Consensus Therapy: A Provisional Systemic Framework for Addressing Perceptual Misalignment in Couples

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Abstract

Perceptual discrepancies can contribute to couple distress when partners respond not only to one another's behavior but also to inferred intentions, emotions, and relational meanings that the other person may not endorse. This article presents Consensus Therapy (CT), a provisional systemic framework informed by research on Perceptual Agreement (PA) and subsequently developed through clinical work with couples. CT organizes intervention around five interrelated processes: identifying perceptual discrepancies, clarifying intent and emotional experience, checking partners' representations through paraphrase, developing functional consensus while preserving meaningful differences, and translating shared understanding into workable expectations. The framework is designed for selective integration with established couple-therapy approaches rather than as a replacement for them. An actual, de-identified clinical case illustrates CT applied to a recurring pursuit–withdraw pattern in which self-regulation was interpreted as rejection and reassurance-seeking as pressure. Future research should examine the feasibility and measurement of session-level perceptual alignment, its relationship to broader PA, and whether explicitly targeting perceptual misalignment contributes to relationship outcomes.

Keywords: Consensus Therapy, Perceptual Agreement, couple therapy, perceptual misalignment, systemic practice

Introduction

A partner becomes silent because they feel overwhelmed and want to prevent an argument from escalating. The other experiences the silence as rejection and presses for reassurance. The questions, intended to restore connection, are received as criticism or intrusion, prompting further withdrawal. Although both partners may agree about what occurred, they assign different meanings to the same interaction and respond to those meanings as though they were established facts.

Communication difficulties and emotional distance are among the most commonly reported concerns among couples seeking therapy (Boisvert et al., 2011), and communication responses can become patterned under conflict or perceived relational threat (Light, 2026). Partners do not respond only to each other's observable behavior; they respond to what they believe that behavior communicates about intention, emotion, commitment, and the state of the relationship. Research on romantic conflict similarly suggests that partners' inferences about each other's goals may be only partly accurate and can reflect projection of their own goals (Worley et al., 2023). Taking care of a practical task may be meant as an expression of care but received as avoidance of emotional engagement. A request for reassurance may be an attempt to restore closeness but experienced as control. In these situations, communication difficulties persist not necessarily because partners lack the ability to express themselves, but because the intended message and the meaning attributed to it remain misaligned.

This article uses the term *perceptual misalignment* to describe discrepancies between how one partner experiences and understands a relational event and how the other partner represents that experience. Misalignment may involve assumptions about a partner's emotions, intentions, needs, personal meanings, or experience of the relationship. It can appear as mistaken inferences about what a partner meant, conflicting relationship narratives, or emotional blind spots in which one partner remains unaware of distress that is highly salient to the other. Perceptual misalignment does not mean that one partner necessarily possesses an objectively correct interpretation or that differences should be eliminated. The clinical question is whether partners can recognize where their representations diverge, determine which meanings the other person actually endorses, and develop a shared description of the interaction that permits more deliberate responding.

From a systemic perspective, these discrepancies can become embedded in recursive interactional patterns (Light, 2026). Each partner acts on an interpretation of the other, and that response may evoke behavior that appears to confirm the original interpretation. Silence interpreted as rejection elicits pursuit; pursuit experienced as pressure elicits additional withdrawal. Over time, partners may become increasingly certain of their private explanations while becoming less curious about the other's internal experience. The resulting cycle is sustained not only by emotion and behavior but also by the meanings through which each partner organizes the exchange.

Established couple-therapy approaches already address many elements of these processes through emotional and attachment-focused work, cognitive and behavioral intervention, communication training, and acceptance (Doss et al., 2022). The proposed contribution of Consensus Therapy (CT) is therefore not the discovery that partners misunderstand one another or an entirely novel set of clinical techniques. Rather, CT organizes assessment and intervention explicitly around

discrepancies in relational perception: what each partner experienced, what the other believes they experienced, what was intended, what was received, and what description of the pattern both can endorse.

