

Helping Two I's, and a We:

A Conflict-Focused Framework for Integrating Individual and Couple Treatment

Most therapists describe themselves as eclectic, drawing on various treatment strategies depending on the nature of the problem they confront in that session. Effective clinicians tend to develop a broad range of treatment intervention strategies plus skills for working at various levels of the system—individual, couple, and family. Treatment that attempts to be comprehensive and integrative, however, risks becoming disorganized, ad hoc, and even unethical.

Conflict-focused thinking offers useful antidotes to these risks because the theory covers such a broad range of treatment aspects. Conflict-focused theory defines emotional and marital health, explains why various pathological symptoms emerge, explains why various treatment interventions return pathological conditions to states of well-being, and suggests additional new treatment options. The theory integrates psychodynamic and behavioral components under one overarching set of conceptualizations. Lastly, its applicability to multiple levels of functioning--individual, couple, and family—makes it particularly useful for attempts to integrate individual and couple treatment formats.

This paper explores how conflict-focused theory contributes to three dilemmas that arise when treatment includes both individual and couple treatment formats. (a) How does a conflict-focused treatment framework provide theoretical integration to keep treatment coherent and systematic? (b) Who should be in the treatment room when? And (c) What ethical issues does dual formats raise, and how can these be addressed?

REVIEW OF THE LITERATURE

Research has solidly confirmed the importance of treating the couple relationship when individuals who are married seek psychotherapy. (depression, alcohol, side effects that are iatrogenic)

At the same time, clinical experience clarifies that couple therapy at times needs to be augmented with individual sessions. For instance, when individuals in a couple present with long-standing emotional difficulties, one or both may need extended individual work to become mature, emotionally resilient, marriage partners. When emotional health of partners is asymmetrical, one spouse may feel impatient with sitting through extended but essential interventions that the other needs in order to move forward—and the more needy partner may feel blamed if interventions are asymmetrically focused on him/her.. Resistance to change may be higher when the partner is watching. Issues that a spouse was unwilling to explore in view of the other may be possible to address only in the privacy of individual work. And when issues outside the marriage, such as relationships with work colleagues or with a difficult boss, prove to be the source of emotional dysfunction that is contaminating the relationship, individual sessions may prove both the most efficient and effective treatment format .

Yet a third treatment option is to utilize individual therapeutic interventions with both partners present in the treatment room. Within couple sessions, for instance, brief individual depth explorations of each partner's transference issues gives one spouse essential insight while the other gains new empathy for his/her partner. (Research examples, including my work)

A conflict-focused conceptual framework provides an integrative theoretical structure plus pragmatic interventions for multi-faceted individual, couple, and individual-in-couple treatment.

KEY CONCEPTS IN CONFLICT-FOCUSED THINKING

A comprehensive psychotherapy theory needs to account for why symptoms have developed, how they can be alleviated, and how similar emotional distress symptoms can be prevented in the future. A good theoretical map thereby gives the therapist clarity about where s/he is going, options as to which routes will get there, and guidance about what to do next when treatment feels stuck. Psychotherapy theory then helps the therapist to keep treatment well-organized, cohesive, efficient, and forward moving.

Conflict-focused thinking utilizes one conceptual map to guide both individual and couple interventions. The same structure can also guide full family treatment when it is appropriate to include children and/or grandparents in treatment sessions.

(1) Sources of emotional distress: Conflict-focused conceptualizations begin with a single basic assumption: *Conflict, within or between people, lies at the core of emotional distress.* If I want to go outside to enjoy the late afternoon sunshine, and I also feel that I have to stay in and finish writing this paper, I am likely to experience some form of emotional tension from this intrapsychic conflict. If a mother wants to start serving dinner and her children insist on continuing to play outside, she and they are likely to experience tensions and distress from the interpersonal conflict. Distress may also be evoked by a conflict with circumstances. For example, if I want to go outside—perhaps I have an urgent need for fresh air to alleviate a headache from indoor stuffiness—

-but the temperature outside has dropped too low and wind and hail would make a walk impossible, my frustration results similarly from conflict.

