Couples Therapy with One Partner
Thorana S. Nelson

ABSTRACT. Systemic Couples Therapy (SCT) can be used when only one partner in the couple is attending therapy, whether the partner is unable or unwilling to attend. The model uses integrated components of Structural, Strategic, Bowen Family Systems, Behavioral, and Solution-focused therapies. The philosophy, integrated concepts, and various stages of therapy are illustrated through the case of Amy, a substance abusing woman.

KEYWORDS. Couple therapy, substance abuse, integrative therapy, substance-abusing women

Systemic Couples Therapy (SCT) is an integrated model of couples therapy that was designed for substance abusing women (e.g., Nelson, McCollum, Wetchler, Trepper, & Lewis, 1996). The model was developed from a similar model taught at the Menninger Clinic and continues to evolve. SCT uses components of Structural (e.g., Minuchin, 1974), Strategic (e.g., Watzlawick, Weakland, & Fisch, 1974), Bowen Family Systems (Bowen, 1978), Behavioral (Jacobson & Margolin, 1979), and Solution Focused (de Shazer, 1985) therapies. This paper outlines the components of SCT and focuses on its integration and use with women whose partners are not attending therapy. It is recognized that others (e.g., MRJ, Michelle Weiner-Davis) have discussed relationship therapy when only one person is present. However, those...
other models used concepts and interventions from strategic and solution oriented therapies, respectively, and did not integrate other models into their approaches. There are many situations when only one person is present including when the partner is unable or unwilling to attend therapy. Using SCT when only one partner is present in therapy is illustrated through therapy with a substance abusing woman, but it can be used with both men and women and for many kinds of problems, both individual and couple, where a strengthened relationship is a principal goal.

THE PHILOSOPHY

It is fairly widely accepted that women, in general, are socialized more toward relationships than are men. Women substance users tend to develop drug habits as part of their relationships, in reaction to relationship problems, to satisfy relationship requirements, and with more social rituals (e.g., Anglin, Hser, & Booth 1987).

Women substance users often rely on their substance using boyfriends or husbands to take care of them financially, particularly when they have children. Although the goal of helping women leave relationships that are “not good” for them is not part of the model, women, in general, need strengthened selves in order to either be more assertive in their primary relationships or to leave these relationships, regardless of the presenting problem. Women need to find ways to equalize power imbalances, take charge of their own behavior, and use the strengths rather than deficits they learned in their families. Thus, the chief components of SCT are designed to accomplish these ends.

The principal goal of SCT is to help women identify and achieve their own goals by removing barriers associated with primary relationships that keep them from reaching those goals. The role of the therapist is to facilitate the client’s reaching this goal through examining and changing her role in her primary relationships. This typically refers to her relationship with her partner but may also mean relationships with members of her family of origin or with important friends, coworkers, etc. By helping the client develop a more assertive, less reactive, and more powerful self in these relationships, the therapist helps her to make these relationships more supportive of goals that she develops for herself. This will result in a relationship that is clearer and more supportive if it continues.
These aims of SCT are accomplished through an integrated approach to the many facets of a woman's life: the structure, hierarchy, and patterns of relationships; influences from family of origin; and an ability to determine and maintain solutions to problems. The assumptions and concepts of SCT, outlined below, are integrated into a unifying philosophy of couples therapy. Interventions flow from this philosophy and are drawn from the models outlined as well as other models as they assist the therapist and client in their work toward accomplishing the goals of therapy.

The therapy is client- rather than therapist-driven in the sense that the client determines both the goals and the direction of therapy in consultation with the therapist. Through co-development, the therapy is more about the client’s life than how the therapist thinks she should be living it or how therapy should be accomplished. In this way, “resistance” does not exist. Rather, the therapist acknowledges the client’s preferences and avoids practices that are not helpful to the therapy or the client. The therapist places primary importance on the client’s story: what’s important to her, how she tells the story, resources and exceptions that are in the shadows of her story, and the way she relates to the therapist.

