Psychotherapy with Psychotherapists

Treatment of Marital and Family Therapists

Florence W. Kaslow

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TREATMENT OF MARITAL AND FAMILY THERAPISTS

Florence W. Kaslow, Ph.D.

Some years ago the phone rang one afternoon and the following conversation ensued:

> P.G.: Hi! Any chance you have some free time tonight?
>
> F.K.: Yes, when would you like to come over? It's a free evening.
>
> P.G.: About 8:00 p.m. It will probably take several hours, so I'm glad we won't be hurried.

Since Phil[1] was a professional colleague with whom I was to present a paper at a conference, I assumed he was coming over to begin writing. For several weeks we had been trying to arrange a convenient time, and this had fallen into place well. Thus, when he arrived and indicated that he was having severe marital difficulties, and his intent in the phone call was to be making an appointment for a marathon therapy session, I was astounded. He indicated that since he knew every therapist in our geographic area (which was quite true), he had either to travel very far or to select someone he knew. He had decided to turn to me since he had high regard for my therapeutic skill based on his having referred patients to me and having received good feedback, having observed my work directly when I did

teaching-demonstrations at workshops and on videotapes, having discussed our philosophies of therapy and patient care and finding a high level of agreement, and knowing that I held to very stringent rules regarding confidences of friends and colleagues as well as patients. In addition, he felt his wife respected me and would be more apt to join him in therapy with me than any of their other therapist acquaintances. Further, he thought that because I knew them, I could zero in more rapidly on the dilemma and help them reach some resolution in the near future so they could avoid "therapy interminable."

I pointed out the difficulties likely to be inherent in therapy with him, and if she agreed to join him, with them. These included that his wife might expect that I would be partial to him, as the major connective link was through our professional ties; that our collegial interaction would have to diminish during the course of therapy, so that the primary current relationship would revolve around the therapy (and I had some reluctance to set aside our proposed writing and speaking collaboration); and that since I already knew them, my impressions would not be as fresh and uncontaminated as if they were stranger-patients.

Since he was a senior clinician, he was well aware of these problems. But given that he had long been professionally active in the community, he would have run into similar difficulties with any other senior therapist in the

area, and he did not wish to go to a new, junior person. Thus, we agreed to try a few sessions and then reconsider if a therapeutic alliance was indeed feasible.

During that evening's two-hour session, our relationship subtly shifted as he poured out his frustration and turmoil and as I responded as a clinician instead of as a friend to "his story." The next day his wife called, at his request. Since my philosophy of marital therapy recognizes the importance of balance, I offered her a comparable two-hour session alone. She accepted; "her story" (Duhl, 1981) unfolded about her dismay over their bitter conflicts, her recognition that he was so dissatisfied and had already moved away from her emotionally, and her suspicion that he was involved with someone else. She had long wanted to enter treatment, but he had refused, not wishing to make their private life known to anyone in our large yet semi-incestuously intertwined professional world. She was relieved that he had finally sought assistance, and recognized that it would inevitably be with someone they knew; coming to me was acceptable to her as "the vibes had always been good."

After six conjoint marital sessions, the irrefutable fact that became clear was that he felt he had "done time" by staying in the marriage as long as he had and that their differences were both untenable and irreconcilable for him. He had stayed "imprisoned" because he wanted to wait until their

two children had finished high school and also because he was ashamed that even though a marital therapist himself, he could not resolve his own problems and did not like exhibiting his failure to the world in the form of separation and divorce. She was devastated, and bitterly confronted him about the rumors circulating that he was having an affair. In sheer desperation, and apparently hoping that his affirmation that he was would disgust her enough that she would more rapidly agree to a divorce, he confessed that indeed he had been involved for quite a while. She caught me off guard when she turned and angrily hurled the following at me:

M.G.: You sit there so smugly! You have such a great understanding! Are you the culprit? And you pretend to be objective! How dare you—"professional friends!" Do you expect me to believe that?

F.K.: I hope you will believe it. I understand your concern and am distressed by it. But I can reassure you my friendship with your husband is professional and not sexual. [This statement was true, which was why I was nonplussed for a few seconds by her suspicion. Also she had originally agreed to enter into therapy with me stating that she trusted me and my skill.]

P.G.: There you go again—lashing out—blaming the wrong person—not accepting responsibility for your coldness and possessiveness as the factors that drove me away! I don't sleep with all of my female friends! Damn it, how can you think I'd ask Florrie to be our therapist if she were my lover? I'm not and never have been a manipulative cad.

By the end of this tense and turbulent session, he indicated he would begin apartment hunting the next day and move out as quickly as possible—preferably within the week. I queried if she felt she could continue working

with me around the separation, given her suspicions. She rejoined that she wanted to think about it, which was certainly understandable. She called a few days later. She wanted to return immediately as she felt desperately in need of empathy and support and was abashed about her vindictive attack on me.