(2) Sources of clinical symptoms. *Poorly handled conflicts result in clinical symptoms such as depression, anxiety, excessive anger, or obsessive-compulsive and addictive behaviors.*

While the above examples illustrate conflicts that most people would find initially emotionally uncomfortable, and then would resolve in routinely adequate ways, symptoms and psychopathology emerge when conflicts are poorly handled. For instance, if I decide to take a quick break, absorb a few minutes of fresh air, and then return to my computer—a healthy win-win solution—my work will proceed all the more quickly from the brief rejuvenating exposure to the sun. By contrast, heading outdoors to the neglect of work may be part of a procrastination pattern that undermines my ability to succeed in work ventures. Similarly, inability to allow myself simple gratification could result in a neurotic pattern of constricted living, leading eventually to early burnout and depression. Hovering in indecision might be characteristic of a generalized anxious picture. And if my style were to avoid conflicts altogether, I might get up and fix a gin and tonic or eat a plate of cookies instead of either pursuing my writing or fresh air.

(3) Conflict resolution patterns and psychopathology *each pattern of pathology is associated with a specific dysfunctional pattern of conflict resolution.* That is, while win-win conflict resolution alleviates distress, one-sided (win-lose) patterns of conflict settlements create anger and/or depression. Hovering conflict with no settlement invites extended anxiety. Escape attempts to avoid conflict can result in addictions and/or obsessive-compulsive behaviors. (Chart)

(4) Inner and interpersonal congruence. *The same conflict handling patterns yield the same health and/or psychopathology whether the conflict takes place in intrapsychical or interpersonal realms.* In the conflict suggested earlier between a mother and her insistent children, for instance, if the children get their way by dint of loud insistent voices that overwhelm the mother, this solution indicates a dominant-submissive conflict resolution pattern. The children's dominance is implemented via anger, one form of pathology when used inappropriately, and in this case a sign of collapsed hierarchy as well. Their mother is likely to experience some degree of depression, the price of playing the submissive role in dominant-submissive conflict resolution patterns. If both parties utilize anger, fighting will erupt, another sign of dysfunction. If the conflict is avoided, anxiety may hover. Or, an escape route such as the mother smoking or drinking rather than facing the contest of wills, may offer tempting distraction. Because the same patterns of conflict resolution create the same symptoms of pathology whether the conflict is internal or interpersonal, these understandings enable treatment in both realms to be guided by the same conceptual framework.

(Chart-five modes of c-r, and associated symptoms)

(5) *Win-win resolution of conflict alleviates emotional distress.* In the above mother-child conflict, a neighbor might come by, hears the ruckus, and say to the children, "Hurry inside for dinner; I have a surprise for you after you finish!" Excited by this invitation, the children comply with their mother's wish, and at the same time get what they want, which is to have fun. That is, effective conflict resolution, responsive to the concerns of both sides, brings a return of emotional well-being.

(6) Effective conflict resolution skills can prevent similar subsequent distress.

The mother in the above example needs parenting know-how and an accompanying shift to a more authoritative and empowered parenting stance. She then would be able, for instance, to set up routines with her children that enable them to come on time for dinner without power struggles. In general, effective conflict resolution skills depend first on a foundation of effective dialogue skills, generally referred to as communication skills, and second, on mastery of win-win conflict resolution patterns. In addition, parent-child interactions require expertise in win-win interactions in which one participant is an authority figure and the other a dependent.

(7) Healthy functioning depends upon skills, each of which can be seen as specific elements of effective conflict resolution. For instance, failure to listen to one's feelings, a common "neurotic" habit addressed particularly well by existential/humanist treatments, is a failure in one of the elements of conflict resolution. In the second step of effective conflict resolution, exploration of underlying concerns, feelings must be heeded, not suppressed, because feelings are the keys that unlock the doors to understanding specific concerns.

