When Couple Therapy Is Not Enough: The Couple Therapist's Subjective Experience when Considering a Recommendation for Individual Therapy

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WHEN COUPLE THERAPY IS NOT ENOUGH: THE COUPLE THERAPIST'S SUBJECTIVE EXPERIENCE WHEN CONSIDERING A RECOMMENDATION FOR INDIVIDUAL THERAPY

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By

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CERTIFICATE OF APPROVAL

I certify that I have read WHEN COUPLE THERAPY IS NOT ENOUGH: THE COUPLE THERAPIST'S SUBJECTIVE EXPERIENCE WHEN CONSIDERING MAKING A RECOMMENDATION FOR INDIVIDUAL THERAPY by Michelle J. Frisch, and that in my opinion this work meets the criteria for approving a dissertation submitted in partial fulfillment of the requirements for the Doctor of Philosophy in Clinical Social Work at The Sanville Institute.

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ABSTRACT

WHEN COUPLE THERAPY IS NOT ENOUGH: THE COUPLE THERAPIST'S SUBJECTIVE EXPERIENCE WHEN CONSIDERING A RECOMMENDATION FOR INDIVIDUAL THERAPY

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This qualitative study explores how couple therapists experience, think about and decide whether or not to make a recommendation for one or both members of a couple to engage in individual therapy. The study examines situations when the couple therapist felt additional work was needed, and looked at the risks and benefits of making such recommendations.

The questions that were addressed are: Should referrals to individual therapy be made? If not, why not, and if so, why? Are there kinds of couple issues, or attachment styles, that suggest the benefit of both kinds of treatment? What considerations are most prominent in the therapist's decision-making process? What problems or advantages should the therapist anticipate when making a recommendation?

Open-ended, semi-structured interviews were conducted with nine experienced psychodynamically oriented therapists who specialize in couple therapy and who come from varying professional fields and theoretical orientations. Data from the interviews were analyzed using the constant comparative method developed by Glaser and Strauss.

The primary finding of the study shows that, while there were various categories identified for making recommendations, the principal impetus occurs when the couple work is stuck, stalemated, or has reached a plateau. The decision to refer one or both

members of the couple to individual therapy focused on improving the progress of the couple work and endeavoring to place the couple within a psychic space where they can listen to, and talk to each other, and have a productive exchange.

Results indicate that couple psychotherapists in this study felt that individual therapy was oftentimes an important adjunct to the couple work; however, these therapists did not make a recommendation for individual therapy without substantial thought and consideration.

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CHAPTER 1: INTRODUCTION

This research examines the couple therapist's thinking and decision-making process when making a recommendation for one or both members of a couple to engage in individual psychotherapy. I used the grounded theory approach to explore therapists' thinking with respect to the clues or information that may unfold in the couple work that might prompt such a recommendation.

The Problem and Background

Johnson and Lebow (2000), in their article, "The 'Coming of Age' of Couple Therapy: A Decade Review," established that couple therapy is a significant and important modality of treatment in our time. They state that the acceptance and utilization of couple therapy has increased enormously during the last decade and that couple therapy is the preferred mode of treatment for relationships in significant distress. They emphasize the ever-increasing need for couple therapy by pointing out that "nearly 50% of first marriages and an even higher proportion of remarriages are ending in divorce" (p. 23). They assert that the culture as a whole has come to accept the importance of couple therapy. The fact that couple therapy has come into its own is no longer subject to genuine debate. Marital therapy has evolved into a distinct profession, as well as a subspecialty within the disciplines of social work, psychology, counseling, and psychiatry. Until the popularization of systems theories in the 1960s and 1970s, couples' problems were viewed through the lens of existing theories designed to understand individual psychology. Jeremy Holmes (2001), in the foreward of an edited volume entitled *Adult Attachment and Couple Psychotherapy*, distinguishes three major theories which conceptualize couplehood: the psychoanalytic tradition, especially the

Klein-Bion contribution, systems theory, and attachment theory. But this analysis begs my question: when is couple therapy inadequate or when is something more needed?

Couple therapy is no longer just marital counseling where homework is given and the emphasis is on good communication. For instance, object relations couple therapists now address both the interpersonal issues and the intrapsychic issues that are awakened and triggered in the couple's dynamics. While much has been written about couple therapy within cognitive-behavioral models and psychoanalytic models, particularly object relations theory, the question of whether to refer one member of the couple for individual therapy scarcely arises. My own interest focuses on the psychoanalytic approaches to couple therapy with a concentration on attachment and object relations theories. It is within these models that this question, while sparsely covered, is at least addressed.

The idea for this study presented itself to me on several different occasions when I felt perplexed and perturbed that a couple I was treating was not making hoped-for progress. In one instance, when I recommended individual therapy for a woman in a long-term couple therapy case whose husband was already in a long-term individual therapy, the referral did not take as she only saw the therapist for a few months. What I had hoped would be beneficial to her was that she might have had the container of individual therapy to explore and integrate material that had been triggered in her relationship. In this case it did not work: this woman could not attach to a new therapist. A colleague of mine reported a consultation with a renowned couple therapist. When presenting a difficult couple in which the woman was very depressed, she asked, "Should I consider individual therapy for her?" The consultant never answered the question

directly, but skirted around it. From these two anecdotes, I was struck by the importance of questions such as, "Should referrals to individual therapy be made or not?" If not, why not, and if so, why? Are there kinds of couple issues, or attachment styles, that suggest the benefit of both kinds of treatment? What do couple therapists think and do about these questions? There does not appear to be a protocol, and the subject involves some controversy.

There are several controversies involving the appropriate connections between individual and couple therapy. Some psychoanalytic couple therapists (Sander, 2004; Rothstein, 1992) feel that couple psychotherapy functions as a pre-therapy with the goal of getting both members of the couple into individual analysis. Yet others feel that individual agendas, hidden or otherwise, undermine the relationship, so that individual therapy is often essential before the couple can benefit from conjoint therapy (Lazarus, 1992). Therapists and researchers at The Tavistock Marital Therapy Institute in London, influenced by attachment theory, raise the issue of choosing the appropriate modality, individual or marital (conjoint) therapy for any particular couple. This group is unique in that they often treat the couple in both individual and couple therapy using two therapists working simultaneously with the couple, thus the conjoint therapy becomes a foursome. Each therapist also works individually with one member of the couple. However, despite this way of working there is controversy within the Tavistock group about which model is appropriate for certain types of couples. For instance, Lyons (1993) and Ruszczynski (1993), in separate contributions to a volume edited by Ruszczynski (1993), speaking of the same type of couple, contradict each other as to whether such a couple should be seen together in the same session or separately.

Within the object relations model intrapsychic problems and interpersonal problems of each member of the couple are addressed within the modality of couple therapy. That is, both types of therapy, individual and couple, are taking place with both members of the couple present. Are the questions I raise solved by this approach? Do object relations therapists refrain from recommending individual therapy because they address these issues within the couple therapy? This appears to solve the problem of referrals to individual therapy, yet there are circumstances identified in the object relations literature when recommendations for individual therapy are made (D. Scharff, 1982; D. Scharff & J. S. Scharff, 1991).

The question of whether or not couple therapy is enough or whether one or both members of the couple need individual therapy to make the needed changes in themselves and in their couple dynamics, is mentioned in passing by the leading American object relations couple theorists, Jill and David Scharff. The Scharffs (D. Scharff, 1982, 2001; D. Scharff & J. S. Scharff, 1991) draw heavily on Fairbairn's (1952) theories of intrapsychic structure and Klein's (1946) concept of projective identification. They expand on Fairbairn and Klein by making transference and countertransference the center of their technique in treating couples. While, in passing, they give a few examples of circumstances in which they may make a recommendation for individual analysis, they do not discuss the clinical or theoretical bases for these referrals in any way beyond the specific cases (D. Scharff, 1982).

My research focused on the central issue of whether or not a couple therapist recommends individual therapy for one or both members of the couple and, if so, what are the specific circumstances. Some therapists feel it should never be done (Basham &

Miehls, 2004), while others feel individual therapy is not only an important adjunct to the couple work, but a necessity (Holmes, 2001). A controversy also exists involving the question of when couple therapy might not be appropriate at all. Applying attachment theory to adult relationships, Hazen & Shaver (1987), and Johnson (2003; 2004) as well as the practitioners at the Tavistock Marital Studies Institute (Holmes, 2001; Bartholomew, Henderson & Dutton, 2001) suggest that couple therapy is not adequate for individuals with a disorganized attachment style where there is early trauma, particularly in the area of sexual or physical violence. This is in direct contradiction to what Basham &Miehls (2004), also working with trauma survivors, believe is the best way to work with these couples. These vast discrepancies and the absence of consensus suggest the need for further analysis.

Though research on the value of specific treatment modalities (couple or individual) for specific problems (Emanuels-Zuurvenn & Emmelkamp, 1996; Gilliam & Cottone, 2005; Halford, Bouma, Kelly, & McD Young, 1999), does not provide any conclusive evidence that one modality is better than the other, it does show that individual and marital problems often occur together, thus emphasizing the complexity that couple therapists face. Within the body of cognitive-behavioral research, there is also some controversy as to which modality is best for certain disorders. However, for the purposes of this research, since my interest is in psychoanalytic approaches to couple therapy, I did not review the cognitive-behavioral studies.

The Research Question

The purpose of the study is to explore the couple therapist's thinking about when he or she is inclined to make a recommendation of individual therapy for a member of a

couple. Based on the paucity of literature about this topic, I surmised that such recommendations are intuitive decisions. The following sub-questions were addressed; Are there particular psychological problems, "disorders," or attachment styles that couple therapists feel cannot be treated within the context of the couple therapy? Under what conditions do couple therapists think about recommending individual therapy? At what point during the couple treatment might this come up?

This qualitative study focused on the subjective experience of the couple therapist, using a grounded theory approach (Glaser & Strauss, 1967). The data was drawn from in-depth interviews. The constant comparative method of qualitative analysis as described by Strauss and Corbin (1998) was used to analyze the data.

Significance of the Study

Adult human love relationships are complex. The people who come for help often feel desperate. There are many complicated theories about the interactions of adults in intimate relationships, which include a sexual bond. Working with couples is some of the hardest work that a therapist can do because of the many and complicated transferences that are in the room at one time. This research focused on one aspect of treating couples in the hope of making couple therapy more effective. While this aspect may seem small in the context of the entire body of work on couple therapy, I hope it will be useful to those of us who alternate between exhaustion stemming from the complexities of couple work and the experience of immense gratification and joy when the work goes well, especially when the couple has children.

CHAPTER 2: THE LITERATURE REVIEW

Stated in its simplest form this research addresses the question: "When is couple therapy not enough?" or "When something more than couple therapy is needed, why is that so?" This research focuses on couple therapists' thinking when making a recommendation for individual therapy. That couple therapy remains an important modality of treatment is assumed. I will limit my focus to psychoanalytic forms of couple therapy and to the two primary theoretical schools in the psychodynamic traditions that have been applied to couple work: object relations theory and attachment theory. There are, however, some psychoanalysts who treat couples and do not adhere to either of these schools and view couple therapy as pre-analysis (Rothstein, 1992; Sander 2004). Sander suggests that couple therapy functions as a precursor to individual analysis. He feels that after about a year, many couples reach a plateau while the underlying problems continue to be unresolved. He then terminates the couple work and either makes a referral to individual analysis or to couple group therapy. Other psychoanalytic couple therapists who do not fall into either object relations or attachment theory are the intersubjectivists, namely Ringstrom (1994), Shaddock (2000), and Trop (1997), but I will not be addressing them in this literature review.

Although I will not focus in depth on object relations couple therapy per se or on attachment theory applied to couples, it is useful to amplify the differing views in the literature regarding if, when, and why referrals should be made, and whether or not couple therapy should continue in parallel with the individual therapy. Generally, therapists from both of these schools work with couples together, that is, with the two members of the couple and one therapist; this is called conjoint therapy. Object relations

and attachment couple therapy foster change in both the interactional pattern of the couple and in the intrapsychic dimensions of the individuals. In both theoretical approaches, the focus is on the relationship; however, there are differences regarding the mechanism of change. In object relations couple therapy change is thought to be accomplished by helping individuals in the couple take back their projections and learn to understand triggers for such things as anxiety and withdrawal in the relationship. Attachment theory as applied to couple therapy helps individuals in the couple with affect regulation, which is seen to help in the development of trust. Attachment theory also helps the therapist and the couple understand their particular attachment style, thereby helping them to understand their internal working models and behavior in intimate relationships. In both schools, practitioners believe trauma from the past is healed through learning to let down defenses and become vulnerable, by mourning and grieving the past with the partner and couple therapist as a witness.

Object relations and attachment couple therapists usually work with both members of the couple in the room together. However, there are a few instances in the literature that point to exceptions. It is these exceptions that are the objective of my research. The following literature review will briefly describe object relations couple therapy and attachment theory as applied to couples, and some models that use a combination of these and other theories in their approach. I will identify, from the literature, those times when something more is needed and the couple therapist makes a recommendation for individual therapy to another therapist or sees the individual in parallel, concurrent therapy.

Object Relations Couple Therapy

Object relations theory derives from psychoanalytic theory and is most applicable to a model of marital interaction because it emphasizes how internalized representations of important familial figures and early relationships shape the individual personality and adult relationship patterns. In this section I will give an overview of object relations theory and how it fosters change in the couple. I will then discuss countertransference because it is a crucially important concept to object relations couple therapists. I will also include a sub-section on the assessment phase of object relations couple therapy because that is when decisions will be made to either see the couple together or to see one or more individuals in concurrent psychotherapy. I will also note the circumstances when the object relations couple therapist makes a change in the frame of the couple work from meeting conjointly to meeting alone with a member of the couple for one or more individual sessions, in what are called concurrent sessions.

Object relations theory was developed by Melanie Klein (1946), an early Freudian, and then expanded upon by W. D. Fairbairn (1952), who added his own understanding of the intrapsychic structure of the infant's mind. These ideas were first applied to couples by Henry Dicks and Enid Balint at the Family Discussion Bureau in London in the 1950s, and later taken up by Jill and David Scharff. The Scharffs expanded their work with couples by including sexuality. They believe the works of Masters and Johnson (1966) and Helen Singer Kaplan (1974) were a major addition to couple therapy. It is in the area of sexuality that a recommendation for individual psychotherapy sometimes occurs in their work. There are two other areas within object

relations couple therapy where I have found examples of a referral to individual therapy. They are in the realm of countertransference or during the assessment phase of treatment. These two areas will be highlighted in the following discussion.

Jill and David Scharff (1991) found great meaning in the object relations view that individuals are organized by the fundamental need for relationships throughout life. I, too, find these ideas absorbing and hopeful because, although individuals may relate to their current intimate others by referencing past objects, they also can heal and change by virtue of their realization of this dynamic, and an acceptance that the new object can offer a new experience.

Projective identification is one of the most important concepts of object relations theory. Object relations theory posits that each individual's internalized object relations contain both negative and positive self-in-relation-to-others aspects. In an intimate relationship, these positive and negative internalized object representations are reciprocally played out through a process of projective and introjective identification. In this process, each partner splits off and denies intolerable negative aspects of self and projects them onto their partner who is now viewed as containing these split-off traits. Partners attempt, unconsciously, to induce their spouse to act in accordance with projections. Because partners usually have a capacity to unite, react, or interact with the projection, they behave in such a manner that confirms the original projection. This process explains what Dicks (as cited in D. Scharff & J. S. Scharff, 1991, p .ix) called the unconscious fit. Dicks stated that repressed aspects of individuals' personalities determine the unconscious fit between spouses and that these hitherto unacknowledged aspects can later seek expression in consciousness when in the safety of the marital dyad.

In healthy couples, projective identification can add aliveness to the relationship but in distressed marriages it becomes defensive and can be destructive. The Scharffs (1991) describe this process:

> It is the function of all primary relationships to transform trauma into health and growth and to provide buffering against everyday trauma and regeneration following major setbacks. This transformation function begins with the mother and father's protection of the infant. It extends to adult spouses or to partners who offer protection, soothing, and stimulation of growth potentials for each other and then for their children. (p. 326)

Transference and countertransference are also important concepts in object relations couple therapy. Object relations therapists relate in depth and get first hand knowledge and exposure to the couple's defenses and anxieties and they then interpret them to foster change. They use transference and countertransference as central guidance mechanisms and focus on the relationship of the couple to the therapist and to each other as components of healing. In this use of the therapeutic relationship, complete with transference and countertransference feelings, the couple therapist is interpreting from the perspective of the therapist's own emotional connection with the couple and not from a purely theoretical stance. Object relations couple therapy enables psychodynamic therapists to join with couples at the level of resonating unconscious processes to provide emotional holding and containment, and enables the members of the couple to identify with the therapist and learn to provide this holding for each other. This idea of holding and containment comes from the work of D. W. Winnicott (1971), a member of the middle school of British object relations theorists. In this way, the therapeutic potential of the couple is enhanced. From inside shared experience, the object relations couple therapist interprets anxiety that has previously overwhelmed the couple, and so unblocks partners' capacity for generative coupling (D. Scharff & J. S. Scharff, 2005).

Couple therapists must understand their countertransference feelings towards the couples they treat in order to not "act out" their feelings. As stated above, I believe it is within the area of countertransference feelings that thinking about recommending individual therapy for one or both members of a couple can occur. This topic will be covered in a sub-section below.

There does not seem to be an explicit theoretical position regarding the decision of whether or not to recommend individual therapy among object relations couple therapists and there is not much written about it. I have found a few examples in the literature of object relations couple therapy where an individual referral is described. One is in the case of a sexual problem. Another is in the case of ambivalence in one member of the couple. And yet a third is described in treating what is called the borderline/schizoid marriage. Because couples are complex, thinking about or making a recommendation for individual therapy appears to be done on a case-by-case basis. Often, there are multiple factors in each couple's unique constellation. I will now relate these examples from the literature on object relations couple therapy where recommendations for individual therapy or psychoanalysis were made and described.

The Scharffs (1991) cite a case in which a recommendation of psychoanalysis was made for the wife. Sex had been a regular and well-functioning part of their premarital life, but once married, the woman developed an aversion to sex. The Scharffs state that this same problem had occurred in the woman's first marriage and because of the failure of that union, she was motivated to prevent further loss. The sexual problem was the only problem identified by both spouses in the marriage and there was no known physical

reason for it. The Scharffs do not explain why they could not address this problem within the couple context though they do amplify their decision:

> Because there was no sexual dysfunction of physical origin and because as a couple they agreed that their marital relationship was gratifying, and since Tom, who had no demonstrable pathology, was supportive of Tamara while not supportive of the continuation of the sexual difficulty, it made sense to recommend individual treatment for her low sexual desire. (p. 36)

Another example by an object relations couple therapist of a change in the frame of the work, from conjoint to individual, is discussed by Siegel (1992). When working with couples that report abuse, intimidation, or violence, Siegel sees the individual members of the couple in concurrent manner, meaning separate sessions with each spouse, conducted by the same therapist, whose focus is placed on the couple's relationship. She states that an abused spouse has lost the ability to regulate esteem and soothing functions and may have difficulty gaining strength in the presence of the controlling or abusing partner. But she also states that the existence of abuse does not dictate that partners be seen concurrently. She considers that if each can maintain an observing ego they should be seen conjointly, meaning together. Siegel does not refer the clients to another therapist, but sees them herself. This is a different constellation than making a referral for individual therapy to another therapist, but it also constitutes a break in the couple therapy frame.

McCormack (1989, 2000), another object relations couple therapist, describes his work in what he calls the borderline/schizoid marital constellation. He calls the presenting problem an external manifestation of difficulties in the intrapsychic processes of each spouse ensuing from a part-object transferential relating rather than relating with reality testing (1989, p. 299). The treatment of this marital constellation, in which each

spouse has a severe personality disorder, requires application of the concept of the holding environment as an essential treatment construct, with the therapist as manager of the holding environment. He states that it is the holding of the struggle of the conflicting feelings of love and hate and the wish to destroy and fear of being destroyed, over time, that helps heal the relationships. The couple therapist provides an "alternative self-object" (McCormack's term) relationship experience necessary to the development of the self-nurturing capacity and to whole-object relationships. McCormack works by shifting the level of interaction from the interpersonal to the intrapsychic by engaging the spouses in separate dyadic interactions. He feels that this interaction decreases transferential relating in that the spouses are no longer in direct relationship, and thereby, it helps the therapist create time, space, and a boundary in which to help each spouse be with and process the experience that occurred in the spousal interaction. This helps to create an observing ego in the spouse who watches him work with the other spouse. This separate dyadic interaction de-escalates the blaming and shaming and reactivity, and it establishes an oscillating experience of togetherness and separateness, which is part of the normal relatedness of the oedipal level of development. McCormack says this intrapsychic exploration is different from individual therapy but similar. It is different in that it occurs in the context of a marital therapy and the issues explored arise in response to a marital interaction. It is also different from individual therapy because both spouses are in the room and, what each spouse discusses is influenced by the modifying presence of the other. In addition, the observing spouse may interject, which at times may be impinging, but also may provide valuable information that the participating spouse has denied. And lastly, it is different in that the therapist is in relationship to both spouses; the therapist's

internal image of the spouses and their relationship is not shaped solely by one spouse's view of the other, but by his experience of the marital interaction and his separate relationship to each spouse. Through this work, each spouse develops a more differentiated, autonomous, and less defensive sense of self. Spouses become better able to contain their thoughts and feelings instead of impulsively acting them out. Through direct experiences, each spouse comes to recognize the importance of containment and develops a sense of mastery and competence.

This makes a very strong case for seeing the couple together in conjoint sessions. However, McCormack (1989) describes situations where individual sessions with the same therapist are needed. He writes: "individual, as opposed to conjoint sessions may be used if the latter are deadlocked, but must have as the primary goal the treatment of the marriage" (p. 308). He does this only if this change in the usual frame is carefully explored with both spouses and the goal of the individual sessions are made explicit. McCormack (2000) discusses the therapist's need to be strong and set limits with the intense aggression in these couples: "The therapist may have to insist that one of the spouses remain quiet, and may even shout. In extreme circumstances, the therapist may meet with the spouses separately for several sessions to establish a working alliance from which to better manage impingements" (p. 202). It seems that he is describing couples who do not have an observing ego, and are generally unmanageable. Again, this is different from making a referral to another therapist for individual therapy, but it is a noted change in the frame of couple therapy.

