The Family Journal: Counseling and Therapy for Couples and Families
2018, Vol. 26(4) 405-410

DOI: 10.1177/1066480718803342
journals.sagepub.com/home/tfj
SAGE

Imago Relationship Therapy Alignment With Marriage and Family Common Factors

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Abstract

Marriage and family common factors are used to understand the curative elements in marriage and family therapy (MFT) models of treatment. Sprenkle, Davis, and Blow identified four common factors of well-established MFT treatment models. This article deconstructs Imago relationship therapy (IRT), a widely used model of couples therapy, for the purpose of determining whether IRT utilizes the four curative common factors of MFT in its theory and practice. The analysis indicates that IRT does utilize the four broad common factors of MFT shared by other well-established models of MFT in addition to its narrow model factors that make it unique.

Keywords

common factors, couples therapy, Imago relationship therapy, marriage and family therapy

Imago relationship therapy (IRT) is a contemporary model of couples counseling that has had widespread use and is considered a well-established model of couples therapy (Helmeke, Prouty, & Bischof, 2015; Jakubowski, Milne, Brunner, & Miller, 2004). While its empirical data are moderate, its use among therapists worldwide is strong and growing. IRT is a synthesis of various well-researched models of therapy including cognitive behavioral, attachment theory, psychodynamic, systems, and social learning theory. Its main therapeutic tool, the couples dialogue, is a variation and deepening of the commonly used active listening tool used in many couples therapy models (Mace, 1975; Markman, Stanley, & Blumberg, 2010).

The purpose of this article is to deconstruct IRT to determine whether its treatment theory, methods, and emerging research are compatible with marriage and family common factors. Common factors have been determined to be important for the delivery and benefit of positive psychotherapy outcomes. Common factors outline the mechanism of change and act as a theoretical model which new therapeutic models should be mindful of when designing their emerging theories and practices (Wampold, 2015). While no one model can claim superiority over another, models remain the mechanism by which common factors are delivered (Karam, Blow, Sprenkle, & Davis, 2015). This article is a post hoc analysis to determine whether IRT utilizes theories and practices that adhere to marriage and family common factors. As IRT becomes more widely utilized, this becomes an important step in its effort to become an evidence supported treatment model by knowing that its treatment theory and methods adhere to researched models of positive change.

Research into common elements that surface in successful individual therapies led to the study of common factors in marriage and family therapy (MFT; Davis & Piercy, 2007a, 2007b; Sprenkle, Davis, & Lebow, 2009). D'Anniello (2013) recently deconstructed three contemporary models of family therapy—narrative, solution focused, and cognitive—and determined that each of these models did indeed fit the common factor model of MFT. Deconstructing these three common family therapy models was important in determining whether these model-driven therapies also contained the common factors known to promote positive outcomes. Therapy models often become so focused on their own theory and technique that they omit looking at factors that create change in dyadic systems and foster positive change in relationships (Davis, Lebow, & Sprenkle, 2012). This article is an attempt to examine the theory and techniques of IRT to determine whether it also utilizes the marriage and family common factors necessary for positive outcomes in couple therapy.

History of Relational Common Factors

The concept of common factors has been of interest to the mental health community since first proposed by Rosenzweig (1936). In his article, Rosenzweig (1936, p. 415) determined that all available therapies were effective in some way if the therapist had an "effective personality" and adhered to a treatment system relevant to the problem. He also acknowledged

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that certain mental health disturbances required certain kinds of therapy for effective treatment (Rosenzweig, 1936). Common factors research has made a resurgence with the advent of managed care and short-term treatment models. Lambert's (1992) work is the most frequently cited finding broad factors influencing client improvement include 40% from extra-therapeutic factors (personal strength and family factors the client brings into the therapy), 15% from the treatment model utilized, 15% from the expectancy effect (the client's confidence in the treatment model and their own desire to progress), and 30% from their developed relationship with the therapist including therapist cordiality, empathy, and acceptance. Lambert's seminal work was replicated and expanded upon by Miller, Duncan, and Hubble (1997).

