FAMILY PROCESS

The Couple Therapist as Moral Agent

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Partners in intimate relationships rely on each other to meet essential emotional needs. This mutual dependence creates reciprocal obligations, engendering a moral dimension to intimate relationships. This moral dimension involves questions of fairness, equity, and justice which are often central to couples' presenting complaints in treatment. This paper proposes that moral considerations in couple therapy are not only inevitable, but potentially beneficial, and illustrates how they can inform the therapist's case conceptualizations and interventions. This paper will also explore the therapist's responsible use of her moral influence through an examination of personal values. This paper utilizes concepts from psychodynamic and family systems theory to illustrate key points, but the ideas presented apply to therapists with diverse theoretical orientations.

Keywords: Couples; Couple Therapy; Moral Considerations

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> Marriage is a relationship that involves the well-being of another person, which makes it an inherently moral experience. (Fawcett, Fawcett, Hawkins, & Yorgason, 2013 , p. 517)

I have met with Jim and Sue for three sessions when I first speak with Sue's therapist:

> I'm really glad Jim has finally agreed to come to couple therapy. He has been unwilling to for some time. The main issue is that Jim is emotionally checked out. He doesn't show any interest in Sue's life and rarely helps out with the kids. Last month, when Sue's mother broke her hip, Sue was beside herself with worry and Jim didn't seem to notice. Another issue is sex. Jim seems to feel entitled to it and he gets upset with Sue when she turns down his sexual advances.

Later that day, I speak with Jim's therapist:

> Jim has been reluctant to come to couple therapy because he's afraid that Sue will just berate him. Jim feels like the constant target of Sue's anger—the message he hears over and over is he can do no right. When he tries to initiate intimacy, she rebuffs him and criticizes him for his attempts. He's really unhappy.

In this clinical vignette, Jim's and Sue's therapists put forth their views of obligations, equity, and fairness in intimate relationships. Sue's therapist believes that a spouse deserves a partner who is interested in her feelings, responsive to her needs, and involved in family life. She is entitled to freedom with respect to her body and should not be subject to frequent requests for physical intimacy.

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Jim's therapist believes that a partner deserves someone who can regulate negative emotions, be considerate of his feelings, and support (or at least not undermine) his self-esteem. A partner also deserves physical intimacy. Both therapists indicate that the couple therapy should redress the partner's obligational failures, thereby appealing to the moral dimension of intimate relationships.

This paper will explore moral features of intimate relationships arising from partners' reciprocal obligations. Through case examples, it will illustrate how moral considerations inform the couple therapist formulations and interventions. The definition of morality guiding this paper is offered by Killen (2018): "a set of prescriptive norms about how individuals ought to treat one another, with respect to fairness, others' welfare, equality and rights" (p. 770).

THE MORAL DIMENSION OF COUPLES' RELATIONSHIPS

An implicit but foundational tenet of most psychological therapies is that we depend on important others to meet essential emotional needs (e.g., psychoanalytic therapy, emotionally focused therapy, attachment theory [Ainsworth, Blehar, & Wail, 1978; Baumeister & Leary, 1995; Bowlby, 1960; Deci & Ryan, 2014]). In adulthood, our intimate partners shoulder much of this responsibility. This dependence creates interpersonal obligations for those significant others, lending a moral dimension to relationships. As the moral philosopher Kellenberger asserts, "obligation [in relationships] is an inescapable element of morality" (Kellenberger, 1995, p. 11). Later, he writes, "all of morality in one way or another rests upon relationships . . ." (p. 429).

Furthermore, a primary reason that couples seek treatment is that they feel their partners are failing to meet mutual obligations—failing to provide sufficient love, concern, support, respect, or physical intimacy. During couple treatment, partners appeal to this moral dimension in statements such as "I deserve more. . ." or "it's only fair that. . .". Many couple therapists are attuned to these moral concerns, which inform their assessments: *Is he responsive enough to her needs? Participating enough in the household responsibilities? Asking for too much sex? Providing too little physical intimacy?* The question, "Is he or she treating the other fairly?" is a central question in couples' lives and, consequently, in couple treatment.

A related issue is the interplay between needs and obligations. Do one partner's needs necessarily confer obligations on the other? For example, to what extent should a partner regulate her own emotions versus looking to her partner for emotional support?[1] "Where do my obligations begin and end?" is a pivotal question in a couple's life.

