VOLUME 32, NUMBER 2 Spring 2017

THE SAN DIEGO PSYCHOLOGIST

The Official Newsletter of the San Diego Psychological Association

In this issue

President's Corner

by Annette Conway, Psy.D.

Welcome to the Spring 2017 issue of the San Diego Psychologist!

My beginnings in clinical practice were a time of trial and error, as beginnings often are. Early in my career, I had not established whether (and at what point in therapy) to include the partner or family of an individual client. When I did encourage my clients to bring significant others or family members to session, they would show up with their spouse, mother, father, maybe a brother, and so on. My most memorable experience from those early days is about a Latino client, to whom I implored at the end of a session, "Por favor come in with your family". The next week, imagine my surprise when I saw that the gentleman had arrived with 23 members of his family!

I learned two important lessons on that fateful day: that I needed to have more structure in my therapeutic process and that family is a vital part of treatment. In my 20 years of practice, I have worked with many, many clients, and the one thing I keep coming back to is the value of treating the client in the context of his or her family, rather than as an autonomous individual.

I am pleased to focus this issue of the San Diego Psychologist on Couples and Family Therapy. Research shows that Marriage and Family Therapy is as (and in some cases, more) effective than Individual Therapy, in that it facilitates the change in patterns created by the family system. For clinical reasons, couples and family counseling gives the therapist an opportunity to conduct a thorough biopsychosocial assessment of the couple or family needs. Valuable information regarding family dynamics, coping

abilities, communication skills, social relationships, and conflict-resolution skills, in addition to the individual client's self-report can contribute to a more accurate case formulation and therefore, a more appropriate treatment plan. In addition, how the therapist "experiences" the couple and/or family supports or questions organizational abilities, boundary fluidity, cultural and religious customs, and daily rituals of the client.

As you read this issue of the San Diego Psychologist, we want to remind you of SDPA's full-day conference on cutting-edge issues and up-to-date information on complex issues facing youth, families and communities, in collaboration with The California Association of Marriage and Family Therapists, San Diego Chapter, The San Diego Academy of Child and Adolescent Psychiatry, and the San Diego Psychiatric Society. It has been exciting working closely with our allied professional associations to provide this valuable educational opportunity to clinical practitioners, educators, behavioral health, and child welfare and community organizations in San Diego County.

The CICAMH collaborative also sponsors a Free Networking Event every August at a local brewery. This year's Summer Networking Social is scheduled for Sunday, August 27, 2017, 3:00pm - 6:00pm at Stone Brewery, Liberty Station 2816 Historic Decatur Rd #116, San Diego, CA 92106. It is a great opportunity to connect with other individuals with the purpose of enhancing professional and social networks, in addition to learning more about community resources. I hope to see you all there!

Editorial

by Gauri Savla, Ph.D.

Dear SDPA members and guest readers,

Welcome to the long-overdue *Spring 2017* issue of the *San Diego Psychologist*. Clearly, we are well into summer, but the

reason for this delay is that we had no content for our issue by the original May 31st publication date. Simply put, we did not receive a single response to our call for articles. The articles that comprise the current issue with the theme of *Couples or Family Therapy* were directly solicited from the authors, identified as experts in their respective fields.

As clinicians, we know the importance of alliance building, perceptiveness and intuition, and the ever-changing dynamic between the self and other in any therapist-client dyad. These parameters become much more complicated when the therapist has to maintain an alliance with the couple or family as a unit while balancing an alliance with each member of the unit, and at the same time, helping them navigate through and resolve their conflict. The therapeutic process is a delicate dance that demands a special set of skills on the part of the therapist.

Each of the five articles in this issue presents either a challenging problem relevant to couples or family therapy, a focus on therapy with families from minority or underserved populations, or both. Ms. Estes, a licensed marriage and family therapist specializing in working with clients from the LGBTQ community and ethnic or cultural minority groups has written a thoughtful article providing basic guidelines for therapy with these highly underserved clients. Dr. Wexler, a clinical psychologist and chair of the SDPA Fellows Committee has drawn from his decades of working with couples in conflict to present his fascinating essay on helping nurture intimacy in relationships. Dr. Spring, a nationally acclaimed expert clinician and author on helping couples navigate infidelity; she will be headlining the conference on *Sex and Relationships* at The Relationship Training Institute in San Diego this November. Mr. Witter, a licensed marriage and family therapist has focused his article on one of his specialties, i.e., working with emotionally escalated couples. He has artfully described his use of Emotionally Focused Therapy in guiding these couples through their emotional pain and insecure attachment to a place of safety and security. Last but not least, Dr. Falicov, an internationally heralded clinical psychologist specializing in working with immigrant families has described two case examples highlighting common issues that can create conflict between immigrant couples. She describes her culturally-sensitive therapeutic process while never losing sight of the developmental cycle of couples that pervade all cultures.

I sincerely hope you learn as much from this issue on *Couples and Family Therapy* as I did. Our next issue, which will be published in late summer, will focus on the urgent and current topic of ***mental health in the current political climate***. The topic was unanimously selected by the SDPA Board, in the hope that there are enough of you who feel passionately about writing about your experiences and thoughts regarding this tumultuous time in our nation's history and its emotional fallout. ***The submission deadline for the Summer 2017 issue is August 1st.*** Please help us make this issue a success with your contributions.

Please share your feedback in the comments below, or email me at TheSanDiegoPsychologist@gmail.com.

Thank you for reading.

What to Consider When Working with Underserved Populations

by Jennine Estes, L.M.F.T.

