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An Affirmational Approach to Treating Gay Male Couples

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Many difficulties presented in therapy by gay male couples derive from the men feeling emotionally insecure within the coupled relationship. Attachment theory, gender acculturation, and the developmental process of growing up gay can provide therapists with an understanding of why many gay males have problems maintaining secure attachments with other men. Integrating accelerated experiential dynamic psychotherapy with aspects of structural family therapy and emotionally focused couple therapy, a model of clinical intervention is described in which the therapist actively expresses his own affirmation, compassion, and empathy toward the couple in an effort to highlight and deepen the men's emotional connection. As treatment progresses, the therapist works to facilitate the men becoming more emotionally present with one another and, in the process, form a more secure attachment by providing affirmation, compassion, and empathy to each other.

KEYWORDS: Gay male couples; attachment theory; accelerated experiential dynamic psychotherapy.

Many gay men in psychotherapy have difficulty forming and maintaining long-term romantic relationships. This article examines these difficulties through the lens of attachment theory and suggests a model of clinical intervention for gay couples based primarily on accelerated experiential dynamic therapy (Fosha, 2000) as well as structural family therapy (Greenan & Tunnell, 2003) and emotionally focused couple therapy (Johnson, 2004). This affirmational approach is designed specifically to help gay male couples develop greater emotional relatedness and form more secure attachments.

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Attachment theory (Bowlby, 1969, 1973) is a rich account of how infants in their early relational experiences with a primary attachment figure, usually the mother, come to feel secure (or insecure) internally and also secure within relationships. In these early bonding experiences the mother is attuned to the child's affect, mirroring and validating it, while also, at times, respecting the child's need *not* to engage with her. It is the child's sense that the mother is emotionally present and reliable that allows the child's autonomy, self-reliance, and independent exploration to develop more fully. Out of these intimate dyadic exchanges with the mother, the child also learns the rudiments of regulating affect and develops "an affective competence" (Fosha, 1991, p. 49), i.e., a capacity within the self to regulate emotional ups and downs and to have full affective experiences (Fosha, 2001). In this regard, good mothering has two aspects: being present emotionally when the child needs and wants it, while allowing the child distance and separation when the child does not. When attachment goes well, the individual learns to be autonomous and independent as well as relational and dependent; that is, the attachment bond is not simply a vehicle in which an individual develops autonomy, but one in which the individual becomes comfortable with emotional dependency.

In the last 20 years, theorists have applied attachment theory to adult romantic relationships (Feeney, 1999; Hazan & Shaver, 1987). Not all couples form attachment bonds. An attachment bond is a unique relationship with four defining elements (Hazan & Zeifman, 1999): (a) proximity maintenance (partners expend energy to be in each other's presence physically and emotionally); (b) separation protest (partners experience some negative feelings when they are apart); (c) secure base (each offers the other emotional security, where emotions can be experienced together and affirmational feelings for the other can be expressed and received); and (d) safe haven (each provides the other a safe port in the sea of life, a place where energy is replenished and where one's ventures into the world can be launched anew). As an example of a couple providing a secure base and safe haven to one another, a gay man said in session recently, "When I am feeling right with my partner, I can take on the world."

In applying the attachment model to couples the central idea is that, based on experiences with early attachment figures, the individual develops an *internal working model* for how close relationships are supposed to function. Broadly stated, securely attached children grow up to expect from, and provide to, their romantic partners both emotional closeness and individual autonomy, while insecurely attached children develop one of three attachment styles: avoidant, anxious or ambivalent, or disorganized (Ainsworth, Blehar, Waters, & Wall, 1978). Avoiders limit their emotional connection to others and withdraw in the face of heightened affect. The anxious or ambivalent pursue intimacy in such forceful, self-defeating ways that their partners seek distance. Disorganized attachment, thought to develop in children exposed to early trauma, seek connection but reject it when it does occur. Cross-sectional studies have uncovered in adult romantic

relationships the same attachment styles seen in children (Hazan & Shaver, 1987). Moreover, longitudinal research has begun to demonstrate some consistency in attachment style across the life span (Berlin & Cassidy, 1999; Scharfe, 2003). New relational experiences, however, can change an individual's attachment style from insecure to more secure, or vice versa (Berlin & Cassidy, 1999). A *corrective emotional experience* toward achieving greater security can occur in real life with more secure partners, or in psychotherapy.