(8) The basic communication skills are the vehicles by which one travels the pathways of conflict resolution. Similarly, a tendency to blame, characteristic of paranoid and borderline conflict resolution patterns, violates one of the basic communication rules, that is, one can talk about one's own thoughts and feelings, or ask about the other's, but talking about the other is out of bounds. Blaming blocks capacity for insight, that is, for exploration of underlying concerns. Blaming also engenders

defensiveness in the other person, again derailing effective collaborative information sharing.

(9) *Effective treatment generally aims to accomplish three goals::*

- *Alleviation of symptoms* such as anger, fighting, depression, anxiety, or obsessive-compulsive disorders.
- *Resolution of current conflicts*, internal and interpersonal
- *Improvement in communication and conflict resolution patterns* for prevention of subsequent symptoms and distress.

(10) Progress toward these three goals can be organized in multiple ways. One method, which I refer to as the Laundry List method, (1) begins by alleviating *symptoms* that are interfering with ability to function at home, at work, or in treatment (e.g., excessive depression or anger), (2) then *resolves one conflict* a week from the laundry list of conflicts generated in the first session plus additions to the list from arguments that have emerged in the intervening week and (3) gradually introduces communication and conflict resolution skills as part of the weekly conflict resolution experience. This on-the-job training format seems to work well for many couples with the goal for each week's session being resolution of one dispute plus coaching in one partnership dialogue skill. This treatment strategy was used in the case below.

In general, however, with regard to which goals to address when, treatment requires that (a) symptoms that interfere with functioning in the therapy session, at home, or at work must be alleviated first. (b) if communication and conflict resolution skills are too ineffective to allow for even guided conflict resolution in the sessions, initial attention must be focused on explaining basic communication guidelines and practicing these in

order for subsequent interventions to be therapeutic. (c) if there is a pressing situation that is time-sensitive or that is stimulating particularly emotionally intense conflict (such as children with problems, an affair, or a financial decision) this dilemma needs immediate attention in order for the system to relax enough to be productive on other issues.

(11) To determine the specific agenda for each session—that is, what symptoms to alleviate, what conflicts to address, and/or what skills to build--each spouse needs to say what they would like to use the session for. The therapist also needs to verbalize his/her ideas about what s/he feels is important to do in the session.

(12) Within the session, choosing as session focus can lead to step one of conflict resolution, expressing the initial positions. Subsequently, the best guide to where the therapist should address his/her questions in exploring underlying concerns is to follow the flow of feelings, noting and exploring issues manifest by a furrowed brow, watering eyes, a frown, an emotional tone of voice, etc.

CASE ILLUSTRATION: Couch Potato Meets Superman

The case that will be used to illustrate the principles of integrating individual and couple work within a conflict-focused treatment was a challenging one. Brett and Marcia presented with particularly entrenched and long-standing hostilities and despair. Their home was ravaged by frequent outbursts of intense anger from both spouses; their marriage was teetering on the brink of divorce; and their teenage children were distressed by the pervasive anger and unhappiness.

Brett, a highly successful lawyer, tall, and attractive, was fed up with their household situation; his wife, also high-functioning in the business world, was a large

woman who at home felt incapacitated by depression. At one point in treatment they described themselves as Couch Potato meets Superman, a reference to the reality that as Marsha had withdrawn increasingly from household participation, her husband Brett had taken over in a pattern that systems therapists refer to as an under-functioning/over-functioning couple

Brett and Marsha's marital problems had begun approximately eleven years ago, around the time of the birth of their third child, and had intensified during the last 4 to 5 years. During this time multiple stresses had overwhelmed the family. The last two children were just one year apart. Marsha experienced severe depression. Her father died. Marsha quit her job; Brett beginning to panic about their financial situation and to fear that too much weight was on his shoulders, insisted that his wife return to work and additional schooling. While Marsha later was glad she had developed solid professional skills, at the time she felt coerced into commitments she did not feel ready for. Brett also set his wife on a slim budget, which she resented as giving her no control over decisions. Meanwhile, Brett felt excluded from Marsha's life planning. He felt she wouldn't show him her game plan--not understanding that in fact she didn't know what she wanted from life other than that she didn't like having decisions made for her, and also unaware of the extent to which he was engaging in paranoid-like projection of his own tendency to secretiveness.