CT is presented here as a provisional systemic framework derived from research on Perceptual Agreement (PA; Ivanov & Werner, 2018). Its clinical procedures were subsequently developed through work with couples experiencing recurrent discrepancies between intended and received relational meanings. The framework specifies a structured process for identifying perceptual discrepancies, clarifying intent and emotional meaning, checking partners' representations against the other partner's account, acknowledging differences, and negotiating workable expectations. It is offered for clinical consideration and empirical testing, not as an established or empirically validated treatment. The next section examines PA as the conceptual and empirical foundation from which the framework was developed.

Perceptual Agreement: Conceptual Foundation and Evidence

PA refers to the degree of correspondence between each partner's account of their own internal experience and relationship and the other partner's representation of that account (Ivanov & Werner, 2018). It encompasses partners' understanding of each other's emotions, needs, intentions, roles, recurring interactional patterns, and experience of the relationship. PA is therefore not equivalent to similarity, affection, or agreement about what should occur. Partners may hold divergent preferences or experience the relationship differently while still understanding those differences accurately. Conversely, partners may appear compatible or agree on surface facts while assigning markedly different meanings to the same interaction.

PA is best understood as target-referenced congruence rather than access to an objective relational truth. One partner's description of their own experience serves as the criterion against which the other partner's perception is compared. This criterion is clinically meaningful but not infallible: individuals may have limited awareness of their own motives, may describe their experience differently over time, or may communicate it inconsistently. PA therefore does not determine which partner possesses the correct interpretation of an event. It assesses whether each partner's representation of the other corresponds to the experience that the other person currently endorses.

PA overlaps with several neighboring constructs but is not reducible to them. Thought-feeling or empathic accuracy concerns how accurately a person infers another's thoughts and feelings in interaction, whereas metaperception concerns how accurately a person represents how they are viewed by the other (Vorauer et al., 2025). Perceived partner responsiveness refers to the extent to which a person experiences a partner as understanding, validating, and caring (Arican-Dinc & Gable, 2023). Shared reality with a close partner concerns perceived overlap in subjective states about the world more generally (Enestrom et al., 2025). PA differs in using the target partner's own report as the reference point for evaluating the other partner's representation across relational domains.

This distinction is clinically useful because couple distress often involves interaction with an inferred version of the partner. A person may respond not to what the partner reports feeling or

intending, but to what that person assumes the partner must feel or intend. For example, temporary withdrawal may be interpreted as punishment even when the withdrawing partner describes it as an attempt to regulate distress. Financial provision may be offered as care but experienced as a substitute for emotional availability. PA directs the clinician's attention to the correspondence—and discrepancy—between self-description and partner perception rather than to behavior or verbal skill alone.

In the initial empirical investigation, dyadic PA was operationalized by comparing each partner's self-ratings with the other partner's ratings of that partner across multiple relational characteristics and measures, with greater correspondence yielding higher PA scores (Ivanov & Werner, 2018). PA was approximately normally distributed and was not significantly associated with age, education, ethnicity, or relationship length. The individual PA measure demonstrated one-month test–retest stability of $r = .75$; for the dyadic PA measure, the mean one-month test–retest correlation across items of its self- and partner versions was $r = .66$. Baseline PA was also prospectively associated with relationship satisfaction one month later. These findings are consistent with PA showing relative stability over the one-month period studied and argue against a simple explanation in which PA merely increases with time together.

PA was strongly associated with relationship satisfaction, accounting for 72% and 64% of the variance in male and female partners' satisfaction scores, respectively, in the original sample (Ivanov & Werner, 2018). Higher PA in that study was also associated with self-esteem, constructive communication, and openness/self-disclosure, whereas lower PA was associated with projective mystification, a construct developed by Werner et al. (2001) referring to the tendency to assume privileged knowledge of a partner's inner experience; behavioral communication, a construct developed by Ivanov and Werner (2010) characterized by indirect, emotionally charged signals; jealousy; and demand–withdraw patterns. Together, these findings suggest that greater correspondence between partners' representations tends to occur alongside more constructive patterns of communication and relationship functioning.

These findings support PA as a measurable and clinically relevant relational construct, but they do not establish causal direction. Although PA is distinct from interpersonal accuracy, research on romantic partner perception cautions against assuming that greater correspondence is uniformly beneficial; accuracy and bias can coexist, and greater accuracy may be less adaptive in some contexts (LaBuda & Gere, 2023; Simpson et al., 2003). Greater PA may contribute to satisfaction and constructive communication, but better-functioning relationships may also facilitate more accurate partner perception, and PA may partly reflect broader processes such as attachment security, relationship positivity, openness, or communication competence. Existing findings therefore support further study of perceptual alignment while leaving its causal role unresolved.

