SISTEMSKA DRUŽINSKA PSIHOLOGIJA - SKOZI PSIHOTERAPEVTSKO PRAKSO

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Carole Eigen, licencirana ameriška psihologinja in družinska terapevtka je predstavila pričujoč prispevek v okviru programa študija iz klinične psihologije na Oddelku za psihologijo Filozofske fakultete v Ljubljani in dovolila, da se predstavljeno delo objavi v naši reviji.

Predstavila je psihoterapevtski proces zakonskega para iz svoje prakse, skozi katerega opiše teoretične predpostavke in značilnosti družinskega sistema zakoncev skozi razširjeno družino in več generacij. V jasnem jeziku, ki ga avtorica uporablja, lahko bolje razumemo, kako se tako zdrave kot tudi problematične lastnosti obeh partnerjev dopolnjujejo in nadomeščajo in na kakšen način sta si partnerja vzdrževala sistem odnosov, zaradi katerega sta poiskala strokovno pomoč.

ABSTRACT

Carole Eigen, Ph. D., a licensed American psychologist and family therapist, presented this paper as a part of the programme of studies in clinical psychology at the Department of Psychology at the University of Ljubljana. She kindly allowed to publish this article in this journal.

Theoretical and clinical background is presented through the psychotherapeutic process of a marital couple from her private practice. It is clearly demonstrated how healthy and problem making attitudes in a family system fit together and how a problem making system of communication and relationship holds itself unless professional help is been found.

FAMILY SYSTEM'S PSYCHOLOGY - THROUGH PSYCHOTHERAPEUTIC PRACTICE

This case study of a marital couple is representative of my theoretical and clinical background in the area of family psychology. Family systems theorists postulate that symptoms of psychological distress are selected and maintained by the relationship context in which they are embedded. Clinical efforts to alleviate psychological distress must create change in the interactions among the persons currently involved in maintaining this distress (Green &Framo, 1981). The goal of this conjoint couples psychotherapy is to move toward a reorganisation of the structure of the relationship by altering the characteristic pattern of interaction and the style of communication between the spouses.

The theoretical framework that underlines this couples' treatment addresses the relationship between intrapsychic and interpersonal spheres that influence marital adjustment. Framo (1972) has utilised concepts from object relations and systems theory to describe how unresolved intrapsychic conflicts, derived from dysfunctional patterns in the original family, are acted out or defended against in the interpersonal dynamics of the couple. Psychological symptoms result from the conflicts between individuating, autonomous strivings, and enmeshment within the original family system (Framo, 1976).

Bowen's system theory bridges the gap between psychodynamically oriented approaches which emphasise self development, intergenerational issues and significance of the past, and systems approaches which restrict their attention to the family unit as it interacts in the present (Goldenberg & Goldenberg, 1985). Bowen (1978) developed methods to direct couples back into each spouses family of origin to work through unresolved conflicts that are interfering in the current marital relationship.

The theoretical orientations and methodology described by Bowen and Framo were used to treat this couple. In addition, Kaplan's (1974) method of combining behavioral techniques with psychodynamic couples therapy for the treatment of sexual dysfunctions was useful when a specific sexual issue emerged later in the therapy process.

COMPARISON TO OTHER TREATMENT MODALITIES

Conjoint treatment of marital couples focuses on specific relational problems. The therapeutic process is more structured in comparison to psychodynamic modalities most often used in the treatment of an individual client. Family of origin history is gathered by objective questioning rather than by free association, dream analysis, or introspection. Transference toward the therapist is not encouraged or analysed. The therapist takes an active, directive stance rather than a neutral interpretive position.

The methodology employed in the treatment of couples has some similarity to cognitive behavioural modalities in that conscious thoughts are believed to play a prominent role in mediating emotion and behavior. However, the emphasis is on altering the current interactions and expectations of the spouses through the use of rational exploration of family of origin roles, and communication styles.

Behavioral therapy, based on social learning theory, has also been modified to apply to the treatment of couples. Techniques similar to biofeedback have been found most useful to treat sexual dysfunctions. In contrast to the traditional behavior therapist who actually conducts the learning process, the role of the therapist in this modality is to coach the partners to act as therapists for one another by reinforcing instead of punishing each other's desirable behavior, and conversely by ceasing to reinforce sexually destructive responses (Kaplan, 1974).