While treatment models are only 15% of what influences change in psychotherapy, they remain important. Therapist should continue to have solid training and experience in one or more treatment models that are situation specific and evidence based (Sprenkle & Blow, 2004; Luquet, Brown, Shulkin, Shulkin, & Brainert, 1999). Treatment models help the client bring some order to their confusion and add what are discussed as "narrow factors" (Lambert, 1992; Sprenkle & Blow, 2004; Sprenkle et al., 2009) or treatment factors that are specific to and enhance the process of change.

Nearly all marriage and family models have as their underpinning the emphasis on family strengths, an understanding of family systems theory, use of therapist empathy, creation of a safe setting, and acceptance of others and their situation. Research by Sprenkle et al. (1999) lead to the emergent literature and use of common factors in MFT. Four factors seem to be shared by well-established and well-researched models of MFT including "...(1) conceptualizing difficulties in relational terms, (2) disrupting dysfunctional relational patterns, (3) expanding the direct treatment system, and (4) expanding the therapeutic alliance" (Sprenkle et al., 2009, p. 34).

Most established marriage and family models share these broad common factors, and will also have factors specific to the treatment model, or what is referred to as model dependent factors. The narrow aspects of these model dependent factors often taught in training programs are the skills and theory of the model and include conceptualizations, interventions, and outcomes (Davis & Piercy, 2007a). Model independent factors are broader concepts that are not directly taught by the model. Typically beyond the control of the model, they can include therapist variables, client variables, the therapeutic process, the therapeutic alliance, and expectancy and motivational factors (Davis & Piercy, 2007b). Davis and Piercy (2007a) studied three commonly used models of MFT concluding the essential nature of both independent and dependent factors "...because the client's chaos was replaced with the therapist's order (i.e., their model)" (p. 338).

Determining whether a model is aligned with the four MFT common factors requires a deconstruction of a model's theory and practices. As previously mentioned, D'Anniello's (2013) deconstructed three contemporary models of MFT using Sprenkle et al. (2009) MFT common factor model. D'Aniello determined that narrative therapy, solution-focused therapy, and cognitive therapy did indeed align with MFT common factors because each worked toward disrupting dysfunctional relationship patterns and conceptualized difficulties in relational terms. IRT was developed by Hendrix (1988) and has since attracted thousands of adherents to its theory and practice through additional professional text (Luquet, 1996; Luquet & Hannah, 1998; Hendrix, Hunt, Hannah, & Luquet, 2005) and training programs for professional counselors and therapists (imagorelationshipsinternational.org). Its synthesis of widely used theories and practices and manualized format make IRT useful and accessible for both clients and therapists.

Experimental research on constructs such as partner selection, marital difficulties, and satisfaction were supported in a study of 100 South Korean couples (Euh Oh & Minichiello, 2013). Yet there is but a moderate amount of outcome research in IRT. A random control study of 12 weeks of IRT indicated positive results that were sustained at follow-up (Gehlert, Schmidt, Giegerich, & Luquet, 2017). The couples in this study were also found to have an increase in empathy toward each other (Schmidt & Gehlert, 2016). Additionally, in a small, controlled study, 14 participants showed significant improvement in accurate empathy responding (Muro, Holliman, & Luquet, 2015). Additional quasi-experimental design research of IRT delivered in both office and workshop formats among diverse groups indicates strong positive effects on marital satisfaction, changes in empathy, problem-solving skills, and global distress (Hannah & Luquet, 1997; Holliman, Muro, & Luquet, 2016; Luquet & Hannah, 1996b; Muro & Holliman, 2014; Schmidt, Luquet, & Gehlert, 2016). Brain changes in regions associated with language and mood regulation were also observed in a 90-day course treatment of IRT using quantitative electroencephalogram (DuRousseau & Beeton, 2015). Despite supporting research, for IRT to sustain itself as a viable evidence-based method of treatment, it will need to develop a substantial research base. For researchers to feel comfortable with their research efforts, they will need to feel comfortable that the model is in alignment with acknowledged relational common factors.

IRT Alignment With Relational Common Factors

As a treatment method, it is important that IRT align with accepted relational common factors. Common factors reveal a model's adherence to known curative or change factors and allow practitioners to assess a model's strengths and weaknesses. In this article, the theory, practice, and emerging research of IRT will be assessed utilizing Sprenkle et al.'s (2009) four common factors in couple and family therapy.

