Therapists' Perceptions of Their Roles and Functions in Imago Relationship Therapy

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DECLARATION OF ORIGINALITY

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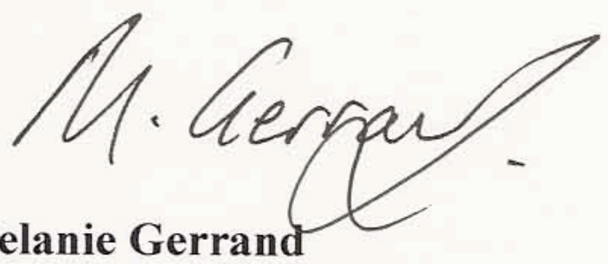
The author hereby declares that this whole research report, unless specifically indicated to the contrary in the text, is her own original work and that it has not been submitted for any degree at another university.



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ABSTRACT

Couple therapy research demands a shift in focus from quantitative to qualitative studies that explore therapist behaviours such as the role of the therapist due to the significant gap between research and practice, where research is often irrelevant and inaccessible to clinicians, and errors in practice are repeated and perpetuated as a result of lack of insight into therapeutic functions. Research on couple therapies also lacks focus on recent modalities such as Imago Relationship Therapy (IRT), a formative and recent modality of couple therapy in South Africa and internationally that requires empirical research and evaluation. Studies addressing therapist qualities and skills necessary in dealing with diverse populations such as South Africa are also lacking. The subjective experiences and perceptions of eight Imago relationship therapists practicing in a South African context were thus explored and described within a qualitative paradigm to provide an in-depth account of their role. Semi-structured individual interviews were used to explore their role, and responses recorded and analysed using thematic content analysis. Findings highlighted underlying complexities of this role as a result of evident contradiction, irony, and paradox within participants' experience. Firstly, the core function of establishing safe connection for the couple proved ironically 'unconnecting' and theory-driven in nature, which also provides a sense of safety and reduced responsibility for the therapist. The role of the Imago therapist was also indicated to be a part of participants' identity and life philosophy. The second theme highlighted the inherently paradoxical nature of the role because perceptions of a 'non-expert' and 'background' role in fact requires active and expert therapeutic functions as they remain acutely connected to the couple's process. Thirdly, the intuitive nature of this role was reiterated as participants' experienced both favourable and limiting therapeutic encounters in a positive and congruent way, which has implications for increased therapeutic growth. Finally, although participants' experience of their role in South Africa highlighted IRT's underlying theoretical orientation of universal connection, they did not seem aware of this underlying theory as informing practice. This raises questions about implications on their role given the importance of theory in influencing the way the therapist thinks about the client. Findings generally contribute to narrowing the research-practice gap providing insight into the practice of Imago therapy, which may in turn add to richness of theory.

Key words: Imago Relationship Therapy, couple therapy, role of the therapist, safe connection, couple therapy research, history of couple therapy, qualitative research, thematic content analysis.

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1. Chapter One: Introduction and Rationale

1.1 Introduction

Critical to the rationale of this study is that most of the research on relational therapies has focused on very few forms of treatment, and interventions of more recent types of couple therapy such as Imago Relationship Therapy (IRT) have not yet been well specified (Johnson & Lebow, 2000; Lebow, 2000). IRT is viewed as a relatively formative and recent modality of couple therapy as it is only in its third decade of practice internationally and was only introduced to South Africa a little over a decade ago. As a result, empirical evaluation and research on IRT is still in its infancy (Hendrix & Hunt, 1999). As of yet in South Africa, there has been only one outcomes-based study on IRT interventions very recently at the University of Stellenbosch (Lawson, 2008), and one study on the use of IRT in Christian marriage counselling (De Klerk, 2001). Furthermore, an extensive search on available research on couple therapy in South Africa yields very sparse findings, with most articles located in the *"Psychoanalytic Journal of South Africa"* which explore couple therapy and couple distress from psychoanalytic and psychodynamic perspectives. In addition to this, research on couples therapy in general has been largely confined to First World populations, such as middle-class North Americans (Brammer, Abrego & Shostrom, 1993; Johnson & Lebow, 2000) thus warranting the exploration of a mode of couple therapy as practiced in South Africa by South African couple therapists. To follow is additional foregrounding and rationale for this study.

1.2 Implications of Couple Distress and Conflict

Distress in intimate relationships, as well as failure to develop a satisfying intimate relationship with one's partner is recognized as the single most frequent presenting problem in psychotherapy (Johnson, 1998; Johnson & Lebow, 2000; Long & Young, 2007; Veroff et al, 1981, cited in Sholevar, 2003). Statistics indicate that more than one half of the couples that marry will separate and divorce (Pinsof & Wynne, 1995). South Africa is by no means exempt from such statistics with figures indicating that of all

recorded divorces in 2007, forty eight percent were the result of marriages that did not exceed 10 years of marriage (Statistics South Africa, 2009). Conflict and distress in intimate relationships, as well as divorce or separation in turn have a variety of negative effects on the physical and mental health of children and adults. For instance, marital conflict and divorce have been clearly linked to a variety of negative psychosocial consequences for family members, including psychological, physical, and financial consequences amongst spouses and children (Byrne, Carr & Clarke, 2004; Estrada & Holmes, 1999; Gottman, 1994; Gurman, 2008; Lebow, 2000). Moreover, couple distress acts as a predisposing or a maintaining risk factor for many individual psychological disorders such as mood disorders, anxiety disorders, alcohol abuse, and psychoses (Byrne, Carr & Clarke, 2004; Pinsof & Wynne, 1995; Williams, Riley, Risch & van Dyke, 1999). Couple distress also increases the risk of problems in children such as attachment and behavioural difficulties, development of poor coping responses, lower social competence with peers, and academic difficulties (Byrne, Carr & Clarke, 2004; Long & Young, 2007; Pinsof & Wynne, 1995).

The value of addressing and treating distress in intimate relationships for the sake of individual and family wellbeing is thus highlighted. Moreover, couple therapy is now also indicated as a treatment of choice for certain psychological disorders. For instance, couple therapy is becoming an empirically supported treatment for depression and appears to have the advantage of both alleviating depressive symptoms and improving the marital relationship in a way that exceeds improvements of individual treatment or no therapy (Dessaulles, Johnson & Denton, 2003; Gilliam & Cottone, 2005). A stable intimate relationship also appears to positively affect the course and outcome of narcissistic personality disorder (Links & Stockwell, 2002). Therefore, whereas the role and function of a marital therapist was to preserve marriages at all cost three decades ago, couple therapy today has also become a highly effective instrument to help spouses achieve a higher level of personal development and maturity, regardless of whether the outcome is staying married or getting divorced (Sholevar, 2003).

1.3 Shortcomings in Couple Therapy Research and New Directions

In spite of a strong awareness of the prevalence of marital difficulties and the financial and emotional hardships that are created by couple distress and divorce or couple separation, as well as the numerous benefits gained through couple therapy, the mental health community has not focused strongly on the couple relationship (Long & Young, 2007). Long and Young (2007) argue that professionals in the field of mental health have until recently been preoccupied with the individual which has resulted in training, and hence practice, that has focused almost entirely on working with a single client. In addition to a lack of focus on the couple relationship, research in the field of couple therapy is needed as it informs practice, tests theories and models of couple intervention, and expands the knowledge base about the nature of couple functioning as well as the nature of various ways of treating couple discord (Stabb, 2005).

Research literature also highlights numerous gaps regarding the nature of extant research within the field of couple therapy with a consequent need to expand on the repertoire of research being done in the field. A lack of broader methodological focus has contributed to a significant gap between research and practice where research is often viewed as irrelevant and inaccessible to clinicians, practice is not research-informed, and errors in practice are repeated and perpetuated (Sprenkle, 2003). For instance, whilst reviews of marriage and family therapy outcome research in the 1990's are substantial and demonstrate the overall efficacy of marriage and family therapy (Christensen et al., 1998), and the need for marital and family therapy outcome research continues, the need for studies that explore *why* marital and family therapy is effective has been highlighted (Wynne, cited in Christensen et al., 1998). The need for research examining the therapeutic change process and how it comes about within the therapy context has therefore also been stressed (Sprenkle & Bischoff, as cited in Christensen et al., 1998).

Moreover, whilst studies exploring the process of change in marital and family therapy are not scarce, most of these studies have quantified the process and outcome using objective measures, and an alternative approach of examining change and process qualitatively has been recommended (Chistensen et al., 1998). A qualitative, open-ended

approach that analyses the therapeutic process from for instance, the client's or the therapist's perspective, may thus reveal aspects of the change process that may be overlooked by hypothesis-testing quantitative methods (Moon, Dillon, & Sprenkle, as cited in Christensen et al., 1998). Therefore, whilst concerns about the negative impact of marital discord and divorce will continue to provide the impetus for research on more effective means of couple intervention (Christensen & Heavey, 1999), the need for a *"discovery-oriented, hypothesis-generating"* approach to understanding the therapeutic process and to suggest relationships between therapeutic variables has been recommended (Wynne; Piercy & Sprenkle; Pinsof; Stanton, cited in Christensen et al., 1998, p.178).

According to Whisman & Snyder (cited in Halford & Markman, 1997) research also indicates the need for a greater understanding of moderators and mediators of the change process in couple therapy, for example, the role of the therapist in the therapeutic change process. In spite of the noted significance of the role of therapists in therapeutic change however, research literature points to further significant gaps in our knowledge regarding these roles (Blow, Sprenkle, & Davis, 2007). In particular, the need for focus on therapist behaviours and interventions that may lead to important moments of change in therapy, as well as the need to determine the nature of active ingredients in different models that contribute most to successful therapy, has been noted and stressed (Beutler, Williams, & Wakefield, cited in Johnson & Lebow, 2000; Bray & Jouriles, 1995). A clearer understanding of the therapist's role involves understanding *how* the therapist operates during the session and such an understanding of their role is important for interventions to be employed most effectively (Baucom et al., 1995; Whisman & Snyder, 1997, in Halford & Markman). Careful description of the therapies being evaluated is thus a necessary step forward in the field (Pinsof & Wynne, 1995).

Returning to the focus of this study, although some preliminary empirical findings on IRT exist and represent a promising beginning, Berger (cited in Hendrix & Hunt, 1999) has challenged Imago clinicians and theorists to conduct more extensive efficacy studies such as those using long-term follow-up, control groups, randomization of couples, and objective measures (Hendrix & Hunt, 1999). However, given recommendations above within couple therapy research to engage in qualitative exploration of process variables

within couple therapy such as the role of the therapist, this study is inclined to favour Berger's (cited in Hendrix & Hunt, 1999) suggestion of process studies that, for instance, explore couples' reactions, variations in the therapist's role (such as passive facilitator vs. active leader), and theoretical studies that would examine hypotheses emerging from Imago theory that have also been recommended (Hendrix & Hunt,1999). Exploring the role of the Imago therapist may, for instance prove valuable to research given the posited uniqueness of the role of the Imago therapist. That is, whilst IRT is amongst other modes of couple therapy that view the couple as the client and focus on the relationship as foundational, it was the first to assign therapeutic agency to the couple and remove it from the therapist (Hendrix, cited in Brown, 1999).

A significant need for couple therapy to be tailored to the specific needs of diverse patients and populations across the socio-economic scale also exists (Kaslow, 2005). Research in the field of couple therapy has lagged behind regarding issues of diversity, for instance, studies that address particular personal/therapist qualities and skills needed to deliver effective couples therapy to specific populations such as ethnically diverse couples, rural couples, and homosexual or bisexual couples, are lacking (Hovestadt, Fenell, & Canfield; Bean, Perry, & Bedell; Bepko & Johnson; Laird; cited in Stabb, 2005). In addition, couple interventions that have proved effective have yet to be examined on a diverse population of couples (Christensen & Heavey, 1999).

1.4 Aims of this Study

In keeping with recommendations in couple therapy research for qualitative hypothesis-generating studies that encompass the exploration and documentation of process aspects of the therapeutic encounter, in an attempt to explore the complex multilevel process of couple therapy, and as a means to contribute to the knowledge base of more recent types of couple therapy, this study aims to explore the perceptions of Imago relationship therapists regarding their roles and functions in doing Imago relationship therapy. In light of the lack of couple therapy research relating to diverse populations, this study also aims to explore the perceptions that Imago relationship therapists have of their roles and functions as they practice within the South African context. Inquiry into the subjective, experiential dimensions of their roles as Imago relationship therapists is believed

necessary to add to the understanding of the complex and multi-level process involved within the therapeutic change process.

In response to the shortcomings in the methodology applied in the field of couple therapy such as those described above, a growing body of process research exists that makes use of methodology such as discourse analysis, conversation analysis, and content analysis to discover what therapists do in therapy (e.g. Couture & Sutherland; Cogan & Gale; Rober, van Eesbeek, & Elliot; cited in Blow, Sprenkle, & Davis, 2007). With this in mind, and given the explorative nature of the study, the qualitative method of thematic content analysis has been used to interpret participants' perceptions of their roles as Imago therapists. This frequently accepted qualitative technique allowed for the great volume of participants' responses to be placed into meaningful units or categories for further interpretation and placement into common themes in order to provide knowledge and insight about the role of the Imago relationship therapist. This method was believed to be appropriate for facilitating the exploration and documentation of participants' perceptions and subjective experiences of their roles as Imago therapists, without presupposing the nature of their roles based on prior literature and information pertaining to the roles of Imago and other types of couple therapists.

1.5 Research Questions

In line with the aim of this study to explore the role of the Imago Relationship therapist and in an attempt to note principal themes relating to this role within the therapeutic encounter, this study seeks to explore the following research questions: (a) What is the perceived role of the Imago relationship therapist? (b) How is the role of the Imago relationship therapist perceived to be distinctive from, and similar to, the role of couple therapists in other traditional forms of couple therapy? (c) What are some of the perceived strengths and weaknesses of practicing this form of couple therapy? (d) What is the perceived role of the Imago relationship therapist in South Africa?

1.6 Chapter Layout

As indicated above, Chapter One begins by introducing the need to explore IRT empirically as well as the topic of couple distress, followed by the most significant implications of this on individual and family wellbeing. Coupled with this, several significant shortcomings in current and past research within the field of couple therapy are highlighted as further rationale for this study. Chapter One also includes an overview of the aims of this study, a brief explanation of the methodology that was used to pursue these aims, as well as the research questions addressed to achieve this objective.

Chapter Two is aimed at orientating the reader in terms of the history and current status of couple therapy. This includes an overview of the origins and development of the theory and practice of couple therapy, as well as insight into past and current research within the field of couple therapy. The current and overwhelming focus on efficacy and effectiveness outcome research in the field is highlighted, and subsequent gaps in couple therapy research are noted for the purpose of providing rationale for this study. It also examines the need for couple therapy to narrow the gap between research and practice, the need for focus on therapist variables such as the role of the therapist as it contributes to the therapy process, and treating specific and diverse populations appropriately. The most commonly utilized forms of couple therapy (including the role of the therapists) are also described briefly in Chapter Two as a point of reference for the reader when reviewing findings regarding the role of the Imago relationship therapist.

Chapter Three details the research method of the study. The research aims, design and procedure, and the method of analysis are reviewed, followed by a brief reflection on the ethical considerations for this study. Chapter Four encompasses a thematic analysis and discussion of the interview data collected from participants. Finally, Chapter Five is a discussion and summary of the overall findings encountered, as well as the limitations of this study and implications for future research.

2. Chapter Two: Literature Review

2.1 Introduction

This chapter will focus briefly on the developmental and conceptual history of the field of couple intervention by commenting on emerging trends in theory and practice that ultimately led to the manifestation of couple therapy as it is known today. Moreover, a brief overview of the nature of research pertaining to the practice of couple therapy during its development will be given, as well as recent and current trends in couple therapy research, perceived gaps and controversies in couple therapy research, and subsequent recommendations for the future direction of research in the field. In light of these recommendations, the rationale of this study will be restated and the roles of couple therapists from the most commonly utilized and most well documented orientations to couple therapy will be explicated as a point of reference for the intended exploration and documentation of the perceived role of the Imago relationship therapist as delineated in the aims of this study.

2.2 Contextualizing Couple Therapy

2.2.1 Atheoretical Beginnings

Although couple therapy manifested as a psychotherapeutic modality in the mid twentieth century, attempts to strengthen marital relationships and to resolve marital conflict, are as ancient as the institution of marriage (Sholevar, 2003). In their classic tracing of the history of marital counselling, Broderick and Schrader (cited in Gurman & Fraenkel, 2002) identify four distinct phases in the theoretical and clinical history of couple therapy. In its earliest stages, the role of helping married couples resolve their marital conflicts traditionally belonged to people such as clergymen, obstetrician-gynaecologists, physicians, social workers, college professors, and even extended family members, who took it upon themselves to offer counselling advice and guidance to couples in distress regarding adaptive family and marital roles (Broderick & Schrader, 1991; Gurman, 2008; Sholevar, 2003; Sullivan & Christensen, 1998).

2.2.2 Psychoanalytic Experimentation

This early atheoretical period of marital counselling was followed by the emergence of professional marital counselling in the 1920s and 1930s, which drew from the theoretical foundations of psychoanalysis and entailed a lengthy period of psychoanalytic experimentation (Gurman 2008; Sholevar, 2003). This was due to the prominence of the psychoanalytic perspective at the time, which proved to be the only coherent theory of human behaviour that was frequently applied to the clinical study and treatment of marital discord (Gurman, 2008; Gurman & Jacobson, 1986). A variety of theoreticians established the theoretical foundation for marital therapy during this time, such as C.P. Obendorf in 1931, who focused on the role of "interlocking neuroses" in symptom formation of married couples, and proposed that a neurosis in a married person is strongly anchored in the marital relationship (Gurman & Fraenkel, 2002; Sholevar, 2003).

Although other psychoanalytic experimentation occurred cautiously during the late 1950s and early 1960s, most contributions evidenced no new developments in theory (Gurman & Fraenkel, 2002). Instead, experimentation and change in the field centred around the format of delivering marital therapy. A significant step forward in this regard was taken by Mittelman (cited in Gurman & Fraenkel, 2002) who began seeing couples concurrently, which meant that both partners were treated individually but by the same therapist. This was later followed by an even more daring step by Mittelman who initiated joint sessions with one couple as a result of their conflicting stories when seen individually (Gurman & Fraenkel, 2002). In spite of the drastic change however, marital therapy still captured the essence of the presumed mechanism of change in concurrent and individual marital therapy of the day, namely, that it was the role of the *therapist* to rectify partners' distorted mutual perceptions as though the therapist was the authority on what was rational and what was not (Gurman & Fraenkel, 2002).

In the meantime, other non-conjoint psychoanalytic marital treatment methods emerged in which the centrality of the individual(s) prevailed, and as long as marital partners remained either exclusively or predominantly in individually formatted therapies, the therapist's role as central change agent remained, as the healing potential within the couples' own relationships was not yet recognised (Dicks, as cited in Gurman &

Fraenkel, 2002; Sager, 1976). It was not until the early 1960s that psychoanalytic couple therapy began moving toward an emphasis on the conjoint approach. In spite of this though, the assumption still held that understanding the couple's "interlocking" adaptive and communicative systems required that the therapist have a clear appreciation of each partner's individual psychodynamics and developmental history that was assessed in the traditional patient-therapist dyadic setting and within triangular transference interactions, rather than in the couple relationship itself (Gurman & Fraenkel, 2002; Sager, 1976).

Psychoanalytic couple therapy would soon seem to disappear from the marital therapy scene for almost two decades, however, with two major influences contributing to its demise. Firstly, was the apparent lack of effective interventions that seemed rooted in the continued emphasis on the traditional patient-therapist transference, which in turn did not allow for the evolution of interventions that emphasized the significance of partner-partner transference (Gurman & Fraenkel, 2002; Sager, 1976; Sager, 1981). The second challenge was the introduction of the family therapy movement which railed against the practices of traditional mental health disciplines, as well as the prevailing, individually oriented views of psychoanalytic/psychodynamic therapy principles and their unwarranted pathologising of individuals in relational contexts (Fraenkel, 1997; Gurman, 2008). It was also at this point in the 1960s that the field of marital therapy was referred to as "a technique in search of a theory" (Manus, cited in Gurman, 2008), because while psychotherapists were increasingly treating couples with marital problems, they lacked conceptual clarity or coherence to their work (Gurman & Jacobson, 1986).

2.2.3 The Influence of Family Therapy

Although psychoanalytic thinking did not die out completely, it became fragmented and marginalized by dominant schools of therapy at the time, especially by the incorporation of family therapy (Gurman & Fraenkel, 2002). Until such time, views of couple interaction as well as methods of couple intervention were mainly inferred from abstract theories of individual adaptation and change (Johnson & Lebow, 2000). The relationship between marital therapy and family therapy thus marks a controversy in constructing the history of couple therapy as strong views were held that a focus only on the dyad forces

the observer to ignore the structure in which the dyad functions (Fraenkel, 1997; Gurman & Fraenkel, 2002; Gurman & Jacobson, 1986).

In spite of some disagreement regarding family therapy's part in the formation of couple therapy as we know it today however, early family therapists argued that relationship functioning and individual functioning co-evolve, as each influences the other (Lebow, 2000). Consequently, most major family therapy theorists have had something to say about the place of marriage in overall family functioning, the sources of conflict and disharmony in couples, and about the guiding principles of couple intervention (Gurman & Fraenkel, 2002). The contributions of four clinical theorists are particularly representative of the kinds of conceptual changes that family therapy had on theory development and clinical practice of couple therapy during this era (Gurman, 2008).

Don Jackson's concept of "family homeostasis" for instance, highlighted the need for families to resist change and maintain homeostasis, which ultimately became central to his understanding of couple functioning and his inadvertent focus on dyadic relationships (Gurman & Fraenkel, 2002). In addition, Jackson's discussions of marital relationships led to the concept of marital "quid pro quo" (problem-solving in a dyad by negotiation, based on mutual give-and-take), which later became central to the early development of behavioural marital therapy (Gurman & Fraenkel, 2002; Tsoi-Hoshmand, 1975).

Virginia Satir was another major influence, and although well published in the field of family therapy, also ultimately focused her systems-oriented therapeutic contributions on dyadic functioning, especially the marital dyad (Gurman & Fraenkel, 2002). Moreover, unlike "systems purists" of the day, Satir did not negate the importance of historical family origins of problems, nor did she ignore the matter of marital choice of a partner with similar difficulties and degrees of selfhood, which was a topic of great concern to psychoanalytic marriage therapists of the day (Satir, 1964, as cited in Gurman & Fraenkel, 2002). Focusing on such matters led to her belief that symptoms arise in individuals when the 'rules for operating' do not fit the need for survival, growth, and intimacy, with the result that dysfunctional marriages follow dysfunctional rules that limit individual growth and dyadic intimacy (Satir, 1965, as cited in Gurman & Fraenkel, 2002). This understanding has played a significant role in the development of couple

therapy grounded in attachment theory (Greenberg & Johnson, 1986; Johnson, 1998a). Primacy was thus given to the functioning and experiences of the individual as much as to the individual-in-relational context (Gurman & Fraenkel, 2002).

Also of significant influence to the development of couple therapy theory and practice, was the father of multigenerational or transgenerational family systems theories, Murray Bowen. As with Jackson and Satir, in spite of his systemic theoretical roots, his clinical work strongly emphasized the marital dyad as the central treatment unit to the point that working with the marital couple was his preferred format for therapy even when the presenting problem was not marital conflict (Gurman & Fraenkel, 2002). Bowen brought to couple therapy the concept of 'differentiation of the self', believed in relational causes of all psychological and psychiatric problems, and worked with couples partly as a way of trying to avoid pathological multigenerational processes (Gurman & Fraenkel, 2002). The nature of the Bowenian therapist's role was central to clinical practice and played a central part in establishing trends in the field of couple therapy toward present-centred, interaction-centred, and symptom-centred therapeutic methods (Gurman & Fraenkel, 2002; Long & Young, 2007). Moreover, although there are relatively few "Bowenian" therapists due to the limited availability of the high-level training required, there has been no other historically oriented transgenerational method of couple treatment from within the world of mainstream family therapy that has had as much widespread influence, and whose language and constructs have pervaded the practice of multigenerational couple therapy (Gurman & Fraenkel, 2002).

Finally, in spite of the great influence of Jackson, Satir, and Bowen, nobody had as much influence on the practice of couple therapy as Jay Haley during the time of the family therapy movement (Gurman & Fraenkel, 2002). Haley (1963, as cited in Gurman & Fraenkel, 2002) published a classic paper entitled "Marriage Therapy" which arguably marked the defining moment at which the remains of fading marriage counselling and psychodynamic marital therapy movements were incorporated by family therapy. Haley advocated the importance of power and control as central relational dynamics of marriage, as well as the opinion that symptoms serve functions for the system, which became hallmark concepts of the strategic approach to couple and family therapy (Nicols & Schwartz, 1998).

By this time (1980s) the need for conceptual foundations was overcome as the field had begun to accumulate a substantial body of empirical research (Gurman, Kniskern, & Pinsof, 1986) which both documented the efficacy in general of (conjoint) couple therapy, and provided an empirical basis for at least some of the important and recurring decisions that needed to be made in clinical practice (Gurman & Jacobson, 1986). Although only a handful of important texts regarding couple therapy appeared during this time, a variety of central topics were being discussed and a critical mass of couple-focused psychotherapists was beginning to redevelop (Gurman & Fraenkel, 2002).

2.2.4 The Current Era in Couple Therapy Development

Broderick and Schrader (1991) suggest that the final and current stage in the development of couple therapy has been marked by refinement, extension, diversification, and integration. Couple therapy has, for instance, afforded the appearance of three particular models of treatment over the last decade and a half that have boasted increasingly solid research bases, as well as continual modification, and conceptual and technical refinement as a result of such research (Gurman & Fraenkel, 2002). For instance, Behavioural Marital Therapy (BMT) is reported to be the most intensively and frequently investigated method of couple therapy boasting some of the most important publications on couple therapy with the result that it demonstrates significant modifications and refinements in terms of its underlying treatment model and its application (Gurman & Fraenkel, 2002; Halford, 2001).

Although not as widely familiar as BMT, Emotionally Focused Couple Therapy (EFT) and Insight-Oriented Marital Therapy (IOMT) have also established a strong empirical base. Whilst EFT has come to represent the first significant reattachment among couple therapists to the broader historical MFT field exemplified by experiential contributors such as Rogers and Perls and the humanistic values and methods of Satir, IOMT provides the most substantial empirical grounding to date for the re-emergence of the suppressed psychodynamic couple therapy methods of the 1960s, as well as the re-emergence of the "self in the system" (Gurman & Fraenkel, 2002). The development of IOMT has in turn led to a renewal of interest in psychodynamic elements of marital therapy and the emergence of a growing number of integrative couple therapies (Gurman & Fraenkel,

2002). Moreover, a number of clinical theorists (e.g. Scharff & Scharff, 1991; Seigel, 1992; Bader & Pearson, cited in Gurman & Fraenkel, 2002) have been working to clarify psychodynamic theory as it applies to conjoint therapy and to refine intervention strategies and techniques to achieve changes usually sought in these therapy approaches (Gurman & Fraenkel, 2002).