In summary, conjoint treatment of couples utilizes aspects of psychodynamic, cognitive and behavioral treatment modalities. Modifications in the focus of treatment and therapist's role have been made to address the relationship as a system, rather than the personality structure of the individual.

ASSESSMENT OF SYSTEM DYSFUNCTION

The marital system is assessed in a series of clinical interviews during which diagnosis and treatment are inseparable. Although diagnostic instruments are being developed to assess family interaction patterns, they are not yet practical for clinical usage (Eigen & Hartman, 1987).

The content and the mechanism of the assessment process are consistent with the goal of altering the structure of the couple's interaction pattern. The information needed to formulate a treatment plan includes (1) the history of the presenting problem (who has the symptom, when it originated, how it developed, how the family reacted), (2) history of the nuclear family (nature of spouses courtship and marriage, impact of children), (3) history of each spouses family of origin (sibling position, degree of differentiation from the system) (Goldenberg & Goldenberg, 1985).

A genogram or structural diagram is constructed to depict the family's relationship system over three generations. The dates of birth, marriage, separation, divorce, death, geographic moves, and periods of ill health, are schematized in a family tree fashion in order to obtain a systematic picture of the family's key life events (see Appendix A, p.). The process of collecting historical data through the use of this orderly procedure is consistent with the therapist's role and objective to remain clear of the couple's emotional turbulence and enable each spouse to define him/herself in relationship to each other and the issues in a rational manner.

Other observations that are important for assessment of the couple's needs are the spouses' commitment to the marriage, whether they basically love each other, their style of fighting, the quality and quantity of their sexual relationship and their motivation for therapy (Framo, 1981). The couple's attention is then turned away from the presenting issue in order to explore the emotional processes and tensions between them to which each is reacting and contributing.

OVERVIEW OF THE CASE

Referral

This couple was referred in April, 1986 by a psychiatrist whom they consulted after a two week period of separation. The separation was precipitated by an argument in which the husband struck his wife. Marital therapy was requested by the couple because the wife was hesitant to resume living together and the husband was intensely concerned about the viability of their marriage. The assignment of each spouse to a separate therapist seemed contraindicated because of their pressing need to focus on the marital relationship. Neither spouse had sought psychological treatment prior to this marital crisis and there were no drug or alcohol problems.

DSM - III - R Diagnosis

Both husband and wife were given a diagnosis of Adjustment Disorder with Mixed Emotional Features (DSM-III-R Axis I: 309.28). The onset of anxious and depressed symptoms in each spouse was sudden and coincided with the marital conflict.

The husband's characterological traits which caused social and subjective distress are consonant with a diagnosis of Personality Disorder NOS (Axis II:301.90) with dependent, obsessive compulsive and avoidant features. A diagnosis of the psychosexual disorder, Premature Ejaculation (Axis I: 302.75) was made toward the end of the first year of treatment.

Demographic Data

The wife, 32 years of age, is tall and substantially overweight, yet, she maintains an attractive and carefully groomed appearance. She is employed as a school guidance counsellor and presented herself as competent and assertive in her approach to the initial interview. The husband, 35 years of age, is as tall as his wife, but of more slender build. He attended college only briefly, and is employed as pressman for a major newspaper. The husband stared intently at his wife who sat partially turned away from him. He was visibly anxious, and hesitated to make eye contact with me. On first impression, the wife seemed more formidable than her husband.

History of the Presenting Problem

In exploring the presenting problem, the wife tended to smile incongruously while she discussed the conflict between them. She reported that angry interchanges were a recent occurrence and that she is not a good fighter: "I say what I think and then when it doesn't go anywhere, I leave the room." The last argument escalated to the point of name calling. The husband struck his wife when she attempted to close the bedroom door behind her. She was outraged and made arrangements to leave the house immediately. She remained at her married brother's home during the next few weeks.

