Individual and Family Therapy

FAMILY DRAMAS IN CLINICAL PRACTICE

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INDIVIDUAL AND/OR FAMILY THERAPY

Dramatis Personae

Mrs. B.: About forty, housewife and graduate student, was referred by her individual therapist whom she had been seeing for about one year. She was unhappy with her marriage, and there had been no change. Her therapist agreed and referred her and her husband for marital therapy. She has had the bulk of the responsibility for their three children ranging in age from eight to twelve and for the home generally, doing minor home repairs, caring for the yard, etc. She feels the marriage lacks intimacy and a sense of partnership. During most of the conjoint therapy, which has lasted about four months, she has continually been the expressor of any feelings.

Mr. B.: Also about forty, a biological researcher working long hours, including weekends when he is writing grant applications. He comes to marital therapy reluctantly, as he is happy in his marriage, unhappy only in that she is not satisfied.

Dr. S.: About forty, calm, curious, generally letting his patients develop their agenda. In this scene he more actively tries to shift the focus from her unhappiness to eliciting more of his feelings.

Setting

The 1970s, a psychotherapist's office, books lining two walls; the titles on one wall are about the family and family therapy; on the other they are about psychoanalysis. There is a couch and four chairs, three of which are arranged to form a triangle. Mrs. B. enters followed by Dr. S.

Mrs. B: I don't know why Allen is late. Things are quiet at home, but it is as if there is a cold war going on. Underneath there seems to be a lot of anger.

Mr. B.: (Arrives looking at his watch) You must have started early. (Takes his seat and looks abstracted, as if he were still in the lab. Catches himself, looks directly at his wife.) So, what's on your mind?

Dr. S.: You still want Ann to start off. What is on *your* mind?

Mr. B.: For some reason Ann has not wanted to make love the last two weeks. (Matter of factly)

Dr. S.: How do you feel about that?

Mr. B.: I feel she is disabled. There is something wrong with her. She is clearly unhappy and that makes me unhappy. That's why we are here. (Mrs. B. is visibly more unhappy as he says this but remains silent. Mr. B. looks directly at Dr. S.) If your wife were disabled with some illness, you wouldn't get angry with her, would you? (said somewhat challengingly)

Dr. S.: You seem more annoyed about being here today. How do you feel about being here?

Mr. B.: I don't like it much; I was in the middle of an experiment.

Dr. S.: What keeps you from saying that?

Mr. B.: I don't want to hurt your feelings. You are a decent enough person. You haven't done anything to me.

Mrs. B.: I know so little of what goes on inside of you; all you talk about is your work. (encouraged by the therapist's lead)

Mr. B.: I just can't do it. I admire how the kids can come right out and say what they feel, like Lizzie did yesterday. I still remember when I ran in to tell my parents something exciting. My father threw me out. (Mrs. B. moves up in her seat, seems interested)

Dr. S.: How would you feel if the marriage broke up?

Mr. B.: (Almost as if it were a fact) I would survive. When the wife of one of my professors died, he went back to work the next day. I would be sad because of the children, but I would survive. (Pause) You keep implying there is something wrong with the relationship. Aren't you interested in seeing it that way because you see couples. If she were psychoanalyzed and got over her feelings toward her father, or whatever, she'd be happier and we wouldn't be here now.

Dr. S.: Did you notice that when you insist that Ann is the problem she becomes cooler and when you talk more of how you feel she is more interested; yet you still feel you will be thrown out, as you were by your father, if you express how you feel.

Mr. B.: I do remember a lot of bad feelings in the past. I don't want to be reminded of them, or feel them again.

This scene, a common one in the family therapist's office, illustrates the pervasiveness of the traditional common-sense viewpoint that emotional disturbances reside usually [within another person] rather than within *and* between people. We saw in *Hamlet* (chapter 1) that all the major characters

saw Hamlet as the identified patient, in part, to ward off some painful aspects of themselves. Mr. B. would similarly prefer to see any unhappiness residing in his wife. That this externalizing defense comes to plague him is in fact an example of the Freudian concept of the return of the repressed. In the usual, fully internalized conflict the repressed most often returns in the form of dreams and symptoms. When families are seen where externalizing defenses predominate, the repressed aspects of one person are often evoked and provoked in another. When this happens, the separation of intrapsychic processes and interpersonal processes is quite artificial as these processes are always mutually influencing one another. It is however quite difficult to study these levels simultaneously, and understandably therapists tend to simplify the task by doing either family therapy or individual therapy. These modalities, however, like the varying lenses of the microscope distort one level while another is being illuminated.

