From one person to two person psychotherapy: Considerations and practicalities for including the partner in the treatment

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Attestation of authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person, nor material which to a substantial extent has been accepted for the award of any other degree or diploma of a university or other educational institution, except where due acknowledgment is made in the acknowledgements.

Signed _____ Date_____

Jonathan Hay 30th June 2011

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Abstract

This dissertation explores problems and considerations that arise when individual psychotherapy warrants consideration of the client's partner, and they are subsequently introduced into the therapy either at the onset or at a later stage in the treatment. A systematic literature review was conducted and themes that emerged include: how individual psychotherapy impacts on the client's partner; when to consider including the partner in the treatment; varying psychotherapy formats for treating both partners - including changing from individual to couple therapy, and introducing a simultaneous individual or couple therapy; and the advantages and disadvantages of one therapist treating both partners compared to two therapists conducting separate therapies. Although client's partners are often overlooked or thought of as external factors, there are a variety of options for including them in the treatment.

Introduction

The situation is a common one. A client comes for individual psychotherapy but either at the start or as the therapy progresses their partner also appears to be part of the struggle. Perhaps the client's presenting problem appears closely intertwined with their significant other; for example, feeling depressed as a result of constant fighting at home. Maybe the client makes progress in their individual therapy but their partner struggles to accommodate their changing loved one. As a result the therapist may be left wondering if it would be helpful to include the partner in the therapy. However, most trainings - because they tend to concentrate on either individual or couple therapy - provide little guidance on how to manage these situations; either introducing the partner into the therapy dyad and thus changing to couple therapy, or adding a simultaneous individual or couple therapy to the original format. Without guidance it is likely the therapist will then either continue with what is familiar, hoping that it is adequate, or be faced with unknown territory if altering the therapy format is deemed necessary. This dissertation explores that unknown territory in order to put together some best practice guidelines for managing these scenarios.

Changing the format of the therapy is a complex task and carries many considerations. For example, can the significant other be integrated into a psychotherapy format that is already established with their partner? How should confidential information that was obtained during the individual therapy be treated now the partner is also included in the therapy? Should a referral be made to a different therapist so that they can begin with an equal allegiance to both partners?

In order to address these types of questions I conducted a systematic literature review. While the literature contains few empirical studies or trials, it does have several case studies and expert opinion pieces. These have been read critically, the insights pooled and analysed,

and several guidelines and clinical considerations have been extracted. The findings have been assembled into three chapters and are outlined as follows:

Chapter 1 covers what the literature tells us about why psychotherapists might consider changing from a traditional individual psychotherapy to one that also includes - or at least considers - the partner. Topics in this chapter include consideration of an individual therapy bias, situations where individual therapy may lead to new problems emerging that include the partner, times when significant others may resist or even sabotage their partners therapy, and ethical reasons for considering the impact that individual psychotherapy has on significant others.

Chapter 2 explores how the psychotherapy format can be changed when including the partner in the treatment. It looks at how the therapy format should be decided and includes some general indications for choosing between individual or couple psychotherapy. It considers the usefulness of meeting the partner at the beginning of therapy and raises some considerations around getting the partner to attend. The chapter then explores converting an individual therapy into a couple therapy. Finally, it looks at options for mixing the therapy format; these options include simultaneous individual therapy for both partners as well as simultaneous individual and couple therapies.

Chapter 3 addresses the issues that may arise around having one therapist versus two when working with these varying formats. It considers the main hurdles that face each, such as how confidentiality will be managed by one therapist when two partners are seen separately, or alternatively, the challenges that face two therapists when trying to work collaboratively.

The dissertation concludes with a summary of findings and makes recommendations for further research.

Methodology

The research problem is as follows: What is best practice for transitioning from individual to couple psychotherapy or combining both?

In the manner of Evidence Based Practice (EBP), this dissertation aims to systematically review all available information that addresses this problem. EBP aims to use the best available evidence to provide recommendations for the highest quality of care to patients (Melnyk & Fineout-Overholt, 2004). This fits with my intention: gathering evidence to best serve the client in this common - but rarely described - scenario.

EBP is sometimes criticised as it relies on best available evidence, but factors such as a publication bias raise the possibility that not all research will be published and available (Dickersin, Chan, Chalmers, Sacks, & Smith Jr, 1987). Tonelli (2001) also points out that knowledge obtained from clinical research may lack a human factor and might not necessarily equate to what is best for the patient that sits before the clinician. Tonelli suggests that EBP should not discount the value of clinical wisdom, which aligns with Sackett et al. (2000) who define EBP as "the integration of best research evidence with clinical expertise and patient values" (p. 45).

Systematic review

During a preliminary exploration of the literature, no articles were found that specifically addressed the research problem. Sporadic mention was sometimes given that related to the topic; however, these mentions were brief and usually appeared deep within other more broadly themed articles. Therefore, a research methodology was needed that would bring together all available information and critically organise it into a useful clinical paper.

A systematic review is "the process of locating, appraising and synthesising evidence from scientific studies in order to provide informative, empirical answers to scientific

research questions" (Dickson, 1999, p. 44). It is the means by which EBP is achieved and is a commonly used method of gathering relevant data and synthesising into a useful body of information that addresses a specific clinical problem. A systematic review is a more effective method than the traditional literature review because it demands a rigorous and methodical approach to locating and organising information in order to address a clearly focused clinical question and minimize bias. A systematic review commonly uses the following steps: a focused clinical question; a defined search strategy; critical appraisal of data; data pooling and analysis; and classification of the evidence (Schneider, Whitehead, & Elliott, 2007).

Other research methods were considered but were deemed less suitable. For example, a narrative review is commonly used to explore a broad topic that does not necessarily include a clearly defined clinical question or defined search strategy. This method was considered unsuitable because of the specifically focused question that needed to be addressed. Another approach considered was a meta-synthesis. This research method aims to produce new interpretations from existing individual qualitative studies in order to provide unitary or over-arching frameworks. A meta-synthesis was also deemed unsuitable because preliminary searches showed a lacking of in-depth studies related to the research question. (Schneider et al., 2007). Thus, a systematic literature was decided upon as the most suitable research method to address the problem.

Inclusion and exclusion criteria

This systematic review focused specifically on psychodynamic psychotherapy literature. Non-psychodynamic modalities such as CBT or Narrative therapy were excluded unless they were being described within a psychodynamic framework. For an article to be included it had to include reference to *both* individual and couple therapy with the same client. Articles were excluded if they only referenced one approach and not the other.

Search strategies

My literature review began with a comprehensive database search. The databases I included were PsychINFO, Psychoanalytic Electronic Publishing (PEP) and Medline via PubMed. Variations on terms used to describe couple therapy were searched for when they occurred in articles that also included the words **individual AND psychotherapy**. The variations I used were **conjoint, marriage, marital, couple, relationship.** I also searched for any articles that referenced the terms **concurrent** or **simultaneous** AND **psychotherapy**.

Search words and findings are listed in *Figure 1*:

PsychINFO : Keywords	Total results	Useful results
Conjoint AND individual AND psychotherapy	168	7
Marriage AND individual AND psychotherapy	312	9
Marital AND individual AND psychotherapy	398	11
Couple AND individual AND psychotherapy	401	10
Relationship AND individual AND psychotherapy	1848	12
Concurrent AND psychotherapy	395	8
Simultaneous AND psychotherapy	245	6

PEP : Keywords	Total results	Useful results
Conjoint AND individual AND psychotherapy	42	4
Marriage AND individual AND psychotherapy	27	3
Marital AND individual AND psychotherapy	93	10
Couple AND individual AND psychotherapy	82	9
Relationship AND individual AND psychotherapy	169	3
Concurrent AND psychotherapy	81	5
Simultaneous AND psychotherapy	55	3

Medline via PubMed : Keywords	Total results	Useful results
Conjoint AND individual AND psychotherapy	166	4
Marriage AND individual AND psychotherapy	1285	8
Marital AND individual AND psychotherapy	1957	12
Couple AND individual AND psychotherapy	428	5
Relationship AND individual AND psychotherapy	5933	11
Concurrent AND psychotherapy	657	5
Simultaneous AND psychotherapy	293	4

Figure 1. Keywords and search results

To supplement the relatively small number of useful search results that were produced from the database search I conducted an extensive non-systematic search following the

references from each article. In addition to this I undertook a hand search for any relevant information from books and articles contained in the AUT library and further literature was sought using Google Scholar. I also consulted with colleagues and e-mailed experts in the field. The search continued until saturation was reached.