The husband expressed embarrassment and surprise at the extent of the anger between them and his uncharacteristic loss of control. He stated clearly that he did not want to be separated from his wife because: "She is part of me." He felt helpless to influence her decision in spite of his anxious wish that his wife return home. The wife expressed doubt about remaining married; although she was no longer concerned about her safety, her decision to return home and attend couples sessions was made reluctantly.

Marital history

The wife attempted to represent the couple by speaking for them both when questions relating to their marital history were posed. The husband tended to sit with his arms and legs tightly crossed, furtively watching her. He volunteered little during these initial sessions, and expressed his opinion only when asked directly.

The couple had maintained separate apartments in the same building for several years before marrying two years earlier. Both are self-sufficient and have mastered the social tasks that are usually opposite - sex related. He cooks and cleans effectively; she is comfortable going places alone and managing money. In response to the question of what attracted them to each other, the husband stated that he was impressed by his wife's friendliness and independence; she was attracted by his kind and thoughtful manner which reminded her of her brother. No mention was made of a physical attraction and questions pertaining to their sexual relationship were answered obliquely. Sexual contact has been disappointing and infrequent after the first year.

Both spouses experienced the loss of the same-sexed parent during adolescence. Neither the husband's German/English mother nor the wife's Jewish father objected to the marriage. The religious difference between the couple was experienced as the least of our problem". The wife reported that her husband is in "constant" contact with his mother, but that she seldomly sees her father. The couple made the decision not to have children prior to getting married.

Couple's current interaction pattern

The couple has developed a pattern of interaction which allows them to maintain both physical and emotional distance. They each express dissatisfaction because they have little in common but they are ambivalent about relating more intimately. The husband's ambivalence is revealed in these conflicting statements: "I prefer to work around the house and would like her to work with me," and then "I don't mind that she goes out all the time because we can't agree on how anything should be done." The wife's ambivalence is also evident in her statement: "He is always uncomfortable when we go out with my friends so I don't even ask him."

Distancing mechanisms include occupying different rooms and maintaining strictly enforced schedules for alternating household responsibilities. This "fairness" principle worked well before marriage, but now breaks down in times of stress. For example, the wife often becomes ill with bronchitis. This is sometimes met with solicitous attention from the husband, but at other times with unfavourable demands, such as that she sleeps on the sofa because her coughing disturbs him.

Husband's family of origin

The husband's family of origin was explored first in order to encourage him to participate more actively in the sessions. The husband described his parent's relationship as distant. His father worked as a pressman and then held a second job which kept him away from home. He reported that his father's temperament was similar to his own in that he seldom expressed his opinions or made decisions involving the family. The husband described his relationship with his mother in the following manner: "We were very close. She let me get away with everything." He was school phobic in elementary

school and continued to be excessively absent throughout his school career. His mother "worked this arrangement out" with school officials so that his absence was unprotested. He was well-behaved and managed to keep up academically, but he had few friends.

In his senior year of high school, the husband formed a brief relationship with a girl who became pregnant. They married, but shortly afterward his mother convinced him to annul the marriage. He never maintained contact with the child, but used the occasion of her birth to leave home and join the army. He said: "I had no rights because I had no interest; she's 17 years old now".

The only sibling is his sister, two years his junior. Mother and sister did not get along, but the father was able to intervene on the daughter's behalf. A significant recollection exemplifying this was of an argument between brother and sister in which the 16 year old son called his sister a name. The father became infuriated and struck his son who retaliated by striking him back. The father "stopped being angry and just went away". After his father's premature death from a stroke at age 52, the son inherited his union book and took his place at work. He was 19 years old and away in the army when his father died. He started, "I never made peace with him; I never even knew him". The mother remarried in 1980 which allowed her son to maintain more physical distance and establish his own residence. He describes his stepfather as a warm Italian man who lets his mother wear the pants.

Theoretical Formulation of the Husband's Family System Dysfunction

The husband's family of origin was dysfunctional in several ways. The parents werw unable to exercise their parental roles which resulted in a blurring of generational boundaries. The emotional divorce between the parents led to a mother-son alliance which made real the child's fantasy od dividing the parents and violating the incest barrier. The husband was unable to differentiate himself from this original merger with his mother and move toward emotional autonomy. The symptom of school phobia, in which the family's rules superseded the societal injunction to attend school, permitted him to remain at home and close to his mother. The excluded father became rivalrous with his son and the rage which erupted during the son's 16th year remained unresolved. The son responded with rage reactions to the abdication of sex role and the impotence of his father.

