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مقدمه

به جرأت می‌توان گفت ریشه‌های زوج‌درمانی در ابتدای این سده آن‌قدر تنومند شده که با هیچ بادی از جا در نمی‌آید. مبانی تجربی این حوزه که در دو دهۀ اخیر جمع‌آوری شده است به زوج‌درمانی در تقویت و تحکیم روش‌هایش، عبرت‌گیری از اشتباهاتش، و تعدیل بعضی ادعاها و قُمپزهایش کمک کرده است. رویکردهای بالینی متعددی در مسیر یکپارچه‌سازی قدم برداشته‌اند و با ادغام مؤلفه‌های ریشه‌دار و قوی خود نظام‌های بالینی نو، چندبعدی[1]، و کثرت‌گرا[2] آفریده‌اند.

بیش‌تر افرادی که در درمان حاضر شده‌اند به‌دنبال ریشه‌کنی مشکلات زناشویی‌شان بوده‌اند، تا سایر مسائل (وروف و همکاران، ۱۹۸۱). طبق تخمین‌ها ۵۰٪ افراد به دلیل مشکلات زناشویی پا به درمان می‌گذارند و ۲۵٪ نیز علاوه بر سایر مشکلاتی که دارند از مشکلات زناشویی نیز رنج می‌برند. هرچند پیمان‌شکنی زناشویی را از دلائل طلاق معرفی کرده‌اند، پر واضح است که عامل اصلی آشفتگی رابطۀ زناشویی احساس یأس ناشی از فاصله‌گرفتن از هم است که تعارض و خیانت از پس آن ظاهر می‌شود (گیگی و کلی، ۱۹۹۲). با افزایش مسائل و بحران‌های زناشویی حوزۀ زوج‌درمانی آن‌قدر گسترش یافته است که همۀ این مسائل را در خود جا می‌دهد.

سه دهۀ قبل، وظیفۀ زوج‌درمانگران حفظ و نجات خانواده در برابر مشکلات بود، اما امروزه زوج‌درمانی به ابزار مؤثر و مشکل‌گشایی تبدیل شده که زوج‌ها چه بخواهند با هم بمانند و چه بخواهند متارکه کنند با کمک زوج‌درمانی می‌توانند به رشد و بلوغ شخصی بالاتری دست یابند. گسترش اخیر زوج‌درمانی به کاربرد پیشگیرانۀ آن در *برنامه‌های غنی‌سازی رابطۀ زناشویی*[3] برمی‌گردد که هدفش بهبود رضایت زناشویی و رشد شخصیت زوج است.

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1. multifaceted
2. pluralistic
3. marital enrichment programs

اگر افزایش تکان‌دهندهٔ آمار طلاق را نشانهٔ شکنندگی رابطهٔ زناشویی و فراوانی ازدواج‌های نامطلوب تلقی کنیم، باید اعتراف کرد که حوزهٔ زوج‌درمانی هم‌چنان گسترده‌تر خواهد شد. با وجود افزایش *مشکلات هیجانی مرتبط با ازدواج*[1]، شگفتا که برنامه‌های آموزشی انگشت‌شماری در حوزه‌های روان‌پزشکی، روان‌شناسی، و مددکاری اجتماعی وجود دارد که به ارائهٔ آموزش و کارآموزی بالینی زوج‌درمانی بپردازد. دلائل این بی‌اعتنایی به آموزش زوج‌درمانی روشن نیست، اما فقدان مبانی نظری یکپارچه، تسلط روان‌شناسی فردی بر روان‌پزشکی غربی، نبود نظام تشخیصی مقبول، تردید دربارهٔ بازپرداخت بیمهٔ درمانی برای زوج‌درمانی، جایگاه پائین‌تر مشاورهٔ زناشویی، و زمینه‌ها و اصول حرفه‌ای متفاوت زوج‌درمانگران می‌تواند از عوامل زمینه‌ساز این بی‌توجهی باشد. اثربخشی زوج‌درمانی بر انواع اختلالات جایگاه آن را در مداخله‌های روان‌پزشکی ارتقاء داده و آن را به مداخله‌ای مهم تبدیل کرده است.