PA must also be distinguished from the more immediate clinical indicators proposed within CT. A partner's endorsement of an accurate paraphrase and both partners' endorsement of a functional-consensus statement are session-level markers of understanding, not equivalents of the broader PA measures used in the original research; their validity and relationship to established PA measures remain to be tested. CT proposes that systematically identifying discrepancies, clarifying intended

and received meanings, and checking partners' representations may improve momentary understanding and, over time, contribute to broader relational alignment and repair.

Development and Current Status of CT

The findings reviewed above raise a clinical question: How might a therapist work directly with discrepancies between one partner's self-described experience and the other partner's representation of that experience? CT emerged from efforts to translate this question into a clinically usable process. Its procedures were subsequently developed through couple-therapy work with partners whose difficulties involved recurring discrepancies between intended and received relational meanings. In such cases, the clinical task was not only to facilitate emotional expression or behavioral change, but also to identify each partner's assumptions about the other's experience, compare those assumptions with the partner's own account, and help the couple construct a description of the interaction that both could recognize.

Five recurring clinical tasks were organized into the CT framework: mapping perceptual discrepancies, clarifying intent and emotional experience, checking partner representations through paraphrase, acknowledging differences and building functional consensus, and negotiating expectations and reaching closure. CT consequently functions as both a case-formulation lens and an intervention sequence. As a formulation lens, it maps how divergent perceptions participate in recursive interactional patterns and how those perceptions may be shaped by personal history, relational context, and present circumstances. As an intervention sequence, it structures the movement from identifying a perceptual discrepancy to clarifying its meaning and rehearsing a different response. These tasks may be incorporated into broader couple-therapy work when perceptual discrepancies are clinically salient.

CT is not proposed as a comprehensive new school of couple therapy or as a replacement for established treatments. Its present basis consists of published research on PA (Ivanov & Werner, 2018), related relational and couple-therapy literature, and clinical observations that informed the framework's development. The purpose of the present article is to specify CT sufficiently clearly for clinical consideration, critical evaluation, and future empirical study.

Consensus Therapy: Principles and Five-Step Clinical Process

CT organizes clinical work around discrepancies between partners' experiences of a relational event and their representations of each other's experiences. Rather than beginning with a global account of the relationship, the therapist ordinarily selects a specific interaction that both partners can recall and examines how its meaning developed. The focus is not only on what each person said or did, but also on what they felt, intended, inferred, and believed the interaction communicated about the relationship.

The process follows three guiding principles. First, partners' descriptions of their internal experiences are treated as essential clinical information, although they may remain partial, evolving, or open to further reflection. Second, understanding another person's experience is distinguished from agreeing with their interpretation, excusing their behavior, or accepting equal responsibility

for the interaction. Third, consensus is pursued only to the degree necessary for the couple to construct a sufficiently shared account of the pattern and make more deliberate choices within it. CT refers to this outcome as *functional consensus*: a mutually endorsed description that represents each partner's stated experience, identifies how their responses interact, and provides a workable basis for subsequent action. Functional consensus does not require identical perspectives, agreement about every fact, or equal responsibility for the interaction.

CT organizes this work into five interrelated steps. The sequence is iterative rather than rigidly linear. Therapists may return to an earlier step when a new discrepancy emerges, emotional activation limits reflection, or an apparent agreement does not accurately represent one partner's experience.

1. Mapping Perceptual Discrepancies

The first step identifies where partners' representations converge and diverge. The therapist selects a focal interaction and invites each partner to describe their own experience, including relevant emotions, intentions, needs, and personal meanings. Each partner is then asked to describe what they believe the other experienced and intended.

The purpose is not to decide whose overall account is correct, but to compare self-description with partner perception. A partner may correctly recall the observable sequence while misunderstanding what the event meant to the other person. The therapist distinguishes what occurred, what each partner experienced and intended, and what each inferred about the other.

