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Combined Individual/Marital Therapy: A Conflict Resolution Framework and Ethical Considerations

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This paper illustrates how couple and individual treatment formats can be intertwined. A conflict resolution theoretical framework structures treatment around three goals: (1) relieving symptoms (anger, depression, and marital distress), (2) facilitating resolution of the couple's conflicts, and (3) building communication and conflict resolution skills. The literature review focuses on why combining individual and couple therapy is often important for married clients. "Two Bicycles," an illustrative case incorporating both conjoint and individual interventions, is presented and analyzed with regard to when each format seems beneficial. Ethical and practical issues raised by dual format treatment include potential harm, informed consent, dual roles, confidentiality, and time and financial costs.

KEY WORDS: conflict; conflict resolution; couple therapy; individual therapy; depression; anger; integration; integrative therapy; marriage; marital problems.

Difficult couples require complex treatment strategies. I have found from experience that supplementing couple treatment with individual interventions facilitates forward movement with these challenging cases. This paper presents an extended case example to illustrate how a conflict resolution treatment structure[2] can guide this kind of intertwined couple and individual treatment.

The paper begins with an introduction to the theory underlying a conflict resolution treatment. After a short literature review and a relatively full

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[2]Conflict resolution treatment is sometimes also called conflict-focused treatment. The terms are used interchangeably.

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presentation of a case, "Two Bicycles," I explore the principles underlying my decisions regarding couple and individual treatment formats. The paper concludes with consideration of ethical and practical issues raised by this case, and in general by treatment that incorporates both conjoint and individual interventions.

Conflict resolution theory emerged as an early product of the psychotherapy integration movement. I first published the theory as an article in *Journal of Integrative and Eclectic Psychotherapy*, the predecessor of this journal (Heitler, 1987). In large part because of the climate of support for integrative thinking that I experienced in SEPI,[3] I expanded the basic ideas into a book, *From Conflict to Resolution* (Heitler, 1990). Since then I have published several book chapters, audio tapes, and a video demonstrating specific conflict-focused treatment techniques (Heitler, 1992, 1994a,b, 1995a,b). Conflict resolution theory and techniques are used by practicing clinicians, and are included in the *Psychologists' Desk Reference* (1998), but have not as yet been empirically validated in academic research.

CONFLICT RESOLUTION TREATMENT

Conflict resolution treatment rests on a familiar premise. *Conflicts lie at the core of emotional distress; effective conflict resolution brings resumption of emotional well-being.* Conflict may occur within a person (intrapsychic conflict), between people, or between a person and situational factors.

To understand pathology, it helps to begin by knowing what health looks like. Conflict-focused theory is based on observations about information flow and conflict resolution in healthy problem-solving dialogue. This knowledge base has come from a synthesis of the marital therapy literature, the mediation literature developed in the fields of law, business, and international relations, and my clinical experience working with individuals, couples, and families.

Conflict resolution theory offers an information flow model for understanding emotional health, distress, and treatment. How people handle their conflicts, that is, their patterns of information flow in negotiating personal decisions, differences with others, and life challenges, defines their level of personal maturity. Healthy conflict resolution with open and smooth information flow sustains personal well-being and nourishes goodwill in relationships. Poorly handled conflicts in which information is denigrated, suppressed, or otherwise not allowed to flow smoothly result in the negative emotions, self-defeating behaviors, and relationship difficulties we call psychopathology.

[3]The Society for Exploration of Psychotherapy Integration.

Conflict resolution theory posits that four detours from the pathway of healthy conflict resolution lead to the four primary types of psychopathology (Heitler, 1990). A *fight* route leads to anger syndromes (ODD, borderline functioning, paranoid functioning, etc). A *flight* route yields the avoidance psychopathologies (addictions and other obsessive–compulsive disorders). Immobilization, that is, a *freeze* route with the conflict remaining in consciousness without any action response, sustains anxiety (including panic disorder and agoraphobia). And a *submit* route, giving up in the face of conflicts, results in depression.

These four detours create the same emotional syndromes irrespective of whether the conflicts have arisen in the intrapsychic realm, in interpersonal disputes, or between a person and situational factors. This congruence of conflict resolution patterning in the intrapsychic and interpersonal realms makes conflict theory particularly helpful in therapy that treats spouses' individual issues plus their marriage problems.

Psychotherapy in this perspective involves identifying conflicts that have been handled with psychopathological detours, and then re-resolving these conflicts with healthier strategies. Better solutions to the conflicts alleviate the psychopathology and restore well-being. Therapy in this model therefore (1) alleviates symptoms, (2) finds more satisfying solutions for life dilemmas, and (3) teaches skills for better problem-solving (conflict resolution) in the future.

Therapy Integration and Conflict Resolution. Conflict resolution is by no means a new way to look at the process of psychotherapy. In my earliest days of graduate school training I recall professors talking about therapy as a way to help people to resolve their conflicts, a word used interchangeably with issues, problems, differences, or troubles. Psychodynamic theory proposes a conflict-based model in which conflicting wishes and fears (id) and values and beliefs (superego) rely on a third party mediator, the ego. Gestalt theory, which describes conflicts as "unfinished business," is most explicitly a conflict model. Gestalt technique has perhaps gone the furthest in helping therapists to observe the subtle cues of "breaks in the flow" that indicate the presence of an intrapsychic conflict. Gestalt theory also stresses the importance of bringing conflicts into the here and now of the therapy room for resolution, a vital principle in conflict resolution treatment. Behavioral therapies, and particularly behavioral marital therapies, also focus on conflict, delineating communication and anger management skills essential for conflict resolution.

Therapists who use a conflict resolution framework need a broad repertoire of therapeutic interventions in order to facilitate different aspects of the resolution process. Pharmacological, cognitive–behavioral, paradoxical,

and solution-focused interventions work particularly well at the outset of treatment when symptom reduction is a primary focus. Psychodynamic and Gestalt interventions facilitate exploration of the deeper concerns that evoke strong feelings in conflict situations. Behavioral interventions are essential to the skill-building aspects of treatment.

In turn, conflict resolution expertise and a conflict resolution theoretical overview can enhance therapists' effectiveness with many of these interventions. Pharmacological, paradoxical, and solution-focused interventions, for instance, are strengthened if their use is augmented by skill-coaching to ensure that future conflicts do not yield regressions. Psychodynamic interventions increase understanding of family-of-origin sensitivities; conflict-resolution paradigms then remind the therapist that the job isn't finished until new solutions to these sensitivities have been found. Gestalt therapists can utilize the three steps of healthy conflict resolution to transform top-dog/underdog interactions into healthy mutual problem-solving. And systemic therapists can utilize conflict resolution visualizations to address individuals' intrapsychic conflicts.

Perhaps the most important use of conflict resolution theory, however, is as an overarching framework for organizing integrative treatment. Clients want their therapist to have a systematic plan of action. In a 1999 study, Estrada and Holmes asked marriage therapy participants what had most hindered and what had helped their treatment. Respondents disliked when a therapist seemed to be wasting time or seemed unclear about the treatment. They liked when their therapist was active, directive and focused, and provided a safe and empathic therapeutic environment.

The complexities of treating two individuals plus their marriage can easily result in treatment that wanders instead of maintaining clear direction. Integrative therapists with a broad treatment repertoire may especially risk becoming scattered in their interventions and reactive instead of proactive. Conflict resolution thinking keeps an integrative therapy flexibly responsive to clients' needs and yet well-organized, systematic, and steadily forward-moving.

REVIEW OF THE LITERATURE ON INDIVIDUAL VERSUS COUPLE TREATMENTS

For some time therapists have expressed concern that individual therapy with a married individual may inadvertently harm the spouse, the marriage, or both. As early as 1944, Mittleman advocated more serious consideration of the patient's spouse, noting that improvement in one spouse was not always met with enthusiasm from the partner, and even, with considerable

frequency, precipitated adverse reactions. Patients may have been more cognizant of the negative impacts of individual therapy than the therapists. A 1958 article in *Cosmopolitan* (Anonymous, 1958), for instance, was entitled "Psychoanalysis Broke Up My Marriage."

Starting in the 1950s (Moran, 1954) and intensifying in the 1960s a number of researchers focused on this dilemma of iatrogenic (doctor-induced) harm from treatment. Kohl (1962), Pinckney and Pinckney (1965), Hurvitz (1967), Fox (1968), and others consistently found that in a substantial proportion of cases, successful treatment in individual therapy resulted in either the development of emotional problems in the spouse or deterioration of the marriage.

