

Parents in couple therapy: An intervention targeting marital and coparenting relationships

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Abstract

This article describes the treatment framework and core therapeutic principles of the integrative brief systemic intervention (IBSI), a manualized six-session intervention intended for parents seeking couple therapy. IBSI aims to work on the couple's presenting problem, considering its specific impact in the marital and coparenting domains. The basic premise of IBSI is to consider that, when working with couples who have children, therapeutic work on their coparenting alliance may be used as a lever, as both parents may be particularly motivated to improve their relationship for their children's benefit. Increasing the coparenting alliance may then facilitate work on deeper conflicts within the marital relationship. The core therapeutic principles of IBSI are: (1) joining with the couple as romantic partners and a coparenting team from the start of the therapeutic process; (2) supporting the parents in increasing their awareness regarding their children's behavior and emotional experiences when facing their parents' conflicts; and (3) working on the spill- and cross-over effects between marital and coparenting relationships (i.e., exploring how conflict or positivity spills over from one relationship to the other or crosses over from one partner to the other). Therapeutic work following these main

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therapeutic principles is expected to improve the quality of both relationships. A clinical case is provided to illustrate the core therapeutic principles of IBSI.

KEYWORDS

brief intervention, coparenting, couple therapy, marital relationship, parents

INTRODUCTION

Couple therapy has been validated as an efficacious and efficient approach (Bradbury & Bodenmann, 2020), with reviews and meta-analyses showing its possible efficacy for improving marital satisfaction and reducing comorbid disorders in individuals (e.g., Rathgeber et al., 2019; Sexton et al., 2011; Shadish & Baldwin, 2005; Sprenkle, 2012; Von Sydow et al., 2010). Notably, efficacy and effectiveness research on couple therapy has mostly assessed marital satisfaction and individual symptomatology, rarely including other family outcomes, such as parent–child relationship quality or child adjustment (Darwiche & de Roten, 2015; MacIntosh & Butters, 2014).

Nevertheless, couple therapy with parents has specific characteristics. First, coparenting conflict (i.e., lack of coordination and cooperation between parents in childrearing) is related to worsening difficulties in the marital facets of relationships (Zemp et al., 2018). Mutual support in parenting efforts is connected with higher-quality marital relationships (McHale & Irace, 2011); therefore, addressing the coparenting relationship in couple therapy may also improve marital relationship quality. Second, destructive conflict can be detrimental for not only the partners themselves but also their children's well-being and development (Davies et al., 2012; Murphy et al., 2016). Coparenting is a more proximal predictor of child well-being than marital relationship quality (Holland & McElwain, 2013); coparenting quality affects child adjustment, even after controlling for marital satisfaction (Teubert & Pinquart, 2010). Therefore, targeting the coparenting relationship in couple therapy could also benefit children.

Coparenting in couple therapy research

Two uncontrolled effectiveness studies regarding the impact of marital counseling on several commonly assessed dimensions (e.g., marital satisfaction and affective communication), which also assessed conflict over childrearing in parent couples (approximately 75% of the sample), showed that marital counseling (Hahlweg & Klann, 1997; Klann et al., 2011) effectively improved marital satisfaction but not coparenting conflict. Another study (Ledermann et al., 2007) used a randomized controlled design with parent couples experiencing childrearing distress, finding that a couple prevention program targeting marital stress and coping positively impacted marital relationship functioning but did not decrease coparenting conflict. The authors of these three studies suggested that to achieve effects for coparenting, a more tailored approach for parent couples would be more appropriate.

Some studies have demonstrated improved coparenting. Gattis et al. (2008) assessed the efficacy of behavioral couple therapy on marital satisfaction and coparenting and child adjustment (half of the sample were parent couples and coparenting was targeted when needed). Results showed improved marital satisfaction and decreased coparenting conflict over the course of therapy and at two-year follow-up. Moreover, coparenting conflict mediated the relationship between marital satisfaction and child adjustment (Gattis et al., 2008). Lastly, a brief

systemic intervention (Vaudan et al., 2016), including work on coparenting and childrearing when relevant, showed improved marital and coparenting quality, with effects being maintained three months after therapy completion. However, the increase in coparenting quality was not as strong as that for marital quality.

These studies, including parenting-related outcomes for couple therapy, produced conflicting results, indicating that improvements in parents' marital relationships do not systematically translate into coparenting-related changes. This is intriguing, as several studies showed a link between marital and coparenting quality (e.g., Mangelsdorf et al., 2011), suggesting that improving one relationship could naturally help improve the other. The available findings suggest that including work on the coparenting relationship in couple therapy when appropriate improves coparenting (Gattis et al., 2008; Vaudan et al., 2016), compared to either unspecified interventions (Hahlweg & Klann, 1997; Klann et al., 2011) or interventions focused on other aspects (e.g., communication skills; Ledermann et al., 2007). Further research is needed to clarify whether techniques that incorporate both marital and coparenting relationships can lead to greater changes in family related outcomes. It is also necessary to clarify whether this type of approach should be used only if parents are experiencing parental distress in combination with marital distress, or whether specific coparenting work is valuable even if the request falls within the marital sphere.