A therapist might ask each partner, in turn:

> "What was happening for you at that moment? Now describe what you believe was happening for your partner."

The therapist notes where each partner's representation corresponds with, remains uncertain about, or diverges from the other's self-described experience, without assuming that discrepancy itself is pathological.

2. Clarifying Intent and Emotional Experience

Once a discrepancy is identified, the therapist helps the partners differentiate the behavior, the intended message, the meaning received by the other partner, and the emotional impact that followed. For example, insisting on a detailed plan may be intended to reduce anxiety but received as controlling; handling a problem independently may be intended to protect the partner from additional stress but experienced as shutting them out.

Clarifying intent does not erase impact, nor does emotional impact establish what the other partner intended. Both are necessary for understanding the interaction. The therapist also avoids treating the speaker's first explanation as necessarily complete. Intentions may be mixed, only partly conscious, or reconstructed after the event. The goal is to help each partner articulate the account they can presently endorse while remaining open to complexity and further exploration.

Useful questions include:

> "What were you trying to communicate, obtain, or prevent?"
>
> "What did your partner's response mean to you when you received it?"

This step often reveals that behavior experienced as hostile, indifferent, or controlling also served a protective or regulatory function. Identifying that function can make the pattern more understandable without removing personal accountability for harmful conduct.

3. Checking Partner Representations Through Paraphrase

In the third step, each partner attempts to represent the other's experience in language that the other person recognizes as sufficiently accurate. CT uses paraphrase as a target-referenced check on how the partner's experience is being represented. The paraphrase should capture, as relevant, the speaker's emotion, intention, personal meaning, and anticipated or feared consequence.

For example:

> "You became quiet because you felt ashamed and overwhelmed. You were trying to prevent the argument from becoming worse, although your silence made me think you were shutting me out."

The speaker then identifies what the paraphrase captured and what still needs correction. The therapist may slow the exchange, separate interpretations from the partner's own account, and invite revision.

The aim is not exact verbal repetition or compelled validation. It is the demonstrated ability to hold the partner's account without immediately replacing it with one's own interpretation. Speaker endorsement indicates that the paraphrase represents the experience the speaker currently reports; it does not verify an objective account of motives or events.

When both partners can accurately describe each other's accounts, the interaction becomes available for joint examination rather than continued argument between two privately assumed realities.

4. Acknowledging Differences and Building Functional Consensus

Accurate understanding does not necessarily eliminate disagreement. Partners may continue to differ in their needs, regulation styles, values, memories, or judgments about what should have occurred. CT therefore distinguishes perceptual alignment from uniformity.

The therapist helps the couple acknowledge these differences without automatically construing one style as healthy and the other as deficient. At the same time, normalization should not obscure conduct that is intimidating, degrading, coercive, or otherwise harmful. Differences in internal experience may both be understandable even when responsibility for behavior is unequal.

A functional-consensus statement ordinarily represents each partner's experience or intended function, identifies the discrepancy between intended and received meaning, and describes the recursive effect of their responses.

For example:

> "When one partner becomes overwhelmed, temporary silence helps them regulate. When that silence is not explained, the other experiences it as possible rejection and seeks immediate reassurance. The increased questioning then adds to the first partner's sense of overload."

Both partners should be able to endorse the statement as a fair description of the interaction, even if they continue to disagree about aspects of the event.

A functional-consensus statement is not a negotiated fiction that places incompatible factual claims on equal footing. When disputed facts, breaches of trust, or questions of safety materially affect treatment, those matters may require separate assessment rather than being absorbed into a symmetrical account of "different perceptions."

5. Negotiating Expectations and Reaching Closure

The final step translates the shared understanding into a specific change in how the partners will respond when the pattern recurs. The therapist helps each person identify a voluntary, observable, and feasible action rather than relying on broad promises such as "communicate better" or "be less sensitive."

The agreement may involve naming a need before withdrawing, specifying when a paused conversation will resume, checking an interpretation before responding to it, clarifying a boundary, or establishing a brief cue for a recurring pattern.

For example, one partner might say:

> "I'm getting overwhelmed. I need about ten minutes to calm down, but I'll come back."