Countertransference in Object Relations Couple Therapy

Countertransference is one of the most important concepts in object relations couple therapy. Psychoanalytic couple therapists have struggled for many years integrating the therapist's reactions to the patient as a valid and useful form of information about the couple and the treatment process. Because countertransference is such an important concept in object relations couple therapy, and because my research may show that couple therapists make recommendations for individual therapy or certainly consider doing so based on countertransference, I will go into some detail in describing it.

The definition of countertransference is elusive and has changed over time. Siegel (1997) states:

> While it is generally accepted that countertransference is composed of the therapist's personal or subjective reactions to the patient/client system, there is disagreement as to whether all reactions should be regarded as countertransference or only those that create a departure from the therapist's typical therapeutic style or frame. (p. 3)

For the purposes of this research, I will deem countertransference to include the full range of the therapist's reactions, including the therapist's subjective experience.
In addition to countertransference, there is a particular kind of behavior that derives from the couple therapist's countertransference, called an enactment. An enactment occurs when a therapist behaves in a way that departs from his or her normal or typical therapeutic stance. An enactment in psychotherapy refers to the interactional and behavioral aspects of the transference-countertransference dynamics between therapist and patient, or how a patient and therapist act upon one another through unconscious communication and interpersonal influence (Jacobs, 1986, 2001). In a panel presented at

the American Psychoanalytic Association in 1992, McLaughlin & Johan defined countertransference enactment as an actualization of the transference, unwittingly engaged in by the analyst. It is viewed as the patient's unconscious efforts to engage the analyst in reciprocal action: a two-party playing out of the patient's most fundamental internalized configurations (Hirsch, 1998). Some of these reactions may also stem from the therapist's own internalized family relationships and emotionally charged issues (Siegel, 1997). Some of the therapist's experiences are also stimulated by the couple and mirror some aspect of the couple's relationship. In other instances there are reactions that are more specific to the current situation of the couple, which are especially powerful if the therapist is facing similar issues in his/her own life.

Couple therapy seems to evoke specific and intense kinds of reactions that do not necessarily occur in individual psychotherapy. Sharpe (1997) has found that countertransference reactions engendered in couples therapy to be more potent, complex, chaotic, and unruly than those activated in individual treatment or perhaps in any other modality. Therefore, according to Gerson (1996), enactments occur regularly in couples and family therapy.

Wallerstein (1997), when writing about her work with divorcing couples and the therapists that she supervised, says that she was struck by the extraordinary lack of psychological distance between therapist and patient, and the ease with which identifications move back and forth across the therapeutic interface. Examples of countertransference when working with couples who are divorcing include the intense pain that may be aroused if the clinician experienced his own or a parental divorce, or the arousal of thoughts such as "I am glad I am not married, so I don't have to endure what

this couple is going through. I'm not even in a relationship," or "my marriage looks good compared to theirs" (p. 116).

Although I found only one example of a couple therapist describing a recommendation for individual therapy that grew out of an enactment, I thought that my research might show that this can be a substantial motive. As described above, couple therapy can cause intense feelings in the couple therapist and may cause a couple therapist to unwittingly "get rid of" a difficult member of a couple by referring them to individual therapy. There are some types of couples, particularly those who are narcissistically vulnerable, where enactments frequently occur and result in a rift between therapist and patient(s) that cannot easily be cured. Siegel (1997) writes that countertransference reactions are predictable with narcissistic couples because the narcissistic vulnerability stems from precarious self-esteem. The narcissist therefore endeavors to either devalue or idealize the therapist. This same type of couple's struggle with envy might first be revealed to the therapist by her own intense feelings of envy toward the couple or by feelings of inadequacy. The therapist may also be pulled into a control struggle with one or both of the spouses, reflecting the couple's intrapsychic and interpersonal problems in this area.

Couples in which one or both have borderline qualities can also be difficult. Goldstein (1997), who writes about couple work where borderline qualities exist, believes that therapists who work with this type of couple know all too well the strong emotions that are typically aroused. She says the specific nature of borderline dynamics and behavior stimulate fluctuating, disturbing, contradictory, and sometimes seemingly irreconcilable reactions in the therapist. These couples who often have urgent needs,

turbulent interactions, and flagrant behavior make couple therapists vulnerable to lapses in empathy. She warns that if countertransference feelings are not understood, the treatment can be derailed:

> There is a tendency for therapists who work with borderline couples to experience feeling out of control and to become highly reactive. Anger, feelings of being shut out, rejected, devalued, and abandoned, retaliatory impulses, taking sides, and avoidant behavior is common. Frequently, therapists may feel totally overwhelmed by the couple or are swept up into the unfolding drama, thereby losing their ability to intervene effectively. (p. 76)

Thus, we can predict that enactments can occur easily given the intense feelings when working with borderline patients in couple therapy. But enactments don't necessarily lead to referrals to individual therapy or to termination of the couple work. They can be recovered from and can create a shared experience among all three participants, which can help to bring therapeutic change (Carpy, 1989).

A good example of an enactment in couple therapy is described by Solomon (1997) in an article entitled "On Love and Lust in the Countertransference." Like many psychotherapists coming from a relational or intersubjective perspective, Solomon exposes considerable personal feeling in her writing. She tells of a couple who had a terrible fight, following which the man called to schedule an appointment, hoping Solomon could persuade his girlfriend to come in together with him for a couple session. Solomon called the girlfriend who not only refused but also stated that the relationship was over. Solomon ended up meeting with the man in individual sessions several times over the course of the next month. When the patient realized, in his transference to Solomon, that he creates havoc in relationships in the same way as he experienced with his mother, he called his girlfriend to endeavor to re-establish the relationship. She agreed to continue the couple work but, predictably, also felt betrayed by the therapist

who had acted in her absence. Solomon admitted that she fell into a trap by allowing the man to change their work and see him individually. The couple recreated their painful patterns in the therapeutic situation, but, were able to maintain an adequate therapeutic bond so that they could re-experience the painful emotions of love and hate and could begin to unravel the threads of past and present and reconnect in a less destructive way. "Examining what occurred, acknowledging that there was a break in the therapeutic alliance, and not putting the fault on patients' projection or other pathology became part of the healing" (p. 152). Although this case does not involve a referral to individual therapy, it involves a change in the frame of the therapy. It is a case that had a positive outcome.

Cases of countertransference enactments described in the literature on couple therapy tend to be ones where there is a positive outcome, not situations where the enactment led to the couple quitting therapy or changing therapists. An exception is the enactment situation described by Sid Aaronson (2007) where the couple did quit therapy. I had expected my research might show how couple therapists sometimes make referrals out of their unexamined countertransference reactions. However, this was not the case for this particular group of couple therapists.

A change in the frame of working with the couple to working with one member in individual psychotherapy is a fairly common occurrence for couple therapists. This kind of shift can happen for a number of reasons, one of which is countertranference feelings. Sometimes, both the couple and the therapist sense that the couple work has either met the stated goals, reached a plateau, or one member of the couple is more motivated and committed to doing deeper work. Once the couple therapist begins to see one of the

partners in individual psychotherapy, my view, which is consistent with my understanding of psychoanalytic couple therapy, is that the couple therapy has ended and cannot be resumed with the same therapist. I include this in the section on countertransference because the feelings toward the member of the couple who wishes to do deeper work and the feeling towards the member who wants to stop the couple work, falls within the realm of countertransference but the change in the frame is not necessarily only due to countertransference. This change from working with the couple to working with one individual differs from referring to another therapist, but I suspect my research may include such instances as well. Whether or not a shift is made in the couple work does not deny that couple psychotherapy stirs up intense countertransference feelings in the therapist.

Assessment Phase Referrals for Individual Therapy in Object Relations Couple Therapy

A time when recommendations for individual therapy might commonly be made in object relations couple therapy is in the assessment phase of the couple work. I will describe the assessment models used by D. Scharff and J. S. Scharff (1991) and by Siegel (1992).

D. Scharff and J. S. Scharff (1991) typically conduct an assessment phase of five sessions before they are ready to provide a formulation of the presenting issues and recommendations to the couples. Their assessment consists of one or two conjoint sessions, one or more individual sessions for each spouse as indicated, and finally a couple session where the formulation and recommendations are given. I will expand on this summary with an example that the Scharffs provide. This is a case where both members of the couple had individual problems that interfered with what they described

as mature reality assessment and responsibility. The woman was already in individual therapy but her individual therapy had become blocked because she could not free herself of a fantasy without working on her relationship with her husband. Concurrently, the husband suffered from an inhibition affecting the relationship. D. Scharff strongly urged the husband to consider the option of intensive individual treatment for himself, either immediately or after a waiting period, if it turned out that couple therapy could not reach his individual inhibition adequately. D. Scharff explains his thinking: "I thought it likely that he would need intensive individual therapy because of the castration anxiety, the shakiness of his male identity, and because previous less intensive therapy had not helped him" (p. 97). This example also identifies the situation where one spouse is already in individual therapy and the other spouse is not. I suspect that my research might disclose that this is a common situation when a referral is made for individual therapy. Do couple therapists accept a couple who arrive with this imbalance or do they typically recommend that both spouses engage in individual therapy? Is the female or male partner more commonly in concurrent individual therapy?

In her assessment of couples, Siegel (1992) sees the individuals separately when there are destructive projective identifications and uncontrolled anger. She feels that such couples should never be seen conjointly. She will however, see each member herself and does not make a referral. Siegel, in the sessions with each individual, keeps the current marital situation and the dynamics that cause and exacerbate the projective identification the focus. Siegel will also see a member of a couple individually if she feels that there is a strong element of resistance and lack of commitment. She states: "Although this raises the clinical issue of how to handle secrets that are shared with the

therapist, it is imperative for the therapist to learn of any plans to end the relationship and of the existence of extramarital affairs" (p. 82). Siegel believes these sessions are necessary because if a spouse is investing more energy in leaving the relationship than in repairing it, the other partner's attempt to restore intimacy at this time is usually insufficient to help the spouse recommit to the marriage. Her attitude is that conjoint therapy that attempts to improve the relationship while ignoring the ambivalence of one partner is doomed to fail.

Attachment Theory

Attachment theory applied to couple therapy, according to Holmes (2001), has had a long gestation. It began with John Bowlby's work (1969, 1973, 1980), which described patterns of infant-caregiver interaction. Bowlby proposed that there is an attachment system that is developed in infants by one year of age and continues throughout the life span. His focus was on understanding psychopathology as a result of trauma or ruptures to the attachment system. Holmes said, "Attachment theory is an ideal vehicle for thinking about couples" (p. xiv). Attachment bonds in childhood are intimately linked with patterns of interpersonal relatedness throughout life. Although attachment theory does not provide a precise method of working with couples, it provides a conceptual base with which to understand couple interactions. Helping couples understand their interactional style also assists in regulating affect within the relationship. Couple therapy from an attachment perspective shifts the focus of treatment from the security of the individual to the security of the couple relationship. Bartholomew, Henderson and Dutton (2001) state that: "Couple therapy may help partners to

understand their mutual needs for security and closeness, and to find ways for them to function more effectively as a source of security for one another" (p. 61).

In Bretherton's (1992) history of attachment theory, she relates how Bowlby's attachment theory was operationalized by Mary Ainsworth in what she called the Strange Situation, a laboratory research design that produced a classification of secure and insecure attachment patterns in infants. Bowlby (1969) proposed that attachment behavior is defined by proximity seeking, safe haven behavior, separation distress, and secure base behavior. Attachment behaviors play a central role in establishing and maintaining close and intimate relationships. When threats occur, the human brain is wired to look for protection.

Bowlby believed that the attachment system is a behavioral system that is inborn in animals and humans. It serves the purpose of protecting the organism so it can eventually procreate giving his theory an evolutionary basis. Bowlby drew on concepts from ethology (the science of animal behavior), cybernetics, information processing, developmental psychology, and psychoanalysis. He revolutionized the thinking about a child's tie to the mother and the disruption of separation, deprivation, and bereavement (1969).

Bowlby and Ainsworth worked together at Bowlby's research unit in London in the late 1950s, and Ainsworth went on to test Bowlby's ideas in Uganda. She then devised The Strange Situation study in Baltimore, Maryland where she compared her findings from Uganda to mother-infant dyads in Baltimore. Ainsworth contributed to the concept of the attachment figure as a secure base from which an infant can explore the world and formulated the concept of maternal sensitivity to infant signals and its role in

the development of infant-mother attachment patterns (Bretherton, 1992). Ainsworth paved the way for many studies on the infant-mother attachment bond. The categories that she coded in her research are secure, anxious, and avoidant attachment styles.

Hazen and Shaver (1987) are social researchers who applied attachment theory to adult romantic relationships. They translated Ainsworth's infant attachment styles into adult terms in their study of attachment and romantic love. The terms they use to classify adult attachment styles are the same as those used by Ainsworth. These categories are: secure, anxious/ambivalent, and avoidant. Main (Main & Morgan, 1996), another attachment researcher, later added a fourth category, first called unclassified, and now called disorganized.

Many authors have written about attachment styles, both in infants and in adults (Bartholomew, Henderson & Dutton, 2001; Basham & Miehls, 2004; Bretherton, 1992; Feeney, 1999; Hazen & Shaver, 1987; Johnson, 2003, 2004; Karen, 1994; Nelson, 2005). "Adult attachment patterns are increasingly viewed as key elements that influence the development of intimate partnerships" (Basham & Miehls, 2004, p. 113).

In a secure attachment, the infant or adult is confident that he/she can count on the attachment figure and is capable of intimacy. In "The Strange Situation", the babies first showed signs of missing their mother, but quickly settled down and played. When the mother returned, they smiled and vocalized and were easily soothed. As an adult, securely attached individuals are able to show empathy and have an ability to talk about emotions.

In an anxious/ambivalent attachment, the infant or adult is unable to trust in the availability of attachment figures. In "The Strange Situation", these babies were clingy

and could not settle down and be soothed. The babies often cried, appeared anxious and lacked confidence that the parent would be available. "The ambivalent/resistant group was the most upset by the separation and at reunion would alternate between seeking and rejecting contact" (Nelson, 2005, p. 58). Their whole attachment system seems to be on a hair trigger and, as an adult, it does not take much for such a person to become upset or jealous. The person with an anxious/ambivalent style of attachment believes that he/she will be rejected by the attachment figure.

In the avoidant attachment style, the infant or adult is unable to trust that the attachment figure will continue to be available. In "The Strange Situation" the baby cried infrequently and looked unperturbed. As an adult, a person with an insecure/avoidant attachment style is emotionally distant and self-reliant.

In the last attachment style, which Main initially called unclassified and later disorganized attachment, the babies in "The Strange Situation" showed interrupted movements or frozen behavior. Their adult relationships are chaotic and confused. Individuals with this style want to be close to an attachment figure but closeness is painful. In this style, the attachment figure is both desperately sought after, and at the same time, resisted.

Johnson (2003, 2004) has developed a form of couple therapy, which she calls emotionally focused couple therapy. It has become a popular form of couple therapy and is based on attachment theory. Her philosophy is that relationships are at the core of human experience and that emotionally fulfilling relationships are integral components of mental and physical health. Johnson (2003) writes:

> The research on secure attachment offers the couple therapist a clear empirically validated model of healthy connectedness, and thus a specific picture of what

> couples should, in the best case scenario, be able to do at the end of therapy. (p. 108)

Johnson (2004) uses Bowlby's ideas of what a securely attached child does, i.e., regulates distress on separation from an attachment figure, sends clear assertive signals as to needs when reunited, and trusts and accepts comfort and reassurance. She helps couples by helping them experience what she calls "softenings." In a softening, a newly vulnerable spouse reaches out to a now accessible and engaged partner and asks for his or her attachment needs to be met. These are considered pivotal moments and offer an antidote to the cycle of negative interactions that have plagued the couple. She helps couples identify moments that felt unsafe and insecure so that they do not block change in the couple. One of the most important aspects of her work is helping couples learn to contain and regulate their negative emotions so that someone who has been a blamer in the past can learn to modify his or her anger and express other emotions such as sadness and longing. The withdrawing spouse can then touch and share the helplessness and uncertainty that cues this stance.

According to Johnson, emotionally focused couple therapy occurs in three stages. Her model is a short-term model of couple therapy and she believes that couple therapy is the primary mode of treatment. Johnson, with the exceptions noted below, does not emphasize referring a member of a couple for individual therapy. She works with trauma survivors and believes that emotionally focused couple therapy is successful in these cases with the only difference being that for traumatized couples, the treatment process is longer, 30 to 35 sessions, as opposed to 10 to 12 (2004). Emotionally focused couple therapy is contraindicated with couples who are clearly separating. Johnson recommends referrals of abusive partners to group or individual therapy to help them deal with their

anger and control issues. Johnson also states that some attachment traumas from the individual person's past, such as sexual abuse, may require individual therapy in addition to couple therapy, but believes that often the trauma can be worked with in the couple context.

It is within the literature on attachment theory applied to couples with a history of childhood trauma that the question whether or not couple therapy is sufficient is addressed. There is a controversy within the attachment literature as to how to best help these couples.

Bartholomew, Henderson, and Dutton (2001) write about couples with traumatic and/or abusive histories. They cite Bowlby, who proposed that the *strength* of attachment bonds is unrelated to the *quality* of the attachment relationship. Attachments to a mother or lover who is abusive are as strong as attachments to one who is kind and loving. Believing that it is emotional unresponsiveness that underlies the marital conflict, their approach, within the conjoint model, is to help couples understand what is aroused in each when a partner is emotionally unresponsive. Here, they feel it is necessary to have both members of the couple in a conjoint session. Bartholomew et al. describe their point of view:

> Individuals who lack confidence in the availability and responsiveness of their partners will be prone to high levels of attachment anxiety, leading them (in some cases) to act in aggressive, seemingly counterproductive ways in an attempt to gain proximity to their partners. Couple therapy may help partners to understand their mutual need for security and closeness, and to find ways for them to function more effectively as a source of security for one another. (p. 61)

Bartholomew and collaborators believe that relationship abuse may be understood within a dyadic or relationship context, and that both persons in an abusive relationship need to be considered in relation to one another. In a study to test their hypotheses they found

physical and psychological abuse to be closely linked, and that psychological abuse can be just as harmful and hurtful as physical abuse, in many cases even more so. They amplify their position with the following statement: "Much, if not most, relationship abuse is reciprocal or bidirectional in nature. In such cases, it can be hard to distinguish the role of abuser from that of victim" (p. 50).

Their research was done with couples in which there was violence and the abuser was either in a program, separated from the partner, or both. In practice, Bartholomew et. al. (2001) work in conjoint couple therapy with couples who have the potential for severe violence. Although not specifically stated, I would infer that in couples where there is current, ongoing violence, the authors would refer the abuser to a program and recommend individual or group therapy for the victim.

The idea of changes in the frame because of the special needs of trauma survivors emerges in the literature several times. One view is offered by Holmes (2001) in his foreward to Clulow's (2001) volume on attachment theory and couple therapy. Writing about trauma survivors, Holmes describes a situation in which the couple therapist calls for parallel individual therapy.

> Trauma can altogether destroy part of the security regulating system (Garland, 1998), leaving partners bereft of strategies for responding to threat. Internal working models are not just restricted but also have lacunae-for example- in the area of sexual or physical violence. Disorganized attachment, typified clinically in patients suffering with a borderline personality disorder, provide no consistent relationship pattern for their partners to adapt to, and, except when partners are excessively avoidant, tend to have radically unstable relationships. Couple therapy here needs to occur in parallel with individual help. (p. xix)

Holmes's observation seems very important because no one else has identified this particular insecure-attachment style, the disorganized attachment, as an indicator of the

need for individual therapy in parallel with the couple therapy, although work with trauma survivors seems to be a trigger for some couple therapists to recommend individual therapy. Bartholomew et. al. (2001) do not distinguish between the different kinds of insecure attachment styles; however, this idea of needing individual therapy in parallel with the couple work may be something that occurs in their work. Parallel individual therapy for trauma survivors is only used in the work of Basham and Miehls (2004) where active physical abuse exists. Otherwise, they always work in conjoint therapy with the couple. Their work will be reviewed in the section below on combined theoretical approaches.

Combined Theoretical Approaches

There are several therapists writing about couple therapy who use a combined theoretical approach. These couple therapists use the theories of object relations and attachment, but also include other theories with which to treat couples. I will describe their approaches, and point out if or when they make a recommendation for individual therapy, or when they change the frame of the conjoint work.

Feld (2004), a social worker, describes her work with a couple who had a history of childhood trauma, coupled with a sexual dysfunction. Her usual approach is to work with a couple conjointly with the focus on helping the couple to understand the interactional cycle. In this case, however, she made a referral for individual work. I will first describe her theoretical foundation in working with couples, and then describe her referral to an individual therapist.

Feld (2004) sees psychoanalytic thinking and systems models converging in couple therapy through the understanding of the couple dyad as stemming from the

infant-mother dyad. She writes: "These attachment and dyadic systems approaches focus on self-regulation and interactive regulation of affect. Therefore, they have considerable relevance to work with couples and their interactive difficulties" (p. 420). If the focus is on the couple's interactional cycle, it is unclear why she would make a recommendation for individual therapy. She does so in the case of a couple whom she began seeing just before the September 11, 2001 attack on the World Trade Towers in New York. The woman was 39 years old and wanted to become pregnant, but her husband had been avoiding sex and had become impotent. Feld states that she sometimes had an individual session for each to help establish and then strengthen a secure base for the therapeutic relationship. She does not elaborate on the rationale for these individual sessions. This regrettable omission appears typical in the literature. One can conclude that this author's motive in writing about the case may not have been to provide insight into the decision to meet individually, but rather to discuss a couple who was traumatized by the Twin Towers attacks. In one individual session with the husband, she raised the idea of individual sex therapy with him, to be done with another therapist, because she felt pressured to come up with a solution that would allow the wife to become pregnant. Here is an example of a recommendation made for two reasons: first out of an enactment and second, because of a sexual problem. Feld acknowledges that the recommendation of sex therapy was an enactment, and afterwards, she describes how she was forced to understand her own tendency to avoid the client's anticipated anger. She then explores this empathic rupture and describes how, through the therapist's empathic stance, each partner can process his or her own experience and construct new meaning. The issue of

individual sessions within the couple context, or, as they are called, concurrent sessions with the same therapist, is merely touched upon in passing.