Coparenting in clinical family and couple therapy literature

In clinical *family* therapy literature, therapeutic work on coparenting has been conceptualized and applied in slightly different ways. Work on the marital relationship is generally considered a prerequisite for achieving results with family interventions and decreasing symptoms in children. Minuchin (1974) described the importance of the “parental executive subsystem” for family functioning. According to structural theory, symptoms in children may arise when inappropriate boundaries within the family (e.g., detouring and cross-generational coalitions) prevent the parental executive subsystem from fulfilling its protective role and authority. Other pioneers, such as Satir (1964), viewed parents as architects of the family, considering the interparental relationship as the axis around which other family relationships are shaped. Satir posited that conflictual marital relationships lead to a dysfunctional family triangle, which prevent the adults from fulfilling their parental roles. Boszormenyi-Nagy (Boszormenyi-Nagy & Spark, 1973) provided a crucial understanding of the impact of parental conflict on children. Therapists' multidirectional partiality leads them to consider the impact of problems and symptoms on each individual, including absent or unborn generations, referring to the principle of relational equity. A therapist will thus encourage each partner in a marital conflict to consider the other's best interests while also, as a parent, considering their child's best interests. Similarly, in multi-generational therapy (Andolfi, 2017), therapists may invite the partners' children or parents to physically participate in the couple's treatment, so their perspectives can be voiced, and their presence experienced as positive resources for the couple.

To our knowledge, there is no model in clinical *couple* therapy literature that specifically articulates work on both the marital and coparenting relationships. It is more common to work on reciprocal patterns of interaction when treating a couple's problematic dynamic. For example, in emotion-focused couple therapy (Greenberg & Goldman, 2008), the therapist identifies the interactive dance in which the partners are caught to help them overcome their difficulties, be they negative cycles related to affiliation (e.g., demand–withdraw cycle) or influence (e.g., overfunctioning–underfunctioning cycle; Greenberg & Goldman, 2008). Other authors, such as Scheinkman and DeKoven Fishbane (2004), also propose work on vulnerability cycles that adversely affect couples' overall relationships. If these cycles triggered by individual vulnerabilities (e.g., abuse, maltreatment) are activated within a couple's relationship, one of the

partners will adopt a “survival position” (e.g., not get too close), thereby provoking a reaction in the other and creating an impasse. The underlying rationale of these models is that interactional cycles generally affect several domains of a couple's life (i.e., as partners, as parents, or in relationships with their family of origin; Zimmerman & Dickerson, 1993).

With parent couples, however, it may be relevant to address whether these interactional cycles differ between the marital and coparenting areas. Certain domains may be preserved while others are not (e.g., parental efficacy maintained despite marital conflict), or different cycles may characterize these domains (e.g., an overfunctioning–underfunctioning cycle in the coparenting relationship but a demand–withdraw cycle in the marital relationship). If we assume that the interactional dance may differ between domains, working only on romantic cycles may be insufficient if another cycle is perpetuated at the coparenting level. Thus, it may be necessary to work on what transcends the different roles and relationships and on what is specific to certain domains and relationships.

Outside the family and couple therapy fields, some programs offer combined interventions on marital and coparenting relationships; however, they target specific populations, such as divorced or new parents, as part of specialized coparenting programs (for a review, see Eira Nunes, de Roten, et al., 2021), making them unsuitable for parents seeking couple therapy.

INTEGRATIVE BRIEF SYSTEMIC INTERVENTION

The well-established distinction in the family development field (e.g., McHale & Irace, 2011) between coparenting and marital relationships is highly relevant when conducting couple therapy with parents. In the clinical couple therapy field, this distinction may initially appear artificial to clinicians, as they usually target general dysfunctional interactional cycles rather than the marital and coparental domains separately. We propose that this distinction be used as a tool for working with parent couples specifically to explore and work on their roles and experiences as partners and parents. There are three main reasons for this proposal. First, parents may be more motivated to initiate change in their coparenting functioning in the early stages of treatment, driven to improve their relationship for their children's sake. Second, there may be different dynamics in these two domains that do not evolve in the same way or at the same pace, and this can only be revealed through domain-specific exploration. Third, parent couples may come to couple therapy but present with co-morbidities, such as difficulties in the parent–child or coparenting relationship, or be parents of a child with special needs.

In this paper, we describe the IBSI treatment framework and its core therapeutic principles, then illustrate the intervention using a clinical case to demonstrate how couple therapy may help parents by strengthening their marital and coparenting relationships. The treatment framework resulted from the collaborative work of the three first authors with support from the other authors.

