ENGAGING MEN

SAMPLE CHAPTER

in

Couples Therapy

EDITED BY

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C H A P T E R 2

The Challenges of Conducting Male-Sensitive Couples Therapy

Common Pitfalls and Clinical Recommendations

DAVID S. SHEPARD AND MICHÈLE HARWAY

Couples therapy can be extremely challenging work, and a number of authors have noted the numerous clinical mistakes therapists can make, including failing to structure sessions, giving up on relationships prematurely, allowing arguments to escalate, timing interventions poorly, overcontrolling emotional expression, and accepting unfounded myths about the nature of healthy relationships (Doherty, 2002; Gottman, 1999; Weeks, Odell, & Methven, 2005; Weeks & Treat, 2001). After highlighting common therapeutic errors, these authors offer their own solutions, and in this chapter, we will follow that same sequence. Our particular focus is on where treatment can go awry when the clinician is not male sensitive. We define male-sensitive therapy as conceptualizing and intervening with an awareness of the particular fears, expectations, vulnerabilities, and strengths male partners bring into the treatment process. Our own thinking on male-sensitive couples therapy has been strongly influenced by the past two decades of scholarship on men and

http://www.routledgementalhealth.com/engaging-men-in-couples-therapy-9780415875882
masculinity, much of it authored by researchers and theorists associated with the New Psychology of Men studies movement (Levant & Pollack, 1995). However, our thoughts are also drawn from our combined experience of over 50 years of clinical practice with couples and our long-standing efforts to bring a gender-aware perspective to our work.

Needless to say, over the course of our careers, we have made clinical errors too numerous to mention, many related to unintended insensitivity to the male partner. From our backlog of mistakes, we have identified five pitfalls we believe are the most salient for the couples therapist: failure to sustain the therapeutic alliance by inadvertently taking sides against the male partner; failure to monitor countertransference reactions against the male partner; failure to recognize male avoidance and withdrawal behaviors as symptoms of depression; failure to recognize the therapist’s own internalization of traditional gender role norms; and failure to correctly assess intimate partner violence. The first four failures are related in that they are likely to stem from the clinician’s lack of familiarity with current scholarship on the psychology of men and masculinity. On the other hand, we have included the need to assess for intimate partner violence (IPV) with a full appreciation that most couples therapists have received at least some training in this area. However, although both men and women can commit acts of violence toward their partner, it is still mainly men who are the perpetrators, and it is a challenge for even experienced clinicians to assess and respond effectively. We would be remiss if we did not include failure to address IPV as a critical pitfall in male-sensitive couples counseling.

**CHALLENGE 1: MAINTAINING THE THERAPEUTIC ALLIANCE AND SUSTAINING BALANCE**

Bordin (1994) defined the therapeutic alliance as an emotional bond between clinician and client, a connection based on trust, shared goals, and clearly defined tasks; it is a relationship that is at once conscious and collaborative. As in individual therapy, the quality of the therapeutic alliance in treating couples is critical to the outcome of treatment (Knobloch-Fedders, Pinsof, & Mann, 2007). To form and maintain that alliance, the couples therapists must maintain a position of balance in relation to both partners: The therapist interacts with both partners similarly, using empathic and challenging statements for both, demonstrates an equal commitment to understanding both, and shifts attention from one partner to the other in an ongoing process that ensures both partners stay engaged in the therapy. Additionally, the therapist conceptualizes marital distress from a perspective that avoids identifying one partner as the source of the presenting problem, instead using a systemic lens for viewing each partner’s behaviors as a reaction to the other’s (Garfield, 2004). What destroys the alliance is when therapists take one partner’s side or are even perceived to have taken one partner’s side; this outcome
is most likely to occur when therapists fail to demonstrate equivalent empathy for both partners’ emotions and viewpoints, challenge one partner more frequently or with more intensity than the other, and assign causality to one of the partners in their case conceptualizations.

When we look at just a few of the common reasons couples come in for therapy, it quickly becomes apparent why male partners can challenge therapists’ capacity to maintain balance—it sometimes seems that men are the cause of the couple’s problems. For example, men are unfaithful significantly more frequently than women (Kadin & Lusterman, this volume; Peluso, 2007). Men have a more difficult time containing their anger when they are physiologically aroused, and are also more likely to withdraw and stonewall in difficult conversations (Bergenstal, this volume; Gottman, 1999). Men are more likely than women to struggle with identifying, verbalizing, and disclosing vulnerable emotions, processes critical to fostering intimacy (Levant, 1995; Rabinowitz, this volume; Wexler, 2009). Men are more likely to begin therapy with ambivalence, which requires therapists to attend to their conflicted feelings and resolve any negative transference, in turn robbing the female partner of time spent on relating to her (Englar-Carlson & Shepard, 2005). We point out this list of issues men bring to the therapeutic process not to suggest men are the problem or women bear less responsibility for troubled relationships, but rather to highlight how strong the temptation is for therapists to stray from a balanced position in both their thinking and their interventions.