I continued working with them individually through the separation and legal divorce, trying to help them through their anger, bitterness, resentment, and sense of failure (Kaslow, 1981). She also had to cope with the desolation of being "unwanted," rejected by a man she still loved and saw as a very important person. She did not look forward to being single; she had liked her married lifestyle. He wanted "out" quickly, was willing to be generous in a settlement to exonerate himself from some of his guilt, and wanted very much to be able to see his girlfriend openly post-divorce, as their clandestine relationship troubled him. M.G.'s depression lasted many months, as did her desire to retaliate for the hurt and humiliation he caused her.

Once the legal divorce was finalized and the economic divorce agreed upon (Bohannan, 1973; Kaslow, 1983), Mrs. G. began to settle down and accept the marital dissolution as a "fait accompli." In the aftermath period, she began to date and rebuild her life, continuing in treatment several months after her ex-husband had felt finished and had terminated.

This first instance of treating another therapist and his partner caused me to ponder the intricacies of this process. It seemed similar to, yet also different from, other therapies I conducted. I was certain that I felt a little more anxious, a little more desirous that the outcome be "successful," whatever that meant, and a little more concerned because covertly I felt I, too, had more at stake in treating a mental health professional who knew a great deal about therapy after years as an artful practitioner and supervisor and who could potentially be hypercritical. I was conscious of being more attuned to boundary issues and ambivalently intrigued about potential competitive strivings if the therapist-patient should try to become cotherapist. Also at risk was a friendship I treasured. Perhaps the initial tap root for this book was planted when that case commenced and periodically during its course when I reconsidered the efficacy of treating them.

Subsequently, while still living in Philadelphia, I found my practice included an increasing number of therapists as patients with their spouses and, often, their nuclear or extended families. Since my relocation to Florida in 1980, this trend has continued so that currently close to one third of my patients are other therapists. In age they range from 28 to 55; about half the therapists are men and half are women; there are roughly equal numbers of psychiatrists, psychologists, and social workers. The question of why and how some individuals become identified as therapists' therapists and others are never sought out by their colleagues continues to fascinate me. The

following material—which shifts among ideas presented in the literature, clinical vignettes, and observations and assumptions drawn from colleague input and patient responses—represents an attempt to look at this issue, particularly regarding the modality of marital and family therapy.

MANDATORY THERAPY AS PART OF TRAINING: TO BE OR NOT TO BE

Traditionally, the field of psychoanalysis has required that anyone in training to be an analyst must undergo a full didactic analysis. This is to combine therapeutic aspects as well as learning components. One's own analysis was and is today the quintessential way to experience and come to know what analysis consists of, what is involved in exploring the unconscious regions of one's heart, soul, mind, spirit, and cognitive processes. It is believed that a person can not guide an analysand into this interior domain unless one has already personally thoroughly travelled there, abreacted painful events, continued tasks that had been short-circuited by arrested development, and reached a high level of insight, self-acceptance, and comprehension of unconscious as well as conscious processes and motivations (Langs, 1981).

But didactic analyses, like "purely" therapeutic analyses, are costly and time consuming. They may last three to five years and be held four or five times a week. Anyone entering this process must make a major commitment

of energy, time, and finances to it. They generally should be prepared not to relocate during this phase of their life since the entire analysis should be conducted by one person. Those who are considered masters of the art of psychoanalysis are dubbed "training analysts," a title much revered. Only a training analyst is deemed qualified to conduct a didactic analysis, so the choices in any community are necessarily limited. Since he or she is likely to earn a substantial portion of his or her total income this way, "professional courtesy" is not the rule, and may be, of necessity, a rarity. Sometimes it is possible to become an analysand of one of the training analysts at an institute; then the fees may be substantially reduced.

What have been and are the implications of this kind of requirement on other segments of the psychotherapeutic community?

During the past 50 years in the United States, the picture has varied greatly in different departments of psychiatry, psychology, and social work. Some have "required" individual therapy and others have "strongly encouraged" it. Conversely, some have been reluctant to accept students and interns who are in treatment, purporting concern that needing therapy themselves, they may be too unstable or too self-immersed to be ready and able to focus on and treat others. Wherein lies the truth? Or are there several truths? Three questions come to mind:

1. Is it not advisable to experience therapy from the patient's vantage

point as one critical aspect of coming to comprehend what it means to unveil one's self-doubts, innermost fears and longings, and well-disguised secrets?

2. Should any person embarking on a career as a therapist be deprived of or discouraged from tasting the personal privilege and pressures that accompany the therapeutic journey toward self-knowledge, personal growth, and improved functioning?

3. Should at least part of one's own journey encompass the modality or modalities one is planning to practice?

My bias is that the answer to the first and third questions is a clear yes; to the second, a rather definite no.