Treatment framework

IBSI is a manualized intervention (Carneiro et al., 2012, manual available from the authors upon request) with four chapters:

Chapter one provides background for the model's development. Originally, this systemic six-session intervention was developed in the larger context of several collaborative efforts between clinicians and researchers to provide brief therapeutic interventions for individual and families using different theoretical approaches (e.g., Drapeau et al., 2008). Brief interventions are designed to accelerate change through targeted therapeutic interventions and to increase couples' involvement in treatment (Dewan et al., 2011). However, when they requested

it, couples were offered more than six treatment sessions. When more sessions were scheduled, a new contract was created; either the IBSI continued in the same format as with six sessions or only a few ad hoc sessions were scheduled, depending on the couple's needs.

Chapter two features the general systemic framework. It summarizes the general principles of systemic-oriented approaches related to the definition of the therapy goals and treatment of the presenting problem. In the specific context of brief treatment, the IBSI model promotes therapists' collaborative positioning in relation to clients (Anderson, 1997), inviting the clients to be co-actors and jointly responsible for the therapeutic process. In each session, client feedback is sought regarding their experiences with the therapeutic process and therapeutic relationship to promote dialogue and reflexivity regarding the intervention (e.g., Gingerich et al., 2012). This technique is called a feedback ritual because it is used in a ritualized way at the beginning of each session (Macaione et al., 2018). Another example of the importance of feedback in psychotherapy may be found in Pinsof's work (Pinsof et al., 2015). Change can be empirically assessed and tracked through a client-report feedback system (Systemic Therapy Inventory of Change, STIC). The partners' feedback is also systematically used by the therapists to guide their decisions.

Chapter three describes the three phases of IBSI:

1. Session 1 is dedicated to creating a therapeutic space (Tilmans-Ostyn & Meynckens-Fourez, 1987) and defining the problem in terms of concrete interactive behaviors, thus allowing minimum objectives to be set (Nardone & Watzlawick, 2004).
2. Sessions 2 to 5 (intervention phase) allow for work on a couple's objectives. The systemic techniques are generic to other models, as described in the manual. Accordingly, therapists will use techniques they prefer or consider most appropriate within the general framework of systemic practice. What is unique to IBSI is that these interventions are guided by the core therapeutic principles detailed in the manual's fourth chapter (see below).
3. Session 6 is dedicated to reflecting on the intervention and possible follow-up. Both partners are invited to evaluate the progress made and whether they reached their goals. This session also allows therapists to work further on possible relapses and help couples anticipate their reactions to future difficulties.

Chapter four describes the core therapeutic principles, which aim to guide therapists in incorporating therapeutic work on both the marital and coparenting relationships within the couple therapy setting.

Core therapeutic principles

Three core therapeutic principles are intended to promote change. As in systemic couple therapy, the therapist in IBSI focuses on the relational issues that brought the couple to couple therapy (e.g., sexual problems, infidelity, work-related stress). Therefore, the therapist does not prioritize work on coparenting over work on other relationship issues, and the extent of the work done on the marital or coparenting relationship is left open.

First principle

From the intake or first session, the therapist aligns with the couple, considering them to be partners and coparents. In doing so, the therapist shares their vision of the couple comprising both marital and coparenting relationships and orientates their questions to obtain information on both (e.g., "What are your expectations of each other as partners

and coparents?” “How do you feel you contribute to the romantic and coparenting relationships?”). The therapist provides concrete examples of what is covered by the marital and coparenting relationships and assesses the couple's satisfaction and expectations in both domains. Psychoeducation about the impact of marital and coparental conflict on children can be a valuable tool at this initial stage to make parents aware of the importance of working on their relationship. Keeping in mind from the beginning that couples are both romantic partners and coparents favors the connection between experiences and emotions in both domains, whether the subject being discussed is related to the marital or coparenting relationship (e.g., “How do you feel the issues you came to therapy for, the cheating between you, have impacted John or you as a parent?” or “How do you feel the issues you came to therapy for, struggling to agree on child-rearing issues, have impacted Delia or you as a partner?”). These questions can be asked using circular questioning (Selvini Palazzoli et al., 1980) or techniques from different systemic therapy models, such as the miracle question (De Jong & Kim Berg, 2002; e.g., “If you woke up and the problem of cheating between you was fully resolved, would that have an impact on John as a parent?”).

These questions may be asked in the first session during the goal-setting phase, but may also be relevant at other times in therapy. Another way of connecting with the couple as partners and parents, regardless of their children's ages, is to explore their experiences during the transition from couple to parents to determine whether their marital problems are potentially related to this period. Many problems for couples take root during this life stage, such as the father feeling excluded from the mother–baby dyad, the mother feeling unsupported, and the onset of sexual difficulties (e.g., Hughes et al., 2020). Therefore, marital tensions may have resulted from difficulties integrating the romantic and coparenting dimensions. This approach allows the couple's difficulties to be reframed (“we are a couple in crisis”) for a more nuanced view of their relationship, where they realize, for example, that their high expectations as parents weakened their marital relationship. This allows partners to maintain a positive view of their resources and identity as a couple. Overall, the first principle aims to help partners broaden their vision of their functioning as a couple and identify dynamics that could potentially differ depending on the domain.