Mr. B. is partly correct when he states that his wife's unhappiness is the problem. He is also partly correct in his assumption that something in her past history is "responsible" for her unhappiness. Were it not for her discontent he could get on with his research without this unpleasant intrusion of therapy. Nonetheless his labeling and treating her as disabled serves his defensive needs and intensifies her emotional withdrawal and their current impasse. It also simultaneously sustains the level of detachment that Mr. B. has been comfortable with for reasons of his own history and psychic

economy. Lest it look like all that is required is his becoming less defended, I should add that subsequently in a dramatic reversal he felt in his guts that should the marriage break up it would be largely because of him. This relevation led his wife to respond limply as she began asking herself whether she indeed did want more intimacy. She was more comfortable, in fact, in maintaining herself (out of a sense of guilt) as being unloved. Her response confirmed his feelings that he is best off remaining detached. This new awareness made it even clearer that this couple unconsciously chose one another to keep a distance that suited each of them. Their mutual awareness in the conjoint sessions of this shared dynamic in fact paved the way for further resolution.

Because of the tendency to focus only upon the individual, the practitioner of individual treatment tended not to concern himself with changes in the patient's family. Yet any effective individual treatment, including chemotherapy, has unpredictable and mostly unstudied effects upon other members of the family. A number of years ago I saw a family where the mother, after many years of manic-depressive illness, was cured of this manifest illness by the discovery of Lithium. One might have thought this to be a most welcome event in the life of her family. The father, who for years had been overfunctioning in relation to his wife's disorder, became unaccountably depressed (see Jacobson 1956 for an early analytic view of such interaction). It was as if they shared an unconscious need for a

"caretaking" relationship within the marriage. The introduction of Lithium in this case for a clear-cut mental illness nonetheless disturbed their object-relational balance, requiring further intervention. Clinical psychiatry abounds with such family systems effects of traditional treatment. The successful treatment of a child, for example, is not always a welcome event if the child's illness also serves regressive needs of one or both of the parents.

The very nature of the individual paradigm precludes studying the systems effects of individual treatment. This is graphically illustrated in a letter Freud wrote to his colleague Abraham over sixty years ago. Quite matter of factly he noted the frequency with which psychoanalytic treatment resulted in the patient's divorce. This observation, off the scientific record, was not then considered of any particular relevance. Only in the past decade or so, with the advent of the family systems paradigm, have researchers thought to look at what impact individual and family treatments have upon the family. (See Gurman and Kniskern 1978 for an excellent recent review.) Because we now study and treat the family, Freud's aside in a letter now serves as a stimulus for questioning when, why, and how individual therapy leads to divorce or to an improvement in family relations. A corollary question is how can family therapy effect meaningful changes in individuals. These questions are not merely of theoretical interest. A significant number of my consultations involve couples whose marital relationship has become threatened after one member has been in treatment for a number of years.

Their conscious and unconscious needs no longer complement one another, and their marriage "contract" (see Sager 1976) has changed. Because of changes in the marital equilibrium catalyzed by individual treatment, the spouse in treatment or often the untreated spouse decides he or she wants a separation. While this may often be an appropriate and welcome outcome for all concerned, it is not necessarily a fortuitous one and may be a disequilibrium that can be corrected by involvement of the spouse in treatment. A husband in such a situation commented that in retrospect his wife seemed to stop talking to him around the time she started her individual therapy. It may have suited him not to talk with her at the time, but again, we see that individual treatment sets in motion complex changes in family interaction that are often out of awareness and of course never studied. Financial resources are often strained at these times, and the individual therapy itself is often jeopardized by the budgetary changes that come with a separation.