In addition to refining clinical treatment approaches, couple therapy has also extended itself to include the treatment of individual psychiatric disorders over and above the treatment of relationship conflict and distress (Gurman & Fraenkel, 2002; Sholevar, 2003). Couple therapy has therefore emerged as an intervention for individual symptomatology, especially when the relationship may play a role in the etiology, maintenance, or worsening of individual symptoms (Johnson, 1998). Couple therapy's fundamental assumptions were also diversified in the late 1970s and 1980s. That is, whereas earlier systemic theories shifted therapists' focus from individuals to dyads, a movement toward a more diversified and extended conceptual view of couple and family therapy developed to take account of broader social beliefs and forces that impacted on couples, such as gender, race, ethnicity, social class, sexual orientation, culture, religion, education, and other differences (Fraenkel, 1997; Gurman, 2008). Feminism, multiculturalism, and more recent postmodern critique of the positivist trend in psychotherapy, have also assisted in broadening the 'concentric ring' that previously encouraged the close focus of couple therapy to that of dyadic interaction (Gurman & Fraenkel, 2002).

The 1990s marked another major thrust in the development of couple therapy, namely the movement toward integrative clinical theory and practice, highlighting the great tendency in couple therapy toward modes of therapy that are eclectic and integrative (Gurman & Fraenkel, 2002; Sholevar, 2003). The three major strategies of integrative model development include the common factors approach, which focuses on elements of therapy found in most treatments; technical eclecticism, which combines techniques from more than one model whilst one model remains dominant; and theoretical integration, which involves creating a superordinate framework that draws upon multiple viewpoints (Stricker, cited in Gurman & Fraenkel, 2002).

In spite of attempts at refining, extending, diversifying, and integrating within the field of couple therapy research however, the current era of couple therapy is not without critique regarding longstanding trends in the nature of its research. In light of this, recent research in couple therapy will be noted along with critique and shortcomings of such research that has stimulated the need for different types of research in the field, such as the explorative nature of this study. To follow is also a brief definition of couple therapy, as well as a description of terminology relating to couple therapy that will be utilized for the purpose of this study.

2.3 Defining Couple Therapy

More than twenty years ago, couple therapy was described as having the goal of alleviating stress and conflict in marriage, as well as encouraging the maximum development of each marital partner as an individual human being (Humphrey, 1983). This understanding of couple therapy does not appear to have changed much over the past decades, and has recently been described by Sholevar (2003, p. 419) as *"a broad range of treatment modalities that attempt to modify the marital relationship with the goal of enhancing marital satisfaction or correcting marital dysfunction"*. The relationship (rather than the individual spouses) is considered to be the patient in couple therapy. This implies that two reasonably healthy spouses may form a symptomatic or dysfunctional relationship, although the effects within the relationship of the underlying emotional disorders of each spouse are a common contributor to the formation of a dysfunctional relationship (Sholevar, 2003). The goal of couple therapy thus includes the enhancement of the couple relationship and the treatment of any underlying emotional disorders in one or both of the spouses, with a further aim of progression by the couple to a relationship on a higher developmental level (Sholevar, 2003).

2.3.1 'Couple' versus 'Marital' Therapy

Although most intimate, long-term adult relationships continue to be constituted by what we know as "marriage", it seems more appropriate to think in terms of "couples" rather than "marriages" given this era of increased viability and existence of alternative relationship styles and family structures (Gurman & Jacobson, 1995), such as married or

co-habiting heterosexual couples, and same-gender couples. Today the word "couple" is more universally descriptive of the bond between two people, and also excludes any judgmental tone of social value implied by the word "marriage" (Gurman & Jacobson, 1995; Sullivan & Christensen, 1998).

Moreover, even though the majority of research has been conducted on married couples, the ideas set forth about clinical practice within major models of couple therapy are salient even outside the traditional relational construction of marriage, making extant therapeutic interventions applicable to other adult romantic relationships such as heterosexual cohabiting relationships and same-sex relationships (Christensen & Heavey, 1999; Gurman & Jacobson, 1995). As a result, the more inclusive term 'couple' will be used in this study rather than 'marital' or 'marriage', unless otherwise stated in an historical context. The term 'couple therapy' will therefore also be used instead of 'marriage therapy' or 'marital therapy' to refer to dyadic therapeutic intervention (unless stated otherwise in an historical context), as this is consistent with recent developments in the field. A fundamental change in nomenclature from "marital and family therapy" to "couple and family therapy" has also occurred out of respect for the diverse forms of family in our society (Walsh, cited in Lebow & Gurman, 1995). The latter terminology will thus also be used in this study where reference is made to couple therapy and family therapy together.

Finally, a number of choices exist regarding the format of couple therapy. These include individual therapy, in which marital/couple issues are worked on with only one of the partners; concurrent therapy in which partners are seen respectively by the same therapist for individual sessions; concurrent therapy with different but collaborating therapists; group couples therapy; and conjoint therapy, in which both partners are seen simultaneously/conjointly by a single therapist who therefore has access to the clients' interactive patterns (Brammer, Abrego & Shostrom, 1993; Humphrey, 1983; Martin, 1994). The latter format will underpin discussion in this paper as it remains the most favoured type of couple therapy amongst therapists in alleviating couple distress (Pinsof & Wynne, 1995; Sholevar, 2003), since it's inception by Mittelman in the 1950s as a result of couples' conflicting stories presented during concurrent therapy sessions (Sager, 1994).

2.4 The Status and Nature of Research in Couple Therapy

As reflected in the dynamic evolution of couple therapy, this is a profession with complex theoretical roots. The theoretical ideas of a profession are not, however, static and evolve along with various eras of thinking (Becvar, 2003, as cited in Sexton, Ridley, & Kleiner, 2004) as well as through various shifts in prevailing paradigms (Kuhn, 1964, as cited in Sexton, Ridley, & Kleiner, 2004). The existence of reasonably credible research on couple therapy is also quite recent, and marital therapy/therapy remained a field in dire need of data for more than its first forty years, essentially having little to show for itself empirically until the mid 1970s (Gurman & Fraenkel, 2002). The middle to late 1970s marked a turning point in the research history of couple therapy as the field began to accumulate a critical mass of empirical studies of treatment outcomes, and because such studies appeared to have implications for clinical practice in terms of guiding some important aspects of treatment planning (Gurman & Fraenkel, 2002), numerous views exist that challenge and question the value of outcome-based research and instead encourage methodological revision and expansion in the field of couple therapy research (Gurman & Fraenkel, 2002; Jacobson & Addis, 1993; Lebow & Gurman, 1995; Pinsof & Wynne, 1995; Sprenkle, 2003). To follow is thus an overview of developments, trends, and choice points within the current era of couple therapy research, along with subsequent gaps in research and recommendations for future research that serve as rationale and support for the nature of this study.

2.4.1 Efficacy and Effectiveness Studies: A Longstanding Focus in the Field

Although the amount of research done in the field had grown considerably by the mid-to-late 1980s, it was suggested that the culture of marital and family therapy (MFT) did not support research due to the number of charismatic individuals that created models and became successful through workshops and lucrative book contracts without offering evidence for its efficacy beyond personal testimony (Crane et al., 2002, as cited in Sprenkle, 2003). In response, couple therapy research appeared to enter an era of competitiveness during the 1980s, marked by 'competing sects' claiming their models to be most effective, which seemed to lead to a lack of healthy scepticism in the field (Werry, 1989, cited in Sprenkle, 2003). Following this, the early 1990s demonstrated an increased emphasis on specifying and operationalising interventions, and the

development of a much less self-congratulatory and more honest assessment of the efficacy of couple therapies (Gurman & Jacobson, 1995). Indeed, the field of couple (and family) therapy is now held to a significantly higher level of accountability in which couple (and family) therapists are required to demonstrate outcomes and use 'best practices' (Alexander et al., 2002, as cited in Sexton, Ridley, & Kleiner, 2004).

As a means toward accountability, the current era in couple therapy research has been marked largely by attempts to demonstrate that treatments have credible empirical support. The result has been that the clinical representativeness of couple therapy outcome studies have until now been examined in the context of the efficacy-effectiveness distinction (Wright et al., 2007). Methodology has thus focused on proving the effectiveness and efficacy of couple therapy in various areas, such as studies comparing the relative effectiveness of different types of couple therapy (i.e. comparative clinical trials), measuring the power of couple therapy, establishing the effectiveness of couple therapy in treating individual disorders, and attempts at predicting the responsiveness to couple therapy.

2.4.2 Clinical Trials Research

The most basic question that has been asked about couple therapy is whether it works, and has been addressed in research by comparing couple therapy with no treatment at all (Christensen & Heavey, 1999). Studies assessing the relative effectiveness of different couple therapies are also used to measure effectiveness and are aimed at answering the question of which therapy works best. These entail clinical trials that compare two or more distinct models of couple therapy, primarily on the measure of efficacy (Jacobson & Addis, 1993). Literature seems to agree that whilst most therapies that have been reasonably well researched (especially BMT, EFT, and IOMT) and have proven superior to no treatment, no strong or statistically significant evidence exists that any one of these models is more effective than the others or any other approach to couple therapy (Christensen & Heavey, 1999; Gurman & Fraenkel, 2002; Pinsof & Wynne, 1995; Shadish et al. 1995). It has also been suggested that when differences have been indicated, they have appeared bias toward the allegiance and expertise of the investigators (Jacobson & Addis, 1993; Shadish et al., 1995).

The question of how powerful couple therapy is has also been addressed in several ways. For instance, effect sizes are measured that allow inferences to be made about whether treatment has had an effect, and also how large that effect was (Christensen & Heavey, 1999; Gurman & Fraenkel, 2002). The rate of improvement or the percentage of couples that indicated 'improvement' or 'satisfaction' at termination of treatment or follow-up is also a means used to calculate effect size (Gurman & Fraenkel, 2002; and others). In addition, the power of couple therapy is researched by measuring the clinical (vs. statistical) significance of change in a couple following treatment, as well as by assessing the durability of post-treatment effects, and assessment of possible 'negative' effects or deterioration as a result of treatment (Gurman & Fraenkel, 2002; and others).

Finally, effectiveness studies in couple therapy have evaluated the treatment of a wide range of individual psychiatric disorders including depression, alcoholism, and schizophrenia due to recognition of the significance of the relational dimension of mental disorders and the ability of couples therapy to enhance treatment efficacy (Gurman & Jacobson, 1995; Sholevar, 2003). This avenue of research in couple therapy has been in response to the knowledge that couple distress acts as a predisposing or a maintaining risk factor for many individual psychological disorders such as mood disorders, anxiety disorders, alcohol abuse, and psychoses (Byrne, Carr & Clarke, 2004; Pinsof & Wynne, 1995; Williams, Riley, Risch & van Dyke, 1999).

In sum, whilst there is a convincing body of evidence that supports the efficacy and effectiveness of couple and family therapy, there is little evidence that they are differentially effective i.e. relative to each other (Baucom et al.; Lebow & Gurman, cited in Johnson & Lebow, 2000; Shadish et al., cited in Sprenkle, 2003; Pinsof & Wynn, 1995). In spite of the great amount of time and effort that has gone into such studies, research suggests that little has been learned from them (Jacobson & Addis, 1993). Moreover, although controlled clinical trials remain a powerful methodology for establishing whether interventions have an effect and whilst they remain the 'gold standard' for scientific and external recognition, there is increasing recognition that demonstrating statistically significant differences between intervention and control conditions, and between models is not very informative about the clinical significance of change resulting from interventions (Markman, Halford, & Cordova, in Halford &

Markman, 1997; Sprenkle, 2003). Focus on this type of research also continues to contribute to the lack of attention given to other important types of research, such as qualitative investigations (Sprenkle, 2003).

2.4.3 Empirically Supported Treatments

A major outcome of clinical trials research has been the establishment of a formal category of couple therapies that have gained the status of being 'empirically supported treatments' (ESTs). In order to gain status as an EST, a therapy must essentially be considered "efficacious and specific", demonstrate that it is significantly better than a no-treatment group or placebo, and be demonstrated to be superior to alternative treatments in at least two independent studies (Beach, cited in Sprenkle, 2003). Only four approaches to couple therapy have been designated as empirically validated by the American Psychological Association, namely behavioural couple therapy (BCT), cognitive-behavioural couple therapy (CBCT), emotion-focused couple therapy (EFT), and insight-oriented couple therapy (IOCT) (Worthington, Lerner, & Sharp, 2005). Although CBCT has demonstrated its effectiveness as an empirically validated treatment, the three modes of couple therapy that remain the primary recipients of such empirical testing (described above) and subsequently with the strongest research base and support are BMT, EFT, and Psychodynamic/IOCT (Baucom et al., cited in Johnson & Lebow, 2000; Bray & Jouriles, 1995; Byrne, Carr, & Clark, 2004; Dattilio & Epstein, cited in Dattilio, 2005; Gurman & Fraenkel, 2002).

Although the value of evidence-informed practice is strongly supported, much critique exists both inside and outside the field of couple therapy about what it means to be an EST (Wampold; Duncan & Miller, cited in Sprenkle, 2003). For instance, certain treatments are described as "privileged" due to having been researched far more than others, and the subtle message is also sent by the EST movement that other models that have not received much treatment are inferior (Sprenkle, 2003). However, whilst empirically validated treatments receive increased recognition and status as being superior modes of therapy in the field of couple therapy, research has not been able to demonstrate the superiority of any particular couple therapy approach as all seem to be reasonably and similarly effective (Pinsof & Wynne, 1995; Baucom et al.; Lebow &

Gurman, cited in Johnson & Lebow, 2000; Sprenkle, 2003). In addition, it is argued that ESTs are inclined to promote the treatment of problems as being homogenous although the problems themselves are not homogenous (Sprenkle, 2003). As a result, ESTs are viewed as reducing treatment options and client choice, and do not pay sufficient attention to 'client fit' with a particular treatment approach or take account of the unique nature of the client's problems (Sprenkle, 2003).

Finally, the question is raised about whether the highly controlled trials necessary for designation as an EST are representative of clinical practice (Sprenkle, 2003). In keeping with this, Shadish and Baldwin (cited in Sprenkle, 2003) argue that the implied understanding of what has been empirically evaluated by the label of EST is too narrow, and that a significant amount of empirical support exists for a great number of therapies that are not recognized as ESTs. A major critique of ESTs is therefore, that the distribution of research across models of treatment is highly skewed and that such 'gaping holes' in the knowledge base of couple and family therapy need to be filled (Lebow & Gurman, 1995). Moreover, it is argued that EST criteria place too much emphasis on statistical significance, thereby marginalizing those studies that do not have sufficient statistical power (Sprenkle, 2003). Such critique raises caution about the conclusions drawn from the knowledge that a specific approach is an EST, such as whether other less researched models are not as good or whether an EST is necessarily the appropriate treatment for a particular client or problem.

2.5 Traditional Forms of Couple Therapy

A diversity of methods grounded in a number of well defined theories have developed within the field of couple therapy. For the purpose of this study however, only certain modalities will be broadly addressed in terms of their underlying theoretical framework as well as the role of the therapist in carrying out underlying therapeutic aims of each modality. The therapies selected below are those identified as most used by couple therapists today and that have been designated as empirically validated by the American Psychological Association, namely BCT, CBCT, EFT, insight-oriented couple therapy, and Bowenian systems therapy (Long & Young, 2007; Worthington, Lerner, & Sharp, 2005). These models are discussed as a point of reference to the reader when exploring

and noting themes relating to the role of the Imago relationship therapist as discussed in the analysis section of this study.

2.5.1 Behavioural Couples Therapy (BCT)

BCT employs a range of learning theories and techniques based on operant and social learning principles of human behaviour, and views couple satisfaction and distress in terms of reinforcement (Christensen & Heavey, 1999; Sholevar, 2003; Wile, 1981). Distressed couples are believed to engage in interaction patterns characterized by mutual punishment rather than mutual positive reinforcement (Byrne, Carr & Clarke, 2004), whereas couples are satisfied as long as their ratio of reinforcement to punishment in the relationship is positive (Brown & Brown, 2002; Christensen & Heavey, 1999). Couples are therefore believed to become attracted to one another because of the mutual reinforcement they generate for one another, which inevitably decreases over time due to inevitable differences and arguments that increase the mutual punishment and decrease the reinforcement they experience (Christensen & Heavey, 1999). Since behaviour therapy views learning as the main cause of problems, it is primarily concerned with how people learn and unlearn dysfunctional behaviour, and how human behaviour is maintained by rewards and punishments from the environment and other people (Long & Young, 2007; Patterson, 2005). Therapeutic focus is thus on the rewarding and punishing aspects of partners' interpersonal behaviours with the aim of modifying behaviour through the application of learning principles (Long & Young, 2007; Patterson, 2005).

Although behavioural therapy initially only focused on behavioural exchange contracts, it has since evolved to include foundational principles also aimed at increasing the level of reinforcing exchange by teaching communication and problem-solving skills that will enable couples to cope with their differences in a constructive manner by ultimately minimizing punishment and maximizing reinforcement (Byrne, Carr & Clarke, 2004; Christensen & Heavey, 1999; Hannah, Luquet & McCormick, 1997; Johnson & Lebow, 2000). Much like communication and problem solving, behaviour exchange involves the commonsense notion that individuals do not contribute freely to a relationship in which they do not feel they are receiving what they need relative to what they are receiving from their partner (Patterson, 2005). In addition, behavioural theory now applied to

couples also includes skills such as negotiation, assertiveness, increasing positive reinforcement, and identifying and modifying cognitive errors (Long & Young, 2007).

The emphasis in behavioural couple therapy on learning new behaviour and skills is reflected in the role played by the therapist. Wile (1981) suggests that the behavioural couple therapist has a precise picture of what is considered appropriate couple behaviour, with the result that the role of the therapist may be viewed as quite coercive in efforts to promote this behaviour. Because BCT aims to change the way couples deal with each other, the therapist teaches *behaviour exchange* by helping couples identify positive acts that each can do for the other, encouraging couples to engage in these behaviours, training them to show appropriate acknowledgement for them, and by asking the couple to reward even small changes in their partners in order to encourage even greater development toward the desired outcome (Christensen & Heavey, 1999; Martin, 1994; Sayers & Hayman, 2003). Learning effective communication is also central in BCT as much of the punishment that occurs between partners is in the form of unpleasant or aversive communication (Sayers & Heyman, 2003). *Communication training* requires the therapist to teach certain skills in communication to partners, and typically focuses on learning specific skills such as respect, expressing oneself without blaming one's partner, reflective and active listening, negotiation, timely discussion of problems, overcoming mind reading, and nonverbal communication (Christensen & Heavey, 1999; Long & Young, 2007). In *problem solving training*, the therapist also takes on the role of teaching couples how to define problems explicitly, how to generate potential solutions for these problems, how to negotiate and compromise on possible solutions, and how to implement and evaluate solutions (Christensen & Heavey, 1999; Christensen et al., 1995).

In addition to a psychoeducational role of teaching or training couples in the use of various skills and behaviours, the therapist also plays an active part in modelling appropriate behaviour and communication by role playing with one member of the couple whilst the other observes and then practices what the therapist has demonstrated (Long & Young, 2007). The role of the therapist also includes providing reinforcement for positive communication and by giving feedback to the couple, such as pointing out the

couple's progress, complimenting improved behaviours and skills, and pointing out areas for improvement (Long & Young, 2007).

2.5.2 Cognitive-Behavioural Couple Therapy (CBCT)

Since the establishment of Behavioural marital therapy, it has been argued that not only behaviour matters in relationships, but also partner's interpretation of that behaviour (Baucom & Epstein, 1990). Early investigators thus recommended the inclusion of cognitive restructuring typically used in individual therapy in order to alter partners' interpretations of one another's behaviour (Beck et al., 1979, cited in Christensen & Heavey, 1999). In the 1980s, behavioural marital therapists subsequently added established cognitive assessment and intervention methods to enhance the effectiveness of treatments that are generally used in conjunction with BCT (Dattilio & Epstein, 2005; Halford, Sanders, & Behrens, cited in Johnson & Lebow, 2000).

CBCT therefore also includes the foundation of the behavioural underpinnings to relationship enhancement and modification of dysfunctional interactions by focusing on Behaviour exchange, communication training, and problem solving (Patterson, 2005). In addition, five cognitive aspects have been implicated in couple distress and are addressed by CBCT, namely: (a) selective attention about events occurring in couple relationships, (b) distorted attributions or beliefs about the causes of positive and negative relationship events, (c) inaccurate expectancies or predictions about events that may occur in the relationship that are based on attributions, (d) inaccurate or inappropriate assumptions or beliefs about their partner and how their relationship works, (e) extreme or unrealistic standards about one's partner and/or relationship (Baucom & Epstein, 1990; Baucom et al., cited in Dattilio & Epstein, 2005), all of which represent cognitive distortions that maintain destructive interaction patterns in distressed couples (Byrne, Carr & Clarke, 2004). The essence of cognitive intervention is cognitive restructuring of these five elements, which is typically achieved with the integration of the behavioural components of communication and problem solving (Patterson, 2005). The cognitive aspect of CBCT therefore focuses on the role of bad thinking as the cause of emotional and behavioural problems and proposes that if one's negative or distorted thinking patterns can be corrected, then behaviour will also change (Long & Young, 2007). A significant part of

therapy is thus aimed at addressing distorted thinking about the other person and about the relationship (Mckay, Fanning, & Paleg, cited in Long & Young, 2007).

In keeping with the above aims of therapy, cognitive-behavioural couple therapists have traditionally viewed therapy primarily as a skill-building process in which the role of the therapist is based largely on the teaching of relationship skills (Epstein & Baucom, 2002). Moreover, the role of the therapist is characterized by active engagement on the part of the therapist to collaborate with the couple in order to identify and modify specific behaviours, cognitions, and emotions that contribute to their conflict and distress (Epstein & Baucom 1998). This collaborative effort on the part of the therapist involves observing and probing for such factors as couples interact with one another in conjoint therapy sessions (Epstein & Baucom, 1998; Epstein, Baucom & Daiuto, 1997). Due to exchanges of negative behaviour amongst couples being associated with relationship distress, an important initial role of the therapist is to observe and assess behavioural interactions between the couple (Epstein & Baucom, 2002). This may be achieved as the therapist conducts a 'functional analysis' by gathering information about antecedent events or conditions and consequences that are associated with more positive and less negative behaviours (Dattilio, 1998).

Baucom et al. (1995, p. 79) suggest that *"overall, the therapist's role can be viewed as an active, somewhat directive role in which the therapist is attempting to isolate and help the couple produce needed change in cognitive, behavioural, and emotional realms"*. Being active often involves explicit interruption of destructive spousal interactions that are based on irrational assumptions (Sholevar, 2003) as the therapist attempts to shift the couple's conceptualization of the problem to one of reciprocity and circular causality, and assist the couple to see how each individual's negative cognitions and behaviour can contribute to a cycle of distressing negative exchanges (Epstein & Baucom, 1998; Epstein, Baucom & Daiuto, 1997). The role of the therapist is also a rather complex one as focus alternates between (1) cognitive, behavioural, or emotional aspects of partners and their relationships; (2) the individual as primary focus instead of the relationship as the focus of intervention; (3) relative emphasis on content rather than process aspects of the relationship (Baucom et al., 1995).

As a result, the therapist's role shifts depending on whether therapeutic focus is on cognitive restructuring versus teaching the couple behavioural skills (Baucom et al., 1995). This difference is highlighted in the therapist's role of attending to the process versus the content of the couple's relationship and way of interacting (Baucom et al., 1995). For instance, while couples are learning the behavioural skill of problem solving, the therapist's primary focus is on process or how couples communicate and interact with one another, in order to assist couples in learning how to problem solve effectively (Baucom et al., 1995). In this instance, the role of the therapist is educational in nature as much focus is placed on skills training (Epstein & Baucom, 1998). When considering cognitive factors however, there is a relative shift in the therapist's role to a greater focus on content because negativistic and distorted cognitions are evaluated by their content and their incongruency with other information (Baucom et al., 1995). Process aspects of cognitive restructuring do also exist and are not ignored as the therapist challenges the couple to become aware of when cognitive distortions are at play in their relationship and how this is related to their behaviour and emotions (Baucom et al., 1995).

Another primary role of the therapist is to psychoeducate the couple with a framework for understanding relationship discord that includes the role of cognitive factors in relationship functioning, as well as how emotional and behavioural responses can result from cognitive processing (Baucom et al., 1995). In this way, the therapist attempts to get the couple to a point of uncovering their own dysfunctional cognitions and identifying when the same issues arise in other instances (Baucom et al., 1995). Consequently, cognitively orientated couples therapists explore each partner's thoughts to uncover irrational or unrealistic beliefs about the partner and the relationship so that couples may learn alternative beliefs and attributions conducive to mutually reinforcing patterns of interaction (Byrne, Carr & Clarke, 2004; Johnson & Lebow, 2000; Luquet, 1998).

2.5.3 Emotionally Focused Couple Therapy (EFT)

EFT is a theoretically and technically integrative approach to doing couples work that draws its ideas from gestalt therapy, family systems therapy, attachment theory, and experiential psychology (Bradley & Johnson, 2005; Johnson & Greenberg, 1995). It was founded by Les Greenberg and Susan Johnson who began to recognize that change

occurred in couples when they could express their emotions to each other in a safe environment (Long & Young, 2007).

At a clinical level, EFT integrates a family systems approach and an experiential approach so that the circular cycles of interaction between people are highlighted, whilst simultaneously focusing on the emotional experiences of each partner during the different steps of the cycle (Johnson & Denton, cited in Denton, 2008). EFT's foundations in experiential psychology also emphasize individual awareness and the role of affect in change (Greenberg & Johnson, 1986). An experiential view of human functioning holds that people are not purely rational or cognitive, that experiencing is primary, and consequently that the disowning of emotion and needs is viewed as problematic (Bradley & Johnson, 2005; Greenberg & Johnson, 1986). Experiential therapy thus aims to lead clients to experience, become aware of, and *process* their emotions (Bradley & Johnson, 2005). The processing of emotions is therefore primary in EFT as emotions are viewed as orienting partners to their own needs, organizing responses and attachment behaviours, and activating core cognitions concerning self, other, and the nature of relationships (Bradley & Johnson, 2005).

The systemic focus on interpersonal patterns and the experiential focus on affect are in turn understood within an attachment context of separation distress and an insecure bond (Bradley & Johnson, 2005). EFT's is also largely based on Bowlby's attachment theory, holding the assumption that distressed couples experience disruption of attachment within their relationships (Bailey, 2002; Johnson & Lebow, 2000). Attachment needs for secure relationships with available and responsive others are viewed as adaptive and natural rather than as indications of dysfunction or immaturity (Bradley & Johnson, 2005) with the result that distressed relationships are viewed as insecure bonds in which healthy attachment needs are unable to be met due to rigid interaction patterns that disallow emotional engagement (Johnson & Greenberg, 1995). Such lack of engagement and need fulfilment leads to the relationship being controlled by insecurity and methods of coping with this insecurity, where fighting actually represents fighting for a sense of safety and security with each other (Bradley & Johnson, 2005; Johnson & Greenberg, 1995). The initial disruption in attachment between the couple is believed to evoke primary emotions such as fear of abandonment which later give rise to secondary emotions such as anger

(Byrne, Carr, & Clarke, 2004). Negative interaction patterns then follow in which secondary emotions are repeatedly expressed by attacking or withdrawing from one's partner, whilst primary emotions remain hidden and are not expressed (Byrne, Carr, & Clarke, 2004).

