# 77 TREATING HIGH-CONFLICT COUPLES

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In high-conflict couples the frequency and/or intensity with which the partners express anger interferes with their ability to sustain a healthy loving relationship. The following clinical methods, drawn from the research literature and clinical experience, enhance safety in treatment and at home, and improve the probability of positive psychotherapy outcomes.

## SETUP FOR TREATMENT

**1.** *Arrange the chairs to encourage dialogue flow between the couple and to maximize your ability to intervene quickly.* To encourage spouses to talk with each other rather than through you (the therapist), place three chairs in an equilateral triangle (no side-by-side sitting as on a couch). Rollers on the therapist's chair are useful. When tensions rise, roll the chair between the couple to block dialogue flow or next to one spouse for calming individually focused interventions.

**2.** *Record treatment sessions.* Bring a recorder or encourage clients to bring one. Include consent-to-record forms in clients' initial paperwork; check that both spouses have signed before beginning to record. Explain that the recordings are for them only; you will not keep a copy. Assign listening as homework; repetition enhances learning. Recordings are contraindicated, however, if divorce proceedings are imminent, lest one spouse use them against the other.

**3.** *Explain your confidentiality policies.* My rules for talking about secrets are as follows: (a) I am not free to disclose anything said in a couple session, or that we even had a session, to anyone not present at the session; (b) when I meet with one spouse individually, I am not free to disclose what was said by one spouse to the other, or even that we met for a session; (c) confidentiality binds me, not them, so after individual sessions they can choose whether and what to share with the other; and (d) when there is danger to self or others the rules flip. I then am required to report.

**4.** *Establish a one-therapist treatment policy.* Multiple therapists (e.g., for individual and couple treatment components) may make treatment unsafe and undermine progress. I require that couples in treatment with me take a break from individual work with other therapists. I conduct individual and couple sessions as needed, integrating the work from both formats. Most sessions are with the couple; individual sessions break through impasses. The one exception is when special expertise is needed, such as referral for medication (Heitler, 2001).

Why this policy? Multiple therapists leave each with partial information. For instance, in a rare situation in which I allowed one spouse to continue in treatment with her individual psychotherapist, the individual therapist taught our mutual client "assertiveness training."

When the wife tried out her new skills at home, the shocked husband knocked her down a staircase. The individual therapist, not being in a format where she could prepare the husband to receive his wife's new behavior, had inadvertently created a dangerous situation.

DIAGNOSIS

**1.** *Delineate goals.* Ask the partners to discuss with each other what they have come to treatment to accomplish. This question simultaneously sets goals and enables you to observe their capacity for insight and collaborative dialogue. At the outset of each session determine goals similarly for that particular hour. Observe and address skill deficits such as speaking in *don't wants* instead of *would likes* or responding with negations such as *but*.

**2.** Obtain a threefold diagnostic picture.

- Identify individuals' symptoms (depression, anxiety, anger, or character pathologies).
- Generate a laundry list of conflicts about which the couple argues.
- Note communication and conflict resolution skill deficits.

**3.** *Detail the couple's anger and argument patterns.*

- Ask what tends to trigger fights, their frequency and duration, highest levels of escalation, how fights end, how the spouses recover, how each feels about the arguments, and whether drugs or alcohol are involved. Bear in mind the tendency of people with anger problems to minimize and deny rages, emotional abuse, and physical violence.
- Note externalizing (blame, criticism, accusations), lack of insight or responsibility taking, and controlling behavior (telling the other what to do, controlling finances and friends, etc). These habits suggest abusive patterns, undermine the credibility of a client's self-reports, and suggest that individual sessions may need to precede couple work.
- Assume that high-conflict individuals typically have overlapping clinical patterns. For example, an abusive individual may show paranoid, borderline and narcissistic tendencies, hot-reactor quickness to anger, bipolar or sociopathic indicators, and/or alcohol or drug use.
- Verify your data by meeting privately with each partner, asking the partner or spouse to wait outside of your office for a few minutes. Ask direct questions using explicit words like "shouts," "curses you," or "hits you" to make it easier for spouses to admit to what is actually happening. "What is the worst your partner does when angry?" "How do you respond?"; "...the worst you do?" "What is your partner's response?"
- Reflect back to clients that "I only get mad because *s/he*..." signals non-responsibility-taking for anger.

**4.** *Note contraindications for couple treatment sessions.*

- Unwillingness to agree that violence is out of bounds, at home or in session
- Poor impulse control or other signs that psychotherapy may be unsafe
- Reprisals after sessions for comments by the partner that the abuser disliked
- A paranoid stance characterized by a fixed ideational system about the other, rejection of nonconfirmatory data, externalizing, and projection
- Drug or alcohol abuse
- Hyperfocus on the other and controlling behaviors that suggest verbal, emotional, or physical abuse

Address these symptoms in individual therapy prior to and/or simultaneously with couple treatment. Offer simultaneous individual therapy for the healthier partner to enhance coping skills and prevent depression. Add couple treatment later.

