



## The Solo Note: Therapy With One Spouse Through Systemic Individual Marital Therapy (SIMT)

Anisha Shah & Veena A. Satyanarayana

To cite this article: Anisha Shah & Veena A. Satyanarayana (2011) The Solo Note: Therapy With One Spouse Through Systemic Individual Marital Therapy (SIMT), Journal of Family Psychotherapy, 22:4, 297-312, DOI: [10.1080/08975353.2011.627800](https://doi.org/10.1080/08975353.2011.627800)

To link to this article: <https://doi.org/10.1080/08975353.2011.627800>



Published online: 05 Dec 2011.



Submit your article to this journal [↗](#)



Article views: 511



View related articles [↗](#)



Citing articles: 2 View citing articles [↗](#)

## **The Solo Note: Therapy With One Spouse Through Systemic Individual Marital Therapy (SIMT)**

ANISHA SHAH and VEENA A. SATYANARAYANA

*Department of Clinical Psychology, National Institute of Mental Health and Neurosciences,  
Bangalore, India*

*The debate over conjoint versus individual marital therapy seemed to have ended many decades ago with criticisms and counter-criticisms. Yet, this skepticism in marital therapy literature about the effectiveness of marital therapy with 1 partner does not translate into efficient practice guidelines. In this article, the authors propose a new model for therapy with 1 partner using a systemic perspective with the aim to address marital and other issues, named systemic individual marital therapy (SIMT). The authors demonstrate this therapeutic reality first by using a case report that illustrates client material where a new individual therapy perspective is required. Then, the authors show findings from a brief qualitative research that emphasizes the importance of client experiences. SIMT goals, structures, processes, and conceptual issues are subsequently presented, followed by discussion on some of its theoretical positions.*

*KEYWORDS* case report, indicators, model, systemic approach, systemic individual marital therapy

The theory of conjoint sessions has become a very powerful force in contemporary research and practice initiatives in marital therapy. Reviewers of couple/marital therapies have deliberated over conjoint versus individual session formats through criticisms and counter-criticisms, especially in the 1980s. Individual marital therapy (IMT) became a well-known terminology,

---

Address correspondence to Anisha Shah, Department of Clinical Psychology, National Institute of Mental Health and Neurosciences, Bangalore, 560029, India. E-mail: anishah@nimhans.kar.nic.in

and came under intense scrutiny at that time. Most had reached a very clear verdict then that IMT is an ineffective form of treatment and markedly inferior to conjoint approaches. Since then, these views have influenced literature on marital therapy so broadly that conjoint theory has become the foundation of marital therapy practice around the world. Marital therapy training, practice, and research in India have also evolved with a similar emphasis on conjoint sessions. Skills for conjoint sessions are developed through supervision, and marital therapy is defined as one with at least five conjoint sessions for research purposes. Effectiveness of an integrated model of marital therapy using conjoint session approach has been evident from practice, as well as research, in India (Shah, 2010). Nonetheless, over the last decade we encountered certain challenges from our married clients seeking help for relationship difficulties. Hence, we modified marital therapy application to meet these challenges, despite the skepticism in literature over the effectiveness of marital therapy with one partner. Hence, through this article, we aim to reopen the case of IMT with a different kind of conceptual clarity.

Gurman and Kniskern (1978), through their influential reviews, advanced the notion that IMT is markedly inferior to conjoint approaches, as they found only a 48% improvement rate, but double the rate of deterioration, than all other forms of marital therapy. The widespread acceptance of this conclusion encouraged practitioners to exclusively rely on conjoint modes of treatment. Consequently, clients whose spouses were unavailable or uncooperative were either refused treatment or offered treatment that was believed to be inferior. One partner presenting for marital therapy was considered a contraindication, as the belief was that therapy with one spouse would lead to divorce. Research in this area was also stalled until Wells and Giannetti (1986a) re-reviewed research studies purportedly challenging this conclusion. They opined that no conclusions could be reached regarding the absolute or relative effectiveness of IMT due to gross flaws in design and implementation. In response, Gurman and Kniskern (1986) said, “. . . marital therapy that combines a predominant use of IMT with conjoint treatment may be less effective than marital therapy that combines a secondary use of IMT with conjoint format” (p. 58). They even acknowledged that combined treatments are quite common in the everyday work of most clinicians. This point continues to be valid in current marital therapy practices at our center. In two research studies on marital therapy (Isaac, 2004; Kalra, 2008), the total number of sessions ranged from 10 to 39, of which conjoint sessions ranged from 7 to 25 and individual sessions ranged from 0 to 28. An average of about 12 conjoint sessions (Isaac, 2004) and 16 conjoint sessions (Kalra, 2008) were reported with two to four individual sessions. This is perhaps a typical structure for marital therapy practiced around the world.

