Men in Marital Therapy

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> The greatest ordeal in life is marriage—it is the central focus for enlightenment and the natural therapeutic process in the culture.
>
> —Carl Whitaker

Men are often more deeply involved in their marriages and families than is apparent. If masculine inexpressiveness and feminine symptom expression blind therapists to a couple's commitment, therapy will be greatly hindered. It is the marriage that is potentially the most therapeutic relationship; any intervention should recognize and facilitate this rather than ignore or try to replace it. When therapists recognize this, they are prepared to see caring, commitment, and hope where there appears to be only pain, conflict, and alienation.

Psychotherapy is a verbal, dependent, nurturing, and expensive experience. Therefore, women are traditionally allowed to want psychotherapy and men are not. If a man seeks help, especially from another man, he experiences himself as weak. Men, and their wives, are frightened by men not being strong and silent, so they silently conspire to protect the man from these feelings. Men do this by labeling wives (or children) as the problem, by providing them with symptoms, and by sending them for help. They do not mind if wives spend all that money; women are expected to spend money, men to conserve it. Women also spend words and feelings, and men conserve them. How nicely role expectations create conflict.

Assumptions

First, all symptomatology is part of a relationship complementarity. If one partner shows a symptom, this serves a relationship function, and the spouse will help keep the symptom in place. This helps to avoid labeling either partner as "patient"(usually the wife) or "villain" (usually the husband). It also makes it imperative that couples be seen together in therapy. Seeing one spouse alone, usually the wife, leads to maintenance of the role set-up or to divorce.

Second, couples come for help most often when trying to accomplish a transition in the natural development of their family. The "problem" may have existed for some time, but professional help is sought when it is serving to delay a stage of growth. These stages, according to Milton Erickson, are courtship, marriage, childbirth and dealing with the young, middle marriage, weaning parents from children, and retirement and old age (Haley, 1973). The case studies presented will relate to two of these stages.

A word of caution: This chapter is written from the point of view of a male therapist seeing heterosexual married couples. The basic principles will apply in other situations. These basic theoretical principles follow and will be illustrated through case studies. The two theorists who have had the most impact on my work are Virginia Satir and Carl Whitaker.

Theoretical Principles

VIRGINIA SATIR

In her classic work, *Conjoint Family Therapy,* Virginia Satir delineates a number of basic concepts that apply to work with couples. These concepts are family pain, the identified patient (IP), homeostasis, family triangles, and metacommunication. In addition, her thoughts concerning the appearance of symptoms and the inclusion of the absent parent will be useful to cite here.

Amending her definition of identified patient to focus on one of the marital partners, we have "a *spouse* who is most obviously affected by the painful marital relationship and most subjected to *family* dysfunction." This symptom carrier is "sending an SOS about the marital pain and resulting family imbalance; her/his symptoms are a message that s/he is distorting her/his own growth as a result of trying to alleviate and absorb the *marital* pain" (Satir, 1983, p. 2).

As stated, the IP in a marriage is usually the wife, fulfilling her societal role of keeper of the feelings. When the husband is the symptom carrier, it most often takes the form of alcoholism or physical illness, thus providing only an indirect entrance into therapy.

Satir further hypothesized that "when one person in a family has pain... all family members are

feeling this pain in some way" (Satir, 1983, p. 1). This is not limited to the symptom of pain. Again, when the children are not used as IPs, the most likely carrier of family pain is the wife. Even when the symptom is male alcoholism, this seems to dull his pain and increase hers.

Family (marital) *homeostasis* is defined by Satir as "a process by which the family balances forces within itself to achieve unity and working order" (Satir, 1983, p. 1). Thus the IP's symptoms and behavior not only serve an individual function, they serve to maintain a balance in the marriage. The fears seem to be of extreme marital disharmony, abandonment, or a severe breakdown in the non-IP spouse. The particular sense of the symptoms or behaviors can only be understood in terms of the relationship. The case study of Mr. L. and his wife will later provide an illustration of this.