**THE MODEL**

**Assumptions**

There are several assumptions that connect the different components of SCT. One is that people’s relationship contexts are important in both maintaining and resolving problems. This may work differently for some women because our society typically encourages women to pay more attention to relationships than to self and to consider what other people think over their own experiences and needs. To the extent that these relationships facilitate satisfying lives, they are helpful to women in terms of resolving problems such as substance abuse. To the extent that these relationships encourage behaviors and experiences that are detrimental to one person in the relationship, especially the client, they tend to promote the development, maintenance, and exacerbation of problems. Therefore, this model assumes that open, negotiated relationships are healthier than unbalanced, oppressive relationships.
A second important assumption is that relationship contexts are strong and healthy only when the people in them have clear "selves": a sense of self-efficacy; an ability to think rather than react in tense situations; an understanding of one's own values and priorities; an understanding of others' values and priorities as separate from one's own; and an ability to distinguish self from other, thinking from feeling. Bowen (1978) refers to this as the "differentiated self," which is not the same as being selfish or thinking only of oneself. Nor is this the same thing as autonomy. The differentiated self has a strong ability to be intimate with but separate from valued others and to maintain a sense of self under stress.

A third assumption is that changes made by one person in a relationship will result in changes in others in the relationship. That is, as one person changes, others must adapt to those changes, which means making changes themselves. These changes aren't always the ones that the first person might prefer, but create disruption in the relationship system and open up opportunities for further change that is beneficial to the individuals, the relationship, or both.

A fourth assumption is that people have resources and are able to utilize them once they are identified. Resources may take the form of education and new knowledge, but may also take the form of understanding the nature and patterns of relationships as well as the ability to choose how one behaves in relationships. People may need help in identifying potential consequences and forestalling them as well as encouragement in using new resources.

The fifth assumption concerns cultural contexts. The rules, values, practices, and mores of different cultures relate to class, ethnicity, race, region, religion, etc. Each of these cultural contexts presents unique opportunities and resources as well as constraints as individuals strive to understand and change their lives.

A final assumption is that these particular models can be integrated, even though they may differ in principal mode (e.g., raising intensity in Structural therapy vs. reducing intensity in Bowen Systems therapy). This is accomplished by the mindfulness of the therapist in terms of long term goal, short term goal, and effects of different interventions. For example, if the intent of a homework assignment was to reduce intensity so that partners could talk (e.g., by choosing a calmer time to talk about changes) and the effect seemed to elicit a fight, the
therapist must attend more to the effect than the intent and modify the homework, anticipating potential effects.

Several components of different models are incorporated into this way of working with couples. These relate to conceptualization, assessment, and intervention. The model is illustrated through the case of Amy, a substance abusing woman.

Amy is a 32 year old Hispanic woman, married, with a 10 year old daughter, Karen, from a previous relationship. Amy has had trouble with drugs, has been in prison, and her daughter lives with her mother. Amy is pregnant and she and her husband, Tom, live with Tom's mother. Tom does not attend therapy with Amy.

Amy began using cigarettes in junior high, something most of her friends were doing. They thought it made them look "cool." Later, when she was dating more, Amy used alcohol because her boyfriend wanted her to. She thought that he and his friends accepted her more and she found partying more fun when she was at least a little high. Amy used heroin for the first time when she was about 19. She had recently had her first child and the baby's father was a user. Amy felt lonely and isolated from her girlfriends and found that using heroin with her boyfriend was both exciting and relaxing for her. When she talked about not using, her boyfriend threatened to leave her, saying she was "no fun."

Conceptualization

Structural Family Therapy. This model of family therapy attends to issues of subsystems, boundaries, and rules of relationships. Primary relationships must have clear boundaries. Other people and relationships may have access to and influence in this system, but it must be able to maintain itself without undue interference.

Amy and her husband were expecting their first child and also living with his parents. Tom took the position that they needed to live by his mother's rules while they lived with her and Amy agreed. However, she saw signs that her mother-in-law might want more influence over the baby than Amy was comfortable with.
It was important for Amy to develop a sense that her marriage and her relationship with her mother-in-law were both important, but different. She needed to not fight with Tom about his mother's behavior, but enlist him in strengthening the boundary around their marriage so that they were the ones making decisions about their child. The boundary needed to be permeable so that Tom's mother's ideas and opinions were considered, but not so that they were either dictating all aspects of the couple's life or coming between Amy and Tom.

Relationships also fare better when the power arrangements are negotiated and not dictated by either party, others, or some sense of "that's how it should be."

In Amy's and Tom's families, the traditional Hispanic family mode of male authority was predominant. They were each aware that this way had not worked well for them in other relationships and wanted things to be different for them now. However, this was difficult for them to negotiate, particularly because they were living with Tom's mother. Also, Amy's father had not lived with her when she was growing up, but she had visited him often at his mother's. She described him in typical alcoholic terms, but seemed to adore him when he was not drinking. These nontraditional messages from her parents seemed to loosen her culture's traditional influence on Amy.

Strategies for working with power arrangements in different relationship systems must address the unique arrangements of each system.