The exploration of moral concerns in couple treatment has historical antecedents. Among the first theorists to introduce moral concepts into couples' and family treatment was Boszormenyi-Nagy (1987). (See also Fowler & Wenger, 1997.) He promoted the idea of "ethical interconnectedness" and emphasized the interpersonal responsibilities family members have for one another (Boszormenyi-Nagy, 1987). He invoked concepts such as "accountability" and "fairness" and proposed that the aim of treatment was to create "equitable distribution of burdens and benefits" among family members (Boszormenyi-Nagy & Krasner, 1986, p. 336). With respect to couples, he and Krasner wrote that "marriages founder or succeed based on the question of whether or not two people develop the capacity to be responsible for the consequences of fairness and trust" (Boszormenyi-Nagy & Krasner, 1986, p. 336).

[1]For a detailed exploration of the balance between emotional self-regulation vs. partner provision of emotional support, see Goldman and Greenberg (2013).

Subsequent theorists have elaborated on the moral dimensions of intimate and familial relationships (Doherty, 1995; Melito, 2003). Feminist theorists in particular have drawn attention to the need to redress gender inequities in family life (MacKinnon & Miller, 1987; Sheinberg, 1992). In her writings on partner violence, Goldner (1998) makes the following observation about the nature of morality in couple therapy: "[Having] both partners in the room intensifies the moral dimensions of treatment, making issues such as equality, respect, fairness, intimidation, and violation emotionally real" (Goldner, 1998, p. 266).

The next section will address the following questions: Is the therapist's moral influence justified, or is this beyond her purview? Do moral considerations violate the principle of therapeutic neutrality?

NEUTRALITY AND THE THERAPIST'S INFLUENCE

Historically, impartiality has been considered a priority of most therapeutic approaches (Fife & Whiting, 2007). The origins of therapeutic neutrality can be traced to Sigmund Freud's fervent advocacy of analytic neutrality and his emphasis on the client's autonomy and self-determination (Hoffer, 1985; Hoffman, 2009). This grew, in part, out of his desire to distinguish psychoanalysis from techniques such as hypnosis. He was also concerned about the analyst imposing his own values on the patient, fearing the negative therapeutic effects of undue influence (Gullestad, 1993; Safran, 2009). Freud's papers on technique underscore the importance of neutrality. For example, he wrote that "the doctor should be opaque to his clients and, like a mirror, should show them nothing but what is shown to him" (Freud, 1912, p. 118).

Fife and Whiting (2007) have pointed out that this stance is reflected in many therapeutic traditions. They cite the behavioral and humanistic schools, in addition to psychoanalytic schools, as proponents of the principle of neutrality. However, they also illustrate how many subsequent theorists have challenged the feasibility of a value-free therapy as both practically and theoretically impossible. (Fife & Whiting, 2007). Melito (2003) in his work on values in psychotherapy makes the astute point that value-free therapy is itself a value. Beutler (1979) argues that psychotherapy, by its very nature, is a form of persuasion in which the therapist induces the client to adopt a new set of values. From this perspective, a value-free therapy is antithetical to the purpose of treatment.

Meissner (1983), writing from a psychoanalytic perspective, also advanced this position:

> [I]t becomes for all practical purposes impossible for the analyst's [therapist's] values not to impinge on the analytic process, and this would include both technical and personal values . . . [H]e is a human being with convictions, beliefs, social and cultural attitudes, moral and ethical values, standards of what he believes and espouses to be right and wrong, good and bad, healthy and unhealthy. (p. 582)

Doherty (1995) contributes to this discussion as well. In his book, *Soul searching: Why psychotherapy must promote moral responsibility,* he endeavors to "re-envision psychotherapy as a moral enterprise." He asserts that, while most therapists concede that values play a role in therapy, fewer feel comfortable with their own role in adjudicating moral issues and beliefs (p. 14). His main thesis is that "therapists at times should consciously influence clients to change their behavior in light of the moral issues involved." Moreover, he continues,

> In my view, we inevitably influence our clients' behavior and moral thinking: therapists have already done it for a century by promoting the moralit

> y of self-interest. A crucial issue is how respectful and responsible we are with our influence. (p. 17)

Goldner echoes Doherty's call for including moral considerations in therapy:

> My experience in violence work has led me to believe that we ought not disclaim our enormous if implicit moral authority by narrowly restricting our professional attention to clinical theory and technique. Rather, we need to develop ways to enhance our sense of responsibility about that authority—by cultivating a stance of self-conscious moral engagement in our work. (Goldner, 2004 , pp. 349–50)

This point is also reflected in Fowers and Wenger's (1997) article on contextual family therapy. They assert that while Boszormenyi-Nagy introduced moral concepts into family therapy, he strove to preserve the therapist's neutrality. They challenge this position, asserting that the family therapist must, at times, go beyond the role of facilitator and become an arbiter in the discussion. Fowers and Wenger write that contextual family therapists "do have specific ideas of what fairness consists of, and they can and do intervene with families to shape their definitions of relational justice" (p. 160).