The findings of these studies may have influenced subsequent burgeoning interest in marriage and family therapies. Multiple studies over the last several decades have established that marital therapy is effective and is the treatment of choice for marital distress (see Pinsof & Wynne, 1995, for a review).

On a more encouraging note, Hunsley and Lee's 1995 meta-study of the impacts of individual treatment on marriages suggests less negative consequences from individual treatment for married clients than earlier studies had been indicating. Perhaps the increase in female therapists is decreasing the difficulties. In the past, patients were mainly female and therapists mainly male, inviting inadvertent negative comparisons between the consistently nurturing therapeutic relationship and troubles at home. Treatment with a same sex therapist may reduce this risk. In addition, newer treatments such as EMDR and cognitive–behavioral interventions rely less on a strong therapeutic bond for their effectiveness than do traditional psychodynamic treatments. Contemporary therapists may also be more likely to steer clients in individual treatment away from complaints about their spouse and instead toward identifying what s/he can do for more happiness at home. Lastly, with the spread of AIDS and more understanding of the many costs of divorce, our society seems to be swinging back to a more positive regard for the institution of marriage. In response, therapists may be less likely to support divorce as a solution to personal growth concerns.

At the same time, research has found that couple therapy is not a panacea. Marital therapy seems to be not particularly helpful for depressed patients who are not experiencing marital distress (Jacobson et al., 1991). There also is evidence that couples treated with behavioral treatment improve initially and then show deterioration in the relationship over time (Jacobson et al., 1987; Snyder et al., 1991a).

Studies by Johnson and Greenberg (1985), Snyder et al. (1991a), and Snyder (1999) suggest that a pluralistic couple therapy approach that

combines marriage skills training with exploration of strong emotions leads to longer-lasting improvement. Simply having both partners in the treatment room is not enough. Distressed couples seem to need to improve their communication skills and also to explore deeply and understand empathetically the strong feelings that emerge between them.

One 1990s research trend is to compare several types of treatment for the same problem. A 1996 study (Zuurveen & Emmelkamp, 1996) for instance compared individual cognitive therapy with marital therapy for treating depression when there were also marriage difficulties. Both treatments clearly alleviated the depressive complaints. Both treatments had a generally positive impact on the marriage, but the effect on the relationship was significantly stronger in couples receiving the marital treatment.

Beach and O'Leary (1992) obtained similar findings when they compared individual cognitive therapy with marital therapy for depressed patients with marital discord. In their study marriage treatment was more likely to improve the level of marital satisfaction along with lifting the depression. In a similar study with alcoholics, Bowers and Al-Redha (1990) found that the outcomes of the two treatment methods did not differ significantly in the initial posttreatment assessments. However, the couple therapy seemed to facilitate greater maintenance of improvement. Conjoint treatment resulted in higher relationship satisfaction 6 months posttreatment, and significantly less alcohol consumption 1 year posttreatment.

In a 1993 study, O'Leary and Rathus investigated clients' perceptions of what was most helpful in cognitive and marital therapy for depression. Individual treatment gave clients enhanced sense of control over their thoughts and feelings. Marriage therapy resulted in improved communication and the relief and goodwill that came from a sense that both partners were putting in effort toward improving the marriage. Clearly, both are vital.

CASE ILLUSTRATION: TWO BICYCLES

Ben: I feel like we're on a two-seater bicycle and I'm doing all the peddling for both of us.

Julie: I feel like I'm peddling hard but Ben's looking down a different road and doesn't see my attempts to please him.

Ben called for therapy on the recommendation of his physician who was concerned about Ben's increasing demoralization. In keeping with conflict resolution principles, I suggested he bring his wife to the initial assessment.

Intake Session

Ben and Julie's assessment began in the waiting room prior to their first session. Their registration packet included a symptom checklist that enumerated both individual and couple distress symptoms. A checklist is a very efficient way of gaining initial information about the symptoms, emotional states, and kinds of marital problems that treatment will need to remediate.

Once Ben and Julie had joined me in my office, I suggested that they discuss with each other why they had come to treatment. That way I could simultaneously gather standard intake information and assess their interactions. Julie and Ben kept avoiding interaction with each other by turning to talk with me. Their extreme tension with each other may have been a first hint that we would soon hit treatment blockages for which supplementing couple treatment with individual sessions would be very helpful.

As I gathered diagnostic information about Ben and Julie, I sorted the data into three categories: symptoms, process (of communication and conflict resolution), and content (of conflicts). I wrote each kind of data into the appropriate box on my preprinted intake form, organizing the information from the outset into the three-part conflict resolution treatment framework.

Symptoms

Ben and Julie presented with long-standing hostilities, periodic eruptions of intense rage, and entrenched despair. Their marriage of 15 years had been teetering on the brink of divorce for the past 4 or 5 years. Julie, a high-functioning participant in the business world, was a tall and attractive 44-year-old woman, heavier recently than her normal weight, who felt small, powerless, resentful, and often incapacitated by depression in her home. Ben, an exceptionally successful lawyer, age 49 and, like his wife, tall and attractive, was fed up with his unpleasant household situation, yet was strikingly unable to see his role in his wife's distress. At one point they described themselves as Couch Potato meets Superman, a reference to the reality that Julie had withdrawn increasingly from household participation, and Ben, with mixed emotions, had taken over much of the cooking, cleaning, and childcare. In systems parlance, their marriage had devolved into an underfunctioning/overfunctioning spousal partnership.

History of symptoms. Ben and Julie's marital problems had begun around the time of the birth of their third child, and had intensified as a series of stresses had overwhelmed the family during the last 4–5 years. The second and third children were only a year apart; Julie's father died, Julie

experienced a severe depression, and she quit her job. Ben then began to panic about their finances. Fearing that too much weight was on his shoulders he insisted that his wife return to work and enroll in additional schooling. Julie later was glad she had developed solid professional skills, but at the time felt coerced into commitments she felt unready to handle. Ben also set his wife on a slim budget, which Julie resented as giving her no control over decisions.

Meanwhile Ben felt excluded from Julie's life planning. He felt she wouldn't show him her game plan—not understanding that in fact Julie did not know what she wanted from life other than that she did not like having decisions made for her. Ben was unaware of the extent to which his accusations of withholding information were projections of his own tendency toward secretiveness.

Conflicts

I asked Ben and Julie to generate a laundry list of their conflicts, again having them talk with each other, taking turns listing topics that generate tensions in their household. I asked for titles only, not explanations. I explained that I would serve as secretary, taking notes, because their list would serve as part of our structure for organizing the therapy. When Ben and Julie had settled all the conflicts on their laundry list, and any others that had emerged in the meanwhile, they would probably be ready to graduate.

Conflict Resolution Processes

Ben and Julie's discomfort with talking with each other was understandable. They both lacked the basic talking, listening, and dialogue skills essential for smooth information flow. In addition, even before hitting the rapids with their closely packed series of life stresses, Ben and Julie's equilibrium as a couple had relied on precarious conflict resolution patterns. Julie had devoted her energies to what she thought would please Ben—in conflict-resolution terminology, a pattern of excessive altruism. Ben had approached marriage from an egocentric stance—that is, he responded to situations primarily from the perspective of how they impacted him rather than with skills of bilateral (two-sided) listening. When he didn't appear to be getting what he wanted, he either gave up and felt depressed, or resorted to coercive anger tactics.

When Ben had decided Julie should return to work, Ben had angrily insisted and Julie had given up on what she knew she needed for herself

in order to end the fighting. This dominant–submissive pattern of decision-making, especially on an issue of such major import and cost to one spouse, had precipitated the couple's downward emotional spiral of depressive and angry interactions.

Other First Session Objectives

The importance of assessing the couple together, not just assessing Ben and Julie as individuals, was dramatic in this case. Had I never seen these individuals interacting, and instead had only spoken with each of them individually, I would have operated on very partial data. When they met with me alone, both of them appeared healthy and delightful. Ben's denial of any problems with anger and lack of unawareness that his behavior was controlling would have left me diagnosing with confidence that his impossibly depressed wife was his only problem. Julie was an equally convincing victim. I could easily have concluded that she would be completely fine except for having married such a controlling and, as she kept saying, "mean," man. Watching Ben and Julie interact, by contrast, immediately clarified that both were strong players in their unfortunate drama.

Prior Therapy. Julie had been in individual therapy for many years. The treatment focused on her depression, on the difficulties she had experienced growing up, and on her current marital frustrations. She described this therapy positively, saying she found it "supportive."