Second principle

In IBSI, the therapist encourages higher awareness of the repercussions of couple conflicts on child well-being and adjustment. Based on clinical experience, the premise of IBSI is that partners are initially more likely to work together to benefit their children rather than focus on their deep-rooted marital difficulties. It has been clinically observed that during a marital crisis, the motivation to change for one's partner or the relationship is often reduced, while the motivation to change for one's children generally remains intact.

Therapeutic work on couple difficulties—and their repercussions for child well-being and adjustment—can take different forms. The strategies used depend on the questions and difficulties the couple expresses during the first session and the exploration of the couple's functioning in the marital and coparenting domains.

Difficulties experienced in the marital relationship only

When a couple comes to therapy with a specific marital problem (e.g., sexual or infidelity problems), the therapist prioritizes that problem, but may, at some point during the intervention phase, use the couple's resources as coparents to consolidate or increase their coparenting alliance, which, in turn, may motivate them to overcome other difficulties. Some marital difficulties may be so intense and persistent, or the partners so unengaged in change, that working on the coparenting relationship may be an effective therapeutic lever.

One avenue is to acknowledge and value the couple's resources in the coparenting domain. The therapist can highlight the ability they both have to care for their children's well-being. Thus, the therapist will help the partners imagine what life would be like if their marital difficulties disappeared, and work to develop the couple's resources to achieve this goal, rather than focusing on past events and mistakes. Coparenting successes are seen as resources—or exceptions to marital difficulties—that can help partners reach their goals (Berg, 1994).

The therapist may also suggest that parents reflect on how their children feel about and experience marital conflicts they witness. This aims to shift the couple's focus from the marital difficulties to reflect on family functioning and explore their children's perspectives. The therapist may also invite the partners to recall their own childhood memories, and in particular of arguments between their parents, which can increase their empathy for their children.

Difficulties expressed in both the romantic and coparenting relationships

In this situation, the therapist can articulate work on the marital issues with work with coparents concerned for their children's well-being. Without setting aside marital distress and the couple's needs in this area, the therapist may decide to first work on the coparenting relationship, if they assess the parents to be more involved in this area, if they are experiencing significant difficulties in the parent–child relationship, or if the children themselves are presenting with symptoms.

More precisely, the therapist leads the coparents to observe and describe their children's reactions in relation to the witnessed interparental conflict (Cummings et al., 2008). Parents can also reflect on their children's role in the conflict. As Cummings and Davies (2010) described, children may interfere with, avoid, or be emotionally dysregulated during interparental conflict. Work on these issues can increase coparents' awareness of the impact their tension has on their children, which may be a powerful motivator for change. When coparents become sufficiently insightful regarding their children's experiences and feelings (Oppenheim & Koren-Karie, 2002), they are able to empathically understand the motives behind their children's behaviors in terms of thoughts and emotions, and are open to challenging their children's views. Coparents' empathy with their children's experiences may be encouraged by simulating a child's presence during the session or connecting the parents to their child's experiences using circular questioning technique (Selvini Palazzoli et al., 1980). Once the coparents understand their children's emotional experiences related to interparental conflicts, the therapist may use these experiences as a therapeutic lever. This reframes possible changes in each partner as positively impacting both the couple and their children. Questions such as “who would benefit most if you changed” can lead parents to shift their focus away from their conflicts and toward a better perception of how change benefits their children. This may also help the couple to shift from blame to more constructive action.

To improve the coparenting relationship, the therapist can work on strengthening the coparenting alliance by looking for each parent's “good reasons” for their childrearing beliefs (Boszormenyi-Nagy & Spark, 1973; Kotchick & Forehand, 2002). The therapist can allow understanding and expression of each parent's internal motivations (e.g., parents wish to pass on values they hold dear and inherited from their family of origin). Interparental conflict can then be positively reframed, and the coparents can become less critical of each other's childrearing beliefs. The therapist can also propose some minor expectations for change in the coparenting relationship to allow the couple to experience small successes (e.g., asking the first parent what the other parent could do to help them change, leading each parent to identify and validate each other's changes). This procedure can restart the validation process (Boszormenyi-Nagy & Spark, 1973) within the coparenting subsystem, providing an opportunity for each parent to recognize the merits and efforts that their partner is making toward helping their children and family. This can then be transferred to the marital domain, where expectations are higher and difficulties more deeply entrenched.

The therapist can reduce interparental conflict by preventing each parent from interfering with or sabotaging the other's childrearing. When interparental conflict is too severe, it is possible to define “parental territories,” at least for a defined period of time. Each parent then becomes responsible for one area (e.g., school, table manners), without criticism and disqualification from the other. In these cases, therapy can help develop a model for managing coparenting conflict by emphasizing how important it is for parents to protect their children from destructive interparental conflict. In less severe situations, coparenting conflict can be positively reframed by showing that children can benefit from educational differences.

