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CHAPTER 8

Combining Couples and
Individual Therapy

An intersubjective systems viewpoint, which views our subjective worlds
not as distinct entities but as fluid constructs formed in a continual dynamic
relationship between personal and interpersonal realms (see Chapter 5), ne-
cessitates a rethinking of the rigid boundaries between individual and con-
joint therapy. In this chapter we will discuss treatment modalities in which
the therapist intervenes at both the individual level and at the relationship-
systems level to facilitate development.

Couples therapy and individual therapy can be combined from two direc-
tions. An individual client can seek support for his relationship by bringing
the partner in for concurrent treatment, either to put what he is learning into
immediate practice or to try to interrupt the way the relationship is under-
mining his progress. Another scenario is when one or both partners in cou-
ple therapy choose concurrent individual sessions to receive additional
support for relationship issues or to address more intensively deep issues
that surface in conjoint sessions. Although there is an unwritten rule against
working in multiple forums with the same patient, I have found that many
therapists, both those trained in family systems and those trained in psy-
choanalytic theories, will do so when they feel it is necessary, and a substan-
tial number will do it routinely.

Much of the objection comes from an outmoded notion of transference as
a kind of pure culture of experience, uncontaminated by the outside world.
From an intersubjective point of view, this notion of purity is a complete fiction that ignores the reality that all experience is embedded in a multitude of contexts. Consistent with intersubjectivity theory's rejection of rules or techniques, the therapist is free to begin by asking in what treatment context(s) can a particular patient be helped most effectively? Recalling the dictum of Orange, Atwood and Stolorow (1997), the answer is to fit the frame to the picture, not vice versa.

An implicit intersubjective relationship obtains between a couples therapist and an individual therapist who are treating the same patient. As Burch and Jenkins (1999) point out, in an article entitled “The Interactive Potential Between Individual Therapy and Couple Therapy,” “A sense of territory is evoked, and a subliminal awareness of other transference-countertransference fields is added to the original one” (p. 232). Referrals by one clinician for simultaneous couples treatment by a second are made with hope “for some extra benefit to their own work through this adjunctive work.” Frequently there is an extra benefit derived from such referrals, but it is also the case that the “transference-countertransference fields” such referrals create work at cross-purposes.

The frame of combining individual and conjoint treatments works well with many therapeutic “pictures.” There are no a priori diagnostic guidelines. Indeed, many patients suffering from profound developmental deficits may require it, while otherwise healthier patients may find it intolerable. We will begin our discussion with an overview of the theoretical and clinical issues that arise in combining individual and conjoint treatment, and then present a case example.

THEORETICAL FOUNDATIONS

In considering the combining of treatment modalities, we return to the critique of the myth of isolated therapy begun in Chapter 1: challenging the belief that a patient’s experience in therapy can be separated from his ongoing experience of his present-day relationship surround also challenges the artificial fire wall between individual and conjoint treatment.

The classification of subjective experience (Shane and Gales, 1997) into old-self/old-other, old-self/new-other and new-self/new-other configurations accounts well for the differing contexts of a patient’s experience within the analytic situation. But surely her ability to wrest herself free of the province of her unconscious invariant organizing principles to attain the
notion of purity is a complete fiction in a multitude of theory’s rejection of rules or tech-ning in what treatment context(s) of ectively? Recalling the dictum of the answer is to fit the frame to the obtains between a couples thera-erating the same patient. As Burch entitled “The Interactive Potential Therapy,” “A sense of territory is ther transference-countertransfer-
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ce (Shane and Gales, 1997) into a new-self/new-other configura-xts of a patient’s experience within ability to wrest herself free of the organizing principles to attain the longing-for new-self/new-other experience is affected at every juncture by the context of her present-day-self/present-day-other relationships. It is the argument of this book that, contrary to the classical view that present-day relationships “contaminate” the analytic frame, therapy must address the task of building and strengthening the connection between the patient’s subjective world and the relational matrix that sustains it.