The couple had also attempted marriage therapy. Although they had liked the therapist, they had terminated this treatment because the sessions did not seem to be resulting in any visible changes and had not instilled any optimism for their future. The therapist had not articulated a plan of how what they were doing in the sessions would lead to relationship improvement, nor enabled the couple to experience progress in the sessions. Instead, their treatment sessions, in which the spouses each expressed what distressed them in the relationship, exacerbated both spouses' anger, defensiveness, and resentment, amplifying the negativity in their household.

From a conflict resolution perspective, the earlier marriage therapist seemed to have attempted to launch conflict resolution. Allowing Ben and Julie, however, to express *don't likes* rather than *would likes*, that is, complaints rather than requests, inadvertently invited failure. In addition, by uncovering conflicts without then guiding the couple to resolution, the therapy inadvertently increased their despair. Therapists who lack expertise in communication and conflict resolution can easily make these errors.

Renewing Hope. I usually try to schedule couple intake sessions for 1.5 h rather than the 45 min of a single session because there is so much to

accomplish. I assess the presenting problems, conflicts, and content patterns; find out about prior treatment; establish goals of treatment; and restore hope. Renewed hope tends to bring about at least a temporary truce in a couple's hostilities and a commitment to the treatment plan. A massing of hope-renewing strategies eventually succeeded with Ben and Julie.

My first conflict resolution strategy for rebuilding Ben and Julie's optimism was to explain that their problems had come from inadequacies in their communication and conflict resolution skills. Skills can be learned. Ben and Julie both felt less blamed when their problems were attributed to insufficient training for marriage partnership. Neither was a bad person; they just lacked marriage prerequisites. When difficulties are attributed to extrinsic and changeable sources rather than sources that are intrinsic to the individuals or fixed, they engender more optimism (Seligman, 1998).

Second, I used the systems therapy strategy of framing problems in historical perspective to reduce guilt and blame. The arrival of the third child, then the challenge of raising two boys so close in age, followed by Julie's father's death, had precipitated Julie's depression and slipped the family onto overload.

Third, I explained the relationship between conflict resolution patterns and depression. Depression can be seen as a disorder of power, and as a byproduct of dominant–submissive conflict-resolution. Julie had begun to feel powerless when she felt overwhelmed by the demands of caring for the two young boys, especially given the reduction in her energy during her grieving for her father's death. Meanwhile Ben was surprised to learn that coercing Julie into returning to work had actually worsened the depression he was trying to help her to overcome.

With these understandings of how their problems had come about we discussed how therapy might rectify them. Ben and Julie signed on for treatment. No doubt they each continued to believe that the other was the source of their problems, and that maybe this new therapist would finally fix their spouse. In any case, by the conclusion of their first session Ben and Julie did look happier, and had agreed to a treatment plan.

Treatment Plan. Ben and Julie's treatment goals targeted the following objectives, which I have arranged in the three-part conflict resolution diagnostic format.

1. *Alleviation of the presenting symptoms.* Individuals: Anger and depression (both spouses), plus anxiety and weight gain for Julie. Couple: an adversarial relationship with chronic tension, frequent fighting, emotional distancing, and a lack of positive friendship or intimacy interactions.

2. *Resolution of the specific marital conflicts.* The initial laundry list included the following: the appearance of their home, who would drive their daughters to Girl Scouts, decision-making about finances (solo or partnership) and about long-term career planning, Julie feeling "set aside" rather than included in the family, and John wanting affection. An underlying chronic issue was commitment, that is, whether or not they would stay married.
3. *Communication skill-building.* Basic talking and listening, with a particular focus on anger management, shared decision-making, conflict resolution, apology and other emotional healing strategies, and redevelopment of positive emotional sharing.

Treatment Overview

Ben and Julie's treatment initially involved weekly sessions. We took 2-month breaks in the summers, and toward the end tapered off with the last 6 sessions spanning 9 months. Of 63 total sessions, 45 were couple sessions, 7 were individual sessions for Ben, and 11 were individual sessions for Julie. The individual sessions had been scheduled symmetrically until toward the end of treatment. In the last several months, Julie utilized an additional four sessions to make progress on her individual issues when Ben's work demands were making his attendance at sessions difficult.

Individual treatment occurred in three formats. Within a couple session I sometimes worked in depth with one spouse while the other watched. Later I would work symmetrically with the other. This option benefits both spouses simultaneously; while one is gaining insight, the other gains empathy.

A second option for individual interventions was to meet for brief (5–15 min) individual time within a conjoint session, with Ben and Julie taking turns stepping out to the waiting room. This option proved especially useful when tempers were flaring. Separations calmed the situation. Talking individually with me then gave the angry person a chance to discuss privately the concerns that had fueled the flare-up. Separations in these hot moments also served another vital objective. They provided excellent opportunities for practicing the routines all couples need for mutually disengaging when they are becoming too irritated to talk together productively.

Third, in more extreme circumstances I scheduled individual treatment sessions, bearing in mind the following principles: (1) Either spouse could request an individual session. (2) I might sometimes initiate them. (3) When we scheduled a session for one spouse we would generally schedule a session for the other, aiming for symmetry. (4) Because Ben and Julie could afford only one session per week, scheduling individual sessions would create a 3-week interval between their couple sessions, a distinct disadvantage.

Treatment Structure. Treatment after the initial assessment was organized with what I call the *laundry list strategy*. Each session began with my asking Ben and Julie what each of them wanted to put on the session's agenda. In general, the result would be one or possibly two conflicts to resolve, often from the original laundry list and sometimes from additional issues that had arisen over the week. The conflict resolution process included exploration of family-of-origin sensitivities and transferences that had been evoked in the conflict. In addition to resolving a specific issue, I generally would introduce more or less one new skill each session. We continuously practiced previously introduced skills as we discussed and resolved each specific conflict. Treatment would be ready to end when the list of conflicts all had been aired and settled, and Ben and Julie had the skills to discuss together without a therapist's help other differences that might arise.

Alleviation of Symptoms

In the early phases of treatment, and later as needed, symptom reduction was a primary focus. When symptoms interfere with personal functioning, with ability to utilize treatment, or with both of these, they need to be alleviated before the laundry list and skill-building aspects of treatment.

To eliminate Ben and Julie's presenting problems of anger and depression, I used a broad range of interventions including medications, visualizations, and psychoeducation. We worked mainly in the couple treatment format, but also scheduled several individual sessions for each spouse.

Medications. To participate in therapeutic dialogue, people have to operate from a reasonably normal emotional zone. Antidepressants eased Julie's depression and also dampened her quickness to anger. I felt that Ben also would benefit from medication, but he was highly resistant to the suggestion.

Accomplishing this intervention consequently required the scheduling of individual treatment sessions—one for Ben and, to sustain symmetry, one for Julie. Ben was totally opposed to taking medication. Especially for clients with narcissistic and/or paranoid tendencies in which shame and power are ever-present concerns, changing one's mind in favor of a therapist's suggestion can feel like loss of face. Eliminating the audience of the spouse decreased this potential shame factor for Ben.

In the privacy of an individual session Ben was able to let down his defensiveness enough to engage with me in a process of conflict resolution. I listened to his concerns—he did not want the shame of being labeled emotionally disturbed; and he was against "taking drugs." He then listened to my concerns—that his anger, blaming, and depression were consolidating into

a paranoid stance with fixed beliefs and refusal to consider nonconfirmatory data. With stalled informational processing—like a computer hard drive that has frozen—making headway in treatment was next to impossible. We both agreed that he was feeling increasingly desperate and unhappy. Our conclusion: Ben agreed to try antidepressant medication for a brief trial period. Fortunately, within days of starting the medication, Ben's depression, anger, and paranoid cognitive processing had diminished noticeably, and treatment again began to move forward.

Individual Treatment Interventions

Alleviating Julie's depressive collapses and Ben's pervasive anger proved difficult. Why did individual sessions seem to help? When couple treatment stalls, individual sessions offer an alternative; this explanation rests on the theory that anything different is better than more of the same. Another explanation may be divide and conquer. That is, when symptoms loom large or seem fixed, they necessitate techniques that take more time than can be devoted in a couple session, need the simplicity of a unitary focus on one individual, and need the extra nourishment of a one-on-one therapy relationship.