Adult coupled relationships are not exact replicas of the original attachment bond between infant and mother for a variety of reasons and thus are much more complex. For one, adult attachment bonds are reciprocal rather than hierarchical (Hazan & Zeifman, 1999). In adult relationships, each partner serves as an attachment figure to the other, unlike the early child–mother relationship, where only the mother serves as an attachment figure to the child. Second, adult romantic bonds have an erotic component that is disinhibited, unlike in the child–mother dyad. In fact, several theorists have argued that attachment may be an inappropriate model for romantic love precisely because of its sexual component (Mitchell, 2002). "Hot" sex, with its pursuit of the dangerous and forbidden, seems, on the face of it, the antithesis of safe, secure attachment.

Finally, there is the complexity of gender in making comparisons across attachment dyads. How gender-specific is the internal working model that individuals develop about close relationships? Do we learn one internal working model about how men are supposed to function in romantic relationships and another about women? If internal working models are gender-specific, the attachment model's application to adult romantic relationships might have its clearest implications for heterosexual men and homosexual women, given that the original attachment bond is usually with the mother. But where does that leave heterosexual women and homosexual men? The father as an attachment figure has been relatively ignored in attachment theory, yet experience with the father, in theory, should be a primary factor in how individuals of *both* genders learn to relate emotionally to men. The father as an attachment figure seems crucial in the emotional development of gay males in that it is in this dyad that boys learn just how emotionally vulnerable they can be *in the presence of another man* without being shamed. For gay boys, this imprint about male-to-male closeness can have lasting consequences when they form romantic same-sex relationships as adults.

Despite these complexities, attachment theory offers clinicians useful guidelines in assessing and treating couples. One popular model of couple therapy—emotionally focused couple therapy (EFT; Johnson, 2004)—is based on attachment theory and has demonstrated in clinical research to be effective in treating distressed couples. EFT strives to strengthen the couple's attachment bond, helping distressed couples re-engage with one another. The EFT therapist works moment-to-moment with the couple, encouraging each to express deeper emotional needs. Johnson's model has recently been applied to gay male couples (Josephson,

2003). Like that application, the affirmational approach described here provides a corrective emotional experience in vivo that helps a male couple increase their emotional relatedness and come to feel more secure with one another. However, the affirmational approach is derived primarily from accelerated experiential dynamic psychotherapy (Fosha, 2000), a model of individual treatment that utilizes attachment theory and greatly emphasizes the therapist's affirmation of the patient. This model is also based on a modified version of structural family therapy (Greenan & Tunnell, 2003), which directly addresses the unique attachment issues for gay men and the unusually difficult tasks they face in same-sex coupling.

THREE TASKS OF COUPLEHOOD VIEWED FROM ATTACHMENT THEORY

Not only do many gay men have difficulty forming secure attachment bonds to other men (Mohr, 1999), many gay male couples encounter special challenges in mastering three basic tasks that all couples—heterosexual or homosexual—face in becoming a couple (Tunnell & Greenan, 2004): (a) creating a couple identity by forming and maintaining appropriate boundaries with the outside world; (b) accommodating and accepting each other's individual needs and differences; and (c) negotiating closeness and distance. Each task of coupling shares a similarity to the process of forming an attachment bond.

Both attachment bonds and coupled relationships have properties that give them structure. Boundaries must exist around an attachment bond and around a couple, giving these relationships structural integrity and separateness from others. In the early stages of forming an attachment bond, the relationship must become primary to all others. Child and mother protect their special relationship from outside interference, from other children, and, at times, even from the father. Couples must also define their relationship with boundaries and protect it, keeping out those who would interfere, for example, family members and friends who want attention or may even disapprove of the relationship and other adults who would threaten their bond sexually or romantically.

Gay male couples face particular obstacles forming a stable couple identity because neither the mainstream, heterosexist culture nor the gay culture totally support them. Creating a couple identity in the context of a generally homophobic society that refuses to validate same-sex relationships legally and socially is daunting. At best, a gay couple is granted a limited acknowledgment by mainstream society, and their status as a couple is almost always marginalized, leaving most same-sex couples feeling "less than" (Greenan & Tunnell, 2003) and creating "relational ambiguity" (Green & Mitchell, 2002) for them about their coupled relationship. Many male couples internalize this inferior status and do not push to gain further acceptance from their families or from society at large. Moreover, segments of the gay community are unsupportive of long-term same-sex

relationships. The Gay Rights Movement that began in 1969 focused on individual political rights and individual sexual freedom, and many contemporary activists, rather than advocating now for gay marriage or civil unions, are disdainful of the movement for mimicking the institution of heterosexual marriage and forsaking their queerness (Belluck, 2003; Warner, 1999). On a more everyday level, other gay men may threaten the couple by not honoring its sexual boundaries (e.g., pursuing sex with one or both men), accepting common beliefs in the gay community that gay relationships are not stable and do not last and that gay male couples are rarely monogamous.