THERAPY THAT INCLUDES ONE'S SIGNIFICANT OTHERS

Since the focus of this chapter is specifically marital and family therapy, let us briefly review some documentation of what has transpired in the past. In 1968 Nichols wrote a highly informative article entitled "Personal Psychotherapy for Marital Therapists." He describes the philosophy of and approach taken at the Merrill-Palmer Institute's postdoctoral intern training program regarding resolution of the training-treatment question. During more than 10 years preceding the writing of Nichol's article, the Institute had carefully delineated a pattern that separated yet coordinated personal psychotherapy and supervision for the interns. Each intern was assigned by

the head of the training program to a primary supervisor who carried the main responsibility for designing the case load to meet training-learning requirements; in addition, he or she was assigned to other supervisors drawn from the Institute's multidisciplinary staff with expertise in other treatment modalities. Another member of the Institute's psychotherapy training faculty, not engaged in supervising the particular intern, was assigned as the psychotherapist (Nichols, 1968, p. 84). The modal number of therapy sessions was two per week, although the requirement was only for one.

Nichols indicated that the unique feature of the program was that treatment was mandatory, that it was provided within and by the training institute, that therapists were assigned rather than selected by the interns, and that much faculty time and energy was invested in coordinating supervision and treatment to maximize the benefits derived from both experiences. Over time, wives of interns were sometimes accepted into treatment by the husband's therapist. (The implication seems to be that all interns there were male then.) Nichols interpreted what appears to have then been a rather progressive development as concrete recognition of "the belief that the intern's own marriage and family life affect his learning and functioning as a psychotherapist and are an integral part of his professional well-being" (p. 84).

That this needed to be posited then because such a realization was not a generally accepted fact or practice seems surprising a decade and a half later. What is even more astonishing is that such involvement of the spouse, even in programs oriented to training skilled marital and family therapists (and not mere technicians) is still the exception, rather than the rule. Rarely is it obligatory; just as rarely is it stated that what happens to the trainee during his or her rigorous and personally demanding graduate or postgraduate training has an impact on the family. The combination of emotional turmoil and disinhibiting that may occur; the soul-searching and self-questioning; the intensive involvement in reading and classroom studies; the mesmerizing qualities of clinical practice; the deep engagement with fellow-trainees, faculty members, supervisors, and therapists all converge to bring about changes in the trainee's attitudes, behavior, personality, and way of being in the world. Sometimes the working through of disagreements with and attachment to a cotherapist can be quite profound and disquieting because of the importance this relationship assumes (Kaslow, 1980). Clearly then, not only does the therapist's family life affect his training and practice, but his professional development has interpersonal ramifications for his family life.

To return to the illumination of issues provided by Nichols (1968, p. 85) in discussing the Merrill-Palmer model: confidentiality was respected assiduously. Faculty member/therapists kept the content of treatment

sessions private. Nothing could be shared with other members of the faculty training team without the intern's permission. Nonetheless, broad understanding of the intern's strengths and stresses might be "shared with others on the training team at appropriate times," as when a supervisor might ask the therapist's opinion about pressuring an intern for increased productivity. Also, on occasion, a supervisor might suggest that an issue raised in supervision could be dealt with more appropriately and beneficially in therapy. Obviously, when therapy is conducted by a member of a training faculty, great caution must be exercised to see that boundaries are respected and protected so that trainees feel safe in the confines of the therapeutic sanctuary.

Nichols (1968, p. 85) made a strong case for the value of including personal therapy as part of the training phase. He posited that as an integral aspect of the program, it enabled the intern to make more effective and productive use of the experience. It provided an avenue through which to process the tensions and strains created in a postgraduate program, such as getting entangled in struggles with those in authority, trying to manipulate one's supervisors, or coming up against one's own blocks and clinical ineffectiveness with patients. Thus, through the therapeutic process, energy did not remain bound up in these struggles but became available for learning and clinical tasks. The major intention of the treatment component for trainees was to enable them to become more effective professionally, to

enhance their ability to intervene beyond the level of obvious and tangible problems, and to enable them to be able to risk establishing intense therapeutic alliances, when appropriate. Their actual personal therapy provided an in vivo prototypical experience of what therapy is and can be. Restructuring personality and curing psychopathology were not the key objectives.

In the psychotherapeutic portion of their training, those interns who evidenced severe difficulties in working with patients in dyads and in being in triangular relationships were helped to appraise their strengths and limitations realistically and perhaps counseled to remain individual psychotherapists or to "emphasize the teaching-academic side of [their] vocational identity in the future" (Nichols, p. 87). One can question this latter point based on the idea that one should not teach clinical theory and technique in an arena in which one is not a successful practitioner, able to model one's work and supervise that of trainees from the vantage point of an active, competent clinician.