Essentially then, EFT views partners as 'being "stuck" in certain ways of regulating, processing, and organising their emotional responses to each other, which then constrict the interactions between them and prevent the development of a secure bond' (Johnson, 1998, p. 451). These constricted or limited interactional patterns are in turn assumed to evoke and maintain states of negative affect within the relationship (Johnson, 1998). It is postulated that it is not people's feelings and wants that cause problems in marriage (Wile, cited in Greenberg & Johnson, 1986), but disowning or disallowing of these feelings and wants that gives rise to ineffective communication and escalating destructive interactional cycles (Greenberg & Johnson, 1986). The major goals of EFT are thus to help couples access and reprocess the emotional responses governing their interactions, and to structure interactions that will facilitate secure bonding and safe emotional engagement (Bradley & Johnson, 2005; Johnson, 1998). As a result, accessing and expressing primary feelings, needs, and wants by distressed couples is believed to assist in adaptive problem solving and in turn produce intimacy (Greenberg & Johnson, 1986).

Broadly speaking, the role of the therapist is to focus on the expression and understanding of feelings that typify relationship distress in order to re-establish the development of a secure attachment bond between partners, soften emotional responses, and restructure negative interactional cycles (Brammer, Abrego & Shostrom, 1993; Byrne, Carr & Clarke, 2004; Johnson & Lebow, 2000). At times, this may involve an active and directive role from the therapist by evoking emotional experiences in the couple or partner, suggesting and interpreting feelings and thoughts when necessary, setting up new interactions with authority between the couple that appear dangerous and difficult for them, and structuring relevant tasks for the couple (Johnson & Greenberg, 1995; Johnson, 1998). In contrast, the therapist's role may also be non-directive and less active at other points in the process. For instance, in creating a safe space for the couple, the therapist listens to and reflects each partner's experience, and also accepts and acknowledges partners' respective experiences (Johnson & Greenberg, 1995). Moreover,

the therapist can be less active at the end of therapy by handing over initiative to the couple and affirming their achievements (Johnson & Greenberg, 1995).

Johnson and Greenberg (1995) also stress the importance of creating a positive working alliance as central to the role of the therapist in implementing EFT, as all other aspects of the role of the therapist are affected by the nature of the established bond between the therapist and the couple, and the therapist and each partner. This alliance is developed early in the therapy process by the therapist's ability to provide structure and safety, and by the therapist's sensitive tracking and reflection of partners' experiences (Johnson & Greenberg, 1995). EFT's roots in systems theory also delineate the early role of the therapist to join with each partner and the system *as it is* before attempting to create change (Johnson & Greenberg, 1995). Once a secure alliance is established, an important role of the therapist lies in changing partners' perceptions of each other, rather than changing an individual's self-view, so that they will be encouraged to express important underlying feelings in therapy and in turn give and receive validation (Estrada & Holmes, 1999; Johnson, 1995).

Moreover, as couples begin to feel safe enough to risk encountering threatening aspects of their experience, the therapist has the very important role of encouraging couples to allow themselves to be more completely who they are and to express the full intensity of their emotions (Johnson & Greenberg, 1995). This may involve active blocking by the therapist of the couple's usual pattern of interactions and focusing them on critical underlying feelings, evoking intense and difficult emotional experiences within the couple or from one partner so that more primary aspects of experience also arise, and helping partners use newly formulated emotional responses to expand on their ways of relating to one another e.g. hostility may evolve into expressions of desperation and grief (Estrada & Holmes, 1999; Johnson & Greenberg, 1995). In this way, the EFT therapist is responsible for helping couples recognise negative interaction patterns, pinpoint the secondary emotions on which these patterns are based, and finally to instead experience and express the primary emotions which underpin secondary emotions (Byrne, Carr & Clarke, 2004).

2.5.4 Systems-Oriented Couple Therapy

Although an enormous variety of systems approaches to couple therapy exist, there are many ideas that link these approaches, and where there are differences, these are usually complementary rather than contradictory (Fraenkel, 1997). As a result, an attempt is made here to give a concise description of the major principles and practices of systems-oriented couple therapy which incorporate several traditional systems approaches, rather than attempting to cover the many sub-variants of this orientation to couple therapy. Some preference may, however, be given to Bowenian couple therapy at times as this has been identified as one of the five most utilised forms of couple therapy and because other influential family therapy methodologies have focused very little on couples (Long & Young, 2007).

Most essentially, systems approaches to couple therapy view marital or couple conflict as a symptom of a problem within the couple or family system, where change in one part of the system is seen as showing up and affecting other parts of the system (Long & Young, 2007). As a result, it is the system, rather than the individual, that must be treated in therapy (Long & Young, 2007). Following from this, most systems theories hold that the causal links among elements in a pattern are circular rather than linear (Fraenkel, 1997). Applied to the couple system, this means that each partner's behaviour is viewed as a reaction or adjustment to the behaviour of the other – for example, one partner withdraws because the second nags while the second nags because the first withdraws (Wile, 1981). Circular causality in turn constitutes an organizing principle in systems theory, namely, negative feedback or homeostasis (Wile, 1981). In essence, once a couple has achieved some sort of equilibrium in their relationship, they may be seen as resisting and counteracting all forces that threaten this equilibrium or status quo (Wile, 1981). As a result, homeostasis is viewed as a pathological element in the system and therapists assume the role of finding a way to address this homeostasis (Wile, 1981).

At a broad level, all systems therapies also seem to agree that individuals' problems always occur in context (Fraenkel, 1997; Gerson, 2005). The most important contexts are those involving intimacy, such as relationships with spouses, significant others, and other family members, as well as the organization of the relationships that regulate the roles and patterns of the individuals involved in the systems (Gerson, 2005). Thus, the context

of problems is also believed to be largely rooted within internalized norms, values, and beliefs about appropriate and inappropriate social behaviour drawn from the couples' dominant culture or subculture, including the spousal or family system (Fraenkel, 1997). As a result, systemic theory of couple dysfunction holds that problems manifest due to overly rigid, limited interpersonal patterns, in which certain attributes of one or both partners become highlighted whilst other more adaptive abilities are under utilized (Fraenkel, 1997). Such elements of the couples' internal and social context, may therefore either contribute to sustaining the problem, or serve to make resources available for change in the relationship and each individual (Fraenkel, 1997). This results in the rationale behind most systemic psychotherapeutic approaches that in order to change a person, that person's context must be changed (Gerson, 2005). Investigating the current context alone is not, however, believed to be enough within a systemic orientation to couple therapy. The context of previous generations is also of great significance and involves tracking family patterns of past generations in order to establish how current patterns can be connected to past patterns passed on from one generation to the next, referred to by Bowen as a "multigenerational transmission process". (Gerson, 2005; Papero, 1995).

Understanding the multigenerational context of individuals within the couple system also underlies the concept of differentiation underpinning system-oriented couple therapy. Bowen, for instance, holds that life for all individuals is accompanied by chronic anxiety and the level of anxiety is influenced by the amount of differentiation gained from one's original family members and within oneself (Long & Young, 2007). Lack of differentiation is evidenced in two ways: individuals may behave in a manner displaying a fused state with family members or partners, or they may be cut-off from others and display too much individuality – in both instances demonstrating poor differentiation (Gerson, 2005; Long & Young, 2007). Differentiation for each member of the couple is thus seen as central for the relief of couple distress and dysfunction, which involves separating thoughts from emotions and the self from others, each member learning to act autonomously and intimately, and being able to function interdependently with one's relatives (Gerson, 2005; Kerr & Bowen, cited in Gladding, 2000; Long & Young, 2007). On the other hand, for individuals still operating out of their original family relationships and unable to function independently, intimacy cannot be achieved as this is confused

with dependence and a state of fusion with one's partner (Long & Young, 2007). A major goal in system-oriented couple therapy is thus to raise the level of differentiation in each partner by helping them to separate themselves from their family of origin and develop their own self-concept as an individual (Brammer, Abrego & Shostrom, 1993; Fraenkel, 1997; Gladding, 2000; Long & Young, 2007).

The role of the therapist is in turn aimed at enabling couples to be more honest and to gain enough courage to differentiate as individuals (Long & Young, 2007). According to Long and Young (2007), this entails a role of coach and teacher with four main functions: (1) to define and clarify the relationship between partners, (2) remaining 'detriangulated' from the couple emotional system, (3) teaching the couple about how emotional systems work, (4) demonstrating differentiation to the couple by letting the couple know where the therapist stands on an issue, referred to as taking an 'I' position. An early function in the therapeutic process involves the therapist gaining a thorough family history of at least three generations which is then explained to the couple so that they gain an understanding of their families of origin have influenced what each has brought to the relationship (Long & Young, 2007).

Within their role, therapists take primary control of therapy sessions by asking questions and coaching the couple (Long & Young, 2007). As the therapist asks questions to one partner, the other listens and is then asked to report thoughts that arose as he or she heard the partner speaking (Long & Young, 2007). In this way, each member is given a chance to externalize their thoughts, which helps them differentiate because it draws the distinction between the two as individuals (Long & Young, 2007). The therapist then clarifies the discussion for the couple and insists that both partners take responsibility for their own parts of the problem (Long & Young, 2007). The role of the therapist also involves attending to issues of how leadership is shared, partner and family roles, rules about communication, boundaries, and the recursive patterns of communication that prohibit problem resolution within couples (Brammer, Abrego & Shostrom, 1993).

2.5.5 Psychodynamic Couple Therapy

The origin of psychodynamic couple therapy lies, not surprisingly, within the psychoanalytic theory applied to individuals, in which the focus is on the intergenerational aspects of client problems (Sander, 1998; Savege Scharff & Scharff, 1997). "*The most complete version of psychodynamic couple therapy is object relations couple therapy"*, based on the use of transference and countertransference as central guidance mechanisms (Scharff & Savege Scharff, cited in Gabbard, Beck, & Holmes, 2005, p. 67). Object relations theory has however emerged as the most fitting psychoanalytic theory in addressing marital interaction and family dynamics (Savege Scharff & Scharff, 1997). The views of Dicks (1964, cited in Polonsky and Nadelson, 2003) have become central in psychodynamic couples work. Dicks recognized how partners united at a level beyond conscious choice, compatibility, and sexual attraction, and proposed that this occurred due to partners object relations, and the re-enactment of past dynamics from within their family of origin (Polonsky & Nadelson, 2003). Couples' current symptoms are thus viewed as representative of unresolved losses or relationships with family members in the past (Brammer, Abrego & Shostrom, 1993; Polonsky & Nadelson, 2003). Moreover, underlying this approach to couples therapy is the belief that couples unconsciously choose marital partners who allow one another to repeat familiar interactions from early or childhood experiences, and who can provide optimal gratification for unconscious neurotic needs, with the result that internalized intrapsychic conflicts of the spouses cause a trade-off leading to marital conflict (Brammer, Abrego & Shostrom, 1993; Sholevar, 2003).

As a result psychodynamic perspectives focus on projection processes and unconscious re-enactment of past experiences between partners that result from transferential ties to significant others within their family of origin (Johnson & Lebow, 2000; Polonsky & Nadelson, 2003). As these transferential ties distort a couple's experience of each other, the psychodynamic couple therapist acts to encourage partners to work toward differentiation from their family of origin through insight or actual encounters with their parents in order to move beyond the unconscious factors that contribute to repeating patterns that deplete the relationship (Brammer, Abrego, & Shostrom, 1993; Polonsky & Nadelson, 2003; Sager, 1994). Moreover, the therapist aims to help couples to feel entitled to, and clarify their thoughts and feelings, and thus gain insight into their self,

critical thinking, and relationship patterns (Johnson & Lebow, 2000; Patalano, 1997). Therapy is a collaborative effort between the couple and the therapist in which the therapist helps the couple to begin to communicate verbally and emotionally, teaches good listening skills, points out incongruencies in the communication process, and emphasises restraint on acting out of antagonistic feelings (Patalano, 1997).

For the therapist, doing psychodynamic couples therapy may be conceptualized as a process aimed at helping partners' gain insight into their original conflicts so that they can begin treating their partner as a present reality rather than as a reflection of the past (Long & Young, 2007). This involves improving the couple's capacity for containment of projections by learning to modify each other's projections, distinguish them from aspects of the self, and then take back these projections, which allows them to perceive one another accurately (Savege Scharff & Scharff, 1997). The overarching goal of psychodynamic couple therapy is therefore to interpret, work through, and make conscious the couple's regressive transference so that they have new choices about how to relate (Sander, 1998; Scharff & de Varela, 2005).

As a result of dealing with sensitive unconscious material, one of the primary roles of the therapist is to develop a safe and empathic 'holding environment' by recreating a nurturing 'maternal' environment (Long & Young, 2007). It is therefore important in the initial phases of therapy that the therapist become actively involved with the couple in discussing their difficulties, and clarifying the difference between what one partner intends and the other perceives (Polonsky & Nadelson, 2003). Fostering a collaborative working alliance is also largely dependent on the therapist's capacity to tolerate the anxiety of emerging unconscious material and affect, and by negotiating a way of working that meets the couple's needs without compromising the therapist's integrity (Savege Scharff, 1995; Savege Scharff & Scharff, 1997). Underpinning the role of the therapist is also the principle of remaining fundamentally nondirective and not doing too much so as to let themes emerge in their own form and time, and to remain neutral as to how the couple chooses to use therapy by following instead of leading (Savege Scharff, 1995). In so doing, the therapist becomes a transitional object that the couple can use (and abuse if necessary) as they project unconscious object relations onto the therapist (Savege Scharff, 1995).

A major task undertaken by the therapist is to give feedback in many ways, which is generally referred to as making interpretations (Scharff & de Varela, 2005). At a basic level, the therapist observes things the couple has not observed, links two or more events that belong together, and places emphasis on things that they have observed but not given much weight to (Scharff & de Varela, 2005). As the couple's experiences and unconscious object relations become evident in therapy, it is the role of the therapist to hold these, share in the couple's experience, and put words to their experience (Savege Scharff, 1995). This may involve making more complex interpretations or suggesting hypotheses of their development and how this has contributed to patterns in which they are stuck, making interpretations of bodily symptoms, and developing a picture of the unconscious assumptions that power conscious behaviour (Scharff & de Varela, 2005). The therapist must also wait for associations – often in the form of dreams, fantasies, or emotional reactions from partners – through which to trace the unconscious thread of their object relations and its relation to the transference (Savege Scharff, 1995).

With such information at hand, the therapist then interprets or reformulates the couple's current dilemma in terms of its psychological meaning in order to help them understand the roots of their problems, and give them overt insight into the processes both within and between the individuals (Dare, 1986; Long & Young, 2007). For instance, the therapist may interpret partners' projective identification processes brought forward from their families of origin (Long & Young, 2007). The therapist thus needs to remain aware of transferences and countertransference reactions in the therapeutic space in order to recognize partners' object relations and how to engage with these therapeutically. Interpretation from the experience of countertransference of the couple's transferences in the here-and-now of the therapeutic sessions forms the most powerful tool and task for the therapist (Scharff & de Varela, 2005). Constant monitoring of countertransference is thus a central function of the therapist. Interpretations of transferences to the therapist are particularly helpful as both partners benefit: the affected individual begins to integrate and understand his/her projections, whilst the observing partner is able to see an interactional pattern develop between the therapist and the affected partner that parallels his/her own experience, and also be exposed to their altered perception of the other person more clearly (Polonsky & Nadelson, 2003).

On occasions, the role of the therapist may also involve psychoeducating the couple about concepts inherent in this therapeutic modality (such as repetition compulsion, mutual projection, and projective identification) in order to help them understand the idea of reenactments in the relationship (Polonsky & Nadelson, 2003). Finally, it is also the role of the therapist to foster well-timed termination of the therapeutic process. This entails an assessment by the therapist about whether or not the couple is ready for termination, working with the couple's typical way of dealing with separation and loss as evidenced when ending each time-limited session or breaks in therapy due to holidays etc., as well as using the opportunity to review the course of therapy and anxieties about proceeding in life without the therapist as a guide (Scharff & de Varela, 2005; Savege Scharff & Scharff, 1997).

2.6 Imago Relationship Therapy

IRT is a couples treatment originally developed by Harville Hendrix and popularized in his book *Getting the Love you Want: A Guide for Couples* (1990). It was founded as a consequence of the personal and intellectual relationship of Harville Hendrix, Ph.D, and his wife Helen Hunt, M.A (Hendrix & Hunt, 1999). Due to finding little information in the literature on marriage that they found relevant in their personal experiences, Hendrix and Hunt used their own marriage as a laboratory in which to study the dynamics of intimate partnership (Hendrix & Hunt, 1999). In addition, Hendrix studied married and unmarried couples in his practice, as well as the relational insights of various schools of depth psychology, personality theory, behaviourism, systems theory, western spiritual traditions, and quantum physics (Brown, 1999; Hendrix & Hunt, 1999). The result was a synthesis of ideas and processes that Hendrix and Hunt systematized into Imago Relationship Therapy, followed by their cofounding of the Institute for Imago Relationship Therapy in 1984, which offers workshops for couples and training for therapists in many parts of the world (Hendrix & Hunt, 1999). Although IRT originated as a clinical theory of marriage and marital therapy, reflection on the greater implications of the unconscious dynamics of marital interactions led the authors to develop a set of meta-theoretical assumptions about the nature of the universe (cosmology) and therefore of human nature (anthropology) (Hendrix & Hunt, 1999). According to Hendrix and Hunt (1999, p. 171), *"these assumptions posit the self's cosmic origins, its evolutionary*

inheritance, its psychological development, and its social adaptation, with special reference to their influence on the unconscious purpose and dynamics of intimate partnership".

The first cosmological assumption underlying IRT is that human beings come from the same source and are made of the same 'stuff' that the universe is made of (Zohar, cited in Hendrix & Hunt, 1999). This understanding that we are an incarnation of the essence of the cosmos in turn informs and gives specific direction to our lives and hence to the clinical theory of IRT (Hendrix & Hunt, 1999). In particular, Hendrix and Hunt (1999) infer our connection to the cosmos through two clinical examples. Firstly, couples in therapy are unconsciously trying to resolve connection in order to achieve healing, recover their wholeness, and complete their developmental evolution; secondly, when couples become conscious (self-reflective) and intentionally cooperate with their unconscious strivings, they achieve the goals formerly mentioned (Hendrix & Hunt, 1999). Because we are an instance or microcosm of the universe or macrocosm, these observations in turn suggest that the universe is in a process of self-expansion, self-completion, self-repair, and self-awareness (Hendrix & Hunt, 1999). Moreover, since consciousness is the basic fact of human experience, and given that we are the point where the universe has become conscious itself, it follows that the 'stuff' of the universe is conscious Itself (Hendrix & Hunt, 1999). From this point of departure, it is inferred that all "things" (animate or inanimate) are mutations of consciousness into form; therefore every "thing" is a nodule of consciousness interconnected in a field of consciousness (Hendrix & Hunt, 1999; Luquet, 1996). Ultimately, from this it follows that humans' obsessive drive (most dramatically evident in couples) to restore and maintain connection also reflects our participation in the processes of the cosmos (Hendrix & Hunt, 1999).

These assumptions point to the relational structure of being which represents a paradigmatic shift from the prevailing ontology of separation, which advocates the individual as primary, self-contained or isolated, and self-sufficient (Brown, 1999; Hendrix, 2005). An ontology of relationship is instead favoured by this cosmology, where each particle is in some way intimately present to every other particle in the universe, constituting a unified field and connecting all individual things (from persons to

atoms) by essence and purpose (Hendrix & Hunt, 1999; Luquet, 2005). IRT reflects this ontology of the microcosm as a reflection of the macrocosm, and so focuses on what Buber (1958) calls the "between" as the primary reality for couples in which the self emerges in relationship to another (Brown, 1999; Hendrix & Hunt, 1999; Luquet, 2005). Whilst the reality and importance of the individual is not deemphasized and the intrapsychic not denied, IRT embraces a shift in attention to the quality of the "between" so that the prevailing ontology of separation is amended by an ontology of relationship (Hendrix & Hunt, 1999). Imago theory thus puts individuals in the context of the relationship and recognizes the relationship as the primary power in the formation of and the injuring of the self, thus making the *relationship* the unit of analysis (Brown, 1999; Luquet, 2005).

Moving from a cosmological to a psychological understanding, the major thesis of IRT is that the purpose of the unconscious in terms of choosing a marital partner is to finish childhood. Partner selection is therefore an unconscious match between a mental image of one's parents/caregivers created in childhood that is called the 'imago' (Hendrix & Hunt, 1999; Brown, 1999). The imago match is critical to the theory as it highlights the conscious purpose of individuals to recover wholeness by restoring connections that were broken or arrested in childhood by need frustration (Hendrix & Hunt, 1999). Furthermore, although we choose partners fitting a profile of both positive and negative traits of our caregiver, the intensity of our attraction is due to a match in negative traits – that is, those connected to need frustration, which in turn tie in with the unconscious desire to finish childhood (Hendrix & Hunt, 1999). Since unmet needs from childhood are brought into adult intimate relationships for resolution, and since one's selected partner shares the same limitations as one's parents, those frustrations are inevitably reactivated and re-experienced (Hendrix & Hunt, 1999). Partners then try to coerce the other partner into being or becoming the ideal parent (i.e. to fulfill unconscious unmet needs) and thus get into a power struggle, which leads to conflict and marital disjunction (Luquet, 1996). IRT provides an opportunity to *'cooperate with the intention of the unconscious by creating a "conscious marriage" in which partners intentionally meet each other's childhood needs'.* (Hendrix & Hunt, 1999, p. 170).

IRT is not a completely new theory as it incorporates key developmental theories and integrates some of the best elements of well-known psychotherapeutic methods such as behavioural, cognitive, psychodynamic, and humanistic psychology (Crawford & Upchurch, 1999; Johnson & Lebow, 2000; Mason, 2005). Incorporation of these techniques and procedures within Imago theory are also described by Hendrix as developing from experiences within his personal and professional journey (Hendrix, 2005). For instance, a foundational procedure in IRT called mirroring, is essentially the Rogerian reflective technique which came about during a heated argument between Hendrix and his wife when she suggested that they take turns relaying their experiences to one another whilst the other listened and reflected what had been heard before taking their turn (Hendrix, 2005). Mirroring evolved from a one-level exercise to the current three-stage Couples Dialogue/Intentional Dialogue process consisting of mirroring, validation, and empathy (Hendrix, 2005).

Another foundational procedure of Imago therapy known as the Container exercise, was essentially based on a rage-reduced exercise by Hendrix and his wife's mutual therapist who used Transactional Analysis and Gestalt methods in his practice (Hendrix, 2005). Hendrix's wife again suggested that they use a process that their therapist called "The Four R's: Rage, Rest, Rub, and Relaxation" to deal with their anger toward each other, which over time became modified into the seven-step structure of the Container exercise used in IRT (Hendrix, 2005). The power of the Container exercise was further grounded in Jung's theory of projection in which he developed the concept of "holding", rather than reacting to, the projections of the other as a means of de-energising these projections. The Behaviour Change Request process, learned from a social learning theorist, Richard Stuart, as well as the Holding exercise, suggested by Martha G. Welch who wrote 'Holding Time' (1989), were also added as fundamental techniques in IRT (Hendrix, 2005).

Hendrix also developed a systematic and detailed description of the stages of human development by synthesizing the theories of Margaret Mahler, Daniel Stern, Harry Stack Sullivan, and Erik Erikson which in turn led to the development of the new characterological profiles, a clarification of the meaning and function of symbiosis, and

the recognition that IRT concepts and processes are reflective of the emerging paradigm shift from an ontology of separation to an ontology of connection (Hendrix, 2005).

2.6.1 Roles and Functions of an Imago Therapist

Given the shift from the individual paradigm to the relational paradigm, the role of the therapist in IRT is also viewed in a different light. Most significantly, in the individual paradigm which advocates individualism or a separateness of self, the client's trust of the therapist is considered more significant than the client's trust in significant others in order to heal and overcome developmental crises (Luquet, 1998). In shifting to the relational paradigm however, the therapist has to rely on the client's primary relationships to provide the mirroring and the experience of 'vicarious introspection', and the development of empathy necessary to heal and discover a sense of self (Luquet, 1998). Imago therapists thus operate from the assumption that when connection is restored and stabilized, what previously appeared to be individual or systemic pathology disappears (Hendrix, cited in Brown, 1999).

The role of the Imago therapist in turn is to facilitate a therapeutic process that empowers the partners in the relationship to heal each other and become therapists for each other (Gerson, 2005; Hendrix, cited in Luquet, 1996) thus delineating a role of facilitator, coach, or supervisor, where the focus is not on the intrapsychic functioning and dynamics of the individuals within the dyad or system, but on their relationship (Hendrix, 2005). In light of the above explanations of traditional forms of couple therapy, Hendrix and Hunt (1999) also suggest that most major types of relationship therapies employ a psychoeducational approach and address relationship difficulties on a cognitive level, focusing on the intrapsychic state of the individual rather than on the relationship built between them. Because such therapies usually rely on the use of negotiation and contracts, and teaching communication skills however, contracts and negotiation merely reinforce power struggles and power differences in the relationship, which are in turn likely to reinforce dysfunction (Hendrix & Hunt, 1999).

Because conflict between couples is seen as an automatic process rooted in the unconscious rather than as being part of the intentional abilities of the conscious brain, a

major therapeutic goal is to help couples reach a point of becoming less automatic in their reactions to one another by making unconscious childhood wounds conscious (Gerson, 2005). The role of the Imago therapist is key in facilitating the growth of this conscious marriage. The main method for helping couples to move toward a conscious relationship is to provide the couple with a cognitive and experiential understanding of the purposes of romantic love and the power struggle, to create a safe environment, and to establish a process for breaking the symbiotic fusion (Gerson, 2005). The traditional role of the therapist as an expert hierarchical system is replaced by an egalitarian model of 'therapist-facilitator' (Gerson, 2005; Hendrix & Hunt, 1999). Rather than delivering 'expert' functions such as interpretation and confrontation, couples are helped to cooperate with what their unconscious is trying (but failing) to do through interpersonal conflict (Hendrix, 2005). This enables couples to recognise the role of romantic partnerships as a means of healing developmental arrests and unsatisfied needs from childhood and that we each carry an unconscious image of our early caretakers in our psyche which ultimately guides romantic attraction (Hannah, Luquet & McCormick, 1997; Luquet, 2005).

This role of 'therapist-facilitator' is highlighted in the function of the therapist to encourage emotional expression using the primary therapeutic tool of IRT called the 'Couples' Dialogue' (Gerson, 2005; Luquet, 1996). The Couples' Dialogue is a three-step process that includes *mirroring* (reflecting) of the partner's message, *validation* of the partner's point of view, and the expression of *empathy* toward the partner's feelings that enables couples to break symbiotic fusion, differentiate as separate selves, drop their projections, and ultimately connect with the subjective reality of each other (Hendrix, cited in Brown, 1999; Luquet, 1998; Luquet, 2005). Research has even shown this process of Imago dialoguing to be effective in ADHD couple and family relationships where internal reactivity and defensiveness is typically even stronger than amongst couples (Robbins, 2005). In IRT the therapist facilitates this process by guiding the couple through the dialogue process, which in turn encourages partners to let down their defences and reveal their wounded and vulnerable selves, allowing each partner to recognise and accept the subjectivity of the other, thus differentiating them as individuals (Gerson, 2005; Luquet, 2005).