Brett had contacted me for marriage therapy on the recommendation of their physician. Marsha had been in individual therapy for a considerable length of time. She found the sessions supportive and interesting. They tended to focus on the difficulties she had experienced growing up and sometimes also addressed her current marriage

frustrations, but did not seem to create changes her current life situation or depression. The couple had also been to a marriage therapist whom they both liked, but they both felt that the sessions had not resulted in any changes, instilled renewed hope for their future, or presented a clear plan of how the sessions would lead to relationship improvements. .

Treatment in the conflict-focused format consisted of x sessions extending somewhat over a year and a half. **X sessions were conjoint; in addition, Brett had x individual sessions, and Marsha had x.** The goals of treatment were (1) alleviation of both spouses' presenting problems--anger, depression, and generalized distress (2) resolution of the specific marital conflicts that kept recurring with ever-increasing frustration and hostility for both spouses and (3) either establishment of a more cooperative home environment or dissolution of the marriage.

Treatment concluded with the couple having decided to stay together. They had attained relatively cooperative if not fully affectionate functioning. Both spouses had grown significantly in understanding and accepting themselves and each other more fully. At the same time, they both felt more skilled with the cooperative partnership skills they had gained in treatment. While their improvements felt still somewhat fledgling and fragile to me, realities of a new job for Brett and vacations for all of us forced us into a somewhat early but nonetheless successful termination. In a follow-up phone call two years subsequent to their treatment, the couple's gains were holding with continued gradual improvement in family solidarity.

To explain how and when individual and couple treatment components each contributed to treatment progress, I will separated the tri-partite braid of therapeutic interventions into its three main components: alleviation of symptoms, resolution of

current conflicts, and improvement in conflict resolution patterns. Each of these components included a diversity of interventions: psychodynamic family of origin exploration, behavioral changes, cognitive restructuring, and systemic changes in alliances, power relationships, division of labor, and closeness and distance patterns between the spouses. All of these interventions were guided by the overarching conceptual framework of helping the couple resolve their conflicts and improve their conflict resolution patterns.

Alleviation of symptoms

The main presenting problem of this couple was ongoing animosity, generally handled with sullen avoidance of each other, and periodically punctuated by loud and vituperative arguments. In addition to a pervasive negative tone between the partners, there was virtually no positive interaction—no smiles, no occasional affectionate interchanges, and very little civil dialogue beyond essential information exchanges. There had been no sexual intimacy for at least a year.

Brett's presenting problems (as per a self-report problem checklist): anger, depression, sleep difficulties, irritability, , plus marital tension, arguments, emotional distance, and communication problems. The primary symptomatic focus for him, however, was anger.

Marcia's presenting problems (from the same checklist): the same as her husband's plus anxiety and weight gain. The primary symptom focus of our treatment was depression.

Which interventions to do when presents major dilemmas in this kind of multi-problem case. In general, I begin with restoration of hope. Explaining to a couple that

their problems have to do with inadequacies in their skills at talking together when they have differences offers the optimistic perspective that skills can be learned and progress therefore could occur. Their anger, depression, and anxieties were by-products of insufficient conflict resolution patterns. Adding the historical perspective that the arrival of a third child seems to have been the time period when the family slipped onto overload led to the revelation that decisions about Marsha continuing to work at that point had tipped the scales. Brett at that time had suddenly felt panic about financial issues. Marcia felt forced into accepting a job she did not want to have to take. The couple's dominant-submissive decision making pattern at that time, fueled by Brett's anxiety about finances and Marsha's lifelong tendency to take an outwardly compliant, inwardly angry, stance, resulted in Marsha's increasing depression.

Eliminating Marsha's depression would take three forms of intervention:

1. Antidepressant medication, to change the biochemical energy levels.
2. Individual treatment to help Marsha break free of the depressive stance she had learned as a coping mechanism in childhood.
3. Couple treatment to insure that Marsha's movement from passive-aggressive and helpless "couch potato" into active participation in the family would be greeted by a more accepting and less controlling stance from Brett. Continued critical and coercive behavior from him would otherwise undermine and make unsafe any growth from Marsha.