Have you ever worked with a client who was the victim of a brutal beating because he was gay? Or has a client ever shared with you that they have been shut out of a community simply because of their skin color? Has a client resisted opening up to you out of fear that you won't understand their religious orientation? These are real cases and situations that are all too common with underserved populations. The specialized mental health training and education required to properly help this group cannot be emphasized enough.

Definition of an underserved population

Underserved populations are groups of minorities, such as same-sex couples, ethnic minorities, the physically impaired, polyamorous relationships, and refugees. They face both daily struggles and lifelong challenges that impact them emotionally, physically, psychologically, and financially.

For example, in my group practice, we work specifically with the LGBTQ (gay, lesbian, bisexual, transgender, and queer) population and help our clients process and address the various layers of discrimination, hate attacks, family rejection, shame, and isolation that they have been through or will face.

Considerations when treating underserved populations

As mental health professionals, it is our responsibility to be educated on the specific struggles of underserved populations and consider how we can best address them. This may include approaches that are unique to any other client population you deal with.

The first area to consider when working with a minority client is to be aware that there may be layers of pain. Each client can emotional scars, but the underserved group has additional scars that are different in the sense that they have seen negative impacts on their education, career, place of residence, family, and more.

This group has not typically had space to talk about their experience, often being shut out because these experiences are not part of traditional social norms. For example, the LGBTQ community is commonly known for being "closeted," having to disown parts of who they are and starting as early as childhood. Shame grows rapidly when disowned parts are kept in the shadows, unspoken. Furthermore, when society sends additional shaming messages, the corresponding pain increases. In relationships, the history of being open or closed about their sexual orientation impacts the security in the relationship. Couples can often draw close to

one another, sharing similar experiences and understanding one another. At other times, a partner may struggle with the degrees of their openness which impacting the security in the relationship. In short, underserved populations carry pain, and it must be recognized.

Secondly, know that discrimination and the fear of discrimination is real and alive. For example, the Orlando nightclub shooting resulted in the deaths of 49 people in a gay club, and is one of the many hate attacks that keep people fearful for their safety simply because they are in a same-sex relationship. Another example of how clients are impacted is by the history of African American slavery and the current legacy of discrimination resulting from that.

My team of therapists works with LGBTQ clients and clients of color who have experienced hate attacks that range from public verbal abuse to being beaten to the point of hospitalization and fighting for their life. Even though we are in 2017 and live in San Diego, a city that values equality, it is still important to understand your client's trauma history and to know that your client's fear of discrimination is alive and real; they will always be scanning their environment to assess if the space is safe.

In a couple, the fear of social discrimination impacts the relationship on various levels. If one partner withholds their affection, it sends a message as if they don't care or not proud of the relationship. The lack of communication around the discomfort can leave the other partner feeling in the dark and taking it personally. Other times, couples can come together and connect on their experiences.

Third, realize your clients' decisions for the future are impacted by their religion, skin color, or sexual orientation. For example, a lesbian couple planning on having a child will reconsider where they should live to ensure their child will be safe and accepted in the neighborhood. Or a Hispanic couple moving to an all-white school district will worry about how to help their child fight discrimination.

What we can do to help our clients

First, there is no better way to help your clients than to **talk about it**. Ask the questions. Lean in to the uncomfortable topic of religion, ethnicity, or sexual preferences. Create a safe space for them to open up, because some people likely haven't had that before. The more they talk about the rejection, physical and verbal attacks, and discrimination they've encountered, the more power they have. We need to help our underserved clients process their experiences so they don't remain cloaked in shame.

Secondly, help them **own all parts of themselves**: their skin color, sexual orientation, religion, etc. Empowering our clients to feel proud of who they are will help combat the shame, embrace their community, and acknowledge the courage and strengths they have.

Next, **address the inevitable feelings of loneliness and isolation**. For example,

transgender clients and their families often feel very alone, so connect them to groups where they can share stories and support one another. Encourage your clients to seek out their community either face-to-face or online. Supportive communities are out there; your clients just need the help knowing that those connections can be healing and are an important part of feeling more confident in their own skin.

Finally, even though San Diego is very open-minded compared to other cities across the country, there are still violent crimes geared toward race, sexual orientation, and other minorities. Better yet, they may experience rejection by their own family and friends. Help your client with **setting boundaries**. This includes developing a situational awareness and determining where it is safe to take their armor down and where they must keep it up. Encourage your clients to get educated when traveling to foreign countries knowing where it is safe versus unsafe for them to go.

In conclusion, underserved populations are impacted by the past, present and future. Their emotional and psychological scars influence how they connect with peers and loved ones, seek job opportunities, and engage in their communities. By getting trained and educated on the struggles underserved populations face, we can help them through the challenges, enhance who they are, and help them have a voice.

The Path of Intimacy

by David B. Wexler, Ph.D.

When I see a couple for the first time, I usually open with a good old-fashioned, open-ended question to get the ball rolling: "What are you doing here?". I pay close attention to their opening line in response, i.e., "the headline story." Often, it is clear that they have thought about this carefully, and the first answer to this question tells me exactly what our project is going to be together: "*I have a drinking problem and it's killing our marriage,"* or "*It just seems like we have drifted apart,"* or "*My husband found out that I have been seeing someone else and he can't forgive me*." Less often, I get a vague answer that doesn't tell me much, typically, and ***"We have a problem with intimacy."***

I never presume what "having a problem with intimacy" means to these particular two people. Are they not having sex? Are they having sex but not enjoying it? Are they not speaking to each other? Have they drifted into leading separate, distant, parallel lives? Do they not feel safe and trusting with each other, thus blocking intimacy? Is someone having an affair? Does it seem like they just don't like each other very much? Over the past quarter century of working with couples, I have heard enough of these statements and discovered the true meaning behind them, which has led me to develop a map of the multiple components of an intimate relationship. I call these components the *Four Pillars of Intimacy*.