Third principle

The spill-over and cross-over dynamics between the romantic and coparenting relationships are explored with each parent in the other's presence, to understand how each parent's perceived marital distress negatively impacts their own coparenting alliance (spill-over dynamic; e.g., McDaniel et al., 2018; Morrill et al., 2010), and how the perceived marital distress negatively impacts the other parent's coparenting alliance (cross-over dynamic; e.g., Pedro et al., 2012). This work can also be done by exploring the opposite path—the negative impact of coparenting conflict on marital satisfaction. It is also worth highlighting how the resources of one relationship can possibly benefit the other (Bonds & Gondoli, 2007; Pedro et al., 2012).

In the rarer case of couples presenting with coparenting difficulties only, therapists can explore resources these couples have developed to cope with marital tension and how these can be used to manage coparenting conflicts. In this case, couples are encouraged to “take care” of the impact their conflicts have on their children, just as they have succeeded in “taking care” of their marital relationship.

Limitations of integrative brief systemic intervention

An important aspect when working on coparenting is the quality of each parent's bond with their children. It may be difficult for parents to cooperate if one is abusive in parenting. When parental guidance is lacking, work on parenting must be done before or in addition to IBSI treatment, such as within the framework of child psychiatric follow-up. Moreover, inviting the couple to work on their coparenting relationship can be a hurtful experience; in becoming aware of their coparenting distress, they risk feeling overly guilty about their parenting. It is then critical that therapeutic work helps them become more responsible as coparents, rather than increasing their feelings of guilt. Another limitation concerns couples who come to therapy because they perceive the romantic sphere as invaded by parenting issues. Working on their coparenting relationship might initially lead them to feel this further decreases their romantic intimacy. In these situations, it is important for therapists to directly state the reasons for their approach, which ultimately aims to enable couples to set healthier boundaries (Minuchin, 1974) between the marital and coparenting domains.

CASE EXAMPLE: LINDA AND PHILIP

Linda and Philip participated in a randomized controlled trial evaluating IBSI efficacy. This case was selected at random from the IBSI group. The couple's personal data were modified or removed to guarantee their anonymity. Below, we provide information about the partners, their request for therapy, the therapists, and a detailed analysis of the sessions. This analysis,

conducted by a team of four IBSI clinicians and four researchers, was the result of observing six therapy sessions. It aimed to highlight the application of IBSI's core therapeutic principles.

Couple's information and request for therapy

At the time of treatment, Linda (32 years old) and Philip (35 years old), both white, had been married for 10 years and had two children, Eroan and Alessia, who were 8 and 3 years old, respectively. Linda stopped working after Eroan's birth, but had resumed working full-time as a childhood educator due to Philip's professional difficulties. Philip previously worked as a surgeon, but had left his employment two years prior due to psychological problems. He had seen a psychiatrist since the beginning of his difficulties, which consisted of burnout, anxiety, and a depressive state, and diagnosed as adjustment disorder with mixed anxiety and depressed mood. Both Linda and Philip expressed that their request for therapy was motivated by a need for support, as they struggled with the impact of Philip's psychological problems on their day-to-day family life.

Therapists' information

Two experienced female co-therapists took charge of the treatment. Both had graduate degrees in psychology and were certified systemic psychotherapists. Therapist 1 had worked for 16 years as a systemic couple and family psychotherapist and 11 years as an IBSI therapist. Therapist 2 had worked for five years as a systemic couple and family psychotherapist and four years as an IBSI therapist. Therapist 1 was also among the IBSI clinicians who analyzed the case.

Therapy analysis

Phase I. Creating a therapeutic space and setting objectives

Session 1

The first session was dedicated to understanding the couple's request and working on precise objectives that could realistically be met within six sessions. This session also allowed the impact of Philip's psychological disorder on their marital and coparenting relationships to be explored, and to encourage them at the beginning of therapy to become involved as a marital dyad and coparents (*first therapeutic principle*). Regarding their marital relationship, Linda explained that she was suffering due to the fluctuations in Philip's emotional state. During difficult times, she felt their relationship was broken; she did not know what she was allowed to say and felt that Philip was only present physically. When he was better, she felt that it required much effort to "recreate" a romantic relationship, and she did not have the energy to make that effort. Philip was frustrated by what has become a distant relationship between them. Exploring then the coparenting relationship led Philip to express that, when sick, he felt unable to contribute to family life—"I cannot do more"—while Linda discussed her frustration over returning to full-time work. Her goal was to be there for her children, as she felt a mother should be "available all the time." Finally, the therapists explored the impact of the couple's marital and coparenting difficulties on the children (*second therapeutic principle*). When asked, both Linda and Philip expressed that their children did not show any particular reaction to or question the situation.

Defining therapy goals

The therapists helped the couple clarify their expectations for therapy. Linda hoped therapy would give her a better understanding of how to cope with Philip's psychological problems, so she could feel less guilty of hurting him when she communicated with him. Philip expected less tension and fewer arguments in their marital relationship, as he tended to hold on to resentment and bitterness after conflicts with Linda. The therapists validated the partners' expectations by considering them as realistic for the six-session setting. Therefore, the therapy goals were to improve the quality of the couple's interactions and help them cope better with Philip's illness. Given the brief nature of this intervention, these goals had to be precisely formulated, specifying with the couple what was expected by "better-quality interactions" (e.g., "When will you consider the other's behavior toward you to have changed?").