تاریخچه

مشاورهٔ زناشویی[2] و *زوج‌درمانی*[3] زائیدهٔ قرن بیستم‌اند. تلاش برای تقویت رابطهٔ زناشویی و حل تعارض‌های زناشویی[4] عمری به درازای ازدواج دارد. کمک به زوج‌های جوان برای حل تعارض‌های زناشویی به‌طور سنتی منوط به حضور ریش‌سفیدها و اعضای خانوادهٔ گسترده بود که دیدگاه‌شان دربارهٔ استرس‌های رابطهٔ زناشویی ریشه در تجربه‌های شخصی‌شان داشت. با کاهش نفوذ خانوادهٔ اصلی در قرن بیستم، روحانیون و پزشکان برای کمک به زوج‌ها آستین‌ها را بالا زدند. زوج‌ها برای حل مشکلات زناشویی به هر دوی این گروه‌ها مراجعه می‌کردند زیرا در برهه‌های پراسترس و مهم چرخهٔ زندگی خانواده با آنان ارتباط داشتند و از مزایای رابطهٔ درمانی پیش از بروز مشکلات بهره می‌بردند.

مشاورهٔ زناشویی حرفه‌ای در دههٔ ۱۹۲۰ و ۱۹۳۰ میلادی پدیدار شد. *مرکز مشاورهٔ ازدواج نیویورک* در سال ۱۹۲۹، *شورای ازدواج فیلادلفیا* در سال ۱۹۳۲، و *مؤسسهٔ روابط خانوادهٔ آمریکا* در سال ۱۹۳۹ تأسیس شدند که همگی در پی ارائهٔ خدمات مشاوره‌ای متمرکز بر مشکلات زناشویی بودند. نظریه‌پردازان متعددی نیز در خَلق مبانی نظری زوج‌درمانی دست داشتند. ک. پ. اُبرندورف (۱۹۳۸) در مقالهٔ کلاسیکی با عنوان *«جنون دو نفری»*[5] هذیان پارانویای مشابهی را در زوجی گزارش داد و معتقد بود روان‌پریشی در یک فرد متأهل پیوند تنگاتنگی با رابطهٔ زناشویی دارد. او به

1. marriage-related emotional problems
2. marital counseling
3. couple therapy
4. marital conflicts
5. folie à deux

واکنش‌های روان‌پریشی مکمل در همسر فرد اشاره کرد که جنبهٔ مهمی از روان‌پریشی فرد متأهل را تشکیل می‌دهد. ب. میتلمن (۱۹۴۸) نیز همزمان از روشی برای درمان زوج‌ها استفاده کرد و طبقه‌بندی روان‌تحلیلی از مشکلات زناشویی ارائه داد که بر پایهٔ *مدل ارضای نیازهای مکمل زناشویی*[1] استوار بود. مبانی تجربی زوج‌درمانی وقتی ابداع شد که در میانهٔ دههٔ ۱۹۶۰ از فنون رفتاری برای درمان اختلالات زناشویی استفاده شد. در ابتدا حساسیت‌زدایی و آموزش جرأت‌ورزی را به کار بستند که محصول مدیریت وابستگی شرطی‌سازی کنش‌گر بود. سپس، رفتارگرایان به‌طور گسترده از مفاهیم شناختی و درمانی استفاده کردند. دههٔ ۱۹۹۰ سال‌های ادغام و یکپارچه‌سازی مدل‌های نظری گوناگون بود که در آن زمان متخصصان از *مداخله‌های التقاطی*[2] استفاده و آنها را از نظر تجربی ارزیابی می‌کردند.

پیشرفت‌های حوزهٔ بزرگ‌تر خانواده‌درمانی در دههٔ ۱۹۵۰ آشکار شد. پای مفاهیم *تعادل‌جویی*[3]، *ارتباط*[4]، و *تعارض‌های خانواده*[5] نیز در رابطهٔ زناشویی باز شد. در همین دهه پویائی خرده‌گروه‌ها نیز در موقعیت‌های زناشویی کشف شد.