What does healthy intimacy look like?

The healthy, vibrant, loving, trusting, connected, self-actualized relationship rests on the *Four Pillars*. When these pillars are shaky or collapsing, the structure they hold up collapses as well. Not every couple has all of these pillars in great shape, but there is a direct correlation between the strength of these pillars and the healthy intimacy they experience. No one pillar is any more important than the others; rather, they create a synergistic effect.

The first pillar is *Safety & Security*. No relationship has a fighting chance of true intimacy if one or both partners do not feel safe. Intimacy requires vulnerability, and vulnerability requires safety. Physical safety is paramount, in that, any threats of violence are totally incompatible with intimacy. Similarly, the relationship needs to be free of lies and deceptions, as well as threats of abandonment, humiliation, and betrayals, i.e., there needs to be emotional safety and security. If your partner is emotionally or physically threatening, or emotionally or physically unfaithful, or fundamentally not to be trusted to refrain from deeply hurting you, how can you be intimate?

The second pillar, *Knowing & Being Known*, refers to the ways in which both partners truly know each other. Even if you feel reasonably safe, you are not likely to experience intimacy unless you really know each other. The rewards of truly knowing another and truly being known by another are enormous. This goes beyond knowing details of your partner's life; it also includes knowing about his or her inner world, vulnerabilities, fantasies, dark places, and wonderful places. Knowing leads to empathy, which leads to genuine acceptance, which in turn paves the way for true intimacy. Some couples have this naturally, some need to work harder to enrich it, and others never achieve it.

The third pillar is *Affection and "Likeability*." These qualities contributing to intimacy show up in multiple venues: physical touch (non-sexual), non-verbal cues (like smiling), verbal statements (like "I love you" or "I'm so proud of you"), and generous behaviors or gestures (like bringing someone a cup of coffee or laughing at their jokes). When this area of a relationship is thriving, both parties feel consistently and genuinely liked by the other. The joys and rewards of feeling genuinely liked help people withstand the inevitable assaults and dissatisfactions in the course of any normal relationship.

The fourth pillar, *Passion, Chemistry, & Sex*, is the most complex. The other three pillars are, more or less, receptive to conscious effort and creative manipulation if the individuals are truly motivated. Passion, chemistry, and sex are more difficult to consciously generate. Many couples who have at least moderate levels of attraction may lose that connection, and the strategies for generating more passion often rest on making sure that the other three pillars are solidly constructed.

Why can't we all just get along?

There are only three reasons why intimacy gets complicated. And the story you tell yourself about why you are struggling with intimacy, or why your partner is, can make all the difference in the world.

Reason #1: Pure Fear

For a thousand reasons, we carry fears associated with intimacy. We feel vulnerable. We are afraid of being hurt, rejected, abandoned, humiliated, or betrayed. Everyone is afraid, but some of us are more afraid than others, almost always because of experiences growing up that have shaped us, consciously or unconsciously.

Reason #2: Cluelessness

Another reason that often complicates intimacy is gender-specific intimacy behaviors that backfire; men, in general, have not been sufficiently schooled in the art of empathic communication with women. Women often seek verbal intimacy in ways that may alienate men. Many men confuse the intensity of sexual intimacy with the big picture of full intimacy and seem mystified when their female partners seem uninterested, turned off, misunderstood, or disrespected. Women often try to be "helpful" by offering excessive suggestions or interpretations of their male partners' behaviors, who may perceive that behavior as controlling or maligning.

Reason #3: Not Caring and/or Burned Out

If you are in this category, don't bother reading this article because it will not help you. You may "suffer" from a personality disorder of psychopathy, or your "dismissive attachment" may have shut you down so profoundly that you have permanently given up on the possibility of human intimacy. You may be missing a chip for normal human interaction.

If you are in a relationship with someone like this, my best advice is to get out.

Why bother with nurturing/enhancing intimacy?

This might seem like a rhetorical question to those among us who naturally crave intimacy in all its forms. But to those who are conflicted about intimacy or are reluctant to engage in the rituals that seem to enhance intimacy, here are some good reasons to reconsider that reluctance:

Intimacy feels good: Attachment stimulates vasopressin and oxytocin, the "bonding" chemicals in our brains.People who have lived a long and rich life consistently attribute their emotional wellbeing to relationships, rather than accomplishments.

***It usually beats the alternative*:** The alternative to experiencing genuine intimacy is loneliness and alienation. Some people who consistently fail at intimacy may decide that pursuing it is not worth the pain of failure. Rarely do these people express mental wellbeing and contentment from life. It must be acknowledged that nurturing intimacy in relationship can be demanding. Commitment comes with loss and conflict and vulnerability, and in rare cases, even even trauma.

Intimacy can facilitate the resolution of other relationship issues:: When there is a solid foundation of intimacy, every other relationship bump in the road remains a bump in the road and nothing more. It is easier to listen. It is easier to accept criticism. It is easier to bounce back after spats and hurt feelings. It is easier to accept dull periods, losses, disappointments, frustrations, sexual deprivation, sexual rejection, differences on vacation preferences, disputes about child-rearing philosophies, and everything else.