Yet another dynamic seems to be that individuals who are sensitive to shame can focus on their part of problems with less defensiveness if an audience (the spouse) is not present; Ben's session about medications fit this pattern. Also, enmeshed couples like Ben and Julie are too magnetic, attracting each others' criticism and blame with such force that their attempts to focus within themselves for insight prove difficult. Lastly, when each spouse's symptoms were triggering the other's, their vicious cycles calmed more easily when the participants were physically separated. In any case, scheduling occasional individual treatment sessions with Ben and Julie did seem to help significantly with relieving their depression and anger.

The term vicious cycles definitely pertained in this case. Ben's anger fueled Julie's depression. Julie's depressed immobilization and withdrawal from participation in the work of the household in turn triggered Ben's thought that he had to handle everything himself. This thought touched off deep long-standing resentments about having to carry more than his share. Ben then became angry, incurring more depression in Julie. The cycle can also be described starting with Julie's depressive collapse, which felt to Ben that his wife was withdrawing affection from him, further fueling his hurt and anger. Receiving this anger, Julie then felt even less desire to be affectionate. As she said repeatedly, "Who wants to be affectionate to someone who hurts you?"

Fortunately, separating the two spouses physically for several individual therapy sessions did enable each spouse to take personal responsibility for their behavior and develop more effective options. In these individual sessions I used multiple interventions, several of which I will describe. First however I want to discuss a treatment error.

A Treatment Error. Asking about prior and current therapies in the initial intake session, I heard how supportive Julie was finding her individual therapist. With appreciation for Julie's dependent relationship plus some nervousness about not wanting to take a case away from another therapist, I consented to relax my usual policy of asking clients while they work with me to take a break from any other therapy relationships. For a long time we made very little headway in alleviating Julie's depression or in gaining behavior changes in her interactions with Ben. Only when Ben one day angrily complained that all this therapy was costing too much did I remember that Julie was enrolled in dual therapy courses. She agreed to take a break from working with the other therapist at that point on the condition that I be available to whatever extent she or I felt she needed individual sessions. Without the counterweight of a therapist allied with Julie against her husband, Julie began to utilize the sessions with me, conjoint and individual, in a more genuine change process.

Julie: Conflict Resolution Visualization for Depression. In an individual session with me shortly after Julie had ended her therapy relationship with the additional therapist, we utilized a conflict resolution visualization[4] for alleviating her depressive collapse (loss of personal power). I suggested that Julie close her eyes and picture a moment when she felt angry. She saw herself mad at Ben.

> *Therapist*: Who looks bigger in that scene, you or Ben?
>
> *Julie*: Ben, though not as much as he used to be. He used to rage about something every night. Now it's just several times a week, and seething instead of acting out.
>
> *Therapist*: Allow yourself to suddenly shoot up tall, like Alice in Wonderland. From this bigger size what can you see about Ben that you couldn't see when you felt smaller than him?
>
> *Julie*: He's like a vulnerable little kid . . . I feel compassion. I need to give him a lot of understanding, approach him more and reach out to him. When I'm small, I can't invite him in to play. When I'm big, I can.

A conflict resolution visualization first identifies an incident in which a conflict induced a depressive collapse, that is, a change from normal to depressive functioning. The incident will come to mind in response to some version of the following questions: "Allow an incident to come to mind when

[4] A protocol for the conflict resolution visualization for treating depression can be downloaded from the internet at *www.therapyhelp.com.* Click on depression on the home page and scroll down to the bottom of the information.

you have been irritated. Who (or what) do you see? What are they doing? What are you doing?"

To check that the incident has in fact triggered depression, I ask for comparative sizes. If a client is depressed they will see themselves as smaller, corresponding with their feeling of power loss. Visualizing themselves as larger returns a sense of personal power. From this more empowered stance, clients can look freshly at the problem situation, seeing it in a new way. With this additional data they then can find new options for handling the conflict in a more win–win way.

Ben: Psychoeducational Anger Treatment. In Ben's individual sessions psychoeducational and cognitive–behavioral interventions proved effective antidotes to Ben's angry controlling behavior. Ben first had to admit that his anger was an ineffective and costly method of getting what he wanted. The privacy of the individual session helped to accomplish this essential step. In fact, however, homework reading of the chapter on anger in my book *The Power of Two* seemed more effective than my verbal explanations in his sessions. Homework reading is a particularly private form of individual therapeutic work. Reading at home alone Ben did not have even a therapist to save face in front of. With his defenses furthered lowered by this private setting, he seemed to be more able to absorb new information.

We also addressed Ben's controlling behavior. In conflict resolution thinking, any behavior is a solution. Working backwards through the steps of conflict resolution, I asked Ben to close his eyes and picture the underlying concerns to which telling Julie what to do was a solution. Ben realized that his controlling behavior was intended to bring Ben signs that Julie cared about him. In fact, these attempts to get Julie to do what he thought would make him feel cared for typically backfired. For instance, "I want you to make chili," he told his wife. Trying to please her husband, Julie did make a big pot of chili for the family. When the meal was served, though, Ben experienced more disappointment. "I'm still not getting my needs met," was his thought when the chili came to the table without cornbread. He expressed anger at Julie, incurring resentment instead of the affection he longed for. What would be a better solution? Controlling his wife and becoming angry when she had not fully done what he had expected clearly was not succeeding. Ben realized that instead he could refocus on himself, become a more likable husband, and open himself to receiving the messages of caring that Julie in her own way did in fact try to give.

Ben's learning proceeded in fits and starts, with repeated episodes of progress and then back-sliding. Anger problems are like drug addiction. The temptation is strong, when situations become frustrating, to resort back to the easier solution of abandoning self-restraint and exploding. Ben's overall pattern, however, was of definite improvement with angry episodes

decreasing in frequency and intensity over time. The notion that people with anger problems simply repeat an abuse–regret cycle again and again has to be distinguished from the realistic difficulties of building consistency with newly learned behavior patterns. In Ben's case, when back-sliding occurred, scheduling an individual session as a quick refresher course was a helpful option.

Couple Treatment Interventions

Couple treatment proved a good format for gradually changing Julie and Ben's dominant–submissive conflict pattern to collaborative shared problem-solving, and for choreographing exit–reentry routines to prevent angry explosions.

Changing the Dominant–Submissive Patterns to Collaboration. For mature problem-solving dialogue, Julie would need to be able to verbalize her concerns and preferences. I noted at the outset of one session that Julie had said nothing when I had begun the session with my standard question, "What would you like to focus on today?" Julie acknowledged, "I have a lot of things to talk about but unless it's acute at the moment it's difficult for me to focus on my one thing." She thought a bit, and then continued, "I need to live *my* life, to please my*self*, not just keep trying to meet Ben's needs. I feel like I'm not in his equation, not a partner in his decision-making. But I do the same. I put myself dead last . . . My needs come last, the same as when I was growing up and my voice never counted in my family. I want to switch from 'dead last' and 'only others count,' to 'I count and you count.' " With this resolve, Julie began trying to speak up for herself.

Ben, instead of dominating, needed to learn to hear, digest, and utilize his wife's input. The idea that Julie's opinion and concerns could count without his therefore being eliminated helped. As long as he had assumed either/or thinking, listening to Julie meant that his own opinion would be lost. Psychoeducational insight into his concerns rather than psychodynamic historical exploration again proved most helpful in Ben's growth.

At times Ben and Julie's roles in the dominant–submissive interactions would switch. Julie therefore also had to learn that "throwing a fit" was not acceptable, and Ben needed to learn to remove himself at these times rather than take a submissive posture.

The couple treatment format was essential for treating these interactions. Because Ben had minimal insight and much denial regarding his anger, being able to analyze angry interactions as they occurred in sessions was invaluable. Similarly, Julie needed the joint sessions to practice again and again moving from "dead last" to voicing her perspectives.

For instance, in a later session Julie poignantly reiterated her core depressive cognition "I don't know what to do to please him!" She then realized again that, paradoxically, what she could do was to stop trying to please Ben. She needed to "ride her own bicycle," beginning with reading her own inner compass. Conjoint sessions gave Julie weekly opportunities to practice using her voice in a setting that was safe; the therapist made sure that Ben took her perspectives into account.

Anger Control With Exit–Reentry Routines. We also used the format of couple sessions to establish shared guidelines for anger management. Ben and Julie like the idea of regarding anger as a stop sign. Anger, like a stop sign, warns a person where there is a problem. However, dealing with problems by picking up the stop sign and battering people with it is not an effective tactic.

Ben or Julie then designed exit–reentry routines. They agreed that when either of them began to feel irritated, they would at least pause, and if need be they would exit from the provocative situation. Each of them would be responsible for calming themselves, and for thinking about better nonangry ways to handle the problem. Pursuing a discussion once irritability was rising would only result in more polarization, higher tempers, and hurt. As to reentry, they would reconnect first by testing the waters with pleasantries about a neutral topic. Once they were both clearly calmer again, Ben and Julie could and would resume genuine problem-solving dialogue.