The other might respond:

> "Okay. I'll wait, and when you come back, I'll ask what was happening instead of assuming you're leaving the conversation."

The therapist rehearses the wording and clarifies what each partner is—and is not—committing to do. Closure means that the focal interaction has been understood sufficiently to support a concrete next response. It does not require complete emotional resolution, immediate affection, or agreement about the relationship as a whole.

The agreement is treated as provisional and reviewed in light of what occurs outside the session. If it fails, CT directs attention not only to whether the partners complied but also to how the cue was interpreted, what contextual conditions interfered, and whether the agreement accurately addressed the process sustaining the conflict.

Across the five steps, CT moves from identifying a perceptual discrepancy to constructing an endorsed account of the interaction and testing a more deliberate response.

Therapist Stance and Clinical Boundaries

CT requires a multipartial systemic stance, consistent with the contextual-therapy tradition of multidirected partiality developed by Boszormenyi-Nagy (Boszormenyi-Nagy & Krasner, 1986;

Ducommun-Nagy, 2025), in which the therapist seeks to understand and accurately represent each partner's experience without assuming that their interpretations, actions, or consequences are equivalent. Therapeutic formulations are treated as hypotheses rather than authoritative accounts of either partner's inner life. When the therapist identifies a possible function of a behavior—for example, withdrawal as an attempt to regulate shame or questioning as a bid for reassurance—the relevant partner is invited to confirm, revise, or reject that formulation.

Understanding a behavior does not require excusing it. A protective intention may coexist with harmful impact, and both partners may contribute to a recursive interaction while bearing unequal responsibility for particular actions. Similarly, one partner's emotional response may be understandable without establishing the factual accuracy of the interpretation that produced it. CT therefore distinguishes understanding from agreement, explanation from justification, and systemic participation from equal responsibility.

The pace of the five-step process is guided by the partners' capacity for reflection. Because the capacity to mentalize can become less reliable under heightened emotional arousal (Luyten et al., 2020), the therapist slows or pauses the exchange when either partner is no longer able to consider the other's perspective effectively. Likewise, difficulty producing an endorsed paraphrase is treated as information rather than as failure: the therapist may need to clarify the speaker's account further, reduce arousal, or distinguish inability to understand from disagreement with what has been understood. The sequence advances only when both partners can participate meaningfully rather than merely comply with the procedure.

CT also distinguishes relational meaning from questions that require factual or ethical assessment. A dispute about what an interaction meant may be appropriate for perceptual clarification; allegations involving deception, intimidation, coercion, breached agreements, or safety cannot simply be reframed as two equally valid perceptions. In particular, conjoint couple treatment may be inappropriate when coercive control compromises safety and voluntary participation (Wathen & Mantler, 2022). Functional consensus should never require a partner to affirm an account they believe to be false or to accept shared responsibility for harmful conduct.

Finally, perceptual meaning is culturally and contextually situated. Norms concerning emotional expression, directness, privacy, hierarchy, gender, family obligation, and autonomy can shape both what a behavior is intended to communicate and how it is received; communication preferences themselves vary across cultural contexts (Ge et al., 2022). Therapists should therefore explore the couple's own cultural meanings rather than privileging a particular communication style, consistent with culturally responsive approaches to couple counseling (Leeth & Mendoza, 2025). Consensus-oriented work should also be suspended or modified when coercion, fear, or major power asymmetry compromises either partner's freedom to disagree, correct the other, or make voluntary commitments.

Clinical Illustration: Pursuit, Withdrawal, and Misread Intent

The following illustration is based on an actual couple treated by the author. Identifying and nonessential contextual details have been altered to protect confidentiality. Dialogue was

reconstructed with reference to contemporaneous handwritten clinical notes and is not presented as a verbatim transcript. The case is included to illustrate the clinical application of CT.

Presenting Pattern and Formulation

A professional couple, married for seven years, entered therapy following increasingly distressing conflicts. The immediate subjects of their arguments varied and were often relatively minor, yet a recognizable interactional sequence repeatedly emerged. Partner A had a longstanding difficulty tolerating frustration and sometimes responded with abrupt anger. Afterward, A tended to withdraw. Partner B experienced both the anger and the subsequent withdrawal as personally meaningful, frequently assuming responsibility for A's emotional state and becoming increasingly anxious about rejection.