تعریف

زوج‌درمانی (درمان رابطهٔ زناشویی) به طیف وسیعی از مدل‌های درمانی اشاره دارد که خواستار تغییر و اصلاح رابطهٔ زناشویی با هدف افزایش رضایت زناشویی یا بهبود ناکارآمدی‌های زناشویی[6] هستند. ناکارآمدی زناشویی گاهی به‌شکل ازدواج پرتعارض و ناکارآمد آشکار می‌شود و گاهی همانند آتش زیر خاکستر پنهان است و به بروز نشانه یا ناکارآمدی در یک یا هر دو همسر یا فرزندان‌شان می‌انجامد. در زوج‌درمانی، رابطه را *بیمار* می‌دانند، نه زن یا شوهر را. این تمرکز به این معناست که زن و شوهر سالم هم می‌توانند رابطهٔ زناشویی نشانه‌دار یا ناکارآمدی بسازند. با این حال، ارتباط تنگاتنگ اختلالات «روان‌رنجوری» و هیجانی بنیادین هر یک از همسران، از عوامل زمینه‌ساز شکل‌گیری ازدواج‌های ناکارآمد است.

زوج‌درمانی

در کل تمایل به محو مرزهای نظری و فنی زوج‌درمانی با مشاورهٔ زناشویی است، اما ماهیت کاربست زوج‌درمانی متمایز از مشاورهٔ زناشویی است. زوج‌درمانگران از روش‌های سنجشی گسترده و متنوعی

1. complementary needs satisfaction model of marriage
2. eclectic interventions
3. homeostasis
4. communication
5. family conflicts
6. marital dysfunction

استفاده می‌کنند و دانش سیستمی دربارهٔ شخصیت، رفتار، و شناخت یا *نظریهٔ ارتباطی ــ سیستم‌ها*[1] را برای بهبود فرآیندهای درمانی به کار می‌بندند. دانش این حوزه به آنان کمک می‌کند همهٔ رفتارهای آسیب‌زا و سازگارانهٔ زوج را بسنجند و با استفاده از مدل‌های درمانی زناشویی یا فردی به آنان کمک کنند. هدف زوج‌درمانی بهبود رابطهٔ زناشویی و درمان اختلالات هیجانی زن یا شوهر است. گرچه هدف غایی در درمان زناشویی هم‌چنان ناشناخته است، پی‌آمد نهایی باید پیشرفت زوج در ایجاد رابطه‌ای رشدیافته‌تر باشد.

مشاورهٔ زناشویی

مشاورهٔ زناشویی طیف وسیعی از مداخله‌های فنی را در بر می‌گیرد که در پی کاهش تعارض‌ها و اختلاف‌های زناشویی[2]اند. وجوه مشترک و هم‌پوشانی‌های آشکاری بین زوج‌درمانی و مشاورهٔ زناشویی وجود دارد. این مداخله‌ها حتی توصیه‌های مسئله‌گشا را هم شامل می‌شوند. به‌طور کلی تمرکز و هدف درمانْ حل مشکلات فوری، ارائهٔ حمایت‌های هیجانی، و ارتقای عزت‌نفس و خوش‌بینی زوج است. هدف درمان بازساخت‌دهی ساختارهای ارتباطی و شخصیتی زن یا شوهر نیست.

موارد کاربرد و منع‌کاربرد زوج‌درمانی

زوج‌درمانی در موقعیت‌های متنوعی که ناکارآمدی ارتباطی یا ناتوانی در فرد متأهلی وجود داشته باشد کاربرد دارد. مشخص‌ترین حوزهٔ کاربرد زوج‌درمانی زمانی است که تعارض‌های زناشویی آشکاری وجود دارد که به ناراحتی مشخص و شدید زوج منجر شود. بارها دیده‌ایم که این زوج‌ها در جست‌وجوی زوج‌درمانی برمی‌آیند زیرا از طلاق واهمه دارند و یا می‌دانند از پس مدیریت مؤثر مشکلات‌شان بر نمی‌آیند. با این حال، در بسیاری موقعیت‌ها، مشکل زناشویی پنهان است و خود را به صورت نشانه یا ناکارآمدی در یکی از همسران یا فرزندان نشان می‌دهد.