Wells and Giannetti (1986b), however, pointed out how the evidence against IMT was invalid, as it was contaminated, but agreed that research and practice must examine not only combinations of conjoint and IMT, but “new

forms of IMT” (p. 65). In the 1990s, Lewis, Trepper, McCollum, Nelson, and Wetchler (1990), through their National Institute on Drug Abuse-funded grant on couple-focused therapy for substance-using women, published a series of reports (McCollum, Trepper, Nelson, Wetchler, & Lewis, 1993; Trepper et al., 2000; Wetchler, McCollum, Nelson, Trepper, & Lewis, 1993) on systemic individual therapy (SIT). Their model integrates several family systems theories, and is delivered in one of two formats: SIT or systemic couple’s therapy. More recently, the Helsinki study found that solution-focused individual therapy was as effective as short-term psychodynamic therapy in treating depression and anxiety disorders (Knekt, Lindfors, Härkänen, et al., 2008; Knekt, Lindfors, Laaksonen, et al., 2008). Further, a recent meta-content analysis of 38 randomized control trials demonstrated the effectiveness of systemic therapy across settings (individual, couple, family, and group) in the treatment of mood disorders, substance use disorders, eating disorders, and comorbid medical conditions (von Sydow, Beher, Schweitzer, & Retzlaff, 2010). This article shows one such new form of IMT, with a conceptual anchor in the systemic theory: systemic individual marital therapy (SIMT).

Many tend to believe that the ideal situation in marital therapy would be when both spouses seek help for difficulties in their relationship and are fairly motivated to address the same. In reality, however, the therapist may not always enjoy this privilege. The obvious problem here seems to be due to one spouse refusing consent for therapy or unavailability of either spouse due to several reasons. The therapist, therefore, ought to be flexible toward accommodating one spouse in therapy who presents with marital difficulties and is fairly inclined to work on them.

The SIMT proposed here makes use of the systemic framework to address marital difficulties of one spouse. The reasoning is that change in one individual can alter other structures in the system. This is consistent with the systemic framework, which postulates that change in a microsystem inevitably brings about changes in the macrosystem. The main objective is a stable restructuring of the individual system, which might take the form of a firmly changed perception of the problem. The technique of circularity is valid in the individual context as well, although the standard three individual questions cannot be made, and immediate verifications of retroactions of other members is not available (Burbatti, Custoldi, & Maggi, 1993). Instead, the therapist and client often have to be content with the psychological presence of the spouse.

This form of therapy differs from traditional individual therapy approaches—like psychodynamic, cognitive-behavioral, or experiential therapies—as the emphasis in the SIMT is essentially systemic. It is a result of clinical reality, which has necessitated a flexible approach from the therapist to address marital concerns of one spouse. Family therapists usually leave it to the referred person to choose either an individual context or couple/family context. Systemic work with individuals or family therapy

without a family is another context that can promote change (Jenkins & Asen, 1992). Empirical data to vouch for the efficacy of such an approach is as yet inadequate. Clinically, however, it has proven to be a useful perspective to adopt because it has been rendered as efficacious as traditional marital therapy.

The model proposed here initially evolved from practice of psychotherapy for women who came with marital issues associated with affairs and disclosures, hurts in relationships, and concerns about marital issues and family. The therapy content defied formulations from an individual psychopathology perspective. IMT sessions 3 decades ago perhaps had psychodynamic or behavioral orientations. These did not fit many of our clients.

In all such cases, therapists initially assumed that the therapy is likely to be inferior when efforts to convert to the conjoint format failed. However, this changed as soon as a systemic formulation was developed and retained in supervision discussions. In initial years, this was largely occurring for cases under the supervision of Anisha Shah. Later on, it was echoed in the practice of those trained as such, as well as in their own independent supervision work not under the direct influence of Anisha Shah. Reflections on these patterns during teaching and training brought more clarity and motivation to share it with a larger group of practitioners. To do so, we first illustrate our model through a case report, then present findings from a brief qualitative research where clients' reports of therapy boldly underline the scope for variations in therapy structure. Finally, the principles of the SIMT model are presented, followed by discussions and conclusions.