The second task of becoming a couple is working out differences. Once an emotional connection is made and functions over time, individual differences inevitably emerge. In normal infant development the child begins to assert the self, with its needs for autonomy and individuation, prompting the mother to recognize that the child is different from her and has needs incongruent with hers. Similarly, as couples come to know one another, individual differences that had been submerged become salient. These differences have to be dealt with somehow, and men often find differences between themselves and other men very difficult to negotiate.

Men, in general, seem neither biologically disposed nor socialized to accommodate to the needs of *another man*. Once the limerence phase in gay male relationships has passed, the work of accommodating to each other's differences begins. Men often have one of two dominant responses to conflict: to fight or to flee (Tunnell & Greenan, 2004). In male-to-male relationships, men are socialized to fight and control one another rather than to cooperate, negotiate, or compromise. Only in war, sports, or business might a man cooperate with another man (and only if he is on the same team and only for a specific task). Moreover, empathy per se is a skill that does not come easily for many males, straight or gay. (Recently, I listened to a heterosexual husband in session explain how he attempts to be empathic to his wife: "I think about what it is she might be feeling given her situation, and I try in my mind to put myself in her place. Then I figure out what she is probably feeling, and then I know how to respond." For him, empathy is an entirely cognitive, left-brain operation.) In male-to-male relationships, being emphatic toward another man runs counter to the dominant impulse to compete and raises the fear of becoming emotionally vulnerable. The other dominant male response to conflict is to flee from it, distancing himself by either stonewalling (refusing to talk) or becoming preoccupied with extrarelationship endeavors (career, exercise, substance abuse, outside sex).

Finally, a couple's regulation of closeness and distance bears much similarity to attachment processes, in which mother and infant go in and out of states of emotional attunement with one another, sometimes being connected and sometimes being separate. Compared to the other two tasks of coupling, closeness–distance regulation—how much distance and how much closeness, and how to navigate

the transition from one state to the other—seems the most pivotal in determining relationship satisfaction or despair. Without a modicum of success here, a couple generally is neither willing to pursue a more stable couple identity nor motivated to make the efforts necessary to accommodate to the other's individuality. On the other hand, if both partners are satisfied with the degrees of intimacy and separation in their relationship, they pursue other relational tasks more eagerly. A solid emotional connection that allows for individual autonomy can make other problems less burdensome.

Although male couples can have problems in any of these areas, it is closeness–distance regulation that is often the most troublesome, primarily because of their lack of experience in emotionally attaching to men and specifically in asking for, and receiving, emotional closeness. Gender acculturation prepares males in Western society to be more comfortable with autonomy and females to be more comfortable with relatedness and connection (Chodorow, 1978; Gilligan, 1982). Females are socialized to show emotional sensitivity toward others, and males are socialized to be self-reliant and independent. Moreover, males are more likely to be shamed, particularly by other males, if they are "too" emotional. As a gay boy is discovering his same-sex attraction in childhood and adolescence, his experiences with other males can sometimes be traumatic and can lead to his developing a particular internal working model about male-to-male relationships which says that emotional vulnerability with another man is dangerous.

THE RESIDUAL EFFECTS OF GROWING UP GAY

Gay boys discover their sexual attraction to males typically in early childhood and adolescence. Whether their internal reactions to this discovery are positive, negative, or mixed, the almost universal behavioral response to the discovery is to hide it. Most gay boys, already tacitly understanding and internalizing the homophobia of the culture, know it is not safe to express this most fundamental aspect of who they are. To deal with the contradiction between who they know themselves to be and who they must pretend to be, many boys develop and present a "false self" (Greenan & Tunnell, 2003), passing as heterosexual to their families and friends. They become experts in impression management (Goffman, 1959, 1963), carefully managing their behaviors and personalities in order not to incur the social judgment of others. Fosha (2000) has written that when the authentic self must go underground, it is a "Faustian bargain": "The individual must choose between preserving the integrity of his attachment ties and that of his affective self experience . . . giving away the affective soul in exchange for a measure of security" (p. 33).

Sometimes even before the gay boy himself has figured out he is attracted to males, others have. One of the early signs of homosexuality is gender-atypical behavior (Green, 1987), with boys showing avid interest in toys and activities

deemed socially more appropriate for girls, including cross-dressing. Gay boys are subject to the same male gender acculturation as straight boys. All boys must adhere to the ideal male gender role (Brannon, 1976): (a) show "no sissy stuff" (demonstrate one's difference from females); (b) be the "big wheel" (be superior); (c) be the "sturdy oak" (show no emotional vulnerability); and (d) give 'em hell (be powerful). Boys who violate the rules are subject to severe social sanctions, especially by other boys and men. As early as age five, boys are called "girlish" and "sissy," slurs that are one step away from being called "fag" or "queer." Although slurs about other minority groups are often punished by adults, slurs regarding gender violations are tolerated. Policing young boys by taunting and shaming them for gender violations, other males shape the young boy to conform to the male gender role.