Whitaker and Miller (1969) have already stressed the possible untoward impact of individual therapy "when divorce impends." Where they urge a family evaluation at such times, I would go further to state that a family evaluation is also indicated when a patient comes for marital problems *before* divorce impends. This may sound like the family paradigm is overly preoccupied with preserving the family's structural integrity rather than elucidating the relevant dynamics. This is often a problem with practitioners

of either modality who because of their own values and countertransference try to influence (often unconsciously) the outcome of their patients' life circumstances. To minimize such tendencies, practitioners of either modality in my view optimally ought to have had a personal analytic treatment (see Wynne 1965).

When a practitioner works "analytically" in either modality, the goal is the greater autonomy and individuation of each person ideally through the greater awareness and working through of the roots and less conscious dynamics of their relationships. The result, as distinguished from that goal, may bean improvement in the relationship and at other times in its dissolution. In beginning a family therapy, I exlicitly state that the goal is not the preservation of the marriage but the greater individuation of each member through an appreciation of factors often out of their awareness that have contributed to their difficulties. This approach differs from many therapists who see themselves primarily as behavioral ("system") change agents and "insight" as a relic of the old individual paradigm. Except in cases of the more acute psychosomatic and psychiatric disorders, acute family crises, or in the more chronic, undifferentiated family systems, I find such emphasis on change seriously flawed by the therapist's imposition of his own values and need to manage others.

NONCLINICAL FACTORS INFLUENCING PARADIGM CHOICE

We have established that in reality, intrapsychic and interpersonal determinants are always at work. The question remains, When is it most appropriate to do individual and/or family therapy? Before turning to that question, I shall raise a preliminary question of the nonclinical factors that determine paradigm choice. This will be discussed under three headings: (1) therapist factors, (2) client factors, and (3) sociocultural and institutional factors.

Therapist Factors

There is, of course, the obvious factor of the relative newness of the field. For this reason many older clinicians never trained in this specialty practice only individual therapy. Beyond that historical factor it is clear that younger trainees when exposed to both of these approaches seem to gravitate to one or the other of them for reasons of personal temperament. Training programs ought to be aware of such early preferences as they may reflect correctible limitations of particular trainees.

The single most important factor and the one that probably explains the long history and persistence of the individual modality is the almost universal preference for the privacy and intimacy of the dyadic relationship. T he most natural, almost instinctive reaction of an individual in pain is to seek aid from a helping individual. It is a natural, almost instinctive reaction for the helping

person, by varying degrees of identification and empathy with the sufferer's pain, to respond to the plea for help. This felicitous fit is first established in all of us by having participated in the caretaking mother-infant dyad. Within the psychoanalytic situation this is an inherent part of the relationship that must also be analyzed (see Stone 1961).

There are many trainees and family therapy "purists" who will not see individuals because they are uncomfortable with these more regressive transference and countertransference pulls. They are often more comfortable with greater therapeutic activity and management. One sees this trend toward therapeutic activism most fully explicated in Minuchin's structural approach (1974) (see chapter 8). He advocates the active restructuring of family systems from the very start. The popularity of this approach fits well with the activist temperament of many, especially trainees overly eager to help. It also fits in with the American value of active mastery of problems, be they technological or psychological. With many families this approach is necessary, but, with many families such activism undermines their autonomy and coping capacities. On the other hand, and far more frequently, some trainees and "purist" individual therapists temperamentally avoid family and group therapy. They may defensively prefer the individual therapy setting because of discomfort with the greater "activism" family treatment usually requires. Also family therapy is inherently more complex. There is a multiplication of data in seeing more than one patient at a lime. Also there is

multiplication of the resistances, which must be dealt with in all modalities. Families are no more eager to change than individuals are.

The temperamental preferences for individual and family therapy are inevitable, and most competent individual or family therapists need not learn the other modality. It is important, however, that those involved in diagnostic screening evaluations and deciding which modality is most appropriate be familiar with both. We now turn to the patient and family forces (hat determine choice of modality.