At the same time, eliminating Brett's angry, critical and domineering behavior also would take three components:

1. Antidepressant medication which seems to attenuate anger as well as depressive reactions.
2. Individual treatment in which Brett could be confronted on his anger, rage outbursts, and controlling and critical behaviors, could understand the costs of this method of trying to get his needs and desires met, could be aided with learning to read his projections, and eased into a cooperative, as opposed to hostile/controlling partnering stance.

Reciprocal interlocking pathologies: Marsha's depressive collapse felt to Brett that she was withdrawing affection from him, which she was, and also resulted in her no longer carrying her share of at home division of labor. Her depression triggered anger and abandonment depression in Brett. His anger and frustration in turn continued to fuel her depression. Eleven years later Brett and Marsha's Brett's anger and coercive style of family leadership continued to be locked into a reciprocal interaction cycle with Marsha's social, emotional, and functional depressive withdrawal. Both spouses repeatedly pointed fingers at the other as the causative agent; neither seemed willing to observe their part in the cycle or to recognize anything they might do differently that might lead to change...

What, from a conflict-focused perspective, would have to change for this relationship to become a healthy one? Basically the couple would have to change from dominant-submissive interactions to collaborative partnership, beginning with a change from finger-pointing to each taking personal responsibility for their own behaviors.

These skills would take considerable time to build with this couple however. In the meanwhile, medications could offer a helpful treatment boost.

Medications looked important because in order to talk cooperatively with each other spouses each need to be operating from a reasonable normal emotional zone. Brett acted angry and felt depressed; Marsha acted depressed and felt perpetually angry. I encouraged them both to avail themselves of antidepressant medication. Unfortunately, however, Brett insisted that he did not want or need to use medication. Thus one of the first conflicts we needed to address emerged as a patient-therapist conflict.

Resistance to therapist suggestions is one of the indicators for an individual session. Changing one's mind can feel like loss of face; eliminating the audience decreases this potential shame factor. Resistance to medications then can be handled with the same basic conflict resolution patterns as conflicts between spouses. I needed to hear Brett's underlying concerns; he needed to hear mine, and together we could map a consensus solution responsive to all of both of our concerns. (his concerns and mine)

Medications helped Brett in fact more than they helped Marsha. Antidepressant medication reduced Brett's ever-present quickness to anger, insistent biting criticism and accusatory blame, and also his pervasive sense of hopelessness. Most relieving to me as a therapist, with medication Brett's paranoid-like fixed beliefs that all his problems were caused by his wife relaxed enough to allow moments of self-reflection and insight into his part of the difficulties. Effective marriage therapy would have been difficult if not impossible without the individual sessions that enabled Brett to let go of his opposition to medication.

Marsha's depressive sense of powerlessness, by contrast, was not alleviated with medication. Her depressive habits of thinking and acting (or more precisely, of passive-aggressive inaction) were too firmly entrenched. Growing up with perpetual criticism from an antagonistic father and then more recently absorbing eleven years of verbal assaults, unilateral decision-making, and domineering behavior from her husband had fixed the patterns too firmly. It gradually became clear that alleviation of this fixed depressive stance would take individual work to loosen. Depressive withdrawal and passive-aggressive inaction were the only coping mechanisms Marsha could rely on for self-protection from her husband's hurtful comments. She couldn't afford to give these up in his presence until she was assured that her new coping techniques would genuinely give her more safety. Individual work gave her the safety to explore her resistances to change privately and to begin to explore change options without prematurely exposing her vulnerability.

Marsha's individual treatment sessions utilized the conflict-focused understanding of depression, specifically, that depression is a disorder of power that both causes and results from dominant-submissive conflict resolution. I use the term "depressive collapse" to describe the feeling of being small and powerless that people experience as they go from normal to depressive emotional states. (exs from sessions)

Symptom removal and resistance to change are probably the two main reasons I schedule individual sessions within a treatment that includes individual and couple treatment components. Skills can and generally need to be learned together, coordinating both partners' growth, unless resistances prove too strong. And most conflicts benefit from both parties there to be brought to resolution, though shuttle diplomacy, as we will

see later in this article, is sometimes also an important option. Symptom reduction, by contrast, often seems to benefit from the simpler focus (one participant at a time) and lack of audience of one-on-one treatment.