The *family triangle* is a construct by which Satir describes how the spouses and one child (the IP) form a three-cornered structure to alleviate, minimize, or divert attention from the marital conflicts. Again, this serves the purpose of preventing fantasized or real catastrophe resulting from intimate spousal interaction. The therapist (especially the male therapist) who innocently (naively?) accepts the IP wife into individual therapy is forming a "therapy triangle." Intimacy and energy are diverted into the client-therapist relationship, and "successful" therapy often leads to divorce. It is important to remember here that divorce is often a way of maintaining certain structural aspects of the marriage. Thus the therapist can serve the marital homeostasis by keeping the wife in long-term, anxiety reducing therapy that promotes no individual change, or by forming an intense, "productive" therapeutic alliance that helps avoid catastrophe through distance or divorce.

The great power of these maneuvers can be understood only if *metacommunication* is understood. The denotative level of communication is the literal content. The meta-communicative level is a comment on the content *and* the nature of the relationship between the communicators. Therefore, when words say, "I will be glad to help you with your anxiety and feelings of low self-esteem, Mrs. Smith," the metacommunication often is, "We will continue to see you and your symptoms as the problem, and protect your husband from breaking down and abandoning you. In return, I would appreciate it if you would adore me as if I had great potency and wisdom."

Because these latter messages are nonverbal and partially, or wholly, out of awareness, they are

very difficult to respond to or change. When therapy is defined as couples therapy, a statement is being made on the meta-level of the importance of both spouses' participation.

CARL WHITAKER

Whitaker has four assumptions about marriage that underlie work with couples. They express his reverence for an optimism about marriage. They also convey his belief in the power of the marital system over the dynamics of the individual.

First, the choice of a spouse is "done with purpose and wisdom"(Neill & Kniskern, 1982, p. 164). This is accomplished on the unconscious level, and the reasons are therefore never totally understandable. This assumption should lead the therapist to appreciate the "rightness" of the marriage, and to understand the "joint responsibility couples have for all aspects of the marital relationship" (Neill & Kniskern, 1982, p. 164).

Second, marriage is "an attempt by the individual to complete himself or herself' (Neill & Kniskern, 1982, p. 164). There is deep yearning for intimacy and closeness, and marriage is the best chance to achieve this. Therefore, the "healthiness" or "viability" of a marriage is judged by its potential for intimacy. One can more easily accept many serious difficulties if this potential is seen.

Third, marriage functions at a primitive (unconscious) level most of the time, and does not need to be hampered by trying to make it orderly or consistent. For example, Whitaker would not see the need to teach communication skills to couples. While I do not take a stance quite as extreme as his, I strongly emphasize facilitating the natural structure and communications pattern of the marriage, rather than trying to impose a "right way" to relate.

Fourth, the pathology of the individual is not the focus. More specifically, he believes that "one partner carries the symptoms and the other partner carries the repression and stability" (Neill & Kniskern, 1982, p. 184) in the relationship. Therefore, no matter how extreme or obnoxious the behavior of one partner, the therapist should search until the system function of the symptoms and the stability are found. The case studies will serve to illustrate this.

Male Issues

Three recurring issues that confront male therapists and male clients in couples therapy are competition, sexuality, and adequacy. These themes will be indirectly addressed in the following case studies.

Competition has too often been seen in terms of victor and vanquished. Competition may be seen as two peers, most often friends, struggling together head to head. They experience their strength, and feel closer when the competition is over. Because verbal skills are in short supply, the competition provides a framework for learning to love each other. A usually unspoken rule is that the competition does not have a girl or woman as the prize.

This model has seemed to translate directly to work with couples. Male therapists often arm wrestle, figuratively, with the husband. This is an exhilarating, revealing experience that temporarily excludes the wife. It helps the therapist to bond, and to lay the foundation for resolving later differences. The case of Mr. and Mrs. P. provides a good illustration of this phenomenon.

This competitive bonding also seems to balance the sexuality that exists between male therapist and female client. Because the wife has been excluded from the male-male bonding, the husband feels less threatened when he is excluded from the male-female bonding. In addition, since the sexuality is experienced in the husband's presence, his fantasies do not tend to enhance it unnecessarily. Most often, the sexuality is acknowledged in some humorous way. One woman related a "Dear Abby" column about a therapist who asked his female client to take off her clothes in the eighth session. When I asked, "What number session is this?" we all laughed and never needed to address the issue any further. The primary function of addressing the sexuality between male therapist and female client is confirmation of its existence for the client, and usually requires only brief attention.