In the husband's undifferentiated family, there was no opportunity for the son to experiment with a wide range of flexible roles necessary for functioning outside of the family. As a result, he remained socially isolated and unable to choose a separate career path. When his father died, the son borrowed his identity still further by replacing him at his job. The emotional cutoff of father and son inhibited the son's resolution of his overinvolved relationship with his mother.

The husband repeated his family relationship dilemma in his marriage. He continues to yearn for merger with those he loves and views his wife as part of himself. He then feels possessed and traped and in danger of losing his personhood. He acts on the need to break away by engaging in self absorbing activities which are accompanied by a sense of isolation and depression. The violent episode between the couple which preceeded entrance into therapy was a repetition of the sudden outburst of rage between father and son.

Wife's Family of origin

In contrast to the husband's enmeshed mother-child relationship, the wife experienced a distant, competitive and angry relationship with her own mother. She perceived that her brother had the position of importance with her mother. Her father, who had been the youngest of 9 siblings, was still dependent upon his older sisters and was also unavailable to her. She maintained a better sibling relationship with her brother, who was two years older, and with her extended family, especially her mother's sister. This older aunt was the parenting figure for both the wife and her mother. The aunt raised the wife's mother when their own mother died prematurely. She is described as "not very warm, but you know where to stand with her". The wife described her mother as "a grabber" who always wanted something and was generous only with food which she provided by the family's delicatessen business. She stated, "The only time my mother took care of me was when I was sick and she brought me chicken soup. Then she acted like a mother".

The wife attempted to reconcile with her mother during the long illness which preceeded her mother's death. When she was 15 years old, she bought her mother clothes to enable her to attend a wedding. She shopped with great care and assembled an outfit, but her mother decided not to attend. She reported being unable to come to terms with their relationship: "I could never do anything right for her, up to the end. I was relieved when she died".

The wife learned to be socially appealing and successful with her peers. She spent her adolescence in the home of a friend. She later resolved her "family needs" by forming a close alliance with her brother and sister-in-law. However, this substitute parental relationship was marred by a jealous component which came to the fore when her brother's first child was born and she felt excluded from her special position.

Theoretical Formulation of the Wife's Family System Dysfunction

Generational boundaries were also blurred in the wife's family of origin. Both the wife and her mother were raised as if they were siblings by the mother's older sister. The wife was a parentified child who reversed roles with her immature mother. She attempted to combat this generational imbalance by developing somatic complaints, thus forcing her mother to stay in a parental role. Her mother then suffered a prolonged illness and early death which the wife was unable to mourn. The wife's father was still enmeshed in his family of origin and unable to assert his position as head of his own family. The wife remains emotionally cut from her father whom she regards with disdain because he is "too involved in self-pity" to recognize her needs.

The wife denies the intensity of her unresolved emotional attachment to her parents by acting more independent than she is. She uses physical distance and internal distancing mechanisms to control the anxiety resulting from these dependency needs. She longs for emotional closeness, but is unable to allow it. Instead, she continues to create substitute families from her social relationships. These more congenial relationships reduce the immediate anxiety, but leave her emotionally isolated under stress.

Theoretical Formulation of Couple's Relationship

During the process of exploring the family dynamics of each spouse, the current relationship structure and pattern of interaction between the couple became clearer. Both members of the couple had inadequate relationships with the same sex parent and lacked appropriate sex role modeling. The husband experienced his mother as domineering and engulfing, and his father as helplessly enraged and emotionally unavailable. The wife experienced her mother as critical and demanding and her father as self-centered and dependent upon his own siblings.