Several unique aspects of intersubjectivity theory offer permission to work in this way. The most important is that intersubjectivity, rather than reifying pathological structure, views pathology as part of a dynamic and ongoing developmental system. Since pathology is inextricable from the contexts that support it, where to intervene in the system—for example, which contexts to alter—is a pragmatic, rather than a dogmatic question. One might choose to work at the level of exploring childhood trauma, or on the here-and-now relationship with the therapist, or on the dynamics of the patient’s marriage. Or, as described in this chapter, on several of those contexts simultaneously. Furthermore, rather than prescribing a rule-bound method of doing therapy, intersubjectivity merely requires investigating the meanings of therapeutic interventions for each patient.

In a model that combines individual and conjoint sessions, the individual sessions provide a forum for investigating the meanings for the patient of breaking the frame and bringing his partner into treatment. Even when this experience leads to a disjunction with the individual therapist, as when a patient experiences the therapist as siding with his spouse in a conjoint session, the potential exists for acknowledgment and repair, experiences that can strengthen the patient/therapist tie. Working intersubjectively rapidly establishes a strong therapeutic alliance. The therapist’s nonjudgmental exploration of the patient’s subjective world, as well as a nonhierarchical attitude, can quickly create a sense of shared purpose. Finally, the commitment to the investigation of subjective experience, rather than to the illumination of an objective truth, by definition welcomes the existence of differing subjectivities in the same room or the same treatment, including those of two partners and their therapist.

CLINICAL CONSIDERATIONS AND PROTOCOLS
Working with patients in both conjoint and individual forums creates unique clinical issues, especially in regards to confidentiality and loyalty. Be-
cause this is relatively uncharted territory, I will describe here my own approach, which has evolved primarily through trial and error.

When I work with the same patient(s) both individually and conjointly, I make it clear that any information shared in a private session is privileged. This is as much a personal decision as anything; in the individual sessions it releases me from having to listen from the other partner’s perspective and enables me to focus exclusively on empathic exploration of the patient’s experience. I also make it clear to both partners that my basic stance is to advocate for the relationship. This is not a moral or judgmental position; it is an a priori, existential decision on my part intended only to provide me with a workable context. Keep in mind that, from my point of view, advocating for each partner’s development is also advocating for the relationship. Therefore I do not scrupulously try to balance my attention. I will work with one partner of a couple individually for as long as it takes to help overcome a problem or achieve a developmental goal.

Working separately with one or both partners and keeping the confidentiality of the individual sessions might seem to put the therapist in the triangulated position of either taking sides or keeping secrets. In my experience, that has not usually been the case. Maintaining and actualizing a commitment to multiple subjectivities rather than to some single objective truth allows me to tolerate the ambiguity of holding contradictions without feeling confused or torn apart.

For example, a narcissistically vulnerable patient whose mother was psychotic or depressed complained in individual sessions about neglect by his wife, citing as evidence her not serving him the right kind of vegetables. He was creating a terrible self-fulfilling prophecy, whereby his anger and criticism, originating in his childhood experience of his mother, would contribute to his wife’s withdrawal and eventual depression. His preoccupation with his wife’s neglect made it impossible to focus, in individual treatment, on the genetic material, so I suggested that perhaps we could help him separate past experience from present problems by bringing his wife in for couples sessions. He agreed to give it a try.

In the couples sessions, his wife begged me to help my patient overcome his terrible childhood. That was the only hope she could see for the marriage. I understood that her depression was caused by the fact that she felt responsible for fixing his childhood pain, an impossible task. I said that I didn’t think it was her job to fix her husband at all, and recommending that she try not to engage him when she felt he was confusing her with his
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mother. She visibly brightened. When I asked my patient how what I had
said affected him, he replied that he didn’t want to make his wife depressed
and was glad to see her smile again.

Of course, I never would have worked this way if I did not have a strong
therapeutic alliance with my patient. Nonetheless, I can imagine this sce-
nario backfiring. The risk that my empathic failure could permanently derail
the therapy had to be weighed against the risk of not intervening in the on-
going relationship, in the context of which my patient was generating an un-
healthy new cycle while reinforcing his invariant organizing principle that
his needs would never be met. I could have referred the couple to an outside
therapist, but they had tried couples treatment and the therapist had in-
sisted that my patient needed antidepressant medication. As it turned out,
my patient assimilated my willingness to go into conjoint treatment as pro-
tecting him, even while I moved to protect his wife. Advocating for a rela-
tionship system that was not dominated by his repetitively themed
organizing principles was indeed a kind of protection, and, in light of the
fact that his own father had remained uninvolved in the traumatic emo-
tional life of the family, created a powerful new therapeutic reality.