One representative incident occurred while the couple was waiting in a long restaurant line. Partner A became visibly frustrated. Although A did not blame B for suggesting the outing, B interpreted the reaction as evidence that the situation—and therefore A's anger—was somehow B's fault. A subsequently withdrew, describing the withdrawal in therapy as an effort to calm down and manage feelings of shame about the outburst. B interpreted the silence quite differently: as evidence that A remained angry, was shutting B out, or might eventually give up on the relationship.

The partners' subsequent responses amplified the discrepancy. At times B sought reassurance through increasingly urgent questions; at others, B suppressed distress to avoid provoking further withdrawal. A experienced the questioning as pressure and interpreted B's distress as a reason to create still more distance. Thus, the couple often agreed about the observable sequence but assigned substantially different meanings to it. Silence meant regulation to one partner and possible abandonment to the other; pursuit meant an attempt at reconnection to one and escalating demand to the other.

CT formulation focused on this recursive interaction rather than locating the problem exclusively in either partner. Both partners were responding to inferred meanings that the other did not fully endorse. At the same time, the formulation did not treat their contributions as equivalent: Partner A remained responsible for managing expressions of anger, while Partner B's self-blame and pursuit were understood as responses that contributed to the continuation of the interactional cycle but did not cause Partner A's anger or outbursts.

Developmental history was explored as a possible context for the pattern rather than as a definitive explanation. Partner A described earlier experiences involving intrusive family boundaries and difficulty managing frustration, whereas Partner B described a history of seeking parental approval and sensitivity to signs of being rejected. These histories provided hypotheses about why autonomy and abandonment carried particular emotional weight for each partner. The couple also had substantial relational strengths, including commitment, empathy, and repeated efforts to repair conflict. Their customary reconciliations, however, tended to reduce immediate distress without changing the interpretations that made the next rupture so threatening.

Application of CT

Treatment initially focused on slowing selected conflict interactions sufficiently for each partner's interpretation to become visible. In the restaurant incident, Partner A described the silence following the outburst as an attempt to regulate shame and avoid further escalation. Partner B had understood the same silence as continuing anger and relational rejection. Partner B, in turn, described the urgent questioning as an effort to restore contact and reduce uncertainty; Partner A had experienced it primarily as pressure.

The therapist then asked each partner to represent the other's account rather than defend their own. The distinction between understanding and agreeing became important. Partner B did not have to regard A's withdrawal as an ideal way to regulate emotion in order to understand that rejection was not its intended message. Likewise, Partner A did not have to agree that reassurance was necessary in every conflict to recognize that B's questioning arose from fear of losing contact rather than simply from a wish to criticize or control.

A reconstructed portion of the exchange illustrates this process:

> Therapist: When you became quiet, what were you hoping your partner would understand?
>
> Partner A: That I was overwhelmed and needed a little time. I wasn't trying to leave or punish anyone.
>
> Therapist: And what did the silence mean to you?
>
> Partner B: That I was being shut out again. I thought A was still angry with me.
>
> Therapist: Before we decide what either of you should do differently, can you tell A what you now understand the silence meant from A's side?
>
> Partner B: You were overwhelmed and ashamed about getting angry. You were trying to calm down, not reject me.
>
> Therapist: Is that close to what you meant?
>
> Partner A: Yes. I needed space because I felt awful about how I reacted.

The process was then reversed. Partner A was asked to describe what B had been attempting to accomplish through repeated questioning. This helped separate B's intended bid for reassurance from the pressure A experienced as its impact.

The emerging functional consensus was not that either response was inherently appropriate. Rather, the couple developed a shared description of the sequence: when A became overwhelmed, withdrawal helped A regulate but, without explanation, signaled possible rejection to B; B then sought immediate reassurance, which increased A's sense of pressure and made further withdrawal more likely.

Treatment translated this understanding into a small behavioral agreement. Partner A agreed to name the need for space while explicitly signaling an intention to return, using language such as, "I need a few minutes to settle down, but I'm coming back." Partner B agreed to postpone further questioning during that interval and return to the issue when A re-engaged. The wording and timing

were rehearsed in session so that the break would function as a communicated pause rather than an ambiguous disappearance.