**5.** *Make safety arrangements.* The vast majority of high-conflict couples spontaneously exit before physical violence is likely. However, if there is any risk of physical

violence, remove guns from the home, prepare escape options for the victim partner, and build awareness in both of the increase in danger with alcohol and drug use. Clarify the danger of even "minor" violence (e.g., a small push can cause a serious head injury). Encourage a temporary separation, a double-domicile living arrangement for the couple, or a safe house if violence risk is high.

TABLE 77.1. Levels of Anger Escalation

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| Level 5: Violence against people: grabbing, pushing, choking, shaking, hitting, sexual aggression, punching, burning, use of weapons such as a knife. |
| Level 4: Violence against things: slamming doors, throwing things, hitting walls. Shaking a fist in a threatening manner. |
| Level 3: Verbal violence: blaming, criticism, sarcasm, name calling, lecturing, shouting, accusing, issuing intimidating threats. Harangues that build a case to justify anger. |
| Level 2: Bickering, repeating the same points multiple times, talking louder, talking faster, getting snippy, critical, or defensive; feeling adversarial, desiring to win, proving who's right. |
| Level 1: Low-level anger feelings such as irritation, frustration, emotional overload, upset expressed in normal voice tones and I-messages. "I feel frustrated. My concern is...." |

## TREATMENT

**1.** *Aim to accomplish three main strands of treatment.*

- *Ameliorate symptoms.* Anger, anxiety and depression. Arguments. Narcissistic, borderline, hysteric, paranoid, abusive, and/or bipolar features.
- *Guide win-win resolutions of conflicts.* In the process, note, explore, and rectify negative impacts from problematic earlier relationships (Lewis, 1997).
- *Coach collaborative communication and conflict resolution skills*, teaching spouses how to address their differences calmly. People with histories of excessive anger need to aim for zero anger or fights, as small spats can be like a little alcohol for an alcoholic.

**2.** *Ensure safety.* Early in treatment, teach disengagement/self-soothing/reengagement routines to prevent hurtful fights and violence escalations (see Table 77.1). Practice these routines in the session. Inquire intermittently about the couple's experiences with their exit routines to ensure their plan is fully effective.

**3.** *Initiate a collaborative perspective.* Block attempts to change the partner; teach each partner to focus instead on what he or she could do differently. Clarify each partner's contributions to the negative interaction cycles, and what each can do toward creating positive interaction cycles.

At the same time, if one partner is abusive, then his or her individual pathology may be the starting point for most of the conflict. While most high-conflict couples have a takes-two-to-tango dynamic, some high-conflict couples are more like a *bank robber and bank teller.* Explain this dynamic in a kindly but clear way, blaming the pathology (e.g., the volcanos inside you that erupt so quickly), not the person.

**4.** *Develop face-saving explanations for the couples' conflicts.*

- Identify external or developmental stresses that may have overloaded the system (e.g., arrival of children, illness, financial setbacks).
- Explain the role of insufficient communication and conflict resolution skills.
- Identify the anger, dialogue, and conflict resolution models in each spouse's family of origin to clarify where each participant learned his or her patterns. Compassionately explore parents' histories.

**5.** *Intervene immediately at first departures from collaborative interaction.* Interrupt the dialogue with a question or comment; restart it by prompting cooperative skills. If anger rises, ask the healthier spouse to step out for a few moments. Talk quietly to calm the angry spouse. Explore his or her concerns before inviting the partner back. If an angry spouse threatens to leave a session, praise the departure impulse, inviting a return when he or she feels calmer.

**6.** *Gradually introduce and practice the four communication skill sets that enable couples to sustain a harmonious relationship.*

- Emotional self-regulation (ability to stay calm without anger outbursts)
- Positivity (expression of appreciation, agreement, affection, good humor)
- Collaborative communication (talking, listening, and dialogue skills)
- Win-win conflict resolution (for healing past conflicts and making shared decisions for upcoming actions)

Most high-conflict couples fit the adage "if they knew better they would do better." At the same time, high-intensity emotions can overpower the ability to utilize new communication and conflict resolution skills. Therapists need therefore to prevent emotional eruptions by teaching exit routines.

**7.** *Address symptom removal.* Insufficient conflict resolution skills create and maintain psychopathology. To remove symptoms, readdress conflicts with healthier dialogue and conflict resolution patterns.

- *Anger* settles conflicts by domination.
- *Anxiety* and *tension* signify that conflicts are hovering unaddressed.
- *Depression* emerges when conflicts are settled with one partner giving up.
- *Addictive* and other *obsessive-compulsive disorders* (including eating disorders and hypochondria) indicate escape from conflicts by means of distraction.

**8.** *Teach about anger.* Teach the physiological, cognitive, and other changes caused by anger arousal (e.g., high arousal decreases ability to take in new information, to think flexibly and to create new solutions). Like physical pain, angry feelings indicate problems. Angry actions however seldom effectively ameliorate them. Clarify that people yell to get heard; yet the louder they yell the less their partner is likely to digest their message.