## CASE REPORT

The case report presented here was seen in therapy by Veena A. Satyanarayana under the supervision of Anisha Shah.

### Psychotherapy Setting

The therapist had completed 5 years of a psychology program and 1 year of clinical training in a mental health training facility at the time of conducting this therapy. She had completed marital and family therapy training (details available from Shah et al., 2000), and was undergoing psychotherapy training (details available from Rao, 2001).

### Presenting Complaints

Ms. R, a 30-year-old married woman, presented with the chief complaint of guilt associated with being a bad mother. She had been married for 4 years,

and had a 2½-year-old daughter. The client was concerned about her style of parenting, felt inadequate as a mother, and had a tremendous amount of self-blame. She expressed concern that her child was not completely toilet trained, and was also repeating certain words with a lot of emphasis on specific syllables, which she thought was a speech problem. She felt responsible for her child's difficulties with speech and toileting. She experienced guilt about the same, and sought reassurance that the problems would not persist and could be corrected. Clinical evaluation revealed that she did not warrant a psychiatric diagnosis. However, because the client was distressed about her relationship with her child, she was taken up for therapy.

### Therapy Structure

The client was seen for 12 therapy sessions: initially, three times per week, and later spaced to biweekly and weekly sessions. Following termination, a follow-up session was held after 3 months. Another follow-up interview was conducted some time later for research purposes, mentioned later.

### History

Initial therapy sessions revealed the following: The client was fairly well-functioning prior to her marriage. She construed herself as “a liberated woman,” “confident,” “financially secure,” a “high achiever,” and “independent.” She resisted marriage for a long time, as she wished to pursue her career. However, she eventually consented to a marriage arranged by family. Prior to the wedding, she did not have the opportunity to get to know her partner. Following the wedding, she relocated to a different city. She felt insecure and lonely, as her husband hardly spent time with her and, in her opinion, “continued to prioritize work over family.” Communication was not open between them, and financial transactions were not very transparent, which made the client uncomfortable. Although she was distressed about the lack of open communication, she herself chose not to explore certain areas, as she felt incapable of dealing with the truth. Although her husband provided material comfort, he was not available emotionally.

She had difficulty accepting her new role, coupled with anger and regret over giving up her previous role and identity. Differences in their backgrounds, upbringings, and interests soon magnified. She also developed a strained relationship with her mother-in-law, as she would instigate conflict between the couple, and also with other family members. Eventually, she had no cordial relationships with members of her husband's family.

Her self-image was further shattered when she accidentally conceived her daughter. She said she lost respect for herself because of her “irresponsibility” and “callousness.” The client was not keen on continuing her pregnancy, but was forced to do so. Although she decided to cope with her

distress by resuming her career, she soon had to give it up due to medical complications following conception.

She reported that marriage, in many ways, meant a series of losses: loss of relationships, loss of a job that she cherished, and her identity of self as “liberated” and “independent.” This resulted in anger at herself, which gradually generalized to the child as well. The client had significant complications during and after delivery, which left her both physically and emotionally drained. Because the baby was in the incubator and subsequently in the neonatal intensive care unit, bonding between mother and baby did not occur in the first few weeks. Due to that, the client was unable to enjoy her baby in the initial few weeks. This evoked critical remarks of being “a bad mother,” who did not have a “maternal instinct.” This contributed to her sense of inadequacy and a low sense of worth, which she eventually internalized. She continued to harbor anger toward her husband, who continued to be an absent figure.

The client also perceived a change in her relationship with her mother. She reported that her mother was, in many ways, a source of strength. Ever since she returned to her hometown, following delivery, her mother was very critical of her and made her feel inadequate as a mother. Because she recalled her childhood as unpleasant and regarded both her mother and grandmother as bad mothers, there was a struggle to be different. This resulted in a need to be oppositional to authority figures, which only evoked more criticism. She was also distressed about not enjoying any activity with the child. As the frustration escalated, it finally sought expression in the episodes of rage, where she would shout at her baby. The displacement of her frustrations further strained her relationship with her child. Her child was terrified of her, and became fussy and adamant. The child did not cooperate while feeding, bathing, and so forth. She attributed this to her being inadequate and not “good enough.” Her need to overcompensate for the lost hours with her child made her highly sensitive and anxious about the child’s development. She acknowledged that she was slightly inflexible in her way of functioning. She set high standards for herself and others around her, and would be upset if she fell short of that. Her need for perfection and her inflexible way of functioning further complicated the picture, leaving her and the others frustrated.