Male adequacy is often tied to competition and sexuality, but is best understood in therapy in terms of mutuality. Client and therapist can only be adequate together; if one feels inadequate, both do. The model for this is parental, rather than peer—parental, as in delight and approval given in response to a son's accomplishments, especially when they surpass one's own. When male clients assert a direction for their marriage contrary to one that the therapist has been fostering, one ought to feel like a proud parent

witnessing a son's move toward independence.

The issue of adequacy seems also to be addressed effectively when feelings of inadequacy are shared openly. Husbands are often surprised by how bewildered and overwhelmed the therapist may feel in the sessions, but relieved as well to find that another man does not have all the answers for him and his marriage.

In my experience with couples, an issue that has not been a central one is commitment. Only when two people have not yet "coupled," or are about to "uncouple," does it get much attention. Men are consistently as committed to the relationship as their wives. If evidence of the commitment is sparse, the couple is helped to rediscover it. I have rarely been called upon to help a couple create it.

CASE 1: MR. AND MRS. P.

> Bad fathers make it easier for the kids to leave home and family.
>
> —Carl Whitaker

Mr. and Mrs. P. suffered for 25 of their 30 years of marriage before they sought help with a stage of development. Mrs. P. had been in individual therapy for two years with another therapist. She was involved in severe marital and family problems, but her husband had refused to come into therapy. The individual therapist had referred them to me, and they finally came for an initial consultation. Mrs. P. was friendly, gracious, and obsequious, while Mr. P. presented an extremely belligerent and hostile stance. His nonverbal message was, "I'd rather be anywhere than here; if you're not careful I will walk out; this certainly is our first and last meeting."

My own internal response was complex: I first thought, "I'd love to tell this mean S.O.B. to leave." That felt good; it helped me feel strong enough to tussle with him. My second thought was, "How can I connect with this man?"; and I began searching for parts of me that might empathize with him. As we began talking, I decided that letting them tell their story and show their relationship by talking to each other would be futile because of the alienation between them. I decided instead to alternate as an individual, person-centered therapist for each of them. It seemed that hope would come from a sense of

empathic response and connection with me, rather than from their own relationship. I wanted both of them—but especially Mr. P.—to feel that I understood them because we were similar inside. As a pre-termination discussion later indicated, this proved to be a fortuitous choice.

Mrs. P. began by telling of their long-term squabbles, most involving conflicts over the children. She presented herself as a soft, sympathetic mother. Mr. P. responded by confirming her implied picture of him as an unreasonable, raging bully. He cursed his children, became red-faced and rigid, and seemed to be frightening his wife. I wondered, "When have I felt or acted like this man? What has pulled the monster out in me?" Memories came immediately flooding in, of times when I was trying to discipline my children and be a "good father." When my wife saw me being too harsh, she became extra soft and permissive; an immediate coalition of mother and children versus father resulted. At these times I felt chastised, guilty, and, most important, on the outside. With this image, it was relatively easy to ally with Mr. P. When experiencing his guilt, hurt, and helplessness at being put on the outside, partly in response to his own excesses, I could easily understand his rage and manner.

As I reflected his feelings, I also used my tone of voice and choice of words to show him glimpses of the harsh, rageful husband/father in me. This was very risky for me; I don't usually show the negative sides of myself that quickly. However, it proved worthwhile. I began to feel a bond forming between us. By the end of the session he had relaxed, and the couple decided to continue therapy.

Mr. and Mrs. P. stayed in therapy for just over a year, attending weekly. They worked on resolving their great divergence over their children, and moving through the "weaning parents from children" stage of family development. We focused on helping Mrs. P. become angrier and setting more limits with the "children," some of whom were still dependent on the P's even though they were in their twenties. A major transition came when the parents decided to move out of state, leaving their six oldest children, aged 19 and up, to fend for themselves.

In a session a few weeks before termination, Mr. and Mrs. P. discussed their marriage, Mrs. P.'s individual therapy, and our therapy relationship. They presented a poignant picture of the breakdown of their marriage relationship. After two of their children had been born, the closeness that they had initially experienced began to disappear. The economic, physical, and emotional stresses of raising a

family led to conflict and alienation. Mrs. P. found herself going to the children for comfort, and Mr. P. found himself alone, on the outside, usually seen by the rest of the family as the "bad guy." He related this in a soft, vulnerable, almost pleading tone. He was both mourning what he had lost, and relieved and glad that he and his wife had regained some of this closeness.