PITFALLS AND COUNTERINDICATIONS

A decision about combining individual and conjoint modalities can only be
made on a case-by-case basis. Conjointly exploring the individual issues of
each partner in a couples case has the advantage of building empathy be-
 tween the partners and enlisting their support for one another. A potential
pitfall of suggesting individual treatment for either is that it sends the mes-
gage that some material is out of bounds or too much for the relationship to
handle. In fact, when one partner requests individual work, it is important
to confirm that the other partner does not infer that he or she is the source of
the problems in the relationship.

There are times when bringing an individual patient’s partner into con-
joint treatment is counterindicated—primarily when doing so would
threaten the original patient/therapist alliance. A case in which negative or
wildly fluctuating transference predominates would be a poor candidate.
But an overly idealized transference might be as problematic, in that the
therapist’s building an alliance to the spouse could precipitate a traumatic
loss of the idealizable function of the therapist.
A potential problem for bringing in the spouse of an individual patient arises when the spouse experiences the individual treatment as a threat to the marriage. Sometimes this can be dispelled and an alliance can be established all the way around. At other times, however, alliance is impossible. For example, a man contacted me for treatment when he realized that he had been acting to please people rather than following his own desires in every aspect of his life, his career, his marriage. He wanted to work on his marriage, but he wanted to see me individually for a few sessions first. Operating on my general assumption that each individual’s growth is good for a marriage, I agreed. It turned out he desperately wanted his wife to validate his perceptions, functioning as a newfound selfobject, but she found his changes completely disruptive and wrote them off to midlife crisis. When she came in for a conjoint session at her husband’s request, it was clear that she blamed his “awakening” for destroying the marriage, and with it the fabric of her world. It was equally clear that, on account of the individual sessions I had had with her husband, she saw me as part of the problem. Because my attempts to show empathy for her devastation were ineffective, I referred them to an outside couples therapist.

The worst pitfall one can encounter in a modality combining individual and conjoint sessions is one partner’s confidential revelation of an affair or other potentially devastating secret. In these cases I am still bound by commitment to keep confidentiality. There are times when this can work favorably, as when the individual sessions act as a kind of container for the troubling material, allowing it to be “metabolized” through interpretation and working through, in a safe forum. In one case, a woman patient was able to discuss her obsessive crush on a younger colleague in a way that helped her not act on her urges.

However, if the affair or secret is posing a real threat to the relationship, I will do everything in my power to have it brought out in the conjoint sessions. There is a point where the need to confront one partner or to protect another supersedes the need to honor differing subjectivities. Recalling the discussion in Chapter 6 of the way confrontation can be empathic, I would stress again that allowing a duplicitous process to proceed in conjoint treatment is unempathic to both partners.

In marital treatments where the tie between the partners is weak or the partners are disengaged, concurrent individual therapy might exacerbate the problem. The request for individual treatment could be a request for attention that was missing in the marriage. Providing an alternative source for
that attention could derail the couple from confronting the problems in the marriage.

Highly volatile marriages must be evaluated on a case-by-case basis. In some cases an angry or unstable partner will greatly profit from the support of individual treatment, and be better able to participate in the conjoint sessions. In couples where the volatility centers on issues of secrecy and betrayal, however, conjoint treatment is counterindicated. In the case of Beth and Richard that we have been discussing, Beth’s suspicions of Richard’s outside relationships, as well as Richard’s style of protecting his boundaries by not revealing his thoughts and feelings, led me not to schedule collateral sessions, as much as both partners could have benefited from the additional support.

CASE EXAMPLE

Alan and Ruth were a childless professional couple in their forties who had been married for seven years at the time they contacted me for couples therapy. From the outset it was clear that their relationship was in trouble. Both spoke of a sense of hopelessness: Alan seemed rather bitter, while Ruth seemed fragile and very sad. After several conjoint assessment sessions I proposed that they both see me individually on a weekly basis as well as in a weekly conjoint session. I made the suggestion of this modality based on my understanding of the profundity of the marital problems and of the fragility of both partners’ self organizations. They agreed to this plan, and treatment has been going on for about two years.