Therapists also have to deal with the risk of a countertransference identification with the female client: Whether the therapist is male or female, he or she is likely to share certain values with the female client. For example, it is good to talk about relationships, express emotions, allow for dependence on others for help, verbalize emotional needs, and see intimacy as an essential prelude to sex. Thus, while therapists may be likely to agree that conceptualizing the couples’ difficulty from a systemic perspective, avoiding blame, and sustaining equivalent empathy for both sexes are essential to achieving balance, doing so is no easy feat. The following vignette illustrates how these temptations can play out in a session:

Mark and Annette were in their mid-30s and had been married for 5 years, with two small children. Six months ago, Annette sought individual therapy to deal with her growing dissatisfaction with the marriage. In therapy, she realized the extent to which she had settled for a relationship with an emotionally reserved man who was unlikely to communicate on a level that satisfied her needs for closeness. Her weekly sessions gave her the opportunity to vent her frustrations without “dumping” them on Mark, but this well-intentioned strategy wasn’t working, as Mark noticed her becoming increasingly irritable with him and escalating fights over petty issues. It was Mark who insisted they seek couples counseling, but Annette readily agreed.
Mark and Annette presented as intelligent, insightful people who had a palpable connection to each other. In the initial session, Annette described her frustrations with Mark in soft language; tears flowed easily as she disclosed her fears that the marriage could not survive if Mark didn’t work on expressing his emotions so she would know what was going on inside of him, and hopefully, feel closer as a result. As she cried, the therapist leaned forward, softened her voice, and gently indicated she understood her pain. The therapist thought, “I like this woman; she is in touch with her deeper emotions and risks sharing them; she works hard not to be harsh toward her husband; she owns her own role in their distress by admitting she failed to demand more from him. She makes it easy for me to empathize with her. I feel like I am doing good work when I talk to her.”

Mark presented as a kind man, certainly overregulated in his affect, and the first to admit he has trouble talking about his emotions. He grew up in a family environment characterized by a cordial superficiality between his parents, where the rule was people should be pleasant but avoid strong emotions. Mark quickly agreed with Annette that he needed to work on learning how to express his emotions better. With a chuckle, he said, “It won’t be easy for me, you know.” Annette reacted sharply to his light tone. “Mark, this is very important to me. I don’t know if I can stay married if you don’t do this.” Mark immediately assumed a serious look on his face, though finding it difficult to make eye contact with her, and said to the therapist, “I do want to change.” The therapist thought, “I like Mark, too. I’m going to enjoy helping him learn how to own his feelings and share them. This case is going to go very well.”

The therapist subsequently proceeded to help Mark loosen his restricted emotionality and found numerous strategies in the literature for achieving this goal (e.g., Johnson, 2004; Rabinowitz & Cochran, 2002; Wexler, 2009). Initially, Mark positively responded to the interventions and truly got better at expressing his emotions in therapy. However, one month into the treatment, the couple reported that they had had a terrible fight, after which Mark had completely shut down emotionally, Annette was about to give up on the marriage, and the relationship was in crisis. The therapist thought, “What happened? It was going so well. Did I miss something?”

Several clinical errors events occurred in the first session that disrupted the therapeutic alliance and led to relationship deterioration: (a) The therapist’s focus on Mark stirred up both resentment and an underlying shame at being labeled as the source of the problem, which he kept under wraps in sessions but eventually led him to shut down his emotions at home—his habitual strategy when faced with conflict. Mark’s eager acceptance in therapy of the notion that his restricted emotions were dysfunctional represented his sincere desire to do whatever it takes to “fix” the relationship. But inwardly, this focus on his emotional life was both wounding and frightening, challenging a lifetime of
socialization experiences teaching him that the expression of vulnerable feelings ran counter to the masculine ideal. (b) The therapist had challenged the partners unequally, pressuring Mark to change without confronting Annette’s need to control him, a behavior that had manifested in how she defined the couple’s problem in the initial session. Mark had silently watched the therapist respond soothingly to Annette’s tears, observing the therapist’s compassionate voice and approving head nods. The Annette he knew could be so different at home—demanding and argumentative to the point that Mark would withdraw in order to cool down his surging, adrenaline-fueled anger. (c) Finally, Mark had entered therapy fearful that a female therapist would ally with his wife, and focus on female-associated skills, which meant the strengths he brought to the relationship would be minimized. Not only were these fears realized, but the therapist failed to bring out into the open the possibility that Mark might have understandable anxieties about a female–female coalition forming against him.

Garfield (2004) recommended that in order to maintain balance and strengthen the alliance, the therapist needs to spend more energy connecting with the male partner at the beginning of therapy, while still keeping the female partner engaged. Her issues will certainly be addressed, and in future sessions given the attention they need, but the therapeutic alliance paradoxically becomes more secure when the therapist focuses on engaging the male in the first sessions. Indeed, two research studies did find that the strength of the bond between the male partner and the therapist was more important than the female–therapist alliance in predicting outcome (Bourgeois, Sabourin, & Wright, 1990; Symonds & Horvath, 2004). Nevertheless, we would modify Garfield’s recommendation by suggesting that both partners need to experience balanced attention from the very beginning, but it may require additional effort to engage the male (e.g., noting his strengths, inviting him to talk about his work), especially if he has a tendency to withdraw. We have also found it useful to frame the emotional expressivity versus restrictiveness issue as processing-style differences; this approach removes the implication that the therapist values an expressive style and relieves the male partner of his fear that the therapist prefers his wife’s personality over his. We might say, for example, “Annette, you tend to feel first and then think about your emotions, which is valuable in getting you guys to feel close. Mark, your style is to think first and take longer to tune in to your emotions; that’s a real strength in making critical decisions in the marriage, plus, I’m guessing it’s a strength for you at work. What are your thoughts about how it affects your marriage?”

When the therapist is female, it is especially important that she ask the male partner whether he has any concerns about working with a woman counselor. She can elicit a discussion of his fears, reassure him, and encourage him to give her feedback if at any time during therapy he is feeling ganged up on (Englar-Carlson & Shepard, 2005). When the therapist is a man, he can have a similar conversation with the female
partner, but also recognize that the male partner still may have anxieties about a therapist–female partner coalition, and they need to be addressed openly. In both cases, transference issues need to be monitored: The female therapist may be perceived as the abandoning mother and the male therapist, the competitive, even emasculating, father. The degree to which the therapist discusses transference issues depends upon theoretical orientation, but regardless of the model the therapist uses, it is important that male withdrawal behaviors be recognized as possible signs of a rupture in the therapeutic alliance and a loss of balance.