Each spouse's current role reflects their position in their family of origin; older overprotected brother joins with disfavored younger sister and they compete like siblings for scarce emotional resources. The husband took his family role as the dependent partner, while the wife holds the complementary independent, indifferent role she held in her family. The husband becomes the nurtured one who insures the continuity of the relationship and helps his wife conceal her own dependency by displaying it for her. When gratification within the relationship becomes nil, the wife attempts to reverse roles by developing physical symptoms, an acceptable means of gaining comfort because the symptoms are attributed to outside causes. This rapid reversal of roles reveals the basic picture of mutual dependency.

The husband chose a dominant female who is able to interact more successfully with the outside world in a pseudo-independent, almost masculine manner. He has found a parental substitute who is afraid of intimacy and also emotionally unavailable. The wife chose a nurturing male whom she hoped would replace her distant mother, and instead, confirmed her true expectations that he would be ineffectual and unable to meet her needs.

Initial Course of Treatment

The strategy in the initial phase of treatment was to explore the patterns of interaction in each spouse's family of origin in order to lessen the stress on the marriage and make explicit the way in which unresolved parental relationships were currently being reexperienced in the marital relationship.

The couple remained distant from each other during the therapy sessions and all signs of the angry struggle which originally motivated them quickly receded. Their hesitance to commit to active participation with me in the therapy process parallelled their reluctance to commit to each other and tolerate the anxiety of relating intimately. The husband gradually became less apprehensive and began to make direct contact with me by volunteering more information. However, the wife's dissatisfaction seemed to increase and she became more remote.

The therapy process was not well enough established to withstand a two week break in treatment during the summer. The couple formalized a

marital separation at the wife's initiative. The husband felt abandoned and returned to his mother's home. I referred the husband back to my colleague for individual treatment because he was depressed and socially isolated. His therapist suggested that he also join my therapy group. He remained in contact with his wife and used the support of the therapy group to reestablish his marital connection and loosen his tie to his mother.

Resumption of Marital Therapy

The couple reunited and sought to reenter marital therapy after five months. The wife's feelings about the extensive support system established by the husband and my dual role as group and marital therapist were explored. She experienced the group as her ally during the period of separation and expressed relief that her husband was facing difficult issues. She acknowledged her resistance to reaching out in this way for herself. The simultaneous treatment modalities served to make both spouses more available to the task of maintaining and exploring the marital relationship.

Treatment Strategy

The strategy was to keep the emotional system between the couple sufficiently alive to be meaningful and sufficiently toned down to be dealt with objectively. I maintained an active stance by questioning one spouse and then the other to ascertain their thoughts in reaction to the other's communication. Thus, they were able to remain engaged with one another and to hear each other without the usual tension that is automatically discharged between them (Bowen, 1971).

Tracing each partner's family of origin patterns in a conjoint process helped both spouses to recognize that the other's anger and disappointment has roots in parental relationships. The husband's experience of reentering his mother's home motivated him to actively engage in the task of establishing a healthier emotional distance from his overinvolved mother. The wife recognized the significance of this struggle and could now be supportive. The experience of marital separation also stimulated the wife to establish a more connected relatedness with her father.

Interventions into Family of Origin

The goal of the interventions into each spouse's family of origin was to explore how of these emotional systems operate and to facilitate the process of differentiation of self in relation to these systems. The husband was enabled to explore the possibility of shifting his "spouselike" responsibilities to his mother into his mother's present spouse by establishing a man-to-man relationship with his stepfather. He began to ask his stepfather for assistance with a construction project and increased the amount of time spent alone with him. The husband also structured his family visits so that meals were planned with his wife in their marital home. His mother's daily phone conversations were limited and he was able to enlist his wife's cooperation in taking calls that felt intrusive. He was able to confront his anxious feelings when his mother turned her attention to his sister by becoming interested in establishing his own sibling relationship.

The wife was encouraged to structure a "no demand" relationship with her father by requesting that he take her to lunch at regular intervals. She began to be aware of her automatic angry response to the perception that her father sought sympathy from her. She determined to keep her mother out of their conversations and establish a person-to-person interaction with her father. She began with neutral tasks such as seeking advice on an investment and proceeded toward more personal interaction by seeking information about the family situation while her father was growing up.

Each partner was relieved to be out of the focus of negative attention and was able to listen with empathy to the difficulties and disappointments in the other's attempts to make in vivo reparations with the remaining parent. The spouses became less alienated from one another and a mutual commitment to the marital relationship began to form.