If the father senses that his son is effeminate and possibly gay, he often distances himself from the child (Isay, 1989), thereby initiating a rupture in the boy's attachment to his father. Fathers often participate in shaming the boy for his gender-atypical behavior, and boys, in self-defense, learn to limit their interaction with the father for fear of what he may do or say; that is, boys participate in their own distancing from the father because they sense his disapproval. Far from affirming his son, the father's covert disapproval and sometimes outright rejection this early in the boy's development is traumatic, causing feelings of isolation and despair. If he is also being shamed by male peers, he usually cannot turn to his parents for support or guidance as that leads to more shame. In fact, parents are often the first people to show homophobic behavior toward the boy. Given that the boy may not even think of himself as gay at this point, all he experiences is that he is, in some profound and unacceptable way, different from other males. Out of self-defense, gay boys are forced early on to overly develop an emotional autonomy, learning not to share their innermost feelings with others, especially other males, because the social consequences are too risky. Relationships with women may be the one socially sanctioned context where men, gay or straight, are allowed some freedom from gender role constraints, where they can show their limitations and vulnerabilities. Western societies seem to prohibit both sexual and emotional intimacy between men (Tunnell & Greenan, 2004), social norms that gay male couples violate.

In short, many gay boys grow up fearing being too emotionally vulnerable to other males for very good reason: Actual experiences have taught them that many men are not to be trusted with their innermost feelings. The outcome of their socialization is that by young adulthood, gay males have learned to minimize, or even deny entirely, their need for emotional contact with other males, even though they may be sexually active with men. By adulthood, most gay males seek a coupled relationship with another man (Green, Bettinger, & Zacks, 1996) but are often unprepared for how to relate emotionally to their sexual partners.

CLINICAL APPLICATION

The affirmational approach is designed to increase emotional relatedness in gay male couples and, in the process, help them form more secure attachments. This approach is an application to couple therapy of accelerated experiential dynamic psychotherapy (AEDP; Fosha, 2000), a model of individual treatment designed to access more rapidly core emotional states often defended against. In AEDP the therapist becomes an attachment figure early on by continuously affirming the patient, by attuning to and tracking emotional states moment-to-moment from the first session on, and by helping the patient manage anxiety and defensiveness in order to experience deeper, core affects in session. Emotions are brought to the surface, processed, and shared together so that the patient not only learns not to fear them, but actually comes to welcome them because in the aftermath of experiencing deep feeling, there is a serene, peaceful calmness, which Fosha called a *core state transformation*. The patient feels very good about having deeply connected to his own core being as well as feeling appreciative toward the therapist for having provided a positive relational experience. After such intimate interchanges, Fosha emphasized the necessity of actively exploring with the patient what the connection with the therapist felt like, a meta-processing of the experience that deepens it even further so that the patient takes in the positive affect of being more relational. As in the process leading to more secure attachment, the person gains not only a sense of individual well-being, but simultaneously comes to value and cherish the emotional connection with another person.

The affirmational approach is also a further extension of a model of structural family therapy adapted for male couples (Greenan & Tunnell, 2003), a here-and-now model of treatment that focuses on eliciting *enactments* (directing the couple in the session to talk to one another rather than to the therapist) to provide clues to how the men have structured their relationship in problematic ways. However, in more traditional structural family therapy (Minuchin, 1974; Nichols & Minuchin, 1999), after enactments, the therapist uses confrontation or *unbalancing* to raise the couple's anxiety about their dynamics in order to provoke them to change. The therapist's interventions described below do not employ confrontation at all. I believe that many couples can be helped to change without being provoked or confronted by the therapist, therapeutic maneuvers that are often met with increased resistance or defensiveness. In the interventions below the therapist uses more supportive, gentle, and "soft" interventions to affirm, encourage, and facilitate the couple's making changes to their relationship. This more supportive approach is particularly useful in working with gay men, who often come to therapy expecting the therapist to be judgmental about same-sex relationships. More specifically, unlike traditional structural therapy, where the goal is to *raise* the anxiety of the couple to provoke change, these interventions are designed to *lower* the anxiety of the couple to facilitate change.