Following sections will include clinical examples to expound upon these ideas by Doherty, Goldner, and Fowers and Wenger.

THEORY OF MULTIPLICITY

A central tenant of this paper is that moral considerations should be considered alongside the therapist's preferred clinical theory. Further, moral ideas should compliment, rather than compete with, explorations of the couple's experiences and needs. This can be accomplished through the framework of multiplicity (Goldner, 2004). Rather than applying exclusively a moral *or* a clinical lens, the therapist embraces several paradigms which she holds in mind as she listens to the couple. At times, this may lead the therapist to explore a partner's needs, vulnerabilities, and feelings. At other moments, she may highlight mutual obligations, including issues of fairness and equity. Goldner describes explicates this view:

> The clinician situates the couple's relationship and its dilemmas in multiple discourses, all of which are "in play" as the clinical situation unfolds. Feminism, object relations inquiry, systemic thinking, cultural factors, neurobiological evaluation, and any other perspective one has cared enough to master may make a claim on an interview, as the therapist becomes aware that she has begun to think in cultural (or psychodynamic, or biological, etc.) terms. As that particular paradigm begins to bring certain themes into focus. . .like a kaleidoscope, another framework starts coming into view. (Goldner, 2004 , p. 360)

A moral framework is not selectively applied to certain couples because mutual obligations are foundational to all intimate relationships. Couples on the healthier end of the spectrum typically need little moral guidance as they have a "built in" attunement to issues of equity and justice in their relationship. They instinctively prioritize their partners' well-being and are concerned about their partners' needs and feelings.

Other couples, like the ones to be described in the case examples below, rely on the provision of a moral scaffolding. Again, this does not require the therapist to choose between a moral *or* empathic/exploratory framework. On the contrary, moral considerations serve to guide the therapist's inquiries into a deeper understanding of the couple's experience and dynamics. For example, when the therapist believes that a partner is failing to meet a reasonable expectation in the relationship, the therapist can empathically explore the origins and meaning of the partner's challenges. Boszormenyi-Nagy asserted that obligational failures in relationships frequently stem from childhood deprivation or

victimization (Boszormenyi-Nagy & Krasner, 1986, p.102). The therapist's attention to moral concerns identifies avenues for exploration in the treatment.

It is important that moral considerations emanate from the therapist's assessment of the couple, not from the couple's attempt to enlist the therapist as arbiter. Frequently, partners endeavor to conscript the therapist into his or her army of one, to battle the opposing side. In these instances, it is helpful for the therapist to understand the frustration and helpless that often underly these recruitment attempts. Partners put pressure on the therapist in this way when they feel unheard, unrecognized, and alone. It is essential that the therapist speaks to these feelings in the treatment.

The following section will present clinical examples to elucidate how moral considerations influence the therapist's assessments and interventions. It will also illustrate how a moral framework dovetails with the therapist's preferred therapeutic orientation.

CASE EXAMPLE I

The first clinical vignette is presented by Scheinkman and Fishbane (2004), who write from a family systems perspective. In their paper, they discuss a clinical vignette involving a couple who sought treatment a few months after the girlfriend, Sara, began graduate school. Because of the time Sara devoted to her studies, her boyfriend, Mark, felt "neglected and rejected" (Scheinkman & Fishbane's, 2004, p. 284). Subsequently, he became "furious and accused her of being with other men," which left her feeling confused and overwhelmed. In the course of their treatment,

> the therapist set limits on Mark's intimidating behavior, suggesting alternative ways for him to express his needs for connection. She [the therapist] encouraged Sara to be more outspoken about her need for boundaries in order to do her studying and to reassure Mark that she was faithful to him. (p. 284)

Here, the therapist invokes the moral category of intimidation to influence how the couple will resolve their conflict. Along with the introduction of this term, the therapist further encourages a change in Mark's behavior with Sara's aid by offering him reassurance of her commitment to him. The salient point is that the therapist's use of the word "intimidating" is a subjective *and* moral assessment that leads to a particular framing of the couple's problem.