Altering the style of communication

The couple's dysfunctional style of communication became apparent and was dealt with directly in session. For example, the couple reexplored the decision to have children. The wife was ambivalent and expressed fear of the demands that a child would make on her. She complained about the "hassles" and the commitment involved. She continued to raise the issue which demonstrated her interest and yearning, but she was unable to seek reassurance and encouragement directly.

The husband had a child for whom he failed to assume responsibility, thereby forfieting contact with her. His gulit and feelings of loss stimulated a desire to raise a child. Initially, he accepted his wife's ambivalence as if it were a final decision. She was enabled to invite his expression of feelings about wanting a child. He displayed resentment at having allowed her to decide this important issue for them both. The wife was relieved to learn that her husband was willing to make this commitment to their ralationship. He overcame his reluctance to take a position and broke the pattern of withholding his opinion and then harboring resentment which was expressed through passive aggressive behaviors.

The style of communication around decision making was examined many times with various relational themes to reinforce the notion that clear expression of feeling was possible and more satisfying than the symbiotic wish that the partner can know one's thoughts. On each occasion it was pointed out that this produces conflict because it challenges identity and masculinity.

Active interventions into specific complaints

The conscious complaints that the couple presented as unsatisfying aspects of their relationship were seen as fitting into their need to protect thei investment in their perception of one another (FRamo, 1972). For example, the wife's obesity was presented as unappealing by the husband. THe wife coutered with a revelation of her husband's sexual problem of prematre ejaculation. The treatment strategy was to deal directly with each of this presenting problems.

The couple was encouraged to embark on a joint dietary programme. The husband denigrated his obese wife because she demostrated an inability to discipline herself and indulged in overeating. It disturbed him that she was gratifeid by an indulgence that he could not allow himself. On previous occasions, she responded to his criticism by eating more. When she actively dieted, his vicarious participation came ti light when he began to sabotege the dietary plan by supplying firbidden foods. Open discussion which allowed each spouse to observe the part that he/she played in this interaction was then pursued.

The wife, likewise, had an unconscious investment in her husband's inadequate performance as a sexual partner. She was upset because of the unsatisfying sexual experience, but her ambivalence about his success was demostrated when direct therapeutic interventions were made.

Although it is often essenstial to work on sexual difficulities in the course of couples counseling, the decision to use prescribed exercises was made cautiously and represented a turning point in the treatment. The alternative solution was to refer the couple to a sex therapist which would isolate the sexual symptoms from the interpersonal struggle. It was decided to treat the sexual dysfunction as part of the symptomatology that the couple system used to avoid intimacy.

The sexual history revealed that the wife was easily aroused and able to reach orgasm. The husband had always experinced ejaculatory incontinence and his physician confirmed that this was without organic basis. The teratment plan was based on the hypotheisis that premature ejaculators do not clearly perceive the sensations premonitory to ejaculation (Kaplan, 1974). The therapeutic task prescribed (stop-start and squeeze technique) were aimed at teaching the husband to recognize preorgastic sensations and avoid being distracted by the process of sexual engagement with his wife. The wife's resistance became apperent when she encouraged violation of the prescription to avoid intercourse which led to continued failure.

Focus on the sexual dysfunction precipitated rapid and intense emergence of interpersonal issues. Resistances and disagreements which arose in connection with sexual exercises were metaphors for interpersonal issues that pervaded the totality of their relationship. The husband's symptom parallels his disposition to hold himself aloof in order to resist incorporation by a powerful female. He experienced his wife's requirement for ejaculation delay as an attempt to dominate him. During the sexual exercises, the husband wanted to receive the undivided attention of his wife. He reversed his symptom so that he became unable to reach orgasm during the manual stimulation employed in the exercises, but would continue to ejaculate immediately on penetration. Although he was dismayed at his failure of control and her frustration, his fantasy was that failure would lead to continued special attention. This infantile wish was frightening and repellant to his wife. In the context of the sexual exercises, she found him to be withdrawn from her and experienced his failure as deliberate withholding.

