending on what is necessary to further each person's goals.

Since guilt is such a central and destructive force in the experience of difficult couples, its role should be openly explored and discussed. In the case of Sam and Jody, it was the interpretation of how each felt too guilty to be in control while the other was out of control which turned the entire therapy. Talking about guilt with difficult patients can help to explain and relieve hopelessness, depression, self

destructive behavior, failure to improve, and inhibitions in self-assertion. Talking about intense worry and omnipotent feelings of responsibility for each other and their families helps put in perspective why these patients are so tormented by guilt. Interpreting the connection between their destructive behavior and their guilt helps give hope and direction out of their repetitive behaviors.

Other Considerations

The case of Sam and Jody illustrates many of the complicating factors which plague difficult couples including disturbed childhoods marked by parental loss, abuse, and neglect. Both partners also had significant depression and substance abuse. These factors play a destructive role in the life of the couple but often cannot be adequately addressed in the couples therapy alone.

After an initial evaluation, it's often wise to recommend individual therapy for one or both members, refer for a medication evaluation, or recommend Alcoholics Anonymous or other substance abuse interventions. It is to be expected, however, that these recommendations may not be followed, since difficult patients feel undeserving of help and typically eschew rational treatment plans. They also test to see if being "bad" patients will provoke the therapist to dislike or reject them. The therapist has to retain the same balance described above between wanting to help and tolerating frustration when the patient doesn't permit it.

It's also important to remember that difficult patients don't enter individual therapy easily. Often, partners will allow coming to treatment for the couple but not for themselves. The old maxim that patients can't get better unless they want to is not completely true. Some patients are not healthy enough to "want" to get better for themselves. They might feel guilty getting too much and would not be able to initiate or sustain individual therapy. Some difficult patients feel unsafe facing a therapist one on one because of the patient's transference expectations that the therapist would be as dangerous as her parents were. Such a transference expectation is weakened in the couples setting where the therapist can be seen as an ally to each partner. After an initially successful experience early in couples therapy, patients may feel safer, more deserving and dare to pursue further help which they may have felt too "greedy" to ask for initially.

The couples therapist, like any therapist who works with such difficult patients, needs to be able to tolerate the patient being self-destructive and slow to get better without rejecting them. It would be an error if the therapist, in her zeal to be helpful, insisted on adjunctive treatment or no treatment. Some therapists will refuse to see a couple if one partner refuses needed adjunctive treatment. Such a proscription would eliminate many difficult patients from getting any help. The therapist should follow the rule of meeting the patient where he is and that may necessitate an incomplete and inadequate treatment at first. As therapy progresses, however, the partners can begin to feel more entitled to appropriate help and act less self destructively.

In the case of Sam and Jody, the therapist tolerated destructive behaviors between the partners for many months including emotional abuse and alcohol abuse. Even though I strongly recommended they stop drinking, join AA, and get into individual therapy, I did not make it a precondition of our continued therapy since I didn't believe they would have been able to follow through and succeed initially. Working through each partner's guilt and feelings of omnipotence toward the other was a precondition to each being able to pursue individual treatment, which they eventually did. I did not interpret "resistance" but instead interpreted the legitimacy of their needs and the guilt which undermined their ability to meet their needs.

Taking Heart

What helps the therapist keep from getting as discouraged as the couple? What keeps the therapist from being another casualty, dragged into the partners' repetitions rather than staying poised to lead them out? Certainly the therapist needs to be alert to her own countertransference feelings and at the first eerie chill, begin to wonder what spell is in the air, what tragedy is being subtly replayed. Remembering these

are spells and repetitions helps snap the therapist out of the role of victim into that of an agent for therapeutic change.

But more than holding this awareness, the therapist must make peace with her task and maintain a perspective of what is possible and what is not. The most common cause of professional distress or “burnout” in any field is when the person’s goal regularly exceeds her reach. The therapist must temper her natural omnipotent wishes to help her clients and stay grounded in what is realistically possible. Difficult patients from dysfunctional families regularly struggle with their inability to set appropriate goals and resist irrational guilt. The therapist must be able to do this to maintain her own sanity and to set an example for her clients.

The therapist’s goal and task needs to be staying centered and positive in order to achieve maximal effectiveness. In order to do that, the therapist has to achieve a balance between helping and not helping, paying equal attention to process and outcome. It would be nice if Jody stopped drinking, Sam stopped harassing, and they both found happiness together. But if the therapist tied her task to those goals, she would experience despair along with the couple. The therapist’s task has to be maintaining her own sanity and effectiveness whatever the couple does, which is the strongest way to help the couple eventually approximate their potential.

The therapist can shoot high, hoping for and designing a plan which tries to address all of the couple’s problems. The therapist can be blatantly optimistic. But the therapist’s self esteem and sense of accomplishment should not be too tied to the difficult couple’s apparent progress lest it be dashed against the rocks.

The therapist should be mindful of progress, so that strategies that result in gain can be expanded and strategies that don’t work can be relinquished. Couples need to be reminded of what is working and when things are better, even if very slightly. The therapist can want progress and push for it but should not be defeated by its absence.

The therapist should remember that doing one’s best is a tremendous achievement during the treatment of the difficult couple, and in itself is very therapeutic to the couple. Doing one’s best means not being defeated easily, not acting out of panic or guilt, retaining the ability to see and speak, and maintaining the ability to respect and care about the partners as human beings. Knowing that you’ve done a respectable job under difficult circumstances can be very rewarding, even if you can’t relieve all the suffering and solve all the problems. If the therapist can retain balance and stay positively engaged, she can break the difficult couples’ spell. The work itself can be very rewarding and the couple can benefit from a refreshing experience which may offer a completely novel opportunity for change.

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