In my clinical experience, rarely does the person whom the therapist considers "intimidating" concur (at least initially) with that assessment. He or she (in this case the boyfriend) needs "psychoeducation," that is, persuading. Moreover, we do not know if Sara herself described feeling intimidated or unsafe, or whether the therapist introduced this idea into the conversation. For some clients, the therapist must provide the scaffolding of a relational universe in which basic rights are recognized. If, on the other hand, Sara did use that terminology, the therapist "sided" with her in her perspective. After all, a client expressing feeling unsafe is not necessarily grounds to ask his or her partner to change. For example, some people feel unsafe when their partner raises his or her voice in the slightest. Therefore, the therapist's assessment involved moral considerations that limited the ways the couple could resolve their conflict.

The therapist also used her moral influence when she encouraged Sara to "set boundaries so that she can study." The therapist, in other words, communicated that Sara is entitled to pursue her graduate education and that Mark should support her in her pursuits. The therapist then discussed with the couple some of the ways in which women in our culture are socialized to be "overly accommodating." In this way, the therapist helped Sara to establish appropriate boundaries so that she could study, helping us to see how the therapist can both *shape and constrain* the couples' resolution of such impasses.

Instead of encouraging Sara to set boundaries, the therapist could have explored with Sara whether she had considered reducing her coursework so that she could be more available for Mark. The therapist could have encouraged Sara to reevaluate the importance to her of pursuing graduate studies, given the toll it was taking on the relationship. However, the therapist did not pursue these avenues because they would have conflicted with the therapist's strongly held views about gender and equity in relationships—that is, the reciprocal rights and responsibilities partners have in relation to one another.

In highlighting the moral features of the therapist's intervention, it is important to note that moral concerns are part of a broader objective of a family systems approach—the therapist illuminated the couple's core dynamic triggered by Sara's and Mark's respective vulnerabilities. Indeed, this is the primary thesis of Scheinkman and Fishbane's paper: "the overall goal is to help them [the couple] move from highly reactive positions to more reflective ones, from automatic actions and reactions to greater differentiation, awareness, and flexibility" (p. 285). Within a family systems approach, the therapist highlighted moral features of the relational dance that could undermine the rights and responsibilities of both partners in the relationship.

CASE EXAMPLE II

The following case example features a couple from my own practice. When I first met with Lucas and Bill, Bill spoke about how Lucas would shut him out emotionally, which he described as Lucas "putting up a wall." Lucas agreed with Bill's assessment and stated that he struggled to respond to Bill's bids for emotional engagement. Lucas would often feel overwhelmed and want to retreat. He recognized this as problematic and wanted to become more receptive to Bill's emotional needs.

Initially, I focused on the underpinnings of Lucas's difficulty with emotional engagement—I explored the experiences, anxieties, and historical background that led to him to self-isolate. I also discussed the dynamic of pursuer–withdrawer to help the couple appreciate their respective roles in their relational dance (Christensen & Heavey, 1993).

As our work progressed, Lucas indicated that, despite his efforts, he continued to struggle to be responsive to Bill's feelings and needs. As we discussed their interactions further, it seemed that Bill's bids for emotional engagement were frequent, allowing Lucas little physical or emotional space. Bill was quick to anger when Lucas was not immediately attentive or available to him. Lucas seemed to go to great lengths to accommodate Bill and to minimize his own needs and interests. Indeed, my conceptualization shifted from one of pursuer–withdrawer to that of a demander–appeaser. In this cycle, one partner's efforts to appease lead the other to increase his demands, in part because the appeasement itself gives legitimacy to the demander's behavior.

As I learned more over time, I understood that Bill's attempts to control Lucas were his way of managing profound anxiety about separation and dependence. This anxiety grew out of painful childhood experiences of abandonment and loss. Lucas's willingness to capitulate reflected his own childhood experience of having to subordinate his needs and interests in order to preserve his attachment to his mother. Underlying each of their positions was a great deal of anxiety as well as confusion about partners' roles, responsibilities, and obligations in relationships.