Basham and Miehls (2004) write about working with couples where there has been trauma and abuse, and present what they call a "case specific practice model" customizing their treatment to fit the specific couple. Their couple therapy practice model focuses on the sequelae of childhood sexual, physical, and/or emotional abuse. Basham and Miehls base their work on social theory, family systems theory, trauma theory, object relations theory, and attachment theory. They speak of incorporating different theoretical models into a whole through blending or melding of constructs. They propose a process of synthesis by combining discrete, at times even contradictory, constructs into a unified entity, but they never suggest seeing an individual alone or making a referral for individual therapy except in the case of physical violence. This is an extreme position to take because, although proponents of both object relations and attachment theory also feel strongly that a couple should be seen together, there is more flexibility within those models. Basham and Miehls believe that childhood trauma affects individuals in their capacities for attachment and intimacy and "the majority of trauma survivors find themselves in relationships that require active work" (p. 4).

Basham and Miehls (2004) further describe their position as based upon both object relations and attachment theories: "Since a relationship base provides the foundation for the practice model, it is essential to understand relationship patterns through the lenses of object relations and attachment theories" (p. 11). For them, the assessment of object constancy is an important factor to assess in all couple systems along with the identification of interpersonal patterns that do not work and are self-

defeating and self-sabotaging. They see couple therapy as acting as a holding environment in helping members of the couple to become more independent and autonomous and in developing the capacity to be alone, concepts derived from object-relations theorist Winnicott (1971). These authors discuss the current political climate, which they feel denigrates relationship-based psychotherapy while overvaluing productivity and rapid behaviorally defined progress, and they advocate for culturally informed, theoretically grounded, relationship-based clinical social work practice. They state that treatment for traumatic stress has typically relied on individual and group psychotherapy as well as psychopharmacology and the focus has been on the individual rather than on relationships.

In cases of physical violence, Basham and Miehls (2004) are clear that conjoint treatment is contraindicated. If "physical violence exists, the clinician must advocate to ensure safety for the victim and a couple therapy modality is contraindicated, as it generally inflames an already incendiary dynamic" (p. 165). They cite numerous studies which have substantiated the risks of meeting with a couple in therapy where there is active violence and state that "given the absence of adequate data to support the efficacy of treatment in cases where violence is active, it is safer and wiser to refer each partner to individual and/or group modalities" (p. 187).

Ruszczynski (1993) has edited a volume on the theory and practice of the Tavistock Institute of Marital Studies. The clinicians there do not have a specific position on whether or not individual therapy is an important adjunct to the couple work. The position tends to depend on each therapist and they disagree about their approach. I

will begin with Ruszczynki's description of their general approach and then describe two of their leading practitioners' views.

Ruszczynski writes that the Institute was first known as the Family Discussion Bureau, where Henry Dicks applied object relations theory to couples who were divorcing in great numbers just after World War II. The Tavistock Institute of Marital Studies, as it is now known, still uses object relations theory as its main theoretical base and is now also greatly influenced by Jung. In describing their practice, Ruszczynki (1993) states:

> By the 1970s working with couples included the possibility of working either all together as a foursome [the marital couple and two therapists], or in parallel single sessions, or a combination of the two, the choice of model at any particular time in the course of the therapy being diagnostically indicated partly in relation to the nature and degree of splitting and projection evident in the couple's interaction. (p. 21)

To decide about the best way to help couples, the thinking was that if the couple use excessive splitting and projection, as well as blame, denial, and the other more primitive defenses, then they needed to be seen together, so that the two sides of the split can be located in the same room and so that the two psychotherapists working with them can be witness and party to the nature and degree of the splitting and projective process. This makes a great deal of sense given that many patients in individual therapy paint a picture of their partner that is inevitably one-sided. Ruszczynski, however, goes on to say that if the couple are not using such primitive defenses but have a greater degree of psychological maturity and some capacity for ambivalence and concern for the other, then the work can proceed in either foursome sessions or in parallel, single sessions. He feels that either setting would be appropriate because with less splitting and blame taking place, both partners will be able to acknowledge their part in the tensions of the

relationship, and so the couple psychotherapy is able to move forward. In another part of the book he describes how the two therapists seeing the spouses in individual therapy have license to discuss their patients with each other and that is how the couple work moves forward.

Lyons (1993) who has a chapter in this edited book, offers a completely different view. She states that there is little disagreement among the practitioners about the particular usefulness of conjoint therapy for couples who use splitting and denial, but she herself often recommends individual therapy for members of a couple who use splitting as their main defenses. Lyons cites Skynner who in 1969 outlined some indications and contraindications for conjoint and for individually based forms of family therapy. According to Skynner:

> For couples who have reached but not yet integrated the depressive position conjoint therapy is unsuitable. Later, when the individuals can more easily bear their awareness of guilt and separateness, then either conjoint or individual therapy seems to be equally appropriate. (as cited in Lyons, p. 187)

Lyons (1993) writes that differing opinions on the contra-indication for conjoint therapy exist, but in support of her position that individual therapy is indicated in the cases of splitting she offers the following explanation:

> Clinical observations by the staff at the Institute of Marital Studies suggest that when married partners have begun to see and feel worried and sad about what each one is doing to the other in their relationship, then the couple need individual [therapy] to bear this painful guilt. Individuals who are at this level of development are struggling to acknowledge the coexistence, in others as well as themselves, of destructive and creative impulses and to sustain, with the necessary discretion, the moral conflicts that such acknowledgement requires. (p. 187)

Ruszczynski (1993) recommends individual sessions when persecutory and paranoid anxieties predominate in either spouse. He feels that in cases like these, the couple may not be able to be in a room together and be able to share the two

psychotherapists. Ruszczynski writes that individual sessions are recommended to establish some basic trust and benevolent transference, leading to the possibility of foursome couple work. Individual sessions are also indicated with partners who may be developing more depressive and less persecutory object relations, as the one-to-one sessions offer more direct and detailed psychotherapeutic attention to the painful transition that this psychological development requires.

The Tavistock Institute of Marital Studies is unique in its approach to couples and unique in its available resources. Ruszczynski says that couple therapy continues to be practiced there in the foursome setting because they believe that the use of the concepts of projective identification, particularly as enacted in the transference and countertransference, both between the couple and the psychotherapists, provides a rich understanding of the couple. (The clinic must be well-funded to have such resources for the couples they treat.) He also says that:

> In some cases individual sessions, in parallel, continue to be the appropriate model of therapeutic intervention. This will be made available according to the needs of the couple, and its possible or actual use symbolizes the tension inherent in any and every couple relationship-that between the individuality of the individuals and the partnership they aspire to. In other cases a single therapist will see the couple. Whether particular couples are better aided therapeutically by being seen by one therapist or by two co-therapists is, along side the issue of the gender of the therapist(s) (Morgan, 1992), among the current clinical research of the Institute. (p. 22)

Lastly, Colman (1993) another practitioner at The Tavistock Institute of Marital Studies, writing about marriage as a psychological container, says that some couples come for marital therapy because individual therapy would be far too threatening. "They are people who use the couples therapy as a sort of 'pre-therapy'" (p. 72). He goes on the state: "These couples do not really know what is meant by couples therapy, in fact, they

have precious little idea of what is meant by marriage" (p. 72). This echoes the views of the psychoanalytic couple therapists who also see couple therapy functioning as pre-analysis (Rothstein, 1992; Sander, 2004).

Crawley and Grant (2001), Australian professors of couple psychotherapy, have written the only piece of literature that I was able to find that directly addresses my question "When is something more needed than the couple therapy?" Their practice of couple therapy combines attachment theory, object relations theory, and self-psychology. These authors speak to the controversy of the relative merits of conjoint versus individual sessions for the partners, that is, whether the partners meet together (conjointly), with the therapist or separately. They state:

> In recent years clinical practice has become more pragmatic about the blending of conjoint and individual sessions. It is now common practice for many therapists to use an individual session with each partner as part of the assessment process (Karpel, 1994), and many advocate the occasional use of individual sessions during the course of therapy. Such individual sessions are, however, usually to 'remove roadblocks' for one partner. (p. 463)

Like Sander (2004), they believe that sometimes couple therapy functions as pre-therapy for an individual. When individual pain from one member of the couple (in Sander's terms an "underlying problem"), arises, Crawley and Grant may meet individually with this person. They do so when they deem these individual sessions necessary for the couple therapy to proceed. Such sessions either address a specific trauma that they feel is safer to address in an individual session, or, if needed, to "enable the emergence of a more cohesive sense of self for one partner as a prerequisite for change in the pattern of the relationship" (p.469).

Crawley and Grant acknowledge that the "traditional prescription" in such instances is that the individual therapy should be provided by another therapist because of the danger of strong and confusing transference and countertransference reaction in mixing individual and conjoint therapy. However, they have found that in a number of cases when individual therapy with another therapist was not possible, taking the risk of combining significant individual work with conjoint work was successful and did not lead to negative outcomes.

Crawley and Grant talk about a need for more flexibility among couple therapists, however, I think they, like most object relations and attachment couple therapists, believe strongly in meeting with couples conjointly. They also state clearly that: "While moving from a conjoint format to individual sessions is possible, movement in the opposite direction, from individual therapy to conjoint therapy with the same therapist is not likely to be successful" (p. 472). The initial contract would be with the individual to foster change, and a move to conjoint treatment would involve a different contract with a greater likelihood of issues of betrayal, jealousy, and inclusion/exclusion, creating an obstacle to conjoint work. They clarify this statement by adding that this is different from meeting with one person alone as a prelude to getting the partner involved in couple therapy. In this instance, they recommend also meeting with the other partner alone to even things up. In this case, a contract for individual therapy has not been already established.

From a combined theoretical approach, sexual problems in a couple tend to bring couple therapists to a point where they think that something more may be needed, just as

it does from the perspective of object relations couple therapy. How to best work with couples grappling with sexual problems or difficulties is controversial.

Basham and Miehls (2004) say about their work with survivors of sexual abuse: "Treatment for sexual abuse survivors often involves a combination of individual and group therapies" (p. 25). They encourage the use of an object relations couple treatment approach in assisting couples to work through sexual difficulties, noting that in the past, when survivors of sexual abuse were treated for sex therapy separately, this traditional sex therapy was missing the mark.

Borelli-Kerner and Bernell (1997) who say their work is informed by psychodynamic, ego psychology, object relations, cognitive behavioral, behavioral, and systems theories, address the problem of how to work with a couple after a sexual problem has been introduced into an already existent couple therapy. In an article entitled "Couple Therapy of Sexual Disorders," they outline several options for treating sexual problems. It is refreshing to read that they do not find that the decision needs to be either/or. The first option is to continue to treat the couple as before, shift the focus and mode of working to a short-term sex therapy format assuming the couple therapist is trained in sex therapy, or refer the couple to someone else for a medical examination, sex therapy, or individual therapy. They advocate treating all diagnostic categories of sexual disorders – desire, arousal and orgasmic issues – in couple therapy. Borelli-Kerner and Bernell offer guidelines for the clinician's decision-making about how best to treat a couple with a sexual disorder (p. 168). The circumstances when they definitely refer patients for individual therapy include paraphilia, a condition characterized by abnormal sexual desires typically involving extreme or dangerous activities. "Often the conflicts

and defenses that these patients exhibit make couple therapy difficult if not impossible until they are able to manage their anxiety and join empathetically into a relationship" (p. 169). They also state specifically when to refer someone with sexual problems for a psychiatric evaluation for medication purposes. They write:

> Couples in which one or both members exhibit paranoid, borderline, or severe narcissistic personality disorders are notoriously difficult to treat in any format. These patients, as well as those who are severely depressed, alcoholic, or suffering with sexual problems secondary to medical illness or substance abuse, are best evaluated by a psychiatrist prior to attempting any form of treatment for their sexual problem. These patients may require individual therapy or medication or both. (p. 169)

They leave it up to a psychiatrist as to whether or not the patient requires individual therapy or medication or both.

Summary

I have described the areas and the theoretical lenses through which couple therapists think that something more may be needed than the couple work. I have highlighted the areas that appear to be a kind of trigger that gets couple therapists thinking about this question. The triggers seem to be in the areas of sexual problems, physical abuse, and paranoia, as well as when there has been childhood trauma, and within the area of the therapist's countertransference. It appears that individual couple therapists writing about this question each have their own position on the subject and there is disagreement among them. All of the writings covered in this review provide a strong foundation for the present study and suggest the need for further research to clarify this issue.

CHAPTER 3: METHODS AND PROCEDURES

The purpose of this study is to explore the couple therapist's thinking about when he or she is inclined to make a recommendation of individual therapy for a member of a couple. Based on the paucity of literature about this topic, I surmised that such recommendations are intuitive decisions. The following sub-questions are addressed; Are there particular psychological problems, "disorders" or attachment styles that couple therapists feel cannot be treated within the context of the couple therapy? Under what conditions do couple therapists think about recommending individual therapy? At what point during the couple treatment might this come up? In this chapter on methodology, I move from what instigated my research question and perspectives gleaned from the psychoanalytic and attachment literature on couple therapy to the processes and techniques that guided my study of the phenomenological data.

Design

Since the focus of this study is therapists' experiences as reported in open-ended interviews that invited their thoughts and feelings about recommending individual therapy, a qualitative methodology is most appropriate. Qualitative research relies on interpretive rather than statistical procedures. My research was guided by "grounded theory" as described by Glaser and Strauss (1967) and Strauss and Corbin (1998). In the grounded theory approach, the research is designed with the researcher's intention that explanatory concepts emerge from the data. Thus, theoretical concepts and explanations are "grounded" in the data. As described by Strauss and Corbin, grounded theory is "theory that was derived from data, systematically gathered and analyzed through the research process" (p. 12). Data collection is designed to preserve context; therefore pre-

established categories, which reduce the data prior to interpretive analysis, are avoided. Though this type of research is not intended to form broad generalizations based on numerous participants or extensive sampling, it does involve a rigorous set of procedures intended to provide a systematic process, which attends to reliability and validity. In grounded theory, data collection, analysis, and evolving concepts stand in close relationship to one another.

This approach to research is particularly appropriate for analyzing data derived from participants' personal experiences, allowing the quality of those individual experiences to be retained in the analysis and interpretation. As Strauss and Corbin (1998) state:

> Qualitative methods can be used to obtain the intricate details about phenomena such as feelings, thought processes, and emotions that are difficult to extract or learn about through more conventional research methods. . . . Grounded theories, because they are drawn from data, are likely to offer insight, enhance understanding, and provide a meaningful guide to action. (pp. 11-12)

This type of research is also appropriate for understanding a neglected or insufficiently elaborated theoretical area of thought, such as my topic regarding the couple therapist's approach to making (or not making) a referral for individual therapy.

Patton (1990) writes: "qualitative evaluation inquiry draws on both critical and creative thinking- both the science and the art of analysis" (p. 434). He suggests that researchers be open to multiple possibilities, thereby creating a list of options. Based on my literature review, I have found that different theorists suggest different possibilities for working with couples with similar problems, for example, with traumatic backgrounds. Qualitative research is especially suited to this kind of a study, where there is no one correct answer but, instead, a variety of experiences and approaches to the

phenomenon. Different couple therapists will have different triggers and different points of view about when more is needed than the couple therapy. A comparison between approaches can yield important insights and could even form the basis for recommendations to clinicians.

To gather my data, I interviewed clinicians using an open-ended approach. I drew on Mishler's (1986) view that interviewing is a distinct method of inquiry in the human sciences. He describes the interview as being jointly constructed by the interviewer and the respondent. It is thus a discourse or verbal exchange or interaction rather than a set of questions such as on a questionnaire. Using an open-ended, semi-structured interview guide with questions to probe my interviewees' outlook, I allowed each participant to tell a story as the interchange unfolded. I then used the "constant comparative" method of data analysis (Strauss & Corbin, 1998), whereby each participant's responses was individually analyzed and interpreted for contextual meaning and compared with the responses of the other participants. The analytic process began when the first interview was completed so that data collection and analysis could proceed concurrently. This allowed me the option of revising interview topics as deemed appropriate by the material.

Reliability and Validity

Unlike quantitative research where reliability is demonstrated when the findings are replicable, in qualitative research, different criteria apply. In qualitative research, an interview guide that does not consist of standardized questions is used, and therefore, reliability refers to the trustworthiness of the data rather than the replicability of observations. It is assumed that a participant will, after understanding the purpose of the study and its confidential nature, be an accurate and trustworthy source of information

about the personal and professional experiences in the arena into which the study is inquiring.

Mishler (1986) points out that validity in qualitative research is not based on the assumption that there is only "one true interpretation of an array of data" (p. 110). Validity in qualitative research is based on "the assessment of the relative plausibility of an interpretation when compared with other specific and potentially plausible alternative interpretations" (p. 112). In qualitative research there are often variations among interviewers and across different interviews. These variations are not viewed as errors but as significant data for analysis. The validity and reliability of qualitative research is based on the skill, sensitivity, and integrity of the researcher (Patton, 1990). Mishler (1986) adds that the validity of a qualitative study is in direct relationship to the care and quality of the research process, which consists of observation, interviewing, documentation, the specification of the rules that guide the analysis, the explanation of a theoretical framework, and the ways inferences and interpretations of analyses are grounded in and related to the data.

Participants

Nature of the Sample

This study used a purposeful rather than a random sample. In purposeful sampling, the participants are chosen for their ability to provide information-rich data, which allows for an in-depth focus. Patton (1990) describes information-rich cases as "those from which one can learn a great deal about issues of central importance to the purpose of the research . . . whose study will illuminate the questions under study" (p. 169).

I interviewed nine couple psychotherapists who had at least ten years of experience working with couples and who have had the experience of making a recommendation for individual psychotherapy. Patton (1990) states, "qualitative inquiry typically focuses in depth on relatively small samples" (p. 169). The number of participants is determined by whether sufficient information has been gathered to do justice to the subject in question or to the point of redundancy. "The sampling is terminated when no new information is forthcoming from new sampled units" (Patton, 1990, pp. 185-186). Strauss and Corbin (1998) say that data is to be gathered, "until each category is saturated" (p. 212). Saturation is achieved when no new or relevant data seem to emerge regarding a category, and the category is well developed and demonstrates variation.

My sample consisted of participants from various mental health professions and theoretical orientations. The aim of "maximum variation" sampling is to discover central themes that cut across a great deal of participant variation. A small sample of great diversity yields "high-quality, detailed descriptions of each case, which are useful for documenting uniqueness, and important shared patterns that cut across cases and derive their significance from having emerged out of heterogeneity" (Strauss & Corbin, 1998, p. 172). Although nine participants is a small sample, I tried to maximize variation by identifying diverse characteristics or criteria in the sample.

Criteria for Selection

Participants included in the study had to be experienced psychotherapists, who identify themselves as psychodynamically-oriented, with an emphasis on, or restriction to, couple therapy. This ensured that the therapist sees a larger number of couples in

his/her caseload and has a wealth of experience working with a variety of couples. "Experienced," here, means that a therapist has worked with couples for at least 10 years and, given this length of time, is someone who has developed a personal style of practice and is therefore able to reflect on their clinical work as a couple therapist.

I did not control for gender, age, or other demographic variables such as race or religion, in order to have the widest variation possible. I included representatives of the various mental health professions who are licensed in California: social workers, clinical psychologists, and marriage and family therapists. I did not interview any psychiatrists. I selected participants from different theoretical schools within the framework of psychoanalytic psychotherapy, which included classical, Kleinian, self-psychology, interpersonal, object relations, relational orientations, and attachment or emotionally focused couple therapy. I did not include therapists who practice cognitive-behavioral couple therapy because it is not a psychoanalytic psychotherapy model. I attempted to maximize variation in these areas of licensure and theoretical schools in order to have the broadest view of how psychodynamically-oriented couples therapists address the central concerns of this research.

Recruitment

I recruited participants through recommendations from colleagues, and from the memberships of professional organizations in the San Francisco Bay Area. I sent a letter describing the research project (see Appendix A) to colleagues asking them to recommend potential participants. In addition, I advertised (see Appendix B) in the newsletter of the California Society for Clinical Social Work, briefly describing the

research and asking interested therapists to contact me by phone or e-mail. I also placed the same advertisement in the newsletter of The San Francisco Center for Psychoanalysis.

To those potential participants whose names I received, I sent a letter (see Appendix C) describing the research and its methods. I included a brief screening questionnaire (see Appendix D) and a consent form (see Appendix E) for potential participants to review. I then called by telephone those participants whom I selected for inclusion and set up a time and place for the interview. I reviewed with them the purpose of my research and asked them to prepare for the interview by thinking of several examples of times when they have thought that individual therapy would be beneficial and times when they have made recommendations for individual therapy. To those participants whom I did not choose to interview at this time, I sent a letter (see Appendix F), thanking them for their interest and informing them that I did not need them at this time.