***Intimacy helps cope with loss**:* Researchers on midlife transitions and the psychological aspects of aging identify the inevitable losses involved as we move through different life stages. But one quote about this process that I often pass on to couples offers tremendous perspective and tremendous hope: Real intimacy diminishes "the narcissistic sting of aging" *(Colarusso, C. A., & Nemiroff, R., 1981).* The "sting" may refer to changes in physical appearance, or the realization that we have been imperfect parents or friends or workers. But he rewards of genuine, seasoned intimacy, the kind that can only develop over time on the mutual and emotionally raw ride through good times and through bad, provides a profound buffer to this "sting."

Real intimacy often leads to more and better sex.

Last but not least, for most of us there is no more powerful way to genuinely grow as a human being: The brilliant psychiatrist and psychoanalyst C. G. Jung once said: "One is always in the dark about one's own personality. One needs others to get to know oneself" (Jung, C. G., & Hull, R. F. C. , 1977) .

There is nothing that gives you the opportunity to know who you *really* are more than a truly intimate and authentic relationship. Intimacy is not limited to lovers. The unparalleled personal growth opportunities from intimacy can also be generated in your relationships with your children or parents or perhaps a few select others. If you needed even one more reason to really dig for intimacy, this is it: a purely selfish one.

Secrets, Cybersex, Infidelity, Addiction, Trauma…and Forgiveness?

by Janis Abrahms Spring, Ph.D., A.B.P.P.

After an affair is discovered or revealed, an emotional avalanche is triggered that is often difficult for both patients and therapists to control. In my workshop with the

Relationship Training Institute on November 10th, 2017, I will help therapists help their patients reframe an affair as a psychological trauma, learn how hurt and unfaithful partners respond differently to an affair, appreciate how this difference can promote healing, and learn how partners can make a healthy, self-interested decision regarding reconciliation. I will also present concrete strategies for rebuilding trust and sexual intimacy after an affair.

Infidelity is defined as a violation of sexual exclusivity when a spouse has sexual intercourse with someone other than his or her partner without that partner's consent. But this definition is strictly limited to married (heterosexual) couples and sexual intercourse. Besides including other types of committed relationships, we need to broaden the definition of infidelity to factor in Internet sex. People are spending hours talking intimately with others they will never meet, let alone touch. However, when committed partners learn of this betrayal, they often feel severely violated and decimated. As a general rule, if your partner were in the room looking over your shoulder feeling very uncomfortable with what you were doing, that may constitute an affair. At their core, affairs are about secrets and the violation of trust.

Today, there is a new world of affairs in the domain of cybersex. One of the great attractions of Internet affairs is that you can be anyone you dream of being. You can pretend you are a priest when you are a criminal, a man when you are a woman, and so forth. Often the attraction of an affair is not to the lover per se; that person may be someone the unfaithful partner idealizes or barely knows. Rather, the attraction is to the experience of the self – and that experience of romantic love, of transcending one's personal limitations, can be quite transcendent and emotionally convincing. To reiterate a point I have made in my previous writings, not only can the hurt partner not compete with the fantasy of the affair person (i.e., the unfaithful partner's lover), but the affair person cannot compete with the fantasy of the affair person. Fantasies usually promise more than we get in real life. Before unfaithful partners give up on their spouses for someone they barely know, they should ask themselves to name five things they know they will be fighting over with the affair person.

In my first book, "After the Affair: Healing the Pain and Rebuilding Trust When a Partner has been Unfaithful," I propose a three-stage model for healing.

The first stage is making sense of the trauma of infidelity, i.e., giving a language to its effects and helping partners normalize what they are experiencing. The second stage is making a thoughtful, not an emotional, decision about whether to stay together. The third stage is for those couples who choose to stay together and learn lessons from the affair which will strengthen their bond. Here, I suggest practical strategies for how to rebuild trust, rekindle sexual intimacy, and grant or earn forgiveness in ways that make it human and attainable.

Making sense of the trauma of infidelity

Let us begin with the emotional response of the hurt party. When hurt partners discover their partner's affair, they experience a post-traumatic stress-like reaction in which two simultaneous

and competing responses occur: hyper-arousal and deadening. On the one hand, they may find it difficult to concentrate or sleep, their minds often bombarded with images of the lover. At the same time, they may lose interest in everything that used to give them meaning or purpose.

Hurt partners often describe nine types of ***psychological losses***, described below:

1. **Loss of identity:** You cannot recapture the way you are used to knowing yourself. For example, if you once thought of yourself as zesty, attractive, and capable, you lose all sense of your familiar self after discovering your partner's affair.
2. **Loss of specialness:** You thought that you could make your partner happy the way no one else could, and you now realize that you are disposable and interchangeable.
3. **Loss of self-respect:** Hurt partners often go to extreme measures to win their partner back and feel humiliated by their desperate behavior.
4. **Loss of self-respect for not acknowledging that you were wronged:** Often the cues of deception are obvious, but hurt partners don't confront them because the truth is too shattering. They are left struggling to forgive themselves for not speaking up about violations in the relationship.
5. **Loss of control over thoughts and actions:** Often, hurt partners become obsessed with details and spend hours compulsively checking for information.
6. **Loss of a sense of order and justice in the universe:** There is a sense that the world no longer operates according to specified rules, instead, is arbitrary and cruel.
7. **Loss of religious faith and belief in a higher power:** "If God were good," hurt partners ask, "why would He do this to me? If I were good, why would this happen?"; the hurt partner's sense of alienation and loss of self-confidence are profound.
8. **Loss of connection with others:** Whom do hurt parties turn to? They often want to tell their family and friends but recognize the awkwardness or destructiveness which may follow.
9. **Loss of a sense of purpose and the will to live:** This is an extreme reaction to the affair and can be fatal.