Given that many training program directors agonize over what to do with bright trainees who do not seem to have the personality potential for becoming clinically adept, dealing with this in therapy appears to be an excellent idea. In therapy, the trainee can be confronted with his or her lack of "goodness of fit," can come to terms with it, and can assume responsibility

for career redirection. Some major traumatic hassles could be averted in current training programs. In the decade and a half since Nichols' article was written, counseling out and dropping graduate students and postgraduate trainees for personality factors or lack of clinical aptitude rather than for academic reasons has become extremely problematic; threats of lawsuits for so doing are not uncommon. There are few widely agreed upon objective measures for predicting who will or will not be an effective clinician. Nonetheless, there might be subjective unanimity of faculty that a given trainee is not a good candidate for the field. If this were handled adroitly in both supervision and therapy, how much better able the person might be to integrate this information and use it positively, avoiding seeking recourse for reinstatement through litigation. If the modality is marital therapy for the trainee and spouse, the spouse, too, can express apprehension, confusion, or relief about a recommended change in career direction and feel less like a passive victim.

The issue of marital and family therapy as an obligatory part of the individual's training remains controversial. On the opposite end of the continuum from Nichols, some, like Jay Haley, have asserted that a requirement for personal therapy has no place in the training of family therapists and, in fact, may even be in violation of the trainees' personal rights.[2] The violation of rights is an important ethical consideration that merits attention. It is posited here that if the catalogue for the program

indicates that individual and/or marital and family therapy make up an integral and mandatory part of the program, then the applicant can choose whether or not this is a requirement he or she is willing to fulfill. After students have chosen such a program, there is no danger of their rights being violated. However, if they are not told of this requirement prior to admission, then a complaint of violation of personal rights could well be justified.

A review of the literature that touches on this topic in a global way reveals that many trainers and clinicians believe trainees should enter therapy in order to explore their personal biases, blocks, and points of arrested development and to achieve greater insight and growth. Yet, ideas as to the auspices and structure through which this is to occur are nebulous; thus, the trainee is often in a quandary as to the expectation.

Guldner explicitly spoke to the issue; his stance is quite similar to Nichols'. In his succinct article, *Family Therapy for the Trainee in Family Therapy* (1978), Guldner describes the resolution of this question in the marital and family therapy training program of the Interfaith Counseling Centre, Kitchener, Ontario, Canada. This two-year interdisciplinary postdegree training program, begun in 1972, entailed 25 hours per week including course work and eight hours of patient treatment. Most of the trainees had been in practice for a number of years and had returned

specifically to acquire skill in marital and family therapy. Much individual and group supervision, utilizing direct and indirect methods, is an integral part of the learning experience.

Initially the teaching and supervisory staff all had a strong positive bias toward the importance of therapy as part of training, but they did not make it essential. Soon they became aware of an interesting phenomenon; those trainees involved in personal in-depth therapy were increasingly seeing fewer clients conjointly (Guldner, 1978, p. 128). When asked about this in supervision, they revealed that they thought there were numerous personal issues to be resolved by clients before they could be involved in marital or family therapy. Rarely was such resistance to conjoint therapy evidenced by trainees who were not in individual therapy. As a corollary, trainees in individual training also were less receptive to learning and absorbing the program's general systems theoretical model. Significantly, those trainees whose spouses entered treatment during the same period saw a different therapist, and no overtures were made for conjoint sessions. Since few therapists (besides those on the faculty) practicing in the geographic locale of the Counseling Centre were trained in a systems orientation, trainees were being treated primarily by therapists adhering to a psychoanalytic model.

Next, they decided to utilize group therapy at the Centre. Although it

proved more concordant with the program and successful than individual treatment had been, some nontrainee spouses called for appointments. The consensus was that they felt excluded, jealous, and desirous of a comparable therapeutic or growth experience. At the conclusion of the training phase, some couples called for marital therapy. At that point, the training staff concluded that if the trainees were to have an optimal therapeutic experience consonant with what they were learning and the services they were being prepared to deliver, they should be involved in treatment with their own families.

Out of a successful pilot project, the Centre evolved a flexible model that I think has much to commend it. Applicants were informed, before admission, that there would be a "personal growth/therapy experience as a part of training provided by the Centre staff" and that it would involve significant family members. The specifics were to be worked out in individual contracts between therapist and trainee. Ultimately some entered marital therapy and others entered nuclear family therapy. At times family of origin and intergenerational sessions were held; so, too, were individual sessions. The therapist assigned did not carry supervisory responsibility with the same trainee and had minimal teaching contact. As in the Merrill-Palmer program, confidentiality did not pose a problem, and it appears that potentially confusing and often-feared conflictual overlapping relationships did not surface as a major dilemma.

In addition, in keeping with the Centre's prevention/education thrust in the community, and its inclusion of sex therapy services, all trainees and their spouses were required to be involved in an intensive marriage enrichment experience and in a sexual attitude reassessment experience.