Resolution of current conflicts

As part of the assessment and history-taking in a first session I routinely ask couples to generate together, taking turns, a list of their unresolved conflicts, that is, a list of the issues they argue about or avoid discussing. Marsha and Brett listed their disagreements in two ways, first as specific conflicts, and then, in subsequent sessions, in more metaphorical terms. The metaphors most clearly illuminate the underlying transference concerns that tended to recur in a variety of conflict situations.

1. Finances: Marsha resented her husband's control of all the money he earned, excluding her from input on how this would be used, which she experienced as controlling and as not treating her as part of the family.
2. Housekeeping: Brett resented that the house was not kept more neatly. He particularly resented the appearance of the refrigerator. Marsha resented that one day Brett had emptied the contents of the refrigerator and then told her to clean it.
3. No sex in a year
4. Feeling left out. Marsha gave the example of Brett telling her he was going to take the children to MacDonald's, and then in fact going with them to a nice restaurant and not inviting her.
5. Brett similarly felt unappreciated and rejected, and that his wife didn't care about him.
6. Brett felt he was doing the peddling for both of them.

7. Marsha, using a similar bicycle metaphor, felt that she pedals hard but he's looking down a different road and doesn't see her attempts to please him.

In order to resolve each of these issues, each conflict had to be guided through the three steps of conflict resolution: .The bulk of each session would go to exploring step two, the underlying concerns. For example the specific conflict about the refrigerator began with Brett wanting his wife to clean the refrigerator, and Marsha agreeing that it needed cleaning but not wanting to undertake the task.

Concerns need to be explored with adequate specificity, symmetry, depth, and breadth. For instance....

Gradually "core concerns" emerge from this process. Core concerns is my term for the transference issues that trigger particularly strong emotional responses and that seem to recur again and again in different contexts. For instance, Marsha's core concerns included (1) What I want doesn't count. (2) I have to throw a fit to get what I want to be included and (3) I'm always criticized. These concerns replicated concerns from her relationship with her father growing up. Brett's underlying concerns centered on repetitions of frustrations he had experienced with his step mother: (1) she doesn't really care about me (2) she doesn't do what she should to take care of me and (3) projections of his own feelings onto his wife, especially of being continuously critical.

Clarifying these concerns to some extent resembles cognitive therapy. At the same time, linking these concerns to family of origin realities, a psychodynamic/Gestalt strategy, helps both partners to regard each other more sympathetically. Marsha's opinions didn't count in her family growing up, and her father, a negative and probably chronically depressed person, rained unremitting criticism on her. Her husband Brett did

need to learn to listen to her more respectfully instead of making decisions unilaterally. Marsha needed to unlearn the belief that throwing fits is empowering and understand instead that fits generate return hostility. She then needed to learn to use cooperative dialogue skills in order to get herself heard in a positively empowered manner

Clarifying concerns however in itself does not complete conflict resolution. Each issue needs action plans. With regard to the refrigerator for instance,

Improvement in communication and conflict resolution patterns

Brett and Marsha dramatically illustrated how radically different people can function when they meet one on one with a therapist from how they interact with each other. Either alone with me appeared intelligent, thoughtful, considerate, and mature. I could readily see how an individual therapist who had not seen the couple's interactions could easily be duped into believing that whichever partner they were talking must be the poor victim of a difficult spouse. The two together however regressed to childlike interactions, readily accusing and defending, and showing virtually no effective communication skills. Deficits in tactful talking, in open listening, and in emotional self-regulation blocked even rudimentary cooperative dialogue. Uncontrolled toxic anger spillage tainted the relationship again and again. In addition, higher level communication sequences such as bilateral decision-making, recovery from upsets with apology and learning, supporting each other vis a vis external challenges, sharing intimate self-revelations, or even enjoying or physical intimacy, playful verbal interactions or leisure activity, were virtually non-existent. Each of these deficits needing remediation.