Alan, a business consultant, worked 70–80 hours a week. He was extremely withdrawn in the treatment room. He blamed his problems on his poor business skills—he described himself as a complete failure. However, there was an imperious quality to his tone as he described himself. His self-deprecation seemed designed more to keep others at bay than to invite a sympathetic response to his life struggles. Ruth, a social worker, would complain in a very young, almost whiny voice about the lack of contact in the marriage. She sought desperately to try to get Alan to let her help with his business or personal problems; he, contemptuous and suspicious, called that her “social worker act.”

Alan and Ruth met at a resort that they both had gone to alone. Alan had just come up for the day, but when he met Ruth, he decided to book
a room. Alan later described this as an “almost unheard-of moment of risk and spontaneity.” Later they discovered their shared interest in spirituality. The early part of their relationship was a revelation for both of them. Ruth had been married once before, but had divorced because of her husband’s infidelity. Alan had long believed that he was destined for a lonely bachelors’hood. At first they considered each other “soul mates.” The early phase of their relationship was not all sweetness and light—they had many fights, but found a sense of relief in them, since neither grew up in a household where much affect was shown.

But this initial closeness had given away to a relationship completely dominated by Ruth’s pursuit of intimacy and Alan’s avoidance of it. At the time they entered treatment sexual contact was all but nonexistent. Ruth pleaded with Alan to spend more time with her, but Alan, who had recently started his own business, claimed that he was just trying to survive. Alan would tell Ruth at times like this that he was completely worthless, “lower than pond scum,” as he put it.

In exploring the couple’s history, it became clear that the pursuit/avoidance system had replaced a more selfobject-based organization in response to several emotionally difficult issues. Alan came to see that Ruth did not trust him about money issues, even though he was supposed to be an expert on finances. He took her distrust as evidence that she was preoccupied with her own needs for security and would never offer him mirroring admiration of his accomplishments. Ruth became more and more upset about Alan’s work hours, as well as his angry, critical reactions to her attempts to help. These issues triggered repetitively themed transferences for both partners: Alan saw Ruth as his highly narcissistic and invasive mother, while Ruth saw Alan as her remote and critical father.

Ruth was the middle of three children, with an older brother and a younger sister. Her brother, who was considered a genius, got more attention and more privileges than Ruth. He also used to verbally torment her. Ruth’s mother had been an actress before marriage. She had given up her career when she married. Her father was a highly critical man. Ruth watched her lively mother grow moody and submissive as she got older. This was especially poignant for Ruth, because she was highly identified with her mother, especially as a prepubescent girl. Her mother had wanted Ruth to carry on her own, unlived life—she was given dancing and singing lessons, and auditioned for plays, even
though she was not naturally talented. At puberty, when it became clear that Ruth was a rather ungainly, intellectual child, her mother began to give up on her and withdraw emotional closeness. Her father, on the other hand, began to take an active, if critical interest. He tried to “shape her” by sponsoring her intellect and telling her she was too emotional, even going as far as threatening to hit her if she started to cry. Both of her highly narcissistic parents treated her as extensions of themselves.

Alan was an only child. His mother is a lively, if highly narcissistic woman, his father was an angry, withdrawn man. The one inviolable rule in the household was that Alan was to do nothing to upset his mother. His father would enforce this rule with angry threats. In one individual session, Alan summarized his childhood situation by saying, “It felt almost as if my father would hold me down while my mother would rape me.”

There are striking parallels in Alan and Ruth’s families: both mothers are lively, if narcissistic, both fathers angry and threatening. One significant difference is that Ruth’s father was highly critical of his wife, while Alan’s father would brook no criticism of his.