Amy seemed to be more able to discuss her concerns with Tom than with either her mother-in-law or her mother. Amy's mother had taken care of her ten-year-old daughter since Karen was three. Although Amy's mother had been granted temporary guardianship when Amy went to prison, she had never indicated that she was willing to return custody to Amy. Amy seemed unable to discuss this with her mother or to change it. However, in the previous year, since getting out of prison, Amy had increased her time with Karen and had even discussed some of her values, hopes, dreams, and concerns with her mother about other issues related to her daughter. She was not sure that she wanted
custody of Karen or that this would be the best thing for the girl, given her strong relationship with her grandmother.

Strategic Family Therapy. The basic concepts of Strategic therapy that are used in this model include individualizing treatment, using sequences, and attending to hierarchy. Attending to seemingly paradoxical aspects of the client's context also is important.

Each client is different and it is therefore important to understand the unique aspects of each client's context and not make assumptions about her due to contextual factors such as culture, referral source, or presenting problem. Although there are some commonalities about substance abusing women or any other category of client or client problem, these should be held tentatively and not assumed to be present in any particular case nor should they be considered the totality of the client.

Although Amy fit many of the stereotypes and demographics of "typical" substance users (including diminished social skills, some difficulty holding herself accountable for her actions, occasional relapses, and difficulty with the law), she was able to notice differences in her life, was able to recognize aspects of her life that could be different in terms of helping her resist drug abuse, and very determined to make her life different. She was self-referred rather than ordered to therapy by the court system.

The sequences of interaction for a particular couple where one or both abuse drugs or alcohol often revolve around their patterns of using. The chemical abuse sometimes leads to disagreements and sometimes it follows. It is important to assess sequences around many aspects of the couple's life, not just the presenting problem, in order to find points for intervening. Strategic therapy involves the use of isomorphism: the belief that patterns of behavior are similar across situations and, therefore, intervening in one area can lead to change in another area. However, the introduction of a chemical into the sequence often makes it very different from other sequences that do not include drinking or drug use.

Amy and Tom often argued about his use of heroin. Amy had begun using before she went to prison. She had remained fairly clean during her prison time, but resumed using when she got out
and had only recently decided that she needed to quit when she
found out she was pregnant. She knew that asking Tom to quit
was not likely to be successful, but wanted him to at least stop
using in the house and to not be with her when he had been using.

Sequences of interaction are often embedded in other sequences
that include multiple relationships or occur over longer periods of time
(Breunlin, Schwartz, & MacKune-Karrer, 1992). Family of origin
patterns, discussed in more detail in a later section, also play an impor-
tant part in understanding couples' patterns of interaction.

Amy's family of origin included a number of alcohol and drug
users, including her father and an uncle who also had done prison
time related to his drug use. Amy's father tended to "disappear"
when he was binging and her mother argued with him. Amy
found it very difficult to remain in contact with Tom when he
raised his voice or otherwise argued with her. Amy seemed to
identify with her father's pattern more than her mother's. She
wanted Tom to discuss things with her, but didn't know what to
do when he became defensive, except what she was used to
doing: withdraw and sometimes get high.

Strategic therapy also attends to ideas of skewed hierarchies. This
idea is similar to structural ideas related to power in relationships, but
also acknowledges the ways that people maintain hierarchical roles by
joining in coalitions with people in other generations. In this way, one
person gains power by "standing on the shoulders" of someone in the
previous or next generation.

Tom tended to agree with Amy that his mother was more con-
cerned about the coming baby than Amy preferred. However, he
dismissed Amy's concerns, stating that his mother was "just
excited about being a Grandma" and "she doesn't really mean it
when she tells you what to do. She knows you won't do it any-
way." By dismissing Amy's concerns about his mother, Tom was
also dismissing her concerns about her relationship with his
mother and about his drug use and her wish for more of her
support in getting and staying clean.

Bowen Family Systems Theory. Ideas from Bowen's theory are
important for their attention to family of origin patterns and how these
result in less functional patterns of behaving in current relationships, including those with primary partners, children, and living members of the family of origin. Although worthy, differentiation of self is a difficult goal to reach in couples therapy. Most people do not want to take the time, pay the money, or struggle through the tasks of developing differentiated relationships with their families of origin. Most agencies are unwilling to support such efforts. Nevertheless, many of the concepts are useful, even when clients or therapists are not willing to strive for longer term goals.