CHAPTER 1 – WHY CONSIDER THE CLIENT'S PARTNER?

"Every cobbler thinks leather is the only thing" (Mills, 2000, p. 19).

Introduction

This chapter explores various views suggesting that if a client is in a relationship then the impact of individual psychotherapy on their partner should be a consideration throughout treatment. As will be seen, the first point raised suggests a bias in the literature to either an individual or a couple approach to therapy, but little mention to working with a blend of the two. Next, new problems that might arise in a client's romantic relationship when they are in the process of individual therapy are considered, followed by a look at ways that significant others could resist or sabotage their partner's therapy if they do not appreciate or understand the changes that are taking place. Finally, some ethical arguments are raised which suggest that psychotherapists should not ignore the impact that psychotherapy has on their client's relationships.

A dichotomy in the literature

There is a dichotomy in the psychodynamic literature: that psychotherapy involves either an individual or a couple therapy approach to treatment - one or the other. Whilst some couple therapy writers give occasional note to the usefulness of individual sessions within the couple therapy format (e.g., Johnson, 2004; Scharff & Scharff, 1997) any mention given is usually brief. However, that amount appears generous when compared to the scarcity with which individual therapists mention meeting the couple.

Phillips (1983) says that many psychotherapists lean towards the classical approach which involves only meeting with and treating the individual. He warns that focusing on an

exclusively individual format overlooks the important point that "any form of therapy is an intervention in a system of interpersonal relationships" (p. 11). When an individual is having psychotherapy their treatment affects their significant other regardless of whether the therapist thinks this way or not. Heitler (2001) suggests that focusing exclusively on the individual is overly simplistic and is likely to inadvertently harm some patients. She says: "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" (p. 380).

Whilst many psychotherapists work with both individuals and couples, a widespread view is that they must decide to treat *only* one partner or *only* the couple (Weeks & Treat, 2001). This dualism has little impact when the client's needs are straightforward; for example, individual therapy to help long-standing depression, or couple therapy to help with relationship conflict.

However, as we shall see in the following chapters, sometimes effective treatment may warrant a shift from one format to the other or a combination of both, and subsequently, an either/or approach may not be the best fit. For example, what happens when a client requests individual psychotherapy that seems fitting initially, but as they begin to describe their problem their partner figures prominently in their struggle? Or what happens when individual therapy is underway but as the treatment progresses, change in the client impacts problematically on their partner? In other words, when the need arises, how can we transition from individual therapy to couple therapy, or work with both approaches simultaneously?

An individual therapy bias

Psychodynamic therapists commonly assume that for deep change to occur, individual therapy is the only context that really facilitates this (Burch & Jenkins, 1999). Whilst this

may sometimes be true, couple therapy, others argue, can enable change which cannot be achieved in individual work. "The often fierce and fastpaced interactional field of [couple] therapy is rich in occasions of intimate encounters, providing certain opportunities lacking in individual psychotherapy" (p. 243).

However, psychotherapists who prefer not to work with couples or who are not trained in couple therapy may have a bias for individual psychotherapy making them more likely to assume individual therapy as default and failing to consider whether alternative treatment formats could be more helpful (Zeitner, 2003). Hurvitz (1967) describes how this bias, if unacknowledged, might manifest itself in practice; he depicts a common scenario in which the individual therapist alludes to the fact that in order to obtain greater psychological well-being, a subsequent disturbance in the client's relationships may be either a necessary sacrifice, or simply a reconciliation with the truth.

Another widespread notion voiced by Zeitner (2003) is that any characterological or interpersonal problems experienced by the client will inevitably manifest themselves within the individual therapy, either by disclosure or through observance of the transference. This view, he argues, fails to consider the importance of the intersubjective aspect of all human relationships.

Kottler and Carlson (2003) stress the importance of having a sense of flexibility and a pluralistic approach to psychotherapy rather than simply relying on a rigid format. They say that a failure in therapy happens when the therapist reaches the limit of one model and then is unable to reach for another.

Individual therapy that leads to new problems in the couple

The following two sections will look at some common scenarios that may warrant consideration for change in the therapy format. The first of these is when personal changes in individual therapy lead to problems in the client's relationship with their partner.

Coyne (1976) and Graziano and Fink (1973) both note how individual therapy impacts on the client's psychosocial environment, often placing unwanted changes and demands on significant others. This runs the risk of producing new conflicts or aggravating and compounding old difficulties. Therefore, whilst the common assumption is that individual psychotherapy is for the benefit of all, there is frequent mention in the literature around the potential of a negative impact resulting from changes that are unwelcome by the patient's partner (e.g. Colson, Lewis, & Horwitz, 1985; Kohl, 1962; Moran, 1954; Zeitner, 2003).

Observations of this type are nothing new. Freud (1920) noted the frequency in which he encountered his female clients suffering marital difficulties subsequent to their treatment:

> [I]t constantly happens that a husband instructs the physician as follows: "My wife suffers from nerves, and for that reason gets on badly with me; please cure her, so that we may lead a happy married life again." But often enough it turns out that such a request is impossible to fulfil - that is to say, the physician cannot bring about the result for which the husband sought the treatment. As soon as the wife is freed from her neurotic inhibitions she sets about getting a separation, for her neurosis was the sole condition under which the marriage could be maintained (p. 150).

However, whilst many authors describe their own observations of new problems arising following individual therapy, researchers have reported mixed findings. For example,

Pomerantz and Seely (2000) conducted a study in which they asked 473 undergraduates to envision their partner as having individual psychotherapy and then answered questions describing their distress to specific scenarios. Overall the study found that participants felt some distress at simply imagining having a partner in therapy, with the most distressing responses occurring when clients refused to discuss their therapy, and when partners were unaware of the reason for their partner's therapy. Similarly, Gurman and Kniskern (1978) carried out a meta-analysis in which they analysed over 200 reports and studies that examined relationship deterioration during family or marital therapy. They found that negative therapeutic effects were twice as likely when the patient was seen in individual therapy rather than in a format that included both partners.

On the other hand, Hunsley and Lee (1995) conducted a meta-study of 20 independent clinical samples which looked at the impact that individual therapy has on relationships and they conclude that there are less negative consequences than some early studies indicated. They suggest that perhaps the increased number of female therapists contributes to this decrease in partner difficulties. In the past, clients of therapy have often been female and therapists were usually male which was likely to have invited inadvertent negative comparisons between the nurturing therapeutic relationship and troubles at home. Hunsley and Lee say that treatment with a same-sex therapist can reduce this risk. They also say that contemporary therapists may be more likely to encourage their clients to explore what they can do towards improving their happiness at home rather than simply complaining about their spouse. Hunsley and Lee conclude that whilst individual therapy often causes disruption to the relationship, this disturbance is usually temporary and there is no conclusive evidence to the long-term negative impact on the patient's relationship.

However, a critique of Hunsley and Lee's findings is that psychotherapists cannot reliably predict whether a therapy will be long-term. Therefore, even though Hunsley and

Lee conclude that disruption is often temporary, if the therapist does not attend to the partner in some way, they will be left to make a judgment call on whether or not the client will remain in therapy long enough, or whether the client's relationship is strong enough, to withstand any problems that may have developed during the course of the treatment.

Nevertheless, we must not overlook the fact that client's partners are often pleased with the outcome of their spouses' individual treatment and they commonly find that it benefits themselves as well as their relationship (Lefebvre & Hunsley, 1994). Thus, holding in mind that individual treatment aims to be advantageous, Hunsley and Lee suggest that therapists discuss with married clients both the positive and negative impacts that individual treatment may have on their marital relationship and in doing so make it clear to the client the options of both individual and couple treatment.