Although dialogue may sound like other communication tools such as active listening and parroting, this is only partly true. IRT adds the dimension of fully understanding that the other's feelings are valid and thus that the other person's reality is very real to him or her and does not have to be compromised or blended with the listener's (Hendrix, 2005; Brown, 1999). In this way dialogue teaches couples that their thoughts and beliefs do not have to be symbiotic, and that they are individuals and differentiated (Hendrix, 2005). Implicated in the role of facilitator of the couple's conflict, is the additional function of the Imago relationship therapist to guide the couple in containing the expression of one another's emotions in therapy (Gerson, 2005). Instead of discouraging the expression of intense emotions between the couple, the therapist assists in facilitating dialogue between couples, thus creating a safe environment for intense emotions to be expressed, whilst constantly guiding the couple to remain containers for one another's emotions and transferences, rather than the therapist (Gerson, 2005). Therefore, the healing process occurs in the couple's relationship rather than in the client-therapist partnership and therapeutic focus is on the couple's relationship, not the relationship between the couple and the therapist, which explicitly requires the role of coach and not expert containing the client's transferences (Gerson, 2005). In this way, couples acquire the skills to create a truly mutually therapeutic relationship that steps outside the power struggle, gains access to unconscious childhood wounds, and empowers couples to do the work themselves of healing those wounds (thus finishing childhood) (Hendrix & Hunt, 1999). As a result, couples are facilitated by the therapist to become therapists for one another.

Due to this role shift from the traditional view of therapist to that of facilitator, the Imago therapist must be rigorously trained and highly skilled (Hendrix & Hunt, cited in Berger & Hannah, 1999). In order to commence clinical training in IRT, individuals must (a) possess an advanced degree in the mental health field and be registered with a recognized professional association (b) be in current clinical practice working with couples (c) and be licensed to practice psychotherapy (Hendrix & Hunt, cited in Berger & Hannah, 1999). In addition, individuals must participate in a 'Getting the Love You Want' Couples Workshop prior to training, followed by 96 hours of clinical training and subsequent evaluation of the implementation of IRT in practice, which leads to accreditation as an Imago relationship therapist (Hendrix & Hunt, 1999). The 'Imago Africa' (2009) website cites fifty one accredited South African Imago therapists, which

highlights the formative nature of IRT and the need for it to undergo the extensive research that more established modes such as BCT and CBCT have been exposed to in this country.

2.7 Gaps in Couple Therapy Research

Whilst the recent and current trends in couple therapy research described above have dramatically improved the quantity and quality of research, and have proved useful in studying couple therapy, it is cautioned that the many positive conclusions regarding efficacy and effectiveness of couple therapy need to be tempered by a variety of methodological problems with the research as it requires much methodological and conceptual improvement (Pinsof & Wynne, 1995, Sprenkle, 2003). Moreover, although couple therapy has progressed into a relatively sophisticated treatment modality with growth in clinical techniques and research that reflects the demand for this kind of therapeutic service (Johnson, 1998b), several gaps in couple therapy research have been highlighted and have served as impetus for the development of new trends and movements within the current era of couple therapy research. One of the major challenges in the ensuing decades involves bridging the gap between researchers and clinicians that continues to plague the field (Sprenkle, 2003).

2.7.1 Researcher-Practice Gap

One of the hallmarks of a vital profession is said to be the inextricable link between research, practice, and theory, where theory generates ideas, research tests these ideas, and a stronger foundation for practice is created when ideas are verified (Sexton, Ridley, & Kleiner, 2004). The lack of a broader methodological focus in the field of couple therapy, and in particular, the accentuated focus on outcome research, has however contributed to a gap between research and practice. It has been noted that couple therapy research is too often unrelated to the concerns of clinicians, and often dismissed as inaccessible and irrelevant (Sprenkle, 2003). As a result, practice is frequently not research informed and errors in practice are repeated and perpetuated (Heppner, Kivlighan, & Wampold, as cited in Sprenkle, 2003). Although considerable knowledge has developed through outcome (efficacy and effectiveness) studies in particular, and also

through process research, such findings are said to have little impact on the actual practice of MFT therapists (Pinsoff & Wynne, 2002, as cited in Bradley and Furrow, 2004; Sexton, Robbins et al., as cited in Sexton, Ridley, & Kleiner, 2004), thus highlighting the gap between research and practice as a prominent concern in the field.

2.7.2 The Importance of Therapist Behaviours in Advancing Couple Therapy

Implicated as causal in contributing to the gap between research and practice in the field, is the lack of research relating to specific processes affecting change and outcome in couple therapy. Although recent progress in delineating change progress mechanisms in the field of couple therapy has occurred, the study of therapeutic change processes lags behind the study of treatment efficacy (Heatherington, Friedlander, and Greenberg, 2005; and others). The little process research that has been done is most common in EFT and has typically focused on client processes such as affective processes, and elements of relationship satisfaction and distress (Bradley & Furrow, 2004; Jacobson & Addis, 1993; Gottman, as cited in Johnson & Lebow, 2000). Research trying to gain couples' perspectives and experiences with regard to what they believe is important for change in the process of couple therapy has also been a trend in couple therapy research in the past decade and helpful in informing the work of couple therapists (Bowman & Fine, 2000; Estrada & Holmes, 1999). Such research has also contributed to the building of a scientific understanding of the processes that distinguish between distressed and satisfied relationships, which in turn informs efforts in couple therapy to foster relationship bonds that are mutually fulfilling and stable (Johnson & Lebow, 2000).

As is true in the field of psychotherapy research generally however, relatively little attention is paid to therapist variables such as the role of the therapist, as contributors to outcome in couple therapy research (Blow, Sprenkle, & Davis, 2007). Beutler et al. (2004) indicate that such lack of attention to therapist factors in the past two decades is probably as a result of the emphasis on testing specific therapy models in randomized clinical trials. This argument is supported more recently by authors who suggest that a major reason for the lack of research on therapists is because model developers and their students (who are understandably interested in proving that their models work), conduct the majority of efficacy research in couple and family therapy (Blow, Sprenkle, & Davis,

2007). As a result, literature stresses the need for process research that examines actual in-session therapist variables and behaviours that occur during therapy (Beutler et al., 2004; Bradley & Furrow, 2004; Heatherington, Friedlander, & Greenberg, 2005) in order maximize researchers' knowledge of what actually went on in therapy and to better inform therapists about the active components in the challenging change process of therapy (Johnson et al. 1999, as cited in Bradley & Furrow, 2004; Pinsof & Wynne, 1995).

Furthermore, although the field of MFT has made considerable progress in the past fifteen years with the use of manuals to specify the actual treatment, research in the field is lacking in such methodology (Pinsof & Wynne, 1995). Instead, the current era in the evolution of couple therapy is characterized by dissatisfaction and competing perspectives, which scholars and researchers contribute to the inability of existing theories to adequately explain the complexity involved in clinical practice (Sexton, Ridley, and Kleiner, 2004). An important methodological recommendation with regards to couple therapy research is thus that treatments need to be more carefully defined, verified, and empirically described (Pinsof & Wynne, 1995). According to a meta-analysis conducted by Pinsof and Wynne (1995) on the efficacy of couple therapy, it is impossible to know what actually occurred in therapy in almost all of the MFT research (Pinsof & Wynne, 1995). For instance, although Snyder et al. (1991, as cited in Pinsof & Wynne, 1995) boast the only study to date that has clearly demonstrated the superiority of one treatment (IOMT) over another in regard to long-term effects (up to 4 years), a debate arose concerning what actually went on during each of the therapies in which various authorities claimed that the therapists did not do what they were supposed to do or engaged in activities that were not specified in the manuals and adherence rating systems. The critical point has thus been made that more attention needs to be paid in research to carefully describing the therapies evaluated in studies (Pinsof & Wynne, 1995), and that significant gaps in knowledge regarding the role of the therapist in the therapeutic change process needs to be addressed (Heatherington, Friedlander, & Greenberg, 2005). Thus, whilst there is a continuing need for outcome research in couple therapy, there is also a need for studies that explore *why* couple therapy is effective (Christensen et al., 1998).

The need for continued evaluation of couple therapy in order to understand and treat specific and diverse populations appropriately has also been highlighted (Johnson, 1998). For instance, the degree to which various changes work similarly (or not) for diverse couples remains under-researched and is recommended as a critical area of focus in change process research (Heatherington, Friedlander, & Greenberg, 2005). Recent literature also indicates that some studies have only started to address particular therapist qualities and skills needed to deliver effective couple therapy to specific populations such as rural couples, ethnically diverse couples, and bisexual couples (Stabb, 2005). This serves as further rationale for the nature of this study, which aims to examine the role of the Imago relationship therapist within the context of the diverse population represented in South Africa.

2.7.3 Common Factors Movement

In response to the significant focus in couple therapy on proving various models effective, as well as competitive attempts to accentuate their differences and superiority relative to one another, is a movement that has challenged the long accepted clinical trials research in the field and advocated the value of researching common factors within various models. Common factors may be broadly conceptualized as dimensions within a treatment setting that include client, therapist, relationship, expectancy, and treatment variables that are not specific to any particular model (Sprenkle & Blow, 2004). The common factors perspective began in the individual psychotherapy literature, and has since taken course in the field of couple therapy too as a result of its theoretical and research evolution, and represents one of the critical choices made in encountering theoretical and research forks in the road (Sexton, Ridley, & Kleiner, 2004). The embracing of common factors may therefore be viewed as an oppositional response to the current empirically validated/supported treatment movement, and as a statement of philosophical support of the values of current post-modern research perspectives (Sexton, Ridley, & Kleiner, 2004).

Common factors researchers argue that MFT, and psychotherapy in general, may attribute its effectiveness largely to common elements found in effective models of therapy and the process of therapy itself, rather than due to specific or unique ingredients

found in models (Carr, 2004; Heatherington, Friedlander, & Greenberg, 2005; Sprenkle & Blow, 2004). Moreover, independently developed models often share several commonalities in their conceptualization, delivery, and procedures (Henggeler & Sheidow, cited in Sprenkle & Blow, 2004). This is supported by major meta-analyses of MFT outcome research literature that have reached the same conclusion as in the field of general psychotherapy, namely that few meaningful differences in efficacy exist among models (Shadish & Baldwin; Shadish et al., as cited in Sprenkle & Blow, 2004). As a result, although models are not seen as worthless, they are proposed to work largely, but not exclusively, because they act as vehicles through which common factors operate and so activate or allow for common mechanisms of change (Blow & Sprenkle, 2001; Sprenkle, 2003). In spite of their focus on common factors however, advocates of a moderate common factors position do not propose that common factors versus specific factors need to be as rigid as 'either/or', but instead hold the view that there probably are types of problems, clients, circumstances, and therapists for which a particular model is particularly well suited (Sprenkle & Blow, 2004).

Although many models do offer strategies and techniques that are often highly effective in activating common factors, common factors researchers propose moving away from trying to prove the effectiveness of models and their respective strategies and techniques, as this appears to have led to the proliferation of therapy models and the mistaken assumption that specific models, strategies, and techniques are primarily responsible for therapeutic change (Sprenkle & Blow, 2004). Common factors research therefore goes beyond examining the main effects of various models and attempts to explore and identify various factors that mediate and moderate the effectiveness within various treatment models (Sprenkle & Blow, 2004). Greater focus on research that describes such variables (such as client, therapist, relationship, expectancy, and treatment variables mentioned above), may in turn contribute greatly to knowledge of effective psychotherapy in the field (Sprenkle & Blow, 2004). The common factors perspective also proposes a very positive outcome in that it encourages more process research that examines mechanisms of change or 'why' change occurs – an area of research that is still in its infancy in the field (Sprenkle, 2003).

In terms of the role of the therapist in couple therapy, common factors scholars view the involvement of the therapist as a central force and a key change ingredient in most successful therapy (Blow, Sprenkle, & Davis, 2007). In the broader sense of the term "common factors", which includes all aspects of the therapeutic context that contributes to change, these researchers argue that being a competent therapist is itself a major common factor (Blow, Sprenkle, & Davis, 2007). In the 'narrower' sense, where common factors refer to common mechanisms of change that are embedded in all effective models of therapy, the therapist's role in activating these change mechanisms is also stressed (Blow, Sprenkle, & Davis, 2007). As a result, it is argued that most key changes in therapy are either initiated by the therapist or influenced by the therapist, and that the therapist's ability to identify and maximize these opportunities for change largely determines the therapist's, and thus the therapy's, effectiveness (Blow, Sprenkle, & Davis, 2007).

2.7.4 Multilevel Change Processes

The ongoing historical search for the most effective way to help clients thus seems to have resulted in the recent debate between 'common factors' and specific models of MFT (Sexton, 2007). Whilst researchers seem to agree that finding a common core of factors to explain successful therapy would be a major breakthrough in simplifying practice, training, and research, and in unifying theoretical schools in MFT that often compete with one another, recent scholars do not perceive it to be an adequate alternative to the current theoretical and research problems of MFT (Sexton, Ridley, & Kleiner, 2004). Moreover, whilst there is no question that common ingredients contribute to the efficacy/effectiveness of therapy, and no question that effective models of MFT should and will include core common factors shared by various psychotherapy modalities, it is argued that the current form of the common factors perspective cannot be an adequate solution to the current research and theoretical dilemma in couple therapy because it does not integrate research into practice, provide a conceptual or theoretical foundation to understand clients or change, or provide guidance for the practicing therapist (Sexton, Ridley, & Kleiner, 2004).

It is also argued that the common factors perspective overlooks the multilevel nature of practice, and oversimplifies the complex processes, the crucial research needed to explore therapeutic change, and the rich theory required to explain practice (Sexton, Ridley, & Kleiner, 2004). Consequently, understanding the role of the therapist comprehensively both conceptually and scientifically is argued to be critical in understanding good therapy (whether it is common factors or specific models), and future research agendas, training, and practice (Sexton, 2007). As an alternative to the common factors perspective, researchers suggest that *"a more productive solution is to appreciate the complexity of MFT and to integrate research and practice by building comprehensive multilevel-process models of practice that provide a theoretical and conceptual foundation (through guiding principles) and that describe systematic clinical procedures that serve the basis of practice"* (Sexton, Ridley, & Kleiner, 2004, p. 146). In this way, either/or choosing between common factors and specific clinical models is avoided, and a search for an overarching conceptual schema that captures the complexity of the therapeutic process may be encouraged (Sexton, Ridley, & Kleiner, 2004).

2.7.5 The Scope for Redirecting Couple Therapy Research

It is clear that the knowledge of MFT in the domains of theory and research have evolved and expanded considerably since its founding days (Sexton, Ridley, & Kleiner, 2004). In summary, the conceptual foundations of couple therapy have been influenced by numerous trends in research such as the lengthy period of significant focus on empirical trials/outcome research, the subsequent evidence-based or 'best practice' movement, and the more recent rise of the common factors perspective. The common factors perspective has also recently been challenged by researchers who discourage choosing between common factors and specific clinical models deemed most effective, and instead advocate the search for an overarching schema that captures the complexity of therapeutic change (Sexton, Ridley, & Kleiner, 2004). Perhaps the route forward lies in the advice of Alexander (2002, as cited in Sexton, Ridley, & Kleiner, 2004) who suggests savouring the dialectic and embracing the unification and integration of common factors, as well as the complexity of specific and different comprehensive models of change. This is suggested to be possible if common factors are viewed as necessary, but not sufficient, ingredients within specific comprehensive models of change that guide therapeutic

practice, build theory, and integrate research to promote successful outcomes (Sexton, Ridley, & Kleiner, 2004).

In light of this and the highlighted need for more qualitative process-driven research that aims to specify and describe therapies, as well as explore and describe therapist factors that contribute to effective outcome in therapy and expand on theory development, this study aims to explore and describe the role of the Imago relationship therapist. This also as a means of adding to available process literature and potentially generating ideas for more extensive studies that may contribute to narrowing the commonly occurring gap between clinical practice and research in the field of couple therapy. Moreover, as suggested by Sexton, Ridley, and Kleiner (2004), the discovery of common factors may contribute toward simplifying practice, training, and research, and in unifying theoretical schools that often compete with one another. On the other hand, an investigation of the therapist's role also has the potential to assist in integrating research and practice *without* bypassing the complex multi-level nature of clinical practice by describing systematic clinical procedures that serve the basis of practice (Sexton, Ridley, and Kleiner; 2004).

2.8 Conclusion

In summary, the above literature was intended, to a greater degree, to depict the circumstances in which couple therapy finds itself following a history of attempts to validate itself empirically in terms of efficacy and effectiveness. The result has been a choice point regarding the direction to be taken in couple therapy research, as authors and researchers alike have highlighted the need for more research in the field that is qualitative in nature and aimed at exploring and describing variables of the therapeutic process such as the role of the therapist. Moreover, a handful of couple therapies remain dominant in the field due to repeated empirical investigation and documentation whilst the less-explored forms of couple therapy have often been labelled inferior as a result of lack of exposure through research. Consequently, this study attempts to begin to bridge such gaps in couple therapy research by exploring the role of the Imago relationship therapist – a couple therapy modality that remains relatively unexplored and documented. In addition, the literature was aimed at providing the reader with a foundation to the most

commonly utilized and empirically supported forms of couple therapy as a point of reference to the exploration of the Imago relationship therapist's role.

To follow is a description of the research methodology utilized in this study to gather information about what Imago relationship therapists perceive their role to be, and in so doing, to support the need in couple therapy for more research of an explorative and descriptive nature.

3. Chapter Three: Methodology

3.1 Research Design and Procedure

Given the aims of this study to explore therapists' experiences and perceptions of their roles and functions as Imago Relationship therapists and to document themes from such exploration, a qualitative research design was employed. Several characteristics of qualitative research implicate its appropriateness to this type of study. Firstly, the focus of qualitative research coincides with that of this particular study, namely, the subject matter of human experience which pays attention to narrative accounts, description, interpretation, context, and meaning (Kazdin, 2003). Qualitative research is designed to describe, interpret, and understand human experience, as well as elaborate on the nature of participants' experiences and the subjective meaning attached to such experiences (Eliott, Fischer, & Rennie, 1999; Kazdin, 2003). Such a design is considered particularly well suited to the nature of this study as it aims to contribute to the much needed empirical description and definition of various couple therapies that is greatly lacking in the field of couple therapy research (Sexton, Ridley, & Kleiner, 2004).

In addition, the data of qualitative research are primarily words and are derived from in-depth analysis of cases (Kazdin, 2003), such as the in-depth analysis of the transcribed responses of participants' interviews. As the focus of this study is on participants' perceptions of a particular phenomenon (i.e. perceptions of their role as Imago therapists), it lends itself best to a qualitative research design. Moreover, the need for discovery-oriented and hypothesis-generating research in order to gain understanding of the therapeutic process and to suggest relationships between therapeutic variables has been highlighted as lacking in the field of couple therapy (Wynne; Piercy & Sprenkle; Pinsof; Stanton, as cited in Christensen et al., 1998), thus supporting the use of a qualitative research design which aims to know a phenomenon in-depth so as to allow for the development of hypotheses and theory (Kazdin, 2003).

In contrast to the proposed benefits of a qualitative design for this study, quantitative or natural-scientific approaches restrict the researcher to a process of objective measurement

of observed characteristics. As a result, such studies omit the richness of individuals' experiences, perceptions, feelings, and opinions, due to the exclusion of variables in their multiplicity, complexity, and context (Kazdin, 2003; Mouton, 2001). Quantitative approaches are also likely to yield more 'surface level' analysis as they lack an insider-perspective typical of qualitative methods aimed at giving insight and richer content (Mouton, 2001). As a significant motivation for the exploration of therapists' perceptions and experiences of their roles as Imago therapists is to contribute to the much needed empirical description of the multilevel complexity of therapies that typically undergo quantitative and evaluative scrutiny, (Sexton, Ridley, & Kleiner, 2004), a quantitative design would thus prove limiting and inappropriate.

3.2 Research Questions

In line with the aim of this study, the following research questions were posed:

(a) What is the perceived role of the Imago relationship therapist?

(b) How is the role of the Imago relationship therapist perceived to be distinctive from, and similar to, the role of couple therapists in other traditional forms of couple therapy?

(c) What are some of the perceived strengths and weaknesses of practicing this form of couple therapy?

(d) What is the perceived role of the Imago relationship therapist in South Africa?

3.3 Participants and Sampling

In keeping with criteria for participation in this study pre-determined by the researcher, qualified and registered psychologists that are also certified in and practicing Imago relationship therapy were solicited for this study. Although participants were also required to be practicing in the greater Johannesburg region of Gauteng, South Africa, the majority of participants were in private practice in the Northern suburbs of Johannesburg and Sandton. A further criteria for participation in this study was that participants should have at least three years of experience in practicing IRT, which was ascertained by the researcher when contact was first made with participants. Socio-cultural demographics were not a consideration in selecting participants for this study, however, the majority of participants (seven out of eight) were white females and only one was a white male.

This was also reflective of the demographic profile of all Imago therapists listed on the 'Imago Africa' website. Participants' age, marital status, and sexual orientation were not considered relevant for the purpose of this study and thus

Participants were recruited using a purposive sampling method. Purposive sampling is particularly appropriate to select unique cases that are especially informative, and also when a researcher wants to identify particular types of cases or samples that may be regarded as representative of the relative population for in-depth investigations (Neuman, 2000; Welman & Kruger, 2002). In other words, a specific target population (namely Imago relationship therapists) was targeted purposefully in order to gain in-depth information about particular phenomena – namely, the role of the Imago therapist. Given the limited number of certified Imago therapists in the greater Johannesburg region (approximately thirty at the time of arranging interviews), participants were purposively located through available contact information of all certified and practicing Imago therapists in South Africa on the 'Imago Africa' website.

In addition, a 'snowball' method of convenience sampling was also used as the researcher made contact with initial participants. Snowball sampling (also referred to as 'network' or 'chain referral' sampling) is a technique involving research participants obtaining access to other potentially suitable participants for the study, and is thus used to identify or select a sample located within a specific network (Neuman, 2000). This method of convenience sampling is particularly appropriate for studies conducted to evaluate a special population (Kazdin, 2003) such as a population of therapists practicing a particular mode of therapy. This means of making contact with participants transpired in the early stages of the interviewing process after making contact with the first four participants through the purposive method described above. Following this, two of these initial participants that were located purposively in turn identified other participants that also qualified for inclusion in the study, who were then contacted by the researcher. In this way a 'chain referral' system or snowball method was initiated and two participants were contacted in this manner. The researcher did, however, resort back to a purposive sampling method in order to attain the remaining participants for the study, as the snowball method did not yield the required amount of participants. Furthermore, the apparent newness of IRT in South Africa, and specifically in Gauteng, was also believed

to be an influencing factor in accessing a greater number of Imago therapists, which resulted in a sample size of eight to be interviewed for the detailed exploration of this study.

3.4 Data Collection Procedure

The suitability of interviews is widely recognized for the purpose of doing explorative research such as this study, as it allows access to the subjective meaning inherent in complex phenomena such as one's perception or experience (Mouton, 2001; Neuman, 2000; Welman & Kruger, 2002). Furthermore, interviews are usually employed in explorative research to identify important variables in a particular area, to formulate penetrating questions relating to these variables, and in turn to generate hypotheses for further investigation (Welman & Kruger, 2002). The researcher thus chose to employ a semi-structured and in-depth interview schedule with open-ended questions that evolved throughout the research in order to capture meaningful data from participants (Appendix A). Semi-structured, face-to-face interviews are also particularly suitable and vital when doing exploratory research as they enable exposure to rich, detailed descriptions from participants (Bless, & Higson-Smith, 1995) such as this exploration of participants' perceptions. Moreover, the semi-structured approach has the benefit of permitting flexible exploration of the phenomenon under investigation (Banister et al., 1994). For the purpose of this study, the interview constituted questions that focused specifically on the perceptions and experiences of participants' roles as Imago relationship therapists in order to address the aforementioned research questions. Although the focus of the interviews was already predetermined however, the semi-structured format allowed participants to speak freely, which in turn enabled unexpected information to surface as well as more comprehensive interviewing of the topic. The open-ended nature of interview questions also allowed the researcher to probe participants' responses in order to yield richer, more descriptive information to be analysed.

As described above, participants were recruited for this study using a combination of purposive sampling and snowball convenience sampling. All participants were contacted telephonically by the researcher, whether located purposively from the 'Imago Africa' website or referred to the researcher by one of the participants interviewed in the initial

stages of interviewing (whose contact details were also located on the website). Following a brief description of the nature of this study, namely, exploring their perceptions of their roles' as Imago relationship therapists, participants were invited to participate in the study as volunteers to be interviewed. Upon agreeing to partake in the study, interviews were scheduled for a time that was convenient for participants, as well at a venue that suited them. Only one participant chose to meet for the interview at Unisa as this was more convenient for the participant, whilst the remaining participants all chose for interviews to take place at their psychotherapy practices.

Prior to commencing the interviews, the researcher requested that participants read, understand, and sign consent forms requesting their permission to be interviewed as well as permission for interviews to be audio recorded digitally (Appendix B and C). Data was thus gathered using a digital audio recorder and interviews varied in length between 45 minutes and 65 minutes. The researcher also made some hand-written notes during interviewing regarding areas of focus or as a mental reminder to return to a specific area of discussion at a more appropriate stage so as not to interrupt participants' responses or chain of thinking. Upon completion of all the interviews, resulting data was transcribed verbatim by the researcher into written text in order to be analysed. As far as possible, transcriptions included aspects of communication such as strong emphases, interruptions and overlaps in speech exchange, and significant pauses, as this method is recommended for a typical psychological interview transcription (Banister et al., 1994). The recorded interviews were destroyed once the interview material was transcribed and utilized for the purposes of the research project.

For confidentiality purposes, the names of all participants or any identifying information on any written material (such as transcripts) were coded with a number and participants were informed that only the researcher and her supervisor would have access to such information, including the participant's name. For example, if the participant was named Jane Doe, that participant's transcript was assigned the title 'Interview One'. This process was repeated for all participants. Original demographic information supplied by participants and information necessary to arrange the interviews was also stored in a secure and confidential location. In spite of these measures however, complete

confidentiality was not possible as partial extracts of participant's experiences remain accessible via this study.

3.5 Data Analysis

Interview information obtained and transcribed was analysed using the interpretive method of thematic content analysis. Thematic content analysis is a technique for gathering and analyzing the content of text, i.e. the words, meanings, symbols, ideas, themes, or messages that can be communicated (Neuman, 2000). This form of analysis has become a commonly accepted and utilized qualitative technique within the social sciences and is particularly well utilized for the purpose of psychological research studies (Kazdin, 2003). In addition, shortcomings in couple therapy research (as outlined in the literature review section) have led to the development of a growing body of research that makes use of methodology such as content analysis in order to discover what therapists do in therapy (e.g. Couture & Sutherland; Cogan & Gale; Rober, van Eesbeek, & Elliot; cited in Blow, Sprenkle, & Davis, 2007). Krippendorff (1980, p. 21) refers to thematic content analysis as a tool that aims to *"provide knowledge, insights, a representation of 'facts', and a practical guide to action"*. This method of analysis thus lends itself well to a study such as this, which aims to expand on the lack of available information and knowledge regarding what therapists' do in therapy in order contribute to the action and evolution of couple therapy treatment.