ارتباط ضعیف و *روابط فرازناشویی*[3] بیش‌ترین علت مراجعه به زوج‌درمانی است. وقتی درمان فردی به بن‌بست می‌خورد، یا به‌خاطر نبود ظرفیت مناسب در بیمار مثل انگیزهٔ پائین یا توانایی محدود برای گفت‌وگو دربارهٔ قرارداد درمانی احتمال موفقیت آن کم می‌شود، باید زوج‌درمانی را مد نظر قرار داد. هم‌چنین، کاربرد دیگر درمان زناشویی وقتی است که ظهور نشانگان در اعضای خانواده با بروز

1. communicational-systems theory
2. marital disharmony
3. extramarital relationships

تعارض‌های زناشویی هم‌زمان شود، یا زوج واقعیت را به‌طرز فاحشی تحریف کنند و بوی *بی‌ثباتی زناشویی*[1] در درمان فردی به مشام بخورد.

از دهۀ ۱۹۹۰ میلادی، پای زوج‌درمانی به درمان اختلالات روان‌پزشکی، از جمله افسردگی، سوءمصرف الکل، و اسکیزوفرنیا باز شده است، و به اهمیت ابعاد ارتباطی اختلالات روانی و ظرفیت زوج‌درمانی برای ارتقای کارآمدی درمان توجه شده است.

موارد منع‌کاربرد زوج‌درمانی انگشت‌شمار است. افشای نابه‌هنگام رازهای زناشویی، مثل اقدامات غیرقانونی زوج، هم‌جنس‌گرایی، یا پیمان‌شکنی زناشویی می‌تواند به توقف ناگهانی درمان یا پایان‌دادن به ازدواج بیانجامد. بنابراین، افشای رازها در زوج‌درمانی را وقتی باید تشویق کرد که زوج به درمان متعهد باشند. وقتی زوجی درگیر درمان‌اند، باید این رازها را در بافت درمان و به‌منظور بهبود رابطه و صمیمیت زناشویی مدیریت کرد.

اگر زوج جلسۀ درمان را به میدان جنگ تبدیل کنند و از درمانگر بخواهند در اقدامات ویرانگرشان به آنان کمک کند، آنگاه زوج‌درمانی مشترک بی‌فایده می‌شود. فقدان تعهد به ادامۀ رابطۀ زناشویی یکی دیگر از موارد منع‌کاربرد زوج‌درمانی مشترک است. با وجود این، جلسه‌های مشترک در از بین بردن دلیل‌تراشی‌های زوج‌های دمدمی که مدعی‌اند به دلائل مالی یا «به‌خاطر بچه‌ها» با هم مانده‌اند مفید است.

انواع زوج‌درمانی

درمان فردی[2]، *زوج‌درمانی مشترک*[3]، و *زوج‌درمانی ترکیبی*[4] انواع رایج و متداول زوج‌درمانی‌اند. بعضی متخصصان از *گروه‌درمانی با زوج‌ها*[5] نیز استفاده کرده‌اند. در مقایسه با اوایلِ ظهور زوج‌درمانی که *زوج‌درمانی هم‌زمان*[6] مدل غالب بود، امروزه زوج‌درمانی مشترک مقبول‌ترین روش زوج‌درمانی است. پژوهش‌های مقایسه‌ای اندکی دربارۀ اثربخشی گونه‌های زوج‌درمانی وجود دارد و تازه آن‌چه هست یافته‌های ضدونقیضی ارائه می‌کند.

درمان فردی

تمرکز در درمان فردیِ اختلالات زناشویی بر رابطۀ زناشویی و تعارض با همسر است. درمانگر در بحران زناشویی می‌خواهد یکی از همسران را ببیند تا چشم‌انداز جامع‌تری دربارۀ بحران زناشویی به

1. marital instability
2. individual therapy
3. conjoint couples therapy
4. combined couples therapy
5. group therapy with couples
6. concurrent couples therapy

دست آورد. وقتی درمان فردی برای مشکلات زناشویی توصیه می‌شود که یکی از همسران نسبت به درمان مقاوم باشد یا به طلاق بیاندیشد، یا درمانجویی که در پی درمان است علاوه‌بر نارضایتی زناشویی از مشکلاتی نظیر فوبیا نیز رنج بکشد. چنین درمانی برای مشکلات زناشوییِ همسران سالمی که شخصیت یکپارچهٔ خود را با کم‌ترین رفتار و گرایشِ خودویرانگر و مازوخیستی نشان می‌دهند سودمندتر و مؤثرتر است. با این حال، صرف‌نظر از آشفتگی‌های زناشویی و آسیب‌های روانی شدیدی مثل روان‌نژندی و سوءاستفاده، درمان فردی گزینهٔ مناسبی نیست.