Based on my own experiences during the past 15 years as a clinician and teacher in graduate, postgraduate, and professional training programs, I thoroughly concur with Guldner's conclusion (1978, p. 132):

> The involvement of trainees in marital and family therapy should be an essential component of family therapy training. Training programs in family therapy generally have as learning goals the acquisition of theoretical concepts, techniques, skills and self awareness. Consistent integration of these elements for implementation in family practice appears, from our data, to come when the self awareness experiences occur within the context of the trainees' own marital and family system.
>
> We see it as important that the trainee's own therapy and training be concurrent and that supervision and therapy are clearly differentiated by ensuring that the trainee is not supervised by his/her own therapist. We do not think it is essential that the therapy be provided by the training center staff when this is not possible, but it is important that the therapeutic and training models and philosophies do not conflict.

Not every practitioner who wants additional training in marital and family therapy can enter a formal graduate or institute-based program. Many people who have been in practice for a while have heavy family and financial responsibilities that they determine preclude half- to full-time enrollment in such programs. Others are unable to relocate to communities

that have such programs. For these reasons, the American Association of Marriage and Family Therapists set up an alternative training route through tutelage under approved supervisors (AAMFT, 1976).

Case Vignette

Don had his masters in counseling and guidance, and worked as a school psychologist in a suburban high school. He had become increasingly interested in the family context of the adolescents he saw, and began reading the relevant family therapy literature. At age 38, he was the father of four children. The youngest was two and the eldest 13 when his interest in advanced training became strong. His wife, Jeanine, did not think she could return to work for several years, and his salary barely covered the family's essential needs. He worked out a training bloc with an AAMFT supervisor, and attended many lectures and workshops in the Philadelphia area, which is rich in outstanding family therapy programs. His supervisor, who urged all trainees to have some marital therapy during the course of training, referred him to me. We contracted for 10 sessions and we hoped that would be enough for him to experience the potential potency of this intervention modality.

Jeanine was reluctant at first, claiming that it was his training and that she saw no need for her inclusion in this way. For her the marriage was fine,

and she did not want the existing equilibrium disrupted. Don's underlying restlessness and resentment did erupt by the third session, as he talked of his desire to go back for his doctorate and his feeling that all of the advanced training, without the title Doctor, would still leave him a second-class citizen in the therapy world with fellow professionals and patients alike. The fourth child had been unplanned, and he haltingly told Jeanine he felt she had trapped him with this last pregnancy because she wanted a large family. Had they stopped with three, she could now work, and he could have enrolled in a graduate program. As he worked through his recriminations, and realized how much he was enjoying the baby and really liked his wife's domesticity, she was able to offer to work part time as a Sunday School teacher and to try to provide some quiet time in which he could read several nights a week. Therapy also focused on issues of self-esteem and competence and how these are intertwined with and separate from titles. He became aware of the mixture of complementary and symmetrical features in their marital relationship. We discussed lifestyle issues and values, and they realized that their basic desires and goals were quite similar; however, there was a disparity in their time tables and how they established priorities. At the end of the 10 weeks, they renegotiated for an additional five sessions since both found that the therapy was enabling them to communicate about heretofore-avoided topics and that they were gaining a deeper understanding and appreciation of each other. Don felt that the merits of conjoint sessions had

come alive for him and that the experience of marital therapy had illuminated the process for him. When they ended at the agreed-upon termination date, they had begun renovating the garage for a future private office for Don, who was already licensed as a school counselor, and Jeanine had gotten a Sunday School teaching job at a synagogue. He hoped to apply the following year to a doctoral program that took part-time students. He went on successfully to complete his supervised training for AAMFT clinical membership; his supervisor reported that his clinical work had changed dramatically during the time he was in treatment; he was much more capable of engaging both partners and working with their interactions and transactions.

It appears that trainees learn how to become marital and family therapists not only by reading the literature, observing senior therapists and peers conducting sessions live and on videotape and critiquing them, attending workshops and classes, and seeing couples and families and receiving supervision on their cases, but also by experiencing the treatment process as patients participating with their partners and/or families of origin or procreation. To me it seems that this last factor is every bit as vital in the process as the other four and that its noninclusion constitutes a serious omission.

DIFFICULTIES IN THE MARITAL/FAMILY THERAPIST'S OWN FAMILY SYSTEM

Becoming and being a marital and family therapist is a challenging, exciting, exasperating, provocative, rewarding, and intense experience. From the time one first enters training, through the years of beginning and advanced clinical practice, we analyze why we gravitate toward this field (see for example Ferber, Mendelsohn, & Napier, 1972; Beliak & Faithorn, 1981). We explore and reconnect with our family of origin in any number of ways including doing genograms and making journeys to visit parents and the extended family (Bowen, 1978; Guerin & Fogarty, 1972). We may reevoke and rework our familial bonds through utilization of family photographs, movies, and videotapes (Kaslow & Friedman, 1977).