Conceptualizing Difficulties in Relational Terms

Through its focus on significant relationships in childhood, IRT conceptualizes almost exclusively in relational terms. Like some well-researched models, such as emotionally focused couples

therapy (S. M. Johnson, 2004), IRT focuses heavily on family of origin experiences to understand present couple conflict.

Derived from the Latin term for image, Imago conveys a theory that each member of a couple carries an "image" or imprint of their childhood caretakers that attracts them to an appropriate mate. This part of mate selection is a largely unconscious process that brings unresolved conflicts of childhood into the present (Hendrix, 1988; Luquet, 1996). Initially, conflicts are masked by the powerful lure of romantic love that keeps them at a low simmer. When romantic love fades and dependency increases, typically after commitment, the couple inevitably enters the power struggle stage.

A survey of 273 couples therapists across diverse theoretical orientations agreed with the assumption that people unconsciously attract to romantic partners with positive and negative qualities of past, primary caretakers. A majority of those surveyed also expressed strong agreement with the assertion that couple conflict creates opportunities for unresolved needs to surface and promote developmental growth (Holliman et al., 2016). Couples engaged in Imago therapy recall positive and negative aspects of their caretakers and their developmental experiences. Through the Imago work-up, their insight is translated into sentence stems that link their perceptions, behaviors, patterns, and current relationship issues to childhood (Hendrix, 1988; Luquet, 1996).

Disrupting Dysfunctional Relational Patterns

The human brain is wired to respond for survival (Rozin & Royzman, 2001). As a result, couples typically fight in predictable ways. When a partner says something that the other takes as a negative, criticism, or slight, there is a response from the reptilian or lower brain stem to enter the fight or flight mode. Gottman (1994) identified four defense-based patterns of couple conflict that he labeled "The Four Horsemen of the Apocalypse"—criticism, defensiveness, contempt, and stonewalling. In one study, Gottman was able to predict divorce for couples engaged in conflict patterns with 93% accuracy (Gottman & Levenson, 2000).

IRT therapists use intentional dialogue to disrupt predictable, reactive patterns and replace them with connecting, empathic behaviors. In this way, intentional dialogue sets the stage for continued relational growth. The therapist begins a session with positive dialogue, such as the Appreciation Dialogue. In this dialogue, partners offer and receive a positive appreciation of one another while simultaneously practicing new dialogue skills. The standard Imago Dialogue follows as a structured exercise allowing partners to express their frustrations while protecting each other's emotional safety. In the Imago Dialogue, negative communication is blocked. Partners are taught to communicate their frustrations in differentiated, respectful, and responsible ways. Receiving partners are taught to listen with curiosity and to respond with mirroring, validation, and empathy. Increasing emotional safety increases the couple's connection, commitment to the process, and the depth of their dialogue.

A commonly used dialogue to move couples beyond an impasse is the Parent–Child Dialogue. One of the pairs is instructed to listen to their partner "as if" they are their partner's parent/caretaker. The listening partner asks two questions: "I am your mother/father/caretaker. What is it like to live with me?" and "What do you need from me that you do not get?" Use of the Parent–Child Dialogue increases empathy through reimaging one's partner as a wounded person attempting to cope with a valid but frustrated need (Clinical Instructor's Manual, 2003; Hendrix, 1988, 1992). This construct is illustrated in the following excerpt from Muro, Holliman, and Luquet's (2016) study:

> I just want you to know that it makes sense to me that when I get upset you can think we're over. Every sense of safety was threatened for you, because you really had no idea what was causing your mother to leave you or to hand you over to your grandparents. So it makes perfect sense—you wouldn't have any idea what will be the thing that breaks me and makes me say, "I'm out of here." (p. 243)

To deal with difficult impasses or rage reactions, IRT incorporates calming skills such as breathing, visualization, or gazing into each other's eyes. Rather than ambush, partners are expected to agree to an appointment for dialogue and to take a time out, if needed, until they are calm enough to engage in safe dialogue.