### Case Conceptualization

The case was conceptualized from a systemic perspective, as the client presented with concerns essentially in the marital domain and was relatively well-functioning prior to this life event. Also, because the client had a predominantly internal locus of control, a strong tendency toward self-blame, and a sense of guilt, this approach was considered suitable. However, the client was not open to discussing these issues in the presence of her

husband, and chose not to involve her husband in therapy. Hence, the client was seen for systemic therapy in the individual context. Other theoretical frameworks used were the feminist approach to help her with motherhood issues and the narrative approach to facilitate coherence in view of self in relationships.

### Progress of Therapy

The client was initially ambivalent about therapy. She had difficulty seeking help from a tertiary care center; hence, engaging her in treatment became important. An attempt was made to engage the client in therapy by not pathologizing her concerns, as she already harbored a significant degree of self-blame and guilt. Yet, it was important not to minimize her concerns, but to keep the focus on her child, as she felt threatened when the focus shifted to the marital dyad. A narrative approach was used in the initial phase of therapy to facilitate articulation of the client's life story and elicit systemic factors.

Once the therapeutic alliance was established, the therapist helped the client make necessary connections in her story. Reflections made by the therapist helped the client feel understood, and positive reframing of some of her concerns decreased her feelings of guilt and self-blame. Use of circular questions also ascertained that the focus was not always on the client. The client was initially reluctant to share negative aspects about her relationship before a "stranger," and was assessing the therapist's reactions by disclosing them in parts. She felt reassured with the nonjudgmental stance communicated by the therapist, and began to gradually let go of her defenses. Circular questions often help in conveying neutrality. Here, they helped make the client talk about others without being judgmental about their behaviors.

Feedback regarding the therapist's formulations of the client's concerns was presented, with emphasis on a systemic understanding, rather than a linear model, which enhanced her receptivity. The therapist was soon able to make interpretations in parts on focal themes of ambivalence and need for control. The client was quick to agree/disagree with the interpretations and was, by now, actively engaging in therapy. Because the client was fairly reflective and insightful, therapy progressed fairly smoothly toward promoting change in her.

Once again, a systemic premise of how change in one system brings about change in other systems was used as a rationale, which motivated the client to work on possible areas she wished to change. The client had internalized therapy inputs, which were evident in her articulation of target areas of change: to strengthen her marital subsystem; work on altering boundaries with extended family members; to minimize intrusion; to be flexible in her style of relating with others; and to relax her expectations of herself, her husband, and her child. Once these goals were achieved to a satisfactory



degree in therapy, the client was prepared for termination. At this point, the client volunteered to bring her husband for a conjoint session, as she thought that he would benefit from feedback about her progress in therapy. He gave feedback regarding gains he had witnessed in her, and he also expressed a commitment to initiate changes in his way of relating to her.

### Complicating Factors and Process Issues

From the start, the client had disclosed significant ambivalence toward therapy. The client's statement in an initial session, "I need therapy not because I am ill, but because I am fine and want to be better," indicated that the therapist ought to be careful not to pathologize her behaviors. She was not very forthcoming in the initial session, and painted a rosy picture of her marital relationship. Even after she engaged herself in therapy, she expressed guilt about projecting her husband and other family members in a negative light before a "stranger." During these times, she used to feel threatened and would block further disclosure. However, she did not miss a single session of therapy. Ambivalence in the therapeutic relationship was a challenge in the initial sessions. Yet, later, the client developed a positive bond and, despite anxieties about terminating therapy, she was able to handle it in a mature manner.

### Evidence from Client Reports

Client experiences of SIMT were elicited through interviews with two clients. Client 1 was the Case Study 1 client. Client 2 was a 34-year-old woman, who had gone through 12 sessions of SIMT with Veena A. Satyanarayana. These interviews were semi-structured, covering the domains of relationship problems, change experienced, and attributions of change. This semi-structured interview had been used in an earlier study on client experiences of therapy (Isaac & Shah, 2003).