We learn that this process is never complete. If we pursue it actively, we can bring about a more satisfactory and ethical realignment of our relationship with our parents as we become more adult and can come into fuller possession of our own "personal authority via termination of the intergenerational hierarchical boundary" during the fourth or fifth decade of life (Williamson, 1981). If our parents are deceased, we can acquire "new life at the graveyard" by visiting and completing not only the grief work but also by modifying the nature of the relational ties. Williamson (1978) describes a valuable process to be undertaken at the graveside that can be utilized as a "method of therapy for individuation from a former dead parent." Through all of the reawakening and reexperiencing of our personal historic past, we are often guided to become aware of the "invisible loyalties" to significant

biological relatives, particularly our parents, and to be mindful of the ethical-existential obligations that accrue by virtue of their having endowed us with the gift of life (Boszormenyi-Nagy & Spark, 1973) and, it is to be hoped, of love. In many programs trainers, educators, and supervisor trainees pre- and postdegree may encourage or even urge participants to deal with issues related to their family of origin. Pressure from therapeutic impasses encountered with one's own patients also serves as a motivating force to resolve the repressed or smoldering conflicts from childhood and adolescence in self-analysis and in individual or multigenerational therapy.

In the past decade and a half, the literature has given serious consideration to the intergenerational ties, values, battles, cut-offs, renewals, and legacies that shape the personality and practice of the family therapist as clinician. But, until recently, few articles have dealt as specifically with the impact of someone's becoming or being a family therapist on the therapist's family of origin and family of creation. One notable exception is Charny's chapter, "The Personal and Family Mental Health of Family Therapists" (1982). Charny points out that family therapists are no more immune than anyone else to family problems. Rather, there are various influences which impinge on the therapist that are apt to heighten the probability of family dysfunction (1982, p. 14). For example, after listening day after day to others' problems and woes, often seeing progress in small increments, and perhaps sitting in one chair in one room for hours on end, some clinicians

are prone to becoming pessimistic and lethargic and to experiencing burnout. Going home after a full day of attentive listening and creative therapeutic interventions, some therapists have exhausted their fund of patience with and empathy for hearing other people's dilemmas (Beliak & Faithorn, 1981). When a male therapist under great stress with extremely difficult patients goes home and his wife wants to talk about even a minor problem, he may irritably grumble or holler that he needs some peace and quiet and complain, "Can't anybody ever respect my wishes?" When the situation to be confronted with the spouse is more serious, havoc can be wreaked when she finds his emotional reservoir depleted. Consider, for example, the S. case.

Case Vignette

Dr. S. was a successful, 31-year-old psychiatrist in the Air Force. He was meticulous, efficient, ambitious, and quite good looking. Seven years before entering therapy with me, he had met a lovely looking young woman, three years his junior. He was then a senior in medical school. She was soft-spoken, reticent, and somewhat dependent. Initially he was attracted to her sweet clinginess, noncompetitiveness, and rather rapid total absorption in his wishes and life dreams. Throughout their two-year, sporadic courtship, he found her shy and demure demeanor appealing and enjoyed her open adoration of him. She felt secure in his strength and decisiveness, needing

the anchoring his fastidiousness and structure provided to her low-keyed, drifting style.

After marriage, during the last two years of his residency in psychiatry, she worked in a job as a secretary in a law office. At night he came home excited about the fascination of the intricate world of human behavior as manifested in patient symptomatology and wanted to bubble over about it to her. She came home disgruntled and tired from a pressured day of typing briefs and arranging court calendars. She longed for appreciation, attention, and comfort. He wanted the enthusiastic receptivity he had received in the premarriage phase of their relationship. Neither derived what they sought from the other. Both became increasingly frustrated and annoyed.

Dr. S. began doing family therapy during his last year of residency, and was assigned to do cotherapy with a sensitive yet dynamic female psychology intern. They worked extremely well together, and shared many professional thoughts and interests. Meanwhile, Mrs. S. felt more and more shut out from her husband's new life, and gradually withdrew. Sometimes he came home to blank, aloof silences. Other times there were hysterical, agitated rages to be faced. He was aware of feeling trapped, yet resisted facing the severity of their rift. The more he ignored the difficulties, praying they would disappear, the more distant and frightened Mrs. S. became. They reached a point of living lives of quiet desperation in the same household,

with little contact. Dr. S. hoped that once he left his residency and was in the active-duty Air Force, all would change. It did—but for the worse. After he was away on a three-week mission, he came home to find his forlorn wife huddled in a corner. He finally recognized her depression and despair, and took her to a local psychiatrist for treatment that lasted for a year. Meanwhile, they had had no children because of the precarious state of their relationship, but were feeling pressured to start a family by parents and friends and by their own life stage time clock before it became too late.