Once a couple is able to dialogue in a safe, intentional manner, they are taught skills to work on recurring issues. One particular intervention is the behavior change request (BCR; Hendrix, 1988; Luquet, 1996). BCRs are positive, measurable, doable, and time-limited requests to address each partner's needs. A BCR might sound like this, "Twice this week, I would like for you to ask me if I need some help around the house and commit to at least 20 min of helping me." The request is healing for the requesting partner, not overwhelming for the fulfilling partner, and typically happily agreed to *after* the fulfilling partner has an empathic understanding of their partner's need.

Finally, a relationship vision (Hendrix, 1988; Luquet, 1996) involves dialogue focused on the future. In this exercise, couples use new insight and skills to protect the sanctity of the relationship, increase caring behaviors, and create goals for the new relationship they vow to cocreate.

Expanding the Therapeutic Alliance

The concepts of joining and creating a therapeutic alliance are primary in MFT (L. Johnson, Ketring, Rohacs, & Brewer, 2006; Minuchin & Fishman, 1981; Niehuis et al., 2016). Research indicates that safety in the therapeutic alliance creates brain changes that decrease fear and allow cognitive, emotional, and behavioral interventions to be introduced and acted upon (Allison & Rossouw, 2013).

In IRT, the alliance is expanded in many ways, but first and foremost, through a therapist's alliance with the couple's relationship. As important as the individual and extended family is

to the relationship itself, the therapist should pay particular attention to the relational interaction between the couple, or what is referred to as the "We" (Hargrave, 2000). Issues of relationship violence notwithstanding, an IRT therapist might request that discussion of separation/divorce be taken off the table for the duration of therapy, given its nature to put partners in defense mode. An understanding of the importance and care of the relationship expands the therapeutic alliance.

A complaint often heard in couple's therapy is that a therapist favors one partner over the other. As a psychoeducational model, IRT positions the therapist as a coach and facilitator to avoid hierarchy and remove the therapist from triangulation. During each session, partners primarily engage with *each other* versus their therapist and become their own active, therapeutic agents. As coach/facilitator, the therapist protects equal opportunities for each partner to be heard and assigns equal responsibility to both partners to utilize the skills taught. This promotes a sense of equal treatment that is paramount to trust in a therapeutic alliance. A therapist also utilizes dialogue when talking with each member of the couple. In doing so, the therapist connects with each partner by mirroring, validating, and empathizing with their concerns. This builds trust as the therapist becomes an advocate for the individuals as well as their relationship (Clinical Instructor's Manual, 2003; Hendrix, 1988, 1992).

Expanding the Direct Treatment System

While IRT is tailored to the couple, Imago therapists incorporate the skills of dialogue with parents and children, siblings, or any other relationship configuration. When working solely with a couple, the larger system is always part of the therapeutic context. Couples are encouraged to use dialogue with their children and new knowledge and skills become integrated practices that replace maladaptive ones in other primary relationships (Hendrix, 1998).

Safe Conversations® is another expansion of the direct treatment system. A large-scale project utilizing the Imago workshop, Safe Conversations expands direct treatment to a broad community in metropolitan areas. Through this endeavor, hundreds of couples and families participate in relationship education workshops and practice groups that might fall outside their realm of access due to cultural, economic, institutional, or language barriers. Scientific studies are being conducted to determine whether community members trained in empathy-based communication can influence the overall health and well-being of their community. While studies are incomplete, a preliminary survey of 2,100 attendees indicated that 95% would return and 98% would recommend the workshop to others (*Valentine's Day Story Safe Conversations*, 2016).

Discussion

It is estimated that there are over 400 models of psychotherapy with distinct, narrow factors (Norcross, 2005). While narrow factors are useful to therapists to determine which model fits their unique therapeutic philosophy and a client's unique situation (Luquet, 1999; Sprenkle & Blow, 2004), broad common factors seem to have more influence on change and outcomes in mental health models.