**CHALLENGE 2: MONITORING COUNTERTRANSFERENCE TOWARD THE MALE PARTNER**

A very different presenting problem illustrates the challenge to sustaining balance when the therapist experiences a strong negative reaction to the husband, and a number of situations can trigger conscious or unconscious hostility and judgment on the part of the therapist. Trust violations and displays of aggression are obvious ones, but even more subtle male behaviors can elicit countertransference (e.g., toward men who persist in using an emotionally detached cognitive style despite therapeutic encouragement to do otherwise). In the following vignette, the therapist monitored her negative reactions and successfully finds male-sensitive empathic language to ensure a balanced position is maintained and the alliance not damaged.

When Rod and Karla came for their first session, Karla was already seething, ready to explode with pent-up anger. Rod was calm, congenial, articulate. As they sat on the couch, Karla made no eye contact with Rod and quickly pulled her hand away when Rod reached out for it. The counselor's immediate thought was “They seem like a couple where the husband has had an affair.” Karla spoke first, explaining why they were there: Their marriage had never recovered from an event that occurred 6 months ago. Karla’s mother had died after her third bout with cancer. The final ordeal had lasted for 2 weeks, during which time Rod, “by choice,” Karla emphasized, went road biking in Italy with a group of male friends. The therapist felt an awareness of shock and heard herself think, “He did what!?” Karla didn’t know which hurt more: her mother’s death or Rod’s leaving her alone when he was fully aware her mother might die at any moment. “So Karla, you felt abandoned that Rod was away during this terrible time for you, and you still are hurting.” (Empathizing with Karla while being careful to word it as Karla’s experience rather than Rod’s actual abandonment.) Karla’s eyes welled with tears as she nodded. Rod interjected forcefully, pleading for understanding from the counselor. “You’ve got to understand. I’m a very responsible guy. I made sure her mother had the best possible care. I invited Karla’s sister to stay in our house. And I’d been training for this trip for two years. It would
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have made no difference if I'd have stayed home, but it would have been terrible if I missed out on this once-in-a-lifetime opportunity." The counselor thought, “Is he incredibly narcissistic, or just clueless about how he hurt her?” What she said is, “Rod, it makes complete sense to you that you would go on the trip. (Letting Rod know she recognizes that Rod thought this through and made a rational choice, implying appreciation for how Rod thinks; also, immediately making it clear she was not judging him or taking Karla’s side.) It was really important to you—probably something you’d been dreaming about for years (empathizing with Rod’s value system and making contact with Rod’s deeper yearnings)—and you stepped up by make sure her mother got good care at the end.” (Using a sports metaphor associated with courageous male behavior; making positive use of a maternal transference by praising him.) Rod’s shoulders relaxed in relief, but Karla was in shock hearing the counselor say this. “And Karla, you’re still stunned—it’s like, how come he doesn’t understand why you feel so betrayed.” (Immediately reestablishing an empathic connection with Karla, using words that reflect the intensity of her emotional experience.)

The art of staying balanced in couples work in general is a kind of dance, where “the therapist needs to be able to move freely back and forth between members of the couple, always attending to the invitations to join one against the other” (Rait, 2000, p. 214). The case of Rod and Karla demonstrates how the art of maintaining a therapeutic alliance in male-sensitive couples therapy is staying equally empathic to both partners when the man is pushing the therapist’s buttons.

CHALLENGE 3: ASSESSING FOR MALE DEPRESSION

For over 20 years, a number of researchers in men and masculinity have speculated that many men with a subclinical level of depression either hide or act out their symptoms in such a way that intimate partners, friends, and even health professionals, do not recognize that these men are depressed (Cochran & Rabinowitz, 2000; Rabinowitz & Cochran, 2008; Shepard, 2002). The notion is that men may mask their depression because overt expressions of sadness and emotional pain conflict with such traditional male role norms as stoicism, strength, and self-reliance (Pollack, 1998). Whether deliberately or unconsciously hidden, the depression does manifest itself in a number of forms, including irritability, expressions of anger, and increased interpersonal conflict; self-medication through alcohol or substance use; and withdrawal from partners and other close connections (Rabinowitz & Cochran, 2008).

The construct of a masked or hidden depression has been difficult to prove empirically (Addis, 2008). Nevertheless, we have found it to be heuristically invaluable in our work with couples, helping us distinguish between couples’ distress rooted in repetitive negative interactional sequences or dysfunctional communication processes, and distress
actually caused by the depression of the male partner. What makes correct assessment especially challenging is that depression can lead to these other, typical problematic couple interactions, and we suspect many couples therapists may find themselves treating these derivative symptoms rather than the true problem. The following brief vignette illustrates why masked depression is easy to miss.

Kate and Roger are a couple in their late 20s, married 5 years with a satisfying relationship for most of that time. When their first child was born 6 months ago, Kate expected Roger to take care of more of the household chores so she could concentrate on attending to the baby's needs. Instead, Roger spent increasing time glued to his computer, spending hours on stock trading sites, and significantly less time engaged in the kind of meaningful, close conversations the two of them had previously enjoyed. Kate found herself becoming a nag, constantly pointing out to her husband that chores needed to be done; Roger would initially complain about her nagging, and then withdraw into his home office, leaving Kate increasingly frustrated, angry, and exhausted taking care of both baby and house. As for sex, it stopped completely.

Therapists treating this couple and not appreciating the role of depression might attend to the pursue–withdraw cycle, perhaps reframing Kate's nagging as an “abandonment protest” (Greenman, Faller & Johnson, this volume; Johnson, 2004) or Roger's withdrawal as “stonewalling” (Bergenstal, this volume; Gottman, 1999). They might facilitate improved communication skills, so both partners can articulate their frustrations and truly hear their partner. They might address the challenge to homeostasis triggered by the new baby, and help the couple negotiate new rules in their system. What they might not do is understand that Roger is depressed; he had yearned to be a father, but watching Kate's intuitive mothering skills left him feeling useless and incompetent. Roger had managed for years to submerge doubts about his competence and value as a man, and when his hopes that fathering would eliminate those fears were dashed, the result was an emotional crash—a depression that manifested as withdrawal; workaholism; loss of sexual desire; and a gradual, painful “shutting down.”