Family members tend to assume roles that function in their families of origin to reduce anxiety. People who grow up in alcohol or drug dependent homes often become caretakers and overfunctioners. They also tend to avoid conflict because resolution is seldom possible when a chemical is overused in a system. They therefore tend to become users themselves or symptomatic in some other way, avoid all conflict in current relationships or, conversely, fight at the drop of a hat, or they may become adept at overfocusing on children or triangling them in some other way.

Amy was very good at avoiding conflict. Her experience with her father’s “disappearing” when things got hot was matched by her mother’s tendency to send her to her grandmother’s when other things were going on. Amy never learned how to discuss problems and find solutions to them. She began using alcohol when she was very young and getting into trouble at school, dropping out in the 9th grade. Her mother dealt with these problems by sending her to her grandmother. Amy tended to use drugs or alcohol when she and Tom got into arguments. She tended to hear any argument as a fight and didn’t know how to control her tendency to flee or get high.

Amy’s family used all of the four typical strategies that reduce anxiety in systems according to Bowen (1978). These include conflict, withdrawal or distancing, symptoms (physical, emotional, or social), and triangling. All families use these mechanisms and, in moderation, they are helpful. However, when one person uses a single mechanism or a particular one excessively, the system tends to function poorly and to be more vulnerable to further stress. Unfortunately, these mechanisms were used in extreme ways in Amy’s family and therefore
contributed to the family's dysfunction and the individuals' lack of differentiation of self.

**Behavioral Therapy.** Behavioral concepts are used to explain how people get caught in nonproductive patterns of behavior through habit. Basic concepts of operant conditioning and social learning help to explain the problem's contingencies as well as other contextual influences such as the client's history and beliefs about the consequences of certain events. Examining contingencies and contexts helps clients to understand their lives differently and to think rather than react in habitual ways. This then allows them to choose new behaviors and to have more efficacy in their relationships.

Communication should be direct, clear, and open and conflict should have minimal space in relationships. People should be able to calmly discuss differences and jointly determine goals and ways to reach the goals without resorting to habits that are no longer useful. Of course, contextual issues must be considered in order to understand the meaning clients attribute to behaviors as well as to anticipate reactions of significant others.

**Solution Focused Therapy.** Two concepts of solution focused therapy emphasize looking for exceptions and "cheerleading" successes. Problems are not occurring *all* of the time; people are able to notice times when the problem is even a little bit better or times when they are able to resist the problem. Similarly, people in the client's relationship system are not always unsupportive, but are, at times, able to be perceived as wanting good things for the relationship and are able to make at least some of those happen. Finally, it is not always necessary to understand problems in order to develop solutions.

Tom was able to support Amy in her desire to get and stay clean when he wasn't using heroin. At those times, even when he had been drinking, Amy perceived him as excited about the coming baby and eager to talk about ways to improve their lives. She experienced him as a competent and even creative problem solver, and it was easier for her to stay in contact with him even when they didn't see eye-to-eye on everything. She noticed that she was more able to be pleasant and that Tom was less likely to withdraw or become belligerent.
Assessment

Assessment in SCT follows from sound clinical practice and utilizes concepts from the different models described above. At this point, the clinician is attempting to examine the patterns and strengths that the client describes and brings to the therapeutic relationship. With couples, the therapist is able to observe interactional patterns and assess many of the dynamics through his or her own observations. However, when only one partner is coming to therapy, the therapist must rely on the client’s report and her/his own experiences with the client. It is important to ask detailed questions to get as rich a picture as possible of the couple’s interactional dynamics.

Assessment content, in addition to basic mental status, the client’s history, and strategies the client has already used to try to resolve the problem, focuses on the concepts described above. By asking the client direct questions when possible, the therapist gets a picture of the relationship dynamics in which the client is involved. By asking questions about multiple relationship systems, the therapist begins to see behavior patterns across systems, but most particularly in the primary relationship. Family of origin information helps the client and therapist understand the dynamics that played an important part in the client’s learning about important relationships, her position in them, and the rules for maintaining them. It is important with women who are abusing substances and may have grown up in severely dysfunctional families or may have been abused in some way to be as direct as possible so as to avoid replicating confusing or even paradoxical dynamics. However, abused women also may be reluctant to admit that they have been abused. This makes it very important to review patterns across relationships to determine her likely behavior with her partner.

The therapist asked Amy about her relationships in her family of origin, how people settled differences, and how she was disciplined. The therapist was particularly interested in how her father behaved toward her when he had been drinking and how her mother was involved in this. Amy reported that her father tended to “go away” when he had been drinking, leaving her with her grandmother and that both of her parents and her grandmother yelled when angry. She reported that the only time she saw anyone get hit beyond a rare “spanking” was when her brother
shoved her into the street and her mother’s boyfriend “beat” him. She reported that when she and Tom disagreed, they both tended to withdraw. Sometimes they “yelled,” but neither used “bad names” against the other.