These anxiety-lowering interventions borrow from AEDP its emphasis on the therapist actively providing affirmation, compassion, and empathy to the patient from the very first session on. In couple treatment, affirmation, compassion, and empathy are explicitly and actively communicated by the therapist both in the early phase of treatment, when the couple is anxious about how they are being perceived by the therapist, and in middle treatment, when they become anxious about being more relational and emotionally present with one another. It is this part of the treatment—working to help each man stay more emotionally present to his partner—that is central. As in EFT (Johnson, 2004), the therapist here gently but actively prods each man both to express his deeper feelings to the other *and* to respond more empathically to his partner.

Two key differences between EFT and AEDP are that (a) the therapist in AEDP more explicitly and actively expresses *his own* affirmation, compassion, and empathy for the couple and for each individual and that (b) once emotional attunement has occurred between the partners, the therapist explicitly deepens the emotional bond by meta-processing it, that is, by asking the partners to reflect on what the experience felt like to them.

Setting Up the Work: Creating a Strong Therapeutic Alliance in Early Treatment

If the purpose of therapy is to help gay men form a more secure attachment to one another, they must first form a secure enough attachment to the therapist. The first stage of couple therapy, called *joining* in structural family therapy (Minuchin, 1974), is unusually important in work with same-sex couples because they often come to therapy expecting to be pathologized by mental health professionals (Greenan & Tunnell, 2003). Therapists must extend themselves to make a gay couple feel good, or at least hopeful, about their relationship in the joining stage. This may be difficult to do because it is often a crisis that brings the couple to treatment, and the couple may not be prepared to take in something positive about their relationship. Affirming the couple can also be difficult for the therapist, who may develop negative countertransferential feelings toward same-sex couples as they describe their relationships and problems.

For example, in taking a history of the couple's relationship in the first session, I routinely ask male couples whether they have an open or monogamous relationship, a question I rarely ask married heterosexual couples. Traditional family therapy has taught that extracurricular sexual activity is inherently pathological, signifying unhealthy triangles where, in order to avoid conflict or anger toward the primary partner, one stabilizes the relationship by bringing in a third party (Pittman, 1987; Lusterman, 1995). Yet many gay male couples who are emotionally committed for the long term do not adhere to sexual monogamy (Bettinger, 2004; Johnson & Keren, 1996). Asking a couple early in treatment if they are monogamous or not

demonstrates that the therapist is mindful of the norms of the gay community, whether the therapist agrees with those norms or not. If the couple says they have an open relationship, I ask, in a matter-of-fact manner, about the rules they have established for sexual encounters outside the relationship. Virtually all gay male couples who have open relationships also have a set of rules regarding them, even if it is "don't ask, don't tell." Most of all, it is important that the therapist not judge whatever arrangement and rules the men have. Nonmonogamy is not necessarily part of the initial problem the men present. As Hazan and Zeifman (1999) have noted, "attachment is not synonymous with sexual fidelity" (p. 349). A gay man in couple therapy once put this succinctly: "I really don't care where he puts his penis as long as his heart belongs to me."

Whether therapists themselves are straight or gay, they must ask informed questions of their gay clients, demonstrating sensitivity to the complexities of gay relationships. In taking a history of the relationship in the first session, it is useful to follow up the question "how long have you been together?" with "what specific date do you mark as your anniversary, and why that date?" Unlike heterosexual married couples, who have more standardized rituals, such as celebrating their wedding date as their anniversary, gay couples must create their own rituals. The date they celebrate as an anniversary varies across couples: for example, the day they first met, their first official date, the day they first had sex, the day they began living together, or, more recently, the date of their commitment ceremony.

Asking a male couple how they refer to one another (e.g., lover, boyfriend, partner, mate, spouse, husband) shows respect for their choice of words and recognizes the distinctiveness of their relationship. Asking the couple what degree of social support they receive from their families of origin demonstrates that the therapist is knowledgeable about the difficulty many gay men encounter receiving their families' acceptance of having a gay son and of his having a relationship with another man. Because many same-sex couples receive little or no support from their families of origin, it is important also to ask about the gay couple's "families of choice" (Westin, 1991), the social support network they feel most close to, which can include friends as well as family members.

By the conclusion of the first session, the couple needs to feel affirmed by the therapist. Because same-sex relationships receive so little validation from society, the therapist must do or say something to the couple that makes the relationship feel valued and worth working on. Often, same-sex couples have survived against many odds, and it is helpful for the therapist to acknowledge this explicitly by showing affirmation and compassion.

> *Case example:* Recently, I began working with a gay male couple whose presenting complaint was the "anger and resentment" both felt toward the other. As I gathered their relationship history in the first session, they mentioned almost casually that the younger one, a native of another country, had no legal status in the United States.