These losses capture the deep and pervasive sense of betrayal, which hurt partners experience when the affair is revealed. The most important strategy for therapists is to get patients to talk about and appreciate their losses. They will be embarrassed to admit how "badly" they believe they are coping. By giving their experience a name and context, however, therapists have a chance to help them feel less crazy, helpless, and alone. This normalization may be the most significant healing gesture therapists can offer their hurt clients.

What about unfaithful partners? Their response to the affair often is quite different, which is one reason why this work is so challenging. As eviscerating as the affair is to hurt partners, it is often validating and expansive for unfaithful partners.

Let us look at some of the more common emotional responses of unfaithful partners. Often their first response is relief. They may be relieved that their secret is out in the open. Next, they are often impatient; they want to move on. But to move on, they must learn to pay attention to their partner's pain. In my book, "How Can I Forgive You? The Courage to Forgive, The Freedom Not To," I talk about how therapists need to help unfaithful partners create "a transfer of vigilance." That means, unfaithful partners must approach their partner's trauma, express remorse, and talk about the lessons they have learned about why the affair happened. They need to address those issues that made them vulnerable to an affair, work to earn trust, and make their partner feel loved and cherished.

At the same time, hurt partners may need to learn to let go of their preoccupation with the injury, and to not bring it up every time they think of it. They also need to take a fair share of responsibility for how they may have created space between them and their partner to allow a third person to come in between them.

Other responses of the unfaithful partner include grief over the loss of the lover, justified anger and the absence of guilt, fear of losing the love of their children, paralysis (the inability to decide whether to end their relationship with the affair-person or marriage partner), and self-disgust.

Both partners need to learn how to manage their fears. The greatest fear of the unfaithful partner often is that they will never be forgiven no matter how hard they work to rebuild trust. The greatest fear of the hurt partner often is that they will never feel safe or that they will continue to turn up evidence that renders them insecure. This belief makes it hard for unfaithful partners to recommit.

Making a thoughtful, rather than emotional decision about reconciliation

The second stage of recovery from an affair requires both partners to make a thoughtful, not an emotional, decision about whether to reconcile. This is a two-step process: making sense of feelings of love, and directly confronting one's ambivalence about returning home. When it comes to feelings of love, both partners may struggle with an intense but unwarranted attachment, i.e., the hurt partner's love for their partner, and the unfaithful partner's love for the person they had an affair with. Hurt partners may love a partner who is incapable of meeting their essential needs. Unfaithful partners may feel romantic love for the lover and be willing to risk everything for someone they hardly know. They may need help understanding the emotional, cognitive, and chemical underpinnings of romantic love so they don't act precipitously and toss away a potentially salvageable relationship with their committed partners.

In deciding whether to recommit to the marriage, partners should be encouraged to express their doubts and fears. Therapists can then help partners respond in a thoughtful way. Typically, partners may wonder, "Yes, you're making changes, but are they permanent or

sincere?"; "Do you want me or just the package?"; "Should I stay for the sake of the children?"; "If I spend more time with the lover, might I be able to make a better decision about what is best for me?" and, "after so much damage has taken place, how can I trust you again?" These questions underscore each partner's ambivalence about recommitting and must be answered thoughtfully.

Rebuilding the relationship

After an affair, there are three essential conditions to rebuilding trust and earning forgiveness. Unfaithful partners must 1) pay attention to the pain they caused and offer a meaningful, generous, specific, heart-felt apology, 2) they must look deeply into themselves and figure out why they strayed so they can protect the boundaries of the relationship, and 3) they must work hard to earn trust and generate feelings of love. Both partners need to take a fair share of responsibility for how they contributed to creating a space between them that made room for someone else, and to work hard to make their partner feel loved and cherished.

Those who attend this course will hear my unromantic model of love and reconciliation. It begins when the unfaithful partner has a funeral for the lover and, turns toward the hurt partner. Then both partners begin to treat each other in ways that foster tenderness, trust, and intimacy. And then, last (not first, as many partners wish), feelings of love may return.

Emotionally Focused Therapy for Emotionally Escalated Couples

by Ian Witter, L.M.F.T.

Sarah and Robert have been married for five years. When scheduling the appointment, Sarah tells you that they've been having "communication difficulties." During the first session, Sarah states that they have been arguing and that the arguments can get pretty nasty. She elaborates, saying that she feels attacked, and blamed for the distress in their relationship, and that she perceives Robert as having an anger problem. Robert, who was sitting quietly up to this point explodes with, "I wouldn't get so angry if you weren't such a nag!" Sarah responds with "This is exactly what I was talking about, I don't know why I even try! Why do you have to be such a dick?!" Robert responds with another derogatory statement about Sarah's character, and you, the clinician, are left wondering about career options at Starbucks. What causes these seemingly out-of-control outbursts among couples? What can you, as their clinician do to help slow them down and get them to a place of safety and connection?

For clinicians who work with couples, such "escalated" couples can be the most daunting of cases. These are the couples who come to therapy seeking assistance, but frequently end up engaging in yelling matches, during which they seem more interested in name-calling and making threats than working on their relationship. As a clinician who specializes in Emotionally Focused Therapy (EFT) in my work with couples, I appreciate the challenges posed by taking on escalated couples as clients and understand why many clinicians refuse to work with them. Escalated couples can make us question our skills as a clinician, and push our buttons personally. Fortunately, EFT was created to work with clients experiencing distress in

their relationship, and can be very effective in working with highly escalated couples. For those unfamiliar with the EFT model, here is a brief overview.