The client’s power position relative to her partner and others also is important. Is she able to speak her own voice, to be assertive; does she have a role in making decisions across a variety of content areas, but most particularly in the identified problem area?

Amy was reluctant to talk with Tom about her concerns related to his using heroin in front of her or being around her when he was high. She could not clearly explain her reluctance or what she thought would happen if she did raise issues. She was a little more willing to consider talking with him about his mother’s role in their baby’s life. She explained this relative willingness by saying that Tom also wanted more control over the baby. He had two children from a previous relationship and had little contact with those children other than occasional visits and occasional payment of child support. He wanted a larger role in his life with Amy and their baby.

Although the therapist cannot observe behaviors directly, as with couple enactments, s/he can request that the client go home and observe her partner’s behaviors and patterns around their interaction. Making the client an intentional observer not only helps gather richer data, but also helps the client to emotionally detach from the situation, increasing differentiation and increasing opportunities for noticing different solutions. Clients who are unable to accomplish this task may benefit from paying closer attention to family of origin dynamics via a genogram and thinking about how she and others in her family might have responded with slight differences in dynamics. This assessment tool also may have the effect of increasing the ability of the client to think about her situation rather than reacting to it, thereby increasing her ability to observe interactions at home.

Through these reports of behavior and reports of observations of behaviors, the client and the therapist begin to get a clearer picture of how the couple interacts around various issues. At the same time, the client is learning more about observing herself and observing and anticipating reactions to changes she may make. She and the therapist
begin to subtly shift roles so that the client is beginning to be more of
the expert in therapy sessions.

Assessment of family of origin patterns and influences is very use-
ful. Although lengthy assessments and interventions are not always
necessary, genogram assessments around several topics can enhance
therapy by increasing the therapist’s knowledge of the client’s rela-
tionship systems as well as provide the client with a different perspec-
tive on her family. These patterns and issues can also be revisited in
therapy when it seems that they may be serving as barriers to progress
or may suggest solutions (Kuehl, Barnard, & Nelson, 1998). Topics
for consideration include the client’s functioning position in the family
(underfunctioner or overfunctioner), ways that people tended to react
under stressful conditions, how marital dynamics were played out,
toxic issues in general, and dynamics around issues relative to the
presenting problem and goals.

The therapist and Amy spent most of two sessions on genograms,
first on Amy’s family and then on Tom’s. Between sessions,
Amy spent time with Tom, asking him questions about his family
that were similar to the ones the therapist had asked Amy. One
interesting dynamic that emerged was focused around family
celebrations. All of Amy’s family went to “Uncle Joe’s” for get
togethers—holidays, birthdays, weddings, or just for fun. At these
times, Amy’s parents both drank, but didn’t fight. Amy’s mother
and her father’s mother got along and children were comfortable
with all adults.

One of the emerging difficulties expressed by Amy was how she and
her mother-in-law had differences of opinion about the coming baby.
By thinking about how Amy’s mother and her mother-in-law, Amy’s
grandmother, were able to get along, Amy discovered new ideas about
how she might interact with Tom’s mother. Amy also noticed how
many of her family members distanced when stressful things were
happening, and how this dynamic did not help resolve problems.

Finally, the therapist assesses the client’s resources and strengths.
How well does she seem to communicate with the therapist and oth-
ers? Is she able to notice exceptions to the problem—times when the
problem is less severe or is not present? Is she able to identify future
pictures of herself and goals for therapy? All of this information
provides the therapist with an understanding of the general abilities of
the client, her resources, and areas that may require special attention in
order to reach the client’s goals.

By this time in therapy, the therapist felt well connected to Amy. Amy seemed to be looking to her less as an authority and more as a trustworthy friend. By asking more questions than giving advice and by valuing Amy’s experience, the therapist had helped the relationship become more egalitarian. Amy began noticing more and more exceptions and strengths in her various relationships—times when she was able to stand up to Tom when he had been using, for example. Amy was still using heroin, although less frequently and more often as a way of distancing. The therapist wanted Amy to look at this as an important goal area because of its potential effects on Amy’s baby, something about which she had expressed concerned.