She related how individual therapy had helped her, but had also brought her to the brink of divorce. She had reached a point where she would have left if he had not come to therapy and changed. She then asked why he had been so resistant to therapy. He related that he had again felt on the outside, labeled as the bad guy. This had been exacerbated when the individual therapist told her not to talk with her husband about therapy. Her therapy had begun to feel like an affair to him, with the therapist preferred over him. Amazingly, she responded by saying that although she wasn't having an affair, she would have chosen therapy over her marriage. As deprived as he was on the outside, she was just as deprived on the inside. Therefore, with her children almost grown, she needed them to be close again, or she would have had to leave for her own survival.

I then asked him about our therapy. He remembered his resistant feelings entering therapy, and reminisced about our first session. He stated that he had trusted me from the beginning, that he didn't feel that I was on his wife's side. I replied that I had sensed his trust, and his pleasure at seeing my "son-of-a-bitch" side. He laughed, and confirmed my perceptions, saying that he had come in prepared not to return. He had changed his mind when he felt that I understood him and that we were alike.

MR. AND MRS. L.

Mr. L.'s first question when he came into my office was, "Am I in a midlife crisis?" He was depressed, most notably over his inability to motivate himself in his work. He was also disturbed by the fact that his wife was confused and upset by his depression and lack of motivation. He presented a tentative, insecure manner, and was clearly afraid to present himself in a definitive way. He was 41 years old, had been married for 9 years, and had a 4-year old daughter. He was in the process of leaving a successful job, and starting his own business.

Although the term "midlife crisis" accurately described the inner experience of the person

involved, “mid-life transition” more effectively portrayed the developmental stage being traversed. “Crisis” focuses on the feeling of “ending,” while “transition” also captures the sense of “beginning” of a new experience. Two interpersonal aspects of midlife transition for married men are a newly highlighted need for acceptance from their wives, and a need for a feeling of commonality with other men. Because of the role expectations men carry, many recognize this latter need much less readily. With this in mind, I decided to talk about my own midlife experience with Mr. L. in our first session.

I revealed that the most significant part of my experience of turning 40 was that I no longer had a sense of an older generation supporting me. My parents are alive and healthy, and I had not depended on them in any significant way for many years. However, suddenly I was more aware that there was no one to take over for me. This awareness was both frightening and exhilarating; it made me feel very alone, but also served to push me to seek more closeness and comfort from family and friends. I also told him that I had begun thinking about my conception of maleness, and my demands on myself. I related that this process helped me to feel stronger, more capable of taking the responsibility for myself, and sharing the responsibility of my family.

As usually happens, my openness stimulated similar self-disclosure in my client. Mr. L. revealed that his parents had both died within the past three years, his mother less than a year ago. He stated that though he had not been aware of it, he had been feeling isolated and without support. His mother had lived with his family during the last year of her life, and her struggle with illness had become very much a part of his family life. As he talked, he realized that he had not given himself a chance to mourn her properly. This awareness allowed him to continue and complete his mourning, both in our sessions and at home.

One ironically troublesome aspect of his mourning involved his inheritance. He had inherited a few hundred thousand dollars. At about the same time he had decided to go into business for himself. He had been slow to work at the business, and was concerned by his lack of motivation. Specifically, he worried that he was too dependent on his inheritance, and would use it instead of his own energy and initiative.

He continued to talk about previously unexplored feelings when he returned for the second

session. Before the birth of their first child, Mrs. L. worked in a professional capacity in the same company as Mr. L. She left her work to raise their child, and they were now planning to have a second. This set of circumstances left Mr. L. feeling all the more alone, burdened with being the sole "breadwinner." Because his wife had been successful herself, it was especially painful and confusing when she doubted his capacity to succeed.

He also talked about his father and father-in-law. He portrayed his father as a somewhat frightened man, definitely not a risk taker. When a challenge had come along, economic or otherwise, he had seen his father as very frightened, almost overwhelmed. His father-in-law may have felt as his father had, but he dealt with his fears differently. He provided a very secure, although somewhat narrow and rigid economic and psychological environment for his children. He did this by staying in the same government position for 40 years.

Mr. L. reported that these two role models compounded his feelings of inadequacy. He feared becoming frozen like his father-in-law, and failing as his father had. He also felt that his wife was getting very anxious because he wasn't providing the same worry-free environment that her father had provided.