زوج‌درمانی همزمان

در زوج‌درمانی همزمان، یک درمانگر هر دو همسر را جداگانه و فردی ملاقات می‌کند. در این قسم درمان اتحاد درمانی قوی با هر همسر به راحتی ایجاد می‌شود و تداوم می‌یابد. این گونهٔ زوج‌درمانی دفاع‌ها و ترس‌های بین‌فردی را کاهش می‌دهد و خودآشکارسازی[1] و درون‌نگری[2] را در محیطی همدل و درمانی افزایش می‌دهد.

زوج‌درمانی مشترک

درمانگر یا تیم درمان در زوج‌درمانی مشترک هر دو همسر را در یک جلسه می‌بینند. این گونهٔ زوج‌درمانی پرکاربردترین روش زوج‌درمانی در دو دههٔ گذشته بوده و بیش از ۸۰٪ درمانگران از آن استفاده کرده‌اند. مزیت زوج‌درمانی مشترک آن است که تمرکز درمان مستقیماً بر تعامل‌های زوج در جایی است که ظاهر می‌شوند. درمانگر با این تمرکز اَشکال ارتباطی و مکانیزم‌های بازخوردی را می‌شناسد که از ناکارآمدی زناشویی حمایت می‌کند. درمانگر می‌تواند الگوهای تعاملی زناشویی، مغایرت پیام‌های پیدا و پنهان، و تقویت رفتارهای قهری خانواده را ببیند. جلسه‌های خانوادگی مشترک در پی تسهیل ظرفیت بازتوانی زوج برای تغییرات زناشویی سازنده است؛ با این حال، نیروهای نهفته نیز زوج را به سمت متارکهٔ نابه‌هنگام هُل می‌دهند.

محدودیت‌های کاربرد زوج‌درمانی مشترک در موارد طلاق است که دل‌مشغولی‌های هر همسر متفاوت است، یا ریشه در اهداف درمانی متفاوت زوج دارد. گاه زن و شوهر می‌توانند با سوءاستفاده از درمان مشترک از آن برای سرزنش همدیگر و جنگ قدرت استفاده کنند، که در این مواقع برگزاری درمان همزمانِ موقت یا دائمی توصیه می‌شود. درمانگر برای زوج‌هایی که عمیقاً از هم فاصله گرفته‌اند و بی‌اعتمادی و خصومت عمیقی بین‌شان هست تلاش می‌کند اتحاد درمانی با هر دو همسر را شکل دهد که گاه از پس آن برنمی‌آید و نمی‌تواند بی‌طرف بماند.

1. self-revelation
2. introspection

زوج‌درمانی ترکیبی

زوج‌درمانی ترکیبی آمیخته‌ای از زوج‌درمانی‌های مشترک و همزمان است که ترکیب‌های دیگری مثل *گروه‌درمانی زوجی*[1] را هم شامل می‌شود. جلسه‌های زوجی مشترک طبق برنامه و در مواقع بحرانی یا در شرایطی که درمان هم‌زمان زوج شدنی نیست برگزار می‌شود. درمان ترکیبی هم مزیت‌های درمان فردی را دارد و هم دسترسی به الگوهای بین‌نسلی و ارتباطی جلسه‌های مشترک را فراهم می‌کند.

گروه‌درمانی زوجی

زوج‌ها می‌توانند در کنار سایر زوج‌ها در گروه‌درمانی زوجی شرکت کنند. زوج‌ها از هم می‌آموزند، از حمایت‌های زناشویی برخوردار می‌شوند، و مانند الگوهایی برای اصلاح نقش‌های زناشویی عمل می‌کنند. بعضی گروه‌های زوجی علاوه بر فرآیندهای گروه‌درمانی، آموزش مسائل زناشویی را نیز در برنامهٔ خود می‌گنجانند (کوخ، ۱۹۹۵). گروه‌درمانی زوجی را وقتی ایگوی زوج قدرت کافی ندارد (در اختلال شخصیت مرزی) و گروه تهدیدی برای آن تلقی می‌شود به کار نمی‌بندیم.

