Clinical skills in couples therapy psychology essay

Couples therapy has not been around in its distinct form for long. Only in 1970, Olson mentioned marital therapy as being in its very early steps. It was usually seen as an extension of family therapy and was never given enough attention. In particular, in family therapy books and other therapy textbooks (Nichols & Schwartz, 1998) it occupies only a small percentage of the books. The reason behind this is possibly the misconception that couples therapy is a part of family therapy and it does not have its own components and techniques. However, what most family therapists came to understand later on was that the majority of them had been working mostly with couples rather than the whole family all along (Gurman & Fraenkel, 2002).

To justify the fact that most family therapists' work is usually with couples Simmons and Doherty (1995) designed a study. Their results showed that family therapists dedicate approximately 59 percent of their practice to couple problems compared to 49 per cent of whole family problems. What is more, a large percentage of family therapists treated almost twice as many couples as families (Doherty & Simmons, 1996). Even therapists from other disciplines devote a considerable amount of time from their practice to engage in couples' therapy (Bevilacqua, 2000).

The reasons behind the decision of a couple to seek therapy are various and sometimes are more than a few. Emotional disengagement, problem-solving difficulties, power struggles, communication problems and jealously are only a small number of reasons that might lead a couple to therapy. What is more, value and role conflicts in the relationships as well as sexual dissatisfaction, extrarelational involvement and violence are a usual phenomenon in the couples who decide that they need professional help.

All the aforementioned reasons can make the couple’s relationship very problematic and unbearable. When people are in troubled relationships are more likely to experience psychological discomfort and physical issues. More specifically, one or both of the individuals might suffer in the long-run from depression, anxiety, suicidal ideation and even turn to substance abuse (Burma & Margolin, 1992). Additionally, they might also experience acute or chronic medical conditions and disabilities such as high blood pressure, impaired immunological functioning, accident-proneness and susceptibility to sexually transmitted diseases (Kiecolt-Glaser, Fisher & Ogrocki et al., 1993). Furthermore, when the couples have children then the difficulties the couple experiences are transferred to their children as well. In particular, the children who are raised in distressed marriages or relationships are more likely to develop an anxiety disorder, conduct problems, depression and even impaired physical health (Gottman, 1994).

Historically, they have been four phases in the development of couples’ therapy as we know it today and each phase has its own sub-stages where important establishments and milestones were achieved. In particular Gurman and Fraenkel (2002) suggest the phases of atheoretical marriage counseling formation, the psychoanalytic experimentation, the family therapy incorporation and the refinement, extension, diversification and integration as the four phases in history for the development of couple therapy.

In the first phase, the atheoretical marriage counseling formation, we can observe that the first relevant associations and laws were developed. According to Broderick and Schrader (1991) during that period there were

four stages that marked four milestones in the development of couple therapy. These stages are the Pioneer stage (1929- 1932), were very few professionals were working towards the establishment of what is now couples therapy, then it was the time of the Establishment stage (1934-1945) during which took place the development of the American Association of Marriage Counselors. Later on followed, the Consolidation stage (1946-1963) where we have the first legal recognition of the profession of marriage counseling. The fourth and last stage is the Formative stage (1964-1978) where professionals tried to scientifically study this area and relevant literature started to develop.

Phase two, was happening simultaneously with phase one of the development of couples therapy and it was called the psychoanalytic experimentation. During this time in the psychoanalytic school of thought, as with the rest of the school of thoughts at the time, the marital therapy sessions were nonconjoint. The therapists' rationale was that through transference and countertransference the individual would be able to face their relationship problems and change their behaviour. During that time very few therapists did actually held joint sessions with one couple (Sager, 1966) failing to realize the healing potential of the couple's relationship (Lewis & Gossett, 2000).

During the third phase the family therapy overshadowed the work that had already been done in the area of marital therapy. Thus, the title of this phase was family therapy incorporation. Even though couples therapy was not as popular as family therapy at the time (around 1963-1985) almost all major family therapy theorists were mentioning the importance of marriage and

the relationship between the couple in the overall family functioning (Broderick & Schrader, 1991). The main change in couples' therapy during this period was the increase in professionals who were practicing conjoint couples therapy.

The last phase is called the refinement, extension, diversification and integration and it starts from the mid-80s until nowadays. During this time and up until now couples therapy has permanently return to the scene of psychotherapy and different approaches and schools of thought have their own techniques and theories about what effective couples therapy is. The most well-known approaches used in couples' therapy are the behavioural marital therapy, the emotionally focused couple therapy, the insight-oriented marital therapy, the psychodynamic couple therapy and the cognitive-behavioural couple therapy.

There are certain therapy skills that whatever the therapist's approach is always helpful to know them and incorporate them in their practice. What is more, the following skills can be used for whatever the issue of the client or clients is. General therapy and interviewing skills are very important in building a trusting relationship between the professional and the client. First of all it is crucial that the client is aware we are actually there with them thus we need not only to be attentive but also to show it. The therapist can demonstrate attentive behaviour by using nonverbal and verbal cues in order the client to see that they are actually listened carefully. Attentive behaviour will make the client feel more comfortable to open up and expose their concerns to the therapist (Egan, 1994). Verbal attending is quite straightforward; anything from the tone of the therapist's voice and rate of

speech to sighs and uhums will help the client keep talking. Moreover, summarizing what the client has just said, reflecting and commenting on their sayings show to the client how carefully the therapist listens.