Anger routines must be choreographed mutually. This is another task that requires a couple treatment format. If partners have not jointly agreed that they will mutually disengage, one might feel that the other is abandoning them, or might insist on pursuing the dialogue. Anger, like sexual energy, can feel like it must run to full release. Both partners therefore need to agree on the new guidelines.

In sum, couple sessions provided a format for live interactions that we could analyze together, an opportunity to design together new mutual anger guidelines, and many chances for both partners to practice new patterns together. Without these couple format sessions, progress in alleviating the individual psychopathology—Ben's anger and Julie's depression—would have been vastly more difficult. Julie's individual therapist of 12 years was probably fighting a hopeless battle trying to make changes with one partner alone. At the same time, the privacy of occasional individual sessions was invaluable at times of impasse. With a predominantly couple treatment format enhanced by occasional individual work, Ben and Julie gradually were able to emerge out of their anger and depressions into healthier emotional states.

Guiding Resolution of Conflicts

Resolving conflicts almost always requires the presence of the conflicting parties, so in most of the conflict resolution sessions, which constituted most of the treatment, a couple format was essential.

Julie and Ben, like most couples, fought again and again over the several conflicts on their original laundry list. In addition, new conflicts emerged each week. Both the repeated conflicts and the new additions were important to resolve so that Ben and Julie could end treatment with their issues all laundered.

Table I lists several of these conflicts, and illustrates the three steps in their resolution. I refer to these three steps as the *win–win waltz*. User-friendly terms like *win–win waltz* make the process seem less intimidating, establish a more relaxed emotional tone, and thereby foster creative problem-solving. The win–win waltz involves the following:

(1) Expression of *initial positions*
(2) Exploration of *underlying concerns*
(3) Creation of a *mutually satisfying plan of action* with a solution set responsive to all of the concerns of both spouses

The conflict topic and initial positions generally could be clarified in a phrase or two when Ben and Julie were suggesting their agendas at the outset of the session. The second conflict resolution step takes the bulk of the time and the emotional energy. Gathering detailed and specific information about concerns inherently stimulates new ideas for solutions. Equally important in the time and energy this aspect of conflict resolution requires, however, is the reality that emotionally loaded concerns typically have originated in subconscious family-of-origin experiences. They consequently often need to be uncovered with Gestalt and other psychodynamic exploration techniques. I rely particularly on a Gestalt-type technique I call a depth dive.[5]

Core concerns. Conflict-resolution terminology refers to recurring concerns that stem from deeper sources as *core concerns* (in Table I, these are labeled CC). That term combines the conflict language of *concerns* with Luborsky's definition of transference as core conflictual issues.[6]

Julie's core concerns centered on four main themes: (1) What I want doesn't count, (2) I have to throw a fit to get what I want, (3) I want to be liked and included, and (4) I'm always criticized. These concerns

[5] A protocol for the depth dive can be downloaded from the internet at *www.therapyhelp.com.* Click *Resources* on the menu bar.
[6] Luborsky (1984), core conflictual issues.

Table I. Three Steps in Guiding Conflicts to Resolution

Topic	Step I Express initial positions	Step II Explore underlying concerns	Step III Find win–win solutions, or a solution set responsive to all the concerns
Finances	B: Keep incomes separate. J: Share them	B: She's not open with me on her career plans; can I trust her? CC: Will I be abandoned? J: B controls what he earns, and earns more than I do. He excludes me like I'm not part of the family. CC: Am I included? Is my voice heard? Is he keeping his money so he can leave?	Sit together and lay out the facts of who is earning how much and spending for what. Agree on a more mutual plan. Agree which expenditures will be individual decisions and which joint. Discuss their long-term career goals. Intrapsychic conflict resolution (in an individual session) for Ben regarding his marriage stance of "one foot on the dock and one foot on the boat."
House-keeping	Who should do what, when, and how?	B: I want a neater house that looks good when guests come. CC: Everything is up to me to do. You don't do your share. J: Don't tell me I didn't clean right. I resent when you emptied the refrigerator and told me to clean it. CC: I always receive criticism. I hate being told what to do like I'm a child.	Refrigerator cleaning could be a weekly family activity with everyone participating. For other chores, each spouse would choose specific assignments, express their preferences about how the others' task would be done, and then focus on their work, not the other's.
Affection	We need more.	B: I feel unappreciated. Does my wife care about me? CC: I want love and caring. J: I feel left out, like when B said he was going to MacDonald's, then took the kids to a nice restaurant. CC: I'm an outsider in my family. How can I be loving to someone who is mean to me?	Both needed to express more positives—to smile, to listen with appreciation to each other, and to include each other in conversations and activities. B: Needed to explore his projection. Did he think his wife was rejecting him because he was rejecting her? J. Needed to explore why she continued to withhold even minimal affection like smiles and compliments.

replicated concerns from growing up with an authoritarian, narcissistic, angry, and probably depressed father who was locked in a negative stance toward his daughter.

Ben's core concerns mainly centered on frustrations he had experienced with his stepmother, who had not bonded positively with him. Ben had felt on the one hand neglected by her and at the same time had experienced her as interfering in his life. The resulting core concerns (transference beliefs) included (1) She doesn't really care about me, (2) She doesn't do what she should to take care of me, (3) She's always critical, and (4) Can I do what I want? At a still deeper level Ben sustained a fear of abandonment from the early death of his mother. He was at risk for acting out with his wife a repetition of the breech in attachment he had suffered at age 6 abandoning his wife as he had been abandoned. Bringing these subconscious concerns to conscious awareness enabled Julie and Ben to understand their intense emotional reactions more fully and more sympathetically. They also began to understand how they were inadvertently recreating the dynamics of their respective families with each other, a phenomenon that Wachtel (1994) describes as cyclic psychodynamics.

Clarifying core concerns does not in itself complete conflict resolution. Each issue that Ben and Julie explored then needed a remedial plan of action, a win–win re-solution. At the same time, solutions need not be permanent. Ben and Julie would always be able to revisit any issue to improve their solutions.

Sustaining Healthy Information Flow During Conflict Mediations

When the goal of an intervention is resolution of a specific conflict, the therapist has to keep the primary focus on content, not process. At the same time, the process has to stay healthy. I used a number of behavioral shaping techniques to keep the dialogue safe and constructive, at the same time trying to keep my interventions unobtrusive. The result was gradual cumulative learning of skills in addition to resolution of each conflict.

Prompting. Toward the dual goals of keeping the dialogue constructive and reinforcing new skills, I frequently prompted Julie and Ben before they would start talking. For instance, to prevent Ben, who looked distressed, from launching with "You shouldn't have . . . !!" I prompted him quietly:

> *Therapist*, to Ben: I would really appreciate . . . .
>
> *Ben*, picking up the cue: I would really appreciate Julie if you would ask me before you turn one of my t-shirts into a dust-rag.
>
> *Therapist*, turning quickly to Julie to prevent a *Yes, but*: What makes sense to you in what Ben just said? Tell Ben, what did you learn?

> *Julie*: I learned you like to make your own decisions about when your clothes are ready to be made into rags. I can understand that. I hate it when you take something of mine without asking.

Julie, and Ben even more strongly, initially resisted these sentence-stem prompts as interruptions. However, as they saw that the prompts really did enable them to talk more effectively together, and that my purpose was to empower rather than criticize them, their trust increased and their resistance diminished. Nonetheless, a difficult part of the therapist's art is to stay on the positive side of the fine line between constructive intervention and frustrating interruption.

Request a Second Draft. Prompting with starter phrases and questions generally seems to feel less intrusive to clients than correcting them after they have slipped off course. Still, post facto corrections in the form of a request for a re-do or second draft are better than allowing bad process. I might say, for instance, "How about saying it again, this time starting with the word *I*. '*I feel*___.' "

Translate. Translating is another post facto option. Translating requires therapist mobility, literally, a chair with wheels. Rolling in to sit aside the offending speaker, the therapist can restate what the speaker just said in a healthier format.

> *Ben*, angrily berating Julie: You shouldn't have been dusting with my t-shirt!
>
> *Therapist*, sliding in next to Ben to talk as Ben: I felt very upset when I saw you dusting the furniture with my t-shirt.

Translations enable the dialogue to move forward and stay constructive with minimum disruption of the flow.