Mr. L. was seeing himself as unmotivated, inadequate, and depressed, and he feared that his wife had also begun to doubt him. He had attempted to reframe this experience, calling it a "midlife crisis." At this point in the therapy, I decided to expand on his reframing to help ease his burden. I stated that he and his family were really attempting to accomplish three developmental tasks at the same time. The three were the stage of childbirth and dealing with the young, mid-life transitions, and the grieving process. I emphasized that three were more than anyone could accomplish easily. He responded with recognition and relief, and went on to discuss past transitions in his life.

When Mr. L. graduated from high school, he wanted a year off before starting college. Family pressure and fear of risk taking forced him to abandon his plans and enter a local college. He performed poorly, and temporarily saw himself as a failure. His advisor at the college reinforced this perception, telling him that he probably was not qualified for college at all.

He was initially very discouraged, and eventually left school and went to work. He then returned to

school at a university away from home, did very well, and proceeded to get a graduate degree. He further reminisced about returning to his original college to see the advisor who had discouraged him. He intended to show him how mistaken he had been. Even though the advisor had left the school, Mr. L. was still able to experience his "moment of triumph."

After this recollection, we explored the relationship between the young man that he had been, and the person that he had become. He quickly portrayed himself then as independent, willing to follow his own ideas about himself, and as productively free-spirited. He was able to see his initial "failure" as an assertion of self, as a way to have the year off that he needed.

We then drew a parallel to his present situation. His lack of activity was redefined as taking another year off. He needed this time to grieve and to rediscover the parts of himself that he now needed. His depression occurred because he had turned the task of rekindling his self-esteem over to his wife. This redefinition excited Mr. L., and gave him a sense of relief, but was not sufficient to complete his therapy. Focusing on the last stage of therapy will demonstrate why this is a case study in couples therapy.

Systems theory would predict that unless the changes in effect and perception begun by Mr. L. were accompanied by contextual changes, the power of the marital homeostasis would negate the individual changes. The marital pain must be relieved so that the symptoms no longer have a function. Therefore, Mr. L. had to bring his wife into therapy to help her to reinforce his growth rather than his symptoms.

Mr. L. shared some of the content of the sessions with his wife at home, but saved the more anxiety producing issues for the safety of therapy. When he told her the meaning of his inactivity, lack of motivation, and depression, she responded with interest but with some doubt. She talked of her own fears, and her need to have him talk about what he had been experiencing. As his story continued to unfold, she shared more about her own experience. She focused on the contrast between her ultra-secure childhood, and the changes Mr. L. kept making in his work. Although she clearly saw their past as successful, his recent inactivity seemed different to her. She mentioned that the death of his mother, with whom she had become very close, left her feeling alone and grieving.

As their interaction continued, she relaxed more and more. Finally, she told him that she could be patient with his process if he would share it with her. She didn't need him to lessen her anxiety by being

an efficient "breadwinner" like her father; in fact, she had chosen him for his willingness to be creative and adventuresome. However, when he did this silently, she felt alone and vulnerable. He was ready to hear this, and used it to solidify his regained sense of self. Responsibility for his self-concept was his again, with the support of his marriage.

Techniques

Avoidance of the "therapy triangle" identification with male issues, and attention to family developmental issues were crucial in helping Mr. and Mrs. P. In addition, two other techniques were used. First, the insertion of oneself into the relationship as a true intermediary, that is, to reflect one spouse's feeling to the partner, then helping the partner understand the underlying vulnerable feelings that are masked by confusing or hostile words. For example, when Mr. P. would say in a rageful voice, "You always take the kids' side! " the therapist might say to Mrs. P., "I feel so angry and hurt when I become the 'bad guy' over and over. " Always ask the spouse spoken for to correct any misrepresentation; then check the partner's understanding, and relay the response back the other way. This is done instead of teaching communication skills, because the couple has lost contact with each other, not because they lack sophistication as communicators.

Mr. and Mrs. P. talked about the early part of their relationship just before termination. Usually this is asked of couples in the first session, which helps to assess the strength and feeling in their initial bonding. This is the major criterion for the later success of marital therapy. The second advantage of this re-exploration is that the couple tends to re-experience both the positive aspects of their relationship, and the high intensity of feeling of that time of their lives. This often helps a wife become reacquainted with the feeling man underlying the cold, unavailable one that she has felt stuck with in recent years.

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