Data Collection: The Interview

I collected data for this study through semi-structured interviews. Strauss and Corbin (1998) advise that when the phenomenon being studied is complex and uncertainty is hard to avoid, an open and flexible approach in the interview process is most effective. They also emphasize the interplay between the research and the data, to which qualitative researchers are drawn. Congruent with this is Mishler's (1986) description of the research interview as a form of discourse that involves two people and that relies on context and mutually constructed meaning. He states:

> Rather than serving as a stimulus having a predetermined and presumably shared meaning and intended to elicit a response, a question may more usefully be thought of as a circular process through which its meaning and that of its answer

> are created in the discourse between interviewer and respondent as they try to make continuing sense of what they are saying to each other. (p. 53)

I developed an interview guide (see Appendix G) and followed a set of procedures, which adhere to this approach. The guide was used to ensure that I covered all the areas relevant to my inquiry. I was extremely mindful of the hazard of being perceived as suggesting or approving any particular response to probes. I did not ask about specific diagnostic categories, although some of the interviewees used them. Patton (1990) describes well the purpose of open-ended interviews:

> The purpose of open-ended interviewing is not to put things in someone's mind (for example, the interviewer's preconceived categories for organizing the world), but to access the perspective of the person being interviewed. We interview people to find out from them those things we cannot directly observe . . . Qualitative interviewing begins with the assumption that the perspective of others is meaningful, knowable, and able to be made explicit. (p. 278)

Procedure

I interviewed the participants for 60 to 90 minutes in the setting of their preference, either their office or mine. I tape recorded the interviews and transcribed them myself so that I could ensure the accuracy of the transcriptions. My interview guide consisted of a set of topics and probe questions to help ensure that I covered the relevant areas of my inquiry. This guide was for my own purposes and was not intended to direct or shape the interview.

Before beginning the tape-recorded interview, I reviewed the purpose of the study and issues of anonymity and confidentiality with the participants (see introduction to interview guide, Appendix G) and asked each to sign the informed consent form (see Appendix F), which they had received, for review, prior to the interview date.

The interview began by asking each participant his or her initial reactions and thoughts about my research question. Following this lead, I raised issues as they emerged in the interview rather than following a preconceived order. In this way, I allowed room for the participant's narrative and flow of ideas about the central research concerns to emerge spontaneously. By using the constant comparative approach developed by Glaser and Strauss (1967), and using the interview guide as a framework, I developed open interview topics for further elaboration as data began to emerge from the interviews. At the end of the interview I asked participants whether they felt that there was something missing in talking about the topic. I also asked them how they felt about the interview process. The following is a description of the topic areas of my interview guide.

The Topics of the Interview Guide

The preliminary interview guide (Appendix G) consisted of a list of topics and probe questions designed to help me attend to areas of inquiry that shed light on the research question. Early interviews suggested additional topics and probe questions that could be added to the interview guide in subsequent interviews. Although the topics in the interview guide are listed in a certain order, during the interview, it was not necessary for me to follow any preconceived order of questioning, as this depended on how each interview proceeded. I began the interview with an introductory statement about the research question. I then asked the participant to begin talking about his/her initial reactions and thoughts regarding this phenomenon. As the interview proceeded, I referred to the topics below.

Participants' Theoretical Orientation to Working With Couples and a Description of Their Current Practice

This topic had several purposes. Inquiring about the participants' theoretical orientation established what the couple therapist meant by having made the self-identification as psychodynamically-oriented. The theoretical orientation became a guide to understanding the clinician's ideas about recommendations for individual therapy. This topic also allowed each participant to create the personal, theoretical, and practical context for our discourse. I asked about the participants' education and clinical training in both individual and couple therapy and asked what current continuing education and consultation or what other influences affect their current work. Psychodynamically oriented couple therapists usually work in a longer-term model, but I asked about the length of time the work with a couple typically takes.

Participants' Structure of Working With a Couple

This topic was designed to elicit participants' thoughts about how they perceive the structure of couple therapy and to discover at what phase they typically make a referral for individual therapy. Since the literature points to several examples when object relations couple therapists made recommendations for individual therapy in the assessment phase (D. Scharff & J. S. Scharff, 1991; Siegel, 1992), I was interested to see if psychodynamic couple therapists followed this pattern and if so, why in this early phase of the treatment.

This topic was also designed to probe the participants' thinking about the impact on couple treatment when only one member of the couple is in individual therapy. Often couples come to a couple therapist by the recommendation of one partner's individual therapist. How do couple therapists think about this imbalance? Do they accept a couple

who arrive with this imbalance? Or do they typically recommend that both spouses engage in individual therapy? Is the female or male partner more commonly in concurrent individual therapy?

Awareness of Transference/Countertransference Dynamics in Couple Therapy

The purpose of this topic was to initiate a discussion regarding whether the participant is aware of the transference/countertranference dimension of working with couples. Transference/countertransference dynamics are an aspect of psychoanalytic psychotherapy with individuals, but since many psychodynamically oriented psychotherapists work differently in couple therapy than they do with individuals, this is certainly a valid area of investigation. This inquiry topic allowed participants to discuss their theoretical orientation, ways of working with couples, and whether they think in terms of the transference/countertransference dynamics. Since the literature review suggests that recommendations for individual therapy are made out of unexamined countertransference feelings (Feld, 2004), I wanted to know about participants' experience of the relationship, if any, between their transference/countertransference dynamics and referrals for individual therapy.

Indications the Therapist Uses for Considering a Recommendation for Individual Therapy

The purpose of this topic was to open up the discussion about making a recommendation for individual therapy. I was interested in what the couple therapists noticed about their inner process, the situations that induced a recommendation, for example, feeling that the couple work was stalemated or at a plateau, or particular information about a member of the couple that unfolded such as childhood sexual abuse,

sexual problems, or paranoia in one of the partners. My literature review suggests that a variety of issues, diagnostic factors or attachment styles have been used to consider individual therapy for one or both members of the couple (Basham & Miehls, 2004; Borelli-Kerner & Bernell, 1997; Lyons, 1993; Ruszczynski, 1993; D. Scharff, 1991). I was particularly interested in what triggers the couple therapist to think that something more may be needed.

Within this area of what indications trigger a recommendation, I also wanted to know whether these couple therapists have particular countertransference reactions to a particular client's issues. As they talked about specific couples I paid attention to their reactions, impressions, and feelings prior to making the recommendation. Which kinds of couples might prompt such a recommendation, for example, personality disordered, polarized, oppositional, hostile/blaming, borderline/schizoid, narcissistic couples or a partner in a couple with a disorganized attachment, or abusive couples? Are there particular emotional conflicts that trigger the therapist's vulnerabilities, such as affairs, parenting issues, sexual problems, separation or divorce, domestic violence, intense aggression, or passive-aggressive behavior that may cause intense countertransference feelings in the couple therapist and prompt a recommendation for individual therapy.

Making the Recommendation To Do Individual Psychotherapy

The idea behind this topic was to explore how the couple therapist conveys his/her thoughts about the usefulness of individual therapy to the client. I was interested in any uncomfortable feelings the couple therapists may have in making this recommendation. Might they feel that by doing so they are suggesting that the client is "sicker" or "more disturbed" and therefore needs more therapy? Might they feel, on

some level, that they want to "get rid" of the person? Or is the motivation that the client's issues simply need more attention than can be addressed in the couple therapy context? In what ways does a recommending therapist believe individual psychotherapy will be useful? What is it like to make the recommendation? Are they comfortable in making it?

What the Therapist Feels If the Client Refuses the Recommendation

This topic concerned the couple therapist's reaction if the client refuses to act on the recommendation. Some of the literature suggests that individual therapy is too threatening to a person, but couple therapy is less threatening. The couple therapy then acts as a precursor to individual therapy. If, after the first time the recommendation is made and the client declines individual therapy, does this recommendation come up later or even disturb the couple work? If so, what is said by the client or what does the therapist observe and explain to the client if making this recommendation for a second or subsequent time?

The Therapists' Personal Feelings

This topic was directed towards an understanding of how the couple therapist's personal sensitivities affect the way they make or choose to not make a recommendation for individual therapy. Perhaps the therapist senses that the client will feel rejected by him/her and does not want to make the client feel rejected, or the couple therapist fears that the client will not attach to another therapist. Perhaps the therapist does not want to lose "control" of the couple and have another therapist influence the client, and thereby influence the couple work.

The Couple Therapists' Thought Process or Intuition

In this topic I was inquiring into whether or not the recommendation for individual therapy was a considered decision or rather was made spontaneously or intuitively. How long did the therapist ponder the decision? I asked for examples of a carefully thought-out decision compared to a recommendation made on the spur of the moment.

After the Recommendation Is Made and the Client Begins Individual Therapy

What happens in the couple work after the person begins individual therapy? How does it change the work and how does the couple dynamic change? How long does the couple work continue? Does the couple complain about the cost of all the therapy?

Closure

Here I intended to discover the couple therapist's experience of our conversation. Did the therapist learn something new or gain a new perspective on making recommendations for individual therapy? Does the participant have anything further to add?

Data Analysis

In contrast to approaches in which all of the data is collected prior to analysis, in the grounded theory approach, analysis of data begins as soon as the initial data has been collected. The data collection, analysis, and eventual theory stand in close relationship to one another: "The analytic tasks include naming concepts, defining categories, and developing categories in terms of their properties and dimensions" (Strauss & Corbin, 1998, p.103).

After completing each interview I immediately noted my initial thoughts, and prior to transcribing it, listened to the audiotape, summarized its contents and noted any themes and initial conceptual categories that emerged. I used the "constant comparative method" as described by Strauss and Corbin (1998) to analyze the transcribed interviews. This systematic process is useful for generating hypotheses from the themes and patterns that emerge organically as participants talk about their experience with the topic. The "constant comparative method" is ideally suited for research that examines the subjective experience of participants (Polkinghorne, 1986). A comparison of data from different couple therapists will highlight similarities and differences in their experience and, in this way, initial categories may be redefined and new categories formed.

Questioning the data is the medium for data collection and a tool for understanding the data that has been collected. In order to begin to make sense out of the phenomenon under study, a grounded theory researcher asks what something in the data is or what it means, and considers qualities associated with categories of data that have been identified. The process of making comparisons can suggest new questions to ask oneself to deepen and broaden one's understanding and to move from the particular to the more general and abstract. Making comparisons between data protocols influences the process of collecting data and may suggest further questions to be asked in interviews, based on the evolving theoretical analysis. When new data comes in, further comparisons are made.

In order to accomplish the comparative analytic process described above, I used the three types of coding procedures suggested by Strauss and Corbin (1998): "open," "axial," and "selective." These procedures do not necessarily take place in a linear,

sequential manner, but can be used concurrently. I began my initial analysis of the transcripts with "open coding," defined by Strauss and Corbin as: "the analytic process through which concepts are identified and their properties and dimensions are discovered in data" (p. 101). I examined the transcripts line-by-line looking for collections of phrases and words or clusters of related phrases that seem important while also paying attention to general themes in order to develop concepts. Strauss and Corbin elaborate: "Events, happenings, objects, and actions/interactions that are found to be conceptually similar in nature or related in meaning are grouped under more abstract concepts termed 'categories'" (p. 102). The work of open coding is to name concepts and define categories.

I proceeded with "axial coding." This procedure involves reassembling data that was broken down in open coding by identifying primary categories and developing the relationship between categories, and associated subcategories, in terms of properties and dimensions, in order to arrive at more precise and complete explanations of the phenomenon.

As my organization of primary thematic categories and their properties began to be clear, I identified a central category around which the others can be organized. Thus my data from all of the interviews was summarized into concepts and sets of relational statements that can best describe my understanding of the findings of the study. This step is what Strauss and Corbin call "selective coding," described as a process of integrating and refining emergent hypotheses developed from the findings.

Presentation of the Findings

I will present the results of this research in Chapter 4 and Chapter 5. In Chapter 4, after describing the participants, while carefully respecting their anonymity and the confidentiality of their material, I will present a narrative overview of the findings. I will then describe the categories and sub-categories that emerged through coding and organization of the data with illustrations from the data.

The final chapter (5) will be devoted to a discussion of the study's implications and significance, as well as its limitations. In it, I will discuss my interpretation of the findings as related to the research questions and to the literature, and make suggestions for future research on this topic.

CHAPTER 4: FINDINGS

This research explores couple therapists' decision-making process involved in making referrals to individual therapy with another therapist. I expected couple therapists in my sample to work with couples not only by addressing the interpersonal and the intrapsychic issues of each member of the couple within the couple context, but also to have thought about one or both possibly needing additional individual work. The study was designed to explore what induces the couple therapist to make such a recommendation. After describing the interviews and the participants I will present an overview of my findings. The findings will then be described within the thematic categories, which emerged from the data.

Description of the Interview Process and the Participants

The Interview

Before I met with each therapist-participant, I asked each to review when he or she may have considered making, or actually made, a referral to individual therapy. While this may have somewhat diminished spontaneity during the interview, I thought it important to ensure that the participants remembered the details of cases since this was the heart of the data for my study. All of the participants except two came to the interview with a list of cases fitting my criteria. One participant had listed the names of all the couples she has seen in the last five years. As I asked questions, she scanned the list to find examples of my questions.

In the beginning of the interview, I asked participants for their thoughts about my research question. Then I asked general questions about how they work with couples,

including if they work differently with couples than with individuals. After a few interviews, I realized that this question did not elicit sufficient material relating to referrals for individual therapy. I then began asking for case material earlier in the interview, which allowed me to obtain at least two case vignettes from most participants. The interviews were unstructured and open-ended, though I introduced questions from my interview guide to help focus participants when needed. Often a case example provided by a participant led directly into an area of interest that I had included on my interview guide. Towards the end of the interviewing, I scarcely needed to refer to the interview guide.

Participants

I will describe the participants according to their group characteristics in order to protect anonymity. All nine participants were very experienced, psychodynamically oriented psychotherapists from each of the licensed mental health professions in California except psychiatry: four clinical social workers, three psychologists, and two marriage and family therapists. Seven were women and two were men, ranging in clinical experience from 13 to 44 years.

One of the requirements of the study was that the participants either identify themselves as a couple therapist or claim couple therapy to be one of their primary specialties and that their practices were at least 20% couples. All participants fit this criterion. While all participants identified themselves as couple therapists, they varied in the percentage of their practice treating couples: four had 50%, one had 40%, one had 33%, and three had 20-25%. The participants, except one in Sacramento, practice in the

San Francisco Bay area. All work in a private practice setting, seeing both individuals and couples.

These are very seasoned therapists who had a great deal of experience working with couples. Four had worked in the field for over 30 years, three for over 20 years, and two from 13 to 17 years. Two were teaching courses on some facet of couples therapy, four were consultants in the field, and six maintained membership in couples consultation groups.

In my recruiting materials (see Appendix A and B) I specified that research participants be a "psychodynamically oriented psychotherapist." All of the participants met this criterion, while some listed additional approaches on the screening form, including family systems, eclectic and existential theoretical orientations, and a variety of others. The other theoretical approaches mentioned during the interviews included psychoanalytic, object relations, contemporary Kleinian, Bionian, control mastery, relational, attachment, neurobiology, emotionally focused therapy, Jungian, and psychosocial. None worked in the cognitive behavioral mode. Even though I deem this information relevant, once I began interviewing the theoretical orientation was not a point of emphasis.

Participant Reaction to the Study

All of the participants stated that they love doing couple therapy although found it very challenging and were eager to hear the results of my study as another piece of information to help the couples they are working with. Though the interviews revealed that many of my participants had not thought systematically about their decisions to make a referral to individual therapy, all were thoughtful and articulate and seemed genuinely

interested in this research. One remarked that it is a "fabulous question," saying she did not have a systematic way of analyzing when additional work is needed and felt it was very useful to consider a more methodological approach. Another said it was a great question, which she enjoyed the opportunity to think about. Some said they eagerly awaited my findings, because of their struggle with the decision whether or not to make a referral. Another participant said that she does not have a thought-out way of making referrals and relies on intuition. Her ruminations focused not so much on whether to suggest individual therapy, but rather on how to go about proposing it to a particular client. This response was echoed by another who, although he thought it was a good and interesting question, said he was struck by the fact that he had not previously thought about what leads him to make a referral; it is "just something that [he] does." All of the clinicians were very willing to share examples of times when they made a referral and many offered examples of times when the referral was not accepted. Most thanked me for the opportunity to reflect on their work and were very honest about their own feelings about the work. Their openness resulted in bringing a depth and richness to the interviews.

Overview

All of the participants sometimes think about whether one or both members of a couple might benefit from individual therapy and all have recommended that one or both members of the couple engage in individual therapy at some time in their practices. However, whether or not they actually make any specific recommendation is not a simple process. All gave careful thought not only to how the recommendation may impact the person and the couple, but also to how to go about telling the client about their

recommendation. How often a particular couple therapist makes a recommendation seems to depend on various factors. Their assessments involve the needs of individual members of the couple, effects upon the couple work, and financial considerations. Often when couples come to the therapist one is already in individual therapy and the individual therapist is the one that recommended couple therapy. I also explored what couple therapists do with this situation.

The risk of making referrals was brought up by many participants with concerns such as creating an imbalance in the couple's work, and wondering what the referral might mean to the couple, including the possibility of the referred member feeling stigmatized. Everyone said that making a recommendation is not simple or easy under the best of circumstances and the timing of the recommendation has to be carefully considered. All participants brought up how they feel about doing couple therapy and remarked on its differences from doing individual therapy as well as the challenges it provides.

The Findings: When Is Couple Therapy Not Enough?

I will discuss my findings in three sections. The first concerns the decision to refer. The second section of the findings is about the cues or prompts that couple therapists use in the making of referrals and the times when couple therapists always made a referral. The final section is about the risks involved when making a recommendation for individual therapy.

Deciding to Refer

All of the participants said that referrals were sometimes necessary to move the couple work along and all saw it as an adjunct to the couple work. They were all careful

not to give the couple a message that they felt hopeless about the relationship. In couple work, as in individual psychotherapy, the therapist does an assessment in the first few sessions. All participants speak of their assessments as involving an unfolding of information, though not necessarily in a structured way. During the assessment, all participants inquired as to whether or not each member of the couple was in or had ever been in individual therapy. This helps them learn about the couple's attitudes towards psychotherapy. They all put a lot of care and thought into the decision of whether or not to refer to individual therapy.

The participants took care when making referrals, even if they had not specifically identified all of the factors addressed in this study. All were careful to not push anybody in a direction that did not feel right. Many of the participants used consultation to discuss cases where they were unsure if something more was needed. One participant told me that she always called the potential individual therapist to make sure they had time and could see the person referred. She said the clients are already not sure they want individual therapy and are already in a lot of pain. She does not want them to call someone and hear: "I am sorry. I don't have any availability, or yes, but my rate is $250 an hour. That would be too discouraging."

Though participants described their reasons for recommending in various ways, all were careful not to convey to the client any hopelessness or sense of rejection. One describes what an individual therapy might be like, for example, "that it will be all for them. Somebody listening to you and helping you sort through all the different levels and layers of yourself in a way that is completely confidential." Many said that for someone already in couples therapy that starts to sound like it has a lot of appeal.

A surprising finding was that couple therapists recommended individual therapy more frequently than I had expected. I began my research not expecting to find couple therapists referring as often as they do based on my own belief that a lot can be achieved within the couple context. In couple therapy, the marriage and what the couple creates between them is the focus, but the internal worlds of each individual and how those internal dynamics affect the relationship must also be addressed.

There were many factors that went into deciding whether or not to refer. One woman told me that she refers people to individual therapy 50% of the time. She asked: "Doesn't everybody at some point think that one of the people in the couple would benefit from individual therapy? I found that I have done it about half the time." Issues involved in the decision to refer fall into the following sub- categories: Timing, Imbalance, and Countertransference.

Timing of the Recommendation

All of the participants agreed that the timing of making a recommendation was crucial with respect to whether or not the referral would take. They offered varying ways of assessing the correct timing; they spoke of the level of trust, the appearance of a need, and readiness. Most of the participants said that they must first establish a solid rapport and sense of trust with the member of a couple before recommending engagement in individual therapy because the person may feel injured or misjudged if it is announced too early. Several of the participants, even if they believed it appropriate from the beginning, would never make a recommendation in the first four or five sessions; others, though, would do so. One participant said she has sometimes thought at the beginning that a referral to individual therapy would be very useful, was then surprised to see the

couple settle down and had to reconsider whether individual work was necessary. Another participant said something along a similar vein, "I tend to wait a fair amount of time. It is not likely that I would (recommend) early on. I want to see what is going to happen in the couple work." This participant leans heavily towards a psychoanalytic approach and has a 50% caseload of couples. Another participant who speaks about "waiting" said:

> There are times when I see the couple for a while and I really know that one should be in individual therapy but I stay with them in couple therapy longer so that I build up some kind of trust. So that they don't feel injured. They feel it more as an adjunct or as an added attraction rather than to be rejected.

One participant is specific regarding what she is waiting for; she describes her timing as "waiting for a signal that the person is ready." That signal could be a lot of distress or, as in one case example, a specific stress. She describes a case in which the client who had just given birth, was experiencing sleep deprivation at a time when early attachment issues were aroused. Another participant made the referral when the woman in the couple developed a symptom, namely trichotillomania. A third made a referral when the husband began abusing alcohol.

Another participant exemplifies both waiting and a response to stress. She practices only long-term work with couples. She gives an example of making a recommendation "sometime in the second year" also bringing up countertransference issues as a prompt to the recommendation:

> I am not quick to do this. Everything that I am describing is sort of evidence that there was sort of a crisis that happened and she collapsed in some ways that made me worry about her. So part of the countertransference would be an anxiety on my part that I wouldn't be able to give her what she needed.

Often, an explicit recommendation that one member of a couple engage in individual therapy follows the therapist's early hints which can prepare the person to be able finally to make use of the recommendation. One participant said to a member of a couple; "This may be something you might want to explore in an individual therapy at some point." Thus the therapist prepares the ground.

Imbalance

An imbalance in the couple therapy may occur when one member of the couple is less able to be self-reflective; this is a situation that can slow down the couple work. It is most likely to happen when the other member is already in individual therapy when the couple work begins. There was a general consensus that this situation could potentially cause an imbalance in the couple work, which would lead the therapist to consider making a referral. One participant, when asked about this issue of a possible imbalance said:

> It seems probably true that when both members of the couple have at some point in their lives been in individual therapy, and let's say one member of the couple is currently in individual therapy, that there is less of an imbalance. It is not 100% sure. Sometimes, people come in and one person is in individual therapy and the other never has been. Then that person has a kind of an intuitive, psychologically minded quality that allows them to participate fully. But there are times when one member of the couple is in individual therapy and the other is not and never has been, and lacks something and sometimes begins to speak to that, that sort of disadvantage at which point I will take it up as a possibility. Well, you seem to be saying that you feel like you are less conversant with this kind of language. Or you have less access than your wife to put your feelings into words and it might mean that it could be extremely useful for you to have you own individual therapy.