Goal Setting

Throughout the assessment phase of the therapy, the therapist keeps in mind that assessments are interventions. However, it generally is a good idea to complete at least most of the assessment areas before determining the goals for therapy. Neglecting certain aspects of assessment may be regretted later when therapy seems to stall and a critical piece of the systemic picture would be useful. That information can be gathered later; however, in this author’s experience, the information can be used sooner if it is overt and can actually prevent stalling. For example, the therapist could focus on Amy’s current relationship system, which does not include her paternal grandmother. However, by knowing how important this woman was to Amy while she was growing up, the therapist was able to keep the grandmother in mind as a potential resource for Amy. Gathering information is not the same as looking for dysfunction.

Goals for therapy often change during the assessment and goal setting stages. Some therapists become overfocused on the goals that the client voices in the first session, becoming frustrated when the goals change at a later time. However, during the assessment, with new information and new angles on old information, the client may refocus her attention on her family of origin, for example, believing that she must reduce the intensity and involvement with her parent(s) in order to detriangle and refocus on her relationship with her partner.
In this way, the map for therapy becomes laid out in greater detail. Important first steps are clarified early on and the client and therapist avoid barriers or constraints.

The goals of this therapy are those decided upon by the client in consultation with the therapist. The therapist may also determine that other goals, such as "increased differentiation from mother," would be very helpful and may keep those goals in mind while working with the client. However, these goals are secondary and may be accomplished along the way rather than being the primary focus of therapy. In this way, the therapy is client- rather than therapist-driven.

Amy decided that her goals for therapy included stopping her use of heroin, continuing her methadone treatment through her pregnancy, and clarifying her relationship with Tom as a nuclear family that would include their baby and put Tom's mother in the role of grandmother. The therapist thought that these were realistic goals and signed a contract with Amy, with the understanding that the goals might change.

**Interventions**

Interventions flow from the assessment and from the models that are incorporated in SCT. Other interventions also may be used as long as the general focus of therapy remains on the client and her work toward her goals, not on her deficits or "resistance." The developers of the original models have written about many practices and interventions that interrupt sequences that maintain problems, for example. However, this therapy is not limited to those practices; other practices, techniques, or interventions that serve to interrupt sequences also are welcome as long as they fit within the value system of the client and therapist. Therefore, the interventions discussed here are only some of many ideas that could be used.

Power imbalances may be addressed in many ways, often through helping the client recognize the imbalances and brainstorming other ways she could behave that would encourage shifts in the power structures of her relationships. For many women, these imbalances are on the side of her having less power. In these cases discussing the use of one's own voice, role play or other practicing (e.g., "empty chair"), and homework assignments can be used to help the client increase her influence in relationships.
In Amy's case, she believed that she had equal power with Tom in some areas of their relationship. By examining these carefully and comparing the sequences to those she noticed around the topic of Tom's heroin use, Amy noticed that she felt powerless in the face of Tom's use. The therapist talked with Amy about her power "in the face of" heroin, how she had decided to quit using it, and wondered how Amy could use that power in her relationship with Tom. After some role play, Amy decided that she was not ready to face this topic, although it seemed less frightening to her now, and to talk with him about his mother's involvement with their baby. She decided there were a couple of ways she could change her part in the sequence of their conflict, most notably by not withdrawing. She went home with this as her homework "assignment."

When homework is not completed, this is taken as a sign that the homework was poorly timed or poorly designed. In these situations, the therapist uses information from the assessment to examine potential barriers. It sometimes happens that a client will agree to homework because, in the therapeutic relationship, her hopes and beliefs were high that she could accomplish it. However, at home, she finds herself in a void of encouragement and unable or reluctant to try something new. At other times, the client agrees to the homework because she does not want to disappoint the therapist. In this case, the therapist must first balance the therapeutic relationship with the therapist in the back seat to the client's work. Milton Erickson called this "leading from behind." The therapist may apologize for being too eager and recoup, discussing the barriers and difficulties with the client and, typically, slowing down.

In the third session, Amy agreed to go home and talk with Tom about her concerns about his mother's involvement with the baby. When she returned, however, she had not talked with him. Rather than seeing Amy as a resistant client, the therapist explored the situation with Amy. Together, they determined that they had not thought clearly about timing, about the best time to approach Tom for a serious discussion.

If the therapist had simply reassigned the homework and Amy had simply agreed, both would have been frustrated and Amy might have
become demoralized. By reexamining the homework and determining smaller steps, Amy was able to experience success and the therapist was able to assist Amy's ability to try new things in her relationship with Tom.