زوج‌درمانیِ ترکیبی کاربردی‌ترین گونهٔ زوج‌درمانی در دهه‌های ۱۹۵۰ و ۱۹۶۰ میلادی بوده است. امروزه، غالب زوج‌درمانگران به درمان ترکیبی علاقه‌مندند که اطلاعات عینی دربارهٔ الگوهای تعاملی زوج به دست می‌دهد.

نظریه‌های زوج‌درمانی

نظریه‌های روان‌پویشی

نظریه‌های روان‌تحلیلی بر مفاهیم مکملیت نیازها، خود، شئ، همانندسازی‌های اولیه، درون‌فکنی، و همانندسازی فرافکن تأکید دارند. در همانندسازی فرافکن، فردی که احساس معیوبی دربارهٔ خود به‌مثابهٔ قربانی دارد و درون‌فکنی‌های بیماری‌زایی داشته است، خود را از محتوای درون‌فکنی‌شده جدا کرده و آنها را به دیگران فرافکنی می‌کند. این محتوای درون‌فکنی‌شدهٔ جداشده وضعیت دو قطبی را می‌آفریند که در آن همسر را ظالم و خود را قربانی معرفی می‌کند (برای مطالعهٔ بیش‌تر فصل‌های ۴، خانواده‌درمانی روان‌پویشی؛ و ۲۱، زوج‌درمانی روان‌پویشی، را بخوانید). افراد در ازدواج بر اساس یکی از قطب‌های پرتعارض‌شان عمل می‌کنند و قطب دیگر خود را به همسرشان نسبت می‌دهند (همانندسازی فرافکن). قطب درون‌فکن‌شده انکار، تجزیه، و به همسری فرافکن می‌شود که مطابق آرزوهای فرد عمل می‌کند. برای وقوع و تداوم همانندسازی فرافکن، شئ باید رفتاری را آشکار کند که

1. couples group therapy

توسط دیگران بر او فرافکنی‌شده است. انتخاب جفت منوط به انتخاب کسی است که بتواند نیازهای روان‌رنجوری ناهشیار فرد را ارضا کند. بنابراین، *تعارض‌های درون‌روانی درونی‌شدهٔ*[1] زوج‌ها به تعارض‌های زناشویی ختم می‌شود. متخصصان معتقدند واکنش‌های انتقالی زوج رابطهٔ زناشویی آنان را می‌سازد. بالتبع، درمان رابطهٔ زناشویی علاوه بر توجه به تفاوت‌های واقعی زوج، باید به درمان و اصلاح درون‌فکنی‌ها و فرافکنی‌ها نیز توجه کند. فرافکنی در روابط صمیمانه تفاوت رابطهٔ زناشویی را با سایر روابط تبیین می‌کند.

افراد همسری را مطلوب می‌دانند یا برمی‌گزینند که بازتابی از نیازهای شخصیتی ارضانشدهٔ آنان باشد. زوج‌های معمولی مایل‌اند نیازها و رگه‌های شخصیتی مشابهی را به اشتراک بگذارند که کار زوج را به تعارض نکشاند. مکملیت نیازهای زوج‌های روان‌پریش بسیار بالاست، و ناپختگی نیازهای آنان بیش‌تر از زوج‌های معمولی است. از این رو، گاه نیازها آن‌قدر شدیدند که زوج برای هم *پاداش‌دهنده* می‌شوند و در حوزه‌هایی که هر یک ضعف و تعارض شدید دارد عملکرد افراطی پیدا می‌کنند (بیش‌فعال می‌شوند). روش دیگر برای تمایز زوج‌های کارآمد از ناکارآمد، شئ انتخابی آنان است. زوج‌های کارآمد شئ وابسته را بر می‌گزینند. زوج‌های روان‌رنجور شئ‌ای را می‌خواهند که عزت‌نفس‌شان را افزایش دهد (خودشیفته). آرمانی‌سازی در سطح بالایی قرار دارد و شئ جانشین بعضی اهداف دست‌نیافتنی می‌شود.