In short, any therapy that has an impact on an individual will subsequently have an impact on their partner. As Garfield (2004) points out, "problems may occur in individual therapy when the therapist is unaware of the impact of the therapeutic alliance on the patient's relationships outside therapy" (p. 460). Therefore, if the individual therapist recognises that they have activated a disturbance in the client's relationship with their partner, Garfield suggests that this is the time for the therapist to encourage a consultation for couple therapy.

Resistance or sabotage by the partner

When the therapist does not give appropriate attention to the spouse's role in the client's difficulties, Hurvitz (1967) says the spouse may be resistant to any change that the client attempts to bring about and may try to sabotage the therapy in conscious or unconscious ways. For example, Kohl (1962) conducted a 10 year study in which he observed marital partners who were not included in the therapy exhibiting various types of reaction to their partners improvement; these ranged from resentment or suspicion of the

therapist or the therapy, recurrence of addictive behaviours such as alcoholism, threats of divorce, through to threats or attempts of suicide. Ackerman (1958) also describes commonly observing one partner improving as the other gets worse, or one partner maturing as the other becomes more depressed.

Similarly, Pollak (1965) and Mittelmann (1944) point out that consideration should be given to the client's spouse, stating that change in one spouse is not always appreciated by their partner. If the partner does not welcome the changes in their previously familiar environment it is possible that they will be resistant to any change or may sabotage the therapy in some way.

Brody (1961) refers to a comment made by Freud about "the family poking their noses into the scene of the operation". Brody responds by saying that the meddling of spouses signifies an attempt to get help for themselves and goes on to say that the barrier which is created by individual psychotherapy could make intrusion the only method by which the isolated spouse can "knock on the door of the partner's analysis" (p.98).

However, these pathological reactions are often predictable, says Kohl (1962), and if a scenario such as this develops then the marital partner should be included in the therapy as early as possible. He says that the therapist's ability to effectively manage the conscious and unconscious hostility of the marital partner has a direct impact on the success or failure of the patient treatment. If and when to consider including the partner in the therapy is, of course, a judgement call. Zeitner (2003) describes a common scenario when after spending time in individual therapy and making significant changes the client complains to the therapist that their "spouse is still reacting to him or her as if he were controlling, helpless, stubborn, or whatever other characteristic might have been the focus of struggle. It is often at this point that the analyst and sometimes the patient, too, become aware of the presence of interlocking pathology which will less likely improve without couple therapy" (p. 350).

Likewise, Carveth and Hartman (2002) write that when the patient has been in individual therapy for some time and begins to notice that their partner is not only not changing with them but they are actually sabotaging any healthy progress, it may be time for the therapist to consider including the partner in the treatment. Kohl (1962) notes that inclusion of the marital partner is indicated when they react to the patient's obvious progress either by a resistance to their partners improvement, or by the development of clinical illness. He says that in these cases it is often clear that the well-being of one partner has a direct relation to the illness of the other and he found that it was not uncommon for the marital partner seeking treatment to actually be the less sick one in the relationship. Indeed, it may be that the partner who seeks treatment may not be the sicker one, and this may be one of the reasons that partners react badly to improvement in the other (Berger & Berger, 1979).

A common opinion amongst individual therapists, says Brody (1961) is that "in prolonged treatment with one individual, the idea has been expressed that if one member, the presumed 'sicker one' got 'straightened out,' the family difficulties would be automatically cleared up" (p. 97). This idea is unrealistic, he explains, because the real problem is still being ignored. He goes on to say that "the untreated partner may be treatment-rejecting precisely because he is afflicted with an even more severe disturbance than the treatment-accepting partner". In other words, the client who arrives at the therapist's office for treatment may not be the only one with a problem, and if treated in isolation, the other's problems, as well as the impact of individual treatment of the partner, are being overlooked.

Ethical reasons for considering the partner

In addition to the practical considerations discussed so far, there are also ethical reasons for considering the partner. Sider and Clements (1982) say that what is good for the individual may not always be good for the couple and they suggest that individual therapists

tend to overlook the ethics of considering the partner and avoid it in a variety of ways. For example, the individual therapist might maintain that there is no conflict between their therapeutic loyalty to the good of the individual and the good of the relationship that they are part. The assumption is that the good of one, in the long run, works for the good of the other. Another common justification they describe is that the therapist's sole interest is in achieving the goals of the therapy which have been defined by the participants of the therapy; the therapist is simply an agent of the process and has no interest in the outcome.

During the initial assessment for individual therapy, many therapists will routinely communicate to the client their qualifications, perhaps discuss the procedure and goals of therapy, and maybe establish a therapeutic contract of sorts. However, fully informing the client of the possible side-effects of therapy is often glanced over during this initial interview (Hare-Mustin, Marecek, Kaplan, & Liss-Levinson, 1979). What is being overlooked is that clients often enter into therapy believing that the process will enhance their relationship with their partner and whilst this may often be true, as mentioned previously there is the possibility that therapy may well harm it (Hurvitz, 1967).

Indeed, "is it ethical to offer married individuals assessment and treatment that does not include the spouse?" asks Heitler (2001, p. 349). Her rationale is that if therapy is started with one individual and not their partner, it introduces the likelihood that an asymmetrical alliance will be developed with one spouse, jeopardising the ability to work with both partners later if the need arises. In line with this, Lefebvre and Hunsley (1994) suggest that partners of clients in therapy should be included in discussion about the possible impact therapy can have on a relationship and that both partners are made aware that any impact to their relationship could be positive or negative.

Phillips (1983) says that in order to practice ethically, therapists need to develop and hold a clear premise of what constitutes appropriate concern for their clients overall

wellbeing. If necessary they should broaden this view so that it includes the patient's wider socio-psychological environment and not simply be confined to resolving unconscious conflict in the individual. "Realistic expectations of the potential benefits and costs of entering treatment should be fostered from the beginning, and include sufficient information regarding possible, albeit unintended, negative side-effects" (p. 10).

Whilst the views expressed so far have all leant towards an ethical obligation to inform the client of the potential outcomes of therapy at the onset, a critique of this is that real life practicalities may not always make this possible; for example, if the client presents in crisis. However, whilst the practicalities of attending to the client's immediate concerns may make these explanations unwelcome or even unhelpful, Phillips (1983) maintains that "therapists must accept the ethical obligation to continually examine the effects of their interventions on the lives of the clients they serve" (p. 12). Therefore, if practical matters make the timing of this conversation inappropriate, then once the crisis is over the ethical conversation should be initiated by the therapist if the client intends to continue therapy. Phillips goes on to say that "just as the physician is obligated to inform the patient of the possible side-effects of a particular drug, and the lawyer is obligated to provide information regarding the possible gains and losses involved in legal action, the psychotherapist incurs a similar responsibility" (p. 10).

Summary

This chapter has discussed how psychodynamic literature commonly focuses on either individual or couple therapy with little written regarding transitioning or combining the two. This dichotomy flows into clinical practice leaving many therapists feeling as if they need to choose one format or the other. An individual therapy bias has been suggested and discussion given to understanding how this bias could be harmful to the client if not

recognised. If the limits of individual therapy are overlooked by the clinician then an individual format may be chosen as default, even when it might not be the best course of action. If indiscriminately applied without consideration of the client's relationship, individual therapy runs the risk of the spouse being resistant to any change made in their partner and the possibility of new problems arising. This would then force the therapist to decide either to include the partner in the therapy in some way or trust that these problems will be attended to appropriately in due course within the context of the individual therapy. Finally, ethical arguments have been raised that suggest an obligation to the therapist to attend to the client's relationship appropriately and also to fully inform the client at the onset of therapy that their treatment may have an impact on their relationship.