When homework is partially completed or completed in a way that is different from how the therapist recalls its discussion, the information is useful in learning more about other barriers, constraints, or problems in the client's life or about the client's creativity. It is very interesting and heartening when a client takes a homework assignment and turns it into something that is better. Using solution focused practices, the therapist amplifies and reinforces successes, even very small ones. Because the therapy is client-driven, the therapist does not see incomplete homework as resistance, but as information for the therapist and client to examine together. The other person's responses also are discussed in light of whether or not the client could have predicted them, what information this provides toward change, and how willing the partner is to engage in activities toward the client's goal. Whenever possible, these interactions also may be used to invite the partner or other people into therapy.

After approximately six weeks of therapy, Amy happened to be at her mother's after an afternoon with her daughter, Karen. She felt good about some changes that she and Tom had made and decided to try something new with her mother. Casually, somewhat timidly, she mentioned to her mother that she would like to spend more time with Karen, but knew her mother was concerned about what that might mean. Instead of getting defensive, as Amy thought she would, her mother said she knew it was a difficult situation and didn't know what to do about it. Amy said that it was difficult for her, too, and asked if it would be ok for her to talk to her therapist about it. Amy's mother seemed surprised that Amy was in therapy and asked how she could help. Amy asked if she would like to go to a session with her. Her mother said she would need to think about it.

Sequences of interaction that may be maintaining the problem are similarly viewed within the problem's context. That is, the client and therapist may draw the sequences on paper or a whiteboard, discuss places in the sequence where the client might do or think something different or do what she is already doing in a different way, and select
homework together that will have the client trying out the new behavior or thought and observing the reactions of others. At the next session, the therapist asks about the homework and uses the client’s report as before to learn more about the system. The therapist encourages successes, sympathizes with “failures,” and helps the client learn from both.

At this point, the therapist may use a solution focused practice of “scaling”: asking the client how far she is toward her goal on a scale of 1 to 10; how hopeful she is that she can make it; how determined she is to make it; how much she perceives others to be cooperative and helpful (including the therapist). The therapist may then inquire about what needs to happen to get a little closer to the goal, to gain more hope or determination, and what she or others need to do for the client to see them as cooperative and helpful.

Part way through therapy, Amy reported that she had had a lapse and had used heroin during the week. Her chemical dependency counselor seemed quite disappointed and had discussed the consequences of using heroin on Amy and her baby as well things that had happened that “made” Amy do it. Amy told her therapist that she knew that nothing had “made” her do it and she was quite frustrated and down on herself. After listening and empathizing for awhile, the therapist asked her how she had managed to not use more than once, knowing how tempting it must have been. Amy was surprised with this question, but had several things to say about how she had kept herself from using more than once. The therapist then asked her how far back this lapse seemed to take her, expressed surprise that it wasn’t as far back as she had thought Amy would place it, and asked her where she was in her progress on the day of the session. Finally, after amplifying and reinforcing Amy’s strategies and successes, she asked her what she needed to do in the next step toward her goals.

Family of origin interventions have occurred chiefly through the genogram assessment. This assessment helped the client to view her life in her family in a slightly different way and to detach herself a little bit in order to develop her ability to think about issues rather than react to them. However, if one of the client’s goals, either initially or later in therapy, is to develop different relationships with members of
her family of origin, the therapist may coach her in behaving in more autonomous ways, neither caving in to family members nor cutting off from them. Two examples follow.

As the client develops her voice more clearly in relation to the therapist, she may be coached to use this voice with one of her family members. This may not be the person that she is most at loggerheads or enmeshed with, but one in which she is more likely to experience success. She is coached in taking “I” positions, listening to the other fully, and not engaging in fruitless conflict, withdrawing, or distracting to another topic. She is helped to take a different position than the one she is familiar with when faced with emotional situations. For example, if she is used to withdrawing, she is coached in ways to “stay with” the discussion or conflict for a while. This can be accomplished in a variety of both behavioral and cognitive ways. For example, she may want to practice some “self talk” to use when she finds herself becoming anxious, talk that will allow her to stick with her plan and be empathic to the other person as well.

Amy knew that her mother wanted what was good for her and for Karen just as she knew that Tom’s mother wanted what was good for Tom and the new baby. She also noticed that, when discussions became tense around issues related to Karen or the new baby, whether she was talking with her mother, Tom’s mother, or Tom, she found herself blaming the other person and then withdrawing, telling herself either that she was not good enough to be a mother or that the grandmothers just wanted to control her. Amy decided to calm herself during these times by repeating to herself, “This Grandma loves [Karen, the new baby] just as my Grandma loves me. She does not want to control me, she wants what’s good for [Karen, the baby]. This self talk helped Amy to not withdraw and to change her part in the conversation.