Client Factors

Just as therapists gravitate toward certain modalities for personal reasons, patients also defensively seek out modalities that may be more comfortable than therapeutic. When, for example, a child's symptomatology is largely reactive to a marital problem and the parents do not want to deal with their marriage, they will be more comfortable if the child is seen as the identified patient and treated in individual therapy. Many having marital problems may also choose individual therapy, hoping for an ally or using the therapist as a "transitional object" to help achieve a marital separation. On the other hand, many families will insist on family therapy in the hope of stemming the independent strivings of an adolescent or one of the spouses. Separation anxiety may thus play a defensive role in the preference for either

modality. The therapist, aware of such determinants, will less likely collude with them while working toward the autonomy and individuation of all involved. Bowen (1978) has emphasized that in most families there are relatively equal levels of undifferentiatedness among most of the members. The treatment of one member of a family will sooner or later have an impact on others in the family. All of them are thus potential patients, often leading to numerous individual therapies which, except for the very wealthy, is usually prohibitive. This needs to be considered in starting an individual therapy, as financial economics as well as psychic economics come into play when other members of the family begin to need and seek treatment in response to a relative's therapy.

Sociocultural and Institutional Factors

The newness of family therapy and more importantly the radical shift from the individual as the identified patient to the family as the patient creates a host of difficulties that have as yet not been resolved. A most formidable problem is that of reimbursement. Health insurance has now become a major form of reimbursement for most medical and psychiatric treatments. Third-party payers, however, have as yet rarely recognized this new modality. Insurance forms usually require the naming of one identified patient with an "insurable" illness. When the diagnosis "marital adjustment," which exists in the American Psychiatric Association's diagnostic

nomenclature, is noted, the form is usually returned for a more individual-sounding diagnosis.

There is still no diagnostic nomenclature for families that can serve as a basis for third-party reimbursement. There is also no agreed-upon theory of family functioning or method of intervention.

Some third-party payers such as Medicaid in New York have recently begun to reimburse clinics doing family therapy by multiplying the individual fee by the number of family members (i.e. patients) present. This multiplication of the hourly rate of reimbursement suddenly made family therapy a much more popular modality. Such is the irrationality of our bureaucracies in dealing with innovation and change. There is a much larger problem involving reimbursement in the field of medicine, for insurance companies increasingly reimburse doctors for procedures rather than for time spent with patients. This "objectification" has disrupted the doctor-patient relationship and created an out-of-control inflationary spiral in the cost of medical care. Hosts of laboratory fees and technological procedures now supplement the fee for the history and physical examination. This is especially problematical for the practitioners of either of the modalities under discussion, as they do not "do procedures." Little wonder that psychiatry has doubled its efforts to return to its medical roots.

Then there is the problem of record keeping. Should there be records for families or for each family member? This has further discouraged the introduction of this modality into clinic settings. The keeping of individual records makes sense for a number of reasons. First, it encourages a more thorough evaluation of each family member. Second, as family membership is often changing, it makes sense to have a record for each individual patient, placing copies of family treatment summaries in each patient's chart. Individual records are thus a reminder that a family system, whatever the degree of its undifferentiatedness, is still composed of individuals in interaction.

There is yet another quite practical consideration that adds to the difficulty of doing family therapy. As family members often work and go to school the actual times that families can assemble are often in the evenings or at least in the afternoons. Scheduling individuals is thus vastly easier.

INDIVIDUAL AND FAMILY THERAPY — WHEN?

Aware that significant intrapsychic and interpersonal forces are usually present in most patients and with some awareness of those just reviewed, nonclinical considerations that determine choice of modality, we ask the critical question, "When do we utilize these modalities?"

As most patients seeking psychotherapeutic help are enmeshed in

complex relationships with significant others, the initial conjoint evaluation of such relationships affords a more balanced unraveling of their mutual interpersonal and intrapsychic difficulties. These are cases in which there is often a transitional crisis in the family life cycle (e.g. a pregnancy wanted by one member and not the other, the problems of the "empty nest," and on up to the interpersonal difficulties precipitated by one spouse's retirement). A period of conjoint therapy will often resolve a presenting problem to their mutual satisfaction. At other times the reduction of externalizing defenses such as the conscious or unconscious blaming of others leads many individuals to want to further resolve their difficulties, in individual treatment or psychoanalysis. Exceptions, of course, to such family evaluations are patients who are single and living apart from their families. They are, in fact, often between families, between their family of origin and their family of procreation, or between marriages. Also, married patients who come primarily with clear intrapsychic conflicts such as a success neurosis, depression following a loss, and symptoms of anxiety, with little involvement of others with their symptoms (i.e., with minimal secondary gain) are generally more suitable for individual treatment. Unless a patient is such an obvious candidate for individual treatment, I almost always first see the family or marital couple in the evaluation stage. This follows Freud's 1905 warning to look carefully at the "family circumstances" of a patient and Dr. Harcourt-Reilly's rationale for family consultations in Eliot's *The Cocktail*

Party that "it is often the case that my patients / Are only pieces of a total situation / Which I have to explore. The single patient / Who is ill by himself, is rather the exception" (Eliot 1952, p. 350; see chapter 2, this volume).