CHAPTER 2 – CHOOSING AND CHANGING THE THERAPY FORMAT

Introduction

The writings so far have suggested that individual psychotherapy can have a significant impact on the partners of those who are in treatment and that in order to practice ethically, psychotherapists need to maintain an awareness of this impact and initiate the appropriate action should the need arise. It has not been suggested that all individual therapists should convert to couple therapists, and the importance of an individual psychotherapy treatment is not being minimised. As Mann and Lundell (1977) point out, when couple therapy methods are applied overzealously without proper assessment of individual needs, they too can have a significant detrimental effect on the therapeutic outcome. What is being suggested is that when a client comes for individual therapy who is in an intimate relationship, then in a sense it is already couple therapy whether the partner is physically present or not.

The following chapter will bring together some views and suggestions from therapists who have included client's partners in various ways. The therapy formats considered range from the partner attending one or more sessions of the individual therapy, through to changing the format from an individual therapy to a couple approach. This chapter looks at factors that can guide therapists when deciding on a format near the start of the process as well as converting the format of an already established individual therapy.

Consumer model

A clearly articulated criteria for deciding whether to opt for individual versus couple therapy has yet to be written and changing or extending the initially requested format carries many considerations (Maya, James, & Steven, 2003). For instance, who should decide on

which format to undertake: should the therapist simply accommodate the client's wishes or might professional opinion take precedence?

Gabbard (1994) considers things such as: What is the patient asking for? Does one client come to the office looking for therapy or are there in fact two clients? During the initial meeting with an individual, do they focus on their own problem or a shared problem with their partner? Does the individual consider their problem as having an internal origin or an external one?

In an ideal scenario, Zeitner (2003) says the therapist will conduct an in-depth assessment and then after discussion with the client reach a consensus over which is the best course of treatment for the presenting problem. McWilliams has a similar view and says that therapists should typically respect the client's wishes in the first instance and then revise the initial decision over time, in collaboration with the client (personal communication, 20th May, 2010).

In the absence of reliable research, it is clinical wisdom that becomes most helpful in choosing between an individual or couple format. The following section will bring together expert opinions regarding indicators for both approaches. First, some general indicators that suggest proceeding with an individual format are outlined below.

Indications for individual therapy

Maya, James and Steven (2003) point out the obvious and state that individual interventions are indicated when one spouse is unable or unwilling to attend therapy. Corcoran (2004) adds that an individual format is indicated if: the client is suicidal, if the individual sees their depression as arising before any relationship problems or as unrelated to their relationship, when the client wants to attend to many personal issues, when there is a lack of commitment to their relationship, if the partner is having an affair, or if marital

violence is present. Johnson and her colleagues (1999) also say that when ongoing abuse is present then an individual format takes precedence. Johnson refers abusive partners to either group therapy or separate individual therapy to help them deal with their abusive behaviour and couple therapy is only offered when the abusive individual has completed their therapy and their partner no longer feels at risk.

Halford and Bouma (1997) say that couples therapy is unlikely to be helpful if either partner is experiencing an acute psychotic episode or if they abuse alcohol to the extent that it inhibits any effective engagement in therapy. Likewise, if somebody is severely depressed and is subsequently unable to engage effectively then individual treatment is likely to be more helpful before any couple work is considered.

If the relationship is ending because of separation or divorce, Crowe and Ridley (1990) say this may be an indication for only seeing one partner. Often that partner will come for help because they are going through the equivalent of bereavement and the therapy may centre on initially helping them mourn the loss of their relationship.

A final note comes from Johnson (2005) who says that when an individual has experienced trauma then individual therapy should be the preferred choice at the onset and couple therapy can be considered to attend to any interpersonal trauma symptoms once the acute individual symptoms have been addressed.

Indications for couple therapy

The following opinions discuss when it may be helpful to suggest a couple format instead of, or as well as, continuing with an individual therapy.

Problems relating specifically to arguments and relationship tension appear to be an obvious starting point for considering couple therapy, say Crowe and Ridley (1990). Another consideration they point out is when a client in individual therapy spends much of the session

complaining about their partner's behaviour. Couple therapy might also be indicated when one partner experiences an increase in stress as a result of the improvement of their partner from their own individual therapy.

Crowe and Ridley (1990) also suggest couple therapy when an individual's problem directly affects their relationship. For example, a wife who has a phobia with sex might believe that the problem is all hers and certainly individual therapy will likely be of benefit to her. However, her problem may also generate frustration for her husband and as a result, his frustration may well impact on her phobia. Thus, couple therapy could allow both partners to explore the part that each of them may be playing in terms of maintaining the problem.

If the primary difficulty seems to be related to an inability to cope with the marital relationship - despite the individual's adequate functioning in other social settings - then Mann and Lundell (1977) say that treatment involving both partners may be a preferable format. Corcoran (2004) mentions that if an individual suffers depression and they perceive their symptoms as being caused by their relationship problems then couple therapy is indicated. Likewise, Maya and colleagues (2003) note that couple therapy should be considered when a client believes that their relationship is playing a primary role in their symptoms. Finally, Brody (1988) points out that if couple therapy is being considered, it is important that each partner is capable of forming and maintaining an alliance with both the therapist and their partner.

Meeting the partner at the start of therapy

The attendance of partners needs careful consideration and meeting them during the onset of therapy has different implications than meeting them later in the treatment. As will be seen in the following section, many authors appear strong advocates for the usefulness of

meeting the significant other near the start regardless of which therapy format they plan to undertake.

Even if the therapist does not wish or believe it necessary to pursue couple therapy, it can be helpful to have at least one session in which the partners are seen together, suggest Mann and Lundell (1977). They believe that this introduces another dimension into therapy, and also helps in reducing observer error. Berger and Berger (1979) believe the therapist can have a more truthful experience of the client when they meet both partners together. They say that it is not uncommon to discover that each partner behaves quite differently when seen alone than when seen with their partner.

Maltas (1998), reflects on her own experience and says that "after more than 20 years of practising individual and couple therapy I am still shocked at the difference between my image of a partner, developed in the course of an individual therapy, and the person who walks into my office claiming to be that partner" (p. 348). Yalom (2003), too, says "never have I regretted interviewing some significant figure in the life of my patients" (p. 211). He makes the point that whenever a patient describes to him their significant other he creates a mental image in his mind of that person, often overlooking or forgetting that the information he is being given is highly skewed by the patient's subjective bias of their partner. Yalom believes that when he meets the significant other he is able to see more fully into the life of his patient. He notes that because he meets the significant other in the unusual setting of a therapeutic session their behaviour and manner will be influenced by the rather odd context. Nevertheless, Yalom believes that the "image of the face and person of the other permits… a richer encounter with [the] patient" (p. 211).

Meeting the partner is not without risk however. In keeping with the views that have already been mentioned, Vaglum et al. (1994) concur with the usefulness of interviewing the spouse when the therapy commences in order to help the therapist better understand the new

patient. However, they warn that this interview not only impacts on the patient, but also on the spouse. For example, rather than ease any negative transference that the partner may have, it may actually increase their feelings of discomfort, perhaps increasing envy, as they see first-hand the closeness and intimacy that their partner has or will develop with the therapist. They say that if the therapist gets any indication that this is occurring then it is important that they make efforts to address it directly.

However, is it a good thing that the therapist becomes privy to information through means other than by disclosure from the client, ask Carveth and Hantman (2002)? They point out that therapists of a post-modern view might state that this type of fact-finding is irrelevant to the therapeutic task [1]. However, they believe that exposure to information about the client (from those who are in relationship with him or her) can help the therapist guard against potential identifications ranging from "twinship experiences or mergers..., to projective counteridentification, all the way to outright *folie-a-deux*" (p.35).

So, many authors agree that meeting the partner can be helpful when a client is in a serious intimate relationship even if couple therapy is not part of the treatment plan (Carveth & Hantman, 2002). Furthermore, meeting the partner at the start of the therapy opens up possibilities of including them later on should the need arise.

Getting the partner to attend

So far we have looked at reasons for considering the partner and reasons why it may or may not be helpful to include them in the therapy. Using the information discussed one is able to begin building a picture of when it might be helpful to include them. If client and

[1] Yalom (2003) voices a similar preference to having no outside knowledge of the patient and as such he always interviews the partner in the presence of the patient.

therapist agree to the partner attending one or more sessions, the next consideration is how to get the significant other to attend.