Toward the end of the first session, I made this fact the focus, expressing my admiration for how they had managed to maintain a 10-year relationship under conditions of such insecurity.

I highlighted the fact that they lived under constant threat that the younger one would be deported. After asking many detailed questions about the limited options available to them, I shared my own feelings by saying, "It makes me so sad that gay couples face such horrible discrimination." (If the couple were heterosexual, the illegal alien could marry the U.S. citizen, and this problem would go away.) My statement of empathy about their situation prompted the man who was the illegal alien to reveal his deeper feelings of helplessness. He voiced hesitation about making friends in the United States for fear that someone would report him to immigration authorities. He could not hold a "real" job and was totally financially dependent on his partner. He had recently visited his native country (an anxiety-arousing ordeal as each time he crosses the national border, there is a chance he will be discovered and deported), and part of him longed to be back there "just to feel safe," yet that would possibly mean ending the relationship. When the couple returned the next session, they reported spontaneously having had a better week and said that they had felt understood by me.

Working at the Core: Facilitating Emotional Relatedness

As in EFT, facilitating emotional relatedness is the heart of this model of therapy. Regardless of the specific problem the couple presents, the therapist pays special attention to the quality of the men's emotional attachment to one another. As Johnson, Makinen, and Millikin (2001) suggested, at the start of treatment, many couples are often emotionally disengaged, having experienced a rupture in their attachment bond that has not been repaired. This lack of secure connection may or may not be part of the presenting complaint of male couples but may nonetheless be fueling it, for example, constant fighting or bickering, one man wanting to open up the relationship sexually, or fighting over whether to have a child (here the man who wants a child may be motivated partly by his desire to share a common task in order to bring the couple back together emotionally, and the one opposed to having children may fear that children will once and for all prevent them from being more intimate as a couple).

In this approach, enactments from structural family therapy are utilized at the very beginning of treatment with a focus on emotional relatedness. As often and as early as possible in the therapy, the therapist encourages the men to talk to one another through enactments, rather than speak directly to the therapist. During enactments the therapist looks for nonverbal cues about how emotionally related they are, tracking how they negotiate moment to moment the dual needs for closeness and distance. Do they allow each other to complete sentences? Is their conversation a real give-and-take dialog that evolves, or does each present

an airtight case like a lawyer, the other eagerly awaiting his chance for rebuttal? Do they pay attention to each other's feelings? The therapist can also directly ask the men which one has the greater need for emotional closeness and who has the greater need for autonomy to hear their own reflections on this dimension of their relationship, but it is actually the nonverbal cues they display as they talk and respond to one another that gives the therapist more clinically useful information. As in AEDP, it is the moment-to-moment tracking of the affective states of both clients during enactments that gives the therapist insight into their capacities for emotional relatedness.

Unlike traditional structural family therapy, however, here the therapist puts affect to the front and center of the couple's work, much as EFT does. In working with male couples the therapist often is confronted immediately with two separate problems: (a) getting each man to open up and share his deeper feelings and (b) getting the other man to be responsive and empathic. Men may be particularly resistant to this type of work. One man in early treatment once said, "You seem to want us to have a Hallmark moment here. Can't we just buy a card?"

Gillian Walker (Siegel & Walker, 1999) summed up the difficulty a gay man may have in expressing deeper feelings to another man:

> Gay men grow up forced to keep everything that is precious about themselves secret, thus confusing what is valued with what is the subject of shame and disavowal. The effects of this growing-up experience are ingrained and longlasting. One man said that, as he revealed something about himself, he would scan his partner for the effect of his revelation. The moment the other person was about to answer, he could feel himself withdrawing, every inch of his body filled with defensiveness and silence, expecting punishment for any act that revealed his authentic experience. It was reflexive—in his muscles. He longed for an authentically honest relationship, but of course his reflexive behavior was not conducive to trust and dialogue, nor was he in fact trained to be comfortable with intimacy. (p. 40)

To facilitate emotional relatedness, as the therapist observes how the men interact in session through enactments, the therapist introduces affect by asking affect-based questions directly, for example, "what are you feeling as you say that to him?" or "how do you feel when your partner says that?" and by monitoring moment-to-moment shifts in emotional states (Fosha, 2000) as the men respond to these questions. One man sighing heavily, for example, is an invitation for the therapist to inquire either to the man sighing, "What was that sigh just now?" or to the partner, "What do you think he feels when he sighs like that? What do you feel inside?" In these moments the therapist teaches the men to become more emotionally attuned, paying greater attention to body or facial cues about the other's affect. If the partner is clueless about what the sigh meant, the therapist may volunteer to the partner what he, the therapist, felt when the man sighed (e.g., "I

don't know about you, but I felt such a sense of resignation and helplessness when he sighed like that"). In other words, until the men can become more emotionally attuned to one another, the therapist strives to be emotionally attuned to each man, amplifying feeling states in the individual, resonating with them, and openly processing them together. As many male couples are not accustomed to sharing affect, the therapist explicitly shares *his own feelings* elicited by each man as a way to model what he wants them to do and to help the men begin to go more deeply inside themselves and beneath the presenting problem.