زوج‌های روان‌رنجور پویایی‌های روانی مشابهی دارند و نواقص رشدی مشترک آنان را مجذوب و شیفتهٔ هم می‌کند. زوج‌ها الگوهای سازمان‌دهی دفاعی متضادی را برمی‌گزینند. بنابراین، گرچه تعارض‌های پویای مشابهی دارند، شخصیت‌های متفاوتی از خود نشان می‌دهند. زوج‌های عجیبی که در فیلم‌ها می‌بینید نمونه‌ای از همین پدیده است. رگه‌های شخصیتی متفاوت که زوج را شیفته و دلباخته می‌کند بعدها کانون تعارض‌های زوج می‌شود.

تعارض زناشویی در نبود آسیب روانی مهم در یک یا هر دو همسر نیز ممکن است اتفاق بیفتد. این پدیده را *روان‌رنجوری زناشویی*[2] نامیده‌اند، که در آن روان‌رنجوری یک یا هر دو همسر برخاسته از رابطهٔ زناشویی است. روان‌رنجوری زناشویی را باید از ازدواج‌های روان‌رنجور جدا کرد. زن و شوهر در ازدواج زوج‌های روان‌رنجور رگه‌های شخصیتی روان‌رنجور دارند که تعامل‌های روان‌رنجور زناشویی را افزایش می‌دهد.

هدف غایی در زوج‌درمانی روان‌تحلیلی ساخت‌دهی مجدد و بازسازی ادراک و انتظارات درونی زوج از همدیگر و واکنش به هم است که پس از تجربه‌های اولیه شکل می‌گیرد و مانع ارتباط کنونی آنان می‌شود. زوج باید احساسی را در خود بیافرینند که متمایز و از درون یکپارچه باشد، و همسرشان

1. internalized intrapsychic conflict
2. marital neurosis

را نیز امن و واقعی تجربه کنند. درمانگران روان‌پویشی در انتخاب مداخله‌های درمانی عمل‌گرا و التقاط‌نگرند. گرچه گه‌گاه این مداخله‌ها فعال و رهنمودی‌اند، رویکرد درمانگر هم‌چنان پذیرش است تا جنبه‌های پذیرفته‌نشده در ادراک درونی زوج در شخصیت آنان ظاهر و یکپارچه شود. با توجه به کوتاه‌مدت بودن زوج‌درمانی، تفسیرهای درمانگر نباید واپس‌رو، بلکه باید یکپارچه باشد. زوج‌های عادی و روان‌رنجور ترجیح می‌دهند روابط‌شان را در قالب رابطهٔ دوتائی تجربه کنند، و روابط دوتائی در جلسه‌های مشترک زوج‌درمانی مقدمهٔ آشفتگی ادراک زوج از درمانگر نمی‌شود. بنابراین، درمانگر تفسیر مؤثری از *انتقال زناشویی*[1] بین زوج و انتقال درمانی در جلسه ارائه می‌دهد (سون، ۱۹۸۶).

ایراد مهم زوج‌درمانی روان‌تحلیلی توجه ناکافی به مسائل رایج در تعامل‌های زناشویی است که ماشه‌چکان فرافکنی‌اند و تحریف‌های برخاسته از انتقال زناشویی را تداوم می‌بخشند.

نظریهٔ قرارداد زناشویی

ساگر *نظریهٔ قرارداد زناشویی*[2] را (۱۹۷۶) تدوین کرد که یکی از رویکردهای نظری انگشت‌شمار منحصر به زوج‌درمانی است. منظور از قرارداد مجموعه‌ای از فرض‌ها و انتظارات خود و همسر است که افراد با آنها به رابطهٔ زناشویی می‌نگرند. افراد قراردادها را با هم تدوین می‌کنند، و هر فرد طوری رفتار می‌کند که گویی همسرش با این تعامل موافق است. بخش زیادی از قرارداد به اشتراک گذاشته نمی‌شود و بعضی جنبه‌هایش ناهشیار است، بنابراین، احتمال سردرگمی زیادی وجود دارد. متخصصان سه سطح برای قرارداد در نظر گرفته‌اند: (۱) کلامی[3]: بخشی از قرارداد به‌صورت کلامی به طرف مقابل گفته می‌شود؛ (۲) محرمانه[4]: بخشی از قرارداد که به‌خاطر ترس از پی‌آمدهای افشای آن با همسر در میان گذاشته نمی‌شود؛ و (۳) ورای آگاهی[5]: نیازهای پیش‌هشیار یا ناهشیاری که فرد از وجود آنها بی‌خبر است. تعارض زناشویی در این رویکرد ریشه در قراردادهای ناموازن و بر زمین‌مانده دارد. شاید قراردادها برای زوج قابل‌پذیرش نباشد، یا بخش‌های هشیار و ناهشیار آنها متعارض باشند. شاید یکی دبه کند و به قراردادها عمل نکند و آنها را به شکست بکشاند. پیچیدگی پویایی‌ها و تعارض‌های زناشویی اغلب به‌خاطر سطح قراردادی است که نیازهای هر فرد را در بر می‌گیرد و فراتر از آگاهی اوست.