The reluctant partner

Odell and Campbell (1998) discuss the common problem of an individual who states a desire to include their partner in therapy but declares that they will not attend. How do you get the other person into the therapist's office? Initially the client should be asked if they have actually invited their partner to come to therapy. Odell and Campbell say that in their experience it is common that the individual client is assuming that their partner is reluctant but they have often not actually asked him or her if they would be prepared to come to couple therapy. They suggest that at times all it takes is an encouraging partner in order to get the spouse to attend therapy as well.

Sometimes, however, the invitation is refused. Odell and Campbell point out that it is important to determine why the invitation was declined. It might be that the reluctant partner has had an undesirable therapeutic encounter before. They suggest that the therapist (after obtaining permission) contact the reluctant partner directly. During this contact, the therapist can address things such as a realistic representation of themselves as a therapist, the client's pride, and also perhaps appealing to the spouse's sense of duty.

Sometimes one partner is unwilling to attend because they are having an affair with somebody else. Or perhaps the couple are having an affair with each other and one or both are also involved in another relationship that has not ended. Crowe and Ridley (1990) say that an ongoing affair is not always a complete block to therapy. However, if the involved partner does attend sessions it is likely that the divided loyalty and strong ambivalence will make therapy very difficult.

Who should invite the partner?

There are opposing views around who should take responsibility for encouraging the partner to attend the therapy. Forrest (1969) takes the position that when it is apparent that the marital partner is directly involved in the presenting issue then the therapist must work hard to motivate and involve the one who did not seek therapeutic services. Similarly, Crowe and Ridley (1990) suggest the therapist make efforts to involve the other partner or contact them directly - especially if communication has been via the partner in treatment - in case they had been misrepresented by the attending client due to their wish to avoid couple therapy.

Framo (1992), on the other hand, says that it is not appropriate for the therapist to get directly involved with inviting other family members to attend therapy. He says that any efforts made directly by the therapist will likely just strengthen any resistance and that inviting others is the responsibility of the client. This will be demonstrated in the subsequent example.

Caution about including the partner

A study was conducted by Halford et al. (1997) aimed at assisting women who reported problematic drinking in their partners. During the programme a number of the participants discussed how they feared assault by their partner if it were discovered that they were seeking assistance. This example highlights the fact that even when the partner is part of the problem there are still occasions when trying to include them may be ill advised. Sometimes, simply informing one partner that the other is in therapy can pose problems.

Even when the therapist strongly believes that including the partner will be helpful, the clients' wishes must be respected. Mann and Lundell (1977) share a sobering account of an overzealous attempt to include the partner:

> A 38-year-old woman was who being treated for depression had many vindictive complaints about her husband's lack of understanding and other faults. The therapist, thinking it would be sound to see the couple together, attempted to overcome the patient's steadfast refusal to agree to conjoint therapy. Eventually an appointment was arranged. The husband appeared punctually; the wife was not present. After a telephone call, the wife joined her husband and therapist in the office 20 minutes late. The therapist attempted without success to discuss the material the wife had presented at earlier sessions. After 15 minutes, the wife said that she had 'had enough' and stalked out of the office. She later telephoned to tell the therapist that he would not be bothered with her again, and that she had told him therapy would not work; she then took an overdose of a drug and had to be admitted to hospital. The overdosage seemed an obvious attempt to avenge herself on the therapist for what she perceived as a devastating humiliation. This patient was delivering a serious message, despite the non-lethality of her overdose; never again have we been this insistent or forceful in arranging conjoint sessions. (p. 116)

Getting the partner to attend clearly extends beyond simple logistics. As well as understanding when it can be helpful, it should not be overlooked that sometimes it could be harmful.

The partner refuses

Even when indicators suggest that it would be wise to include the significant other, the reality is that some people will not attend therapy with their partner under any conditions. In these situations the therapist must work with whatever they have access to. Sometimes this will be enough to bring about change and sometimes it may not (Odell & Campbell, 1998).

Crowe and Ridley (1990) believe that it is possible to provide couple therapy even when only one partner attends the sessions simply because the non-attending partners can be affected by any changes that the attending partner makes. They go on to talk about including the non-attending partner by, for example, the attending one taking home instructions for homework exercises. However, they note that this would only apply to those who are unable to attend for genuine practical reasons and not to those who are simply unwilling to get involved.

Converting an established individual therapy to a couple therapy

Introducing the partner when an individual therapy is already established warrants different considerations to meeting them at the start. A therapeutic alliance will already have been established with the initial client and injudicious introduction of the partner risks damaging it.

Not all therapists believe that the partner can be successfully introduced. Gabbard (1994), for example, believes that if the individual process is well established then it is rare that it can be converted into a successful couple therapy. He highlights the obvious fact that the partner who was brought in later on will feel the therapist's primary loyalty to the other partner and subsequently is rarely able to form an effective working alliance with the therapist. Gabbard suggests that the best solution in this scenario is to refer the couple to a separate couple therapist whilst continuing with the original individual therapy.

Yalom (2003) also believes that when the therapist already has a primary loyalty to one member of the partnership then they are not able to treat the couple. He says that if the therapist attempts couple therapy when they already have a wealth of confidential information from one partner, the therapist will inevitably become involved in a withholding parallel process with the other. Yalom, too, suggests that couple therapy should subsequently

be conducted by another therapist who will have a balanced allegiance with both partners from the beginning.

However, if the risk factors are understood and carefully considered, many authors agree that introducing the partner into an established therapy is a worthwhile, albeit challenging task. Weeks et al. (2003), for example, say that when the individual has been in therapy for a long time it runs the risk of becoming counterproductive because loyalties will have been established with one individual which if threatened can have a detrimental effect on the therapeutic alliance. Wilke (1984) adds that when the partner joins the therapy (and then later leaves) it disrupts the individual process for some time. Nevertheless, he believes that the necessity and the outcome of directly dealing with the relationship concern in the conjoint format is extremely profitable and achievable. Therefore, if the therapist does decide to change to couple therapy having worked long-term with the individual, precautions can be taken with the individual client that involve educating them about what they might be able to expect or feel when the other partner is present.

For example, the long-term client could be warned that they may experience feelings of loss or perhaps even feelings of being judged. The therapist needs to explain that they will attempt to be balanced between both individuals but because the long-term client is likely to feel a sense of loyalty towards the therapist, when this is perceived with the spouse it may be felt as a betrayal (Weeks et al., 2003).

Those with severe narcissistic wounds might feel disappointed if they believe that somebody else in the session got more attention than they did, notes Framo (1992). He suggests that these types of clients need special preparation for joint sessions and an explanation that both parties will be attended to by the therapist. Framo says that it may be necessary for the therapist to keep interaction between partners at a minimum and encourage more direct and empathic communication between the therapist and each client.

Carveth and Hantman (2002) note that care is needed when introducing the partner into therapy. "The analyst who takes on as a new patient the spouse of the acting-out [client] will find that, at every turn, both members of the couple will unconsciously thwart the treatment" (p. 38). They say that whilst the more self-aware client may recognise their feelings and be able to verbalise to the therapist any concerns they might have, the more emotionally retarded client may be completely unaware of any discomfort that they may be experiencing. These clients may act out in destructive ways as the unbearable anxiety increases in response to the therapist having a relationship with the client's significant other.

It might be helpful, suggest Weeks and Treat (2001), to see the partner who is joining the therapy for several individual sessions before commencing a joint session. This will allow the therapist to show some empathy for the perspective of the spouse, which may lessen the degree to which they might feel like a guest at their partner's therapy, or already threatened by their perception of an existing alliance. They also suggest that it might be helpful if the transition from individual therapy to couple therapy is initially done on a provisional basis and if it becomes counterproductive then other alternatives can be explored and possibly pursued. They point out that it is crucial to explore with the spouse who is joining the therapy the possibility of feeling aligned against or ganged up on and an agreement made that they will voice this immediately should it occur. Hurvitz (1967) adds that if a couple format is being adopted to attend to a newly emerged problem, the partner's feelings toward the therapist should also be explored, as the therapist may be perceived as playing a significant role in the arisen relationship difficulty.