D'Anniello (2013) evaluated three contemporary, widely used MFT models for their use of relational common factors: narrative therapy, solution-focused therapy, and cognitive behavioral therapy (CBT). In her conclusion, all make use of common factors when language and definitions are more flexible. As an example, conceptualizing in relational terms for narrative therapy includes a focus on social–cultural contexts, which expands the types of significant relationships that influence MFT issues. In another example, CBT therapists conceptualize MFT issues as rooted in maladaptive relationship cognitions or schemas. This is different than a traditional relational conceptualization rooted in the interactions of a system, yet still reflects relational terms. CBT also acknowledges the role that relational interactions would play in the development of maladaptive cognitions and schemas. Both examples demonstrate adherence to a common factor using a broader umbrella definition. Similarly, the authors propose that IRT fulfills the four common factors deemed important for change in MFT (Sprenkle et al., 1999, 2009) using traditional and broader common factor terms.

First, through its emphasis on family of origin and relational interactions during critical, developmental periods, IRT conceptualizes couple issues in relational terms. A couples' enduring frustrations are typically a manifestation of old or unresolved conflicts that can be traced back to experiences and behavioral patterns used to cope that were established in childhood. When partners see this, they begin to understand the relational nature of their relationship; their frustrations do not lie in each other but in issues that reemerge in adulthood, intimate partnership, and in difficulty understanding and being understood.

Second, IRT's focus on emotional safety and dialogue disrupts and reverses dysfunctional relational patterns. When couples cocreate dysfunctional patterns, negative flooding can overtake the relationship. IRT methods block negativity and intervene at the affective, cognitive, and behavioral level to reestablish a loving connection while partners gain insight into the subsystems and subissues that created their relational patterns. Positive and safe dialogical interactions change the way couples relate to each other. The establishment of safety generates deep-level changes in the brain (Allison & Rossouw, 2013) that allow for more fundamental, lasting change.

Third, IRT's psychoeducational treatment methods take a neutral, supportive stance that prevents favoritism, an oft heard complaint in couple's therapy. The therapist acts as a coach/facilitator rather than a transferential object, helping to hold a couple in equal and safe connection until they are capable of doing so for themselves. The alliance supports both individuals and the relationship they are working to improve, and as with all therapies, is a main change factor.

Finally, while not explicitly stated in the treatment model, therapists use dialogue skills with any configuration of family

or relationship and urge their couples to dialogue outside of the marital system, especially with children. The direct treatment system affects the indirect treatment system (Pinsof, 1995; Sprenkle et al., 2009), and as often happens in systemic models, relationships outside the couple are also changed. Dialogue programs are also extended outside the confines of therapeutic practice. Through Safe Conversations, IRT methods are being expanded into broader communities, addressing the needs of the underserved, first responders, and hundreds of diverse families. Research into these programs is underway to detect changes in the mental health and overall well-being for participating families and communities.

Implications

The assertion made that IRT fulfills marriage and family common factors has moderate research to back its claim. Yet the connection between IRT and common factors had to start somewhere. In this case, we chose to start with theoretical assumptions and practices. IRT scientist/practitioners must continue to investigate outcomes, as well as curative narrow and broad common factors associated with the model.

Researchers working with therapists using the IRT model could develop a model of assessment delivered at regular office visit intervals to establish a practice of routine outcome monitoring (Boswell, Kraus, Miller, & Lambert, 2015) to increase clinical effectiveness. The aggregate data could be made available to researchers to strengthen the assertion that IRT utilizes marriage and family common factors and delineate it as an evidence supported therapy.

By deconstructing IRT using marriage and family common factors, this article reveals that IRT at its core adheres to common practices in couples counseling. While some of its metatheories and techniques are unique to IRT, its basic theories and methods fall within good practice measures as defined by marriage and family common factors. Although important as a way of establishing itself as a safe and useful practice, IRT must continue to increase its research base, especially in the area of outcome research. Quasi-experimental studies have been promising as have small randomly controlled studies, yet IRT has only recently begun the process of being subject to a large scale rigorous control study with follow-up. In today's evidence-based culture, it is essential that IRT is subject to a rigorous study of its treatment outcomes. For IRT to continue to be widely utilized, it will need to establish itself in the research literature as effective, efficient, and with theory and methods within the realm of good marriage and family practice.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

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