EFT is a systemic, evidence-based approach to couples therapy, based in attachment theory. Its underlying assumption is that every individual longs to find a sense of belonging, safety, and acceptance with at least one other person in his or her life. This seemingly innate need for attachment to another exists across socioeconomic classes and cultures. But what happens when the interactions with our partner doesn't feel safe or secure? How do we respond to this relational stress? Couples with an insecure attachment to one another can respond with defensiveness, anger, blaming, and accusations, or distancing and withdrawal. Common manifestations of relational distress include infidelity, substance use, or physical or emotional abuse. EFT views these negative responses as a reaction to perceived abandonment and a fracturing of the desired secure attachment by a partner. By putting these responses in the context of heightened emotional need, EFT helps couples reframe these negative emotional responses as a desire for safety and security. This is done by helping the couple recognize their primary emotions and how these are connected to the underlying attachment needs of each partner. EFT is also experiential, i.e., part of the therapeutic process is to structure new conversations in which the couple can communicate these attachment needs. In short, EFT helps to drive connection through emotional vulnerability as opposed to emotional reactivity.

EFT also views negative interactional patterns within a distressed relationship as consistent and predictable, regardless of the content of the argument. Each partner's relatively predictable relational role is usually related to their underlying attachment style (secure, avoidant, or anxious). As clinicians, how many times have we heard one partner say, "I can never get anything right, so now I don't even try" (avoidant attachment style) and the other state, "I feel like I'm all alone in the relationship, and that my partner doesn't care about my feelings at all" (anxious attachment style). The typically avoidant tend to withdraw into themselves in times of stress. The typically anxious tend to find comfort through interactions with another, and when they don't get comfort, can become critical and blaming in their attempts to find it. When one partner creates distance and avoidance, and the other craves closeness and intimacy, trouble results. EFT recognizes this pattern as the "cycle" that occurs for distressed relationships, regardless of the content of the communication.
EFT is comprised of three stages and nine steps. The typical course of treatment is 8-20 sessions, but underlying issues (trauma, substance use, infidelity) affecting the relationship can extend the length of treatment.

Stage One: Assessment and de-escalation of current negative cycle

Step 1: Create alliance with couple and assess issues that create conflict, with a focus on how these issues are related to the underlying attachment issues for each partner.

Step 2: Identify the negative cycle, and each partner's position in that cycle. Focus on each partner's behaviors, thoughts, secondary and primary emotions, and unmet attachment needs.

Step 3: Access underlying emotions both partners feel in the course of the negative cycle. Hearing their partner's relational experience attached to other vulnerable emotions instead of rigid negative emotions helps to temper their own interactional patterns.

Step 4: Reframe the presenting relational conflict in terms of unmet attachment needs and primary emotions. Frame the negative cycle as the source of the relational distress, thereby externalizing the cycle they experience.

Stage Two: Changing interactional process; restructuring emotional bond between partners

Step 5: Foster identification of previously disowned aspects of self (emotions and attachment needs) and integrate these into relationship by sharing with the other partner. Identify how these disowned emotions have prevented the partner from reaching out authentically.

Step 6: Promote acceptance of the sharing partner's experience, with the goal of each partner believing and trusting what the other partner is sharing, particularly, that partner's underlying emotions and attachment needs.

Step 7: Help facilitate the authentic expression of attachment needs driven by primary emotions directly to one another, so as to dispel the old negative relational pattern.

Stage Three: Consolidation and integration

Step 8: Facilitate new solutions to old relational problems. Given the new pattern of relating to each other, it is easier for the couple to create new dialogues around previous topics they found difficult.

Step 9: Consolidate new relational positions and emotional engagement with one another.

Using these nine steps, EFT restructures the attachment bond between partners, and moves them from a place of functioning independently to functioning from a place of security. Being able to feel as if they are being experienced by their partner from a secure place helps resolve any lingering attachment injuries from childhood. Successful completion of EFT is an effective way of healing from traumas experienced in childhood or from previous relationships.

Structurally, working with highly escalated couples is no different from working with less-escalated couples. In both cases, partners feel that they are unheard and alone, and are protesting what they perceive to be an emotional abandonment. The only difference is that the escalated couple is more verbally critical about it. Many individuals who are so quick to "go on the attack" have experienced what we would call "little t" trauma at some point in their history. While not enough to cause symptomatology associated with Trauma, the injuries experienced in their past are enough to cause an extreme defensive reaction in times of relational stress. These individuals are more likely to externalize what they perceive to be the source of their distress, in this case, their partner. Because they are so quick to escalate, it can

be difficult to remain focused on their underlying emotional needs, and to recognize that these moments of distress are the moments in which they most need connection with their partner.