Simultaneous individual therapies

There are times when the partner may be part of the problem but changing to a couple therapy may not be preferable. For example, Ackerman (1958) says that if both partners are locked in a pathological conflict then separate therapies may be the best way forward.

However, "involving the isolated, non-participating partner in simultaneous psychotherapy may pave the way for such a couple to secure separate treatment", cautions Brody (1961), and "this may represent a continuing pattern of pursuing their separate ways and perpetuating their unhappiness" (p. 98). Heitler (2001), warns that a format in which two separate individual therapists each see one partner creates the dual relationship most likely to eventuate in separation or divorce. She says that this arrangement is most helpful for a couple who are already clear that they want to separate and warns that it is ill-advised for any couple who want to save their marriage.

Ackerman (1958) says that if separate individual therapies are planned then treatment must begin with adequate emotional preparation and clarification of the interpersonal level of disturbance, in order to lay an effective foundation for communication between the two therapists as the treatment progresses. (Further discussion on communication between therapists is given in chapter 3).

Individual / couple therapy continuum

The variations for mixing individual and couple therapy formats are broad (P. R. Brody, 1988). One end of the continuum (see *Figure 2* below) represents a purely individual based therapy where the therapist will only meet with the individual throughout the treatment and the other end of the continuum is a purely couple-based format where the therapist always meets with both partners together. Moving in from the individual end we approach an area that can be described as partner supported individual therapy where the focus is on

individual treatment but the partner may attend some sessions as required. Moving in from the couple end of the continuum is couple therapy with some individual sessions as required. As these two ends of the continuum approach the middle we find an area consisting of individual therapy and couple therapy running simultaneously (Zeitner, 2003).

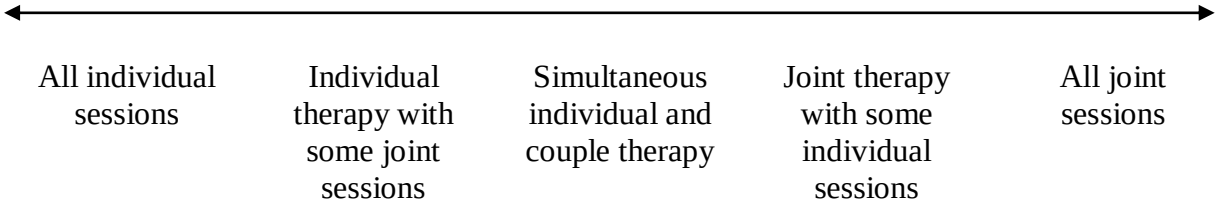

Figure 2. Individual / couple therapy continuum

Mixing the formats

Which format to apply when varies between therapists. Brody (1988) presents a model of psychotherapy where both partners are seen together for conjoint weekly therapy, and each individual is also seen separately for biweekly individual therapy. He points out that this format is aimed primarily at high functioning couples.

However, high functioning is not a prerequisite held by Heitler (2001). She uses a variable format when working with couples where both partners have long-standing patterns of borderline, narcissistic, depressive, or paranoid functioning. She describes a format of three sessions a week; one couple session and one individual session with each partner. Heitler points out that whilst this form of comprehensive treatment can help couples such as these to live emotionally satisfying lives, it does take a significant investment of time and money.

A variable format is also suggested by Berger and Berger (1979) for clients who have more serious disorders. They say that if one partner is diagnosed as having a "serious

character neurosis" then they may suggest individual treatment on a regular basis whilst the partner is seen monthly (sometimes weekly) for couple sessions.

Greenbaum (1983) refers to using a primarily individual format and then using conjoint sessions irregularly, as the need arises throughout the individual process. These joint sessions would usually occur "during periods of crisis from which the patients are unable to extricate themselves" (p. 289). However, Harwood (2004) warns that therapists should only consider including a flexible couple therapy as part of the individual treatment when the therapeutic bond with the individual is strong enough to withstand disruption and repair.

At the other end of the continuum, individual sessions within a couple format are commonly mentioned in the literature (e.g. Johnson, 2004; Lundell & Mann, 1966; Scharff & Scharff, 1997) and are used almost routinely by some therapists for reasons ranging from allowing time for individual assessment through to exploring suspected secrets that may be hindering the couple work.

Summary

Chapter 1 asked why psychotherapists might consider changing from an individual to a couple therapy format. Chapter 2 looked at the next step and explored some views and opinions on how therapists might choose which format to follow and how to implement this. General indicators have been suggested that may help guide in choosing between individual or couple formats, and views have been explored that encourage meeting the partner at the onset of therapy, regardless of whether an individual or a couple format will be pursued. Inviting the partner to therapy is not a task to be taken lightly, and cautions and considerations regarding including the partner in the process have been raised.

Next, the possibility of converting an established individual therapy into a couple therapy was discussed. Views differ on this, in that some therapists believe that a referral should be made to another therapist to begin anew - with equal loyalties to both partners - whilst others believe that with appropriate understanding and preparation, an individual therapy can be successfully changed to a couple therapy format and still be conducted by the same therapist. Finally, conducting a simultaneous therapy to run alongside the initial individual therapy and the variations available within this approach have been explored.

As well as the points already raised, there are countless other factors to consider such as the social and cultural context, the severity of the initial problem, the seriousness of the relationship with the partner, and whether or not there are children involved. The list is endless and ultimately therapists are left to rely on clinical wisdom. However, as Ackerman (1958) points out, the clinician needs to make a decision about treatment early on, despite the fact that at this stage he or she has inadequate knowledge with which to predict with any real confidence the outcome or effect of the therapy on each partner.

CHAPTER 3 – ONE OR MORE THERAPISTS

Introduction

If the therapist and client agree to include the partner in the therapy process, and the partner agrees to attend, the next decision is who should conduct the treatment? The choices are that either one therapist does all the work with both partners, or a referral is made to a colleague. Each approach warrants different considerations. If one therapist conducts both therapies, then confidentiality becomes the pressing issue. If two or more therapists become involved in the treatment, the main concern is how the therapists will collaborate and integrate the different treatments.

One therapist

Some common pitfalls noted by Lundell and Mann (1966) regarding multiple therapists attempting to work together are: hierarchical problems, differences in viewpoint, differences in skill level, assessment differences, communication difficulties, and each therapist taking on the role of advocate for their own patient. Therefore, whilst separate therapists for separate therapies are preferred by some, others believe that both partners being seen simultaneously by the same therapist is preferable in order to overcome some of these potential obstacles. Oberndorf (1938) says that as long as the therapist "is able to maintain a position of analytic neutrality, and impassivity, a difficulty is avoided which may arise when each member is being analysed by a different [therapist]" (p. 474).

Confidentiality

One of the most difficult problems that can arise when partners are seen separately by the same therapist is when one of them shares certain facts with the therapist that are not yet known to the other. There are few guidelines to help the therapist in these situations and differences in handling this matter vary. Whilst some therapists will maintain a secret shared

by one partner, others will refuse to have any contact without both partners present so as to avoid this dilemma entirely (Mann & Lundell, 1977). The following section will discuss three approaches to the challenge of managing confidentiality amongst couples: secrets will not be kept, secrets will be kept, and the therapist will use their discretion.

All information is shared

In this approach the therapist treats all information as if it is common knowledge between partners and is open that they will not keep secrets and that anything that is said in private will be treated as if it was said in the couple sessions. Whilst this stance initially appears to simplify the therapist's task in terms of managing confidentiality, the major disadvantage is that if one partner does have a secret that would affect the relationship, there is a strong possibility that they will not reveal this information. Thus, the therapy will proceed on the assumption that no secrets exist even if one partner or the therapist suspects otherwise. The partner with the secret is forced to lie in order to conceal their information which means that they will have little opportunity to explore their options and choices related to the undisclosed material (Weeks et al., 2003). With this stance the therapist has inadvertently created a format in which there is no safe environment for personal disclosures, and subsequently, no space for exploration of personal issues affecting the relationship (Margolin, 1982). Therefore, whilst this approach absolves the therapist of the responsibility of keeping or disclosing a secret, the likelihood of a halt in the therapy exists and a failure of the therapeutic goal is probable (Weeks et al., 2003) .