My understanding of Alan and Ruth’s history, as well as my assessment of their relationship and the fragile organization of their respective subjective worlds, supported the initial decision to combine conjoint and individual sessions. Both Alan and Ruth clearly needed individual therapy, but their relationship tie was very weak, and probably would not survive the input of three different therapists. Combining individual and conjoint sessions allowed me to provide needed selfobject functions for both partners, while at the same time trying to facilitate moments when those functions could be met from within the relationship. The striking similarities in both partners’ families of origin allowed for synergy between the individual and couples sessions. Each partner desperately yearned for mirroring of their individuality, rather than the selective mirroring they had received as children. The individual sessions, in which those mirroring failures were directly addressed, helped contain the disappointment resulting from selfobject failures in the conjoint sessions, allowing them more and more to become “testing grounds” for new responses, such as directly communicating feelings rather than acting out. Both partners became allied in supporting one another in overcoming the childhood patterns.
About six weeks into treatment they had an incident that resulted in a separation. Alan’s father was suffering from bladder cancer, and Alan had been trying to heal their distant relationship. He told Ruth that he wanted to bring his father to their annual religious retreat. Alan knew that Ruth did not like his father; taking him to the retreat, which represented the last vestige of their spiritual connection, was to her a complete betrayal of their original connection. She shouted, “You’re not my soul mate anymore.” That night he left and took his own apartment.

Despite this separation, Alan and Ruth agreed to maintain the therapy in the same multiple forms, to see if they could save their marriage. Initially the prospects were not good. In this fight, Alan had restructured his family of origin material with Ruth, such that he experienced it as a repetition of the triangle between his mother and his father, in which the mother’s needs must come first. His developmental need for an identification with his father was once again being crushed.

My early attempts to restore the ruptured empathic tie were unsuccessful—Alan had retreated into anger, withdrawal and defensive scorn, while Ruth, growing increasingly desperate, portrayed herself more and more as an innocent and misunderstood victim. This portrayal was highly inflammatory to Alan, who saw it as more evidence that Ruth would never understand him or take his needs seriously. In one couples session, Ruth was trying to get him to see how he frequently “went for her jugular” and attacked her whole being. Alan merely condemned her weakness: “I hate your neediness. It really disgusts me.” Ruth kept repeating to him, rather desperately, that she just needed him to give her a break, to which Alan, in the throws of his repetitive maternal transference, replied, “So then I can’t feel anything at all.” At that moment, any expression of Ruth’s feelings evoked the age-old requirement that he give up his own subjective world and merge with hers.

When I tried to explain to him that Ruth wasn’t after him to give up his feelings, but just to hear about hers, he replied in a cold, flat voice, “I can’t have a self and feel empathy simultaneously.” This attempt to help him accept the “reality” of what was happening in the room was an empathic failure on my part, and merely reinforced Alan’s defensive hyperrationality and belief that he was an unfeeling machine.

At this point Ruth had sagged down on the couch. When I asked her what was going on, she replied—with a statement revealing her invari-
They had an incident that resulted in her having to undergo bladder cancer, and Alan was at the retreat. He told Ruth that he was not ready to talk about his personal issues. Alan, on the other hand, seemed to be avoiding the topic of his personal problems. They both had had enough of discussing their issues. She shouted, “You’re not my therapist, and you have no right to tell me how to live my life.”

Ruth agreed to maintain the therapeutic relationship if they could save their marriage. In this fight, Alan had restructured his relationship with Ruth, such that he experienced being a victim in their relationship. His developmental needs for connection were being crushed.

The ruptured empathic tie were unsecured, withdrawal and defensive singleness desperately, portrayed herself as misunderstood victim. This portrayal was not consistent with the role of the mother. Alan, who saw it as more evidence that he was not the one who needed help, was attacking her whole being. Alan “I hate your neediness. It really does turn me off.”

The attempt to change him, rather desperately, that she just saw him, in the throws of his anger, “So then I can’t feel anything when you’re talking about it. You just shut up your own subjective world and shut out everything else.”

That had been a real turning point for Ruth. When asked if she had ever given up on him, he replied in a cold, flat voice, “I feel simultaneously.” This attempt to change him was happening in the room was reinforced Alan’s defensive Wall was an unfeeling machine.

I own on the couch. When I asked her if she had a statement revealing her organizing principle of blaming herself for the selfobject failures of others—that she “felt completely unlovable.”

It would have been easy to look at the depth of Alan’s narcissistic organization and feel hopeless, but I noticed that, in our individual sessions, when he felt understood and protected, he would have moments of greater empathy for Ruth. If it were possible to re-create that milieu in the conjoint sessions, perhaps Alan could demonstrate this empathy to Ruth, allowing them to reverse their demoralizing pattern and share a more positive experience.