The use of thematic content analysis involved analyzing the transcribed data by organizing it into categories, based on themes, concepts or similar features (Neuman, 2000). In order to 'see' themes in the data, the researcher had to look for patterns in participants' responses and think in terms of conceptualizing themes into categories for the sake of in-depth discussion and description of these themes. To achieve this, analysis of the data underwent the process of coding whereby *"raw data is systematically transformed and aggregated into units which permit precise descriptions of relevant content characteristics"* (Holsti, 1969, p. 95). Three types of coding were applied, namely a) open coding that enabled the researcher to find categories, b) axial coding that enabled the researcher to interconnect the data categories and, c) selective coding, that enabled the researcher to establish the core category/categories (Robson, 2002). As an

iterative process to further refine results and to help ensure interpretive validity of results, the researcher rechecked obtained themes against the narrative process (Kazdin, 2003). In this way, thematic content analysis utilises a set of procedures that enable valid inferences and interpretations to be made from text by reducing and categorising large volumes of material into more meaningful units (Weber, 1985).

3.6 Ethical Considerations

Participants were supplied with a participant information sheet (Appendix A) that invited them to participate in this research study as volunteers and explained that they were under no obligation whatsoever to participate. Furthermore, the ethical responsibility resided with the researcher to obtain informed consent from participants, and to honour all guarantees of privacy and confidentiality. Signed consent was thus obtained from all participants to be interviewed, and for interviews to be digitally recorded before interviews commenced (see Appendices B and C). Additionally, participants were informed of their right to refuse answering any questions they may prefer not to, and that they may choose to withdraw from the study at any point. All interview responses and personal information pertaining to the lives of participants were kept confidential and information was only processed by the researcher and her supervisor to ensure further confidentiality.

Whilst confidentiality is a promise that you will not be identified or presented in any identifiable form, anonymity is a promise that even the researcher will not be able to tell which responses came from which respondent (Sapsford & Abbot, cited in Bell, 2005). As a result of the nature of this study however (i.e. face-to-face interviews), anonymity could not be guaranteed, and so every effort was made to sterilize any data used in the research report. Participants were informed of this limit to confidentiality and that any information that may identify them or their clients referred to during interviews, would not be included in the research report in every attempt to secure the confidentiality and integrity of themselves and their practice. Moreover, due to the relatively small community of Imago therapists, special care was taken when reporting data so as not to reveal participants' identity. In addition, in an attempt to ensure that interpretations of

findings were consistent with the data provided by participants, the researcher undertook to recheck extracted themes against participants' narratives.

According to the American Psychological Association (2002), psychologists are responsible to maintain confidentiality in creating, storing, accessing, transferring, and disposing of records under their control, whether these be written, automated, or in any other medium. Consequently, participants were made aware that material obtained would be maintained in a secure location at the University of the Witwatersrand for a period of five years once it had been transcribed, analysed, and utilized for the study. Furthermore, participants were notified of the measures taken to secure obtained data, namely that transcripts were stored in a secure place by the researcher whilst the research was in progress, and that only the researcher and her supervisor would have access to such information. Participants were also informed that results of the study would be made available to the University of the Witwatersrand's Psychology Department in the form of a printed copy of the dissertation, and of the possibility that results of this study may be published in a journal article.

This chapter has served to inform the reader about how participants were obtained, the method utilised to gather required data, as well as the procedure followed to analyse data. The chapter to follow will thus reveal findings elicited from the data collection procedure, and will be discussed and analysed using the chosen method of analysis with the aim of providing an in-depth understanding of the participants' perceptions of their roles as Imago relationship therapists.

4. Chapter Four: Findings and Discussion

4.1 Introduction

As reported in the literature review, couple therapy appears to be facing yet another cross-road in its evolution. In particular, the current era of research in the field is in need of greater attention to, and exploration of a broader repertoire of couple therapy modalities and specifically more recent and formative types such as IRT, which is lacking in empirical exploration. Exploring the reasons why various therapies are effective as well as describing the nature of factors that contribute to change in the therapeutic process such as therapist variables, rather than a continued focus on whether or not and in what circumstances these therapies are effective, has also been highlighted. Recent research literature in the field thus recommends that more credence be given to describing and specifying the process of therapy through examining and documenting mechanisms and mediators of change such as therapist factors and behaviours. Examining the role of the therapist has been highlighted as a particular area in need of exploration in an attempt to expand the apparently limited parameters of couple therapy research that have tended to overlook the inclusion of studies of a more qualitative, descriptive, and hypothesis-generating nature.

In an attempt to do just that, this study has explored the perceptions of Imago relationship therapists regarding their roles and functions when practicing IRT. This involved trying to gain an in-depth and thorough understanding of what they perceive their role to be. Participants were questioned about their perceptions of the strengths and weaknesses encompassed within their role, as well as how they perceive their role to be similar to and distinctive from the roles of therapists practicing other traditional forms of couple therapy. In addition, participants' responses regarding their role as Imago therapists within a South African context were explored and analysed in an attempt to contribute to the much needed exploration of doing couple therapy in diverse populations. This chapter will therefore provide an overview of emerging themes related to these areas of exploration as understood and interpreted from the perspective of the researcher. More specifically, this will entail a systematic account of the results obtained from participants' responses, as well as a qualitative thematic content analysis and discussion of these

results. Although transcripts were analysed in their entirety, only certain quotes have been selected and included for analysis as these were representative of themes that emerged for discussion.

4.2 Reflexivity

The conventional ideals of science have long favoured professional distance and objectivity above engagement and subjectivity, with the result that quantitative research emphasizes the suppression of material pertaining to the process of research, including researcher subjectivity (Finlay, 2003; Wilkinson, cited in Gough, 2003). Qualitative research, on the other hand, is distinguished by reflexivity as a set of practices that helps situate the researcher and enhance understanding of the topic being investigated by facilitating insights into the context, relationships, and power dynamics inherent within the research setting (Finlay, 2003; Wilkinson, cited in Gough, 2003). Reflexivity in qualitative research involves a process of looking critically at oneself, reflecting on and including relevant personal thoughts and feelings about the research report and process, and ultimately coming to know the self within the process of research itself through a conscious experiencing of the self as both inquirer and respondent, teacher and learner (Finlay, 2003; Gough, 2003; Lincoln & Guba, 2003). In this way, writing is not merely the transcribing of some reality, but also a process of discovery of the subject and of the self (Lincoln & Guba, 2003). The result is that the subjectivity of the researcher and the participants being studied become part of the research process (Flick, 2009), and moreover, that the personal is celebrated as a strength and a resource by the qualitative researcher in order to enhance the quality of analysis (Finlay, 2003).

How this is done varies greatly in practice however. For instance, it may be focused at one stage of the research or applied throughout the research process; it may be enhanced through discussion with colleagues and/or research participants, or simply by regular solitary reflections recorded by the researcher (Gough, 2003). As a result, the diversity of definitions and theoretical positions on reflexivity will inform how different qualitative researchers practice reflexivity (Gough, 2003). In addition, reflexivity can be understood in several ways as determined by the aims and functions of the exercise at stake, as well as the theoretical and methodological traditions embraced (Finlay, 2003). The aims and

functions may in turn be understood in a multitude of ways such as a confessional account of methodology, or as examining one's own personal, possibly unconscious reactions, exploring the dynamics of the researcher-researched relationship, or by focusing more on how the research is socially situated (Finlay, 2003). The functions of reflexivity are also broad and include using it to offer an account of the research, situating the researcher, or voicing difference (Finlay, 2003). In spite of the many variants of reflexivity, however, Finlay (2003) suggests that as a whole it has the potential to be a valuable tool in several ways. That is, to examine the impact, position, and presence of the researcher; to promote insight by examining personal responses and interpersonal dynamics; to expose unconscious motivations and implicit biases in the researcher's approach; to evaluate the research method, process, and outcome; and, to enable public scrutiny of the integrity of the research by offering a methodological account of research decisions.

Whilst deciding how best to engage in a reflective process regarding one's research may appear complex given the many routes to choose from, Bonner (cited in Finlay, 2003, p.17) suggests that to avoid reflexive analysis altogether is likely to compromise the research and make any account of social analysis 'fundamentally incomplete'. With this in mind, it is believed necessary to provide the reader with some reflections on the researcher's process during this study, potential biases that may have affected the process, as well as providing some context regarding participants as a means of enhancing the analysis to follow.

4.2.1 The Process of Collecting Data

Setting up interviews with participants proved to be an especially effortless and speedy task as prospective participants for the study were easy to access from the Imago Africa website and were generally very receptive to partaking in the study. Although their willingness to participate seemed partly motivated by their desire to add to the value of exposing IRT – a potential bias in itself – participants also seemed genuinely interested in assisting the researcher with the task of completing this research study. As a result, interaction between the researcher and participants was generally relaxed and informal. Whilst the relaxed atmosphere during interviews may have led participants to respond in

a more superficial manner, it is the researcher's view that this atmosphere in fact enhanced the quality of responses as participants took their time to respond clearly. This was especially true following the first interview as the researcher realised that the dedicated time of one hour for a single interview was more than enough to get through the interview schedule comfortably.

The researcher's own interest in, and advocacy of IRT is also an important bias to consider. Whilst the researcher tried to remain as aware as possible of her bias toward IRT, this was likely to have had an impact on the quality and tone of the questions directed toward participants, as well as the answers received, due to an inevitable desire by the researcher for participants to respond in a specific way. These biases thus need to be taken into account when reviewing the findings and discussion of this study. Moreover, participants were also informed before the interviews by the researcher that the researcher has a relatively extensive knowledge regarding IRT, and that the researcher had also previously attended an Imago Relationship Weekend as well as more than six months of regular Imago therapy with her partner. In hind sight, it became evident that such knowledge may have compromised the level of detail and richness of responses due to a possible assumption by participants that the researcher understood certain contexts, phrases, and meanings in the answers provided and so unwittingly failed to probe further in order to capture potentially deeper meaning behind responses. For instance, the language used to describe certain processes within their role was quite stereotypical yet well-understood by the researcher. As a result, the striking similarity of language used by participants to describe their role was initially overlooked as a significant area for discussion. Acknowledging the researcher's perspective, as well as the situational context from which the researcher describes and interprets data are thus considered important influences on the outcome of the research (Terre Blanche and Durrheim, 2002).

Furthermore, in doing qualitative research, the researcher must keep in mind that a reality is being constructed on the basis of their interpretations of data with the assistance of participants who provided the data (Eichleberger, 1989). Therefore, alongside the significant influence of the researcher's context in making interpretations, is the potential influence that participants' own context has on the process as a whole. For instance, it is

important to note that most participants have been practicing IRT for significantly longer than the three year minimum requirement for participation in this study. As a result, their responses may have come from a point of reference or perspective that has potentially become habit or second-nature so-to-speak. This may in turn have affected the level of detail or richness in their responses too by potentially giving too much or too little detail.

4.2.2 The Process of Analyzing Data

The most significant area for discussion regarding the process of analyzing data and writing up this research report is that it has proved to be a somewhat fragmented experience for the researcher as a result of several very trying personal experiences occurring alongside the process of this research study. Whilst the researcher was unable to separate personal life experiences from one another, and instead experienced them as a continuous 'whole', the benefit of this 'whole' personal experience was often at the expense of the process of this research study which turned out to be quite staggered in nature. As a result, analyzing and making sense of the meaning behind participants' experiences was often affected by the researcher's own process of finding meaning within her 'whole' experience.

Ironically, and paralleling the process described above, the researcher also experienced thematic content analysis as a frustrating means with which to analyse participants' 'whole' experience without having to separate certain parts of their experience from the greater whole for the sake of creating categories for discussion. Although themes have been separated according to areas of discussion that seem to bide well together, these themes are not mutually exclusive and often overlap significantly in the meaning that they hold for participants regarding their role. Attempting to categorise and separate participants' experiences of their role thus proved especially difficult and frustrating for the researcher, with the result that discussion of responses sometimes felt fragmented rather than representative of their 'whole' experience. This supports critique of thematic content analysis which suggests that material for analysis in the form of text, essentially becomes fragmented and removed from the whole and that it focuses on the content of peoples' experience as manifested in separate parts of the account given by respondents

irrespective of the context of the complete story (Lieblich, Tuval-Maschiach & Zilber, 1998).

In spite of potential areas that may bias the outcome of this research negatively, other aspects of the researcher-participant interaction may be viewed favourably with regard to outcome. For instance, the researcher found participants candidness about the negative aspects of their role as Imago therapists to be highly beneficial in terms of contributing to the much-needed research that describes therapies and therapist variables. Responses appeared to reflect an open-minded outlook toward expanding upon and improving certain aspects of their role as Imago therapists, whilst simultaneously acknowledging areas of their role they found to be highly beneficial to the process of dealing with couple distress. This proved helpful in terms of moving beyond attempts to prove the effectiveness and efficacy of couple therapy models and to engage in much needed exploration and description of therapist variables within the therapeutic encounter as a means of better understanding the complex nature of the process of couples therapy.

4.3 An Overview of Emerging Themes

As described in the literature, the role of the Imago relationship therapist encompasses a number of crucial variables. Several of these variables are evident in participants' responses, and an attempt is made to understand the complexity of their experiences of their role through description and analysis of participants' responses. The initial theme thus emerged as a result of the significant emphasis by participants placed on establishing safe connection for the couple. This aspect of their role is discussed in terms of the irony of establishing connection between partners through a somewhat 'unconnecting' fashion of giving couples information in the form of theory and skills. The way in which participants describe and speak about their role of establishing connection between partners is also discussed in terms of the strikingly similar language used, as it is suggestive of a value or ideal of connecting in relationship that goes beyond mere functions within the therapeutic role and is incorporated into the person of the therapist. Lastly and also related to the overarching theme of safe connection embedded within the role of the Imago therapist, is the irony that therapists' themselves appear to experience

their role in a 'safe' way. The phenomenon of how connecting couples in safety translates into a safe therapeutic encounter for the therapist is thus discussed.

The second theme engages with an underlying and seemingly constant theme of paradox evident in participants' experience and perception of their role as Imago therapists. The paradoxes encountered by the researcher in these responses are discussed in terms of their apparent parallel with the role of Winnicott's 'good-enough' mother as the two roles appear to hold significant similarities of paradox.

Following this, the role of the therapist is discussed in terms of the most significant strengths and limitations within their role as experienced by participants, both of which proved to be experienced by participants in a congruent manner. Participants' ways of dealing congruently with the strengths and difficulties within their role are thus discussed and the significance and implications of a congruent encounter for couples and participants within the therapeutic process are noted.

Finally, participants' experiences of practicing IRT in a South African context are discussed in terms of the importance of theory underlying their role. Whilst responses of working with diverse couples within a South African context reflected both positive and negative experiences of dealing with challenges of diversity, majority of responses seemed to reflect IRT's underlying ontology of connection as participants appeared to view underlying human connectedness as primary rather than differences in culture and social diversity as primary. Participants did not, however seem to make a connection between underlying Imago theory which advocates that human connection transcends the boundaries of cultural and other diversity, and their general experiences of practicing with a diversity of couples. This poses questions regarding the significance of underlying theory in practice, specifically relating to what set of assumptions informs the role of the Imago therapist most significantly. Given the importance of theory in influencing the way the therapist thinks about the client, this may be viewed as an area that may potentially restrict participants' role as Imago therapists.

4.4 Theme One: Establishing Safe Connection

According to the perspective of the researcher, the most prominent theme to arise from interview material constituted the complex and multi-layered role of the therapist of establishing safe connection between partners. However, helping couples connect seems to be achieved in an ironically 'dis-connected' and scripted fashion of providing partners with in-depth theoretical explanations of why they struggle to connect. This somewhat 'clinical' fashion of establishing something as intimate as emotional connection was evident during interviews as responses were generally quite descriptive and theoretical in their attempts to explain the importance and establishment of safe connection between partners as a major part of participants' role.

At a more covert level however, the language used to describe perceptions of their role appears to be a powerful common thread shared by participants and portrays their role more as a life philosophy rather than a set of tasks encompassed within their role. Finally, although the task of establishing safe connection between partners was described as paramount within their role as Imago therapists, this facilitative and 'background aspect of their role ironically also appears to provide participants with a significant sense of safety and reduced therapeutic responsibility when engaging with couples. The importance of this sense of safety for participants within their role when engaging with couples is also discussed.

4.4.1 A 'Script' for Safe Connection

An interesting phenomenon that appeared to take place during the process of interviewing was an apparent 'unravelling' process for participants of how to define and describe their perceptions and experiences of their role as Imago therapists. At the outset, it seemed to the researcher that participants were having difficulty explaining key aspects of their role, as responses seemed to constitute detailed descriptions of Imago theory and the therapy itself rather than participants' experiences of their role in implementing Imago therapy. However, upon closer inspection, it became clear that the role of the Imago therapist *is* very theory-driven and that a significant part of the role hinges upon dissemination of the same psychological information that constitutes theoretical explanations and underpinnings of IRT. The following responses from participants demonstrate that the

concept of creating safe connection between partners depends significantly on the implementation of specific tasks and functions from the Imago therapist that are essentially embedded in Imago theory. This in turn highlights an underlying irony within the role of how establishing connection is achieved through the clinical fashion of giving information to partners.

P2: *Initially I'm quite in the foreground in terms of teaching them the different stages of a relationship, what goes wrong in a relationship, how our brains work, why we get stuck, what's constructive, what's not so constructive […] Trying to explore what the dynamic is between the two of them and how that relates back to their childhoods – looking together. And then […] teaching them the tools… then I move more to the background and it becomes a facilitating, or a coaching kind of role, where they then 'do' the tools so as to strengthen the connection between the two of them, and to do the work between the two of them.*

P6: *I think that such a large part of the role is to understand the nature of conflict and understand that conflict really is what's trying to happen and that it's not pathological […] It's working with those early object relations and really making the links between understanding the buttons that get pushed and how that relates to previous childhood wounding and how often they recreate a situation in the here and now, and how that resembles something of the wound in the past.*

P8: *Imago therapy is looking at the role each person plays in the marriage. It's looking at our backgrounds, looking at where we come from and bringing them into consciousness of what's going on. So for me it's helping everyone to understand that there's no wrong or right, that it's about a relationship, about a connection and it's about the dance that the couple gets into […] My role is really to teach them to communicate, and the connection, to give them the skills so that they can become the therapists in their own marriage.*

P1: *So it's not only learning from the process, there's also learning from the information I give them beforehand. So that it makes sense why I do a dialogue – it makes sense to them why I do a behaviour change request […] If you don't give them information and*

you talk about their childhood, they might respond by saying 'what does my childhood got to do with my conflict?

As evidenced above, responses appear 'recipe-like' as participants describe quite similarly, a specific protocol and progression of tasks that need to take place before the therapy can progress to another level of functioning. In particular, responses indicate a role that is initially driven by an immense amount of detail, theory, and explanation as a way to ultimately get to a place of encountering a *"background"* experience within the role of the therapist. For instance, participants describe their role as being initially focused primarily on linking the couple's current relationship dynamics and reactions to past childhood wounds – or, being *"in the foreground in terms of teaching them…"* Responses indicate this to involve psychoeducating partners using object relations theory about how their past is directly linked to the way in which they experience current relationships, and how they react to their partner due to their respective emotional wounds from the past. This role is further indicated to involve active therapeutic functions such as teaching the couple about the various stages that one encounters in romantic partnerships, explaining why couples eventually get stuck in power struggles where they view their partners as responsible for the conflict and pain that they encounter, and ultimately how their brains function at both a conscious and an unconscious level – where conflict is always rooted within the unconscious.

Although experienced as part of their role, the information given to couples to create a foundation for safe connection is reflected clearly in Imago theory, which explains partner selection and relationship conflict as being rooted within an unconscious desire to attend to need frustration experienced during childhood, which is in turn reactivated and re-experienced in adult relationships in the form of a power struggle (Brown, 1999; Hendrix & Hunt, 1999; Luquet, 1996). It is precisely this information that serves to inform a key part of the role of the therapist in facilitating a conscious relationship between partners by providing the couple with a cognitive and experiential understanding of the purposes of romantic love and the power struggle, and about how conflict is an automatic process rooted in the unconscious and not an intentional ability of the conscious brain (Gerson, 2005). As a result, the role of establishing safe and conscious connection between partners demands that Imago theory be explained to the couple to

this extent. Moreover, although descriptions of their role may appear scripted according to Imago theory, the therapist cannot per se reach a space of being in a *'background role'* (as indicated by participant two) without explaining psychological theory and teaching communication skills first.

Interestingly, this process of *"learning from the information"* seemed to be mirrored during the interview process, as participants needed to explain theory-driven aspects of their role to the researcher before being able to describe aspects of their role as Imago therapists that were less theory-driven. This process has in turn been mirrored within the process of analyzing responses as the researcher has found it necessary to orientate the reader at a level of detail and description of Imago theory – which is inherently a part of the therapist's role – before attempting to explore and document underlying meaning within participants' perceptions and experiences of their role. This apparent mirroring of information and theoretical explanations appears to mimmick the mirroring process within the couples' dialogue where initial stages of the process demand accurate mirroring of the *content* of partners' experiences before their experiences can be understood at a more meaningful level – namely, at the level of cognitive and affective empathy.

In sum, whilst participants' most prominent reference to their roles as Imago therapists is about creating connection, this appears to be achieved in a somewhat 'unconnecting' way of giving information to the couple. Moreover, whilst their role may be perceived as descriptive and greatly resembling explanations of Imago theory, bypassing this would not only be taking from their experiences and perceptions of what it is that they feel is relevant within their role, but would also bypass the insight that their therapeutic role *is* largely embedded in describing theory. In addition, although these responses may appear to merely reiterate and restate Imago theory to a great degree, they also expand on theory by explicating participants' experience of how implementing theory in real life through the vehicle of practice is experienced as part of their role. Such knowledge is particularly helpful given the inability of existing theories to adequately explain, define, and describe the complexity involved in clinical practice, including the role of the therapist in the therapeutic change process (Heatherington, Friedlander, & Greenberg, 2005; Pinsof & Wynne, 1995; Sexton, Ridley, & Kleiner, 2004).

4.4.2 A Language and Philosophy of Safe Connection

Leading from the above discussion regarding the 'scripted' nature of the role of the Imago therapist as a result of using theory in establishing safe connection, is the noteworthy similarity in the language used by participants to describe their role. When asked about what they perceive their role as Imago therapists to be, participants were almost unanimous in describing it primarily as a role of facilitating and co-creating safe connection between partners. Whilst these responses highlight the importance of maintaining focus on establishing conscious and safe connection between partners, the way in which participants describe and speak about this perceived role is strikingly similar and suggestive of a value or ideal of connecting in relationship that goes beyond mere functions within the therapeutic role. Instead, the role of the therapist seems to be integrated into the language, and possibly the person of the therapist.

As evidenced below and in previous discussion, the role of the therapist is greatly informed by 'Imago language' so-to-speak, where responses often appear to be coming from one and the same voice or person. For instance, the following participants all use very similar language in explaining a role that hinges upon 'holding the couple in safe connection'. Such uniformity of language used to describe their role (in responses prior and below) is reflected in phrases such as "*healing childhood wounds", "understanding conflict", "making links", "bringing to consciousness", "bringing about safety"*, and *"establishing safe connection and teaching communication"*. The similarity in language used by participants to describe their role seems to connect participants within their role as Imago therapists, particularly in their plight to bring about safe connection through a function of *"holding"* the couple. Most strikingly, this language used to describe their role is highly suggestive of feminine, and especially, maternal archetypes that encompass a role of nurturing and care. For instance, the notion of 'holding' is especially reminiscent of Winnicott's concept of 'holding' provided by the 'good-enough' mother (Urdang, 2002) and 'connection' is a long-time associated feminine trait (McKinley, 1997). It is in turn commonly accepted social construction that women are mothers and that mothering and motherhood are *"deeply embedded in women's psyches"* (Miller, 2008, p. 39). With this in mind, one might argue that responses indicate participants to

be embracing feminine aspects of themselves, or that individuals attracted to this type of therapy are more easily able to access maternal or feminine aspects of themselves. Given a language and philosophy focused on connection and relationship one might thus speculate the role of the Imago therapist to be especially well-suited to female therapists.

P8: *You're teaching a skill, but the role is deeper than just teaching people a skill. We haven't reached consensus on what the role is, except that it's ... I like the concept that it's holding a safe place for people.*

P4: *It's not problem solving, it's not the therapist being a mediator between the couples – it's a way of connecting a couple and I think that's where it really is different in that the focus is on safety and connection, and everything else is an expansion of that concept. That the therapist holds that concept of safety and connection all the time.*

P3*: If we can bring about safety in a relationship, all the other things will come with it. As long as there's safety, people can go to a place of trusting one another enough to heal their childhood wounding and other things that need to be brought into the process. The role of the therapist before we even come in as a facilitator, is to bring about safety.*

In addition to seemingly connecting participants in their role as Imago therapists, the language of Imago also seems to connect the self of the therapist to a particular worldview or life philosophy embraced within this role. For instance, as indicated by participant eight, holding a safe space for the couple goes beyond the mere dissemination of information and teaching skills. At a *"deeper"* level, this involves *"holding"* a particular *"concept"* in mind, which in turn appears to inform who they *are* within their role. The language used to describe their role therefore appears connected to the individual self of participants. Participants also tend to speak about concepts such as 'holding' and 'safe connection' in an especially familiar way as though these terms do not need explaining; as though doing these things are intrinsically a part of who they are. This is suggestive of a role that is deeply integrated into the person of the therapist and lends itself to the idea below that their role is in fact perceived as a *"way of life"* and a philosophy rather than a role. As succinctly described by participant three below, one may perceive the role to be simple because insight gained is easy to understand, yet their

role is experienced in a more complex way – a way of being and a way of life in dealing with conflict in relationships which is *'hard to live'*.

P2: *The therapy is a philosophy about a way of life and it looks at the patterns that pop up between a couple […] it's more a way of life with which to deal with those issues and with each other in a different way, in a way that's constructive. […] The idea of that is that they incorporate that into their lives so that they can live that way with their children and their friends and their extended family and their colleagues….it has to become a way of life, it's not just therapy where in this hour and a half I'm understanding them and validating them and all of that.*

P1: *Well, I think I live it. I think I eat and sleep and drink Imago. When I went on this workshop I came back and I said to my husband "this was written for me". I think Imago suits my personality – I always say if I lie in my bed at night, you don't count how much money you made for the day, you count how many lives you touched. I do a lot of talks on Imago all over and I always say if we can change the lives of one couple, we've all got a responsibility to change couples' lives, if we can save one marriage we save the lives of at least two children. Broken individuals become broken couples.*

P3: *I say it's simple but it's extremely complex, because it's easy to understand, but it's very hard to live. Imago is a lifestyle, it's not a therapy. I'm still battling to live it in my life – to live with integrity. It's a way of being and perceiving life […] Imago is a lifestyle. When I learnt Imago, as a human being I got on better with my gardener and in life in general. Firstly with myself, then other people, with God and the universe as a whole. […] I really believe Imago is not a therapeutic modality, it's a way of being and life.*

From these responses, it appears that the role of establishing safe connection is incorporated as a part of the lifestyle and identity of the Imago therapist rather than a role that is reserved purely for the therapeutic encounter. One might speculate this to be instinctive and inherent, or integrated into their way of being as individuals above and beyond a mere therapeutic role. In this way, the role of the Imago therapist is experienced and perceived to be a 'way of life' that reaches beyond the mere

implementation of tasks and integration of information that help create a safe space for couples as described above. Thus, whilst their role encompasses skills and functions that initially enable partners to communicate safely with one another, responses indicate a more encompassing and intuitive view of 'role' that seems to be a part of the 'person' of the therapist.