Descriptive Clinical Course

According to the clinical notes, the couple subsequently reported using the reconnection cue during conflicts outside therapy. They described some disagreements as easier to contain and reported that re-engagement occurred more quickly when the pause was explicitly framed as temporary. The central change described in treatment was not the disappearance of disagreement or anger, but a reduction in the certainty with which each partner assigned threatening meaning to the other's behavior. Temporary withdrawal became less automatically equated with abandonment, while requests for reassurance became less automatically interpreted as attack. These observations are clinically illustrative rather than evaluative. No standardized CT process or outcome measures were administered, so the reported changes cannot be attributed specifically to CT.

Relationship to Established Couple-Therapy Approaches

CT shares important processes with established approaches to couple treatment. Contemporary couple therapies commonly employ processes such as emotional engagement, attention to interactional patterns, listening and perspective-taking, cognitive or narrative reframing, acceptance, and negotiation (Lebow & Snyder, 2022). These processes are therefore not unique to CT. The proposed contribution of CT lies instead in organizing these familiar clinical processes around a specific target: discrepancies between one partner's reported experience and the other partner's representation of that experience. CT repeatedly asks not only What happened between you? but also What did you believe was happening for your partner, and does your partner recognize that account?

Emotionally focused couple therapy similarly attends to attachment and recurring interactional patterns and uses emotional engagement to reshape relational connection (Mendoza & Leeth, 2025). CT is compatible with this work but places greater procedural emphasis on checking whether the meaning expressed by one partner is the meaning represented by the other. An attachment-related bid, fear, or protest may be articulated clearly yet still be interpreted differently from how it was intended. CT proposes that perceptual clarification can be incorporated into emotion-focused work when discrepancies between intended and received meaning are clinically salient.

Behavioral, cognitive-behavioral, and integrative behavioral couple therapies address processes including communication and problem solving, cognitive interpretations and attributions, behavioral change, and acceptance (Doss et al., 2022). The distinction is again one of organizing focus rather than mutually exclusive techniques. A request to "give me space," for example, may generate very different responses depending on whether it is understood as temporary self-regulation, punishment, indifference, or impending separation. CT therefore places perceptual clarification before or alongside behavioral negotiation rather than assuming that an agreed behavior carries a shared meaning.

Mentalization-based couple therapy provides another important point of convergence. It aims to strengthen partners' capacity to recognize mental states in themselves and each other and to consider the other person's perspective rather than treating inference as certainty (Bleiberg et al., 2022). CT narrows this broader reflective task to specific dyadic discrepancies and introduces an explicit target-referenced verification process: a partner's representation is checked against the account currently endorsed by the person whose experience is being described. This does not establish objective accuracy, but it makes the discrepancy between inference and self-report directly available for therapeutic work.

Narrative and systemic approaches likewise attend to relational meaning, recurring interactional patterns, and the ways couples organize their experience through relational narratives (Lebow & Snyder, 2022). CT shares this systemic orientation while using functional consensus as a relatively circumscribed clinical product: a brief description of a recurring interaction that both partners can recognize without requiring identical interpretations or a unified relational narrative.

CT therefore does not claim novelty for its individual techniques or propose perceptual alignment as a replacement for established therapeutic targets. Its more specific proposition is that relational perception can be treated as an explicit clinical target, using a structured sequence to identify discrepancies, check partner representations, develop functional consensus, and translate that understanding into action.

Implications for Marriage and Family Counselors

CT offers marriage and family counselors a way to attend explicitly to perceptual discrepancies that may remain embedded within familiar patterns of conflict. Such discrepancies may be especially relevant when partners largely agree about what occurred but repeatedly disagree about what the interaction meant, when repair attempts are interpreted as further injury, or when each partner responds with confidence to assumptions about the other's intentions that the other does not endorse. In these situations, an additional clinical question is whether each partner is responding to the other person's reported experience or to an inferred version of it.