The pattern of male withdrawal accompanied by female pursuit via complaining is obviously an insufficient basis for assessing for male depression, let alone diagnosing it; it is hard to think of couples who do not feature this sequence to some degree. We have learned instead to be alert to additional evidence that may enable us to conceptualize that male depression is playing a central role in the couple's distress. These include the following:

- Physical expressions of shame (e.g., frequent turning away from the partner and looking down)
- Narcissistic vulnerability (a proneness to anger despite the fact that the partner's criticisms are mild or delivered softly)
- Self-critical comments that have a harsh, punishing quality
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- Evidence of self-medication
- A withdrawal that seems more like hiding from the partner than normal attempts at increasing relationship distance
- A personality style characterized by marked cynicism, bitterness, and pessimism
- Unusual difficulty for us as therapists to facilitate the man’s engagement with his partner

Once we have assessed that depression exists, the challenge becomes how to address it in treatment. To be sure, there are a number of minefields: if we raise the issue of depression, the man may hear us as saying, he is “the problem”; labeling him risks a rupture in the therapeutic alliance and unbalancing our relationship with the couple; we may indeed find ourselves over-focusing on the male partner in our treatment interventions, which may increase his self-blame and shame; we may be sending the message that the female partner no longer needs to examine her role in the couples’ struggles.

When we bring up the possibility that the male partner is depressed, rather than present a diagnosis, we try to do so in a way that engages both partners’ curiosity and desire for information, at the same time making it clear that we are open to being wrong in our assessment. The conversation might go like this:

Roger, I’m just wondering. Do you see yourself as depressed? (Immediately assesses client’s level of self-awareness.) OK. Let me just share some research findings with the both of you. (Engages partners’ curiosity; minimizes defensiveness.) Roger, please tell me if any of this fits, or if it doesn’t. (Empowers client to refute the therapist). Kate, I’d like to hear your thoughts as well. (Ensures female partner stays engaged and potentially adds valuable information to therapists’ assessment.) Researchers have found that a lot of guys who know they are stressed, don’t feel like being with people as much, and are just having a hard time enjoying life the way they used to may actually be experiencing a depression. You don’t have to be miserable, crying all the time, and feeling suicidal to be depressed. There are other ways people can be depressed and not even realize it. (Presents concrete information; normalizes male partner’s lack of awareness regarding his depression.) This is especially true for men, because they are taught since elementary school that it’s not cool to feel sad or afraid. I’m guessing, Roger, that you learned pretty quickly that men don’t say, “Hey, guys. I’m feeling pretty sad right now. I need some help. Let’s talk.” (Uses humor and exaggeration to engage male partner in discussion of painful material.) Roger, I’m wondering if you could explain to Kate how you learned to hide feelings? (Initiates dialogue with man leading conversation; facilitates male partner’s self-exploration.)

The desired outcome is that the male partner becomes increasingly intrigued by his own experiences and wants to talk about them with his female partner. She, in turn, develops empathy and compassion for the male partner, as well as greater insight into his life narrative. She also
feels relieved, because her intuitive sense that her partner was unhappy has now been validated. At this point, the therapist needs to add, “I want to make it clear that I don’t see Roger’s depression as the problem here—it’s just a factor. Both of you play a role in the negative cycle that’s been so hard for you to break. But it’s an important factor, and we can do something about it.”

CHALLENGE 4: RECOGNIZING ONE’S OWN GENDER ROLE SOCIALIZATION

There is an abundance of literature that a man’s or woman’s rigid adherence to a stereotypical definition of masculinity and femininity can have deleterious consequences on the person’s mental and physical health (Wexler, 2009). Moreover, even as men and women increasingly experiment with behaving in ways that conflict with traditional norms, there is evidence they will encounter social and economic penalties (Moss-Racusin, Phelan, & Rudman, 2010). It is probably safe to suggest that most couples therapists, even if not aware of the research, recognize the negative impact inflexible adherence to gender role norms has on clients’ lives, for themselves and their partners.

Nevertheless, whether we are female or male, we have all learned the classic hallmarks of the male role—stoicism, dominance over others, aggressiveness and bravado, and avoidance of the tender emotions associated with femininity (David & Brannon, 1976). When male partners deviate from these norms, we need to be careful to monitor our own cognitive and emotional reactions, appreciating the risk of forming negative judgments that stem from our own socialization experiences. Assuming we are free from those judgments can lead to clinical errors.

For couples therapists, perhaps the most damaging stereotype when it comes to conducting male-sensitive therapy is that men are hardwired to have limited abilities in sustaining committed intimate relationships, requiring more autonomy than connection. John Gray’s “Mars–Venus” books have been popular since they first appeared in the 1990s, and have promulgated the message that men are fundamentally different than women when it comes to relationships (e.g., Gray, 1992). Although these books may have played a helpful role for some couples in facilitating acceptance of each other’s differences, they also may be spreading notions largely unsupported by empirical research (Heesacker, Tiegs, Lawrence, Smith, Cawood, & Mejia-Millan, 2006). At the same time, evolutionary psychology theories on sex differences have argued that men are hardwired to seek multiple sex partners while women strive for committed relationships—both in the interest of passing on their genes (Buss & Schmitt, 1993).