4.4.3 Safe Connection for the Therapist

Not unrelated to the overarching theme of safe connection embedded within the role of the Imago therapist, is the irony that therapists' themselves appear to experience their role in a 'safe' way. It seems that the very means in which participants try to make the couple feel safe connecting with one another in fact provides a feeling of safety and containment for the therapist in their connection with the couple. That is, whilst their role encompasses creating safety for the couple, the structured way in which this is done in fact makes the therapist feel safe within his or her role of connecting with the couple. This is noted in responses indicating that there is less responsibility for the therapist, that it is not as tiring a role relative to other forms of couple therapy, that they do not experience the angst and anticipation they perceive to be associated with other forms of couple therapy that tend to focus on fixing problems, and that it generally makes the therapist's role easier.

P6: *I can really only talk from my experience as having done couple therapy prior to the Imago process and my way of working then and my way of working now. What is very distinctive for me is feeling a tremendous sense of responsibility with clients that would come in and there was conflict and a power struggle and just trying to make sense of it. Whereas now I'm almost released in terms of conflicts because I'm able to teach you how to have better and healthier conflict. And help you kind of get your head around the fact that conflict is not that bad. It puts the responsibility in their lap. […] I think the conflict doesn't draw me in. It's a process where you can kind of say "oh ok wow, let's have a look at what this is about", rather than with the angst and anticipation of having to try and solve each issue.*

P3: *Yes, you're free from that role which is wonderful! It makes my role and my work easier. So before I would sit and think who's right and who's wrong – and now I can just put my energy on that space between them…*

P5: *I think the big distinction is the fact that you play that coach role and the nicest part about it is you don't get involved in the couple's problems – they don't bring 'he did this and she did that etc' – you step out of the negativity of the relationship […] It's really nice that you don't get into the couple's issues and almost take on this role of what you're going to do and what you can't do as a partner.*

P2: *I find that colleagues who do not do Imago complain often that they don't like working with couples and couples are very tiring. This is why it's tiring. If I also had to spend an hour and a half about whether the money should be in the safe or not – I would also be very tired. And they won't feel any more connected to each other or safe, in fact I think they'll feel even further away from each other and even more unsafe with each other because it's your opinion versus mine. It's not about that. […] But who's right and who's wrong – how are the three of us going to solve what should have happened there, should it be in the safe or not in the safe. It doesn't matter, it's not about that. So asking questions around that or sticking to that just would not be at all helpful.*

These participants add how the structure or frame provided by the Imago dialogue also adds to a sense of freedom and ease experienced in their role. Structure provided by the dialogue provides a sense of safety and reduced responsibility for the therapist as responsibility is placed with the couple to work through their conflicts and transferences, rather than with the therapist.

P5: *The most helpful thing is you don't get involved in the k*k and you actually come out of a session very often feeling lifted. It's really nice that you don't get involved in the negativity. It also gives you a structure as a therapist to work in which is really nice so you actually have a framework so it makes your life as a therapist much easier that you know that well they start something, let's do a dialogue or a behaviour change. […] having the Imago framework or structure to work within, makes life so much easier. You don't have to do the thinking.*

***P7**: I think being able to have a frame and a position does away with a lot of anxiety floating around. So the anxiety doesn't float around the room – the couple comes in, they sit and you sit, it downs the 'freeflow' of the anxiety. When they get out of hand it helps to just stop the screaming and the shouting and to bring them back into the role […] it's containing for you as a therapist as well because you know exactly what your role is. I think it is very containing. And if I get pulled out it's a disaster and that's why I know when you're pulled out of role and they get out of role, there's anxiety – that's what the psycho-analytic people talk about, it's an incredible anxiety and how to contain it. […] I think that's the beauty of it because it makes you and them safe. The frame is almost set up in the room instead of the room and you being the frame. So there's an aspect of a frame, but it's in a different form.*

***P4:** I found it very similar to go from a systems view to Imago in some way. Except I just felt Imago gave one a really clear structure to work within, whereas in systems you're kind of inventing your structure all of the time. I would say it's harder because the therapist has to keep thinking through their questions and planning through their route […] The therapist doesn't have to be mind-blowingly inventive and creative and interpretative. In fact just holding the process will do a good job, even if you're not brilliant at anything else.*

The relief in responsibility experienced within their role was also described by participants as a distinction in relation to the role of the therapist in other forms of couple therapy. That is, participants describe their role as distinctive in terms of the reduced sense of responsibility and anxiety that they experience due to the Imago structure provided during therapy which essentially releases them of the 'expert' role of the therapist as perceived in other forms of couple therapy described above. In particular, these responses seem to try and express how participants *feel* different in their role relative to the role of the therapist in other forms of couple therapy.

For instance, participant seven seems to be referring to the expected capacity of the therapist to tolerate the anxiety of emerging unconscious material and affect within the role of a psychodynamic couple therapist (Savege Scharff, 1995; Scharff & Savege

Scharff, 1997). In psychodynamic couple therapy, it is the role of the therapist to interpret, work through, and make conscious the couple's regressive transference so that they have new choices about how to relate (Sander, 1998; Scharff & de Varela, 2005). In this case, the responsibility of holding the therapeutic frame is placed largely upon the therapist due to a transference interaction that is established between the couple and the therapist rather than between the couple as in the Imago process. As a result, participant seven highlights the relief in anxiety for the therapist and couple alike, as well as the reduced sense of responsibility for the therapist due to the containing structure or frame provided by the dialogue process as a distinction between the role of the Imago therapist and other forms of couple therapy. The Imago therapist is thus relieved of the anxiety and responsibility that is perceived to accompany the role of such couple therapists because the therapeutic frame takes a *"different form"* through the use of dialoguing between partners rather than through the therapist's engagement with partners in a triangulated fashion.

Similarly, in Bowenian systems couple therapy, the therapist plans how the individual will interact within the system and often aims to keep emotionality down between partners long enough to allow something new to happen in the system (Gerson, 2005). The therapist may also plan ways to generate feelings of anxiety in the couple or family system in order to get partners unstuck but emotionality occurs outside the session (Gerson, 2005). In contrast, the Imago therapist makes use of intense emotional sharing between the couple to promote mutual healing without planning how they will interact (Gerson, 2005). Once again it appears that participants experience their role as less burdensome because they do not have the responsibility of instigating emotionality or directing interaction between the couple. In this way, the frame provided by the dialogue does away with the responsibility of having to make interpretations or *'do the thinking'* because the dialogue process itself helps partners do this for one another. The dialogue also removes the responsibility of the therapist referred to in systems approaches of having to keep emotionality down, or as participant four points out, holding the responsibility of directing the couple's interactions. In this way, the therapist comes to experience his or her role in a seemingly safe way.

4.5 Theme Two: A Paradoxical Role

A paradox may be defined as an opinion or statement contrary to commonly accepted opinion that seems self-contradictory or absurd, but in reality expresses a possible truth. In his book entitled 'The Power of Paradox', Woodhead (2006) reflects on the profound human need for the world to make sense and suggests that we rely heavily on logic to meet this need. This is because we learn from an early age that once you fully understand something it will be logical (Woodhead, 2006). Woodhead (2006) adds that the idea that everything should make sense chains us down and holds us back, preventing us from finding solutions that will work, even if they do not make sense. Winnicott mirrors this sentiment in his request that *"...a paradox be accepted, tolerated, and that it is admitted that it does not have to be resolved. The paradox can be resolved, but the price to be paid is the loss of the value of paradox"* (Playing and Reality, 1971, cited in Geissman & Geissman, 1998). Winnicott is also known for embracing ambiguity and confusing difficulties, and in fact sees uncertainty as "*an opportunity for exploration, for becoming fruitfully confused"* (Appelgate and Bonovitz, p.18, cited in Urdang, 2002). In keeping with this, Woodhead (2006) suggests moving beyond the mere acceptance of paradox to a level of "unbounded thinking" which seeks paradox on the premise that each paradox is a likely signpost leading to unexplored areas. Coincidently, this need to access unexplored areas parallels the need highlighted in couple therapy research to veer away from the obvious and measurable toward investigating that which has not received great focus, namely a shift in couple therapy methodology that allows for exploration and description of therapist variables such as how the therapist engages in his or her role as a couple therapist (Blow, Sprenkle, & Davis, 2007; Bray & Jouriles, 1995).

Although participants did not describe it as such, responses suggested their role to be paradoxical at its core. This was made especially apparent as participants appeared to be trying to describe their role in a way that made logical sense, yet displayed difficulty outlining core aspects of their role that were often contradictory in nature. That is, although the therapist remains in the 'background' as a guide to the couple's process with a focus of maintaining emotional connection and conflict resolution between partners instead of becoming involved in a triangulated therapeutic encounter, responses indicated that this role paradoxically, and inherently, involves being actively present and connected

to the couple's process, and hence pivotal in contributing to the development and maintenance of safety between partners. The second major theme to be discussed regarding the role of the Imago therapist thus includes evident permutations of this inherent paradox and the significance this holds within their role.

4.5.1 The Responsibility of Holding

As noted in the first theme, once the therapist has imparted much psychological knowledge to the couple to help enable safe connection between them, there is a significant shift in their role to a more *"background"* position. In spite of the clarity with which participants described their initial informative or educative role, elaborating on further critical dynamics of being in the background were not 'clear-cut' so-to-speak and most participants appeared to be in touch with the difficulty of trying to describe the complex, and sometimes contradictory nature of this aspect of their role. This 'grey' area brought to light a significant paradox in the role of the therapist. That is, although participants stressed the role of *"placing responsibility"* with the couple to work through their own relationship conflict, the facilitative role of the therapist to enable the couple to reach the point of taking such responsibility is paramount within the process, albeit a less obvious position within the process. As seen in the following quotes, participants refer to their role in the capacity of a facilitator or coach to the couples' process of dialoguing or connecting in a safe way as though the responsibility for safe connection lies solely with the couple.

P2: *... then I move more to the background and it becomes a facilitating, or a coaching kind of role, where they then 'do' the tools so as to strengthen the connection between the two of them, and to do the work between the two of them – because it doesn't help that they have a relationship with me or that I understand what's going on and that I'm hearing them and that I can validate them, but they can't do that for each other* […] *My role enables safety in the way that it establishes the relationship between them and it helps them to look at the wounding within themselves and in each other and to facilitate that in each other. To facilitate safety and connection in the space between the two of them. My role enables that, the fact that I do step out of things and I don't go into things too much.*

P8: *My role is really to teach them to communicate, and the connection, to give them the skills so that they can become the therapists in their own marriage. So it's more a role of a facilitator versus a therapist.*

The same participant adds:

Making them take responsibility for their own relationships […] It's empowering them for them to take responsibility for their own relationship versus them coming in and you being told this happened this week and you've got to sit there and try and fix it.

P6: *I suppose in the true sense of Imago your role is really as the facilitator, that the marriage is the therapy and you facilitate a process of healing that occurs between the two of them.*

P4: *It's not a therapy where the therapist doesn't analyse. Sometimes they'll comment or talk about it, but the therapist's role is to help people connect with one another and to provide a structure where they can learn to do that for themselves at home and not be dependent on the therapist and that there's really one basic skill, which is called a dialogue.*

Whilst participants stressed the importance of allowing the couple to take responsibility for their own conflict by *"leaving them to actually do it"*, or *"do the tools"* (the dialogue), and that it *"doesn't matter"* if they as therapists *"understand"* the dynamics between partners, responses also speak of a less obvious but critical role of holding the couple within this process so that they can "*eventually be responsible for their own behaviour, dialoguing and therapy",* and *"so that they can learn to do that for themselves".* Responses tend to be articulated in such a way however, that the therapist's role of establishing safe connection between partners is minimized relative to that of the couple so that the involvement and responsibility on the part of the therapist in this process may be overlooked. For example, although participants refer to their role of 'enabling safety' between partners, 'helping people connect', or 'giving them the skills to become therapists in their own marriage', emphasis is not placed on *their* role within this process but rather on how the couple is made responsible to do the work. In this regard, Applegate and Bonovitz (cited in Urdang, 2002) speak of the unique usefulness of

Winnicott's concept of the holding environment in articulating the 'silent', supportive, and sustaining role within social work across service settings, and in this case the role of the therapist.

This brings to light the similarity of roles between the Imago therapist and the 'good-enough' mother as described by Winnicott, as well as the inherent paradox within the concept or role of holding provided by the mother, and ultimately the subtle creation of a holding environment. According to Winnicott, holding refers to the quality of the mother's care for the infant without which the infant cannot come into being (Watts, 2002). For Winnicott, the therapist's task thus becomes to provide a holding environment for the client so that they have the opportunity to meet neglected ego needs and allow their true self to emerge (Jacobs, 1995). Responses indicate a similar therapeutic role of holding the couple so that they can 'come into being' as individuals in order to create a space between them that is safe and conscious – a space made safe by the holding support of a therapist/parent where connection can take place at the level of partners' true selves interacting. Responses to follow highlight this paradox of essentially holding the couple so that they can be left to hold one another within the holding environment that is initially created by the therapist.

P3: *I always say to my couples that my job as an Imago therapist is to work myself out of a job ASAP – so that they won't need me. […] Down the line I believe I'm a good therapist if I can sit back in my chair and they can go on as if I'm not even there. Then the witness has become an internal witness – the safety has been built, they don't need an external presence to be the anchor of safety.*

P5: *Obviously the whole Imago model is allowing the couple to eventually be responsible for their own behaviour, dialoguing and therapy – so that they can go home and practice what they've been taught […] We are coaches. You tend to allow them to create their space and teach them the safety in which they can move.*

P1: *You're just the facilitator. The growth happens between them... I create such a safe space between the couple that they become so involved in the process that I can sit here, I*

just say something now and then to facilitate it, but the growth is happening between them.

P4: *...the therapist's role is to help people connect with one another and to provide a structure where they can learn to do that for themselves at home and not be dependent on the therapist ...*

However, the good-enough mother providing this holding environment need not be perfect or ever-present (Urdang, 2002). In this sense, holding is also inherently paradoxical as it involves symbolically 'letting go' of the infant so that the infant's true self can develop, or in Imago terms, so that each partner can develop a differentiated self and break symbiotic fusion referred to in Mahler's theory (Gerson, 2005). This seems to be mirrored in the role of the Imago therapist as the therapist gradually shifts more responsibility to the couple to hold one another. For this to happen however, the good-enough therapist must remain silently supportive in the background, thus ever-maintaining a holding environment for the couple even though partners are viewed as becoming therapists for one another.

The good-enough mother therefore tries to provide what the infant needs, but instinctively and progressively reduces the time lag between the satisfaction of the infant's demands (Jacobs, 1995). The good-enough mother, who starts off with almost complete adaptation to her infant's needs, gradually adapts less and less completely according to the infant's growing ability to deal with her failure (Winnicott, 1953, cited in Jacobs, 1995). The paradox herein is that in addition to support, *"optimal frustration is necessary for ego building"* (Grolnick, 1990, p. 31, cited in Urdang, 2002). As indicated quite distinctly by participant one and three, the therapist aims to become increasingly less involved in facilitating the couples' process so that this 'holding' function of the therapist can serve as an *"internal witness"*, silently holding them in connection.

4.5.2 Connection in Separation

Moving deeper into the role of the mother/therapist who embraces the role of creating a holding environment for the infant/couple, is the paradox of remaining connected to partners and their process, whilst also remaining separate from them. As participants continued to elaborate on their role as Imago therapists they unwittingly seemed to become more in touch with their active part in the therapy process. That is, although most participants began by stressing the importance of placing responsibility between the couple to connect with one another, responses highlight the somewhat 'invisible' role of the therapist of remaining constantly connected to, and present within the couples' process in a pivotal way.

P4: *So for me it's a completely paradoxical therapy where you work at one level and where something else is happening at another level. At the one level there's so much structure, and at the other level there's so much freedom for free association […]. There are so many levels at which it works and it's all a coherent framework.*

P7: *… as an Imago therapist you're much more active in the containment, meaning that if they get out of hand you have to say 'stop' and get back into your role, so you actually take up a much more active position in keeping the frame as opposed to psychoanalytic – you don't dictate. You actually keep your structure and you keep working your structure – if they break it you put them back into the structure.*

P8: *Yes, it's all the managing of the process – the pacing, the tone of voice, helping absorb emotion, keeping them in the process because it's very easy to jump out of the process …*

P6: *I think adding onto my role as facilitator is really joining the couple's system, so I'm not sitting as an expert giving input. I'm really joining with the whole process. You can look at it in terms of post-modernism in that you really try and not be a person sitting on the outside, but that you really step in and join with that system and co-create a new reality, understand the stories that have gone awry and work in co-creating a healthier story…. you are working and creating understanding, but you're not sitting as an expert outside of it. You're very much an active participant in co-creating the story with them.*

As described by participant four, the therapist is *"active but not too involved"* in creating safe connection between the couple. Participant four's response speaks of this innate but delicate balance required by the therapist to maintain *"structure"* within which the couple can function whilst simultaneously allowing partners the *"freedom"* to be healers to one another. This is reiterated by participants seven and eight who refer to the active position of the therapist in keeping the frame and keeping the couple in the process. On the other hand, participant six refers to an essentially converse role of joining the system or the couples' process. Responses indicate that although they are responsible for establishing safety between the couple, this is in fact a role of *co*-creating safety and that they are *active* in maintaining the process *between* the couple rather than *actively participating in* the couple's process. Such 'joining' is therefore a function of being emotionally present with the couple in order to gain emotional insight into their relationship, but *without* participating in their relational dynamics as the responsibility to work through their dynamics stays between the couple. In this way emotional access is gained to the couple's 'space' yet the therapeutic relationship does not become triangulated.

The subtle paradox of Winnicott's good-enough-mother who must essentially remain separate and connected to the infant simultaneously for the sake of the infant's developmental potential, again seems to parallel the inherent paradox in the role of the Imago therapist of remaining separate and connected at the same time. Through being separate but still acutely connected and attuned to the infant's world, the mother assists the infant in gradually separating from the mother whilst still holding the capacity to connect to the other and to the self in a differentiated manner (Watts, 2002). In the words of Winnicott, this constitutes *"the separation that is not a separation but a form of union"* (Winnicott, 1971, cited in Jacobs, 1995). Firman and Gila (1997) refer to this phenomenon in terms of Winnicott's insight about the mother-infant relationship as a paradoxical synthesis of dependence and independence, of connection and freedom. That is, the experience of being or of existence as an independent human being depends on a relational source of being and develops from the relationship between the infant and the "good-enough" mother (Firman & Gila, 1997). In this way, through being separate, the therapist is in fact creating connection between partners.

The following participants expand on this paradoxical role of *co*-creating a healthier relationship between partners as they refer specifically to the therapeutic structure or frame constituted by the actual dialogue process which they must actively maintain, versus their previously described 'background' or facilitative role of allowing the couple the freedom to explore whichever areas of their relationship they feel necessary. The therapist thus seems active in following the couple's lead – *active* in the sense that they keep the couple from 'breaking' the emotional connection provided by the dialogue, and *following* in the sense that they are not getting involved in the content of the couple's problems or directing the couple toward what the therapist feels they 'should' explore in their process.

P1: *...I know emotionally you're part of the space, but you're actually not part of the space. I create such a safe space between the couple that they become so involved in the process that I can sit here, I just say something now and then to facilitate it, but the growth is happening between them.*

P5: *It's a very privileged position and a humbling experience to watch couples connect at a depth. You're outside the process and it's their process, but it is a blessing for you that people allow you almost into that space in terms of their own growth and the depth of their connection and to know that you facilitated that. So as a therapist it's a really nice feeling even though you don't do too much, but to watch that connection and see how people grow and blossom is a very special space to be in.*

P4: *...the energy flow between the couple is far stronger than it is in most therapies. In most therapies it's conducted by the therapist, so it's a triangular process**.** Even though the therapist is part of the process, the couple forget you're there if it's really working well. They really do, they sort of look at you as if "who are you?" at the end of the session. If they've really connected, it's almost hypnotic…*

This participant adds:

Sometimes they don't even realise how much you've been involved because they are in the emotion and then the thing is to move out as soon as there's a sense of safety and stability, and to go in only as much as you are needed.

P7: *... so there's an interior thing happening all the time, because you've got to be in touch all the time to know what's going on, but you leave it to them to actually do it. I've learnt the hard way that if you leave it, it will happen. You've got to trust it and it might take weeks and weeks, but it will happen.*

The paradox of this active, yet uninvolved role is also evident in the above responses indicating that couples may not even realize the extent to which the therapist has been present and involved, and that the couple is often unaware of the therapist's presence. Alongside the 'silent' holding role of the good-enough mother Winnicott sees the key role of the mother as adaptation to the infant which allows the infant a sense of control, subjective omnipotence, and the comfort of being connected with the mother, whilst allowing the infant to 'transition' at its own pace to a more autonomous position (Jacobs, 1995). One might speculate the therapist's role to mimmick this process as the therapist must 'leave them to actually do it', yet the therapist's presence appears to give the couple a sense of control and omnipotence with which to explore their relational space in safety. The nature of such holding is thus critical to the process of maintaining safe emotional connection between the couple and involves active participation from the therapist by remaining emotionally in touch with, and connected to, the couple's process. In this regard, participant four succinctly describes the therapist's role as *"pivotal but invisible"*.

4.5.3 A 'Non-Expert' Role

When asked about ways in which their role as Imago therapists was perceived to be distinctive from the role of therapists in other forms of couple therapy, participants emphasized the view that the therapist is not an expert in the role. As evidenced below, participants seem to equate an 'expert' role to advice-giving, problem-solving, giving explanations, having the answers to couples' problems, getting involved with the content of couples' conflict, and attempting to change their behaviour. Upon closer inspection of responses though, the established role of the therapist paradoxically appears to incorporate a great level of expertise by the therapist that is seemingly not acknowledged or simply not recognized by participants to imply an expert role.

P1: *My problem with other therapies is people will come in and they see you as the qualified person with all the answers so they put their problem on your lap and say solve it, you're the expert, you've got the answers. With Imago Relationship Therapy I think what they realise is that the answers are within them, I'm just the facilitator […] So they trust themselves, they trust the process, I don't get involved in the content, I don't come up with answers because I haven't got the answers – no therapist has got the answers.*

P3: *With Imago you don't have to come up with the explanations – if it's mirrored, people get the realisations themselves. (3.3)*

P5: *A big difference is that very often when you're a therapist in normal couples therapy you take a lot of responsibility for solving the problem, or giving suggestions and all the rest of that – whereas with Imago the couple comes to that resolution themselves. If you look at the one principle of Imago therapy – it says that the relationship is the therapy, the marriage is the therapy ...*

P4: *It's easier to describe it as how it's different from other therapies. It's not problem solving, it's not the therapist being a mediator between the couples – it's a way of connecting a couple and I think that's where it really is different [….] The therapist's role is to watch for things getting out of hand and too much tension building, and to pace and manage the process and guide them in absorbing their emotions and dealing with their emotions without breaking their process. So the therapist is very much a manager of a process, not of content.*

P8: *In some couple therapies when you are the therapist, it's 'mommy here's my problem' – you're suddenly the mom and you've got to sit there as judge, jury and executioner and you must fix them. While Imago is very different, as in you are responsible for your own relationship. […] It's empowering them for them to take responsibility for their own relationship versus them coming in and you being told this happened this week and you've got to sit there and try and fix it. It's a very different space. […] I think an Imago therapist creates the space – because you're not coming off as an expert…*

P2: *I can't just change their behaviour, I can't just tell them from now on you need to speak to each other in this particular way and that's that. […] It doesn't take the triggers away and they can't step into this new way of behaving before healing hasn't taken place at the same time.*

P6: *I think adding onto my role as facilitator is really joining the couple's system, so I'm not sitting as an expert giving input.*

Whilst participants were not explicit in naming the other types of therapy to which they referred, several of the descriptions of the so-called 'expert' role of the therapist pointed out may be noted in other forms of couple therapy. For instance, in both BCT and CBCT the therapist displays a role of collaborating with the couple in order to identify and modify specific problematic behaviours, cognitions, and emotions that contribute to the couple's distress (Epstein & Baucomb, 1998; Long & Young, 2007; Patterson, 2005). In so doing, these therapists take on a role of mediating and managing the couples' content rather than their process (Baucomb et al., 1995), which contrasts the role of the Imago therapist as referred to by participant four above. As the therapist's focus remains largely on content, the therapist gives explicit interpretation of the couple's interactions, tries to shift their conceptualization of the problem by assisting the couple to see how each one's negative cognitions and behaviour contribute to the cycle of negative and distressing exchanges, and advise partners how to interact with one another in more appropriate ways through teaching various skills (Epstein & Baucomb, 1998).

The role of the therapist in EFT is not dissimilar, as the therapist may actively evoke emotional experiences in the couple or partner as the therapist sees fit, and set up new interactions and/or relevant task between partners as seen fit by the therapist (Johnson & Greenberg, 1995). This distinction may also be evidenced between the role of the Imago therapist and psychodynamic couple therapists where therapists take on the role of clarifying the difference between what one partner intends and the other perceives (Polonsky & Nadelson, 2003). Therapists engaging in these types of couple therapies may be viewed as giving expert advice, taking on the responsibility of solving couples' problems, and seemingly assuming a position of knowing what is meant and intended in the couple's communication.

Whilst some types of therapies do take on such active and directive forms of expertise in the role of the therapist, responses above attempt to highlight the perceived non-expert nature of the Imago therapist's role as the dialogue serves to enable partners to come to such realisations themselves rather than relying on expert interpretations and advice of the therapist. This view is more in line with that of Rogers' person-centred approach, which opposes the assumption that the individual cannot be trusted and instead needs to be *"directed, motivated, instructed, punished, rewarded, controlled, and managed by others in a superior and 'expert' position"* (Corey, 2008, p. 169). Moreover, the role of the therapist as an authority who knows best is rejected by this approach (Corey, 2008). However, in spite of the assumption that clients have the resourcefulness for positive movement without the therapist taking on an active, directive role, the therapist's presence through being completely absorbed and deeply focused on the client, is essential for the client's progress (Corey, 2008). In this regard, the presence of the therapist is viewed as being more powerful than any possible technique used by the therapist (Corey, 2008).