Another therapist said, regarding such an imbalance: "I don't do anything with it until it presents itself that I need to but I am always aware of it." She noted that sometimes such couples come and the person in treatment tries to get the partner to agree

to individual treatment saying something like: "I am doing this individual work and the problem with you is you have these individual issues and you need to go and see someone." This therapist describes responding to such a client: "If you keep pushing for her to go do that and she doesn't want to go, it will make things worse. Maybe she can get what she needs in here." This participant also commented that this may be illustrative of other ways this husband pushes his partner to do or be a certain way.

Another participant spoke eloquently about an older couple where the women was in four times a week psychoanalytic psychotherapy. The wife suggested to her husband that he engage in individual therapy because the marriage has been at a stalemate for a very long time. This participant observed that the couple did not have conversations that go below the surface and they are just beginning to do that in the couples work. The therapist noted that the work went very slowly with this couple. The husband, in one session, spoke of feeling disadvantaged in contrast to his wife who sees someone four times a week. This gave the therapist an ideal opportunity to recommend that the husband have his own therapist. However, she says:

> But he rejected it. He feels like it is something he does not need yet he is struggling with what it means to him that his wife is in four times a week treatment. It is hard for him to take stock of what does not feel right or good. He can only take in a little bit at a time. He is very thin-skinned so the couples work has to go slowly.

The therapist adds: "If both members of the couple are also in their individual therapy then the work goes faster."

All participants said that they look into whether one or both members of a couple have been in individual therapy in the past, implying that when both members of the couple have at some point in their lives been in individual therapy, or perhaps a member

of the couple is continuing in individual therapy, the concern of an imbalance is diminished.

Still another participant described her recommendation to the girlfriend in a couple where the boyfriend was already in an individual therapy as follows:

> I tried to connect with her empathically. I talked to her about the limits of her capacity to put her feelings into words. Compared to her boyfriend who had a greater facility for that. And the fact that he would take up more time talking about his feelings and when I would ask her or he would ask her she would seem to shut down or her feelings were inaccessible. And that there was a real disparity and discrepancy there. And I wanted her to have a place in which she could develop those parts of herself, so that she could potentially bring into the couples therapy more knowledge about herself and get more comfortable speaking it and so on.

My last example of an imbalance caused by only one member of the couple being in individual therapy was brought up by the client himself. The participant told me:

> Yes, I did have a guy who did say to me, he said you know, "It seems like she gets all the attention and I feel like you don't really care about my individual emotional growth." I said OK, that's fair. I also understood it as a request for me to give him more attention in the couple context. So, I took note of that. But I did refer him and it worked out really well. They continued in couple therapy and they each had their individual therapists and things actually progressed better. It was very helpful.

Countertransference

In the beginning of the interviews I asked participants about how they used their countertransference in couple work and if they ever made a recommendation for individual therapy out of a countertransference enactment. Everyone agreed that both transference and countertransference are more complex in couple psychotherapy than in individual psychotherapy. In this respect, all of the participants regard couple therapy as difficult and challenging. All of the participants were very aware of their countertransference feelings and used these feelings to help them make decisions

regarding referrals to individual therapy. Many of the participants are in either individual consultation or group consultation with other couple therapists so that they have a place to discuss and understand their countertransference. One participant told me that she works really hard to contain her own feelings and to be empathetic with the couples that she works with.

Another participant said that he is always suspicious of himself when he wants to make a referral. When he finds himself thinking about making a referral, he asks himself:

> What am I not seeing in the relationship? Is that really true that the person needs individual treatment or am I just seeing this person as the cause because I am missing the interactional, the intersubjectivity of it all? What am I getting caught up in? Or am I getting caught up in something that is making me feel like I am taking sides? So, that is just the training of knowing that it is tricky business with couples and knowing that it is so easy to get pulled into one direction, right? I mean it is common to feel maybe more aligned with someone, maybe more identified with somebody or think that this person is so difficult to live with, nobody could live with him or her. Those kinds of dynamics feel like they come up a lot. . . . So, when I am thinking about one of the people going into individual therapy I do usually stop and think. I don't usually act precipitously on that particular thing. My thinking about individual therapy makes me think more deeply and look more carefully at what is happening between the couple and with me and the couple, so I usually don't shoot from the hip about that kind of recommendation.

This same participant describes using his countertransference to help him decide whether or not to recommend individual therapy to a man in a couple who was struggling with depression. His countertransference was a feeling of being very careful toward the man. He states:

> I was careful. Which was significant. As a matter of fact, my carefulness clued me into something about how we, the three of us were protecting him. And then I thought, after something hit me over the head to see it, Oh, I am being careful. I probably was presenting this case in some consultation that helped me do that. Because there was this dynamic of him being the strong helper, he had a good job and was a good provider, kind of a big guy. You know and she was this woman

> who had back problems and she had been in therapy. So there was this collusion to be careful around him. And then I realized that there must be something that he needs caretaking about. You know and so that, I am sure maybe it took nine months or a year to get to that. But when it came up, he really balked at it.

One therapist told me about her negative feelings towards a man in a couple she was treating:

> Well, there is a couple I saw a few years ago and I did have a negative countertransference to the man in this case because I thought he was lying through his teeth to his wife. Turns out I was right although I did not find that out in the course of the therapy. She was already in individual therapy and her individual therapist referred them to me. He was the one that I thought needed to see someone because I had the feeling that he was lying. And so, they didn't stay long. Because it turns out he was lying, he was having an affair with his boss . . . the vehicle that I used was that, um, there were so many thing that were going on that would manifest between them where he was so profoundly ambivalent, and so I was showing him how his ambivalence was negatively impacting the couple and making it very difficult for this couple to move on and come to resolution. So I named the ambivalence and urged him to go to individual therapy.

This participant's countertransference tuned her into the fact that she thought something more was needed although she did not know exactly why.

In the last two examples of the use of countertransference in making decisions about recommending individual therapy, the feeling stirred up in the couple therapist was anxiety in one example and frustration in the other:

> So part of the countertransference would be an anxiety on my part that I wouldn't, I was worried that I would not be able to give her, I would say a sense of inadequacy not being able to offer what she intuitively needs.

> A decision about individual therapy may come out of a feeling of stuckness or feeling that maybe this person needs something more or something different than we are able to do in the couple work . . . feeling frustrated like there is something more that needs to happen that maybe I can't do. It is hard to put into words. I think my feelings get me to think about what is going on, what does this person need. Do I need some extra help? What does this person need? Oh gosh, what do I do with this?

Cues Couple Therapists Use: What Prompts a Referral?

In the following section I will describe specific cues and circumstances that prompt a couple therapist to make a recommendation for one or both members to engage in individual therapy. What became clear to me was that the individual partner's psychological issue was not the reason for the referral but rather how the individual member's issues affected the relationship and the ability of that person to work in couple therapy. For example, early trauma was not necessarily given as a sufficient reason to refer for individual treatment. Sometimes this problem could be worked with within the couple context and sometimes that person needed additional work. That there had been an early trauma might not be the factor prompting a recommendation, although many of the object relations couples therapist said that ideally, in the case of trauma, there would be individual therapy and couple therapy concurrently. One participant referring to a case in which there had been early trauma, said: "I think to some degree it depends on the patient and their willingness and capacity to do individual therapy as well, and to some degree it depends on the therapist and his or her sense of competence." Another participant, when asked about how she works with early trauma said: "After all, each individual is unique and each couple is unique and each dyad and triad are unique, and if the couple therapist has her bearings with a disturbed couple, individual treatment might not be necessary."

The following are addressed individually below and are the categories that typically prompted a referral: The Couple Work Is Not Moving Forward, One Member Has Overwhelming Distress, The Biological Clock, One Member Has Severe Pathology,

One or Both Members have Severe Substance Abuse or Alcoholism and Violence, One Member Is a Survivor of Childhood Sexual Abuse.

The Couple Work Is Not Moving Forward

Many of the participants identified times when they felt the couple work was stuck in some way, stalemated, or described it as not moving along or making progress for the couple. One participant described it as "feeling frustrated," as if there is something more that needs to happen and that maybe she cannot make it happen. Another described a stalemated case; the therapist made a recommendation for individual therapy, but it was not taken, the therapy became derailed and the couple split up. The therapist describes the situation:

> There was a couple where the man did not want to have sex. I suspected a traumatic history but he denied it but absolutely did not want to have sex with his girlfriend and she was getting angrier and angrier and angrier that he was withholding. And they couldn't split up, nor could they make any forward movement in their relationship. I tried so hard with all these different ways to talk about sex with them. And tried to understand what was underneath it, what was the communication about sex? He was very anorexic about a lot of things and sex was one of them. He didn't allow himself to feel good very often. So I recommended individual therapy. They did split up. It was one of these cases where they had to know that they had done everything possible. The relationship was bad when they came into therapy and it was kind of clear that they were going to have to, it was too stuck, she was too angry, she was too hurt. She would not go to individual therapy. She said this is his problem. I am not going to, I am the victim here.

One participant describes being stuck as it seemed "the therapy had run its course." This was a case where the man had an affair and was quite chagrined about it and clearly wanted to protect and preserve the marriage. But the wife could not seem to get over feelings of insecurity and a kind of demoralizing depression that got in the way of her being able to really believe in and receive her husband's love. It was taking the woman an inordinate time to rebuild trust. So the couple therapist concluded that the

woman could benefit from individual therapy and she took the recommendation to individual treatment about six months after coming to couples treatment. A few months later the couple ended the couple treatment and the woman stayed in individual therapy. The couple therapist said the woman realized that there were actually all kinds of things she could make use of in individual therapy. In the couple work, "they sort of ran out of stuff to say and they were repeating the same things over and over again, that she was having trouble trusting him again." The couple therapist describes it as if something had been broken in the woman and between the couple; it felt like the couple therapy was not quite able to get to it.

In another case the couple therapist describes making a recommendation for individual therapy for the wife because she felt that the woman in the couple was not moving along well in the therapy. She felt the therapy had become stuck because the woman was being defensive and rigid, did not speak much, and refused to see what her husband was complaining about. This type of situation where one person is shut down, will not talk, or could be described as extremely introverted is frequently brought up as a reason that participants saw as keeping therapy from moving forward. The presence of depression in one member of the couple was also brought up as hindering the progress of the therapy.

Participants discussed how the couple therapy can become stuck when one person is shut down, will not talk, or is too intellectual. If one of the members of a couple does not have words to describe their feelings and does not have words to describe how their partner impacts them, or they intellectualize rather than talk about their feelings, couple therapists can become frustrated. Referral to individual therapy becomes a possible

solution. One participant brings up a man who was very shut down; he came into therapy only because he did not want to lose his wife, a common scenario. This participant, who has had extensive training in Jungian theory, describes the situation:

> I saw them together for a while but because he was so closed down and shut down and he didn't see that he had any problems, it was hard. Eventually, through the marital therapy he began to see some of his own issues a little more clearly and he agreed to go to therapy. He basically had come to couples therapy because he did not want to lose her but he could not see his part. After a while he began to see that maybe he had some problems, some issue in communication, like his past history, his mother died traumatically when he was a child. So eventually I began to put that in there lightly. I thought that they would not be able to rectify their work unless he got his own work around his early traumas and the things that he was shut down to. Because it affected their marriage so strongly.

This example further reflects the care taken when considering such a referral. I asked this therapist how she might make the recommendation to a person who was so shut down. She answered with the following:

> OK, well, usually then I play down the fact that, again, I always use the thing that I try to equalize out the work so that each person is being able to speak or think about something and the person who has a hard time talking, sometimes it is because of their introversion, sometimes they are just shut down and I say that I think it is, would be nice, to have a person to talk to yourself because it would be less interference, at a time when you are having a hard time speaking up in here. I look at the psychological type and where they came from, can they work in that way, what is the best way for them to work.

Further elucidating this referral decision, the therapist said: "And so to draw those people out is sometimes easier if you are doing individual work than having to cope with your partner, who, when they are very quiet, is often vociferous. That is what I have seen."

Another situation in which the couple therapy often becomes stuck is when there is depression in one member of the couple. Several participants noted that the couple work could not move forward if one member of the couple is or becomes depressed. The

depression manifests itself in several ways. The depressed member may not be emotionally capable of listening to the spouse, either becoming withdrawn or very irritable both in and out of the therapeutic session. Depression in one member of a couple could also fit under the category of severe pathology, which will be discussed below. I include it here because depression is more common than the other types of severe pathology and was identified repeatedly by my interviewees as a time the couple work felt stuck.

The participants provided four variants exemplifying why depression could not be properly addressed in the couple therapy. In one case the depressed husband was afraid of his wife because she would threaten to leave should he describe his feelings. The therapist said to me that "there was no way she was leaving but it would really terrify the husband and he would either get placating or sometimes he would just erupt." The participant went on to say that the wife had unrealistic expectations of her husband and when she would complain, it triggered his own issues of inadequacy. The husband was helped in individual therapy to tolerate her upset and to refrain from taking action, which could then trigger a counterproductive reaction from his wife. The participant added that the wife reacted in a strongly negative way to her husband's feelings, thereby disrupting the work of the couple's joint issues. This participant in this excerpt from my interview vividly describes how individual therapy was able to resolve problems that could not be addressed in the couple sessions:

> So the individual therapy really helped him to manage himself in some of the ways that she was hard for him. In ways that she would scare him by threatening to leave. And we could not get into some of these things because she would dominate. So some of understanding his own hostilities and the passive-aggressive stuff actually was worked better individually. I think the individual therapy allowed more intensive work to be done on these things. Work that could

> not be done in the couples therapy because his wife could be so emotionally reactive to it. When she would react, things would shift and he would then back away from what he was saying. And he would really make the peace. It was very hard for him to stay with his pain and his agenda. And so this was her part in encouraging the passive-aggressiveness. If she couldn't hear it in a direct way, what avenue is left for him to express his upset and pain and anger and so on? So I think it really helped that he had a therapist who could really stick with him on the passive-aggressiveness where as we, in the couples work could get easily derailed from that.

The same participant referred another husband who was also depressed both to individual therapy and for a medication consultation. The therapist told me that what transpired over time was that "the husband was really quite depressed and it seemed that the work in some ways, bogged down, that there wasn't much change occurring, there wasn't much movement."

In this case, the therapist initially brought up the fact that the man might benefit from individual therapy and a medication consultation.

> The man was not interested because he felt it to be a comment about him being the problem, which could be one of the problems in making a referral, but he actually ended up taking both of those referrals, ended up taking some medication and some psychotherapy and it really changed, it dramatically changed the way that he could work in the couple work and also changed just the movement of the couple. So, the level of depression in this fellow was really something that I don't think the couple therapy was going to get at.

Yet another participant who tended to make recommendations for individual work at an earlier stage in the couple work than the previous participant, treated a couple who had been together since high school. "And he was doing a lot of Internet porn that she had discovered and it was my assessment that he was quite depressed and that the porn was a manifestation of that depression." The participant told me that before she made the recommendation, she talked to the husband about his depression and how depression manifests itself differently in men than in women. She asked him to read a book about

depression so that "he and I could get on the same page about my diagnosis." The man read the book and consequently began individual psychotherapy.

A final example is from a participant who also made a recommendation for individual therapy and for a medication consultation. In this case of an unmarried couple, the woman was complaining that her partner would come home from work and just want to go to bed. She said that she would make a nice dinner and then want to snuggle and maybe have sex but he was disinterested. When they went out with friends with whom she anticipated having fun, her partner would look at his watch and want to leave early. The man did not want to take medication because he was afraid of losing his edge; that he would not be sufficiently aggressive or be able to make rapid decisions that he believed his work depended on. Thereupon, the couple therapist advised him if he would not consider medication, that he should try intensive individual therapy. She informed him that she believed that he had been " depressed for a long time. Pretty much your whole life." She told me that his parents had gotten divorced when he was young after a contentious relationship. The therapist said that some of this could be worked with in the couple therapy and it was about one year into the couple work that she made the recommendation. A pressing issue was that the woman wanted marriage and children, but the man remained ambivalent. The man did go into a psychoanalytic individual therapy and stayed for three years while continuing in long-term couple therapy; both modalities resulted in significant positive change. The couple ended up getting married.

One Member of the Couple Has Overwhelming Distress

Many of the participants spoke of feeling prompted to make a referral for individual therapy when one member of the couple had what they called "overwhelming

distress." In these cases, one member was either taking up all the time in couple therapy with crying and emotional expression, or the therapist was worried about them and did not feel that couple therapy was adequate enough to help with these particular issues. In all the examples where the couple therapist made a recommendation for individual therapy to the person who was in such distress, only one of the causes of "too much distress" concerned something other than an affair. On the other hand, that partners entered couple therapy following the discovery of an affair, or that an affair was revealed during the couple work, did not always prompt an individual therapy recommendation. I will explicate this discrepancy below.

In the following cases the revelation of an affair caused overwhelming distress and a sense of betrayal, leading the therapist to make the proposal for individual therapy. In the first example, the therapist immediately observed that the woman was "just beside herself" but a recommendation for individual therapy was delayed about two months. She describes the situation and her thinking:

> It was too much distress. Lots and lots of crying. And I thought it was a need that should be attended to. She needs so much support and I feel that is my job but also to be with him and support him. It feels like we could spend the whole time focusing on her upset. This was true at the beginning but not now, I have only been seeing them for a year and a half, so it wasn't too long before I said maybe you would like to see somebody on your own. Of course, she liked that idea a lot. It is too much to hold in the 50 minutes or so.

This participant further elucidates the reason for the referral:

> She just needs so much more support than I can give her. That is just so apparent to me that she is in such distress. And I can't give her what she needs. I can't just be with her for session after session after session. I don't mean I can't be with her at all. Of course I can, but you know for weeks and months on end, it just doesn't work. The couple sort of gets abandoned and I don't want that to happen.

This couple therapist has a strong systems background and loves working with the system. She went on to say:

> I want them to know that this is couple therapy, that I am holding this couple and the relationship is the client and nothing is going to deter us from that. I don't say that but that is really part of my thinking.

She added that the delay in the recommendation was based on a concern that an early recommendation might be perceived as stigmatizing. This is discussed further in the section below labeled "Risks." This participant mitigates the possibility of the individual referral being perceived as stigmatizing by saying the following: "It looks like you need more support than we can do in here and it might be good for you to talk to someone on your own so that you get the support you need." This participant told me that she says this in a non-pathologizing way because the extreme distress does not feel like pathology to her. "To me if feels like betrayal and it is too much to bear."

A participant, who made it clear that she did not always refer the "betrayed" one for individual therapy in the case of an affair, describes an instance where she did make such a recommendation for a man whose wife had an affair, but there was also an imbalance in the couple in terms of individual development and growth. This was a couple that been together for many years. The wife recently revealed to the husband that she had, not one or two affairs, but abundant affairs during the first fifteen years of their marriage. The participant describes the husband:

> And he was devastated, and he was in a terrible bind. Of course he was furious, the rug had been pulled out from under him, he was beside himself, out of his mind with horror and shock, his world had turned upside down, and she felt very badly about it but also had her own reasons for the affairs. She did not want the marriage to end and so I really felt that both of them needed individual therapy and she was already in individual therapy and I felt like he needed a place for his own grief and his own horror.

When I inquired if the fact that his rage and grief took up too much time and space in the couple work was the reason for the referral, she replied that he needed the individual work, not only for his fury and anguish, but also for his need to discern his own identity, separate from her. They had been together since their early 20s and although the therapist was making a lot of room in the couple work for these discoveries, genuine individuation required that he seek his own therapist. This participant felt that it was something about the number of affairs that the wife had, which really added a different component. Another striking element was his complete obliviousness to his wife's serial deceptions.

A third participant described a couple where the husband had an affair and was working in couple therapy to save his marriage. She worked with the couple for a while but the women's distress was overwhelming the couple work. She told me:

> I eventually referred her to individual therapy. She had a hard time, those that think they have been betrayed, I think betrayal is a hard thing to go beyond for people, so if nothing else they need to work on their own feelings about that if they want to stay in the marriage. And in this case the woman did want to stay but she had such anger and hostility that she just didn't know if she could stay. Even though he really wanted it [the marriage] and stopped the affair. ...The couple stayed in marital therapy for a while after that too [her individual therapy] and when they finished they were still together.

This same participant describes another couple that she worked with:

> The husband had an affair. . . . They came to marital therapy and he acknowledged he made a terrible mistake and it was kind of a one shot deal. And I believed him. But she absolutely did not. This woman was extremely neurotic and suspicious. She was down to taking off his underwear to see if he had semen in there. She was really obsessed, just obsessed with it so we really couldn't do marital therapy because her obsessions were a constant. And it would always turn back to that and I would try to draw him out and it was back to this so I did recommend that she have individual therapy. And she was very mad at me first; she thought he should be in individual therapy because he had the affair. And just couldn't understand why at all she had to do that.

In these cases, the principal reason for making the referral is not the affair itself, but rather that the distress overwhelms the therapy.

In regard to affairs in general, the participants seemed to be split about whether the feelings about the affair should be worked with within the couple context or in individual therapy. About half felt strongly that in cases of affairs, the unfaithful partner should be present to hear all of the hurt and anger from the betrayed one in order to work through this betrayal. One participant said:

> When I work with couples and there is a hurt one, I think it is really important for the erring one or the unfaithful one to be emotionally present, it is part of the healing process, they need to really hear the pain that they have caused. And they need to listen non-defensively. They may need to listen for a long time. And I think it is part of the healing, it isn't just like I am sorry. This is an act, this is something you do that will actually make things better. . . I am not afraid of people having affairs any more because I have seen enough couples that have come through it and the marriage is stronger for having worked through it.

Another said:

> With affairs, I think sometimes the individual treatment can be almost problematic. Sometimes the story that gets told is one-sided. And the individual therapist is not seeing that patient in the context of being with the partner. They are a somewhat different person, they can be all a certain way with the therapist, just the two of them, but in the relationship they can be different.