Finally, one night Mrs. S. had planned a special evening for them, and he called home to cancel saying he would be late because he had a family in crisis. When he came home, he found a cryptic note from his no-longer reticent wife: "Now you have two families in crisis." Alarmed at her acerbic assertiveness, he awaited her return. With great fury she lashed out, telling him he was so busily and selfishly involved in getting trained, becoming proficient, and nurturing his patients and his career that he had reneged on his promises to take care of and cherish her and to nurture their marriage. She chastised that *she* was not the problem, the difficulty was in their relationship, and how come—if he was such an expert in family dynamics—he failed to recognize what had been transpiring in his own domicile? Confronted with such angry accuracy, his blinders fell away, and he agreed to come for marital therapy.

Although this script is derived from an actual case, it closely parallels the scenario of several dozen different therapist couples and families I've seen. It matters not whether the therapist partner is male or female—the issues are similar.

As Charny indicates (1982, p. 42-43), we see that in family therapy, less physical and emotional distance is maintained between the therapist and those participating than in traditional individual therapy. Usually the therapist is sitting in a circle with the family and knows that he or she must in some way "join" the family in order to become an effective change agent. Much of the substance of treatment is interpersonal transactions and deals with universal problems of closeness and distance, individuation and connectedness. Some therapists feel drawn to sharing feelings and material about their own families and engage in considerable self-disclosure. The real-life drama of family living tugs and pulls at one's own humanness and vulnerability; it is not uncommon to see variations on the themes of one's own family being enacted and depicted in one's office. This can lead to genuine encounter of therapist and patients, producing change in all through the painful struggles they share together in the treatment situation. Some therapists have trouble extricating fully from their patient families and carry emotional remnants home with them.

Charny states that from and through family therapy we come to realize

that the idea that there can be personal completeness or freedom from problems in intimate relationships is an illusion. Rather, the goal is to cultivate the strength to live out the process of dealing with life's vicissitudes by being true to and comfortable with oneself and being able to work these out in and through the relationship, reconciling differences, accepting imbalances and contradictions, and integrating opposing positions. When one becomes adept at so doing with client families, when one sees the marked positive results, when one is accorded respect and gratitude, it is troublesome to go home to one's own family in which similar conflicts may abound and yet find that the same creative problem-resolution strategies are to no avail and, in fact, are disparaged as "more of your psychology nonsense and jargon."

Given that "the prevailing context in family therapy is clarification of feelings through actual emotional contact," the patients rather quickly experience the gratification and antidote to loneliness of "being with and talking with." As a result, some family therapists carry over to their own families the desire and expectation for the type of ongoing responsiveness and involvement they experience in therapy. Some come to crave and assume dynamic familial interactions and are disappointed by the fear of closeness and lack of continuous dynamic interplay that characterizes their partner and children, who do not spend the day in the intimate atmosphere of the family therapy sanctuary (Charny, 1982, p. 45). Others go home and

find the family asking for intensity of involvement, and feel unable to continue functioning with great affectivity after a full day of complex interpersonal relations at work.

Many leaders in the family therapy field have gone through at least one divorce and the wrenching agonies of decisions regarding child custody. For some, the divorce signified failure to make life meaningful in the personal sphere; for others it heralded growth and triumph. Were we able to do some clinical research on their personal family histories and dissatisfactions, we would know much more about the specific kinds of problems family therapists face in their own lives. Given that this data is not available, what follows is based on my own clinical experience and observations and on Charny's material.

ISSUES THAT MAY SURFACE BEFORE FAMILY THERAPY

The nontherapist spouse may complain of finding the therapist spouse emotionally drained and a poor listener. Or distress may come from the fact that the therapist spouse demands intense interaction and understanding, eschewing phoniness, mediocrity, and boring routines and activities. The nontherapist spouse realizes that his or her mate perceives that by comparison to the family and home, the office, classroom, or workshop is "where the action is" and home can seem like "Dullsville." The therapist

spouse often believes he or she has become more sophisticated about child rearing, behavior dynamics, human sexuality, and personality integration, and may disparage the spouse's lack of knowledge on these subjects. Although the therapist spouse wants to deal with relationship issues and make a continuing commitment to growth, the other spouse may be more concerned about reality-oriented concerns like finances, housing, and children's schooling. They emphasize different priorities and may have different focal value systems.

Becoming symptomatic can be a fine way for a nontherapist spouse or the children finally to get attention. This may be what it takes to be interesting and worthy of time and energy. It also provides some clout and leverage to convince the "high and mighty therapist" that his or her own family is in trouble and in need of therapy and/or that therapists are inept and can't even keep their own families functional. Whether rescuer or retaliator, the symptomatic member is likely to precipitate the move into therapy.