While psychological sex differences certainly do exist, we would argue that the couples therapist who believes that men do not desire closeness as much as women do are both buying into stereotypes and
confusing the idea of innate tendencies with inability due to gender-role learning experiences. In other words, we believe men not only desire closeness as much as women, but are equally capable of talking about their desires when the therapist helps them to do so. True, some men prefer to avoid analyzing issues of closeness and distance in a partnership, but it is because they do not feel competent at it and are trying to avoid the shame of failing at it, not because they are incapable of articulating their needs (Shepard, 2005). The clinician sensitive to any of these constraints can assist the male partner in finding the courage to express his most profound and deepest feelings and yearnings regarding connection to his partner.

The particular pitfall inherent to seeing men through the prism of stereotype is that the therapist may unwittingly act out, via lost opportunities for empathy, judgmental confrontations, or loss of objectivity, his or her negative reactions toward the man when he behaves in atypical gender role fashion. The following vignette illustrates what happens when a therapist (in this case, a male) deals with a situation in which the female partner has become the primary breadwinner, a dynamic occurring with increasing frequency in this era of two-income families and stressful economic conditions. It also demonstrates how male shame can trigger strong reactions on the part of the therapist.

Jason was a self-employed computer consultant whose business had fallen off dramatically in the last year. On the other hand, Erin’s career as an executive coach was taking off, helped by her outgoing personality, work ethic, and strong organizational skills. In their late 30s with two children, they had been fighting continuously for months, almost always over money issues, and sought counseling to improve their “communication skills.”

Both partners agreed that they were caught in a repetitive cycle where Erin would accuse Jason of not doing everything possible to earn more, and Jason would defend himself. The therapist watched them play out this pattern in the second session. Erin, her voice calm and firm, said to Jason, “Look, honey, I’ll help you develop a business plan. I want you to succeed. But you’ve got to get yourself out there—you’ve got to call people every day. You’ve got to do the legwork.” The therapist thought, “She’s making a reasonable request and she’s being supportive.” Jason snapped back with unexpected anger, “Nothing I ever do is good enough for you. Just get off my back.” The therapist thought, “He’s highly reactive. She wasn’t accusing him of anything. I need to monitor his narcissistic vulnerability.”

Before the therapist could respond, Erin jumped in, this time with steel in her voice. “Jason, you’ve got to take a hard look at yourself. You’re not pulling your own weight. You’ve just got to man up.” The therapist thought, “That was delivered too harshly, but she’s not wrong.” He observed Jason withering, wrapping himself into the couch. “Just back off, Erin, really—just leave me alone … for chrissake, what would you like me to do? You want me to get a job at Staples? Fine. I’ll call them
in the morning.” The therapist thought, “I feel something weak about him, too. I can’t put my finger on why, but I’m not liking him right now. I need to be careful in what I say and focus on the system, rather than on him.” The therapist said to both of them, “Here’s what I see. Erin, you demand that Jason be strong, and Jason, you react by pulling away, and Erin feels unheard and even more angry. That’s the system you’re stuck in. Jason, I’m wondering if we can change this pattern if you actually stand up to her. Tell her how she makes you feel, right now.”

Jason looked in horror at the therapist. He stood up to his full height and paced before the therapist, muttering “I can’t believe this is happening.” The therapist thought, “He’s trying to intimidate me, and I’m losing control of the session.” “Jason,” the therapist said, “I want to help the two of you, but you’ve got to sit down.” He complied. “OK, OK, I’m sitting. But here’s what you’ve got to know. You know how it feels to make less money than her? I can you tell you—it sucks! But I’m still there for her in every possible way. I have dinner ready when she comes home. I listen to her vent about her tough day. I’m there for the kids 24/7. I’m doing all of that and I’m trying to make more money, goddamit, but have you looked at the economy lately?” Erin stepped in, more softly this time: “Jason, all of that is true. You have been wonderful. I just feel … I just feel so untaken care of.” The therapist was now feeling completely ungrounded. “She’s right, he’s right, I’m confused …”

Everyone in this vignette—clients and therapist—was caught up in a conflict-riddled web of emotions arising out of the couple’s shifting gender roles. Erin was in the midst of a tug-of-war between the part of her committed to her career and another part that yearned to be taken care of in the more traditional feminine role learned throughout childhood and adolescence. Through that same socialization process, she had internalized the belief that men are supposed to be strong and the main provider, and when Jason failed at this, she inevitably judged him as weak. Underlying this judgment was a self-condemning voice in her head, saying, “What’s wrong with me! I married a weak man.”

Jason, of course, had internalized the same values and in his darker moments, thought of himself as weak. He struggled to maintain self-regard in the relationship by defending himself and fighting with her. The therapist was confused, because he (and it would be the same with a female therapist) also had internalized these gender role norms, and sensed his own condemnation of Jason, even as his “clinical superego” warned him against it. Ironically, neither Erin nor the therapist was entirely wrong. Jason may very well be weak, not as they have framed it with its pejorative gender role connotations, but in a psychological sense: shame, stress, discouragement, disappointment in himself, and the knowledge that he has disappointed his wife have sapped his emotional resources, leaving him drained of confidence and energy.

The therapist had in this moment lost his ability to decenter, the capacity to step back from his emotional reactions toward his clients and instead think about what the clients are feeling (Basch, 1988).
The same socially constructed definitions of masculinity and femininity constraining both partners' capacities for seeing their way outside of their distress were also handcuffing the therapist. Moreover, his countertransference reactions to male shame were playing a role, as his instinctive negative reaction to Jason stirred up his internal struggle to maintain objectivity.

The challenge this therapist was trying to deal with is one we experience frequently when our male clients’ failure to embody traditional masculinity leads to shame. We sense the male partner’s desperation, and summon our compassion and empathy, yet find it eludes us; there is something about him we just don’t like. While trying not to ally with the female partner as we hear her blame and criticize, another voice within us identifies with her frustration. As a result, we risk not seeing and responding to his pain in not living up to male role norms. We miss sensing, for example, his feelings of inadequacy and the expectation that his partner judges him. We miss noticing the feelings of failure and shame (in Jason’s case, the failure of his career aspirations and shame at not taking care of his family as a “man” should). We miss observing how disconnected the man feels from his wife, retreating from her, or pushing her away with aggressiveness as he tries to reassert his masculinity and shore up his weakened self (as Jason did when he stood up and paced). Finally, we miss the chance to validate the courage and strength it can take for some men to behave in nontraditional ways.