When I asked if he ever had a case where the hurt one was so upset that he couldn't focus on the couple issues he said:

> I don't know that I have had a case where that person was so upset that nothing could get done. I have seen situations where I am not sure that is not going to be the case, where someone is distraught for many sessions and then suddenly there is a shift that occurs.

Another participant who sometimes has made a recommendation for individual therapy in the case of affairs described a time when that was not necessary.

> Well the situations that I have seen in my practice have also been that the couple comes in at some point after the revelation of the affair and the cessation of the

> affair. And, um, I am thinking of two cases. Let's see. In one the guy came in, a straight couple, he had never had individual therapy, he had the affair, young married couple, the affair was very brief, but by the time they came in, I think I used to say to him that he came in with his tail between his legs. And he felt very badly about himself and was willing to use the couple therapy to look more closely at how things had devolved or evolved between he and his wife such that he had gone to bed with somebody else. And his wife was very psychologically minded and had been in a long treatment and had an orientation towards him that was mostly very accepting and forgiving as long as he could speak about his internal process. So there wasn't a whole lot of vindictiveness and aggression, there was sometimes. There was her upset; she didn't minimize her own hurt. But that was a very constructive experience.

Only one interviewee gave an example of a couple where substantial distress, not engendered by an affair, prompted the referral for individual therapy. This was a case in which the husband wept when he described his experiences, and could not be comforted by his wife. The wife, who had a high-powered job, which involved considerable travel, supported the family financially. She was not available emotionally, which was causing problems in the marriage. She had not been allowed to be emotionally dependent as a child and she did not know what to do with her husband's feelings. The husband was already in individual therapy. At one point, the wife opened up and began to cry copiously in every session. The couple therapist recommended individual therapy for her.

> She was grieving for her childhood and saw how barren it had been. And I thought in the couple work that she had gotten to that place, and he was very supportive of her, it was safe enough. But she just needed more attention. I knew that and she knew that.

The therapist observed that the individual therapy strongly complemented the couple work because the woman became capable of speaking of her own feelings. She often returned home from her individual therapy and opened up to her husband, creating the

needed intimacy. When I asked why couple therapy was not sufficient, the participant replied:

> They would come into the couple room and there was a lot of emotion, a lot of emotional closeness. But they would say we need to do this at home. They were making the transition from, " I can talk about my feelings with my individual therapist and with my couples therapy. But at home it is all just, you know." So the fact that she had this session in the middle of the week with her individual therapist, it kept. I am thinking about this out loud, I hadn't really thought about it this way. But I think it provided another bridge that she could think about her feelings not just in couple therapy but also in this other point in the middle of the week. And then she would come home and there wasn't a couple therapy, but she would talk to him, because you know, she had to. So, I think in some ways it was helpful for them both for her to have that experience.

The Biological Clock

This category, which arose in the literature, refers to women's fears about their ability to conceive children and the pressure of approaching infertility due to age. Women in their late thirties, who want to have a child but are in a marriage or relationship where they are working on problems and perhaps their partner or husband is not ready to move forward and begin to start a family, feel a tremendous amount of pressure. Such pressure can get transferred to the couple therapist and a recommendation for individual therapy is likely to be made. Two therapists in my study made a recommendation to individual therapy for this reason.

One participant described a couple where the man was depressed and having children was a burgeoning issue between the two. The woman reached a place where she felt emotionally ready to have a child and was very unhappy that they were not moving forward. The man was uncertain about becoming a father but knew he did not want to lose his wife so he was willing to come into the couple work at this time. He also took the recommendation from the couple therapist both for individual therapy and for

medication to treat his depression. After the man engaged in individual therapy and began taking anti-depressant medication, the therapist noted a huge shift in the couple.

> They were doing better very quickly and he was more available emotionally in the sessions. So I think that was a direct effect of the individual therapy and the medication and that really translated to outside the sessions too.
> So it was a good outcome. They stayed together and had a child and then we terminated. There were a couple of times when I ran into her around town and one time she had a picture of her baby. They were a very nice couple.

It is interesting that in the other case where a participant identified the biological clock as the prompt for a referral to individual therapy, the man was also depressed. This is the couple, also in their late 30's, mentioned earlier within the section, "The Couple Work Is Not Moving Forward." The man did not want to take medication but took a referral for a psychoanalytic psychotherapy. This couple was seen for three years and the recommendation for individual therapy was made about a year into the couple work. Both the woman and the therapist felt that "we just weren't getting that far. And the therapy felt stuck. She was tick, tick, tick. I am not getting any younger." The therapist reported to me that the man made a lot of changes as a result of his individual therapy.

One Member Has Severe Pathology

Almost all of the therapists that I interviewed described couples in which one member had what could be described as severe pathology. When severe pathology existed in one or both members of the couple, they all made recommendations for individual therapy. The type of severe pathology varied. In one case, the woman was anorexic, in another the man was a sex addict and frequented prostitutes and massage parlors. Three participants recommended individual therapy in cases where one person was very narcissistic.

One participant described why more is needed when replying to my question, "What made you feel this person's issues could not be addressed in the couple therapy?"

> I think there are things about both these people that appear to be really severe psychopathology. So I think this is one of the answers to the question you are raising, the broader question. Some forms of psychopathology, very serious ones, seem to be, and I don't think this is always the case, but there were some intractable things here that I think required much more work.

This participant goes on to describe a woman in a couple she sees who was riddled with such anxiety that she became agoraphobic. He had seen the couple for about a year before a crisis occurred in their life; the wife suffered a near collapse, and her anxiety reached a point where she could no longer work. The participant considered that this anxiety was so severe that it could not be contained either by the husband alone, or in the couple treatment. This therapist told me that part of his countertransference was an anxiety that he wouldn't be able to give the woman what she needed.

In another case where individual therapy was recommended, the couple had been married for 20 years, both having had affairs during their marriage. The woman no longer wanted to live with this kind of deceit and had stopped her affairs. The husband stated that he really wanted to have his wife stay in the marriage and he recognized that he had a problem. In the therapist's opinion, the fact that the husband admitted he wanted to have a secret life but also wanted to save the marriage represented a severely pathological degree of unconscious conflict. He claimed that he was ending his most recent affair but the wife had trouble believing him. He admitted his dishonesty with her and conceded that he did not understand his attraction to having a secret life. The therapist told me that he recommended individual treatment because he did not think the

husband could, in his wife's presence, have gotten to the unconscious motivators, behind his desire for a secret life. He explains:

> I think he needed more intensive work because a lot of the reasons this man needs a secret life, which has been a life long pattern, are unconscious. This man traces this need for a secret life back to his father who also had a secret life and I think he would be hampered in the couple work by exploring these things because of his wife.

Other examples of cases where the therapist recommended individual treatment because of severe pathology in one of the partners include one in which the man had a very active masturbatory life watching pornography, which interfered with his sexual relationship with his wife. Another was one in which the woman had made a serious suicide attempt. Regarding the latter case, the therapist gave the couple an ultimatum:

> I was not sure that I was up for a couple that was sent my way when I realized something about who I was dealing with and there was such a degree of crisis, I made sure that both people were in individual treatment and I told them that I could only see them if they remained in individual treatment concurrently because I felt that I was not going to be able to contain the level of anxiety and crisis. . . They were a young, married couple on the brink of separation and the woman was using Vicodin. Her behavior was erratic and she had made a suicide attempt, a serious suicide attempt in the previous eighteen months.

Three participants gave me examples of cases where they referred a member of the couple because of what they called extreme or arrogant narcissism. In the first case the main reason for the referral was that the narcissistic man was taking up too much of the time in the couple therapy. The participant states:

> The guy was pretty arrogant and although he wanted the marriage, he was still quite arrogant about the affair and his entitlement to have it. And he wasn't able to get beyond that very easily. He was taking up all the time in the couple therapy so I said to him: "We have to work together and each person only has so much time to talk and the other person needs to have a chance so we kind of work the three of us rather than one person taking up all the time," and I felt it might be nice for him to have his own person because he has a lot to say. I call it playing the system and with arrogant people it often works. So basically it is narcissism, "You should have a chance to speak about yourself and we can't do all of that in

> here." And so it doesn't look blaming. It looks entitled: "Yes, I deserve that I should do that." So in that case is how I worked it out and he did agree to go and stayed in the couple therapy and they actually saved their marriage. And I think that guy began to soften up more, I think he liked therapy.

The second example of a recommendation made to an extremely narcissistic man was for a couple where the woman was already in individual therapy. In this case the man refused to go.

> He was basically scathing of therapy and of almost everything. He was just flagrantly narcissistic and I suppose this gets us into another realm, which is about personality disorders. In their case, he could not see his wife at all. She was really a function for him. She existed to be nice and pretty and caring. She wasn't at all that, it is not that she wasn't caring, she was, but nothing was ever good enough for him and he expected her to sacrifice her life for him and keep him happy and he was a hypochondriac and he needed a lot of tending to and flagrantly narcissistic and I thought if there were going to be any chance for them as a couple that he needed to be in individual treatment. But he just sort of spurned that. And over the course of the year and a half that I saw them, the relationship went through one crisis after another and eventually she got up her courage to leave him and she did.

The third example of narcissism is in the case of a couple where the therapist described a woman to whom he recommended individual treatment as a thin-skinned narcissist. He describes the reason for the referral as:

> It became clear to me early on that she needed something more. I really thought she needed something more than I was going to be able to provide. She was a thin-skinned narcissist; she had a lack of self-reflection, a lack of ability to self-observe, and could not regulate her affect.

I asked this participant if he also referred her because she was taking up too much time in the couple therapy. He replied:

> Yes, [he laughs] a lot! With a kind of obliviousness. Sometimes she could talk and he would roll his eyes and I would want to roll my eyes, that was part of the countertransference I could not interpret. And I had to be careful about interrupting her. If I interpret or interrupt, it is going to be too wounding. And there were interpretations that I wanted to make about holding us both captive, but you know, these were the thoughts I had which I think they were true, there were ways that she would sort of control things, but I think there was just no way to, I

> mean, that was going to work. . . . There were a series of efforts in recommending individual therapy. Sometimes I would tie it to her pain or her unhappiness. Or sometimes her frustrations in life. And when she would bring something like that up and in the moments when she wasn't blaming him for her state; you know there were ties. That was another reason why I was hoping for individual, thinking that she needed more.

All of these participants felt that these disorders required much more work than was possible in a couple therapy, and the work had to center on the individual who displayed the pathology in order for the couple work to prosper.

One or Both Members Have Severe Substance Abuse or Alcoholism and Violence

All participants agreed that if there were a serious drug, alcohol, or violence problem then something more was needed. All except one said that they would continue the couple work if that person agreed to concurrent individual work. One therapist stated that he would not even work with the couple until these issues were brought under control.

> If someone had a serious drug or substance abuse or dependency problem or someone had a violence problem, then I am not going to be able to do something that is meaningful and, in fact, it would be unethical and unprofessional to treat them.

Another participant told me about a case where she referred the husband for individual treatment because he had a very severe marijuana dependency. I asked her: "Can you remember at what point in the couple work you made the referral?"

> I think pretty soon after I became aware of this. And they hadn't told me this initially. It came out over time. So maybe six to nine months into it. I referred him to a colleague who does a lot of that work for an assessment, thinking that person would decide what to do. They continued the couple work and he continued individual treatment. He did really well in that individual treatment and it was a very good outcome. It was not a straight, linear shot. It took a lot of work but last I heard he was pretty clean and doing much better.

Another participant, speaking in general about drug and alcohol problems, said that she refers to Alcoholics Anonymous or to a 28-day treatment program, depending upon the severity of the problem.

> If they are really down and out I will just say that I don't know how well your marriage can be fixed unless you go to a treatment program. Or at least go every day to an outpatient program. And then sometimes they just go to AA if I feel they can manage to stay there. If they are willing to stop.

Often, alcohol problems were the cause of violence in the relationship. As one participant told me:

> A lesbian couple that I saw had both violence and there was alcohol involved and so psychodynamic work was on hold trying to get them to look at their co-alcoholism. One was becoming violent. She would get really drunk and attack her partner and I said this relationship is not going to have a future this way; you need to get a handle on this. . . . Mostly you are fighting after you have been drinking all Saturday afternoon and Saturday night is your fight night. Because you are primed, drinking all afternoon, not eating anything.

This couple had come to couple therapy because of the violence.

> They reported having terrible fights that involved throwing things. They really knew how to push each other's buttons, much like in the play *Who's Afraid of Virginia Wolfe*. I recommended individual therapy for her anger and AA for the drinking, after four sessions.

Another participant said that she makes referrals where there is domestic violence and she could not think of anybody who has been violent who did not also have alcohol problems. This participant said she would not work with the couple unless the alcoholic person was in treatment for alcoholism.

There were two examples of times when participants referred a member of the couple for individual treatment because of explosive anger that was not due to drinking. In one case:

> There was a point in the relationship where she pulled a knife out on him, they were having a huge argument and she lifted a big kitchen knife and pointed it at

> him, and he described her as really being at the edge of losing control and screaming. And she would always diminish these things. There was a way which she could diffuse things with humor and denial, but in this case he was really making an appeal to me to understand the seriousness of this threat and his fear. And at that point I basically said that I thought she really needed to get herself to individual therapy and I had somebody in mind for her who was extremely skilled and would be able to see where she was coming from.

And in another case where there was extreme rage, a recommendation to individual therapy was made.

> He would have these bursts of rage at his wife that would completely undo her and would either cause her to shut down or cause her to go into a rage of her own. One time he picked her up from the airport and started going off at her about something and she insisted that he stop the car and she got out. She was enraged by his rage.

In these examples referrals were made only in cases of extreme rage or violence; participants made this distinction. Often couples come into couple therapy because there was an instance of pushing, shoving, or hitting and this show of physical anger both frightened the couple and made them realize that they needed help. All participants agreed that once the couple had a place or container to talk about these intense feelings, the physical pushing or shoving ceased. For instance, one therapist described the wife in a couple he worked with who saw her husband as a batterer because he once hit her. The therapist saw it this way:

> I didn't see him as a batterer at all but I had a lot of pressure from the wife to blame him. They had come back from a trip and the husband was physically ill and the woman was in a very bad state, kind of a borderline woman, and wanted him to hold her. He held her for a minute and then said I need to go to sleep. And she said "no, you can't, you can't." He said "OK, I am going to sleep in the other room," and she grabbed his shirt and he punched her. . . . I wanted us to think about the dynamics there but there was a lot of pressure from her to chastise him for his bad behavior, which he completely owned and was appalled at.

In this case the couple therapist told the wife that he did not see the husband as a batterer, which the husband really appreciated and, which the therapist felt was much more helpful

to the couple. By focusing on the interpersonal dynamics, the wife could see how difficult it was for her to soothe herself and regulate her angry feelings. So, in this case the therapist did not make a referral to an individual therapist.

One Member Is a Survivor of Childhood Sexual Abuse

I asked the participants specifically about childhood sexual abuse because this invariably has an effect on the couple's sexual relationship and is much discussed in the literature. While all participants felt that the individual therapy recommendation should be considered in this context, one pure object relations couple therapist said that whether or not individual therapy was necessary would still depend on the individual patient, even if one or both had endured sexual molestation. All participants felt such a recommendation should be considered but not necessarily made. They point out, however, that most of these cases come to them from the survivor's individual therapist and that couple therapy is most often the second therapy sought. The survivor's individual therapist oftentimes says that this is having an impact on the relationship and therefore recommends couple work. The few exceptions where the survivor of childhood sexual abuse was not already in individual therapy were examples from couple therapists who were not practicing in a large city. This is more of a sociological finding, that in the large cities people in general, and the survivors of childhood sexual abuse specifically, are more likely to be in individual therapy or in a group with other survivors.

In one case, where the couple therapist recommended individual therapy, the therapist felt that she could only bring the couple work to a point because the survivor of the childhood sexual abuse was "hung-up around sex and did not want to have it." She states:

> They came in as a couple and she had childhood sexual abuse. She did not want to have sex. They stayed in couple therapy and worked on whatever other issues came up and her individual therapist helped her to want to have sex again and they did work it out. This woman was very upset about the fact that she did not want to have sex. She had pain around the fact that she did not want to have sex. She could not understand it. So that is why I referred her to individual therapy and I told her I felt it was related to her past and that she could work it through. But again, you have to see where the person is. Some people don't want to have sex and they don't ever want to have sex. So they end up getting a divorce. And not having sex with anybody. Because they don't want to and that is their choice, of course, whether they were injured early or not. They don't see it as a problem. This woman was very tortured about the fact that she did not have any interest in sex and I referred her to a sex therapist. And they eventually did have sex.

Many participants suggested that this kind of healing takes a long time and can be frustrating for the partner. One participant refers the partner of the survivor of childhood sexual abuse to individual therapy in order to have his or her own support, feeling that the partner could benefit from individual therapy.

Risks

My participants reported that not withstanding the careful thought they took in making recommendations for individual therapy, there were risks. One participant spoke about what the message of an individual referral might mean to the couple. She felt that the message could be that the couple therapist has lost hope for the couple and was concerned about how damaging this contrary and dangerous message could be. She said that when couples come for couple work they are bringing their precious relationship to you, and accordingly, many participants were sensitive to couple therapy being much harder for patients than individual therapy because of the couple's feeling that this precious thing is so fragile. The same sense of threat that something could happen to a relationship does not exist in individual therapy. While an individual brings immensely important issues to individual therapy, the participants were aware that there can be much

more apprehensiveness when a couple enters therapy, where the individual may feel more exposed. This participant said one of the functions of the couple therapist is to engender hope for the relationship, and accordingly, when making any type of recommendation, care is needed to ensure that neither believes the recommendation is motivated by the therapist's hopelessness about the strength of the relationship. These participants therefore carefully weighed the risk of the undesired message of rejection and hopelessness against the hoped-for benefits of individual therapy for one or both people in the couple.

A participant describes the risks in this way:

> They can feel rejected. They don't always take it; they can feel that they are too much for me. They begin to not trust. It has to be done pretty carefully; otherwise, it could harm the couple therapy. It punches a big hole in the couple therapy. You want to not do that. You want it to be complementary to the couple therapy and supportive. The biggest thing is that they not feel that I am rejecting them. That they are not burning me out or burdening me. "She can't stand us that is why she is sending us to individual therapy."

The discussion of risks associated with making recommendations to individual therapy which participants spoke about will be divided into several categories: Stigma or Identified Patient, Hesitations Regarding Referrals, and Failed Referrals.

Stigma or Identified Patient

All of the participants brought up the risk of singling out one member of the couple for a recommendation of individual treatment, concerned that it could reinforce the idea that one member is "more disturbed" or seen as "the identified patient," a term originating in family and systems theory. One participant said she discusses this with the client if it comes up: "Sometimes people will say something about how he or she is the identified patient or they are being picked on. I always discuss that with them." Another

remarks on the close attention to the arousal of a perception of stigmatization, and listens to how it might be for the couple.

This perception can deter the therapist from making such referrals. A participant said that if both members are not in individual therapy and even though she feels strongly that one could benefit "tremendously" from it, she will not make the recommendation in order to avoid making that person feel like the identified patient. She almost never singles someone out in that way, concluding that this risk outweighs the benefits that might be derived from individual therapy. When asked if she made an exception to this in extraordinary situations, for example, childhood sexual abuse that the patient is already aware of, she responded that she suggests that it would be really useful if they did some work on that in individual therapy. However, in the absence of particularized and egregious pre-existing trauma, she does not recommend individual therapy unless the partner is also seeing his or her own therapist. This participant provided an example of the dilemma of the identified patient. A couple with whom she is currently working are in the midst of a crisis. This therapist was quite sure that one of them would be receptive to a recommendation for individual therapy and the other would not. She reported:

> So the one who would be receptive is much more the identified patient type, but, in fact, both of them really, really could use individual therapy but only one would be receptive to it. Therein lies the rub. That the one who is not receptive to it is the one who appears much more together, and in many ways is much more together.

I said to her: "It sounds like you are being very careful to not convey to the couple that one has more 'pathology' than the other." She replied:

> That is a real bind with them because, in fact, I think the only way this couple is going to move forward is if the one who is receptive to individual therapy, the more messed up one, it is through her changing that this couple will move forward. So, I am more likely to lean on her simply because I think that is the

> only real avenue for change at this point. Because the other one in this couple has dug her feet in the ground. So when her partner changes, it may force a real change in her. In an ideal world, I'd be having her budge a lot. But I don't think she is going to so, from a practical point of view, I have to go where I think change or shifting is possible. She did all the shifting she is capable of in couple therapy and she has stopped. This is a couple I have seen for three years. The entrenched one needs individual therapy but won't go.

Hesitations Regarding Referrals

Therapists in this study spoke of times when they wanted to make a referral but hesitated due to a particular vulnerability in the individual. They were concerned about the possibility that recommending individual therapy might make things worse in the couple treatment rather than better.

One of the hesitations my participants reported regarding making a recommendation for individual therapy concerned the referred person's ability to tolerate such a referral. One participant described her thoughts about this with reference to a client whom she perceived would feel rejected by her making it:

> Well, of course it always enters your mind whether they can tolerate it. But I try to think about it before I just jump in with something like that to see whether the couple therapy can help and see them quite beyond when I think that the person should be in therapy and work out in myself what I think they can handle, or prepare them for it.

Another thought the man in a couple could really benefit from individual therapy, but hesitated to make the recommendation because she did not think he would actually go. In the couple work he was beginning to see how he transferred onto his wife his belief that he was never going to be appreciated and instead would be criticized. The therapist thought that deeper work in individual therapy might help him mourn criticism he endured in his childhood. She decided not to make the recommendation because it

had taken several years in the couple work for him to own his part and she described him as "skittish."

> I am glad he is finally really "in" the couple work and I am quite sure he would not go to another therapist. He feels overwhelmed in his life and time and money are big issues for him. I am so glad that he is in this therapy and I don't want to mess with that, at least not now.

This is a good example of when the couple therapist, while believing that individual therapy might be helpful, refrained from recommending it.

Another participant spoke of a man in a couple whom she felt would be really offended by the recommendation because he has been adamant about not going into individual therapy when his wife has suggested it.