Both clients were interviewed regarding their experiences in therapy. Whereas Client T (Client 1) was comfortable seeking help from a tertiary care center and was fairly comfortable with emotional disclosure, Client R (Client 2) experienced discomfort and stigma, had concerns about confidentiality, and did not want to be "seen." She was ambivalent about seeking help, and had fears about letting go of her defenses. As a result, she took longer to engage in therapy, and experienced guilt about revealing family secrets before a stranger. Although Client R sought help in the context of her child, as it was less threatening, both necessitated systemic intervention, as the focal conflict was clearly marital. Significant intra-therapy factors that facilitated change in both cases were the style of questioning, which set them thinking; and explanatory models, which helped them gain a perspective

about the possible genesis and maintenance of problems. Therapist variables that were perceived as useful were acceptance; respect for the client; style of questioning, which often helped them see what they did not want to; sensitivity to their clients' emotional states; and a genuine intention to help. Clients reported that, as a result of therapy, they were more accepting of self and others, and they were able to rediscover their "self." Client T experienced a sense of empowerment and reduced dependency on her spouse, and Client R became more relaxed and flexible in her approach toward her spouse and child. They also worked toward developing a realistic appraisal of their marital relationship. Clients reported that the changes made in self impacted on the relationship as well. Client T found her husband pursuing her and capable of reciprocating her needs and feelings. Client R's spouse was supportive of her attempts to bring in changes, gave her positive feedback, and tried to initiate certain changes in his behaviors. Clients also reported to have internalized representations of the therapist, which guided their interactions with others. These therapy gains were also maintained over a 2-year period for Client 1 and a 9-year period for Client 2. Similar views about importance of clients' perceptions were found in another brief qualitative study. Seven married individuals were interviewed 6 months after completion of marital therapy to elicit their constructions of relationship problems and change experienced, attributions for changes, and therapists' behaviors. Content analysis of the interviews showed that therapists need to address client apprehensions about coming for therapy, vulnerabilities that they face in the relationship, and the way they would like to engage in conjoint sessions. Therapeutic stance experienced by the client on the aforementioned issues is powerful in client constructions for marital change (Isaac & Shah, 2003).

These evidences also underscore the importance of planning therapy to fit the clients' expectancies. It seems that therapy processes that not only safeguard the client from provoking the system, but also empower them to influence the marital system in a desirable way, are critical for good outcomes.

## SIMT

Some of the basic principles for SIMT are presented here.

### Goals and Outcomes

The goal of SIMT is to promote systemic change through one individual, increase self-awareness in the system, and use that to reconstruct intrapsychic relational configuration.

Systemic intervention has been possible and effective. Clients reported a reduction in distress and obtained a coherent perspective about their

problems; they attempted to bring about changes in self, which improved their relationships with their partners. Clients also felt confident about working on their relationships with other family members.

Therapies with SIMT principles have been effective for many clients seen in our services where we used the previously named formulations from the intake session onward. Many of these clients have kept the treating team informed about themselves over the years. All have remained with their partners. There were no major hurt events since therapies. They have facilitated their relational evolution through many normal family events, like daughters getting married and having children. Moreover, qualitative research approaches described earlier provide objective support for the relevance of this therapy.

Evidences for good outcomes in similar therapy sessions can be identified in the following:

1. Client's reports to therapists about change experiences.
2. Future-oriented themes in sessions.
3. Inter-session events reflecting newer initiatives in relationship encounters known to provoke self-in-marriage and motherhood/fatherhood issues.
4. Decreased need for any other consultations, and no evidence of psychopathology at termination or follow up.

### Structure and Processes

Individual sessions are central in this therapy. Conjoint sessions are not essential, and may provide information about systemic changes, rather than have any specific therapeutic tasks. The therapist's search is clearly about marital outcome of improvement in relationships. Due to hurt events, the client may engage in a psychological search for separation/divorce options as a means of easing pain. However, in cases that helped us define these principles, we found that many such themes were transient, yet essential, for progress in therapy.

Use of circular questions for interventions has been very useful. Circular questions around emotions would bring out the emotional traces of experiences about self-in-marriage. These serve dual functions—they show a systemic orientation of the therapist that supports and conveys empathy to clients, and they help discover tasks for therapists and clients to focus on in sessions that are within clients' choices and controls. Thus, the process facilitates a unique way of empowering the client within the system. The technique of empathy is not considered as useful as using regard and acceptance, and allowing acceptance to be communicated through the narrative style for session content.

All clients conveyed a strong emotional bond with their partners. What was very striking is that they often communicated very empathically about

their spouses (along with complaints about them). A therapist's ability to have this insight into the marital relationship is very important.