Once an affect has been identified and amplified in one partner, relational work is done around it. Can the affect be shared and processed together as a couple, much as a mother helps the infant dyadically regulate affect states? One of the most useful interventions in starting this part of the process, once one member of the couple has opened up emotionally, is for the therapist to simply ask his partner, "How can you help him now with what he's feeling?" In this way the therapist is actively and explicitly encouraging emotional dependency between men, that is, that one can reach out to other men to share difficult feelings so that they become less burdensome to the individual (Tunnell, 1991, 1994). This single intervention begins to chip away at the years of a man's learning that he should never be too emotionally dependent on another man.

For the man in the role of the listening partner, the temptation at this point may be to avoid dealing directly with his partner's affect. He may do this in a number of ways: minimizing, denying, or avoiding the partner's feeling; talking him out of it (e.g., "That's the wrong feeling to have about this"); or providing premature reassurance ("Don't worry, everything will be ok") or premature problem solving (developing concrete solutions to make the feeling diminish). Men often skip over empathy in their desire to do something more concretely helpful to someone being emotional. When the therapist observes that the partner is not being empathic, it is helpful to coach him to stay present, either by suggesting he help his partner go deeper into the feeling (e.g., "What he just said sounds important and meaningful to me. Can you ask him to say more about his feeling and where it comes from?") or by encouraging the listening partner to forestall his efforts to problem solve, that solutions can come later, and for now to tell his partner what he feels as he listens to him. Again, if the listening partner is resistant to trying this, the therapist can volunteer what he felt as he listened. This often stimulates a more empathic reaction in the listening partner.

The therapist encourages the men to bring to one another their feelings, slowly learning that they will not be shamed for doing so. In the process of dyadically regulating each other's emotions the couple becomes more and more intimately bonded. As Fosha (2005) has written, "'getting in sync' is always accompanied by shared positive relational affect." Once this occurs, it needs to be highlighted and discussed explicitly; that is, once a deep emotional attunement occurs, it is essential to reflect on, or meta-process, that experience (Fosha, 2000): "What was this

intimacy that just happened like for each of you? How did our session feel to you?" Here the therapist also gets information about each man's threshold for emotional experience and for relational affect. Even though they may have experienced deep feeling and experienced it as being shared, men may nonetheless feel uncomfortable with that degree of connection. In a recent consultation session with a gay couple, one of the men spoke movingly of his lifelong depression because he could not be the son his evangelical parents wanted, and how for his own survival he had chosen to have no further contact with them. As his partner and I listened, we both became very sad, and I had a tear in my eye. I said, "It is so hard to be a gay man and to be a gay couple when half of the family tree offers no support." Seeing the effects of his story on us, he got uncomfortable and backed away from the deeply sad feelings he had just expressed, saying, "Look, everyone has a burden in life; this is mine. I am over it." Near the end, when I asked what the session had been like for them, the man who had shared his feelings about his parents said he was surprised his feelings of depression and sadness had come up in the first session. On the one hand, he said, it was good to have his sadness shared and heard, but "if all the sessions were going to be like this, we would need to meet only once a month." In further meta-processing he said that his estrangement from his family is just so painful to talk about. My response—again, an affirmational one—was how very much I appreciated his courage in discussing it and in sharing his painful feelings. Importantly, the partner said that, although he knew the details of his partner's estrangement from his family of origin, he had never known the depth of despair his partner carried, and he had felt much closer to him in the last hour.

In couple therapy with gay males, the therapist must often slow the men down as they talk, to emphasize the feeling behind the words and to allow space for affect to emerge.

> *Case example*: Chris and James, a gay couple together 12 years, presented with the issue that Chris wanted to break up. They said couple therapy was their last chance to make their relationship work and that they had, in fact, already signed a "post-nup" separation agreement in case they failed here. Chris resented James for his periods of unemployment and for having to support him financially. Chris said he simply could not trust James. Chris had paid for James to go to inpatient rehab for drug abuse 5 years ago, and although James was no longer using drugs, Chris constantly worried that he would return to a world of drugs that led to sexual encounters outside their relationship. They had not been sexual with each other since James became clean. James's view was that he contributed to the relationship in other ways, for example, by running their household, taking care of their many pets, and helping Chris become less uptight and rigid.
>
> In a breakthrough session 2 months into treatment that produced a marked shift in Chris's push to end the relationship, the following dialogue occurred.