CT can be used selectively rather than as a complete treatment package. A counselor may slow a focal interaction, compare each partner's self-description with the other's representation of that experience, clarify discrepancies between intended and received meaning, and use paraphrase to determine whether the partner's account is sufficiently represented. When useful, this process can lead to a functional-consensus statement and a specific change in how the couple will respond when the pattern recurs. The framework may be incorporated into attachment-focused, behavioral, cognitive-behavioral, narrative, or systemic work when perceptual discrepancies interfere with other therapeutic goals.

Clinical use of CT requires maintaining the distinction between understanding and agreement. Accurate representation of a partner's experience does not require endorsing that person's conclusions, excusing harmful behavior, or assigning equal responsibility for a recursive pattern. Cultural meaning, relational power, and safety remain essential considerations, particularly when either partner's freedom to disagree or participate voluntarily is compromised. Counselors may

monitor whether partners become better able to recognize discrepancies before acting on them, represent one another's intended meanings, use negotiated responses outside sessions, and repair recurring conflicts.

Limitations and Future Research

CT is presently a provisional clinical framework rather than an empirically supported treatment. Its conceptual rationale draws partly on research on PA (Ivanov & Werner, 2018), but those findings are primarily associational and do not establish that increasing PA causes improvements in relationship functioning or that the procedures proposed here reliably alter PA. Likewise, the proposed session-level indicators have not yet been validated as measures of perceptual change.

The clinical illustration involved one couple and cannot establish effectiveness or generalizability. No standardized CT process or outcome measures were administered, and the observed changes cannot be separated from other therapeutic processes or change over time. The applicability of CT across different relationship structures, cultural contexts, levels of distress, and clinical presentations also remains to be established.

The most immediate research priority is therefore basic intervention-development work rather than a large efficacy trial, consistent with staged approaches that emphasize resolving questions of feasibility, process, and measurement before formal evaluation (Skivington et al., 2021). Initial studies should examine whether the five-step process can be delivered consistently and acceptably, whether proposed session-level indicators of perceptual alignment can be measured reliably, and whether those indicators change during treatment. Particular attention should be given to developing brief, session-level measures of target-endorsed understanding and perceptual discrepancy, and to establishing whether these indicators can be distinguished empirically from agreement, general relationship positivity, and compliance with the therapeutic process. For example, after selected exchanges, the speaker could rate how accurately the partner's paraphrase captured their emotion, intent, and personal meaning, allowing target-endorsed understanding to be tracked across sessions.

If these preliminary studies support the feasibility and measurement of the proposed processes, subsequent research can examine clinical outcomes and mechanisms. Relevant questions include whether CT changes broader PA, whether such changes precede improvements in relationship functioning, and whether perceptual alignment explains outcomes beyond established therapeutic processes such as emotional engagement, reflective functioning, communication, or behavioral change. Comparative and adjunctive studies could then test whether explicitly targeting perceptual misalignment provides incremental benefit when incorporated into established couple therapies.

Conclusion

Couple conflict is shaped not only by what partners do or say, but by the meanings they assign to one another's behavior. When those meanings diverge, partners may respond to intentions, emotions, and relational messages that the other person does not recognize as their own. Over time, such discrepancies can become incorporated into recurring interactional patterns and make communication and repair increasingly difficult.

CT offers a structured way to make these discrepancies explicit. Drawing on the construct of PA, CT organizes clinical work around identifying differences between self-reported and partner-perceived experience, clarifying intent and impact, checking partners' representations of one another, developing functional consensus, and translating that understanding into workable responses. The framework does not require identical interpretations or equal responsibility; its more limited aim is to help partners recognize where their perceptions diverge well enough to respond to one another more deliberately.

CT specifies a testable clinical hypothesis: that making partners' interpretations visible, checkable against one another's reported experience, and mutually understandable may alter the conditions under which recurring relational patterns are maintained. By specifying this process clearly enough for clinical use and empirical study, CT provides a basis for testing that hypothesis.

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Informed Consent

No new research participants were enrolled for this article. The clinical illustration is based on de-identified clinical material. Identifying and nonessential contextual details were altered to protect confidentiality, and dialogue was reconstructed from contemporaneous clinical notes rather than presented as a verbatim transcript.

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The author developed Consensus Therapy and maintains a related informational website and the free CoThera application. The author may derive professional benefit from dissemination of the Consensus Therapy framework. No other potential conflicts of interest are declared.

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