In sum, active therapist guidance keeps information flowing collaboratively so that problems get resolved. Bad process quickly derails collaborative dialogue. When therapists allow bad process to slip by, clients feel unsafe and unprotected. Moreover, a therapist's frequent interventions continually shape better skills as each conflict proceeds to resolution.

Teach About Positional Versus Interest-Based Bargaining. An astute psychologist once said to me that when a person first lifts a car hood, the engine looks like an undifferentiated mass of metal. Similarly, when patients begin to look at their conflicts, conflicts look to them like an equally unitary morass. With practice, Julie and Ben learned to differentiate the components that were positions (specific plans of action) from those that were concerns (fears, desires, preferences, etc).

This two-part sort forms the basis for the transition from what negotiation theorists call *positional bargaining* to *interest-based bargaining*. The term *interests* is not very useful in psychological explorations; it sounds both too rational and too selfish. I use instead the term *concerns*. Whatever the

terminology, however, this transition from a tug-of-war over proposed plans of action to cooperative exploration of underlying concerns is critical. When insistence about positions is replaced by attempts to understand each others' underlying concerns, conflicts are transformed into collaborative problem-solving.

Differentiate Types of Conflicts. Teaching couples to sort provocative situations into subcategories of conflict gives them added power to resist distress.

- Conflicts requiring *fix-it talk* usually arise out of changed circumstances that necessitate adjustments in a couple's daily routines. As their work schedules changed, for instance, Ben and Julie needed to redetermine who would drive the children to Scout meetings.
- Conflicts that arise over planning for future actions need *shared decision-making.* Ben had an opportunity to take a 3-month travel Sabbatical. Ben and Julie needed to decide together who in the family would go, where, and for how long.
- Conflicts often require *cleaning up after an upset.* Otherwise emotional mishaps lead to secondary wounding from blame and revenge. For instance, Julie, relying on retribution to recover from a comment that Ben had made that had hurt her feelings, dusted the furniture in their bedroom with Ben's t-shirt, infuriating him. By contrast, healthy emotional clean-up strategies build a shared nonblaming understanding of what happened, use constructive apology, and lead to learning that prevents similar mishaps in the future. These strategies alleviate tensions and heal wounds.
- Discussions often polarize and escalate emotionally because of *poor process.* In these cases, disagreement over the issues is not the problem, although the fighting may sound that way. Instead, conflict has erupted because communication skill errors have hurt feelings and violated concerns such as wanting to be treated respectfully or to have one's opinions count.

After sessions dealing with each type of conflict, I assign homework reading of the relevant chapter in *The Power of Two* (Heitler, 1997). The reading expands clients' understanding of each conflict paradigm. Equally important, couples who learn to refer to a book when conflicts emerge have a resource they can turn to after their treatment has terminated. When they no longer have a therapist mediator, the step-by-step outlines in the book can help them keep on track.

Individual Sessions

Although resolution of most of Ben and Julie's conflicts required the presence of both partners, two situations precipitated requests for individual sessions. When Julie and Ben agreed that they both needed to begin to act more respectfully and appreciatively toward each other, Julie found herself unable to implement the agreement. We arranged an individual session to explore the deeper roots of this resistance/negative reversal.

Second, Ben eventually realized that the couple's attempts to resolve together the question of whether or not to stay married were misplaced. The conflict involved his intrapsychic ambivalence more than couple disagreement. He described himself as standing "one foot on the dock and one on the boat." We scheduled an individual session to explore his concerns on both sides of this dilemma so that he could resolve his ambivalence and commit to a clear plan of action.

Coaching Conflict Resolution Skills

The third element in the tripartite braid of conflict resolution treatment is skill-coaching. Like resolving conflicts, coaching new dialogue skills works well in a couple therapy format. Both spouses need to learn the same new patterns. Both need to experience and learn to recognize when they are relating as enemies and when they are talking as partners.

For the most part I introduced new skills one by one, starting with whatever skill deficit had interfered with Ben and Julie's ability to talk cooperatively that session.

Coaching With Skill-Drill Exercises

I began the coaching segments of sessions by briefly pausing the dialogue to explain a skill that would be helpful at that moment. After the explanation, I either helped them start using the skill right away, or I designed a quick exercise for practicing the skill before resuming their discussion.

Exercises are short drills that repeat a simple pattern, first on a totally nonthreatening topic, and then talking about a real issue. To teach the skill I call *braided dialogue*, that is, dialogue in which each speaker comments on the prior speaker's comments before offering additional information, I give the following instructions.

Therapist: One of you will say a simple sentence. The other then responds with a **Yes** ___ ***and*** _____ format.

I usually give an example. I accentuate the word *and.*

> *Julie*: This room is warm.
>
> *Ben*: **Yes**, this room is warm, **and** I'm wearing a heavy sweater so I thought it was just me.
>
> *Julie*: **Yes**, that is a heavy sweater, **and** I would love if Dr. Heitler would turn down the heat.
>
> *Ben*: **Yes**, turning down the heat would be helpful for me too. **And** I would be delighted if she turned down the heat by not giving me such a hard time about how I don't listen (chuckles all around).

Repetitions

Repetitions enhance learning, a basic principle that therapists know but probably do not utilize frequently enough. At the end of each session, if I have managed our time well, in addition to summarizing our progress resolving the conflict we have focused on, we review the new skill. I assign related reading. Lastly, I give the couple an audiotape of their session.

I routinely audiotape sessions (both spouses sign an agreement the first session), but find that sessions that have involved learning new skills are the ones that clients find most helpful to listen to at home. Clients who do their homework reading and listen to their tapes at home make noticeably faster progress building new skills.

Eliminating Crossovers

One of the skills Ben and Julie needed at the outset in order to make any headway in treatment involved monitoring themselves rather than each other. I use the term *crossovers* for statements that cross the boundaries between self and other. *Crossovers* include you-statements, mind reading, attributing feelings to the other, and telling the other what they should or shouldn't do. As long as spouses are focused on each other they are not likely to be able to learn much in sessions for their own growth.

Ben and Julie's dialogue was replete with crossovers: "You probably think that I..." "You want to show me that..." "I can see you're mad..." "You shouldn't have..." or "Make sure that you..." They needed to eliminate all these instances of interpreting each other's thoughts and feelings, speaking for the other, and telling each other what to do. They needed to replace their crossovers with verbalizing their own concerns and feelings, or asking about the other's.

To help Ben and Julie understand the crossovers concept and the impact of their frequent comments telling each other what to do, I offered Ben and Julie another bicycle metaphor. I suggested that they close their eyes and picture themselves biking together, side by side. They see a problem in the path ahead. What happens if they reach over to pull the other person's bike out of the way? Most likely, this behavioral equivalent of a crossover will cause them both to lose their balance and fall. By contrast, what if one said quickly, "Big rock ahead!" and then each took responsibility for handling their own bike?

Skill coaching may begin by showing clients what not to do, but then needs to offer new guidelines of what *to* do. To counteract crossovers I teach the rule "Talk about yourself, or ask about the other." We then practice I-statements such as "I'd love to..." or "I have an anxious feeling when I..." or "My concern about going is that..." As to asking about the other, I teach the difference between open-ended and yes–no questions for obtaining information about the other person's concerns. Yes–no questions start with wording like "Do you..." or "Are you...?" Open-ended questions by contrast start with *How* or *What*. For instance, "How do you feel about going...?" or "What's your reaction to the idea of..."

The concept, if not the terminology, of crossovers is an elementary one for most therapists. I described the coaching techniques I used with this skill deficit in considerable detail, however, because crossovers were such a profound source of provocation in Ben and Julie's relationship. Crossovers offend the receiver, much as a trespasser crossing uninvited on private land provokes a defensive response.

Like most deviations from healthy information flow, crossovers are both a cause and an effect of psychopathology. In systems terms, crossovers are a hallmark of enmeshment and poor differentiation; in object relations terminology, they signal lack of separation/individuation. As Ben's anger and depression took on paranoid qualities, his intensified focus on Julie resulted in a rain of criticism, blame, and accusations, which are particularly toxic forms of crossovers. Julie's crossovers, by contrast, came from trying excessively to please Ben. Instead of following her inner compass, she guided her behavior on the basis of what she thought Ben wanted from her.

Whether crossovers are a cause of psychopathology, an effect, or both, they definitely provide handles for change. Much of what we call character pathology can be regarded as poor skills. Improve the skills and the pathology decreases. Although the relationship between skills and character pathology is not always quite so simple as that, the rule did seem to hold true for Julie and Ben. As their skills improved, they began to appear and feel more emotionally healthy.