In keeping with my revised conceptualization, Bill's wish to control his partner and Lucas's expectation that relationships required compulsory compliance made them a "neurotic fit" (Galler et al., 2001). From a systems perspective, if Bill were able to reduce the frequency and intensity of his emotional bids and provide Lucas more space and autonomy, Lucas might feel less overwhelmed and better able to respond to Bill's needs. However, this "meet in the middle" approach will be rejected if it conflicts with what one

partner feels "entitled to." The pragmatism of this "give a little to get a little" strategy can offend that partner's sense of justice. Indeed, Bill held tenaciously to his belief that he was entitled to Lucas' constant attention and availability. Lucas felt caught between his compulsive need to placate, on the one hand, and to break free of what felt like an oppressive burden, on the other.

My role in the treatment was to understand their feelings and experiences and to help them develop empathy for one another. My role *also* involved introducing moral concepts into their dialogue, including ideas about the limits of entitlement and respect for personal boundaries. My goal was not to determine the exact outcome but to provide a moral framework that could help shape their dialogue by introducing certain moral parameters. Because the couple was caught in this demand–appease cycle, these parameters needed to be consistently restated to keep them in play.

These considerations were reflected in my interventions. For example, at times, I would say to Bill: "It seems hard for you to give Lucas the space he needs to decompress when he comes home from work. You feel neglected"; or, "It's painful to tolerate when Lucas doesn't always want to spend time with you on the weekends the way you would like." Or to Lucas: "It's so confusing to know whether you are entitled to ask for space when you've had a hard day. You feel guilty for asking for what you need, especially if you think it makes Bill unhappy." Implicit in these comments are thoughts about the relative legitimacy of some needs over others, as well as about basic entitlements in relationships.

Some may argue that the therapist's role is simply to invite partners to engage in a discussion about what is fair, just, and equitable. However, some of our clients come from families in which respect and concern for family members was minimal or erratic. They lack a framework for assessing what fairness, justice, and equity might look like. Some people, like Lucas, have been primed by their family-of-origin to believe that maintaining connections requires subordinating personal needs and wishes. Others bring to relationships a belief that control and domination are acceptable ways of getting what you need. In cases like these, it is our job to introduce moral concepts and provide guidance about rights, reciprocity, and equity in relationships.

Another objection to this paradigm could be that moral considerations should only be brought to bear in cases of physical violence or abuse. This argument seeks to draw a bright line between domestic abuse, on the one hand, and all other behaviors, on the other. However, Goldner (1998, 2004), in her extensive experience in domestic violence, concludes that this bright line does not exist. She argues that a moral framework is applicable to all couple treatment. Goldner (2004) writes:

> It is not that we therapists deserve to be society's moral arbiters but that, in this psychological culture, our expert position rightly or wrongly gives us a kind of moral authority in the sphere of personal life. This is most true of family and couple work, in which the therapist is specifically invited to intervene and to influence the practices of personal life—how people should love, fight, make love, and raise children … [T]he family therapies explicitly *regulate* [emphasis added] social relations and *create* [emphasis added] new regimes of normativity in the process. What we say has direct social consequences—the couple may break up or marry, have a baby or not have a baby, send a child away or bring him home. One partner might end up with more personal freedom (or less), more work (or less), and so on. (p.349)

The examples of both Mark and Sara, and Bill and Lucas demonstrate how, in Goldner's words, therapists "regulate social relations and create new regimes of normativity in the process." In both cases, the therapists helped the couples to renegotiate the boundaries of personal freedom and to redefine personal entitlements.

OBLIGATIONS TO THOSE OUTSIDE OF THE COUPLE

Often, couple therapy involves the needs and interests of people beyond those in treatment. Many couples have children and/or step-children whose needs and interests are directly impacted by changes and decisions the couple makes over the course of treatment. It is, therefore, incumbent on the couple therapist to consider not only the needs and wishes of the couple, but of the family as well. (While this most obviously includes children, it can also include parents, in-laws, etc.)

One newly married couple sought treatment due to a conflict over the husband's daughter from a previous marriage. The wife wanted to be able to hire babysitters when his daughter stayed with them—she wanted to have more opportunities for going out together beyond the weekends when his daughter resided with his ex-wife. She also wanted more flexibility regarding the timing of vacations, even if it meant giving up scheduled time with the daughter. Because of his limited time with his daughter (every other weekend and one night during the week), the husband did not want to risk losing any of it. He also worried that his daughter would feel rejected if she were left with a babysitter, given the already limited amount of time they spent together. In response to this, the wife believed that her husband was "overly sensitive" to his daughter's feelings.