Phase II. Promoting change on the marital and coparenting levels

The intervention phase (Sessions 2 to 5) allows for work in accordance with the second and third core therapeutic principles.

Session 2

The feedback ritual made it apparent Philip's illness made it difficult for both partners to come to this session; therefore, they were tense and reluctant to talk. Consequently, the therapists decided to explore the impact of Philip's psychological problems, externalizing them to alleviate the burden placed on Philip and Linda (White, 2007): "What can the two of you say about the impact the illness has had on your relationship and family life?" The partners explained that Philip's psychological problems caused both of them to feel guilty. Philip was reproachful toward himself for not being a "father-provider, responsible for the economic well-being of the family." Linda was remorseful for pressuring Philip too much to do a better job with the children, knowing that he felt miserable. The therapists observed that Linda and Philip spontaneously addressed the coparenting aspects of their relationship and decided to continue working in that direction.

To understand any coparenting dissatisfaction the couple experienced, the therapists asked Linda and Philip about their expectations for each other. Linda hoped that Philip would understand on his own that she needed help, while Philip wanted her to allow him more leeway to decide how to parent. For example, Linda felt they should put the children to bed together (to recreate what she experienced in her family, "a real family cocoon"), while Philip did not find this to be necessary (in his childhood, either his mother or father was present).

Later in the session, the therapists explored the couple's knowledge of their children. They sought to reinforce the parents' awareness of the repercussions their coparenting tension may have on their children, to work from their insights (*second therapeutic principle*). Regarding shared family activities, one therapist inquired if they had asked the children about their wishes as to whether they wanted them all to be together.

Therapist: *And the children, maybe you could ask them... do they want to do activities as a family?*

Linda: *... I don't know—are they able to answer that question?*

Philip: *... Anyway, they are not asking for us all to be together, they never asked for that... but when we are all at home, they are very happy, it reassures them I think... They also often ask questions about Linda's schedule; they are always keen to know when all the family will be together at home. In my family, it was the same. I liked it a lot when my parents were both at home; it was very reassuring for me. I don't know why it was reassuring, but I liked it a lot, even as a teenager.*

Through this question, Philip was able to share his observations (i.e., how happy and relieved the kids were when both parents were at home) to connect to elements of his past (*second therapeutic principle*). Thus, we can presume this helped him to connect with his children's need for the family to be together at home. Linda agreed and felt that Philip's observations resonated with her.

The excerpt above provides an example of the therapists' work on insightfulness (e.g., promoting the parents' awareness of their children's need to have them both at home). This aimed to support and increase the couple's coparenting alliance. In this case, it allowed the parents to experience emotions related to their children (and themselves as children), which then allowed them to provide nuance to their first impression of the children, which was "they are fine, they never express concern."

Session 3

The feedback ritual allowed Linda to remember that, in the last session, she and Philip were able to talk to each other and just share without looking for solutions. To explore the partners' marital and coparenting resources (*third therapeutic principle*), one therapist asked Linda if she had been able to share anything from her life or concerns with Philip since the last session. Linda explained that she was able to share her concerns regarding Eroan's school difficulties. As a mother, she felt powerless, and it was beneficial for her to be able to talk to Philip.

Therapist: *Was this a new experience for you?*

Linda: *Yes. I tend not to say these things in general. It's just going to go around and around in my head. What was new for me was realizing that it felt good to share.*

Philip: (*Judgmental*) *But it was more than that; you felt entirely responsible for Eroan's situation. You thought, "I'm a bad mother, what did I miss?" I think it's important that you tell me when you're in trouble. I can't guess otherwise.*

In this exchange, the therapist emphasized the innovative nature of this experience. Despite Philip's critical tone, the therapist underlined that Philip was leaving room for Linda to say that she has limits, while also letting her know that he was there for her. This episode reflected an evolution in the coparenting relationship, which was perceived as positive by the therapists and the couple.

Later in the session, Linda allowed herself to share a recent high-conflict coparenting incident: the "cookie jar episode." Linda came home after work and realized that Philip had neither fed nor bathed the children. She started screaming and then threw a cookie jar to the ground, shattering it. This episode summed up for Linda all the moments of tension they had regarding task division, and the fact that she could not ask Philip for sufficient help. Philip responded by expressing his frustration that she was too controlling of his behavior as a father and how he handled household chores.

The "cookie jar episode" was important, as it allowed Linda to finally express her anger. Thus, after being able at the start of the session to share her positive feeling of Philip supporting her, Linda allowed herself to express her anger toward Philip. This episode also highlighted the high intensity of Linda's anger and hence the therapists' need to address and work on this anger so that she could express it in a less destructive manner. Notably, these sequences all concern the coparenting domain as indicated by the examples the couple cited concerning their functioning within the family and with the children. Therefore, the therapists subsequently explored methods by which the couple could better anticipate and manage coparenting tensions and outbursts. This step was to evaluate the couple's motivations for change by helping them take responsibility for the impact of their actions on the children (future-oriented) without becoming paralyzed by excessive guilt (past-oriented).