THERAPY: A NEW FORM OF FAMILY TOGETHERNESS

Once the family arrives for treatment, the therapist patient is apt to speak first—explaining the family dynamics, structure, and history—allying with the therapist and trying to orchestrate the process. He or she may be

embarrassed, defensive, apologetic, overly loquacious, and very uncomfortable. The family is likely to be tense, uncertain in the terrain of the therapist/patient's daily world, and fearing collusion or competition between the treating therapist and the patient/therapist. These issues need to be dealt with early in the therapy so that the focus can remain on the reasons why the family has sought help. The patient/therapist must be assisted in being there as parent, spouse, and family member and not as a cotherapist. Fears regarding confidentiality and loss of professional stature need to be dispelled. If therapist/patient and therapist have other professional interactions, wherever possible these should be suspended or minimized during the course of therapy. For the family, the boundaries should be clarified and demarcated so that no one feels an undue invasion of privacy or fear of exposure.

Once these issues are dealt with and the ideas assimilated, therapy proceeds as it does with other distressed families. Nonetheless, there are some additional considerations. The tendency of the therapist/patient to want to be omniscient and his or her competitive strivings to be "The Doctor" will need to be handled whenever these surface within the context of the family relational pattern and the family-and-therapist system. So, too, wounds to his or her narcissistic pride at being humiliated in front of a therapist colleague by critical family members must be handled. Fear of too much self-disclosure or of not meeting expectations of being a "good" family

in therapy are also common manifestations in this patient population.

Allegations likely to be hurled in such families against the therapist/patient by his or her spouse and children are that "you no longer care about us," and "you find others' lives more absorbing and important than ours." Conversely, the therapist spouse may bemoan that patients appreciate his or her concern and counsel and do not take him or her for granted, whereas family disregards his guidance and takes him or her for granted, never saying "thanks" or giving a compliment. High behavioral expectations and perfection and achievement scripts are common in therapists' families. Spouses and children often vaguely feel that they fall short of the ideal vision of the family. Once these tensions are understood, interpreted, and subsequently minimized the therapist and his or her family can embark on the strange and wondrous voyage of family therapy. But it is urgent that the therapist/captain be highly competent, empathic, strong, dynamic, soothing, tactful, confrontative, authentic, and able to win the battle for structure (Napier & Whitaker, 1978) early in the therapeutic journey. Perhaps it is the therapists who gain reputations for possessing the artful combination of all of the above, like Carl Whitaker, who are privileged to become the family therapists for therapists and their families.

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EDITOR'S COMMENTARY
THERAPIST SELF-DISCLOSURE IN THE PRESENCE OF HIS OR HER SIGNIFICANT OTHERS

Florence Kaslow Ph.D.

Often therapists have spent years being introspective about who they are, how they got to be that way, and what is the meaning of life. This introspective quality, combined with rescue fantasies and, sometimes, the need for structured interpersonal relationships that allow safe contact, can be conducive to entering individual therapy and/or a graduate or professional program for would-be therapists. In their personal therapy, as in some classes and supervisory sessions, a high premium is placed on self-revelation and exploration and the development of self-awareness and insight.

Later, much of the acquired ability in self-disclosure may become submerged as the therapist role generally requires listening and responding to the outpourings of patients and not sharing, as a friend might do, one's similar experiences or diverting attention to one's own current problems. (Some exceptions to this are in encounter and sensitivity groups, in which the therapist role shifts to being that of leader/facilitator, and in some family therapy sessions, in which the therapist might purposefully share vignettes about his or her family that he or she deems relevant and helpful.)

When the therapist enters treatment in conjunction with his or her family, self-disclosure is again necessary. One's feelings, perceptions, wishes, goals, frustrations, pent-up anger, disappointments, alliances are all important aspects of the currency within the therapeutic exchange. The therapist member of the family may be quite skilled in manipulating sessions and may know when to talk and when not to talk to elicit certain responses. He may think he's been through sufficient and significant treatment before and that it's the others who need it, so he should sit back. Or risking self-disclosure may be much more difficult as the need to perceive himself and have others view him as healthy and as a good spouse or parent can impede genuine communication. He knows the Pandora's Box that therapy can unlock, and may not wish to have a potentially cataclysmic storm unleashed. Being in the patient role in the here and now may be dreadfully painful and ego dystonic.

Treating other therapists and their families necessitates consummate patience with this possible resistance in addition to an awareness of the other idiosyncratic themes alluded to in the preceding chapter. Once this is mastered, treating other therapists and their families is a special challenge and privilege.

1. Initials and names have been changed to protect the identity of the therapist/patient and his wife.

2. Comments made by Haley at a workshop for Supervisors of Family Therapy at the Philadelphia Child Guidance Clinic in 1976