Paradoxically, one key to facilitating Alan’s capacity to offer an empathic tie for Ruth was my supporting, in individual sessions, Alan’s perception of Ruth’s own narcissism. He saw Ruth’s suffocating helpfulness in the same light as his mother’s intellectual liveliness: both were a kind of Trojan horse, designed to get him to lower his defenses and be invaded. Despite the extremity of his defenses, Alan did not really feel that his perceptions of either his mother or his wife were accurate. He felt that there must be something wrong with him for having such extreme reactions. When I was able to share with him that I too saw a considerable amount of self-interest in Ruth’s “helpfulness,” he was more able to move beyond his rigid defenses, both in regards to his marriage and to our individual exploration of his childhood experiences.

A telling vignette that emerged in an individual session became a metaphor for our understanding of Alan’s relationship with his mother, and the developmental importance of his wish to ally with his father. Alan had gone to visit his father, who was undergoing chemotherapy; after a visit with his doctor they were at home discussing treatment options and outcomes. His mother chose to stay uninvolved in this vital conversation. She continually interrupted them, however, with details and questions about an upcoming family celebration she was planning. Finally Alan, standing up to his mother for what he described as the first time in his life, said, “Mom, Dad may be dying and you’re talking about who to invite?” Alan was breaking the family rule of protecting his mother here, standing up for his father’s (and by extension, his own) survival.

Alan’s self-delineating selfobject experience, in which he began to accept as valid his feelings about both his mother and his wife, had a profound effect on me. Contrary to the expectation that this validation would
escalate his angry denunciations of Ruth, he became much more able to listen to her experience. Furthermore, his process in individual and con-joint sessions alike was no longer dominated by talk of how defective he was or by long bouts of silence. In one important moment, Ruth was able to tell him how angry she was at his silences and criticism. She was shaking with affect as she recounted her injuries. When she was through we both looked at Alan to see how he was reacting. "I'm right here," he replied, and we both knew that it was true.

Ruth's work in therapy focused on the way she habitually replaced her own experience with concern for Alan's as a means of maintaining their tie. Once in an individual session Ruth was peppering me with questions about my view of Alan—Did I think he was capable of change? What's his diagnosis? I commented that she was again focusing almost exclusively on Alan, rather than talking about her own experience. I wondered if that was a way she could feel close to him, despite all the times he rebuffed her. She thought that was very possible. When I asked her where she might have learned to focus on someone else's issues rather than on her own feelings, she associated to a time in adolescence when she told her mother, a beautiful actress, about almost being molested by the chauffeur: her mother minimized her concerns and talked instead about her own unhappy childhood.

These and other related insights into the nature of her tie to her mother proved pivotal for Ruth. She began to see Alan's withdrawal less as evidence of the fact that she was unlovable and more as simply intolerable behavior. And rather than defending against the abandonment by becoming obsessed with Alan's thoughts and feelings, she began to develop a strong outside support system to help her with the separation. The victim tone she had adopted in couples therapy was more and more frequently replaced by confident assertions of her own needs and feelings.

The individual therapeutic gains helped unlock the reinforcing feedback loop of their relationship system. In the past, Alan's withdrawals would trigger Ruth's desperate attempts to make contact by being helpful, which only caused Alan, convinced of her duplicity, to withdraw further. When Ruth was able to express her anger or make demands instead of asking for sympathy, Alan would actually move closer. Eventually, they began to try dating again. Sometimes these dates brought fun and closeness, and at other times they ended in the old pattern.
Most significantly, Ruth and Alan were developing a means for naming and repairing these disjunctions, which allowed them to move on and try again.

It is hard for most couples to leave the idealization of the honeymoon phase and come to tolerate a relationship comprised of both selfobject failures and successes; for two people with self organizations as fragile as Alan’s and Ruth’s, it is especially difficult. Both partners made significant progress in disavowing long-held and heretofore largely intractable organizing principles, and also in creating relationship experiences that met their respective selfobject needs. The combination of individual and couples therapy helped them to contain their disappointments while they developed a third alternative to either endlessly replaying their relentless pursuit/avoidance script or breaking up.