Nonverbal attending is less direct and obvious than verbal attending and it is very important because clients do receive it and react to it. There is no rule for what is appropriate and what inappropriate nonverbal attending is. However, when nonverbal cues such as eye contact, body posture, pauses within a conversation and facial expressions are congruent with the therapist’s verbal attending then rapport is enhanced. On the other hand, if the therapist’s verbal behaviour shows attendance but their nonverbal behaviour indicated for example boredom then the client is very likely to feel uncomfortable and not valued. It is important that the psychologist is aware of their attendance skills so that in cases where they have to deal with couples of other cultures they do not offend someone by mistake. For example, in our country eye contact is a nonverbal sign of attendance but in eastern countries eye contact might be regarded as offensive. Thus, we should always have in mind not only applying our attendance skills but tailor them to the person that we have in front of us.

An additional skill every professional has to master is how to identify and respond to the client’s nonverbal behaviour. That is, we need to be aware of the client’s body posture, eye gaze, and tone of voice and physical reactions such as sweat. The reason behind this is so that we can read through of what our client says and also increase our awareness of what the client thinks or feels. Sometimes, observing the client’s nonverbal behaviour can also help the client recognize how they come across other people. For example, it can

be a very rich source of information about the client's self when the therapist shares with the client what they have observed about the client's nonverbal behaviour during therapy. That way, the client becomes aware of how their body reacts to their thoughts and emotions and thus how their life is influenced by their nonverbal behaviour.

One more skill that is useful for getting an insight into the client's world is using questions. By asking questions the therapist gets an understanding into the strengths and weaknesses of the client as well as their problems, concerns and future goals. Most often than not the therapist is encouraged to ask open-ended questions in order to let the client respond in their own way. However, close-ended questions are sometimes used when very brief and specific information are is needed from the client. Open-ended questions are used mostly for accessing in-depth information from the client and like " tell me about your goals in life", or " where do you see yourself in five years?" and closed-ended question can follow to deduce more specific information about this question.

After the client answers an open-ended question the therapist can use some reflective listening comments to focus the client's attention on their own thoughts and feelings regarding their response. Reflective listening comments are basically what the client has already said and also, the therapist might attach what they think the feelings of the client are about the comment. By attaching a feeling to what the client has just said, the therapist helps them come in touch with themselves and understand their behaviour through their feelings.

By exercising all the aforementioned skills the therapist is then ready to use one of the most important skills in building the therapeutic alliance between them and the client, that is empathetic commenting. Using empathetic comments we make the client feel that what they say is valued and understood. Empathetic comments go beyond restating what the client said; they are mixture of the client's words, the context of their sayings and their nonverbal behaviour. The therapist might use empathetic comments to show the client that they understand them, to validate the client's experiences but also to support emotional control in cases where the client feels overwhelmed.

Learning to summarize is an important skill for every professional since it can be used to review the information the client has given and get feedback if you understood correctly. The process of summarizing and reporting back builds rapport between the client and the therapist since the client feels that the therapist is an active listener and keen to understand them. In summarizing it is important not to just repeat back what the client said but only to include the key points of the discussion so that it sounds genuine and not as mockery. As we already mentioned summarizing can be used as a means to demonstrate active listening from the therapist's part but also it can be used to highlight themes that tend to emerge during therapy. What is more, summarizing can be used as a transition from one topic of interest to another and also as a tool to decrease emotional intensity in cases where the client feels overwhelmed.

What is more, it is essential as therapists to be able to help the clients tell their stories, their concerns and explore their situation. Thus, we should be

able to work with a variety of styles of storytelling and be flexible to accommodate as many styles as possible since each person is unique and have their own way of interpreting and talking about situations. Furthermore, it is our responsibility to listen actively what the client says and identify any cues that lead to psychological resources the individual has to pump strength from as well as any unused resources they can utilize. Even if the clients are not very optimistic about their resources or the course of their therapy is vital for the psychologist to be proactive and motivate the client. Additionally, some clients might be reluctant or resistant in engaging in therapy even though their partner wants to. In these cases the psychologist can avoid any unhelpful responses to the client's reluctant or resistant comments or behaviour and develop productive approaches to deal with them. An example would be firstly to accept what the client feels and examine the quality of our therapy and intervention as well as exploring our own reluctance and resistance.