Failed Referrals

Many participants informed me of situations where having received a recommendation for individual therapy the client either refused to find a therapist, went for a short while and stopped, or agreed to go but never followed through.

There appear to be several reasons for this. Sometimes the person refused to acknowledge that they had any part in the difficulties in the relationship and did not think that individual psychotherapy would have any benefit. One therapist, facing such a situation, felt like she was "hitting her head against a wall" when making the recommendation that did not take. In this particular case, the therapist said:

> I really wanted to make it clear that I really didn't see that her partner was the sole difficulty. I really wanted to point out that this is a dynamic and there is something for her to be working on, too.

In some cases the person went to individual therapy but stopped after a short time, unable to attach to a new therapist. An example of this was given by a couple therapist who referred the husband to individual therapy because he was using the couple therapy

to talk about his own individual issues that only tangentially affected the wife. The therapist felt the husband was trying to use more and more of the time in the couple session because his wife had her own individual therapy. So he gently raised the possibility that the husband might also want individual therapy. The wife was supportive of the husband taking up the time in the couple work and was not bothered by her husband dominating the sessions with material that was not particularly relevant to the marriage, but the therapist did not think this was an effective use of the time. The therapist described feeling confused about his countertransference, and told me he did not feel right about the husband talking about his own issues in the couple work. The therapist wondered if it was resistance to the couple work or some other factor.

> It was kind of a confusing thing. He had a transference to me, that I think was at the root of this and probably still is, to be honest with you, but it was hard to get at in the couple therapy and I thought it needed to be analyzed. A very idealizing transference. This guy had me infused with wisdom and experience and he would love nothing more than for me to advise him, which I don't do, on all kinds of things in his life. And it is fueled by the fact that their relationship has gotten much better and the couple therapy part has gone really well.

This man took the referral and saw the individual therapist for a few months but then stopped. Another therapist had this to say about a woman who also had trouble attaching to another therapist and simply refused to go. "I think that this particular woman has idealized me in some way and also trusts me in a way. It is hard for her to trust. So that is a dilemma."

Yet another participant describes attachment to the couple therapist appearing to hinder the referral to individual therapy. In the case of a couple whom she has seen on and off for a period over nine or ten years, she suggested that they both go for individual work, but neither would do it. The therapist feels that this couple believes their

attachment to each other may be threatened if they begin to form an attachment with an individual therapist. She had brought it up to them several times:

> I have said to them a couple of times, "I am not sure that I am helping you. You know, I am sort of, I feel like you are stuck in this pattern and I feel like you are not moving forward and it doesn't feel like you are getting what you really need." And I have even brought up the idea that they go see another couple therapist. And they are not having any of it. They have decided on some level that I am going to help them.

In another example, of a referral to individual therapy, the referral was taken but did not work out. In this case, the couple therapist was treating a couple who were struggling with whether or not to divorce. The woman was already in individual therapy. The couple therapist thought it would be very helpful for the husband to have somebody with whom to talk this situation through and she suggested a practitioner to whom she had made previous referrals. She told me:

> I don't refer to him [the individual therapist] anymore and it was totally unhelpful. Because this guy said to him if you are miserable, don't worry. The partner did not want to leave because he did not want to be separated from his children. He did not want to only have the kids part time. He was very involved in the parenting. The therapist said to him you have to stop thinking about your kids and you have to start thinking about yourself and basically you need to leave. Fortunately this client stopped seeing him and I was really unhappy because he [the individual therapist] did not get that this guy was thinking about himself. He was thinking about himself and his need around being a parent. So that was another situation where, you know, it turned out OK but it probably would have turned out better if I did not refer to this person. So that kind of thing makes me be really careful. Because I think a bad referral is worse than no referral.

In another case, after the couple therapist recommended individual therapy to the man in the couple and the man agreed to go, he dragged his feet and never actually sat down with the individual therapist. The couple therapist continued to try; seeing another opening at a time when the man's mother was dying of cancer, again brought up the subject. She said to the man:

> "Would you be willing to consider, at this point, seeing somebody for yourself, just to help you get through this really difficult time?" He started to drink more. I said that is not the best way to cope with your problems. So he took the referral. He took the card. And he called me, "I lost the card." I gave him her number again. He actually called the therapist. And then they could not find a time to meet. He never had a time that they could possibly meet. He just couldn't. . . . So that went on, things got better. He did not feel the need for it anymore. Something happened recently where I re-offered a referral. His drinking continued to be bad . . . and he is reporting back to me his progress. It has been like three weeks now. He called her [the individual therapist]. Which is good. They haven't set up an appointment. He is very good at appearing to be a good boy while undermining. . . . I said you really need to get some time for yourself. We can't do it all in the couple therapy.

This example shows the difficultly clients can have in taking referrals and also, in this case, exemplifies how denial of alcohol abuse impacts couple treatment.

This same couple therapist describes another case where she recommended individual treatment for the husband and he just refused. She told me that she had brought up her recommendation again recently and talked to him about it for several sessions.

> Because he was having some significant distress. I had stopped recommending it for a while. But once in a while something would come up in the couple work and I would say, have you given any more thought to the offer I made at the beginning for you to get some extra attention for yourself? It sounds like you are feeling pretty, I don't think I used the word "depleted'" but that was what I was thinking. You are under a lot of pressure, you are not getting very much from your wife, she is trying to explain to you that she is also feeling very stressed out and kind of emptied out by the baby and have you thought more about it? "I don't have time and we can't afford it!" Always an excuse. They stopped the therapy.

One participant told me about a couple who recently had a baby and she recommended individual therapy for the husband. He had been raised very rigidly and had a sister who had been physically ill, which took up all his parents' time and attention. The therapist recommended individual therapy because she felt the husband did not have a way to articulate his feelings, and in the sessions things would come up for him and he

would look on the verge of tears and his face would get flushed and he would get even less articulate. However, this man would not take the referral:

> I saw them for a little over a year. They had a baby when they came in, the baby precipitated the crisis. It was pretty clear early in the therapy, I would say probably the tenth week it was really clear to me that he was struggling. I said there is a lot coming up for you and it is really hard for you to understand and process here in the couple session. Maybe you would feel some relief and you might feel better if you had somebody to talk to individually. How does that sound? And he would say I don't have the time, I don't need it. We are coming here. I suggested it many times. We never, he never took me up on the offer. I had referrals ready. The minute he said yes, I would hand him a card.

The therapist's understanding of why he would not go is the following:

> He was stubborn, he was dug in, he was terrified. I think he feared that if he actually connected with what may come up for him he would fall apart. His whole identity was being this strong mid-western kid who took care of himself.

Here the couple therapist is describing what Winnicott called "Fear of Breakdown," (1974) that is, a tremendous fear that if he were to let go of the defenses that had gotten him through his childhood even though they were not serving him well in his marriage, he would collapse or fall apart.

The above data reveals the thought and careful balancing that these couple therapists make when deciding to recommend or not to recommend individual therapy, including their assessment of the potential benefit versus the potential risk. Each situation is complex and each couple therapist uses fine discriminations in thinking about and making recommendations for individual therapy.

CHAPTER 5: DISCUSSION

My study explores how psychodynamic couple therapists experience, think about and determine whether or not to make a recommendation for one or both members of a couple to engage in individual therapy. Specifically, I considered such questions as: Should referrals to individual therapy be made? If not, why not, and if so, why? Are there kinds of couple issues, or attachment styles, that suggest the benefit of both kinds of treatment? What do couple therapists think and do about these questions? What are the risks and benefits of making or not making a referral? While I found a paucity of discussion in the literature, the participants in my research were eager to talk about this issue, gave it deep consideration, and told me that they greatly anticipate the results of my study.

This research grew out of my interest in whether or not to recommend individual therapy to the couples I was treating. I found no protocol for such a decision in the literature and wondered how other psychoanalytic couple therapists handled this issue. The results of my study suggest that there is a need for ongoing discussion of the relationship between the two forms—individual psychotherapy and couple therapy. Thus, my findings need to be placed within the context of the problem of the relationship between individual and couple therapy and the absence of a theoretical overview of how practitioners should approach this relationship. It seems clear to me that my participants were involved in trying to work this out for themselves, and they were not always comfortable about it.

This chapter will begin with a discussion of the findings and their implications followed by a look at the relation between my findings and the literature. Finally, I will address the limitations of the study and suggest areas for further research.

Discussion and Implications of the Findings

The most significant finding of this study is that the principal impetus for couple therapists to make a recommendation for individual therapy occurs when the couple work is stuck, stalemated, or has reached a plateau: when the couple work in the triadic relationship is not moving forward and, consequently, the marriage or partnership is failing to thrive. That the couple work was blocked in some way is a central theme within every category of the results. The decision to refer one or both members of the couple to individual therapy is always focused on improving the progress of the couple work and endeavoring to place the couple within a psychic space where they can listen to, and talk to each other, and have a productive exchange.

A stalemate in the couple work may be due to impairment of one or both members of the couple, but very importantly, the stalemate can be caused by the nature of the triadic relationship of the therapist and the couple during the couple work. A sensed imbalance in the couple can also be an impetus to refer and is related to the situation of a stalemate in the therapy. Yet, although the therapists in this study referred more frequently than I expected, they also revealed a reluctance to refer. I will discuss each of these aspects of the decision to refer separately below. I will also touch upon the question of the role of theory in this decision.

Stalemate in the Couple Work

The Couple Dyad

Despite finding certain categories of couple issues where recommendations to individual therapy were frequently made —for instance an affair, attachment styles, psychological diagnoses, or the patients' individual history —the fact that the couple work became impeded remained the primary motivation for considering a referral. The quality of the progress of the couple work is the great initiator of the recommendation for individual therapy.

Perhaps a reason for this most important finding is that even if a member of a couple is identified as fitting into a certain category of distress or pathology, this member may still be able to effectively participate in the couple work. Clearly, there are different degrees of any problem or particular pathology, and individuals are unique in the way they navigate through such issues, so that making referrals to individual therapy was not always necessary. However, when the couple work was perceived to be mired, recommendations were made across the board. In sum, I found that the category of individual dysfunction played a lesser role than the quality of the experience in the couple work.

For example, a depressed person may still be able to hear what a partner is communicating and retain the capacity to respond. It was when the depression had triggered severe withdrawal, preventing communication, that the couple therapist would make a referral. Similarly, individuals with a history of severe trauma in childhood may still be able to regulate and soothe themselves so that, when triggered by the partner, they can calm down without descending into a negative, destructive cycle. In such cases

individual therapy may not be deemed necessary. However, a trauma survivor may become so overwhelmed, hysterical, and blaming that participation in the couple therapy becomes impossible. Even if a person is suspicious of the partner, does the suspicion interfere in all interactions? If so, something more is deemed to be needed. A member of a couple might be narcissistic but still able to see her part in a conflict with her spouse and be able to apologize rather than defensively justify her behavior. On the other hand, a member of another couple might be arrogantly narcissistic, like one described in my data. In this case the man, feeling entitled to having had an affair, would not own any of his part in the couple's unhappiness. The therapist consequently made a strong recommendation for individual work. Thus assessment of whether or not to refer has more to do with the therapist's perception of the couple's level of functioning with each other, in the couple sessions and at home, than with the type of presenting issue, particular pathology, or diagnosis.

The Therapy Triad: Countertransference

Couple work may become stalled because of an underlying personality impairment of one or both members: however, it is significant to note that it may also be impeded by the triadic relationship of the therapist and the couple during the couple work itself. If the triad is functioning well, the work, regardless of the couples' issues, diagnoses, or attachment styles, may still prosper. It would be simplistic to conclude that it is just the couple that becomes stuck. The couple therapist herself is, of course, a large factor in any successful therapeutic relationship. The couple therapist's countertransference was discussed in Chapter 4 as one factor in the decision to refer. We know that a particular couple may be able to work with one therapist but not with another

because of the therapist's psychology and, accordingly, countertransference. The therapist's decision to refer is based on her conclusion that the couple therapy has become blocked, whether the causal factor is the couple's psychology or the therapist's countertransference. While the origin of the failure of the couple work to advance may be due to the therapist's countertransference, it remains difficult to categorize the varieties of this experience. One participant, who writes about trauma and couple therapy, told me that she has observed in various couple consultation groups and among colleagues that some couple therapists are uncomfortable with the presence of childhood trauma and tend to refer that person to individual therapy. Another participant, in stating her position on working with couples with a trauma history, exemplifies the important element of the therapist:

> I think to some degree it depends on the patient and their willingness and capacity to do individual therapy as well and to some degree it depends on the therapist and his or her sense of competence and so on. After all, each individual is unique and each couple is unique and each dyad and triad are unique. I would need to feel that I at least had my bearings with a disturbed couple or with a couple where one or both really come from traumatic backgrounds in order to feel I can do good enough work.

Such comments were not about their clinical cases but about therapists' own internal observations. It was gratifying to find that all of the participants in my study were aware of their countertransference feelings and used this awareness of their own responses to their clients to assist in making a decision regarding referrals to individual therapy.

Imbalance

Another important finding is that the couple therapy can become impeded when there is an imbalance in the couple work. Participants told me in various ways that, in order to maintain a good working relationship with a couple, striking a balance between

the members is essential. Several reasons for an imbalance were described: when one member of the couple is in individual therapy and the other is not; when neither partner is in individual therapy but one member is uncommunicative, depressed, shut down, or excessively distressed; when one member is less self-reflective; or where one member of the couple was able to talk at a deeper, less superficial level, and the other was not. In order for a couple to feel close and vital in each other's life, they must have a deep understanding of themselves and their own part in the difficult interaction or misattunement. If they can talk about their inner experience and make themselves vulnerable, it enables the partners to have empathy for one another. This experience is what we call intimacy. Johnson (2004) calls these moments "softenings." In a softening, a newly vulnerable spouse reaches out to a now accessible and engaged partner and asks for his or her attachment needs to be met. For example, if one can say, "I attack you because I am afraid of being abandoned" and cry about his sadness and grief regarding a childhood abandonment, the partner can then feel close rather than viewing the other as angry and attacking.

Some reasons for an imbalance are specific as delineated in the different categories in my data, but in fact, there is an underlying imbalance in all of these reasons. An imbalance arises in the couple therapy when the therapist must spend more time focusing on one of the members of the couple. This exemplifies a close relationship between imbalance and blocking in the couple work. As one participant stated:

> It seems probably true that when both members of the couple have at some point in their lives been in individual therapy, and let's say one member of the couple is currently in individual therapy, that there is less of an imbalance. It is not 100% sure. Sometimes, people come in and one person is in individual therapy and the other never has been. Then that person has a kind of an intuitive, psychologically minded quality that allows them to participate fully. But there are times when one

> member of the couple is in individual therapy and the other is not and never has been, and lacks something and sometimes begins to speak to that, that sort of disadvantage at which point I will take it up as a possibility.

An imbalance can also occur when one person changes because of their individual therapy or changes as a result of the work with the couple therapist. Being in individual therapy is often because the person has a certain curiosity and the concomitant courage to face oneself. One participant, in speaking of an imbalance, describes her approach to a woman whose boyfriend was in individual therapy. "I tried to connect with her empathically. I talked to her about the limits of her capacity to put her feelings into words compared to her boyfriend who had a greater facility for that." The participant said that the boyfriend would consume more time talking about his feelings but when the therapist would ask the partner to speak, she would seem very guarded, her feelings inaccessible. "I wanted her to have a place in which she could develop those parts of herself so that she could potentially bring into the couple therapy more knowledge about herself and get more comfortable speaking about it."

An imbalance can also occur if only one member of the couple grows and develops, because that person may become frustrated and distressed that the partner is not engaged in a similar transformation. Change in one person, which causes a change in the relationship system, may motivate the other to desire such growth and development as well, or less desirably, the partner who is changing puts pressure on the other to begin individual therapy, or may wish to leave their relationship. The fact that one of the partners is changing, whether due to an individual therapy or to the couple work, upsets the status quo.

Reluctance To Refer

It is evident that the therapists I interviewed liked working with couples immensely. I suspect that because they feel this way, they would encourage a prospective individual client who presents as unhappy in a relationship and who is unsure about attending alone or with the other, to come together as a couple. I think it is because of this passion for the couple work that my data showed significant reluctance of therapists to conclude that individual therapy was indicated. Their reluctance might also represent a concern that it would be an admission of failure on the couple therapist's part. Though not explicitly stated, this can be inferred in that the participants, except for two, did not view lightly the decision to make a recommendation to individual therapy. The therapists' passion for the couple work and their fear that a referral may be an admission of failure may explain why my participants gave such careful thought and appeared to struggle with whether or not to refer someone to individual therapy. There seemed to be an inherent sense that this recommendation, if accepted, would change the couple work significantly. The dialectic in the participants' thinking appeared as follows: on one hand, all were careful not to convey that they felt hopeless about the couple and were not abandoning them or that a recommendation reflected negatively on the couple work. On the other hand, all the participants felt that once the member became engaged in a productive individual psychotherapy, it highly complemented the couple work, moved the couple work forward, thus improving the possibility for a successful outcome.

However, the fact that recommendations to individual therapy are made fairly frequently is understandable since couple therapy can be intense and often opens up an

individual's psyche in ways that may make the partners want more intensive, individual work.

Theoretical Orientation

Another finding from my research into the question of whether or not the couple therapist recommends individual therapy is that the decision may depend on the couple therapist's theoretical orientation as well as on what is occurring in the couple therapy. I was curious about the role of theoretical orientation in the decision to refer to individual therapy. As it turned out, this study did not accumulate sufficient evidence on this issue. However, there is some suggestion that theoretical orientation can make a difference. It is notable that two participants who were highly influenced by systems theory, although they were psychodynamic psychotherapists, and one who described herself as eclectic, tended to refer to individual therapy more frequently and earlier in the couple work than did the other participants. One of these participants told me that she worked "with the system," meaning that she made a very clear distinction between intrapsychic issues vs. interpersonal issues and believed the focus of her couple work should be in the interpersonal realm, while associating an intrapsychic issue with individual therapy. My inference is based on the knowledge that family systems theory arose in reaction to the explicit focus on the individual in psychodynamic psychotherapy. The other participants, more fully identified as psychoanalytic couple therapists with sound object relations training and continuing consultation with other object relations couple therapists, tended to refer much less frequently and to wait longer, at least a period of a year or more, before making a recommendation for individual therapy.

Relationship of the Findings to the Literature

Here I review the salient points of the literature and contrast and compare them to my findings. While referring to the literature reviewed in Chapter 2, I will also include references to literature discovered during the process of analysis that was relevant to helping me understand aspects of the data.

Trauma

One of my own interests is in the area of trauma as it affects an individual's ability to function in a relationship. Is trauma an indication for individual therapy in parallel with couple therapy? The controversy in the couple therapy literature regarding how early trauma is dealt with in couple therapy was also found to be present in practice. Briefly, the controversy centers on the fact that some practitioners writing about trauma in couple therapy feel strongly that when there was early trauma in one or both individuals, both members of the couple need to be seen together in conjoint couple therapy (Bartholomew, Henderson, & Dutton, 2001; Basham & Miehls, 2004; Ruszczynski, 1993), while others feel just as strongly that individual therapy needs to occur concurrently (Clulow, 2001, p. xix).

The Tavistock Institute of Marital Studies, where there is an unusual approach of two therapists and the couple sometimes working as a foursome and sometimes splitting up into two dyads, does not have a specific position on whether or not individual therapy is an important adjunct to the couple work (Ruszczynski, 1993). Their decisions regarding this question are based upon whether the couple uses excessive splitting and projection, as well as blame, denial, and other more primitive defenses.

The work of Bollinghaus and Tarsh (2000) came to my attention since writing my review of the literature. They have worked together for many years treating couples in a foursome frame. Commenting on this controversy they state:

> Whilst we concur with the arguments for keeping couples who are in the paranoid-schizoid position [couples who use splitting as a defense] in therapy together however difficult, our experience does suggest that only the most psychically mature couples who are well entrenched in the depressive position can tolerate the anxieties induced by single sessions for each partner. It has been our experience that cases where we have worked in single sessions – and either kept up regular but intermittent joint sessions or returned after a spell of single sessions to joint sessions – have not proven successful in that format. (p. 111)

Although none of the couple therapists I interviewed work in this unusual model of a foursome, we can extrapolate from their experience. Bollinghaus and Tarsh's decision to split the couple up and meet in single sessions is roughly equivalent to my participants recommending individual therapy concurrently with the couple therapy. They go on to say that:

> These were couples who . . . had reached a state of improvement and who were on the cusp of the depressive position functioning, splitting and denial were diminished, responsibility was being owned and awareness of their destructive actions and phantasies toward the other were to the fore. Nonetheless, undertaking separate sessions provoked regressions in the marriage. (p. 112)

Their experience leads me to believe that, if possible, it is best to keep couples who are functioning in the paranoid-schizoid position, that is, using splitting and blame as a defense, together for couple therapy.

My finding that couple therapists recommend individual therapy across the board when the couple work feels stuck and that the triadic relationship must be considered helps to explain this controversy I found in the literature regarding couples with trauma histories. I think this decision is a function of the therapist's comfort and competence in working with clients with a trauma history, as well as with the individual clients' ability

to understand how their trauma affects their current relationship. However, most importantly, this controversy can be understood in light of whether or not the couple work is progressing. While a member of a couple may have suffered a terrible trauma, she may still be able to speak about it and not be overwhelmed. In such a case, the therapist may not be prompted to refer to individual therapy.

This overarching theme of the couple work becoming mired rather than a particular trauma or pathology prompting an individual referral is in keeping with many social science findings, such as those of Main (Karen, 1994). Specifically, Karen discusses Main's conclusions about attachment styles based on adult interviews (p. 369). When Main (as cited in Karen, 1994), interviewed the parents of the children in different attachment groups, she stated:

> The more I look at the interviews . . . the more I'm astonished by the degree to which aspects of adults' speech will correlate precisely with their child's score on some variable in the Strange Situation, like resistance to the mother on reunion. (p. 369)

Karen says about Main's findings: "Main's work supports an assumption on which much of psychoanalytic treatment is based: that being able to put feelings, especially unwanted feelings, into words makes them available for review and transformation" (p. 370). Applying these observations to my study, I believe that for those couples who were able to reflect on past experiences, and who retained the ability to talk about and understand how their past related to their current functioning in their marriage or partnership, individual therapy was not necessary.