A second new behavior is to accommodate to the other’s wishes, but maintain some control over part of the interaction. For example, a common issue revolves around visits to family members: where people will stay, how long they will stay, and what they will do while they are there. Often, people believe that the only way to avoid repeated conflict is to “divorce” the family. According to Bowen (1978), these kinds of behaviors foster “cutoffs” and are no less dictating of the client’s behavior than are acquiescing or giving in to
the other’s expectations. If the client can go for the visit, stay awhile, and behave partially as expected, she is less likely to receive “change back” messages that discourage change. Rather, she may elect to stay at a friend’s house or motel if the visit is at a distance, stay for only a few hours rather than the whole day, and walk into a different room rather than engage in the conflict or leave.

Partners can be very helpful in both of these endeavors. They can help the client by providing a signal when they think that the situation is escalating (such as a tug on the ear), by suggesting a walk, or by requesting a quick consultation in the backyard. These actions are accomplished best when agreed on by the partner and client beforehand. The act of working together on this plan often helps the couple develop a clearer boundary around their relationship and strengthens their intimacy in a way that does not require talking about their problems.

Amy understood the basic idea around developing a new way of behaving with her family, a way that involved neither distancing nor fighting. She decided to talk with Tom about a situation that he found difficult, rather than one she had trouble with. Her idea was that this would help her rebalance the power in her relationship with Tom so that she was helpful to him without overfunctioning. It also would help her understand what it might be like to be in his shoes when they were with her family. She and Tom planned a way for her to help him not get into arguments with his father’s brother, who had tended to take over the role of fathering after Tom’s father died. Amy was able to celebrate the successes of this new strategy with Tom and to not allow herself to get too discouraged when it didn’t work perfectly.

Many other interventions can be used within SCT as long as the client’s goals and unique system remain the focus. In this way, it is somewhat eclectic in intervention, but the general philosophy, concepts, and goals should be kept in mind, providing an integrative context for working. Paradoxical or “confuse” techniques should be avoided, however, because they often replicate the client’s problem-maintaining system rather than disrupting it. Many women are very confused, for example, by others’ reactions to their efforts to change power imbalances. The overt message often is that women have more power in heterosexual relationships because they are the ones who
press for more closeness and bring up issues. The contextual issue, however, often is that this is a rather impotent power in the face of men’s relative importance in society, their ability to control finances and to control their relationships with others, and that men are more physically intimidating. Therapists, especially male therapists, must be careful not to replicate these dynamics. Female therapists are likely to be perceived by the client as more powerful, however, by virtue of their position in the helping relationship as well as, perhaps, their education, status, and financial power.

**Termination**

Therapy is over when the client says it is over. When the client is ordered or sent to therapy by someone else, the client is still in charge of her therapy. The therapist may want to help the client by discussing the consequences of terminating therapy before the referring person’s goals are met or changed as well as discussing obligations to write reports to referring persons or others. At this point, it is most helpful to the client to have some sort of termination session and, perhaps, to write the report together. Many things in therapy may be left hanging or may change gradually and without particular notice. However, in terms of the reasons that the client established the relationship with the therapist, it is good to clearly redefine that relationship. The client and therapist may officially declare therapy over, in which case the relationship has become much more egalitarian. They may celebrate the client’s learnings and successes and discuss further changes she may want to make on her own. They also can discuss what she has learned about reactions from others to her changes, how she can anticipate those, and how she can adjust her behavior according to her wishes and desires rather than the dictates of others or out of habit.

There are times, however, when clients wish to take a break from therapy with the intention of returning or not, whichever their situation calls for. Successes can still be celebrated and lapses discussed, even when the client and therapist anticipate her returning at some point.

Amy returned to the therapist three months after her baby was born. The birth had been difficult and the baby was born addicted to methadone, as expected. The nurses had not been helpful and had called DCFS after witnessing Amy with the baby in what they believed was an intoxicated condition. The baby had been
placed in the custody of the state. Amy and Tom had moved out of his mother's home, but this development had shaken them so badly that they had moved back in. Amy was demoralized, shamed, and discouraged. The therapist asked Amy how she had avoided heroin during such awful stress, engaged Amy in more conversation about improvements as well as difficult situations, and contracted for more therapy to help Amy regain custody of her son. They worked on regaining the ground that Amy and Tom had made and developing new goals and strategies, based on what had previously worked for Amy.

REFERENCES


RECEIVED: 06/07/00

ACCEPTED: 07/12/00