This understanding of the therapist's role appears to present a similar dichotomy or paradox to that displayed in responses above as the idea of 'therapist as expert' is renounced even though the presence of the therapist seems essential in order for the client, or the couple in this case, to make progress. That is, whilst participant eight points out that the therapist is not *"coming off as the expert"*, there appears to be an innate and seemingly unacknowledged level of expertise within the role of the therapist as their attention remains therapeutically focused on the couple. This in turn appears to parallel the innate level of expertise evidenced in Winnicott's understanding of the 'ordinary' mother. Winnicott (cited in Geraghty, 2000, p. 30) suggests that the mother is *"a specialist in this matter of her own children"* and is fitted to her task *"in its essentials by her biological orientation to her own baby"*. Winnicott expands on this, saying that it is the devotion of the ordinary mother that makes her the expert and the only one who can know how to act for that particular baby (Winnicott, 1965). The expert presence and 'devotion' of the mother to her child seems paralleled in participants' views of their role in the way that they engage with the couple. For instance, responses stress the point that the therapist does not *"come up with the answers"* and instead how partners *"get the*

realisations themselves" or *"come to that resolution themselves"*. Here participants seem to view their role as distinctive from the roles of other couple therapists because through use of the dialogue, couples become experts in understanding and resolving their own relationship conflict. However, as pointed out by participant eight, it is the therapist who *empowers* the couple to reach the point of becoming confident in resolving their own relational issues. Moreover, the therapist must constantly *"pace and manage the couple's process"* and *"guide them in absorbing their emotions"*. Therefore, whilst participants' experiences of their role are based largely on an attitude of allowing partners to remain the experts of their own relationship – and that this translates for them into assuming a 'non-expert' role – the finer detail of enabling partners to engage with one another as experts appears to require a distinguished level of expertise by the therapist.

4.6 Theme Three: A Congruent Role

The next prominent theme observed by the researcher centred largely around participants' experiences of both the positive and negative aspects of their role as Imago therapists. Responses highlighted aspects of their role that they found particularly helpful and useful, as well as areas that they felt to be limiting or needing expansion and revision. It was interesting to note however, that participants appeared to deal with the highlighted strengths and weaknesses in a very congruent manner. That is, participants appeared to respond to difficulties within their role in a way that seemed in keeping with their internal perspective of how best to adapt to these situations, which seemed to make dealing with these difficulties a congruent experience. With regard to the significant strength noted, participants also indicated this aspect of their role to be experienced in a genuine and authentic manner, thus highlighting a great deal of congruence in delivering this specific task within their role. Such a level of congruence when dealing with distinguished aspects of their role is in turn viewed as beneficial to the therapeutic encounter given Rogers' (1980) stance that the likelihood of therapeutic growth for the client is increased if the therapist acts more congruently. These will be discussed in further detail below.

4.6.1 Congruence in Giving Couples Psychological Insight

When asked about the helpful aspects of their role, or aspects viewed as strengths within their role, almost all participants referred to their role of reframing conflict for the couple through psychoeducation. That is, participants experience their role of giving couples the necessary psychological insight about how conflict arises and is maintained through unconscious behaviour very positively and as a strength within their role, especially since this information is easily understood by the couple, and brings a sense of relief and safety for the couple about their relationship. However, although the content of responses refers most explicitly to a perceived strength within their role, the spontaneity and fervour with which participants responded highlighted a significant sense of authenticity that participants appear to encounter within their role. In this regard, Rogers proposes that the therapy process is likely to be adversely affected if the therapist is not fully authentic (Corey, 2008). A sense of authenticity is in turn reflective of Rogers' concept of congruence, which refers to the degree of genuineness or realness on the part of the therapist (Rogers, 1980). That is, if the therapist is congruent, there is a matching between what is experienced in awareness by the therapist and what is expressed to the client (Rogers, 1980).

P2: *I think what's very helpful is the simplicity of the theory around what is going on between them. That there are different phases in a relationship, all relationships will go through those phases and will inevitably end up in a power struggle phase. That we fall in love with a particular person for very particular reasons and let's understand what were your reasons and what maybe unconsciously attracted you to each other. They understand that, the whole misery makes sense to them immediately. I found that no matter how intelligent or not really all that intelligent people are, they seem to get that. […] that helps them understand very well and easily. It diffuses what goes on. It brings them into consciousness.*

P3: *Once people understand the concept that we want the same thing, they have a huge 'ahha'. Once they understand that we have different ways of trying to achieve that same thing […] they have a huge 'ahha'. Once people understand if I do things that will make my partner safe they have a huge 'ahha' with that. So there are simple things that could*

simply be put in place – although behaviour is quite difficult because it goes against all our instincts. I find this excessively and hugely helpful.

P4: *When they get that thing about the unconscious agenda and the childhood wounding and how it's repeating, I think that balances things out a lot where the blame gets diluted a lot.*

P5: *... explaining the basic underlying Imago principles together with some idea that their behaviour's probably normal so that they kind of feel relieved because I think their greatest fear is that you're going to tell them who's at fault and who's right. The nice thing about the Imago theoretical background is that nobody is to blame and you need to sort out your own stuff and take responsibility for it. It immediately makes people feel safer.*

P1: *That already makes a big difference – you cannot believe it. They normally cry when they leave the office. 'We know we're at the right place, we didn't know this'. So immediately you make them feel safe and what happened in their relationship is normal and 'wow, we're not the only couple that look like that', all couples, their relationships look the same.*

P7: *It certainly is dispensing skills and giving couples something to walk out with and take home with them, and I think that's hugely helpful. There is something that they can learn and implement. I think related to my answer in the previous question, it's just the release that I felt in the reframing of conflict and thinking about things in a very different way. Giving them a way to do that. It's been very valuable for me.*

Responses above indicating how *"hugely helpful"* and *"valuable"* participants find their task of giving the couple information and skills suggests that participants really believe in what they do. Coupled with this is participants' genuine appreciation of the sense of relief experienced by couples as a result of giving them information with which to understand and deal with their conflict. These experiences of realness and genuineness by participants imply a strong sense of congruence within their role, where their internal positive experience of this aspect of their role seems to be matched by the positive way in

which they embrace this task and carry it out within the therapeutic encounter. Congruence or genuineness is also considered the most fundamental of the attitudinal conditions referred to by Rogers, where the more congruent the therapist is in the therapeutic relationship, the greater the likelihood that the client will experience therapeutic growth (Rogers, 1980; Thorne, 2003). Given participants' responses indicating the great sense of relief and safety (or therapeutic growth) that couples are perceived to experience after receiving information and skills from the therapist, one might further deduce participants' to experience this aspect of their role in a congruent way.

In particular, participants viewed the *"simplicity of the theory"* as a very helpful aspect within their role as the information given to the couple is easily understood by them. According to Jacobs (2003, p. 28), *'Winnicott's capacity to convey his observations, observations that we too have made but have not yet fully registered, means that time and again in his writing the reader nods in assent, and smiles at the pleasure of recognizing the particular significance he gives to common experience'*. In much the same way, this seems to parallel participants' perceptions of how couples 'nod in assent' so-to-speak in response to the psychological insight given by the therapist and 'smile in pleasure' with relief as couples recognize the significance of 'common experiences' within their own relationship. Participants appreciation of this response from the couple may be seen to contribute to the overall experience of congruence in the therapist's role as the "simplicity of the theory" that essentially describes 'common experience' to the couple is experienced in a helpful manner by participants. Such a high level of congruence is also critical in promoting a climate in which individuals can move forward and become what they are capable of being (Rogers, 1980). Moreover, given couples responses of embracing this information in a very positive way and 'moving forward' significantly, one might conclude that this aspect of participants' role is also experienced by couples as a congruent interaction.

4.6.2 Flexibility to Engage in Therapeutic Interpretation

The message underlying the following responses may also be viewed as twofold as participants not only highlight a significant limitation experienced within their role, but

also bring to the fore the underlying sense of congruence that seems embedded in their experience of their role. In the context of describing perceived limitations or unhelpful aspects of their role as an Imago therapist, participants highlighted their need for more explicit interpretation in particular situations instead of relying purely on the dialogue between the couple for interpretations to arise and be addressed only by the couple. In this regard, it was suggested that the role can become too *"unanalytical"* at times. However, responses also highlight participants' experiences of deviating from this prescribed role because it does not fit with their internal view of what needs to happen for therapeutic growth to occur, so adding to the congruent nature with which they seem to approach their role. Participant eight's response, for example, reflects the notion of being authentic and congruent within her role as an Imago therapist as she highlights that *"you are who you are"* and that this is reflected in how you approach your role.

P4: *Sometimes being too neutral – being too unanalytical. I think sometimes that can be a fault.*

When asked whether this implied the need to interpret more for the couple, the same participant responded:

"Yes, or help them understand the dynamic in a much clearer way than just letting them work it out."

P8: *Well you know when you get trained as an Imago therapist the first thing they say is that you've got to switch off your thinking cap, you've got to switch off that training and go to a different space. I don't believe that. Through my experience I don't believe you can do that. You are present, but you are who you are and you have to use your interpretations and you have to use your therapeutic skills.*

Additional responses highlight the congruence between what participants view to be a limitation within their role, what they think such situations require on the part of the therapist, and how they ultimately choose to respond to this incongruence so-to-speak, in a congruent fashion instead of responding in the prescribed facilitative manner.

P7: *I think the rigid way of Imago where the therapist ... say for instance if you have somebody who's really battling to validate and you know where they should go [...] so*

to be able to start to make interpretations – if I sat in those purely facilitating Imago, we would sit forever because he would not own his depression. […] The limitation then is you don't make an interpretation so when he's battling and she has not seen his depression – to make an interpretation, 'I'm wondering if there's something about her depression that rattles something in you' – I will then speak from my position, moving out of the pure facilitative or coaching role. So if I couldn't do that I'd find it quite frustrating, because in the end it all becomes quite mechanical so that's the downfall of Imago.

***P5**: I suppose if I went the true Imago way I'd see myself as coach, but I don't believe that anybody is purely a coach. I think that one does rely on one's intuition and one does use psychoanalytic psychotherapy intuition to move things. So if you feel that people are just on the cusp, it's not merely coaching, it's saying 'well I'm wondering…, and when you do that I'm wondering…' – just to deepen things. So it is a coach, but I think there's a deeper role involved.*

***P1**: If I see they don't make the connection, I will get a little bit more involved and say 'remember what was the frustration this morning when we started, I feel frustrated when you don't hug or kiss me ... going back to where we are now'… then I will get a little bit more involved to make them grasp it, to see the connection. So if I see they're missing it, then I will get a little bit more involved in the content, but otherwise if it flows and they get it then it's not my place.*

***P4:** Interpretation, I would ask more questions like 'what did you notice', or 'what do you think about this'. Not so much giving an interpretation as trying to get something from them. Or I'd say 'I noticed something, what does it mean to you'. This is still highlighting, there's no way a therapist can't because I would miss things that are outside my framework and I'd pick up things which are within my framework. So there is always a level of interpreting, even the sentence stems are a form of interpretation because I'm highlighting an aspect and pushing something – like 'what worried me the most about that is …' - it's already giving a slot, but hopefully a fairly open-ended one.*

P8: *...you will point out in different ways and say what is similar between this and the last time. What is that core feeling? […] And I might point things out to them, depending on the situation. I'll say to them "what is common between this dialogue and another dialogue that you had?"*

P6: *So very often they need a bit of direct intervention in terms of "I see a link here, what do you think, does it resonate with you?" Just to point out what is obvious and then get them back into dialogue, and often a lot more comes up in dialogue.*

As noted in theme one, participants' understanding of their facilitative role indicates a position of being largely in the 'background' due to keeping transferences between the couple and refraining from making therapeutic interpretations, as unconscious material is intended to be worked through and understood within the dialogue process between the couple rather than in the couple-therapist relationship. Whilst this is in keeping with Imago literature that implies a therapist role of remaining outside of the couple's relationship and avoiding 'expert' functions of interpretation and confrontation (Hendrix, 2005), participants' responses clearly indicate a tension regarding the degree to which this is possible and beneficial within the therapeutic process. This apparent tension seems to imply a need for a certain amount of flexibility in the role of the Imago therapist that allows for a greater degree of interpretation by the therapist to 'move things' for the couple and help them 'see' certain connections when the dialogue process proves inadequate in moving the couple to a point of safer and more conscious connection.

In terms of Rogers' person-centred approach, this 'tension' may be viewed as an incongruent experience for the therapist, where there is conflict between what is genuinely experienced internally and what is ultimately conveyed or communicated to the client (1980). To overcome this, or to achieve congruence, Rogers (1980) points out that there must be a close matching between what is being experienced at the gut level, what is present in awareness, and what is expressed to the client. From the above responses one may deduce that participants indeed have a strong sense of awareness and recognition of a particular limitation within their role, which does not appear to resonate with them at a 'gut level'. Participants in turn respond to this incongruence within their role in a congruent manner by acting in accordance with what they experience as real and

intuitively necessary when dealing with couples. According to Rogers (1980), when this phenomenon occurs, it means that the therapist is openly *being* the feelings and attitudes that are flowing within at the moment, and thus engaging in a congruent and constructive manner that is more likely to enable therapeutic growth.

4.6.3 Dealing Congruently with Early Wounded Couples

The need identified above for participants to be more flexible in their role as Imago therapists is evidenced most acutely in dealing with 'early wounded' couples. Moreover, participants' responses of how they choose to engage therapeutically with such couples are especially reflective of being congruent within their role. 'Early wounded' couples refer to couples assessed by the therapist to have encountered their most significant emotional wounds during the earliest developmental stages of Hendrix's adapted version of Margret Mahler's developmental stages, known as the attachment and the exploratory stages (Fein, 1998). Such couples are typically highly emotionally reactive and impaired, and often display a reduced capacity for empathy and emotionally containing their partner due to the lack of containment and empathy in their own upbringing (Fein, 1998). Essentially, they desperately want their own needs met but find it difficult to meet their partner's needs. Upon reflection of possible obstacles and limitations in their role as Imago therapists, participants almost unanimously referred to their experience that remaining in a purely facilitative or coaching role when dealing with such couples is inappropriate and may even be damaging to the couple. Participants' strong sentiment of disagreement in dealing with such couples in the usual facilitative Imago role is reflected acutely by participant eight in the following response and again highlights the desire for a more congruent experience when engaging in their role.

P8: *I don't believe that Imago's for all couples – not at all. […] I think the bottom line is that you have to choose who it'll work on in terms of this role and I know they say that you can use Imago for early wounded couples, but I find that early wounded couples are very damaging to each other, and maybe I'm not strong enough within that space, but I'm very choosy who I'm going to work with in this process. […] This type of work is very, very deep and you have to have a couple that are committed to each other, that they want to work on this deep level, it's a very vulnerable level, it's a level where you bare your*

soul to each other. It's an honour to work at that level. If one part of that couple is not going to go to that state it's too dangerous and I don't want any part in that process.

Although Imago literature highlights the immediate and important challenge to establish safe connection with both partners by engaging in the process of the dialogue with each of them when dealing with early wounded couples (Brown, 1999; Fein, 1998), responses seem driven by personal experiences of having difficulty dealing with these couples and hence wanting an experience that feels better, rather than by theory. This is reflected below in the need to be more congruent in their role as they act according to what they *believe* is necessary for a healthy therapeutic encounter by engaging with couples in ways they experience as more fitting and more constructive than the traditional facilitative role. As reflected by participants four and five respectively, *"you can't just apply a technique"* and *"you can't go by the book all the time"*. Whilst these responses seem to indicate a willingness by participants to be flexible in their role, doing so involves embracing their *"intuition"* and their *"feelings"* so that their therapeutic experience is a more congruent one.

P5: *It's easy to say you're a coach, but if you're dealing with a couple, and the partner who's receiving is not coping, you've got to be able to pick that up and help them to be there and stay there and when they kind of run out of the room and dissociate, to bring them back in. Or if it's hitting on their own childhood stuff and their anger and frustration comes out, you need to be able to recognise that and keep them there and bring them back to be with their partner [...] If you don't see that as the therapist you're going to mess up the whole session badly.*

P8: *...the traditional Imago role I don't feel is helpful with very wounded couples – the one of letting them come up with finding their solution and their equilibrium [...] That whole theory is very useful, but the attachment and the early exploration wounded couples are the hardest to work with [...] You've got to do it much more slowly and be triangulated – it's more like traditional types of therapy...*

This participant elaborates by adding:

But then you would do a lot of the mirroring and then almost half of the part is to mirror you so that they get used to mirroring and then you ask them to mirror ... so you play around with the same process, but you're much more triangular.

P2: *Sometimes there I have to play a more active role and I can't place that role with them. Then I do the mirroring and I do the validation in front of the other so that they can witness it because I believe that that develops […] it's just that it's not possible for them to do that yet for each other so we have to develop it.*

P6: *So depending on who you're working with you have to choose what you're working with. Even though parent/child dialogues, some people can handle it and others can't, you've got to work with who you're working with and you've got to understand the couples because sometimes that is just so humiliating […] I think that's where your therapeutic ability must come in and your intuition and your feelings. You can't just treat everybody the same, you've got to know who you're working with and why you're working with them – and check out the situation. You can't go by the book all the time, which some people do. I've had couples come in and say that was the worst experience and they never want to do Imago again.*

P1: *So with attachment couples the only problem I've experienced with that is the clinging behaviour. They tend to cling to the therapist – but it's due to their wounding – so you need to become the person that's providing the answers for attachment couples. […] So I always wonder if Imago is really helpful – it is helpful with attachment couples, but they're definitely very long-term therapy.*

P7: *I just slow it down completely, so I don't even ask them to validate each other. We could sit for a year and not even get into the validation stage – because they can't. The narcissist cannot empathise. But it does take a while and that's not Imago, it's my psycho-analytic training.*

P4: *... like I know that certain therapists do the looking into each other's eyes very powerfully and there are certain couples that can't handle that and they run, they don't*

come back. So they're the kind where you say just peep. You can't just apply a technique – there's a level at which there's expertise (4.7).

Although only two of the above participants refers explicitly to the role of mirroring the couple's process for them, all responses imply this to be the way in which they deviate significantly from the 'traditional' Imago role of being a coach or facilitator. In addition to previous discussion on what it means to be congruent, person-centred therapy adds that to be congruent, the therapist must stay in the present and reflect (O'Brien & Houston, 2007). Reflecting refers specifically to mirroring and describes the therapeutic skill of giving back to the client a picture of what has just been conveyed by word or deed (O'Brien & Houston, 2007). In doing the validating, the therapist must be able to mirror or reflect each partner's world at a core level as suggested by O'Brien and Houston (2007). As referred to by participant seven, engaging one-on-one with respective partners by remaining present and mirroring their experiences *"does take a while and that's not Imago, it's my psychoanalytic training"*. In this way, the essential function of mirroring taken on by the therapist instead of by partners makes this shift in their role *"more like traditional types of therapy"*. Whilst mirroring is not unlike the core-level reflection of psychoanalytic interpretation in that the therapist's experience and viewpoint are implicit within it (O'Brien & Houston, 2007), inclusion of their viewpoint and experience also seems to contribute to a more congruent experience within their role. Moreover, the more congruent the therapist is, the more chance there seems to be of the couple being able to reach a space of being able to mirror one another and be congruently and genuinely present with one another. The therapist's congruence of holding the couple in a more active manner than what is suggested in the prescribed Imago role thus assists partners in reaching a healthier and more congruent spaced themselves.

In addition, although this seems to bring into question the purely facilitative role of the therapist as advocated by Imago literature (Hendrix, 2005), it also presents a helpful example of how greater exploration and description of peoples' experiences in research adds to the development of theory and practice (Kazdin, 2003). Moreover, the apparent discrepancy between the intended practice of the Imago therapist and their experienced role whilst doing therapy contributes toward fulfilling the need expressed in couple therapy research to examine actual in-session therapist behaviours as a means of better

informing therapists about the challenging change process in therapy (Beutler et al., 2004; Bradley & Furrow, 2004; Heatherington, Friedlander, & Greenberg, 2005). Findings such as this that describe therapist behaviours are also considered very helpful in narrowing the gap between research and practice in the filed, as it provides clinicians with practical and conceptual information relating to the practice of various types of therapy, which in turn acknowledges the complex processes inherent in therapy and contributes to the rich theory required to explain practice (Sexton, Ridley, & Kleiner, 2004).

4.7 Theme Four: The Imago Therapist in South Africa: A Universal Role

Working as a psychotherapist within any diverse population is bound to have its challenges. Although this was also the view of participants in this study, their view of working with diverse couples within a South African context reflected not only a generally positive outlook in terms of dealing with challenges of diversity, but also appeared to reflect IRT's underlying ontology of connection founded in quantum theory. That is, participants seemed to view these challenges as secondary to couples' seemingly inherent tendency and need to connect. Other responses however, indicated views that reflect assumptions of difference and diversity as primary in human behaviour, rather than assumptions of universal connection as primary. In both instances however, participants did not seem to make a connection between underlying Imago theory which advocates that human connection transcends the boundaries of cultural and other diversity, and their general experiences of practicing with a diversity of couples. This in turn poses questions regarding the significance of underlying theory in practice, specifically relating to what set of assumptions informs the role of the Imago therapist most significantly. According to Gentile et al. (2008), theory is commonly understood to be a set of assumptions that inform the practitioner's understandings about human behaviour, about what constitutes mental health and illness, and about various factors that account for an individual's status. As noted by Brown (1999, p. 22), *"whether therapists know it or not, they are always referring to a theory"* and *"when a couple presents the therapist with something unexpected and/or new, the therapist needs to be able to refer to a theory for guidance"*. Theory is thus constructed by a set of principles that informs

practice in the way in which the therapist *thinks* about a client and applies or offers interventions (Gentile et al., 2008). In treating relationship conflict in a country as culturally and otherwise diverse as South Africa, one may regard theory as especially important as it must inform the way the couple therapist thinks about the experiences of diverse couples.

4.7.1 Connection in Diversity: A Universal Principle

When asked to reflect on their role as Imago therapists as it pertains to working within South Africa's diverse population, participants generally indicated that they experience their role similarly across cultures and various population groups, and that they did not necessarily feel limited within their role during these therapeutic encounters. Whilst participants' observations and experiences of working comfortably with a diverse range of couples may, for instance, be seen to reflect social or psychological theories that may account for experiencing their role similarly across cultures, responses also correspond significantly with the underlying ontology of connection that is central to Imago theory and hence to the role of the therapist. Responses do not, however, indicate that participants are aware of this apparent connection between fundamental Imago theory and the way in which they experience diverse couples within their role. This raises questions about the influence and significance of Imago theory on the role of the therapist.

P7: *For me I've had experience across the range. Cultural, language […] gay couples, homosexual couples, mothers and daughters together. For me the thing is you get personality disorders – the culture is minimal. If you think every culture, every mother looks at their child – for me it's just about personalities using culture as an excuse because ultimately they look at each other – well that's what we're aiming for, we're aiming for connection. When you explain that to people they get it. I'm so cynical – I believe we're not different.*

P6: *I think that no matter what culture or what race – humans are humans and they all want to be heard and they want safety and connection. It's a universal human need. […] I think that applying it to whatever race or culture doesn't matter. […] I've worked a lot*

with gay males, not that many females. Yes, they have their own unique stuff that they bring in, but they're no different to heterosexual couples and Muslim couples – whatever it might be, if you create the safety and the holding – their relational needs are the same.

P5: *Yes and I've used it across all racial groups very successfully, and gays and lesbians. […] I've used it very effectively with parents and children. Very, very effectively. With teenagers it's amazing in terms of connecting with parents and making parents shut up and listen.*

This participant adds that even in the context of working with diverse cultures:

"…once they start doing dialogues and behaviour change requests, the pain and the healing is the same".

P3: *I've seen couples of all race, denominations and colours – high up political people, cross-cultural marriages and I have found Imago can cross over cultures. I believe Imago is a very powerful modality […] I think because Imago at core is a universal and spiritual principle.*

In spite of highlighting some difficulties experienced with specific cultural groups, participants four and one below also draw upon the underlying cosmology of connection upon which IRT is based, which translates in their role as being able to apply Imago techniques across diverse population groups.

P4: *I've had a number of clients who were either mixed race marriages or black clients and I've found that the black clients catch on very quickly and they seem to get good results very quickly and get relief from it, but they don't stick the process through. As soon as they're feeling better they go. I don't know why that is, because it's very often not a financial issue.*

P1: *I find Imago Relationship Therapy very effective with black people – I've got a lot of black clients, but we really struggle with Indian people. […] I also work with a lot of gay couples. That works fantastically – I have no problem with gay couples*

As noted above, participants' report working comfortably in their role as Imago therapists with diverse couples. Whilst their experience of their role in these situations may be attributed to possible personal belief systems or professional and/or theoretical views established as a result of theories of social adaptation, or psychological theories typically encountered during training as psychologists, and as Imago therapists, responses also reflect Imago's fundamental and unique theoretical foundation of connection mentioned before. Responses such as "– *I believe we're not different", "humans are humans", "whatever race or culture doesn't matter",* may, for example, be inferred to support concepts such as 'cross-culture' or 'transculture' learned during academic training and potentially integrated into their way of viewing diverse clients, which is in turn likely to influence how participants view and engage with a diverse range of people. Lahkar (2004) for example refers to 'cross-culture' as looking at culture from within which attests to the idea that people from different cultures are governed psychologically by different principles and do not share the same instinctual drives of sex and aggression. On the other hand, 'transculture' looks at culture from without and posits that people are culturally different but psychologically the same, and assumes that we all share the same basic instinctual drives of sex and aggression, basic and universal laws of developmental phases, and bonding and child development principles fundamental to all human beings (Lahkar, 2004).

Whilst these understandings are valid theoretical influences on the role of the Imago therapist and whilst the latter understanding may account for participants' experiences of working with diverse couples, their perceptions and experiences that couples from varied cultures and populations seem to value and respond to the essence of 'connection' within relationship also points directly to IRT's underlying ontology of universal connection. This quantum understanding of sameness and connection central and unique to Imago theory, transcends social or psychological understandings of human behaviour, and in turn informs the role of the therapist at a different level. Quantum theory that each particle is in some way present to all other particles, thus connecting all individuals, also underlies the foundational Imago technique of the Couples' Dialogue viewed as necessary to return to our original state of connectedness (Hendrix, cited in Brown, 1999; Luquet, 2005). According to Imago theory, the Imago therapist thus operates from the assumption that when this connection is restored and stabilized, what appeared to be

individual or systemic pathology disappears, and since we are all made of the same stuff or energy field, we are bound to have the same experience when in our natural connected state (Hendrix, cited in Brown, 1999). Since it is delivery of this technique within their role that appears to allow participants to experience their role similarly with diverse couples, one might infer their role (particularly that of helping couples restore connection through use of the couples' dialogue) to be a significant expression of the underlying quantum theory. This does however, raise questions about participants' awareness of the premise from which they operate during therapy in their role as Imago therapists, and more importantly, their awareness of the theory that drives the practice of IRT.

4.7.2 Difficulties in Diversity

Adding to the sense of unclarity about theory informing the role of the Imago therapist, participants' experiences of working with diverse couples did not seem to reflect the same theoretical undertones, which also raises questions about theory that is integrated as informing their role. Whilst all psychotherapy is aimed at relieving personal suffering and distress (Prince, cited in Gielen, Fish, & Draguns, 2004), various theories suggest that it attempts to achieve this general objective by means of interventions and techniques that can be integrated with the preexisting corpus of culturally shared knowledge in the milieu in which they are applied, as this is where they make most sense (Gielen, Fish, & Draguns, 2004). As a result, interventions that may work in the culture in which they were developed and intended, often fail when transferred across cultures (Gielen, Fish, & Draguns, 2004). This is often observed in culturally diverse societies when techniques proven to be effective in the mainstream segment of the population are extended and applied to members of ethnocultural minority groups without being modified (Gielen, Fish, & Draguns, 2004). Initial responses seem to support this view as participants point out several specific problems encountered when working specifically with culturally diverse populations in South Africa, such as language, socio-economic constraints, and issues of equality amongst men and women. Participant two in particular, refers to Imago theory as originating in the West and views this as a significant contributor to the difficulties experienced when working with diverse cultures in South Africa.