Our model is an assimilative model, as it is firmly grounded in systemic concepts and uses hypotheses based on circular causality. At no point in therapy is any deviation from this assumption allowed. This rule was crucial, as it helped determine the therapist–client relationship from segment to segment of therapy sessions. This, in turn, facilitated the client's readiness to change. Suitable interventions were then matched to the client's immediate concerns. These ground rules in therapy created an atmosphere of client-directed content, matched with the therapist's interventions (a) of feedback of a systemic hypothesis (intermediate goal: to reduce sense of personal inadequacy/failure expressed indirectly through anxiety and concerns about therapy sessions) and (b) using "enactments" in recent interactions with spouse/child/any other family member from the family of origin of either partner around themes of anger and motherhood.

### Conceptual Perspective

Our experience shows that a systemic perspective can be employed in therapy with one spouse. A system represented in an individual client's material has to be attended to in this therapy. However, for many beginner therapists, understanding the role of system in individual distress is disempowering, as a client appears helpless against systemic dynamics. In SIMT, the therapist employs a bidirectional view of the dynamics and persists on client changes on that count, rather than due to past intrapsychic issues or personality/erroneous cognitions. Systems is a relevant perspective and in keeping with the current trend of changing marital/family systems and needs of clients. However, family of origin issues usually prominent in therapy are not as much about old relational experiences; rather, they are about internalized and unresolved family of origin issues that fuel marital anxieties or anxieties about motherhood.

The marital system existing in the clients' material is conceptualized without using learning theory/cognitive/interpersonal/dynamic theory in the forefront. Narratives are important, and these do require some interpretation. These are best presented within a narrative-humanistic approach, although techniques from other approaches can be effectively integrated with meaningful session tasks. In almost all clients seen in such therapies, marital anxiety was found to be central in the formulation. Marital tensions manifest in many different ways. Marital conflict is often suppressed when systemic anxieties are more threatening to the person's core self-image. Marital conflict is often triggered by dyadic experiences, and opens the unresolved issues around beliefs about marriage and preexisting vulnerabilities about self-in-marriage (Shah, 1996). Gender lens can also help explain what a person does with marital conflict; and this sensitivity is to be retained for female, as well as male, clients.

## Indicators

The model is suitable for a variety of presenting problems, like women seeking therapy for extramarital affairs/jealousy issues complicated by subclinical/clinical depression in the partner and for women with distress related to poor parenting styles originating from anxieties around motherhood. Although somewhat less frequent, it has been relevant for young men with fatherhood-related issues as well where, once again, self-in-marriage anxieties create the primary disturbance in the individual. Other presentation styles where this model is relevant are self-in-marriage concerns, reluctant partner participation, emotional distance of partner from presenting problems, and protectiveness toward partner's vulnerabilities. In the majority of the cases that we have seen, the clients have been in younger marriages, and the majority were in the first- or second-family lifecycle stage.

The partner who presents for therapy may not always be clear about the role of the spouse in therapy sessions. Therefore, the therapist can keep an integrated marital therapy model also ready for application if a conjoint session format evolves strongly with significant tasks/new learning scopes in them.

## Contraindications

The SIMT approach has no known contraindications. Decisions about the types of therapy typically rest on (a) known empirical evidence about the effectiveness of a given therapy for certain conditions, (b) client characteristics, (c) presenting complaints, and (d) the therapist's evaluation and discretion. Care should be taken to practice SIMT only when conjoint systemic therapy is either not indicated (predominance of self-in-marriage concerns) or not possible, although indicated (client does not want the partner to be involved, or partner does not want to be involved). Once initiated, it should be discontinued if the client's attention predominantly remains on external content/partner behaviors and not on self.

SIMT is expected to be more productive for individuals with subclinical distress, anxieties about recent/new relationships like parenting concerns and partner's expectations from oneself as a parent, or common mental disorders (Knekt, Lindfors, Härkänen, et al., 2008; Knekt, Lindfors, Laaksonen, et al., 2008; Trepper et al., 2000) stemming largely from systemic factors, rather than those presenting with personality disorders or major psychiatric disorders.

## DISCUSSION

Kugel (1974) identified some merits of individual sessions over conjoint couple sessions more than 30 years ago. These seem to be relevant even in contemporary practice of marital therapy. Individual sessions with one

partner are more comfortable for therapist to give feedback to that partner about his or her dynamics, as well as make the client concentrate more on what the therapist is saying. In conjoint sessions, because of the couple's interactional dynamics, they often get distracted by the partner. Since then, somewhere under the dominant domain of family therapies supported by research evidence and distinct theories, individual systemic approaches seem to be an alternative that a clinician cannot do without (McCollum et al., 1993; Trepper et al., 2000; von Sydow et al., 2010; Wetchler et al., 1993).