All information is kept confidential

This position implies that the therapist treats all information as confidential. So, if during an individual session with one partner a secret is disclosed, the therapist maintains confidentiality and does not share the information. The immediate problem with this scenario is that the therapist is forced into colluding with the partner holding the secret, which then

excludes the other partner. Inevitably therapeutic progress will suffer leaving the therapy and the therapist ineffective.

Furthermore, if the therapist has been protecting the secret and the betrayed partner finds out then it is likely that they will experience increased emotional trauma through being deceived not only by their partner, but also by the therapist. Additionally, if this dilemma is left unattended it also raises the possibility that the therapist might either consciously or unconsciously find a way to end the treatment due to their personal discomfort or inexperience around how to manage the secret information. (Weeks et al., 2003).

The therapist's discretion

In this approach the therapist can choose to keep information confidential in the short term with the understanding that the partner holding the secret must accept responsibility and aim to either disclose or take a stance that alleviates the secret - for example, ending an affair. If the client remains unwilling to be accountable for their actions then the therapist can make the unilateral decision to terminate the couple therapy without any need to provide a specific reason to the couple. Obviously this action on the part of the therapist would raise suspicion in the partner who is not privy to the secret. Nevertheless, through taking this stance the therapist is upholding an ethical position of refusing to collude with the partner who is holding a secret but still providing them with options to explore which direction they would like to take, within the short-term safety of individual sessions (Weeks et al., 2003).

Weeks et al. (2003) emphasize that when the therapist agrees not to divulge secret information, they do so with the understanding that the client will be held accountable for their behaviour. A clear deadline is given within which the secret must be either resolved or revealed and if this is not done then the couple sessions are terminated. The therapist will then need to provide ongoing individual sessions in order to provide the withholding partner a

place in which to explore and understand their situation and to make a decision about how to proceed.

Confidentiality when the therapy format changes

Margolin (1982) raises the important issue of how confidentiality should be managed when the format of the therapy changes; for example, when individual therapy becomes couple therapy. What should the therapist do with information that was obtained during the course of the individual therapy?

One simple option, she says, is to ask the client if information that is already known can be used in the couple sessions should the therapist feel it necessary. However, if the client declines then that information must be kept confidential which then forces the therapist into a secret holding collusion. And even if the client has permitted that any information can be shared, this agreement would have been reached after the client disclosed private information which means that they may have thought differently about had they known this in advance.

Clear policy in place from the start

Despite the differences in how confidentiality can be approached, there is unanimous agreement that the therapist must have a clear policy on how confidentiality will be handled when working with partners and this policy must be clearly understood by all parties at the onset of the therapy (Margolin, 1982). Bass and Quimby (2006) emphasise the importance of having a carefully constructed confidentiality agreement in place before the therapist agrees to treat clients individually in the context of couple sessions and they go to the extent of providing clients with a printed copy of their policy at the first session. Weeks et al. (2003) point out that the therapist's confidentiality stance should be clearly explained regardless of the presenting problem because influential secrets are not always apparent in the initial sessions or in the early phases of therapy, and may not appear relevant until much later.

On a final note about confidentiality following a change in the format, Margolin (1982) points out that if the client has previously experienced individual therapy then it is likely that they will presume confidentiality between themselves and the therapist. If the policy of the therapist is that they do not keep confidences when working with couples then it is imperative that they inform both partners at the onset of the couple therapy of therapy [2].

Multiple therapists

As previously noted, some authors believe that if an individual therapy is already established then it impractical to try to convert it into a couple therapy because primary loyalties between the therapist and the initial client make it difficult to build an effective working alliance with the partner who joins later. These authors advise that a referral should be made to another therapist who can begin the therapy with an equal relationship with both partners.

Splitting

Whilst beneficial in some regards, multiple therapists working with the same client is not without obstacles. One of the concerns raised is the potential that this format provides for splitting. For example, if the individual therapist is providing an empathic and supportive role but the couple therapist is taking a more challenging stance, it could become easy for the client to cast their therapists as the good one and the bad one. Thus, the need for containment within this therapeutic matrix becomes pressing. Some therapists may be reluctant to make referrals to another therapist because of this risk and depending on the pathology of the individual, the risk of splitting might be a contraindication for a simultaneous therapy (Burch

[2] Heitler (2001) notes one clear exception that applies almost universally to secrets: where that secret could threaten the safety of either the client or their partner.

& Jenkins, 1999). Heitler (2001) goes as far as asking her clients to take a break from any other therapies whilst working with her in order to reduce the risk of this type of complication.

Just as clients may split their transference between the therapists, the therapists themselves may face a similar struggle in their feelings towards their own client, the partner who is being treated elsewhere, and the other therapist. Burch and Jenkins (1999) use the metaphor of a stepfamily to describe the complex transferential dynamics that may arise in this scenario:

> Stepfamilies contain more than one parental system, with differing values, standards, and perspectives. They inevitably have somewhat different understandings of the family situation and different expectations. Likewise, two therapists working with the same person bring different values and perspectives, different organising principles, and work from somewhat different concerns and conclusions. (p233)

Thus, the individual therapist will always lack some degree of investment in the other therapist's client - the stepchild. They will have a greater investment in their own client and it quickly becomes easier to problematize the other than their own (Burch & Jenkins, 1999).

Collaboration

In many concurrent psychotherapies it may be unnecessary for the therapists to communicate with each other because higher functioning patients are able to integrate the specific components from the different therapies without any additional assistance (Graller et al., 2001). However, when patients are more disturbed, communication between therapists will often be helpful and necessary (Maltas, 1998). This highlights perhaps the biggest struggle when multiple therapists have clients in common: collaboration. If separate

therapies are sought then the immediate problem becomes how to integrate the two in order to understand and relate the therapies to the dynamics of the initial struggle (Ackerman, 1958).

Advantages of collaboration

The advantages of collegial collaboration are plentiful. Perhaps the most significant benefit is that it allows several therapists to bring in their combined creative power in order to better their understanding of both the individuals and the relationship dynamics of the clients. When a therapist anticipates a discussion with another colleague it encourages them to review the transference and countertransference themes which in itself improves understanding (Graller et al., 2001). Also, when a colleague sees a client in a different therapy context, their additional experience of the client can be helpful in gauging one's own experience of that person (Donovan, 2003).

Another advantage is that successful collaboration can ultimately reduce the pressure on the therapist. When we feel part of a larger team, it becomes easier to focus on the work at hand. Collaborative work is also invigorating. Sometimes some of the stress that a therapist experiences arises from the isolation in which the work is done. Therefore, working in collaboration with other therapists can ease the loneliness which in turn helps clear the way for an increased vitality to enter the therapeutic work (Graller et al., 2001).

Collaboration is not only about similar thinking but can also be about differences, as both of these can be helpful in informing the therapist's opinions. For example, differences of opinion can aid critical thinking and offer useful challenges that might allow for an expansion of thinking. Agreements, of course, can strengthen the therapist's conviction about being on the right track (Graller et al., 2001).

Risk factors of collaboration

Whilst collaboration can be helpful it can also pose problems and should not be undertaken without proper consideration. When therapists decide whether or not collaborate with their colleagues the primary concern must always be around the impact that this might have on the therapeutic process. The principal danger of collaboration is that the therapeutic alliance might become damaged. For instance, if the patient has experienced trauma or psychological intrusion that has violated their boundaries, an explicit consultation with the other therapist may feel too threatening or overwhelming. It is also possible that information learnt from the other therapist could be premature or even disruptive to the therapists' development of an empathic connection with a particularly fragile patient (Burch & Jenkins, 1999). If sensitive information is injudiciously shared the patient may be left feeling betrayed. Therefore, it is imperative that the therapist request approval from the client before any communication between therapists occurs, as this will allow the client to state if there is any specific information that they would prefer to keep private (Graller et al., 2001).