Therapist: *How could you manage these kinds of episodes differently so that you don't involve the children in your tensions, on the one hand, and on the other hand, better understand what both of you need during these times to avoid exploding and feeling even worse?*

Linda: *Even when the children were babies... I never asked myself if I was tired because someone had to get up. What if one day I said, "Oh, no, I'm not getting up..."*

Philip: *Well, it's happened before. And then I got up and took care of the kids... and it went really well.*

Linda: *Yeah, sometimes it frustrates me to be so hard on myself... (crying).*

The therapist empathized with Linda while gently expressing to her that she probably underestimated the suffering she was experiencing. Philip joined therapist: "Let me know when you are tired, and we'll work it out."

The therapists ended the session by emphasizing the benefit of clarifying these dynamics between the partners: the positive one when they are able to support each other and the more difficult one when they are caught in negative coparenting dynamics (i.e., the more Linda feels compelled to take care of everything in the family, the more Philip puts himself aside). During this session, the therapists felt that strong emotions were at work in each partner.

Session 4

Linda realized during the previous session that she needed to express her feelings more. For his part, Philip reported realizing that if Linda did not express herself, the tension between them would increase. Both considered the need to work together on their family life without tension. The therapists noticed a shift in the dominant narrative of Philip's psychological disorder in their everyday reality (White, 2007). While Philip's disorder was part of this reality, it no longer prevented them from considering their family life together: Linda allowed herself to ask Philip for support and express her anger. For his part, Philip was asserting his opinions and expectations and, from the therapists' perspective, no longer hiding behind psychological problems that prevented him from functioning as a parent.

At this point, the couple could be considered to have had positive experiences as a coparenting team, an area they spontaneously considered to be affected daily by Philip's illness. Following the IBSI approach, the therapists considered that the functioning of the coparenting team could potentially have a positive impact on other relationship domains (i.e., their romantic/marital relationship, *third therapeutic principle*). This view was reinforced for the therapists when Linda brought up an episode in which she had an altercation with a colleague and sent a text message to Philip, who responded with kindness and humor: "Come on, don't worry. When you get home, we'll have a little drink and watch a reality show." That made her laugh, and she was relaxed for the rest of the day. This reflected a crucial step, as the therapists understood that positive change was also occurring in the marital relationship (e.g., Linda asked Philip for help with a difficulty outside of parenting).

The therapists then further explored the impact of the "Psychological Disorder" on Linda and Philip's marital relationship (White, 2007). The partners were less at ease discussing this, as if they were dissociated from their desires and needs. In contrast to their relationship dynamics as coparents (Linda felt responsible for everything and Philip stayed away), Philip appeared to be the one who felt most comfortable addressing this topic. He reported that they had not had a satisfying sex life since they became parents. Linda agreed and explained that she would like to regain her sexual desire. They came to therapy mostly for reasons related to ongoing family functioning, but ultimately felt the need to take better care of themselves as individuals (working less for Linda, putting less pressure on himself for Philip) and as a couple (i.e., regaining the pleasure of spending time together). The session ended with the therapists highlighting the progress made in the couple's courage to talk to each other about their more intimate desires and needs outside of their parental roles.

Session 5

The partners shared with the therapists that after the last session, they talked about the positive moments of their married life and went out to eat together. Notably, the spouses spontaneously looked at each other more than in previous sessions. Philip seemed to be in a lighter mood. They stated that they appreciated discussing their respective opinions during the sessions, but they also realized this was a long-term process, as each of them had a different temperament. They were concerned about quickly returning to their usual dynamics in everyday life.

Their discourse had changed, and they used more “we-statements” (Fergus, 2015; Gottman et al., 2015) such as “we have to change” and “we know we have to learn to think in twos,” while also being able to share their own personal perspectives. The therapists decided to work further on romantic relationship dynamics and assess what the partners still wanted to change and the pitfalls they faced, asking: “How do you take care of your relationship, your ‘couple unit’?”

Philip explained that during the last few years, their relationship had been like a “string” that tightened and could have broken. Linda expressed that they had not really been a “couple unit” until recently: “There was me all alone and there was you all alone.” Philip was very affected by what Linda had shared. During this exchange, Linda and Philip were more non-verbally engaged and livelier than in other sessions.

The therapists noted that this sequence allowed the partners to share what made them suffer in the past, and stressed the importance of being able to anticipate together the risk of future relapses. This relapse anticipation work is typical in an advanced stage of the IBSI process. The therapists also noted the importance of staying close as romantic partners (e.g., both expressing their needs, even in a crisis, without necessarily looking for solutions) and as coparents (e.g., keeping a positive connection with Philip, sending Philip a photo of a moment that Linda and the children spent together) while considering the limitations due to Philip's psychological disorder.

Phase III. Reflecting on the intervention and possible follow-up

During the last phase (Session 6), the therapists evaluated the couple's progress, highlighting the skills each partner acquired.