In cases when the client has difficulties in expressing themselves and explore their concerns the therapist can use some prompting and probing to help the client open up more. Probes and prompts are nonverbal and verbal tactics which are used in aiding the client to talk more openly about their issues. Prompts are brief verbal or nonverbal interventions from the therapist to the client that show to the client that they are not alone to their therapeutic journey and have someone there to encourage them. Verbal prompts include responses such as " yes", " I see" and " okay" whereas nonverbal prompts can be nodding and eye movement. In addition probes help the client name and take notice any issues during therapy. What is

special about probes is that they are designed to provide clarity and to move things forward. Probes can take the form of statements that indicate the need for further clarity, the form of requests as in requesting more information about a certain topic, the form of questions and possibly the form of single words or phrases. However, is important to have in mind to not overdo it with questions and prefer to use open-ended questions to let the client elaborate on their own words. In general, we should try and use probes to help our clients engage fully in the therapeutic process, to explore the client's issues and point of view as well as challenge them in a therapeutic way in order to give them a push forward.

Another crucially important skill for therapists is being able to be mindful. Mindfulness involves an attitude of acceptance, openness to the present experiences and curiosity (Bishop et al., 2004). It is basically the task of attending your current external and internal experiences instead of focusing in the past or in the future (Lau et al., 2006). Being able to attend and focus your attention is an important component of mindfulness and is theorized to increase the ability for prolonged focus and inhibiting thought processes that might distract from the here and now (Bishop et al., 2004). The reasons that mindfulness is so important for therapists are because it is a mean for developing our attending skills (Greason & Cashwell, 2009), it promotes our empathetic abilities (Morgan & Morgan, 2005), and it instils methods of self-care (Christopher & Maris, 2010) as well as improving our mental health (Shapiro, Brown & Biegel, 2007). All in all, there is significant evidence pointing towards the direction that mindfulness practice is related to

increased levels of self-efficacy, empathy and attention (Greason & Cashweel, 2009).

The above mentioned skills are a few out of a variety of clinical skills required for a therapist to be able to enhance the therapeutic process and these skills are pretty much the same for the vast majority of clients. However, when it comes to couple therapy the dynamic of therapy is different from having just one client. Therefore, additional skills are required in order to be able to balance therapy between the two people and make sure that the process is beneficial for both of them. The main principles for a couple's therapist is at the end to decrease the dysfunctional behaviour, to alter the couple's view of the issues they have in order to be more objective as well as increase the couple's communication and emphasize their strengths. From the very start of therapy the psychologist needs to be very perceptive in order to gather information about the couple's interaction and difficulties so they will be able to propose a causal description of the main relationship issues identifying the antecedents (Benso, McGinn & Christensen, 2012).

During couple therapy it is very important for the therapist to be able to ally with both partners and not with only one of them. By allying with both of them it gives the couple the emotional experience of having their separate concerns is heard and respected equally by the therapist. For the formation of the therapeutic alliance the therapist has to be empathetic and present constantly (Johnson, 2008). What is more, the therapist is the source of provision of whatever the partners need, especially at the beginning of therapy so that both of them will feel like they are equally important in the

therapeutic relationships (Gurman, 2008). The difficulty for the achievement of therapeutic alliance in couple's therapy is the obvious fact that the therapist needs to ally not with one but with two people at the same time without destroying the balance. Thus, constant balancing of the needs of both partners is necessary as well as simultaneously showing empathy and understanding to both of them (Gottlieb, Lasser & Simpson, 2008). When strong therapeutic alliance is achieved then the individuals will have the opportunity to recognize the effects of their behaviour on each other and hopefully increase the acceptance of the idea that both partners contributed to their current situation.

In some cases the therapist will have cases of couples where physical violence is present in the relationship. The therapist in these cases has to pay special attention to the psychological, physical and also economic safety of the partner who is the receiver of violent behaviour to ensure the safety of the individual. The majority of different therapy modalities suggest that in cases where there is physical violence in the couple, couple's therapy is not appropriate (Benson, McGinn & Christensen, 2012). One of the reasons that therapists should consider twice before taking in therapy a couple with history of physical violence is that during therapy negative emotions will most probably arise and when the session is over the negative emotions felt during therapy will be dealt at home in an appropriate and most likely violent way putting into danger the spouse. Therefore, in cases of severe or moderate domestic violence psychologists are advised to refer the couple to other kinds of therapy such as violence-focused therapy (Stith, McCollum, Rosen, Locke & Goldberg, 2005). In the case that the therapist believes that

there is no immediate danger to any of the spouses and couples therapy will have a therapeutic outcome it is suggested that the sessions should be structured in a way that avoids conflict and allows both partners to talk and be heard (Benson, McGinn & Christensen, 2012). Thus, the therapist should use all the above mentioned skills (observation and decoding of the nonverbal behaviour of the client, interpretation of the physical appearance of the client etc) to draw an accurate picture of the couple in their mind and avoid therapy turning into a battlefield.

One important goal that the therapist is expected to achieve during couple's therapy is to enhance communication between the two individuals. For this to happen, it is necessary the therapist to have the skills to do it and above all have good communication skills as well. If the therapist has the ability to communicate efficiently with the clients but also in their everyday life it will be easier for them to teach couples rules for communication and model them during therapy. The therapist has to have the skills to be a speaker and a listener at the same time as well as making statements which are specific and focus mostly on emotions instead of beliefs. If the therapist is able to demonstrate such communication towards the couples while in therapy then it will be easier for the couple to comprehend and understand the value of good communication and see how it works in practice.