Although I asked the participants if there was a particular attachment style that prompted referrals to individual therapy, even though two had listed attachment theory as

one of their theoretical perspectives, the participants in my study did not use the language of attachment theory in describing decisions to refer.

Risks of Making a Referral

Therapists in my study alluded to problems or risks in making referrals to individual therapy; for instance, the therapists referred to the risk that a client may have difficulty attaching to a new therapist or may feel rejected by the couple therapist. Further, the person to whom the recommendation is made may feel labeled as the identified patient or the couple may interpret the recommendation to mean that the couple therapist feels hopeless about the couple. My participants, therefore, carefully weighed the risk of the undesired message of rejection and hopelessness against the hoped-for benefits of an individual therapy for one or both people in the couple. The risk of another therapy and therapist negatively influencing the couple work is well described by Christel Buss-Twachtmann (2000). In writing about the central issues of containment, boundaries, and the complex transferences in combined therapies, she describes the intense feelings couple therapists have about this issue. She quotes a friend and colleague who said "I wish I never had a couple where a partner is in individual psychotherapy. It makes life so difficult" (p. 81).

A further risk of combining couple therapy with individual therapy, even when the couple therapist is a respected colleague and has a similar theoretical perspective, is the complication of various transferences and the potential for splitting. However, some therapists collaborate well together and the concurrent therapies can broaden the container, which is especially helpful when a couple needs a lot of attention. One means to ensure a sense of containment would be to refer to a colleague known to collaborate

well. Oftentimes, though, the couple therapist begins with a couple where one member is already in individual therapy with a therapist whose approach is different. Or even the most careful referral may be based on the mistaken belief of compatibility between therapists. This was illustrated in my findings.

The participants in my study were aware of and attempted to guard against another therapy pulling the work in a different direction by thinking carefully about the therapist to whom they would refer and by giving the client just that name. They described taking great care in making sure that the person they referred to worked in a similar framework and was someone with whom they could collaborate. All understood that concurrent therapies can instigate splitting or acting out. I will illustrate how this can occur with an example from my own practice and one from my findings.

The woman in a couple whom I saw in my practice told me that her husband sometimes gets angry and calls her names. Her previous individual therapist had decided that her husband is abusive and focused with her on why she wanted to stay in an abusive relationship. Fortunately, the client did not like this approach and terminated the individual therapy. Rather than labeling the husband's behavior, I understood it in the dynamic context and helped the husband to see that when he gets frightened that his wife may leave him, which she threatens to do, he becomes angry and attacks her verbally. The verbal "abuse" is part of a dynamic described by Dutton in 1995:

> Individuals whose attachment histories have made them especially susceptible to anxiety, separation and rejection may be most likely to perceive ambiguous behaviour by a partner as rejecting and unsupportive, and they may be most at risk for becoming abusive. This perspective is consistent with a large body of literature supporting that abusive men tend to be insecure and overly dependent on their partners, and that jealousy and fears of separation are common triggers of abusive episodes. (as cited in Bartholomew, Henderson, & Dutton, 2001, p. 45)

The wife was helped to see her part in the interaction and stopped threatening to leave. The husband was helped to understand that he becomes fearful of being abandoned. What the other therapist had deemed verbal "abuse" thereupon ceased. This example illustrates how an individual therapist who is not privy to the couple dynamic could interfere in the couple work. This example also shows how imperative it is, in a case like this, if the woman is in individual therapy, for the couple therapist and the individual therapist to collaborate well. While the question of collaboration is a crucial one, it is not in the purview of this research question.

A second example of how an individual therapy could negatively interfere in the couple work occurs where splitting is a major defense. One of my participants reported to me that a woman in a couple had impossible expectations of her husband. One session she would come in an say "He is so unsupportive and he doesn't think well of me and he doesn't do this, and he is not supportive." The next session she would report feeling that "He has really been pretty supportive lately." In another session three times later she would say, "He is never supportive." The couple therapist would then say "Do you remember that session where you felt he was supportive, and she would say "Oh, yes." This is how the couple therapist confronts the splitting. However, if this woman were also in individual therapy with someone with whom the couple therapist did not collaborate, and the woman only told her individual therapist that her husband was never supportive, this one-sided view could be very distorted. On the other hand, if the two therapists collaborated well and the couple therapist helped the individual therapist to see how this woman splits, by viewing her husband as either all bad or all good rather than occasionally simply disappointing, then the individual therapist could help the client

discover that the source of her disappointment was that so many of her needs were not met in her childhood. She could then be helped to mourn and have the additional container of the individual therapy to help in her healing. As poignantly stated by Colman (1993): "The greater the deprivation, the more difficult it will be to give up the omnipotent hope that a perfect marriage will compensate for the inadequacies of past relationships" (p. 93).

Bartholomew, Henderson, and Dutton (2001) looked at treating couples with traumatic and/or abusive histories and current abuse in their relationships. Their work is based on Bowlby's attachment theory. They believe that it is the emotional unresponsiveness that underlies the marital conflict and their approach is to work with couples in a conjoint model by helping them understand what is aroused in each when a partner is emotionally unresponsive. A few of my participants gave examples of referrals to individual therapy or to an anger management program when rage became apparent. My participants also described what they were able to do within the couple therapy.

Couple Therapy as an Antecedent to Individual Therapy

Some participants described the couple therapy as an antecedent to individual therapy. The fact that recommendations to individual therapy are made fairly frequently is understandable in light of the fact that couple therapy can be intense and often opens up an individual's psyche in ways that may make the partners want more intensive, individual work. Sometimes the partner prefers to look at their part in the couple interaction as well as their own intrapsychic issues in individual therapy where it feels safer to expose themselves and without the fear that their partner may use their exposure against them. This idea that couple therapy is an antecedent to individual therapy was

written about by Rothstein (1992) and Sander (2004). They believe that couple therapy often functions as pre-therapy with the goal of getting both members of the couple into individual psychoanalysis. My study lent support to this view and some participants began to see one member of the couple for this individual therapy if the couple decided to end the couple work and all three had the understanding that they could not return to the couple format.

Limitations of the Study and Implications for Further Research

Underlying the research question was the role of the theoretical orientation of the couple therapist. In Chapter 2, I reviewed object relations couple therapy, attachment theory as applied to couple therapy, and combined theoretical approaches to couple therapy. What is the explanation for my findings that the participants in my study who worked from an object relations theoretical foundation tended to refer later and less frequently to individual therapy? I think that object relations couple therapy seems to be some kind of confluence of the intrapsychic and the interpersonal. The object relations couple therapists are generally able to include both the intrapsychic and the interpersonal within the couple work and hence are more reluctant to refer out. And when they do so they only refer to therapists who work from a similar theoretical perspective. An examination of the object relations couple therapist's perspective on the interplay between intrapsychic and interpersonal components may be a suggestion for the whole profession and for the couple therapist practitioner in general. However, my study was not designed to address this question of the role of theory. The sample was small and I selected participants who identified themselves as psychodynamically oriented, a broad

category. I did not set out to compare different theoretical positions. Further research could shed light on this fascinating topic.

What became clear after talking in depth to the very experienced couple therapists in this study is that we do not yet have a treatment model or an overarching way of looking at the relationship between individual therapy and couple therapy. Writers such as Brookes and Hodson (2000) have begun to explore the complexities of having a client in more than one therapy, but this is an area where more research and dialoging needs to be done.

Couple therapists often engage in consultation when the couple work feels stuck. Some participants said they made recommendations on the advice of their consultants. Brookes and Hodson in speaking about what they call the "invisible matrix" (meaning the interrelationships between various professionals) remark: "Occasionally the next session has quite a different feel" (p.15). Perhaps an area for further research would be: How does supervision and consultation move stuck couple work along?

As stated in Chapter 1, couple therapy has become a significant and important modality of treatment in our time (Johnson & Lebow, 2002). "By the 1970s martial therapy had built up a body of clinical experience and its own theoretical underpinnings were well established" (Bollinghaus & Tarsh, 2000, p. 110). Brookes and Hodson (2000) in their book entitled *The Invisible Matrix: An Exploration of Professional Relationships in the Service of Psychotherapy,* state that seeing clients who are in more than one therapy at a time is a fairly recent phenomenon. In our practices today, it is not uncommon for us to see a couple who are also in individual therapy or even group therapy. Brookes and Hodson (2000) amplify their view with the following statement:

> Two decades ago concurrent therapies were the exception rather than the rule, and a couple therapist would have thought long and hard before taking two clients into therapy if one or other of them were already in individual therapy. It is now a fact of the economic life of a psychotherapist that she will need to acknowledge and even work alongside other therapists if she is to make a living in a world that is becoming increasingly psychologically sophisticated. (p. 13)

I think practitioners are still developing the relationship between the two. In practice, individual therapists refer to couple therapists, and couple therapists refer to individual therapists, yet they seem unnaturally separated. There is not an accepted bridging or considered means of communication between the two. It would be interesting to look more systematically at what factors enter into successful collaboration between individual and couple therapists.

Perhaps this unnatural separation reflects the inherent struggle we all have in being part of a couple, poetically captured by Ruszczynski and Fisher (1995) in the title of their book: *Intrusiveness and Intimacy in the Couple*. These authors say that the wish for intimacy combined with the fear of intrusion, defines the central dilemma in the life of a couple. Are we, as couple therapists, afraid of an individual therapy intruding into our work? Or do we welcome it as a creative coupling?

Bollinghaus and Tarsh (2000) also capture the tension between intimacy and intrusion in the following paragraph:

> For all partnerships, marriage (or a long-term committed relationship) is one, which, par excellence, can provide for each partner's most fundamental needs. It has its roots in our archaic longings for intensive primitive closeness, as well, however, as in our archetypal conflicts. Above all else, marriage carries within it the tension of balancing the needs of the individual and the needs of the couple. To put the dilemma another way: at the core of every emotional conflict lies the longing for a close intimate relationship with a significant other, a longing to be self-sufficient, to develop one's own wholeness and capacity for individuation. (p. 103)

My research revealed couple therapists struggling, as I have struggled myself, to discern the right approach for a particular couple who needed more than I could offer, with the absence of a framework to hold them. An ongoing dialogue within the whole profession is needed to investigate and determine the relationship between these two therapies.

APPENDIX A: RECRUITMENT LETTER

Michelle Frisch, LCSW
3326 Twin Oaks Drive
Napa, CA 94558
Telephone (707) 258-3044
mfrisch1@comcast.net

Date:

Dear _____,

I am currently involved in the dissertation phase of the doctoral program at The Sanville Institute in Berkeley, CA. and am writing to ask your help in recruiting participants to interview for my research.

My qualitative study considers those situations when couples therapists feel that something more is needed than the couple therapy, and when they think about or make a recommendation to one of the members of the couple for individual therapy. I am trying to identify the clues or information that unfolds in the couple work that might prompt such a recommendation.

While couples therapy has been established as a significant and important modality of treatment and couples therapists do address both the interpersonal and intrapsychic issues that are awakened and triggered in the couple's dynamics, the question of whether to refer one member of the couple for individual therapy sometimes arises.

I am looking for a small number of experienced psychodynamically oriented couple therapists from any of the mental health professions. By "experienced" I mean therapists who have worked with couples for at least 10 years and either identify themselves as a couple therapist or consider couple therapy one of their primary specialties.

I will spend about an hour with each participant in an unstructured interview that will be tape-recorded. The place and time will be arranged for the convenience of the participant.

Can you think of someone who might be interested and appropriate for this study? If so, you could either tell them about the study and suggest that they contact me, or give me their names and contact information and I will get in touch with them directly.

My address, phone number and e-mail address are at the top of this letter. Please let me know if you have any questions.

Sincerely,

Michelle Frisch, LCSW

APPENDIX B: RECRUITMENT AD FOR NEWSLETTERS

Michelle Frisch, LCSW
3326 Twin Oaks Drive
Napa, CA 94558
(707) 258-3044

Ad to be submitted to professional newsletters:

1. SEEKING PARTICIPANTS FOR RESEARCH STUDY. I will interview experienced psychodynamically-oriented couple therapists to find out what the circumstances are when they think about or make a recommendation for individual therapy to one or both members of the couple they are treating. If you are interested, or would like to hear more, please contact me: Michelle Frisch, LCSW, doctoral candidate at The Sanville Institute. (707) 258-3044, or mfrisch1@comcast.net

APPENDIX C: LETTER TO PROSPECTIVE PARTICIPANTS

Michelle Frisch, LCSW
3326 Twin Oaks Drive
Napa, CA 94558
(707) 258-3044

Date _____

Dear _____,

Thank you for your interest in participating in my doctoral research. This exploratory research will examine how psychodynamically-oriented couple therapists think about or make a recommendation for individual therapy to one or both members of a couple they are treating. My qualitative study will explore the subjective experience of couple therapists when they feel that something more is needed than just couple therapy. I am trying to identify what clues, or information unfolds in the couple work that might prompt the recommendation for individual therapy.

While couples therapy has been established as a significant and important modality of treatment and couple therapists do address both the interpersonal and intrapsychic issues that are awakened and triggered in the couple's dynamics, the question of whether to refer one member of the couple for individual therapy scarcely arises in the literature. I hope, with this study, to bring more awareness of this aspect of couple psychotherapy.

Participation in the study means I will interview you for 60 – 90 minutes, at a time and place convenient for you. I will tape record the interview. I might also follow-up with a brief phone call if I need clarification about something we discussed. If you choose to participate, I hope you will find the process helpful in understanding more about the experience of couple therapists when they feel something more is needed. I will be happy to send you a summary of the study results if you wish.

All interviews will be confidential. Your anonymity and that of any clients you would discuss during the interview will be protected.

Please take a few minutes to review the enclosed Informed Consent Form, a copy of which you would be asked to sign at the time of the interview. If you wish to proceed, please fill out the brief screening questionnaire and return it to me in the enclosed pre-addressed stamped envelope as soon as possible. I will call you to set up an appointment for the interview.

Thank you for your participation. Please feel free to contact me at the above phone number or by e-mail at mfrisch1@comcast.net if you have any questions.

Thank you.

Sincerely,

Michelle Frisch, LCSW
Doctoral Candidate, The Sanville Institute

APPENDIX D: SCREENING FORM

Michelle Frisch, LCSW
3326 Twin Oaks Drive
Napa, CA 94558
(707) 258-3044

If you are interested and would be willing to participate in this research project, please complete this questionnaire and return it to me in the enclosed pre-addressed, stamped envelope.

NAME: _____

ADDRESS: _____

_____

TELEPHONE:
(Days) _____ (Evening) _____

E-MAIL: _____

DEGREE: _____ LICENSURE: _____

THEORETICAL
ORIENTATION: _____

NUMBER OF YEARS IN PSYCHOTHERAPY PRACTICE _____

DO YOU IDENTIFY YOURSELF
AS A COUPLE THERAPIST?

IS COUPLE THERAPY ONE OF
YOUR PRIMARY
SPECIALTIES? _____

APPENDIX E: INFORMED CONSENT FORM

Michelle Frisch, LCSW
3326 Twin Oaks Drive
Napa, CA 94558
(707) 258-3044

THE SANVILLE INSTITUTE

I _____hereby willingly consent to participate in a research study about when couple therapists recommend individual therapy to a member of a couple they are treating in addition to the couple therapy. This doctoral research project is to be conducted by Michelle Frisch, LCSW, under the direction of Sylvia Sussman, PhD., principal investigator and research faculty member, and Whitney van Nouhuys, PhD. faculty member of the Sanville Institute.

I understand the procedure to be as follows:

1) One 60 - 90 minute audiotaped interview will occur in a private, confidential setting to be arranged between myself and the researcher. I will be talking about my thoughts and feelings as an experienced psychodynamically-oriented couple therapist discussing when I have made recommendations for individual therapy to a member of a couple that I am or was working with. This will include a discussion of case vignettes. The researcher will transcribe the audiotapes herself and will make every effort to avoid saying my name or other identifying information about myself or my clients on the audiotape. If such information gets into the interview, it will be omitted from the transcription. I am aware that the audiotape will have an identifying number rather than my name.

2) I am aware that talking about my feelings about what couples stir up in me and situations with particular couples may cause some emotional discomfort. Should this happen during the interview, I understand that I may terminate the interview at my discretion. Should I so request, the researcher will provide crisis counseling at this time. Should I experience discomfort after the interview, I understand that I may contact the researcher who will make provisions for me to receive professional help for a reasonable and limited time.

3) I understand that I may withdraw from this study at any time. I also understand that this study may be published and that my anonymity and the confidentiality of my material will be protected unless I give written consent to such disclosure. Otherwise, no names or individual

identifying information will be used in any oral or written materials. The audiotape will be erased at the completion of data analysis.

4) I understand that I have the option to receive feedback from the results of the study. Please send me a summary of the results at the address below.

Yes _____ No _____

Signature: _____

Date: _____

If you wish to receive a copy of the results of this study, please provide your name and address:

Name:

_____

Address:

_____

APPENDIX F: LETTER TO PARTICIPANTS WHOM I DO NOT SELECT TO INTERVIEW

Michelle Frisch, LCSW
3326 Twin Oaks Drive
Napa, Ca 94558
(707) 258-3044

Date _____

Dear _____

Thank you for expressing an interest in my doctoral research. As you may recall, my research, under the auspices of the Sanville Institute, explores how psychodynamically-oriented couple therapists think about or make a recommendation for individual therapy to one or both members of a couple they are treating. I appreciate your interest in the project and your willingness to be interviewed. It is a small study and, at this time, I have enough participants for the research. Should I need additional participants, I hope that I may be able to call on you at a later time.

Sincerely,

Michelle Frisch, LCSW

APPENDIX G: INTERVIEW GUIDE

First, I want to thank you for agreeing to this interview and helping me with my research. The interview, which I will audiotape, will last approximately 60 – 90 minutes. I am interested in hearing your thoughts, feelings and case examples of times when you have thought about and made recommendations for one or both members of a couple to engage in individual psychotherapy. I am especially interested in whether there are particular kinds of couple issues, attachment styles, certain times in the couple work or particular types of clients that make you think that something more is needed than the couple therapy. (At this point the participants will be asked to sign the Informed Consent Form which they have already reviewed.)

I am hoping you can help me better understand how you are thinking about and working with your decisions about making recommendations for individual therapy. As we talk, I encourage you to bring up examples and case vignettes from your practice that will help me see the specific ways these recommendations are made and thought about. Let's begin by you sharing your initial thoughts about this question.

I. Theoretical Orientation
   a. How do you normally work with couples? What theories affect your work? Do you work differently with couples than individuals? Combine approaches?
   b. With couples, as opposed to individuals, are you more active? Teach more? Interpret?
   c. Your education? Continuing education?
   d. Long-term or short-term model with couples?

II. Structure of Couples Work
   a. What does your assessment phase look like?
   b. What do you do if one member is already in individual therapy? Is it the male or female partner?

III. Awareness of Transference/Countertranference in Couple Work
   a. Do you use your transference/countertranference feelings in working with couples?
   b. Is there any relationship between your transference/countertransference feelings and the making of a recommendation that a member of a couple engage in individual psychotherapy? (Feld, 2004)

IV. Indications for Making Referrals
   a. What are your feelings about the work with a particular couple when you make the recommendation?
   b. Are there particular issues that you feel cannot be worked with in the couple work?

c. Are there particular couple styles (such as hostile/blaming, personality disordered, polarized, oppositional, borderline/schizoid, narcissistic or abusive couples) that prompt a recommendation?

V. Making the Recommendations
   a. How do you tell the person you feel individual therapy would be of benefit?
   b. Are you concerned that they will feel they are the "identified patient"?
   c. Are you worried that they might feel rejected?
   d. What is it like to make the recommendation?
   e. How comfortable are you about making it?

VI. What Happens if the Client Refuses?
   a. Do you bring it up again at a later time?
   b. How does it affect the couple work?

VII. Your Personal Feelings
   a. What sorts of feelings or concerns come up for you when you consider making a recommendation for individual therapy?
   b. Are you concerned that the person will feel rejected?
   c. Are you afraid of losing control of the couple work?

VIII. Thought Process or Intuition?
   a. For how long a period of time did you think that individual therapy would be beneficial before you made the recommendation?
   b. Did the recommendation just happen on the spur of the moment or was it thought out?

IX. After the Recommendation
   a. What happens in the couple work after the person begins individual therapy?
   b. How long does the couple work generally continue?
   c. Does the couple complain about money?

X. Closure: Anything you feel we missed in talking about this topic?
   a. Feelings about the interview?
   b. Final thoughts?

APPENDIX H

PROTECTION OF RESEARCH PARTICIPANTS APPLICATION

(Submitted by candidate to the Institute Office if the Dissertation Committee has determined that the research proposal requires it. Most do.)

Title of Research Project When Couple Therapy Is Not Enough

Principal Investigator: Sylvia Sussman, Ph.D.
(print name and degree)

Investigator: Michelle Frisch, LCSW
(print name)

I have read the *Guidelines, Ethics, & Standards Governing Participation & Protection of Research Participants* in research projects of this Institute (in Appendix D of the *Student and Faculty Handbook*), and I will comply with their letter and spirit in execution of the enclosed research proposal. In accordance with these standards and my best professional judgment, the participants in this study (check one)

_____ Are not "at risk."

__✓__ May be considered to be "at risk," and all proper and prudent precautions will be taken in accordance with the Institute protocols to protect their civil and human rights.

I further agree to report any changes in the procedure and to obtain written approval before making such procedural changes.

Sylvia Sussman Ph.D. June 9, 2008
signature of Principal Investigator/date

Michelle Frisch, June 9, 2008
signature of Investigator/date

Action by the Committee on the Protection of Research Participants:

Approved ✓ Approved with Modifications _____ Rejected _____

Judith R. Schore Ph.D. 6-20-08
Signature of representative of the Committee on the Protection of Research Participants/date

Approved

Judith Kay Nelson, Ph.D. 6-9-08
(signature of Dean & date)

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