Although aspects of Imago theory are rooted in Western understandings of human behaviour however, the core premise of connection that informs therapeutic technique (referred to previously) also represents a shift from the traditional Western paradigm of individualism, and instead represents the relational paradigm which focuses on the relationship and the 'space between' as the unit of analysis rather than the individual or the system (Luquet, 2005). This understanding of the individual self versus the group self is also evident in many societies around the globe such as Asian and Middle Eastern societies that discourage individuation, and value interdependence and the more pervasive group self (Lahkar, 2004). Given responses below, which seem more representative of the former view, potential questions regarding participants' knowledge and professional integration of Imago theory, which ultimately underlies their role, are raised.

P1: *...but we really struggle with Indian people. With Muslims it's part of their culture that the husband is not allowed to be submissive to the wife – he's got to be superior.*

P2: *... if ever clients were sent to me through an employment assistance programme and they're from a different socio-economic background, then sometimes you see that the cultural differences do play a role because there isn't as much Westernisation yet. I think because this is theory that originated in the West. I think that then it's been difficult. For example, in terms of 'exits', in some cultures it is not considered an exit to have relationships with multiple people at the same time and there's a greater inequality between the couple. For example, it's ok for the man to drink or even abuse, and it's hard to then establish that equality – that they must dialogue and that he must try and understand where she comes from, that's hard then. Especially in the African and some of the Indian, like the Muslim, cultures. I came across something that we were worried about originally because in some cultures in Africa it's a sign of respect to not look in the eyes and dialogue asks for that. […] That's something that one has to take into account.*

P6: *I think we need more Imago therapists that can speak a black language or whatever because to do a dialogue when it's not your home language is very hard. I've worked with some black couples and I'm a little bit fluent in Zulu so I can pick up now and then what they're saying, but not enough to do therapy.*

P8: *I think in my experience, (and I haven't had a lot of experience with the black community in my private practice), I find it very hard to do Imago because culturally the men are a lot more domineering....*

P4: *...I've found that the black clients catch on very quickly and they seem to get good results very quickly and get relief from it, but they don't stick the process through. As soon as they're feeling better they go. I don't know why that is, because it's very often not a financial issue. They seem to engage and do very well initially. […] But the interesting thing is that marriage and children sets off the tribal agenda. Where they might have had a lot of equality in the marriage and suddenly children come along, and suddenly the mom's expected to offer all the tribal respect and everything else that she would've normally offered and he expects to rule the roost because he's the father of the family – whereas before he was quite equal and she had quite a lot of say. But we have that too where suddenly tradition kicks in, especially when a child comes along.*

In contrast, participants below seem to adopt an attitude that is more accepting of the differences and challenges also referred to in above responses and that 'working with them' (the challenges) is an inevitable part of their role *"because ultimately it's the connection and not the content"* that is important. This 'content' as referred to by participant seven seems to represent cultural and other challenges when working with diverse couples, which are embraced in much the same way as in the underlying Imago theory of connection. Therefore, these responses do not seem to coincide with the view above understanding that interventions need to be applied within a cultural setting for which that specific intervention was intended due to underlying cultural-specific knowledge that defines theory and practice (Gielen, Fish, & Draguns, 2004). This leads to questions regarding what aspects of Imago theory are more strongly embraced by participants' in their role and consequently which aspects have been integrated into practice more significantly. This also raises questions about the level of understanding or awareness of underlying theory, which is in turn likely to have an impact on participants' experience of their role.

P5: *Obviously there are things that you'd have to adapt, if you have a couple where it's not right for the one partner to look into her husband's eyes, you then discuss the relevance of connecting with the eyes and the man will normally give the woman permission to look into his eyes. It's respecting the culture of each individual. But once they start doing dialogues and behaviour change requests, the pain and the healing is the same.*

P6: *If you take an Arabic or Zulu culture – at the end of the day one's got to work within what is acceptable and instill some sort of respect, so even if there is a slight power imbalance and the woman is subservient, how do we find a way for her to create a voice within her role and how do we find a way of giving him a voice that's not that patriarchal and oppressive – how do we communicate what we're needing in a gentle way?*

P3: *...there are also very practical issues. […] I've had a woman who came with her face covered, only eyes showing so you can't see expression. A lot of the stuff that happens between husband and wife you want to say to them make a picture of how she looks now when she's in a good space, when you fell in love etc – but he can't make a picture because she's got a cloth over her face and she can't take it off because I'm here, and if I'm not here then I can't do the work with them. We need to understand that these things are here and work with them. I think all cultures have their differences.*
This participant stresses the underlying ontology of universal connection reflected in his role by adding:
"...I think because Imago at core is a universal and spiritual principle".

P7: *If you can let the couple speak in their mother tongue about their feelings, it's huge. I don't understand or speak Sotho, but I understand what's going on. Especially when they've tried in English for a month or two and we get to the point where I can see that it's hampering the situation, I say please just speak your own language and I intuitively just follow what's going on. Because ultimately it's the connection and not the content that you're building.*

In spite of seemingly differing views regarding how participants' experience their role when working in South Africa's diverse culture in particular, responses bring to the fore

similar questions about underlying Imago theory that guides practice for these therapists. Since theory not only informs the strategies and techniques that are employed in therapy but in more subtle ways, also the manner in which the therapist interacts with the client (Gentile et al., 2008), these responses raise important questions within the multilevel and complex therapeutic process regarding the which aspects of Imago theory affect how participants interface with diverse cultures.

5. Chapter Five: Conclusion, Limitations, and Implications for Future Research

5.1 Central Findings

This study set out to explore participants' experiences and perceptions of their roles as Imago relationship therapists practicing in South Africa. This involved questioning participants' regarding their understanding and experience of what it involves to be an Imago relationship therapist, the perceived similarities and distinctions in their role in relation to other forms of couple therapy, aspects of their role they find to be helpful as well as limiting, and finally their experiences of practicing IRT within the diversity of the South African context. Through a process of engaging with participants' narratives surrounding their roles, key findings revealed four themes representative of participants' experiences and perceptions of their role as Imago relationship therapists.

The first theme highlighted the significant emphasis placed by participants on their role of helping establish safe connection between partners. Whilst findings revealed this to be a crucial and defining aspect of their role, the irony of helping connect partners in a somewhat 'unconnecting' manner of giving them information was noted. The scripted and recipe-like responses in describing their role also shed light on the role of the Imago therapist as one that is largely theory-driven as the therapist explains underlying Imago theory to the couple in detail. Sharing explicit and uncensored theoretical understandings of the nature of conflict and unconscious behaviour that the therapist is usually only privy to, is also suggestive of a role that aids in balancing power differentials between the couple and the therapist, so contributing to an egalitarian therapeutic relationship.

As a result of the striking similarity in language used to describe the therapeutic focus of establishing safe and conscious connection for couples, the role of the Imago therapist was also suggestive of a value or ideal of connecting in relationship that reaches beyond the therapeutic role and is integrated into the person, identity, and life philosophy of the therapist. One might thus understand this to be a highly intuitive role that is integrated

into the therapist's way of being as an individual as it appears to reach beyond mere engagement in therapeutic functions and tasks. In particular, language used by participants to describe their role of 'holding' and 'connecting in relationship' is highly suggestive of archetypes or traits long-associated with femininity and motherhood (McKinley, 1997; Miller, 2008). One way of viewing this is that the role of the Imago therapist may be well-suited to individuals that are more attuned to, or easily able to access maternal and feminine aspects of themselves.

Lastly, within this theme, findings highlighted the irony that the structure and frame of the Couples' dialogue used by participants within their role to help couples feel safe connecting with one another, resulted in feelings of safety and containment for the therapist in their connection with the couple. That is, the structure of the dialogue proved to create a sense of safety, decreased anxiety, and reduced responsibility for participants as responsibility is placed with the couple to work through conflicts and transferences instead of with the therapist. This relief in responsibility translated for participants into an experience of being able to connect with couples safely, and was also viewed by participants as moving away from the expert role perceived by participants to be inherent in other forms of couple therapy. This facilitative therapeutic role for instance appears to exempt the therapist from the potential anxiety of unconscious material and affect often interpreted and worked through within a triangulated therapeutic relationship typical to psychodynamic couple therapy (Scharff & Savege Scharff, 1997). The Imago therapist is thus relieved of the anxiety and responsibility that is perceived to accompany the role of such couple therapists because the therapeutic frame takes a *"different form"* through the use of dialoguing between partners rather than through the therapist's engagement with partners in a triangulated fashion.

The second theme yielded findings which suggested participants' role as Imago therapists to be embedded in paradox, where each paradox may, as suggested by Woodhead (2006), lead to examination of unexplored areas. The recommendation to investigate that which typically receives little focus also parallels the need highlighted in couple therapy research to move away from the obvious and measurable toward examining unexplored areas such as how therapists may experience their role (Blow, Sprenkle, & Davis, 2007; Bray & Jouriles, 1995). In particular, the noted paradoxes within their role gave some

insight into some of the subtleties within the role of the Imago therapist, which appeared to contribute toward a successful therapist role.

For instance, the difficulty with which participants tried to describe the shift in their role to a more facilitative and background role, highlighted a significant paradox in their role. That is, although participants' expressed role of placing responsibility between the couple to work through their relationship conflict implies that responsibility for safe connection lies with the couple as the therapist remains in the 'background', findings suggested a critical role of holding couples within their process where the involvement and responsibility on the part of the therapist in this process may be overlooked. The tendency to overlook a critical presence may be paralleled to the unique usefulness of the silent, supportive, and sustaining 'holding environment' provided by Winnicott's good-enough mother also seen in therapeutic settings. Findings thus suggested similarly paradoxical roles of the Imago therapist and the good-enough mother. In the same way that the infant cannot come into being without the quality of the mother's often 'silent' care (Jacobs, 1995; Watts, 2002), it appears that so too is the silent and facilitative role of the Imago therapist critical for the couple to 'come into being'. The role of the Imago therapist of symbolically 'letting go' of the couple/infant to heal themselves is thus paralleled to that of the good-enough mother who is ever-present but must paradoxically 'let go' of the infant for its true self to develop. In this way, participants' background role paradoxically involves a far more critical presence from the therapist than is suggested.

Leading from this, the seemingly 'invisible' yet actively pivotal role of the therapist was revealed as participants increasingly began to stress their role of remaining constantly connected to, and present within the couples' process. This paradox highlights the delicate balance required in this role of actively maintaining "structure" for the couple whilst simultaneously allowing them the "freedom" to be healers to one another. Winnicott's insight about the mother-infant relationship as a paradoxical synthesis of dependence and independence, of connection and freedom (Firman & Gila, 1997) is thus also reflected in participants role as they remain separate, yet actively involved in reading and guiding the couple's process.

Although perceived to be a distinction in their role in relation to other forms of couple therapy, the 'non-expert' position of their role as described by participants proved to be paradoxical as well, as their role in fact appears to incorporate a great level of expertise that did not seem to be recognized by participants. Participants understanding of expert therapeutic functions seemed to infer active and directive therapeutic functions of, for example, advice-giving and making interpretations. In this sense, participants did not view their role as an expert role as it is driven primarily by guiding interaction and dialogue between the couple rather than such active and directive therapeutic functions. Findings suggested this understanding of their role to reflect Rogers' view that clients (or the couple) have the resourcefulness for therapeutic growth without an active and directive role from the therapist (Corey, 2008). Nevertheless, the therapist's presence, through being completely absorbed and deeply focused on the client, is essential for the client's progress and is in itself viewed as more powerful than any possible therapeutic technique. In this sense, findings revealed another innate paradox, where although the Imago therapist may not be *"coming off as the expert"*, the role is innately expert in nature due to the level of essential focused attention to the couple's process. Since it is the therapist that empowers the couple to heal themselves in a similar fashion to Winnicott's 'ordinary' mother who is expert in her infant's matters due to her mere devotion and attention to her baby, findings suggested that the Imago therapist may too be viewed as having an expert role. Although on the surface the findings in all these areas of paradox may point to a sense of disharmony in the therapeutic encounter, the opposite appears to be true. That is, at the level of experience, these contradictions in participants' role and therapeutic functions seem to represent a synthesis of harmonious experiences that in fact appear to make their role effective.

Whilst the third theme outlined what participants perceived to be the most significant strengths and weaknesses in their role, key findings indicated that participants respond to both positive and negative aspects of their role in a very congruent and intuitive manner, which appears to have positive implications for the therapeutic outcome of the couple. For instance, although reframing conflict for the couple through giving them psychological information was experienced very positively by participants and as a strength within their role, findings highlighted the authenticity with which they embraced this part of their role. This aspect of their role was also indicated to be a hugely

congruent therapeutic encounter as couples were perceived by participants to find the information given very helpful and relieving. Given Rogers' understanding that the client's likelihood of therapeutic growth is increased when the therapist acts more congruently within the therapeutic encounter (Rogers, 1980; Thorne, 2003), these findings suggested this aspect of their role to be especially beneficial to the therapeutic process. Therapeutic benefits as a result of dealing congruently with the perceived limitation of remaining in a purely facilitative role when more explicit interpretation seems necessary, were also noted. Overcoming this tension or incongruence in their role by seemingly acting according to what they believe intuitively necessary in the therapeutic encounter, adds to the sense that participants experience their role congruently which in turn increases the potential for a more beneficial therapeutic encounter and an increased potential for therapeutic growth.

Moreover, findings indicated a strong desire by participants to experience their role in a way that feels more congruent when working with 'early wounded' couples who find it extremely difficult to hold and mirror one another in the usual Imago dialogue. Being more congruent in these encounters involved participants relying on their 'intuition' and 'feelings' and deviating from the traditional facilitative role of the therapist by taking on the essential function of mirroring respective partners and holding the couple in a more active way than suggested in the prescribed Imago role. These findings of the discrepancy between the intended practice of the Imago therapist, and participants' experiences within the therapeutic encounter also contribute toward addressing the need expressed in couple therapy research to examine actual in-session therapist behaviours as a means of better informing therapists about the challenging process in therapy (Beutler et al., 2004; Bradley & Furrow, 2004; Heatherington, Friedlander, & Greenberg, 2005). Findings such as this that describe therapist behaviours are also considered very helpful in narrowing the gap between research and practice in the field, as it provides clinicians with practical and conceptual information relating to the practice of various types of therapy, which in turn acknowledges the complex processes inherent in therapy and contributes to the rich theory required to explain practice (Sexton, Ridley, & Kleiner, 2004).

Finally, participants' experiences of their role as it pertains to working within South Africa's diverse population yielded findings that raised questions regarding the significance of theory informing the role of the Imago therapist as a result of contrasting experiences when dealing with diverse couples. Whilst participants acknowledged the challenges of working with diverse couples within a South African context, most reflected a generally positive outlook in terms of dealing with challenges of diversity, which also appeared to reflect IRT's underlying ontology of connection founded in quantum theory. That is, participants seemed to view these challenges as secondary to couples' seemingly inherent tendency and need to connect. Other responses however, indicated views that reflect assumptions of difference and diversity as primary in human behaviour, rather than assumptions of universal connection as primary. In both instances however, participants did not seem to make a connection between underlying Imago theory which advocates that human connection transcends the boundaries of cultural and other diversity, and their general experiences of practicing with a diversity of couples. This in turn poses questions regarding the significance of underlying theory in practice, specifically relating to what set of assumptions are embraced by the Imago therapist most significantly in informing their role. Given the importance of theory in influencing the way the therapist thinks about the client, this may be viewed as an area that may potentially restrict participants' role as Imago therapists.

5.2 Limitations of This Study

Probably the most significant limitation to this study is that data yielded discussion that was fairly descriptive rather than analytical. As noted in the literature review, the diversity of theory underpinning IRT makes for a therapy that is difficult to pin down theoretically and essentially diffuse in its theoretical foundations. Whilst the theoretical diversity of this therapy may be viewed as a strength as it is potentially appealing to psychologists practicing in a wide variety of modalities, this proved problematic in the analysis of participants' experiences as responses lacked grounding within consolidated theory and reinforced the diffuse theoretical underpinnings that inform practice. As a result, large portions of the analysis section were quite descriptive rather than analytical in nature. The descriptive nature of findings in turn led to a sense of circularity in the

study, as much of the discussion merely reiterated IRT theory and practice as presented in the literature review rather than raising novel ideas through a proper analysis.

Giorgi and Giorgi (2008) put forward two significant limitations of the descriptive phenomenological method used in this study. The first is that "if a phenomenon or experience cannot be described, then it cannot be analysed and it is imaginable that there are such experiences" (Giorgi & Giorgi, 2008, p. 176). Given the difficulty participants' appeared to have in describing key phenomena within their role, the reader may come to experience analysis of data to lack definitive description of participants' experiences and perceptions of their role. Secondly, this method of doing research is very labour intensive and inefficient, and requires dwelling with the data in order for intuitions to arise (Giorgi & Giorgi, 2008). This points to another significant limitation felt to be inherent in this study. That is, whilst every attempt was made to engage with data timeously and consistently, the process of having to 'dwell' on participants' experiences for 'intuitions to arise' may have contributed to a somewhat staggered flow of the findings.

As in the case of all qualitative research, a limitation of method to consider from the outset of doing this type of research is that findings are not generalisable to the broader populations with the same degree of certainty as with quantitative methods. In this sense, the process and findings of qualitative research may be criticized for representing the subjective views and interpretations of the researcher. In this study for instance, the facilitation of individual interviews were guided not only by what literature suggested to be valuable for exploration, but also by the subjective insights and interests of the researcher that were ultimately incorporated into interview material. This in turn has an inevitable influence on the content and nature of responses and content of material that emerged from participants so that findings of this study cannot be viewed as uniquely representative of participants' experiences. Although the researcher made every effort to eliminate biases such as this during the research process, interpretations cannot be regarded as objectively definitive and the discussion and findings represent only one of many potential sets of interpretations.

The size and nature of the research sample also has implications for contextualizing findings within broader society. Firstly, although a sample size of eight was initially viewed as sufficient, this study may have benefited through interviewing a greater number of Imago therapists. Moreover, seven of the eight participants were white female therapists, and the last participant a white male, all in private practice in socio-economically affluent suburbs of Johannesburg. This adds to the lack of generalisability and validity of findings as responses are not representative of a broader and more culturally diverse therapeutic community. The fact that participants volunteered to partake in this study also represents potential issues of bias in their responses regarding their role. Problems inherent in the use of semi-structured interviews should also be taken into account as the use of open-ended questions may have led to vagueness or ambiguity of answers by participants. In this regard, this study may have benefited by the use of more probing questions when responses appeared undefined or to lack the necessary clarity and depth regarding participants' experiences of their role as Imago therapists.

In addition, the nature of the chosen topic of focus of this study is believed to present a limitation as the 'role' of the therapist proved to be a significantly complex and contentious construct to deliberate. The role of the therapist for instance, permeates so many aspects of therapists' behaviour that it was often a tiresome task to select the most significant aspects of their narrative to include for the purpose of analysis. Moreover, the role of the therapist proved to be significantly intertwined with theory, making it difficult to separate theory from experience in order to maintain a phenomenological rather than a theoretically descriptive focus. In spite of these limitations of method however, the qualitative nature of this study has allowed for discussion of ambiguities and contradictions inherent in participants' narrative and experience, which add to the rich and an in-depth accounts of their experiences. In addition, themes explored in this study were not of a personal and sensitive nature and therefore did not raise ethical constraints common to this type of research.

5.3 Implications for Future Research

In light of the limitations of this study noted above, and in order to reach conclusions that are more inclusively representative of the role of the Imago therapist, future research would do well to include participants from a wider socio-economic, geographical, and practicing repertoire. Gaining larger amounts of information from an increased sample size would also benefit future studies of this nature by making it easier to identify the most prominent and significant themes to be included for discussion, and would aid in increasing the generalisability of findings.

In spite of this however, and as a result of the continuing methodological bias in couple therapy that has undermined qualitative exploration such as the role of the therapist, the therapeutic process may be viewed as under-informed and in need of greater attention. Moreover, since the little attention paid to therapist variables such as the role of the therapist may also be held accountable for the inability of existing theories to adequately explain the complexity involved in clinical practice (Blow, Sprenkle, & Davis, 2007; Sexton, Ridley, & Kleiner, 2004), research of this nature should continue to be promoted and implemented.

Finally, and in keeping with the method of investigation employed for this study, the only way to challenge, rework, and contribute to current theories on the nature of human behaviour is to continue with theoretical and empirical work that allows for a deconstruction of previous traditional understandings and expectations of certain phenomena such as the role of a therapist. This study also serves as a basis to construct and generate future hypotheses that may be researched by using quantitative methodology. Furthermore, the results of this exploratory study will contribute to establishing a knowledge base for further investigations in the view to inform practice and formulate educational strategies to expand upon and challenge current forms of couple therapy. In addition to potentially enhancing the understanding of the practice of couple therapy, information and insight gained in this study may also assist in improving the results or outcome of couple therapy by guiding the choice and application of specific interventions for specific couples, i.e. the knowledge gained as therapists about models of

couple therapy that have not undergone extensive exploration may assist in guiding the selection of specific interventions for specific couples.

5.4 Concluding Remarks

The implications and effects of couple distress have proven paramount in the psychological and physical functioning of people around the world, making it a frequently encountered topic within psychotherapy research, theory, and practice, and hence validating the appeal of this explorative study in its aims to gain deeper access into the therapist's role of helping overcome this human condition. In particular, the role of the Imago therapist has proved to be embedded in contradictions that indicate it to be highly complex and multilayered in spite of clearly outlined functions within this role that are seemingly easy to operationalise. This study therefore provides valuable insight into the relatively formative and unexplored couple therapy modality of Imago Relationship Therapy, and in particular to expanding on the complex experience of the role of the Imago therapist. Whilst this study is only explorative in nature and findings are of a more subtle and non-critical nature, they have the potential to ignite further ideas for more detailed qualitative exploration into therapist behaviours and the therapeutic encounter/process that is needed in couple therapy research.

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7. Appendices

7.1 APPENDIX A: Subject Information Sheet – Participant

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OF THE
WITWATERSRAND,
JOHANNESBURG

Department of Psychology
School of Human and Community Development
Private Bag 3, Wits 2050,
Johannesburg, South Africa
Tel: (011) 717-4500

Hello, my name is Melanie Gerrand and I am conducting research for the purposes of obtaining a Masters degree in Community-Based Counselling Psychology at the University of the Witwatersrand. My area of focus in this research is that of the role of the Imago relationship therapist. The role of the Imago relationship therapist is suggested by the founders of Imago Relationship Therapy to be somewhat distinctive from that of other more commonly practiced forms of couple therapy, and to date, interventions of more recent types of couples therapy such as Imago Relationship Therapy have not yet been well specified. This research project thus aims to further explore the nature of this role as it is experienced and perceived by yourself – a practicing Imago relationship therapist. Due to distress in intimate relationships being recognized as the single most frequent presenting problem in psychotherapy, literature highlights the longstanding need for further research relating to outcome and interventions relating to couples therapy. The results of this research are thus likely to contribute to much needed empirical input regarding available forms of couple therapy. I would therefore like to invite you to participate in this study.

Participation in this research will entail being interviewed by myself, at a time and place that is convenient for you. The interview will last for approximately one hour. With your permission this interview will be recorded in order to ensure accuracy of the research project. Participation is voluntary, and no person will be advantaged or disadvantaged in any way for choosing to participate or not to participate in the study. Participation in this research study will thus yield you no direct benefits; neither will involvement in this research put you at any particular risk. You may refuse to answer any questions you would prefer not to, and you may choose to withdraw from the study at any point. Although complete confidentiality and anonymity cannot be ensured given that you will be met and identified personally by the researcher, every attempt will be made to keep your responses confidential, and to exclude information that could identify you this research report. The interview material (digital audio recordings and transcripts) will not be seen or heard by any persons in this organisation other than myself and my research supervisor at any time, and will only be processed by myself. Interview material will be kept in a secure location at all times. Once the research report has been written up, transcripts and recorded material/interviews will be maintained in a secure location at the University of the Witwatersrand for a period of 5 years.

Results of this study will be reported in a research report written by myself. A written summary of the results to this study will be made available to yourself should you request this. In addition, you may obtain access to results in the final written research report from the Psychology Department and the university.

If you choose to participate in the study you may contact me at your leisure telephonically or via e-mail at the contacts below. Included are also the contact details of my supervisor for this study.

Kind Regards

Melanie Gerrand

Melanie Gerrand
Masters Psychology Student
Tel. (011) 882 8419

Dr. Garth Stevens
Supervisor
Tel. (011) 717-4535

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melanie@themarketingshop.co.za

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Garth.Stevens@wits.ac.za

7.2 APPENDIX B: Consent Form (Interview)

UNIVERSITY
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WITWATERSRAND,
JOHANNESBURG

Department of Psychology
School of Human and Community Development
Private Bag 3, Wits 2050,
Johannesburg, South Africa
Tel: (011) 717-4500

I _____ the undersigned, consent to being interviewed by _____ for her study on _____. I understand that:

- Participation in this interview is voluntary.
- That I may refuse to answer any questions I would prefer not to.
- I may withdraw from the study at any time.
- No information that may identify me will be included in the research report, and my responses will remain confidential.
- The use of direct quotes may be included in the research report.
- My participation in this research study yields me no direct benefits; neither does involvement in this research put me at any particular risk.

Signed :_____

Date: _____

Melanie Gerrand
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7.3 APPENDIX C: Consent Form (Recording)

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Department of Psychology
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Private Bag 3, Wits 2050,
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I _____ , the undersigned, consent to my interview with _____ for her study on _____ being digitally audio-recorded. I understand that:

- The digital audio recordings and transcripts will not be seen or heard by any persons in this organisation other than the researcher and her research supervisor at any time. Processing of data will be done by the researcher and may include involvement by her supervisor.
- All digital audio recordings will kept in a secure and confidential location, with access to recordings being limited to the researcher.
- All digital audio recordings will be destroyed after the research is complete.
- No identifying information will be used in the transcripts or the research report.

Signed _____

Date _____

Melanie Gerrand
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7.4 APPENDIX D: Interview Schedule

The following are proposed questions to be asked to participants in this study, and questions will evolve as interviews are being conducted:

1. What is Imago Relationship Therapy?
2. How does doing Imago therapy manifest in the therapeutic encounter? Can you provide illustrative examples of how it works?
3. What do you perceive your role as an Imago relationship therapist to be?
4. In what ways do you perceive your role as an Imago relationship therapist to be similar to, and distinctive from the role of couple therapists practicing other commonly utilized forms of couples therapy?
5. What aspects of your role as an Imago therapist do you perceive as helpful and unhelpful in dealing with couple distress? Please elaborate.
6. What are some of the obstacles or difficulties that you encounter in your role as an Imago therapist in the therapeutic situation?
7. In what ways do you think your investment in this form of therapy might have affected your answers to these questions?
8. Tell me about your role as an Imago therapist as it pertains specifically to practice in South Africa.
9. Do you think your role as an Imago therapist is relevant in South Africa's diverse population?
10. Is there anything additional about your role that you feel you have not had an opportunity to share in this interview or would like to elaborate on?