In addition to monitoring our personal emotional responses to a man who deviates from role norms, we have found several interventions that have helped us in situations such as the one the therapist experienced with Erin and Jason. First, we may introduce the concept of gender role socialization, and invite both partners to explore how they learned in childhood and adolescence what it means to be male and female. This step immediately shifts the focus out of a tense, blame-withdrawal pattern and into safer ground. Moreover, bringing in the experiences of the male and female partner ensures balance and increases opportunities for reciprocal empathy. We may self-disclose our own experiences here, as a way of facilitating the conversation and sending the message that no one is immune from these powerful developmental forces. Second, we invite the couple to explore the costs on both their relationship and psychological well-being of adhering to or deviating from traditional norms.

Third, we use this discussion as an opportunity to help the male client verbalize emotions, especially when he is the kind of man who has difficulty with identifying or expressing affect. Discussions of socialization experiences, rather than remaining sterile intellectual exercises, can be used as a safe format for the male to describe intensely painful experiences. When he talks about hurtful moments (e.g., failures in sports, rejections by a girl, humiliation by a male authority figure), we help him focus on his emotional reactions, and if given the opportunity, introduce the concept of shame.
Therapist: Jason, can you sit with that feeling for a moment longer? What’s going on inside you as you talk about that memory of trying to ask a girl to go out with you and getting turned down? (Helping Jason focus on the emotional experience in the present.)

Jason: I really was pretty scared when I called that girl. It’s weird, isn’t it, how when you’re 14, girls can have such power over you?

(The therapist brings the focus back to his emotion.)

Therapist: Jason, stay with that feeling of fear when you dialed the phone till you can start to touch it again. Now, tell me where in your body you are experiencing it. What’s going on for you?

Jason: I can remember what it was like when I hung up the phone as soon as I heard her voice. I’m feeling it again right now—in my gut—all the air going out of it.

(The therapist uses this opportunity to explain to both partners that the emotion being described is shame.)

Therapist: The word for that feeling is, shame, and so now when you feel it again, you’ll know that’s what’s going on. Erin, do you know what that feeling is like? (Reengaging the female partner and facilitating a connection between them as Jason reexperiences shame.)

Erin (softly): Do I ever. (She grabs his hand and holds it, strengthening the connection and implicitly letting him know shame is tolerable when you verbalize it with your partner.)

The tendency for therapists to have a visceral negative reaction to a man’s experience of shame in part may derive from therapists’ disowning of or disgust with their own shame. Observing “weakness” in a male partner can activate within us an association first, with his shame, then with our own. By appreciating this process within ourselves, we gain a greater empathy for both the male client and his wife or female partner, who may be undergoing a negative reaction to the male similar to our own. We are then in a position to facilitate an empathic connection between man and woman, where the man has the novel experience of having his shame seen and not judged by his partner—a moment that might help heal wounds from his own male socialization humiliations, but just as importantly, help to heal the wounds in the relationship.

**CHALLENGE 5: ASSESSING FOR DOMESTIC VIOLENCE**

One of the most challenging aspects of working with couples is that interpersonal violence may be present in the relationship and not made known to the therapist. Since the majority of cases involving intimate partner violence (IPV) include a male perpetrator and a female recipient
of the violence, it seems an important topic to include here. The failure to assess for IPV in all couples presenting for therapy constitutes a large pitfall in our clinical work that may have disastrous consequences. Assessment for IPV specifically is critical because couples who are experiencing violence in their relationships are unlikely to volunteer this information and thus the couples therapist must do an appropriate assessment to rule out partner violence. Couples therapists do not always do this.

At the same time, couples for whom violence is an aspect of their relationship often do not report this at intake (Ehreshaft & Vivian, 1996). For one, couples experiencing violence do not see it as an issue of concern, as they might see their problematic or nonexistent communication, their sexual issues or even the infidelity, which may have been the incentive for seeking therapy. The violence, which is usually intermittent in its occurrence, is seen as secondary to the other issues and not the root cause of the couple’s difficulties nor of particular importance to resolving the couple’s difficulties. As a consequence, some couples may not even think to mention that this is an issue with which they struggle. Other couples may not mention the violence because of the shame that its admission elicits: the perpetrator (usually but not always the man) feels deep shame at having beaten his partner, the recipient (who often takes responsibility for eliciting the violence because she has been told that it is her fault) experiences shame for being in that predicament. Moreover, the recipient of the violence, wisely, may not mention the violence since doing so would violate a sometimes unspoken rule that it is to be kept secret and would potentially expose her to renewed beatings.

If the couple does not mention the violence to the couples therapist, then how is the therapist going to find out about the violence? This is where doing a proper assessment to rule out partner violence is important to do in any instance involving couples no matter what they describe as the issue that brings them into therapy. Asking a question directly about physical violence is not likely to yield information about the existence of underlying violence and consequently is not going to rule out its nonexistence. Instead, the properly trained clinician will screen all couples for partner violence using a systematic process such as we demonstrate in the following vignette:

Tony and his wife, Susan, were referred to a therapist for couples therapy because they were having some serious communication problems and were in considerable distress. As is usually the case, the wife called to set up the first appointment. The therapist asked her to describe the issues that brought them to therapy and while she indicated that they were communicating with great difficulty, she emphasized that both she and Tony were eager to get some help. Although IPV had not been mentioned on the phone, because of the high incidence of this issue with couples seeking therapy, the therapist, well trained in IPV assessment, wanted to set up appropriate expectations for the first session. Therefore, she described the intake process she takes with all couples
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presenting for couples therapy and describing difficult communications. The reason for using this process with all couples is because of the incidence of abusiveness in couples and the fact that couples do not volunteer to the therapist information about IPV (if there is any). Failing to do a thorough assessment at intake ruling out the possibility of IPV may result in the therapist treating a couple for a simple communication issue when something more complicated and more dangerous may underlie the case.

