the stone. The artist responds simultaneously to internal images of what s/he wants to create and to each individual characteristic of the stone. The process, even with an inert piece of stone, is one of mutual and reciprocal creation. Psychotherapeutic treatment likewise emerges as a mutual creation in which patient(s) and therapist interweave and reciprocally respond to one another's agendas and plans for growth.

Therapeutic decisions thus are best resolved via a process of integrative conflict resolution. Therapists can err either by too passively following the lead of patients or by assuming that they know what to address without asking patients what they feel is most pressing. However, although the therapist must solicit patients' input, just as the decisions of a sculptor lie with the artist, not the rock, and just as parents must accept responsibility for directing their children's growth, treatment decisions are the therapist's responsibility.

WHO SHOULD BE SEEN IN TREATMENT?

To a man with a hammer, the world is a nail. Alas, this saying can be applicable to therapists. Too often, therapists decide whether to utilize individual, couple, or family treatment on the basis of their particular therapy training rather than on the nature of the problem. This mode of deciding who participates can lead to inadequate assessment and inappropriate treatment.

Misconceptions about how an individual (child or adult) is functioning can occur when the therapist has not assessed the identified patient both alone and in the context of his/her interactions with other significant family members. Someone who appears to be calm and delightful alone can present rigid stubbornness or raging fury in a different context. Likewise, hearing about other family members only through the patient's viewpoint can lead to misjudgments about them. For instance, individual therapists must guess whether the spouses of their patients are being accurately described if they are relying only on the data that has been filtered through their patient's perspective.

Moreover, individual therapy has a definite, but not always beneficial, impact on the patient's family. This unfortunate reality has been studied particularly extensively in the case of agoraphobia. Goodstein and Swift (1977), reporting on the individual treatment of three agoraphobic women, found that one resulted in divorce, one led to the husband's developing severe depression (which lifted with conjoint marital therapy), and the third was precipitating dissolution of the marriage when conjoint therapy was initiated to ease the marital strain. Hafner (1977) studied the husbands of 30

married agoraphobic women before, during, and after their wives' individual treatment. He discovered that a significant proportion of the husbands reacted adversely to their wives' symptomatic improvement, with several developing serious psychological problems.

Similar evidence that progress in individual therapy often negatively impacts spouses and marriages has been found with other emotional disturbances (Hand & Lamontagne, 1976; Marshall Neill, 1977; Mayo, 1979). The emergence of spouse and marital problems as a side effect of individual therapy appears to be far more than an occasional phenomenon.

Several studies have indiciated that marital distress is associated with a greater likelihood of treatment failure or relapse (Milton & Hafner, 1979; Rae, 1972). For instance, Rounsaville, Weissman, and Prushoff (1979), looking at individual treatment with 22 depressed women who reported marital disputes, found that two-thirds of the marital relationships did not improve during the course of treatment, and these women remained depressed or worsened. Sims (1975) found that poor marriages were a predictor of poor therapeutic outcome irrespective of the diagnosis of the individual in treatment; that is, the impact of the family system was stronger than the impact of therapy.

Such results, while disturbing, are understandable. If emotional disturbances arise when an individual does not have better options for negotiating the conflicts with significant others, improving the emotional state must go hand in hand with changing the ways in which conflicts have been and will be handled. To change conflict patterns, all parties involved in the conflict need to make changes.

Given these research findings, how should decisions be made with respect to individual, couple and family treatment? Martin (1977) and Dare (1986) suggest that the critical factor to consider is the patient's current social system. They propose that, with only a few exceptions (delineated nicely in Martin's landmark paper), virtually all married people should be treated in a couple format. Children are best treated with the full family system except, perhaps, when they are responding to a trauma or developmental crisis wholly unrelated to the family (which is rare). Unmarried adults, in the life stage transition between the family of origin and the family of procreation, can be appropriately treated in individual (or group) therapy. Adolescents, because they should be differentiating from their families of origins, may best be seen in a combination of individual and family sessions.

With these guidelines in mind, I routinely ask new patients calling for an appointment if they are single or married. If they are married, I suggest that both spouses should plan to attend the initial treatment session and that