Treating Resistances With a Conflict Resolution Visualization in an Individual Session

While most communication skills-coaching worked well in couple treatment format, the advice a ballroom dance teacher once gave me proved relevant. Sometimes one partner in a couple had more difficulty than the other learning new steps. She would then schedule individual time to work with that one so that when the couple resumed dancing together, they would be on an even learning par. This principle worked well for Ben and Julie.

For instance, later in the treatment as we began expanding the friendship and affection dimensions of their marriage, Julie realized that she was having a very difficult time even offering smiles to Ben. We scheduled an individual session to explore Julie's resistance.

In the individual session I used a conflict-resolution visualization to look more deeply at Julie's concerns. When Julie said she was holding on to distrust, I asked her to close her eyes and picture her distrust.

Therapist: What do you see when you picture the distrust?

Julie: I see all the crap and baggage. It's like a big refuse dump of garbage that goes on for miles. It has everything in the world that I hold on to there. I'm going to hold onto it in my backyard, but it makes me miserable.

Therapist: If you think of that garbage dump in the best possible light, what are you holding on to it for?

Julie: I'm holding on to it to sabotage the process . . . to punish Ben so he'll know he has some responsibility in this. That it hasn't been just me.

Therapist: What might you do to be sure Ben knows that it hasn't been just you?

Julie: He is acting nicer now. I could let myself see that he isn't getting mad the way he used to, or trying to control me all the time. I could listen when he admits that it doesn't work to try to control me with anger like he used to.

Therapist: And what more might you need to do to be sure you're not making yourself miserable?

Julie: I would need to clean up my backyard. Make it just dirt.

Therapist: And would that be enough to be sure you're not making yourself miserable?

Julie: No. I would have to plant grass. And flowers. Then I would have renewed energy and enthusiasm.

This visualization exemplifies how the conflict resolution paradigm can guide exploration and resolution of an individual's resistance, in this case to showing affection.

- Step One: Julie's opposing initial positions were, on the one hand, her persisting withholding of affection and, on the other hand, her feelings of wanting to change.

- Step Two: We explored her underlying concerns on both sides—wanting to be sure Ben understood his role in her misery, yet also wanting to cease feeling so miserable herself.
- Step Three: To find new solutions we first worked within the metaphor, looking at what Julie could do with her huge refuse dump. I kept asking for more details in the solution until Julie had reached what appeared to be a fully satisfying solution—the refuse gone, dirt in its stead, planted with grass and flowers.

I then had Julie open her eyes to translate the metaphor. What would be the real-life equivalent of planting grass and flowers to renew her energy and joie de vivre? She realized that she would rather exercise or garden than continue to sit at home on her couch ruminating on the ways that Ben had hurt her.

Do Skills Really Need to be Taught?

To some extent Ben and Julie's communication and conflict resolution patterns did improve spontaneously. In each session, their basic hostile stance tended to relax; they then would share several positive days together. To sustain cooperation, however, Ben and Julie needed extensive coaching. Otherwise Ben would revert back to criticizing his wife when he wanted something, and Julie would express her anger in return with passive–aggressive inaction and depression. Similarly, if a decision needed to be made, Julie's difficulties putting her concerns on the table would invite Ben's unilateral decision-making; or, if Julie did speak up, Ben's difficulty hearing her concerns brought a depressive collapse.

Using Psychodynamic Exploration to Enhance Skill-Coaching

Family of origin explorations can help couples to understand the origins of their counterproductive communication patterns. For instance, when they were looking at their patterns of recuperating after upsets, Ben recalled that when his stepmother "got bitchy about something" she would punish him for the next 24 hr. Now, as an adult, when he sensed that his wife Julie was bothered by something he had done Ben would react with instant anger. Anticipating 24-hr punishment he was striking back preemptively as he had been unable to do as a child.

Ben realized also that his anger at Julie sometimes mimicked his stepmother's anger. He recalled that, "if you didn't do a chore she would say 'It's not my job to keep up with you . . .' and then would punish rather than

help or encourage me." Ben could see himself following this example when he had heartlessly emptied the refrigerator and demanded Julie clean it, and when he would keep an eye always on whether Julie was slipping from her chores (which, when she was depressed, was frequent) and then scowl and berate her.

In sum, most of the skill-building aspects of treatment occurred in couple session formats. Occasionally, resistances to change or difficulties learning signaled that an individual exploration of underlying concerns and family of origin issues would be helpful. Often we were able to accomplish these explorations within the couple session by my working briefly with one partner instead of having the spouses talk with each other. This format had the added bonus of enhancing the other partner's empathy for his/her spouse. Like full individual sessions, individual-sessions-within-a-session needed to be symmetrical. If there was insufficient time within that session, I generally focused individually on historical explorations with the second spouse in a subsequent session.

Treatment Outcome

In one session toward the latter part of their treatment Ben and Julie returned to their bicycle metaphor.

> *Julie*: I'm trying to ride my own bicycle. I get up, go to work, take care of the kids, do dinner and the house. I hold up my part in the marriage. But I feel alone, not connected with you.
>
> *Ben*: With each of us riding our own bikes I guess we can have more closeness or can move further away. Trying to focus on *my* bike, and give you yours, has reduced my anger. It has made more distance between us. And it may be able to bring us together. When you used to focus on my bike, I used to slug it out with you. Now I ride away. That's better than before, and not yet where I'd like to be. I'd like to ride beside you, focusing in a positive way—feeling your smile, warmth, kindness, affection.
>
> *Julie*: Partly I want to be close too. And partly if we're close, there may be conflict. Distance still feels safer.

The bicycle metaphor helped Ben and Julie to understand their underlying concerns. They then created a solution that worked for both of them. Ben would accept a job promotion that would require significantly more work hours. He would focus his energies mainly on his new job, and would use most of his brief home time focusing on their children. With this career-oriented plan, Ben would feel fulfilled even if Julie continued to need more aloofness. At the same time, the arrangement gave Julie the distance she felt she needed, including time to focus on her personal goals of weight loss and self-confidence building.

Soon after, the time demands of Ben's new job plus summer vacation travel for all of us forced a somewhat premature but nonetheless successful termination. Ben and Julie had recommitted to staying together. Their anger and depression had abated. They had found solutions to most of their marital conflicts, and along the way had learned to talk together cooperatively instead of arguing. Both spouses understood themselves and their spouse more deeply and with more acceptance. I was concerned, however, because Ben and Julie's skills still seemed fledgling and fragile, and the affection and intimacy dimensions of their relationship were on hold.

I telephoned Ben and Julie approximately 2 years subsequent to treatment to request their permission to write their case in this paper. To my delight, the couple's gains had been holding. There had been no return of serious depression or anger for either spouse, they had not resumed fighting, and there had been steady if always tentative increases in trust, affection, and marriage commitment.

INDIVIDUAL AND COUPLE FORMATS: WHICH WHEN?

As the Two Bicycles case illustrates, conflict resolution treatment with married individuals assumes that couple therapy is the primary treatment format, and then adds individual treatment as necessary.

Conjoint sessions have multiple advantages over individual work. The couple's interaction patterns become evident. The personal growth of each individual can proceed in tandem with growth in the other. With the therapist's help, the spouses can resolve their conflicts together, a project neither could do alone. And they can learn new skills together, working toward a shared vision of collaborative dialogue.

What factors indicated to me when Ben and Julie might nonetheless need to switch to a brief individual intervention? Looking back at Ben and Julie's treatment, I generated the following principles:

Individually focused intervention with one spouse while both were present in the treatment room

- If one spouse showed a strong emotion, a striking metaphorical verbal phrase, or a surprising reaction.
- These and other moments that might call for a depth dive to find the earlier life experience that was the basis for the behavior.

Individual treatment for a few minutes with the spouse in the waiting room

- In the initial assessment process, to see individual strengths and to gather data that either would not share in the presence of the other.

- If one or both spouses were becoming excessively heated.
- When one spouse regressed briefly into a hostile or nonlistening stance.

Individual treatment sessions

- *Symptom reduction*, to reduce anger and depression.
- *Shame.* Shame blocked Julie from being able to discuss her weight in front of Ben, and prevented Ben from discussing his rages in front of Julie.
- *A fixed blaming stance*, with difficulty owning a role in problems.
- *An intrapsychic conflict.* To resolve Ben's commitment ambivalence—"one foot on the dock and one on the boat" the individual format was helpful.
- *Resistance* to treatment recommendations, such as when Ben refused medication.
- *Rupture in the therapeutic relationship*, such as when Ben was insulted when I used the word paranoid to describe his mental state.
- *Secrets.* If I sensed information being withheld, I scheduled individual time.
- *Requests.* If either spouse requested time alone, I immediately scheduled it.
- *Stalled treatment.* When one format did not seem to be producing forward movement in symptom reduction, conflict resolution, or skill-building, a switch to the other was helpful.