As a consequence, the therapist described her intake process during the initial phone call. She told Tony and Susan that her intakes with couples consist of four parts: an initial brief segment with the two of them together, a few minutes spent alone with Susan, a similar time alone with Tony, and then a final few minutes to make recommendations for the treatment.

When Susan and Tony arrived for their intake session, the therapist assessed whether Susan appeared to be afraid of Tony or seemed to be doing things to avoid angering him. Since in most cases, the root of IPV is control, the therapist examined whether she is feeling controlled by Tony; she listened for complaints of jealousy, especially those that seem exaggerated; she paid attention to whether there is a pattern where Tony seems to always focus on what Susan has done wrong (victims usually blame themselves); she assessed whether the couple or Susan seem isolated from family and other social support; and she evaluated whether Tony seems to want to be right at any cost. All of these would suggest that this may be an abusive relationship.

With these pieces of information about the couple's interaction style, the therapist proceeded to the next part of the intake, which involves spending a few minutes alone with Susan. As the possibly abused one, she was more likely to disclose incidents of violence if they exist. Then armed with that information, the therapist could speak with Tony with the goal of getting him to admit to abuse. The specific procedure she uses entails asking a series of more and more specific questions about how the couple handles disagreements with the same questions being asked of both, in a sequence described in Harway and Hansen (2004). It uses the freeze-frame procedure in which the therapist asks Susan to describe in great detail how a disagreement has been dealt with.

**Therapist:** I asked Tony to describe how the two of you have talked about the problem he sees with the children and he didn't seem to want to talk about that. Can you think back to a recent time when the two of you discussed this issue?

**Susan:** Well, last Tuesday, Tony came home from work and yelled at the children. Then he turned to me and told me what a lousy mother I am that I can’t control the children. We had a big argument over this but we made up the next day.

**Therapist:** Hold on a second, this is going too fast for me. I’d like to go back over each piece of what happened and go really slowly so
I can understand what happened. So Tony walked in the door. What did he say when he first got home? (Susan responds that he yelled at the children.) What specifically did he say? Where were you when that happened? What if anything did you say to him? And then what did he say or do? (Susan responds to each of these questions.) What did you say in response to that? What happened next? And so what did you say or do then? What did Tony say or do?

The purpose of each of these questions is to break down the interactions in a freeze frame way, freezing each interaction as one might slowly freeze each frame of a movie so as to better understand the details of each scene. Doing so allows the therapist to discern whether any violence may have occurred during the interaction, a detail that often gets glossed over in the client’s initial description of the situation. Note that in Susan’s original description, one gets very little information about the argument itself or the specific behaviors or words of either Tony or Susan.

A little later in the intake if the freeze frame has not yielded information about any violent interactions.

**Therapist:** I know this is probably difficult for you, but I wonder whether during the argument you described in some detail just now Tony ever pushed or shoved you? (Followed by a long list of other physically abusive behaviors, for example, slapping, kicking. The long list is important because there is evidence that some of those behaviors may not be construed as battering or even abuse if a more general question were to be asked.)

After Susan answers the question, the therapist may also ask whether Susan has ever felt afraid as fear is the single best indicator that abuse is a factor. At the end of her time with Susan the therapist should have a fairly clear idea of whether violence is an issue in this relationship. If it is, she must provide Susan on the spot with information as to how she can get some help. If Susan has indicated any existing violence, the therapist is better prepared to ask Tony similar questions, allowing her to be even more persistent with him than she might otherwise be. It will be important to have him own some aspect of the abuse, even if he underplays its significance or intensity. If he discloses that information, the therapist can then make a recommendation for treatment of the domestic violence. She would do so rather than focus on a couple’s communication issue as this may not be the central issue at all.

**Therapist:** I’d like to go over with you the argument you and Susan had over the problem with the children. 

**Tony:** There really was no issue. We discussed it a little, disagreed, and then we moved on.
Therapist: Tony, I’d like to be a fly on the wall and get a sense of what each of you said and did, in detail. So, tell me more slowly now, what happened?

Tony: When I got home from work last Tuesday, the children were out of control. I told Susan that I was tired and that it was her job to control them.

Therapist: What did she say or do? (As Tony responds to this, the therapist uses the freeze-frame approach previously discussed asking about individual interactions and words. She gets to the heart of the argument.) … So what did you do next when she said that to you?

Tony: I called her a bitch!

Therapist: So, then what happened?

Tony: She didn’t like it.

Therapist: How do you know that?

Tony: Because she started to cry.

Therapist: So what did you do next …?

Tony: I was pretty upset …

Therapist: Yes?

Tony: Just that, I was upset.

Therapist: So what did you do?

Tony: I don’t know … I was upset.

Therapist: Is it possible that you may have pushed her a little?

Tony: Is that what she told you?

Therapist: I’m really interested in your view of what happened here.

Tony: Well, I may have pushed her a little … but I didn’t hurt her. She stormed out of the room and went to make dinner.

This admission on Tony’s part is important as the therapist cannot acknowledge that she has gotten any information from Susan about abuse without further endangering her.

Also while some would disagree, most clinicians would concur that doing couples therapy when domestic violence is a factor is not indicated. Most would recommend that the perpetrator be referred to some type of batterer’s treatment group and that the abuse recipient should get therapeutic support during this time.

During the final phase of the intake, the therapist presents the couple with the results of her inquiry. If violence has emerged during intake and she has been successful in getting Tony to admit to having used it, the following may ensue.