I shall briefly present two cases that illustrate the use of family therapy in dealing with a family crisis and, in the second case, preparing individuals for more intensive individual therapy. Both cases began as family life cycle crises. The first was around what has come to be called the "empty nest" syndrome (the Ns). The second couple (the Ps) came with conflicts around having a first child.

The Empty Nest

Mrs. N., a woman in her mid-forties, was referred for individual therapy because of depression and marital difficulties that included her "provoking" her husband to beat her. When she called for an appointment, I suggested that initially she and her husband might come together. She claimed that that was unnecessary as "she was the problem" and that if she were less depressed the marriage would be fine, as there was nothing wrong with her husband. I indicated that she might be right and that she might benefit from individual treatment, but that nonetheless I would prefer to see them together initially. She agreed to ask her husband, who came quite readily.

They were an attractive couple; she dressed more elegantly than her

husband. She took the lead in the sessions and the responsibility for their difficulties. Their four children ranging in age from seventeen to twenty-four were now all out of the home. Their oldest son had just recently been married. Their twenty- four-year-old marriage had had many ups and downs, precipitated by job changes and many moves over the years. She had "sacrificed" herself to his erratic work schedule, which included frequent periods of travel.

The past six months of depression and marital fights made separation seem inevitable. If not, someone "might get killed," as their fights ended with each one black and blue. The fights tended to occur in the bedroom after some drinking. A sexual advance on her part was seen as a demand for genital performance. This led to his withdrawal and her becoming violent and accusing him of longstanding intermittent impotence and not loving her.

Her past history was remarkable in this regard because her biological father, a "wife beater," left his wife, the patient, and her sister when she was an infant. Her mother remarried a man who was initially quite good to her, "warmer than my mother, who was cold and always working, though he also beat me for wrong doings." By the time she reached adolescence, her stepfather began forcing himself upon her sexually. This lasted several years and was accompanied with threats that if she were to tell anyone he would have her put away. Her initial willingness to come for individual therapy

saying there was nothing wrong with her husband paralleled the experience of her adolescence. She would not expose her stepfather's sexual advances or her husband's sexual dysfunction. She wreaked symbolic revenge on her stepfather and self-destruction upon herself in these dramatic nighttime brawls. She thus acted out her guilt over her sexual and aggressive impulses.

We know that such interaction requires the neurotic complicity of both partners. Mr. N. had, as is so often the case, certain parallel childhood experiences that facilitated the collusion of such mutually reinforcing self-destructive trends. He was an only child whose father died when he was an infant, and he had a stepfather briefly when he was about 4. After that he lived with his mother and maternal grandparents. He saw nothing unusual about his childhood, felt it was a happy one, and did not feel it had any relevance to his present life. In the once-weekly conjoint sessions he was extremely deferential and saw their problems as primarily caused by his wife's "multiple personalities." They would have a good week followed by another disastrous blowout as she turned from a loving person to her other personality, "the witch."

Her "sexual needs" were examined more closely and acknowledged as primarily wishes to be close and nurtured. When he withdrew sexually, she felt he was a "stone," like her mother, thereby provoking her violent rages. As she began to make these needs for nurturance rather than genital satisfaction

more explicit, Mr. N. was less threatened and far more responsive. If he were not under pressure to "perform," he could enjoy their sexual relations. By the fourth month of treatment this change in their sexual interaction had generalized to an unprecedented and prolonged, for them, period of good feeling, as well as a sense of renewal of their marriage. They were redecorating their home and felt like newlyweds. Her menstrual period was two weeks overdue, and she thought she might be pregnant, almost repeating the beginning of their marriage when she became pregnant in the second week.