For the first 6 weeks after treatment began, the honeymoon of goodwill about working together plus specific symptom reduction strategies in the conjoint sessions seemed to alleviate much of Ben and Julie's anger and depression. Sporadic back-sliding after that period resulted in a series of four individual sessions for each spouse, scheduled approximately one session per spouse per month. These sessions all addressed symptom reduction—Julie's depressive episodes, and Ben's chronically angry stance toward his wife.

With hindsight I see that individual sessions were particularly helpful when Ben or Julie had been functioning more comfortably and then experienced a relapse. On the other hand, after they had had a 6-week break for summer vacation, Ben and Julie's anger and depressive patterns needed definite immediate cropping. In this case however conjoint sessions worked well, at least until 3 months later when Ben suddenly abrubtly shifted back into a hostile attacking stance. The point I am making is that none of these rules for which treatment to use when are hard and fast. Rather, individual and conjoint interventions expand the therapist's treatment options for fresh initiatives.

In sum, when there was excessive anger in the treatment room, when one client seemed to need privacy, when intrapsychic conflicts needed to be guided to resolution, or when the couple format felt stalled, individual interventions seemed to loosen up the system and yield change. Less may be more in some circumstances, but in psychotherapy, more options seems to make for less chance of impasses.

ETHICAL AND PRACTICAL CONSIDERATIONS

What ethical considerations do decisions about individual and couple treatment formats raise? I would like to discuss several: (1) the ethics of offering individual treatment to married individuals when research indicates possible harmful effects on the marriage partner, marriage, or both, (2) informed consent, (3) practicing within one's competencies, (4) dual relationships and conflicts of interest, (5) confidentiality, and/or (6) values ascribed to marriage.

Is it ethical to offer married individuals assessment and treatment that does not include the spouse? My policy, demonstrated in the Two Bicycles case, is that all individuals who initiate treatment and who are married are encouraged to bring their spouse at least to the first session. I make exceptions if need be, but my starting position, even when the marriage does not appear to be distressed, is that I want to launch treatment with a full systemic diagnostic picture. If I had agreed to see Ben alone for an initial assessment of his depression, I would have launched his treatment with partial and warped information. I also would have developed a potentially crippling asymmetrical alliance with one spouse, possibly jeopardizing my ability to work later as their systemic therapist.

What do other therapists write on the ethics of treating married clients with individual treatment, given the findings of possible marriage harm? Phillips (1983) has recommended that clinicians who work with married clients in individual therapy routinely inform their clients prior to treatment of the significant probability that their treatment will have detrimental effects on their marriage. This advice is in keeping with the ethical duty to inform patients of the risks of any medical or other health-promoting intervention.

Lefebvre and Hunsley (1994) found that some patients' partners are pleased with the benefits to themselves and to their marriage from their spouse's individual treatment. Bearing in mind that individual treatment sometimes is advantageous, their recommendations are that (1) therapists discuss with married clients possible marital effects, both positive and negative, of individual treatment and (2) "Obviously, in any such undertaking it is essential that the client be consulted first about these (individual and

conjoint treatment) options" (p. 189). Informed consent, another ethical principle, is their main concern.

To be sure that they are informing clients fully, Lefebvre and Hunsley specify "there is much to be gained in therapists offering the client's spouse options such as receiving information on the client's treatment and/or involvement in occasional conjoint consultation sessions" (p. 189). From my perspective, treating one spouse individually and keeping the other informed pathologizes one partner. It also misses the treatment benefits of combined individual and conjoint treatment that the Two Bicycles case has illustrated. Similarly, to offer "occasional" conjoint treatments may be appropriate in some cases where one spouse is clearly more needy than the other. The relative proportions of individual and couple treatment interventions, however, need to be determined by the diagnostic assessment.

Offering combined individual and conjoint treatment, however, raises a serious practical issue. The reality may be that individual therapy is offered to most clients by most therapists, irrespective of clients' marital status, because individual therapy is what the therapist knows how to do. It would be an ethics violation for a therapist to offer treatment in which s/he does not have adequate competency; yet individual therapists are not likely to want to send their married adult referrals to more broadly trained colleagues. Therapists trained only in individual treatment methods could limit their treatment population to single adults. More likely, they may need to obtain marriage therapy training.

By the same token, Ben and Julie's case illustrates the importance of therapists being prepared to include at least a brief individual assessment with each spouse, plus individual sessions from time to time. Training for marriage and family therapists needs to include these skills as well as systemic interventions.

Unfortunately in this regard, the limited nature of many therapists' preparation—MD's, PhD's, and Master's level—is likely to continue for some time. In this regard, a reassessment of the breadth of skill training that clinicians need may be important for all the mental health professions.

Another source of reluctance to treat individuals and their marriage may be concerns about dual roles and conflict of interest. Therapists who do not view clients in a systems perspective often believe that they must decide either to treat a husband, a wife, or the couple. The Two Bicycles case suggests that this kind of either/or thinking is overly simplistic and is in itself likely inadvertently to harm patients. Emotional health is based on the complex paradoxical reality that people need both individual happiness and relationship success. Oversimplification of treatment to address just one dimension risks harming the other.

Interestingly, the most pure arrangement in terms of dual relationships—a therapeutic system with two separate individual therapists for married spouses—is probably the most likely arrangement to invite divorce. Participating in this arrangement may be helpful if a couple definitely wants to disengage, but is ill advised for any therapist or couple who may want to save a marriage.

The issue of confidentiality merits significant attention when conjoint and individual treatments are intertwined. What if, in an individual treatment session, one spouse admits to having an affair, a fatal illness, financial difficulties, or some other secret? Some therapists believe the only appropriate policy is complete disclosure. They do not want to be in a position of holding any secrets and therefore offer no confidentiality for individual sessions. They explain at the outset of treatment that they will not carry secrets; any information told to them by one spouse may be shared with the other.

Other therapists feel that a therapist needs to be able to hold private information for each spouse in order to be able to have a therapeutic impact on secret yet potentially extremely important situations.[7] The therapist's job, in this perspective, is to help the carrier of a secret resolve the problematic situation in a positive manner. This latter confidentiality system worked well with Ben and Julie. Ben for instance needed privacy to explore his intrapsychic conflicts about staying in the marriage—"one foot on the dock and one in the boat." This internal recommitment was essential to the couple's treatment. Interestingly, as often happens, talking over the issue in an individual session prepared Ben to share many of his concerns with his wife in a productive subsequent dialogue.

In sum, the crucial ethical practice with confidentiality is a clear policy, explained in detail at the outset of treatment, and reviewed from time to time to be certain that everyone is operating under the same assumptions.

Next come the practical considerations. Time and money both must figure into treatment planning. Ben and Julie benefited from occasional individual treatment sessions in a primarily couple treatment. When difficult family-of-origin experiences, childhood traumas, or character pathology have created two vulnerable adults, however, both spouses may need their marital therapy augmented with more frequent individual sessions. I have treated couples who needed three sessions a week—one marriage session plus individual treatment for both partners' long-standing patterns of borderline, narcissistic, depressive, or paranoid functioning. Comprehensive

[7]Most therapists state one exception: in situations where the secret could physically endanger the patient or the spouse, therapists are legally required to inform the spouse. In this circumstance the therapist, to whatever extent is possible, first discusses with the confiding patient how this sharing can best be accomplished, and then must proceed with disclosing the confidential information.

treatment can enable these couples to live emotionally healthy lives, but it does take significant time and money resources.

Lastly, how much do we as mental health professionals value marriage? If a therapist regards a marriage as sacred, as an essential social institution, or as an entity with its own life, divorce, like suicide, becomes a very serious concern. A therapist then would be very careful to bring no harm to this union, and would make every effort to provide clients with the tools to form a more perfect union. If we regard creating and preserving healthy marriages as equal in importance to sustaining individual emotional health, comprehensive individual/marriage treatment may become standard practice.

In sum, the Two Bicycles case example demonstrates the conflict resolution method for combining individual and marital therapy. The case suggests that therapists *can* enable their married adult clients to enjoy both individual emotional well-being and marriage success.

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