Session 6

The therapists first worked on putting safeguards in place to best anticipate future tension. Then, they assessed the five previous sessions and whether the partners had achieved their objectives. Linda expressed that the sessions allowed her to realize that not everything is related to Philip's psychological problems, she wants to work on herself to change her own attitudes and representations, and she can be reassured to feel “united” with Philip in different areas of their lives, even with their difficulties. Philip explained that therapy brought up the notion of the romantic couple as an important new dimension, and not everything revolved around the children and his psychological problems. He expressed wishing to be closer to Linda.

At this stage, the therapists also considered Linda and Philip to be functioning as a team in different areas of life, and the initial objectives were being met. There was no follow-up plan after the six-session intervention; however, the couple knew they could contact the therapists again if necessary. If this were to occur, the therapists would create a new contract, such as continuing with a six-session intervention using the same model or only a few one-off sessions, depending on the couple's request.

CONCLUSION

The IBSI model was developed by a team of clinicians, who are experts in designing and practicing brief systemic couple and family therapy, and researchers, who are specialists in couple and family psychology and psychotherapy. Collaborative work between the clinicians and researchers occurred at each IBSI development stage: conceptualization, manualization, and implementation. Couple psychotherapy is both art and science (Soldz & McCullough, 2000); therefore, it requires a joint effort to understand how couples can change in therapy and improve different facets of their lives. Implementing a model such as IBSI has been a relatively smooth process, as this provides therapists with the freedom to use familiar systemic approaches in the populations with which they work. However, therapists also need to adopt a brief therapy framework and intervene more systematically than they normally would on integrating the marital and coparenting relationships. In addition, targeting the coparenting dimension is less common in marital therapy than in, for example, child and adolescent therapy. Therefore, couple therapists generally need to become more familiar with the theoretical and empirical aspects of coparenting to address marital and coparental relationships together in marital therapy. During IBSI training, they can learn to use these techniques in a balanced way.

This case provides an example of the IBSI therapeutic process. Here, the therapists' strategy was to reinforce the alliance between the partners as a coparenting and marital team by dealing with the husband's psychological disorder. Using narrative techniques, the objective was to help the couple externalize the husband's psychological problems to avoid saturating the problem with frustration or guilt (White, 2007). By first engaging the couple as coparents, the therapists speculated that the partners could be more empowered and motivated to function as a team if it was for the shared goal of improving their children's well-being. This work was first followed by strengthening the coparenting alliance, and then by sharing coparenting tensions as a dyad and not only as parents with opposing childrearing styles. This evolution in their coparenting relationship subsequently allowed deeper work on their marital difficulties.

Future results will document the efficacy of the model. Indeed, a randomized trial is currently underway to compare IBSI with systemic couple therapy, particularly regarding its effect on marital satisfaction and coparenting quality. In this trial a total of 101 couples living together and parenting a child under the age of 16 were recruited. The couples completed several self-report questionnaires on individual and relationship variables, and participated in videotaped discussions, before and after treatment and at follow-ups (Liekmeyer et al., 2021). Preliminary data were obtained through a process study of six IBSI therapy cases (Eira Nunes, Pascual-Leone, et al., 2021) using the task analysis method (Task Analysis Method, Pascual-Leone et al., 2014). This process study led to a model of moving from coparenting dissatisfaction to coparenting satisfaction through several stages of change (Eira Nunes, Pascual-Leone, et al., 2021).

IBSI was developed to offer parents who engage in couple therapy a more nuanced and targeted outcome than that available in traditional therapy. The field of couple therapy is indeed characterized by a "conjugal vision" of both therapeutic work and its empirical evaluation, omitting conceptualization and evaluation of work on the coparenting relationship with "parent couples" or "romantic coparents." The development of specific models for parents in couple therapy is important in contemporary society, which is characterized by the dominant discourse of both being a successful parent and coparent (e.g., Meeussen & Van Laar, 2018) and having a fulfilling marriage. As such norms can put pressure on parents, these issues may be worth addressing in couple therapy. Furthermore, the high rate of separation and divorce indicates that it is important to work on coparenting relationships in not only separated couples but also intact marriages.

The conceptualization of integrative therapeutic work on both marital and coparenting relationships may be relevant in not only IBSI but also other settings, such as child and adolescent mental healthcare where, conversely, marital aspects may be given little consideration when

working with parents. Finally, this type of model may also be suitable for same-sex parent couples, step-parents (i.e. coparenting relationship between the biological parent and step-parent), or couples who choose to separate during couple therapy (Darwiche et al., 2021) to work on the distinct development of romantic and coparenting relationships and prevent possible negative effects on children. In addition, further clinical and research work on IBSI involving couples from different cultural backgrounds will be needed to assess its suitability in diverse cultures. In some cultures, the concept of coparenting may be defined differently, especially when extended family members assume a significant role in coparenting a couple's children (e.g., Kurrien & Vo, 2004). More knowledge and experience with IBSI will make it possible to determine which techniques are particularly relevant and for whom, allowing the manual to be refined and inspiring new research questions regarding parents in couple therapy.

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