Timing of the collaboration

The stage of therapy at which collaboration occurs can have a significant impact on its usefulness. Graller et al. (2001) say that when outside consultation is sought to help with a stalemate or a crisis it is less helpful than when a full collaboration is being conducted from the beginning of the therapy. If collaboration is implemented at the onset of the treatment then both therapists will have a better understanding of their own transference and countertransferential responses, in addition to the data about their clients. However, if collaboration is sought simply when a problem arises, the conversation between the therapists is more likely to focus on factual information. This could mean that the underlying dynamics will be less visible between the therapists because the lack of any previous communication has prevented the development of a collaborative alliance.

Therapist fear of collaboration

Graller et al. (2001) raise the point that when therapists discuss and share with their peers their way of working, there is a real as well as imagined risk of criticism or judgment from colleagues. They consider anxieties experienced by the therapist to be the most significant impediments to collegial collaboration. Maltas (1998) voices some common concerns arising in the therapist when faced with the prospect of discussing work with a peer:

> Do you call the other therapists, and if so what happens when they prefer not to talk to you? Do you accept "no" for an answer, and do you handle it differently if you know and respect the other therapist? What is the proper role for the patient in integrating the work occurring in the different domains? Do we ask about the other therapy or wait to see if they bring it up? Do we bring in information from the other therapist, especially if it conflicts with what the patient is telling us? (p339).

Though these anxieties are common, Graller et al. (2001) mention that they can be partially eased if the therapist is able to anticipate the benefit of consultation. For example, if the therapist is able to reveal to a colleague their unfavourable fantasies about their client's partner it may provide a rich resource of information and be valuable in unlocking impasses. As summed up by Burch and Jenkins (1999): "The interactive effect of two therapies brings in a new dimension - an affirmation of one therapist's perceptions or a challenge to them - which may move each forward" (p. 250).

Collaboration difficulties

Despite the advantages that collaboration can provide, putting it into practice is not always smooth sailing. Maltas (1998) describes an experience that occurred when she attempted to communicate with the two individual therapists who were simultaneously treating her couple. "Neither therapist showed much interest in my views about the partner

he or she had never met, and they did not seem to consider that the unknown partner might be other than described by the patient" (p. 345). Inevitably what developed was a split in each therapist's view of the others, which created mistrust between them.

Brody (1961) points out that it is unrealistic to assume that communication between therapists will be without problems. Maltas (1998) agrees and says "when different clinicians look at the same clinical situation from different vantage points, and through the lenses shaped by different theoretical orientations and personal experiences, conflicting views can be expected" (p350). Furthermore, on top of the concern of differing views sits the practical hurdle of two therapists in private practice, with busy diaries, trying to coordinate time to talk (S. Brody, 1961). Ackerman (1958) states that integrating the two separate therapies is very difficult and extremely rare, and often lip service is paid to the concept but in reality it does not happen.

It is not only with strangers that communication problems can occur. Maltas (1998) describes a collaborative effort with colleagues with whom she has a long and good relationship, and even within this 'dream team' she acknowledges the difficulties that inevitably arose. However, the difference was that with her colleagues they were able to persevere and discuss these differences and to use them as valuable information in understanding their clients. She concludes that split transferences are to be expected and should be used as meaningful communications for the therapists in the same way that transference is used within individual therapy.

Summary

Chapter 2 looked at the different options available for conducting simultaneous therapies. Chapter 3 explored the next step in this course of treatment by considering two approaches to conducting the simultaneous therapies; the first option is for one therapist to do

all aspects of the work, i.e., doing both the individual and the couple work in separate sessions. The other approach discussed is for multiple therapists to attend to each of the separate formats.

If one therapist does all the work then caution and planning needs to be given as to how confidentiality will be managed. The biggest challenge is how to guard against becoming entangled in an ethical bind if information is shared by one partner that the other does not know, whilst at the same time allowing both clients to explore all of their concerns freely. Three confidentiality stances have been discussed: no secrets will be kept, all secrets will be kept, and secrets will be kept short-term with the understanding that they will be shared or resolved by an agreed time.

If multiple therapists attend to different therapies, the concern then becomes how to integrate these separate formats. Discussion has been given to potential problems facing therapists who work collaboratively and recommendations given to when and how collaboration should occur.

CHAPTER 4 – SUMMING UP

Conclusion

This dissertation has explored how psychotherapists can transition from individual to couple psychotherapy, or a combination of both, when client's partners warrant inclusion in the treatment. The nature of the literature read for this dissertation is not empirical research, but expert opinion. Therefore, the outcome is not a series of established proofs, but rather a collection of useful clinical considerations for the therapist. Based on these clinical considerations this paper has followed a path beginning with why the therapist might consider changing the therapy to include the client's partner, through to how this change in the treatment can be conducted and put into practice.

First, the dissertation discussed possible unfavourable reactions from partners following changes made by their spouse during individual therapy which might indicate a need for adjusting the treatment. Ethical arguments were raised suggesting that therapists are obliged to attend to the client's partner when they are impacted on by the individual psychotherapy. Next, practical considerations were considered regarding how the partner could be attended to should problems arise, with a focus on when and how to include them in the therapy and possible formats that this inclusive therapy could take. Treatment formats considered include changing from individual to couple therapy, as well as introducing a simultaneous individual therapy for the partner or a simultaneous couple therapy for both partners. Finally, two options for conducting the new therapy arrangement were discussed. One option is for the same therapist to attend to both treatments, and the alternative is to involve another therapist(s) to work with the other format. Considerations for each of these options were explored, including managing confidentiality and therapist collaboration.

If a client enters individual psychotherapy and they are in an intimate relationship, the therapist has an ethical obligation to consider the client's partner and any impact that the

treatment might have on them. This is congruent with the New Zealand Association of Psychotherapists Code of Ethics which states that psychotherapists must do no harm; detriment to the client's relationship must certainly fall within this category. Thus, the therapist should discuss with the client early in the therapy the possible side effects of individual treatment so that both the therapist and the client can hold this awareness in mind and be vigilant for any undesirable consequences. If problems do arise then appropriate action can be taken.

Failure to acknowledge the impact of individual psychotherapy on the client's partner runs the risk of undesirable reactions from the spouse as well as the possibility of new problems emerging in the client's relationship. Whilst some might argue that any negative impact is either unavoidable or simply a reconciliation with the truth, as shown in this paper, there are various considerations that can be held in mind by the therapist to reduce this risk or to accommodate some of the problems that might arise. Therapists need to be aware of their own preferences and biases when making decisions about clients in relationships so as to avoid unwittingly dismissing the partner's problems without proper consideration.

Limitations of this study

Due to the word count limitation, not all research available on this topic, which might have been additionally useful and informative, has been presented in this piece. For example, this dissertation has focused primarily on the point of view of a psychodynamic psychotherapist who works with individuals. It would have been interesting to also explore the different viewpoints and beliefs of what facilitates change from the position of, for example, a systemic therapist and a behavioural therapist in addition to the psychodynamically oriented therapist. This may have introduced some contrasting views on the process of change and the importance given to the partner being physically present or not,

as well as differences on the importance of transference in the scenarios discussed throughout this paper.

A significant proportion of the articles that have been included were written in the 1960s and 1970s (and earlier) before any structured couple therapy models had been developed. This perhaps gave these pioneers more freedom to experiment with their practice and in doing so has provided valuable insight. However, it raises the question of how they may have been influenced if they had been able to refer to the researched couple modalities that exist today.

Further research

It is likely that there is much clinical wisdom amongst therapists which is not widely shared simply because it has not been published. Therefore, a series of interviews with experienced therapists would be a valuable undertaking. In addition to this, a large outcome study is also needed that can help make sense of and create visibility of the impact that these different scenarios can provide. What might be examined is the impact of persevering with individual therapy versus including the partner - which also raises the question, does bringing the partner into the treatment detract from the potential that an individual therapy could have provided? If the partner is included, what is the impact of the same therapist conducting the work versus different therapists attending to different aspects of the treatment?

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