The sessions were spent in direct confrontation of the minicrises which arose as unrecognized fears and conflicts surfaced. The couple was enabled to argue constructively and openly in the sessions. Additional sessions were scheduled during this time to monitor the exercises and the emotional tension.

The sexual dysfunction was ameliorated when the emotional tension was brought under control and the couple was able to invest in a rational decision to master the symptom by following the directions in a mechanical fashion. In this way, the husband was able to recognize the sensations premonitory to ejaculation resulting in an increased period of penile-vaginal containment. The couple was able to tolerate the anxiety od sharing this intimate dilemma and experiencing greater closeness.

When the couple gained some mastery of this sexual symptom they turned their attention to planning for a pregnancy and negotiated expectations around this issue. The anticipation of having a child motivated the wife to continue to lose weight and gratified the husband by increasing the amount of sexual contact.

The couple continued to explore the themes of the parental relationships, sexual intimacy, decision making and social expectations and anxieties for several months longer. As they became more satisfied with one another, the husband was able to tolerate increased amounts of social contact. His success in the therapy group supported these efforts.

Evaluation of Treatment

The goal of altering the couple's relationship by introducing change in theri characteristic interactional pattern and their mode of communication was met to the followinf extent:

1. Each spouse made efforts to interact with his/her remaining parent with an increased sense of self-differentiation from the original family system. This process relieved pressure on the marital system and helped each spouse to establish more empathetic understanding of their mate. This enabled them to make a commitment to the relationship and the therapeutic process.

2. The decision-making process in the marriage was altered as the husband was enabled to communicate his opinions and his anger more openly. His level of anxiety and depression was lowered and he engaged in less passive-agressive behavior. The wife experienced relief to be able to rely on him and gradually let down her guard and began to seek his opinion.

3. The relationship became more sexual as the problem of premature ejaculation and associated conflicts were explored. The couple was able to cooperate in order to master the sexual symptom which increased their tolerance for relating intimately.

4. Other specific issues such as the husband's social anxieties and the wife's obesity werw also ameliorated. The participation in joint activities helped the couple to develop a basis for functioning as a unit in preparation for becoming parents.

These changes in the structure of the marital system enabled each spouse to invest constructively in their relationship so that thier marriage is no longer detrimental to the growth potential of each individual.

Ethical Issues

This case was conducted in accordance with the guidelines established by the American Association Standards for Providers and Ethical Standards (revised 1981). Attempts were made to respect the client's freedom of choice and their rights to knowledge about disclosure of information.

The clients were referred to me by my supervisor, Dr. Ferretti, whom they originally consulted. They were informed of my training and status as a permit holder. I obtained their permission, in writing, to share relevant information and tape record therapy sessions for the purpose of supervision and presentation of their case to the licensing board with all identifying information deleted.

REFERENCES

1. American Psychological Association (1981). Ethical principles of psychologists. American Psychologist, 36, 633 - 638.
2. Bowen, M. (1971). Toward the differentiation of self in one's family of origin. In: Andre, F. and Lorio, J. (Eds.) Georgetown Family symposia, a collection of selected papers. Vol. I.
3. Bowen, M. (1978). Family therapy in clinical practice. New York: Aronson.
4. Eigen, C. and Hartman, B. (1987). Replicating the factor structure of Family Adaptibility and Cohesion Scales II. Psychological reports, 60, 775-782.
5. Framo, J. (1972). Symptoms from a family transactional viewpoint. In: Sagen, C. and Kaplan, H.S. (Eds). Progress in group and family therapy. New York: Brunner/Mazel.
6. Framo, J. (1981). The Integration of marital therapy with sessions with family of origin. In: Gurman, A. S. & Kniskern, D. P. (Eds.) Handbook of family therapy. New York: Brunner/Mazel.
7. Goldenberg, I. and Goldenberg, H. (1985). Family Therapy: An Overview. California: Brooks/Cole.
8. Green, R. J. (1981). An overview of major contributions to family therapy. In: Green, R. J. & Framo, J. (Eds.) Family therapy: Major Contributions. New York: International Universities Press.
9. Kaplan, H.S. (1974). The new sex therapy. New York: Brunner/Mazel.