The following examples of upsets-of –the-week illustrate how skill training needs become evident:

1. Son Peter's birthday (shared decision-making)
2. Dinner's ready
3. The Valentine gift (fix-it talk)

Do skills like these really need to be taught? Communication and conflict resolution patterns to some extent improve when the basic hostile stance of a couple is changed to cooperative. To sustain cooperation, however, couples in general, and this

couple in particular, needed extensive coaching of cooperative partnership skills. Otherwise each time Brett did not listen to his wife, Marsha experienced another depressive collapse. Each time Marsha withheld affection in order to experience at least a modicum of power in their interactions, Brett's abandonment anger returned. Each time a decision needed to be made, their unilateral decision-making paradigms resulted in one or the other partner feeling powerless and furious. And each mishap further consolidated both partner's antagonisms as they had no sufficient paradigms for cleaning up after upsets.

In addition to skill-building, family of origin explorations can help couples to understand their transference reactions and also the positive functions that currently dysfunctional patterns initially served. For instance, (10/1/97) Brett recalled that in his family, when his stepmother "got bitchy about something", she would punish him for the next 24 hours. When he sensed that his wife Marsha was bothered by anything he did, Brett would react with instant anger, anticipating 24 hour punishment and striking back as he had been unable to do as a child. At the same time, he often reacted in the manner of identification with the aggressor. He recalled that, "If you didn't do a chore my Mom would say 'It's not my job to keep up with you...' and then would punish rather than helping or encouraging in any way." Similarly, as in the refrigerator incident, Brett seemed to be hypervigilant for when Marsha would slip on doing her chores (which, when she was depressed, was frequent), and then scowl and berate her.

While understanding the family origins of these patterns can substantially decrease resistance to change, and enable old habits to be "pulled out at their roots" and thereby eliminated more comprehensively, new more sanguine responses do not

necessarily miraculously appear. For example, Brett and Marsha needed both to unlearn punishing each other in response to unaccomplished chores, but also to learn to do “fix-it talk.” Fix-it talk is my term for cooperative dialogue about minor changes either of them would like to see in household routines. With fix-it talk skills, Brett could raise his a touchy topic like chores, he and Marsha could talk together constructively about each of their concerns, and they then could map a plan of action that would feel comfortable for both of them. Brett and Marsha’s treatment thus included both approaches to skill change--historical explorations of origins of poor habits and skill-building for the future.

ETHICAL CONSIDERATIONS

Treatment that combines individual and couple treatment formats raises two main types of ethical considerations: confidentiality issues and dual relationship questions.

PRINCIPLES FOR DECIDING WHEN TO USE

INDIVIDUAL VERSUS COUPLE TREATMENT FORMATS

In conflict-focused treatment framework, couple treatment is the default format. Most treatment, with most couples, proceeds primarily in that format. The following circumstances suggest, however, when a switch to one or more sessions of individual work will be helpful:

- Assessment needs to include at least a few minutes of time during which each individual has a private opportunity to confide concerns to the therapist that s/he may have been reluctant to verbalize in front of the spouse.
- Symptoms, e.g., excessive anger, depression, anxiety, drug or alcohol abuse, etc, generally are alleviated more easily and more comprehensively with inclusion of at least some individual work

- When one format is not using, switch to the other.
- When there is a lack of insight in reporting difficulties, use the couple format. The therapist needs to see the difficulties live if a patient cannot see the problems him/herself.
- When emotional states appear fixed (e.g., a fixed blaming stance, or a fixed depressive stance), use individual sessions.
- When resistances to treatment appear in the couple format, schedule an individual session.
- When one partner needs an individual session, schedule a session symmetrically for the other as well.
- Most work generally needs to occur with both partners present. That way both can change in coordination with the other, they both have the same information about healthy communications, and they both understand each other increasingly fully as a result of therapeutic explorations each has made in the other's presence.