The following are some pointers to help clinicians stay connected and focused when working with highly escalated couples:

- During the course of treatment, you may become the focus of either partner's anger. If this occurs, remember that the expressed anger is directly correlated with to the pain of being in a distressed relationship. It can be difficult to remain focused on the underlying emotional pain that a client is experiencing when their defensiveness is directed toward you. Notice that they are becoming reactive because you are touching on the place of their emotional injury – the place where they need support and validation the most. Also keep in mind that their negative response would be no different with a different therapist, working with a different model. The best approach is to validate their emotions and empathize fully.
- Be patient. These couples are often locked into these negative cycles for years. It will take time, patience, a willingness to meet the couple where they are, and persistent validation to help them begin to de-escalate. Continue placing their defensiveness and anger into the cycle.
- Be directive. When highly escalated couples first come in, it is imperative that they speak to you and not to each other. In the beginning, you need to gather information about the negative cycle between them. Letting them speak to each can be like putting a match to gasoline in that they will quickly fall into their negative cycle. Stress that they might hear something from their partner that they disagree with, but emphasize that you need to understand both sides of the relationship.
- Learn to recognize the non-verbal cues indicating your client's reactivity, especially by watching the non-speaking client. Examples include a tapping foot, crossed arms, an eye roll, etc. To be able to say to them, "I know that what Robert is saying is upsetting you, Susan, and you may disagree with what he is saying, but it is important for me to hear how he makes sense of what is happening between you two. I also want to hear how you make sense of this place in which you two find yourself" can be enough to mollify any angry attacks. Remember, their underlying emotional experience is probably hurt, sadness, fear of being abandoned (anxious response), or feeling incompetent, and that they are failing as a partner (avoidant response). Your job is to help them recognize this and be able to share this with one another.

RISSSC (elaborated below) is one of the primary "tools" employed in EFT in order to help clients feel heard and validated. RISSSC helps clients to slow down and engage with their emotional processes rather than their defensive, cognitive processes. It also helps them to stay focused on the emotional content rather what they feel is 'wrong' with their partner.

Repeat: repeat key words and phrases. "It's scary. It's scary to think he won't be there for you. It's scary to feel alone and abandoned in this relationship."

Images: use of images that have emotional content. "You feel shut out – like he's locked himself in a vault, and there's nothing you can do to reach him.

Simple: use simple, concise phrases. "You want to feel connected to him. You long for it."

Slow: use the pace of your speech to create space in room for deeper emotional experience.

Soft: use a quieter tone to provide comfort and connection.

Client words: used to validate and support the client in their story. Repeating key emotional words can heighten the emotions related to their attachment fears, which can help clients engage with their hurt and sadness instead of their anger and defensiveness. "You feel *alone*, like he's not there for you in those moments when you need him the most."

Working with highly escalated clients can be incredibly challenging, but also incredibly rewarding. If we focus on their anger as an expression of their attachment fears rather than an intentional move to injure, we can start to see the deep bonds these couples have toward one another. Be aware that that working with highly escalated couples means being witness to the horrible things they say to each other. You cannot prevent that, but you can make these moments constructive by putting them into the interactional cycle that brings the couple into treatment; that, ultimately is the goal of working with these distressed, difficult couples.

Continuity and Change: Lessons from Immigrant Families

by Celia James Falicov, Ph.D.

Immigrants face the complex reality of adapting to a new culture, while simultaneously having to cope with normal developmental changes. When immigrant families seek intervention, therapists may do well to focus on continuity as well as on change, i.e., accepting that some things should stay the way they are, at least in the present moment, even if they do not perfectly align with their new environment. This approach can create a reassuring familiarity, while giving clients the tools to cope with excessive anxiety and curb further disorganization that can result from the challenges presented by therapy itself.

The clinical vignettes that follow involve aspects of the therapy with two middle class families at early stages of cultural transition from Mexico:

Case 1: "Pretend you are staying; that will help you in case you go back."

The first vignette is about a young Jewish couple, two years post emigrating from Mexico. The wife is depressed, and reports that she misses her home, parents, and friends. The husband, an upwardly mobile entrepreneur, expresses irritation toward her emotional state, stating that she had acknowledged, when they got married, his plan to move to the United States in order to start a business. The wife acquiesces, but states that she did not know then

that he was "asking (her) to live with half (her) heart here, the other half back where 'there are mountains of love ... wasting away'." The husband, who is satisfied with the love he gets from his parents and friends during visits to Mexico, seems to believe that his wife phones her parents too much. (The wife's behavior is consistent with what might be expected in her culture and gender. The strong, nurturant, and controlling attachment between parents and children, observed in families that combine Latin and Jewish cultures is often accentuated in Mexico. This is likely the result of their intense experience of the social and identity problems associated with being a non-assimilated ethnic and religious minority).

I empathize with the wife, acknowledging how much she must miss her kin network, and how isolated she feels in the States with a young child and her husband as her only social network. I wonder aloud if she felt that she had the right to ask her husband to follow her back home this time, if things did not work out for her here. The husband begins to see that he needs to be more understanding of her love losses, and becomes less defensive of the choices they made. With these validations, her own ambivalence begins to emerge. Although she now misses the values and life style of her country and community, she recalls how she too, had wanted to leave Mexico. She had seen it as an opportunity to separate from her sometimes too controlling mother. She had felt that she could "grow more" in this country in the long run. Suddenly, she begins to weep, and says she misses her friends back home. She then reveals a recent embarrassing social disappointment. For the past year, she had been part of a mother - child playgroup. A month ago, she and one of the other mothers, all of whom are Jewish Mexican immigrants, had a nasty falling out. The other two women sided with the other mother and she had to leave the group, thus, eliminating an important support and modeling peer network. Since then, she had been thinking and talking a lot about returning. We talked about how they, husband and wife, could use what they had learned about her present needs from the playgroup experience. I also asked them if they could consider a postponement of a decision about staying or returning for a set period of time. This led to a conversation about how this temporary stability could be used, for example to acquire skills, learn English, develop a support group, improve their communication. It could be a period of building that would serve them well, whether they stayed here or went back. In the wife's words, a chance to "grow more." Pretending to stay did not mean they should not continue all the attachments as if they were returning too, such as frequent phone calls, etc. If after this time she still felt lonesome, she could resume a more focused campaign to go back.