Hedges (2005) even supplied a glossary of systemic terms to be used with individuals, some of which were *ability spotting, circularity and circular questions, positive connotation, reframing, self-other reflectivity, social constructionism, team work, and transparency*, are relevant for practicing SIMT as well. However, there is no known literature on the therapeutic issues related to SIMT.

Jenkins and Asen (1992) illustrated the scope of working with the system in individual sessions. They, however, stressed the importance of allowing the system to enter therapy. Some of the dilemmas articulated here are similar to what was faced by European family therapists, who attempted to combine systemic approaches with that of an individual who is not only part of a system, but also acts as a conscious individual who constructs this system while at the same time being influenced by it (Armour et al., 2002, p. 653). Here, the marital system is kept alive in therapeutic content.

Melito (2006) described a structural-developmental approach to integrate theoretical individual and family therapies. He proposed integration using a lens to identify four common structural aspects. These are intrapsychic, interpersonal, transactional phenomena, and what Ackerman (1962) would have called "circular and interpenetrative" influences. Our model contrasts with Melito's model on certain characteristics. First, it is a model operating at two levels instead of four. Second, for systemic factors, it minimizes the developmental perspective and maximizes the contemporary experiences; whereas for individual factors, historical data are more powerful in therapy. However, there is a need for further conceptual and technical clarity on SIMT, as well as empirical evidence from other practitioners, to improve this model and its application.

### Directions for Future Research

Future research on SIMT can focus on building empirical evidence on both process and outcome parameters, such as relationship characteristics, indicators/contraindicators, duration of therapy, therapeutic alliance and clients' experiences of therapy, therapeutic strategies used, and effectiveness of SIMT on individual and relationship outcomes. Research may also address similarities and differences in processes across SIMT, individual therapies, and conjoint systemic marital therapies. Further, cross-cultural issues specific

to process and outcome of SIMT merit exploration. The research design would need to distinctly assess systemic and marital aspects using measures widely accepted in research in this area. Much of the initial data on this can perhaps also be obtained from retrospective designs and across various types of practice settings. In addition, research may address gaps in literature on integrating SIMT with conjoint therapy models. With these advances, the field will be better equipped to refine the SIMT model along conceptual and operational parameters.

## CONCLUSION

The SIMT model is suitable for practicing psychotherapists who use fused individual and family perspectives for clients in mild to moderate interpersonal distress levels. In this article, we have illustrated how the model developed from psychotherapeutic work with various clients. SIMT provides a way to comprehend clients who seek therapy, complain about others, are anxious about “systemic self,” and do not have a personality disorder or a psychiatric syndrome. Over time, these clients may require occasional consultations for very specific worries. They would be most comfortable seeing the same therapist. The model is perhaps ideal for communities with stable counselling and therapy practices. The clients are likely to show a fairly high degree of self-sufficiency even while facing newer issues. SIMT perhaps facilitates resilience in the systemic individual self.

## ACKNOWLEDGMENTS

This manuscript is based on two conference presentations by the authors:

1. Shah, A. (2001, November). *Disclosures of affairs and reconciliation*. Paper presented at the 13th World Congress of the International Family Therapy Association, Porte Alegre, Brazil.
2. Veena, A. S., & Shah, A. (2003, December). *Marital therapy with one spouse?* Paper presented at the National Conference of Couple and Family Systems, National Institute of Mental Health and Neurosciences, Bangalore, India.

## REFERENCES

- Ackerman, N. W. (1962). Family psychotherapy and psychoanalysis: The implications of difference. *Family Process, 1*, 30–43.
- Armour, M. P., Haug, I. E., with Becvar, D., Braun, H., Elkaim, M., Shibusawa, & Nwoye, A. (2002). International perspectives on professional ethics. In