Apart from the question of how much time the husband should spend with his daughter, I wanted to understand the needs and feelings from which the wife's request sprang. I wondered what her relationship with her step-daughter was like. (It turned out not to be especially good.) Did the wife feel excluded? (Yes.) Did she feel threatened by her husband's relationship with his daughter? (Yes.) In the treatment, I supported the husband's need to preserve time with his daughter and tried to explore ways of addressing the wife's needs and feelings that wouldn't involve reducing that time. To this end, we explored ways of helping her feel more secure in her relationship with her husband and more included in the relationship with her husband and step-daughter. My moral framework also took the daughter's needs into account, endeavoring to preserve the bond with her father.

The argument could be made that the therapist could avoid a moral position, by favoring the husband's position on practical grounds. From this vantage point, advocating for the father's wishes would minimize the couples' future troubles by forestalling the husband's resentment if he surrendered time with his daughter. Furthermore, one could argue that if the daughter learned that she was spending less time with her father at his wife's behest, this might sour her relationship with her step-mother and create further tension for the couple. However, if the therapist exerts influence over the outcome in the father's favor, it could generate resentment in the wife over decreased freedom and flexibility. Either outcome *could* generate resentment in one or more of the people involved. As stated before, my stance emanated from my belief that the father's relationship with his daughter *should* be a central consideration. Generally, my approach with step-parents is to empathize with the sacrifices (that I deem) necessary for blended families to work. This moral framing could be summed up as: "You need to sacrifice—and yes, it isn't fair."[2]

THE RESPONSIBLE USE OF THE THERAPIST'S MORAL AUTHORITY

The therapist's influence in moral matters brings with it an enormous responsibility to use her authority thoughtfully and responsibly. This requires a high degree of self-

[2]Moral considerations pertaining to blended families warrant a paper in its own right. Given inherent conflicting interests and divided loyalties of family members, treatment involving the couple in blended families is rife with moral complexities. For an in-depth exploration of blended families, see Papernow (2013).

awareness as to how her personal values shape her views of fairness, equity, and justice. Meissner (1983), in his work on values, echoes this point:

> Our own personal values, then, become an area for particular self-scrutiny and monitoring, so that we become not only more self-consciously aware of them but also more explicitly and specifically attuned to the manner in which they . . . influence our own therapeutic interventions. (p. 596)

Questions to be considered in this self-assessment include the following: How might therapist's moral perspectives on intimate relationships be colored by negative experiences in personal relationships? How might her assessments be impacted by exposure to a troubled parental relationship? For example, how might being the child of divorced parents influence the therapist's outlook on romantic relationships? How might her own relationship or marital status shape her couples' work?

Another crucial influence on the therapist's values is his or her cultural background, including race. Multiculturalism, described as the "fourth dimension" of psychotherapeutic theory, is now widely accepted as an essential consideration in all forms of psychotherapy (Pedersen, 1999). It is incumbent on all couple therapists to develop multicultural competence. A comprehensive review of the literature on multiculturalism is beyond the scope of this paper, but see Comas-Díaz (2011), Constantine and Ladany (2001), Knapp and Vande Creek (2007), and Tummala-Narra (2015) for ways to develop multicultural competence.

I work with many bicultural and biracial couples, and I sometimes share a similar ethnic or cultural background with one partner but not the other. In such cases, I do my best to avoid minimizing or discounting the values of the partner whose background I don't share. This is complex, because one partner's culture may espouse values that conflict with foundational values of the therapeutic setting, such as gender equality. Thus, it behooves the therapist to familiarize herself with the abundant scholarship on cultural competence.

CONCLUSION

The opening quote of this paper described marriage as "an inherently moral experience" based on partners' obligations to promote each other's well-being (Fawcett et al., 2013, p. 517). This paper explored the implications of this moral dimension for couple treatment. It demonstrated that moral considerations in couple treatment are not only inevitable, but potentially beneficial, and suggested ways in which the therapist can intervene with these considerations in mind. This paper also emphasized the importance of the therapist's responsible use of her moral influence and suggested ways to enhance the therapist's self-awareness about personal values.

This paper was written in the hopes of contributing to the burgeoning couple therapy literature by highlighting an important feature of couple treatment and pointing to areas for future exploration.

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