The oscillation between staying and returning, the comparison between the here and the there, the clinging to the old pieces of attachment even when one is trying to get away from them, is part and parcel of the process of migration. This is not pathological ambivalence, although it may be temporarily connected to symptoms such as anxiety or depression. It is important to accept the oscillation, the not knowing, the ambiguity, and the uncertainty, and to entertain different "as if" positions (as if you are staying, as if you are going back.) The decision cannot be rushed. It seems likely that a common outcome of migration is not an either/or choice. Developing a theme of increasing competence and life experience that enhance self and relationships anywhere, can serve to create temporary deadlines that act as

stabilities. To know whether or not to buy a couch if you are not staying here may be a problem, but signing up for an English class should not be. Anything you can take with you goes.

Case 2: "It is okay to handle your home just the way your mother did."

A young Mexican Catholic couple were facing multiple life cycle transitions along with the many changes imposed by migration. Within a period of four years, they had married, had their first child, and migrated to San Diego, where had their second child right away. They were expecting a third child when they came to therapy. To add to these rapid transitions, the husband's company was growing exponentially, and it was possible that they would have to move to New York. They were both young and had lived with their parents up to the time of their marriage. Each was still struggling with developmental issues of separation/individuation from their families. The myriad accommodations of early marriage in a couple with an asymmetrical style of communication were also part of the equation, e.g., she wanted to watch TV in bed, he wanted to read; he wanted to wake early in the morning, she wanted to sleep in, and so forth. They were also assuming the huge physical and emotional responsibilities of entering parenthood for the third time while still taking care of two very young children, in a country foreign to them, and without extended family support. The wife was concerned about the arrival of the third child and how she was going to handle the different needs and schedules of all family members. She wanted to hire a second helper to care for the children, in addition to the one they hired to help with house-cleaning. The husband objected vehemently to this idea. The house was too small and he needed his privacy. He criticized the wife for worrying too much about keeping a perfectly clean house, preparing elaborate meals, and entertaining too lavishly, unlike her middle-class, American counterparts who did fine without outside help.

It did not seem to me that the husband was suggesting a more egalitarian division of labor in the home, since there was no mention of it. When I asked to clarify, it was obvious that both husband and wife adhered wholeheartedly to traditional roles and division of labor. As we explored together the meaning and actions attached to their role definitions, it emerged that they were both satisfied with their current arrangement. The husband's interference had more to do with the circumstances of migration, i.e., living in a much smaller house and having a limited family and social life had made him more aware and controlling of household decisions than he would have been in Mexico. By stating his own strong opinions he was encroaching on his wife's domain, while she was not in any way involved in decision-making in his domain. He was introducing asymmetry in a complimentary task performance arrangement. The wife resisted; her sense of self was greatly derived from the cleanliness of her house, the variety of the meals she cooked and the exercise she did outside the home which she could only do with household help. She argued that if they had stayed in Mexico she would have even more help than she was asking for now; the matriarchs in her family ran their homes with the help of two maids, a cook, a gardener, and a chauffeur. Her husband was asking her to depart too drastically from the customs of her past. : Another important reason for her resistance involved their frequent visitors from Mexico; it was as matter of pride to

show that her ways and her status had not changed. A home that recreated the cultural features of the homes she knew in Mexico was comforting and reassuring. “Is it old-fashioned,” she said, “to want to have a house JUST LIKE my mother’s?" She was holding on to her cultural and family identity. As she was separating from her parents and becoming a mother herself, she was embracing her mother's skills at running her household. Under the guise of modernization, the husband was dislocating structural continuities at a time of massive changes. They were at a polarized and volatile impasse.

The therapeutic dilemma was that the immediate clinical goal was to support stability, particularly because the baby's birth was approaching. The simplest and most fair avenue was to validate the wife's decisions and her rights as a homemaker. Yet, I worried that in an attempt to secure family stability, I might downplay the possibility that both husband and wife were part of a prevailing cultural system that must regard the wife's sphere as less worthy of respect if it can be so easily invaded by the husband's views. Was the husband's interference with the wife's decisions an indication of a power imbalance that needed to be addressed at the risk of creating even more untimely stress? And wasn't it important to understand the husband's predicament in the new environment? I decided to share my dilemma with them. This generated a discussion from which it emerged that the sense of asymmetry came not from the distribution of tasks but from the husband treating the wife as a child in need of correction when in fact she was a 23 year old woman, mother, wife, and administrator of her household. It also became clear that a key balancing element in the traditional middle class household is the employment of maids. Siding with creating a stable environment to face multiple changes required that this family would not differ too much from a well-established cultural norm where the wife is in charge of the household but she decides how much and what type of help is needed. Empathy for the husband for the difficulties of migration led to an exploration of his affectional (family and friends) and physical losses (space) that he may have been avoiding by attempting to change his wife.

The two cases described here represent intersections and questions about issues of cultural transition. In each case, there are several variables to take into account: the individuals’ developmental stages and interpersonal dynamics, the developmental stage of the family cycle, the stage of acculturation, and the cultural preferences about family organization. They all offer possibilities and constraints to stability and change. The goal of therapy was not to protect the clients from change, but to protect them from the excessive anxiety, further polarization and disorganization that can result from adding challenges to their lives in the name of therapy.