James: I feel that Chris has been so preoccupied and distracted . . . I wonder if he's already made up his mind about the relationship.

Therapist, *initiating an enactment*: So why don't you ask him?

James: Have you decided to call it quits with me?

Chris, *speaking haltingly, softly, and very lovingly*: I'm so sorry . . . I just can't get the love back. I have been hurt so many times by you, your taking me for granted. I want to trust you again, but . . . I guess I live in fear that you will surprise me again. I can't relax in this relationship. I've been trying for a year to get the love back, but it's just not happening for me. I so don't want to hurt you. *(begins to cry)*

James, *touching Chris's arm as Chris cries and speaking very softly*: I am asking for another chance . . . please give us more time. Can't you see I am changing?

Chris: Yes, our day-to-day interactions with one another are smoother, but there is still an intimacy that is missing.

James, now no longer listening to Chris, begins to get defensive, saying he had been good for Chris and pointing out Chris's own role in their problems.

Therapist: James, can you hold off on that? Chris showed real honesty just now, and also real vulnerability, about wanting to get the love back and not being able to. It took some courage on his part to say this to you. He doesn't want to hurt you. What was it like for you to see his tears?

James, *sitting quietly for several minutes, shifting his gaze back and forth between me and Chris, then speaking thoughtfully to Chris*: You may not know this, but ever since I met you 12 years ago, you have been my ballast. You have given me confidence when I lacked it. You remember the details of my life like no one else ever has. My mother still doesn't know what I majored in at Yale. You are so important to me, and you don't seem to know it. You are the first person who has really loved me, and I know I have taken advantage of your love. You think I'm only about your money, but I've been a scared little boy all my life, and you somehow make me feel safe.

Chris: Well, you keep pushing over that ballast. . . .

Therapist: Chris, what do you feel about what James just said? This ballast you've been for him, a scared little boy, during the last 12 years?

Chris, *first unable to answer, simply looking at James in silence*: I know about the scared little boy. I'm one too. I think we initially bonded because we were two scared little boys.

In the remainder of that session the men elaborated on what had made them scared little boys, their sense of isolation and aloneness growing up. Though the details differed, each felt he did not fit in. Being gay did not help. As they reviewed

their life stories, they realized how significant they had become to one another over their 12 years together, despite all the problems. At the end of the session I inquired how the session had gone for them, adding that I myself had been quite moved by their attachment to one another. Both agreed they felt much closer to each other right then.

Over the next few months, Chris put off any decision about separating. James landed a high-paying job and took on more financial responsibility. Notably, the men began to display much more affection to one another during sessions and reported being more affectionate at home. They are now beginning to be sexual again with one another. In a recent session, when I suggested that perhaps our work together was ending, the following exchange occurred.

James: Well, I want us to keep coming. You have taught us how to nurture one another, and it feels good when we come here. It isn't like the couple therapy we tried after I returned from rehab.

Chris: That's right. We wouldn't be where we are now if it wasn't for you.

Therapist: Given that you, Chris, had wanted to break up 4 months ago, is that such a good thing?

The three of us burst into a shared laughter.

Self-supervision: The men, especially Chris, were trying to acknowledge my help and express their appreciation to me. In retrospect, rather than making a joke, I should have received their gratitude more directly.

CONCLUSION

The affirmational approach to couple therapy—explicitly affirming the couple to create a therapeutic alliance, expressing empathy toward them by valuing them as a legitimate couple, and facilitating emotional relatedness—requires the therapist's use of self in ways different from most models of psychotherapy. Although traditional models of therapy require therapists to pay attention to their own subjective feelings as guides to understanding individual patients, families, and couples, few models of therapy advocate that therapists share their own feelings, particularly positive ones, directly with patients.

The purpose of the therapist's expressing affirmation, compassion, and empathy to individuals and couples is not simply to create a trusting therapeutic relationship as preliminary to the "real" treatment. Affirmation, compassion, and empathy can be deeply therapeutic in and of themselves, particularly in working with marginalized populations such as gay men, who often feel unworthy of positive regard from others. Moreover, it is vitally important to have the men reflect on, or meta-process, what it was like to receive compassion from the therapist and from each other since gay men generally have little experience taking in such positive

feelings from another. In couple therapy with gay men the ultimate goal is not only for the couple to feel affirmed by the therapist, but for them to affirm one another and provide greater emotional security to one another.

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