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1. marital transference
2. marital contract theory
3. verbalized
4. secret
5. beyond awareness

نظریهٔ سیستم‌های بین‌نسلی

تمایزیافتگی یا قطب مخالف آن *هم‌جوشی*[1] سازهٔ محوری در نظریهٔ بوئن است. افراد تمایزنایافته به خانوادهٔ اصلی خود می‌چسبند و با هم‌جوشی با دیگران اضطراب‌شان را تسکین می‌دهند. آنان همسری را می‌جویند که در سطح رشدی مشابه خودشان عمل کند، و سبک ارتباطی خانواده‌های اصلی‌شان را با آنان تکرار کند. هدف زوج‌درمانی افزایش تمایزیافتگی زن و شوهر از خانواده‌های اصلی است که با مثلث‌زدایی‌کردن آنان از خانواده‌های پدری میسر می‌شود. هدف‌های دیگر، گسست هیجانی از نسل پیشین و توانایی زوج برای پُرکردن شکاف‌ها و حل دلبستگی هیجانی است.

بوئن از سه راهبرد مداخله‌ای اصلی کمک می‌گیرد. اولین راهبرد تعریف و روشن‌سازی رابطهٔ زن و شوهر است. او از زوج می‌خواهد آرام، مستقیم، کنترل‌شده، و عینی گفت‌وگو کنند. این مداخله معمولاً در کاهش دعواهای زناشویی و هم‌جوشی کارگر می‌افتد. راهبرد دوم آموزش عملکرد سیستم‌های هیجانی به زوج است. بوئن ویژگی‌های احساسی و ذهنی را از هم متمایز می‌کند. مرحلهٔ سوم اتخاذ «من‌موضع» است که در آن درمانگر خود را درون رابطه به زوج معرفی می‌کند و از آنان می‌خواهد در عین بازگشت شفابخش به خانواده‌های اصلی، همان موضع را اتخاذ کنند.

نظریه‌های سیستمی

نظریه‌های سیستمی (یا دقیق‌تر بگوییم *رویکرد ارتباطی*[2] به خانواده‌درمانی) مجموعه‌ای از نظریه‌ها و تکنیک‌هاست. نظریه‌های سیستمی که در این‌جا توضیح داده شده‌اند ترکیبی از نظریه‌های راهبردی‌اند که در آنها خانواده‌درمانگران ساختاری و *مثلث‌محور*[3] بر دو نسل متمرکز می‌شوند. نظریه‌پردازان سیستمی از مفاهیم سیستمیِ کلیت[4]، علیت حلقوی[5]، تعادل‌جویی، بازخورد مثبت و منفی[6]، و الگوهای تعاملی خانواده[7] استفاده می‌کنند. *تعامل*[8] شاه‌بیت نظریهٔ سیستمی است، که تبیینی برای تعارض‌های زناشویی است. زوج‌های پرتعارض هم‌زمان در سطوح خبر و فرمان[9] ارتباط برقرار می‌کنند. ریشهٔ رفتار نشانه‌دار مغایرت سطوح پیام است.

نظریه‌پردازان سیستمی در مفهوم‌پردازی مشکلات زناشویی با هم متفاوت‌اند. مثلاً برای هیلی کانون تعارض زناشویی جنگ قدرت زن و شوهر است، و فرآیند درمان تلاش برای دستیابی به توافقی

1. fusion
2. communication approaches
3. triadic-based
4. wholeness
5. circular causality
6. positive and negative feedback
7. family interactional patterns
8. interaction
9. report and command levels

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