Therapist: Tony, you told me that when you and Susan had that disagreement last week, you got pretty upset and pushed her a little. Right?

Tony: Well, it really wasn’t much of a push, but I guess so.

Therapist: Given that and also the fact that you, Susan, told me about some of your issues which are impeding the progress of this
marriage, I would like to recommend that we put off working on the issues that you have as a couple and first deal with these individual issues. So, Tony, I am going to refer you to a group that a colleague of mine does for men who have issues similar to yours. *(The therapist never mentions abuse or battering by name.)* And, Susan, you should probably consider individual counseling. I can provide you with some names of therapists. At the appropriate time, we may then want to take up the issue of couples counseling again.

**Tony:** Hold on a second … what’s this group you want to send me to?

**Therapist:** Most of the men in the group are in difficult relationships and they are having a hard time getting what they want in the relationship without getting really angry. The group is focused on helping them develop a better and safer relationship. *(The therapist reframes treatment for anger/abuse as increasing relationship skills, making it easier for Tony to embrace the idea of individual treatment.)*

**Tony:** Is it one of those anger management groups?

**Therapist:** I think of the group as more of a relationship building one although learning to control anger may be a piece of what is covered there. It’s difficult to have a good relationship if one person is angry all of the time.

**Tony:** I’m not one of those out-of-control angry guys!

**Therapist:** I know that Tony. I also know that you love Susan and want your relationship to work. *(The therapist avoids confronting Tony or demonstrating judgment; instead, the therapist appeals to his aspirations for a better relationship.)* I think this group could help you a great deal. I hope you will seriously consider it. *(The therapist’s phrasing avoids commanding Tony, which would challenge his masculinity and need for control; instead, the therapist uses the word “hope,” which leaves the choice up to him.)*

The therapist was able to reduce Tony’s defensiveness because she was able to understand the roots of abusive behavior for men. Abusive men were often shamed as children *(Dutton, 1995)* or feared losing their parents’ love. Like most men, they were socialized from an early age to ignore or avoid feelings, especially those related to painful experiences. As adults in intimate relationships, abusive men may experience the cycle of feeling avoidance *(Harway & Evans, 1996, p. 363).* This cycle suggests that when a difficult interaction occurs between an abusive man and his partner, he may unconsciously interpret the partner’s behavior as a rejection, may fear losing her love and simultaneously deflect the feelings, using abusiveness as a way of essentially “self-medicating” against the painful underlying feelings.

In a great majority of cases, referrals to individual treatment—psychotherapy for the female and group work for the male—do not result in the couple getting the help they need. Tony may, in fact, leave
the therapist’s office muttering about that therapist’s incompetence and determined to find a “better” couples therapist who may help with their communication issues. They are likely to find someone who will not assess for the violence and treat their communication problem instead. That is why it is important to ensure that all therapists are adequately trained in this area. If violence does not seem to be present with the couple, then the therapist can proceed with doing more standard couples work focusing on their communication problems.

CONCLUDING THOUGHTS

This chapter has reflected five very different pitfalls in engaging men in couples therapy. Although suggestions for how to deal with these pitfalls have varied, there are two common themes we would like to highlight: the importance of the use of language and the existence of shame as an underlying mechanism in many couples presentations.

*Use of language.* The first theme underscores the need to carefully use language in dealing with the men in the therapy room, in particular, language that avoids shaming, highlights strengths, and presumes the male partner yearns for closeness as much as his female partner does. The therapist treating Mark failed to appreciate how talking about his emotional inexpressiveness made him feel isolated in the therapy room and judged by his therapist, leading him to eventually shut down. Rod’s therapist was more agile with language and, in spite of her own countertransference, was able to attend to his needs for understanding his choices and to use sports metaphors and other male-oriented language to join with him. Roger’s therapist, after identifying his masked depression, presented research findings to the couple, appealing to his intellectual curiosity instead of labeling him as depressed. With Jason, the therapist’s countertransference around gender issues muddied the waters and prevented him from seeing his male client’s shame and desperation. However, talking about gender role socialization and costs of adhering to traditional gender norms provided a safe holding environment in which Jason could start to open up. Finally, Tony’s therapist’s careful use of language to avoid shaming him about his fears of abandonment (which underlie his abusive behaviors) were the key to get him the treatment referral he needed.

*Shame.* One thread that ties together much of what will be presented in the chapters to come is the important role that shame has in many of the issues with which men present for couples therapy. Helping the female partner to avoid shaming the male partner thus becomes one goal of the therapy; a second goal is to ensure that neither the woman nor the therapist contributes to shaming the male member of the couple during the treatment process. Shame underlies a wide range of issues that male clients bring into therapy, starting with the feeling of incompetence many of them feel in relation to doing the work of
therapy, to the incompetence they may feel in relating to their partners. Other examples of shame were portrayed in many of the cases presented in this chapter. The cases include that of Mark whose shame was oriented around his feeling that “his restricted emotions were dysfunctional (and that) this focus on his emotional life was both wounding and frightening.” Roger’s shame was directed at his inability to instinctively know how to father his newborn. Jason was a man whose self-perceived failure to fulfill the male role of provider for his family (and his wife’s endorsement of the same) brought him great shame. Not least was Tony’s shame about his fears of abandonment, which underlie his abusive behaviors.

Although this chapter focused on the challenges of working with men, our goal is not to make the couples therapist feel that men present a host of minefields that require extraordinary sensitivity to avoid. Indeed, if anything, the opposite is true: when the clinician can sustain a strong therapeutic relationship, he or she earns the latitude to make the inevitable mistakes that are inherent to our profession and afford us the opportunity to model the elements of all successful relationships: acknowledging mistakes, listening even harder, connecting through successful empathy, and continually demonstrating a generous curiosity about the complex individual sitting across from us.

REFERENCES