**9.** *Resolve current disputes.* Psychotherapists can guide a three-step movement from conflict to resolution on couples' divisive conflicts as follows:

Step 1: Express initial positions, ensuring that both spouses speak up and both listen to the other.
Step 2: Explore underlying concerns, listing all of both spouses' concerns as one shared list.
Step 3: Design a plan of action, a solution set responsive to all the concerns of both spouses.

**10.** *Teach the four Ss of conflict resolution* (Heitler, 1997):

- *Specifics* lead to resolution; generalities breed misunderstandings. "We spend too much" is less helpful than "We spent $2,000 over our budget this month."
- *Short segments.* In healthy dialogue, participants take turns talking, avoiding long monologues. Listeners can respond only to one point; further data beyond one point per talk time gets lost. When partners ramble or lecture, suggest a *three-sentence max* rule.
- *Symmetry* of air time creates a sense of equal power and equal voice.
- *Summaries* consolidate understanding and propel solution building.

**11.** *Direct information flow.* In general, have spouses talk with each other, not to you. Redirect spouses who talk to you by looking at the listener rather than the speaker or by using hand gestures. In the following specific situations, however, it is helpful to have spouses talk to you to:

- Lower emotional intensities when anger is escalating
- Resolve conflicts early in treatment when the couple's skills are too insufficient
- Accelerate resolution of a conflict when the session time is running short

**12.** *Identify core concerns.* Heated emotions indicate strongly felt concerns, for example, "I hate not being heard!" or "I feel neglected!"

These repeated sources of emotion are usually transference issues or core conflictual relationship themes (Luborsky, Crits-Christoph, & Mellon, 1986). Find the sources of these excessively emotional reactions in prior life experiences by conducting a depth dive (Heitler, 1993). While you conduct a depth dive with one individual, the spouse hopefully can listen, holding his or her comments for the discussion afterward. That way you can explore one partner's sensitive conflicts and simultaneously build compassionate understanding in the other.

Spouses' core concerns will tend to interlock in negative circular interactions. For instance, her thought "I can't seem to please him" and resultant depressive withdrawal may trigger his "I never get the affection I want" and angry complaining stance. His angry complaints in turn retrigger her depressive withdrawal. Replace negative cycles with positive ones; for example, he expresses more frequent appreciation, and she more frequently hugs and cuddles with him. Practice the new patterns, both in sessions and as homework.

**13.** *Allow only healthy interactions.*

- *Prevent poor skills by prompting.* Offer sentence starters to insure safe talking. For example: "I felt (one word) when you...." Or "My concern is...." Or "I would like to... (not I would like you to, or I don't like)..." Prompt open-ended questions with, "Good questions begin with how or what." Prompt digestive listening responses by asking, "What did you agree with in what your spouse just said?"
- *Intervene immediately to request redo's* to modify slippages, such as blaming, criticizing, you-statements, sarcasm, defensiveness, or raised voices. The client can do the redo, or the therapist can offer to translate.
- *Request flips:* Flip *don't likes* to *would likes.* Flip *you make me feel* to *I feel.* Flip *I would like you to...*to *I would like to.* Flip *but* to *and at the same time...*On the listening side, immediate intervention when listening skills are insufficient also is vital.
- *Request that the listener first digest, and then add.* If a spouse negates what she or he heard ("*But...*") or continues on with his or her own thoughts without picking up on what was just said; request a re-do.
- *Translate provocative comments into collaborative formats.* For instance, roll your chair close to the speaker to translate an accusatory "You don't do your part in keeping up the house" to "I feel like I'm doing more than my share."
- *Repeat frequently the basic communication mantras.* The most popular include "Talk about yourself, or ask about the other; no talking about the other." "What's right or useful in what your partner just said?" or "Good questions begin with *how* or *what.*"
- *Set up practice drills to consolidate new skills.* Assign reading or Web-based homework exercise; for example, from PowerOfTwoMarriage.com.
- *Catch misplaced locus of focus.* Abusive individuals monitor their partner, telling them what to think and do. Teach them to be "self-centered." (See Table 77.2.)

**14.** *Learn after mistakes.* Teach the couple that after upsets the goal is to look insightfully at one's own part, apologize, and learn to how to prevent similar upsets in the future (not to punish the other).

**15.** *Teach positivity.* Encourage and practice expressing appreciation, affection, agreement,

TABLE 77.2. Time-Out Routines for Emotional Safety at Home

*Initiate time-outs when you*
- Feel too upset or negative to talk constructively.
- Sense that the other is too emotional to dialogue constructively.

*To initiate a time-out*
- Use a nonverbal signal, such as sports signals. Go to separate spaces without discussion.
- No door slamming or parting comments. Never block the other from leaving or pursue the other when he or she disengages.
- Instead of thinking about the other, focus on soothing yourself or on a distraction.

*Reengage* after regaining normal humor. Talk first about a safe topic. Then resume the tough subject.

enthusiasm, and gratitude to replace the prior criticism and argument. End sessions by summarizing accomplishments.

### *References and Readings*

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### *Related Topics*

Chapter 42, "Assessing and Treating Anger as a Clinical Problem"

Chapter 76, "Conducting Couple and Family Therapy"

Chapter 78, "Treatment of Partner Infidelity"