They felt so good about their relationship that they wished to continue without further treatment, to "cut the cord" of dependence upon me. This precipitous termination seemed in keeping with the other many dislocations in their marriage. Should they return, if the improvement does not sustain itself, they will have had the recent period of unprecedented good feeling as an experience of possibilities they had not thought possible. To have seen her as an individual patient, as she was referred and as she requested, would have colluded with her definition of herself as the bad one or the victim. In their last session when I asked her about that, she said that even though she had asked for individual treatment, she felt sure the therapist would have sooner or later involved her husband. Their six months of severe difficulties began the same month as the marriage of their oldest child and when their youngest was about to leave for college. They were for the first time in

twenty-four years and the only time in their marriage left alone together, just the two of them. At such transitions it is often better to see all the persons involved. With Mr. and Mrs. N., after the crisis abated there was little interest in delving any further. They were delighted with the positive changes and eager to terminate therapy. I left the door open should they feel the need for further work.

We turn now to another developmental, individual, and family crisis, this time around the readiness to start a family.

On Not Starting a Family

Mr. and Mrs. P. both in their late twenties came after seven years of marriage. Mrs. P. was pregnant and wanted to have their child. Her husband, a lawyer working for the government, did not want the child. In the first session, with their immediate conflict pressing, Mr. P. took time to note that he had an "additional neurosis." His parents had divorced when he was seven, and he grew' up with his mother, a "powerful matriarchal" grandmother, and a very resented younger brother. He had always thought that his father had abandoned the family but found out later that he was kicked out for philandering, by the grandmother.

Mrs. P. in the same session expressed her fear of yet "another abortion." She had had one when she was about to start college and met Mr. P. shortly

thereafter. He was very supportive and comforting at the time. He had just been through a similar situation as a girlfriend of his had just had an abortion. They seemed united by this shared experience. As therapy developed, this shared experience had its deeper counterpart in that she also had a younger brother toward whom there was marked, though more unconscious, resentment.

They came to a decision about the pregnancy rather quickly. He felt unable to become a father at the time, and she felt she was "the stronger" of the two and could survive another abortion better than he could manage fatherhood. They agreed that they needed to better understand what had led them to this juncture, and they started marital therapy.

He was having casual affairs at the time, which he stopped when the therapy began. During the course of a year's treatment Mr. P. came to see that he was retreating from fatherhood out of guilt over his oedipal success and recalled breaking down in tears at age twenty when his mother remarried. His first dream in the therapy was that he was sitting in my chair while a high school rival sat in his chair making love to his wife. Becoming a father was simultaneously equated with being ousted by a rival. Just as George in *Who's Afraid of Virginia Woolf?* (see chapter 3) could not become a real father less he fall victim to projected patricidal impulses, Mr. P. was tempted to remain childless. The unconscious passive yearnings toward the father in this conflict

could not be resolved in the marital therapy. This became more apparent when later in the year he somewhat compulsively resumed his extramarital affairs despite a general improvement in the marital relationship. This finally brought the marriage to an end, with a sense of sadness and relief for both of them as well as an awareness that they each had individual problems to work out. Throughout the early phase of treatment they felt they were married to the wrong partners. She felt he was too passive and unreliable, and he felt she no longer "turned him on." By the end of a year of treatment he had a wish to overcome his own conflict and saw the necessity for a personal analysis, which he subsequently began upon referral to a colleague.

Mrs. P. was less convinced that she had a comparable neurosis but agreed to continue in once-weekly psychotherapy, where she began to see her own retreat from oedipal strivings.

Her first dream also dealt manifestly with oedipal wishes. She was giving a party in her mother's house, and she was in charge. Her mother was not in sight. Guilt over these wishes in a subsequent intimate relationship led her to tolerate the occasional "straying" of her friend. Again she saw herself as the "stronger one," and her friend who "needed" these outside relationships as reflecting the general weakness of men. This rationalization masked her masochism in "losing" to the other women.

Mr. and Mrs. P. came to treatment as so many families do when facing a life cycle transition. Within a relatively short period their respective, well-internalized neuroses became manifest, and they saw the need for individual treatment. With the full span of adult life ahead of them they were more motivated to resolve underlying conflicts than the Ns, who, having launched their four children, longed for a harmonious "empty nest" phase of their lives. They never fully acknowledged that they had any individual problems, and should they return for further help, the family modality would again be most appropriate.

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