- R. Massey & S. Massey (Eds.), *Comprehensive handbook of psychotherapy* (pp. 641–667). Hoboken, NJ: Wiley.
- Burbatti, G. L., Custoldi, I., & Maggi, L. (1993). *Systemic psychotherapy with families, couples and individuals*. Northvale, NJ: Aronson.
- Gurman, A. S., & Kniskern, D. P. (1978). Research on marital and family therapy: Progress, perspective, and prospect. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior Change: An empirical analysis* (2nd ed., pp. 817–901). New York, NY: Wiley.
- Gurman, A. S., & Kniskern, D. P. (1986). Commentary: Individual marital therapy—Have reports of your death been somewhat exaggerated? *Family Process*, *25*, 51–62.
- Hedges, F. (2005). *An introduction to systemic therapy with individuals: A social constructionist approach (basic texts in counseling and psychotherapy)*. New York, NY: Palgrave/Macmillan.
- Isaac, R. (2004). *Marital therapy with distressed couples*. Unpublished doctoral thesis, National Institute of Mental Health and Neurosciences, Bangalore, India.
- Isaac, R., & Shah, A. (2003, December). *Client constructions of marital therapy*. Paper presented at the national conference on Couple and Family Systems, National Institute of Mental Health and Neurosciences, Bangalore, India.
- Jenkins, H., & Asen, K. (1992). Family therapy without the family: A framework for systemic practice. *Journal of Family Therapy*, *14*, 1–14, doi:10.1046/j.1992.00439.x
- Kalra, S. (2008). *Emotions in marital therapy*. Unpublished doctoral thesis, National Institute of Mental Health and Neurosciences, Bangalore, India.
- Knekt, P., Lindfors, O., Härkänen, T., Välikoski, M., Virtala, E., & the Helsinki Psychotherapy Study Group. (2008). Randomized trial on the effectiveness of long- and short-term psychodynamic psychotherapy and solution-focused therapy on psychiatric symptoms during a 3-year follow-up. *Psychological Medicine*, *38*, 689–703.
- Knekt, P., Lindfors, O., Laaksonen, M. A., Raitasalo, R., Haaramo, P., & the Helsinki Psychotherapy Study Group. (2008). Effectiveness of short-term and long-term psychotherapy on work-ability and functional capacity—A randomized clinical trial on depressive and anxiety disorders. *Journal of Affective Disorders*, *107*, 95–106.
- Kugel, L. (1974). Combining individual and conjoint sessions in marital therapy. *Hospital and Community Psychiatry*, *25*, 795–798.
- Lewis, R. A., Trepper, T. S., McCollum, E. E., Nelson, T. S., & Wetchler, J. L. (1990). *Couple-focused therapy for substance-abusing women*. Rockville, MD: National Institute on Drug Abuse.
- McCollum, E. E., Trepper, T. S., Nelson, T. S., Wetchler, J. L., & Lewis, R. A. (1993). *Systemic couples therapy for substance-abusing women: A treatment manual*. West Lafayette, IN: Purdue Research Foundation.
- Melito, R. (2006). Integrating individual and family therapies: A structural-developmental approach. *Journal of Psychotherapy Integration*, *16*, 346–381.
- Rao, K. (2001). Training in psychotherapy in the department of clinical psychology, NIMHANS. In M. Kapur, C. Shamsunder, & R. S. Bhatti (Eds.), *Psychotherapy*



- training in India: Proceedings of the National Symposium on Training in Psychotherapy* (pp. 46–49). Bangalore, India: National Institute of Mental Health and Neurosciences.
- Shah, A. (1996, November). *Evaluation of marital distress in a psychiatric setting: An evolving module*. Paper presented at the Royal College of Psychiatrists, Hyderabad, India.
- Shah, A. (2010). Marital therapy and psychiatric disorders. *Indian Journal of Social Psychiatry, 26*, 24–33.
- Shah, A., Varghese, M., Udaya Kumar, G. S., Bhatti, R. S., Raguram, A., Shobhana, H., & Srilatha, J. (2000). Brief family therapy in India: A preliminary evaluation. *Journal of Family Psychotherapy, 11*, 41–53.
- Trepper, T. S., McCollum, E. E., Dankoski, M. E., Davis, S. K., & La Fazia, M. A. (2000). Couples therapy for drug abusing women in an inpatient setting: A pilot study. *Contemporary Family Therapy, 22*(2), 201–221.
- Von Sydow, K., Beher, S., Schweitzer, J., & Retzlaff, R. (2010). The efficacy of systemic therapy with adult patients: A meta-content analysis of 38 randomized controlled trials. *Family Process, 49*, 457–485.
- Wells, R. A., & Giannetti, V. J. (1986a). Individual marital therapy: A critical reappraisal. *Family Process, 25*, 43–51.
- Wells, R. A., & Giannetti, V. J. (1986b). Rejoinder: Whither marital therapy? *Family Process, 25*, 62–65.
- Wetchler, J. L., McCollum, E. E., Nelson, T. S., Trepper, T. S., & Lewis, R. A. (1993). Systemic couples therapy for alcohol-abusing women. In T. J. O'Farrell (Ed.), *Marital and family therapy in alcoholism treatment* (pp. 236–260). New York, NY: Guilford.