AN INDICATION FOR CONJOINT TREATMENT: AN APPLICATION BASED ON AN ASSESSMENT OF INDIVIDUAL PSYCHOPATHOLOGY

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Conjoint treatment is advocated as the treatment of choice for a particular class of patients who do not seem able, at least initially, to benefit from individual exploratory psychotherapy. These people identify a person or persons, usually a spouse, as the primary cause of their difficulty. They show no initial capacity for self-observation. Their needs are childlike, and they show limitations in skills and a striking inability to sustain mutually gratifying relationships. The conjoint situation seems capable of initiating self-observation by confronting them with the reality of the person about which they are making claims. As a therapy, it also initiates an improvement in their marital relationship, thereby helping them potentially to gain that which they crave so desperately, but had been unable to realize except in compromise form, that is, in fantasy or in a relationship with a therapist.

Patients who blame another person, usually a family member, for most of their difficulties and use this claim as justification for making constant demands on other people (including the therapist) and for their life failings may be unable to achieve the self-reflection required for individual psychotherapy. Conjoint treatment, including both patient and blamed party, would seem to be a logical option for treatment in these cases.

The type of patient described above is frequently encountered in psychotherapy clinics. In the author's experience they are partially distinguished by the fact that individual psychotherapy seems to have little or nothing to offer to them. They may seek and commit themselves to individual psychotherapy, but do not seem to be able to gain any insight into the internal causes of their difficulties.

The particular subgroup of patients to be discussed show the following characteristics: they are constantly unhappy, and regard their difficulties as being entirely caused by the misunderstanding and mistreatment by people in their environment. In addition, they focus on one particular

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person, usually a family member, as the chief cause of their problem. It is characteristic of this group that they show a striking inability to succeed professionally and socially. Using this as a reference point, the report will restrict itself to the healthier segment of this group; that is, those patients within the larger group who have a long-standing stable (even if disappointing) interpersonal life, and who seem to have the capacity for an adequate social and professional adjustment, but who for some reason have never been able to realize this.

The difficulties in treating these patients have been alluded to. Indeed, it is hard to emphasize how frustrating and potentially infuriating these patients are to work with. At best, they use the therapist as a reality figure to guide them or simply as someone to absorb their complaints. The comments which are presented later in the text from Mrs. B.'s therapists are typical of the reactions of therapists to this kind of patient.

The kind of patient being discussed is described elsewhere in the literature. Zetzel,[1] in her paper on the "Incapacity to Tolerate Depression," describes patients who show a relative incapacity to tolerate anxiety and depression, but who are not psychotic or borderline. To the extent that these patients cannot tolerate anxiety or depressive affects, they use externalization, denial, and restitution through real contact with an idealized object to defend themselves against these affects. In many cases, these patients seem unable to tolerate and use exploratory psychotherapy. In addition Zetzel[1, 2] feels that many of these patients should not be referred for psychoanalysis and thereby subjected to excessively regressive transference experiences.

It may be worth saying a bit more about the diagnostic issue in these cases. Judging from surface manifestations these patients are not borderline in the sense in which this diagnostic category is used by Kernberg.[3] Rather they present with a more stable interpersonal life and less pervasive use of the mechanism of splitting then do borderline patients.[3–5] This is an important distinction because it places these patients in a more favorable group prognostically.

Briefly, Kernberg's[4, 6] patients make heavy use of the defensive operation splitting. That is, their reality is characterized by contradictory self and object representations (ego states) which are dissociated from one another. As a result, their perception of a situation can alternate rapidly and markedly. One moment, the person with whom they are dealing may be seen as all good and the next moment as persecutory. The patients we are describing also engage in a process where the unwanted images of self and object are extruded. In contrast to the situation which exists in splitting, however, the images are replaced onto specific, often permanent, objects, and the result is a relatively stable interpersonal situation. Because of its stability and the absence of dissociation between contrasting and contradictory ego states, we consider this mechanism to be closer to repression than splitting is and label it externalization. Both mechanisms are used to ward off devalued aspects of the self (e.g., as inferior, worthless, etc.) and correspond-

ing images of objects (e.g., as intending to humiliate, abandon, etc.). Externalization, however, leads to a more stable intrapsychic and interpersonal situation, and should be more readily available for interpretative intervention.

From a broad diagnostic perspective these people have severe character problems. From a libidinal point of view, they have significant features of the oral characters described by Abraham[7] (see also Easser and Lesser[8]). From a structural point of view, they seem to fall within the intermediate range of character pathology proposed by Kernberg.[6] They seem to meet Kernberg's criteria that repression be the "main defensive operation of the ego" with some coexisting "dissociative trends and splitting of the ego in limited areas." In addition, while they show a predominence of oral conflicts and marked "ambivalence" and strife within relationships, they distinguish themselves from Kernberg's "lower level" of character pathology because they show indications of having reached a genital level of psychosexual development and of having the capacity for sustained relationships.

At the same time, since we have no information from the psychoanalyses or intensive psychotherapies of the patients we have worked with we cannot be firm in our judgment of the degree of underlying psychopathology for any particular case. Instead we have to rely on surface characteristics and make inferences about the degree and nature of the underlying pathology. Kernberg[6] makes clear that surface characteristics can be misleading. As an example he describes at length the fact that a borderline personality organization lies beneath the generally well-functioning surface features on the narcissistic character.[9]

The issue then is how to intervene with these very refractory patients in such a way that their capacity to observe themselves will be fostered and developed. It has been our experience in several of these cases that conjoint treatment can accomplish this. In fact, given this experience we suggest that conjoint treatment, which includes the person who the referred patient identifies as the chief source of his or her problem, is the initial treatment disposition of choice in many of these cases.

It is important to mention the place psychoanalysis has in our thinking about the treatment for these patients. The psychoanalytic treatment of severe character disorders is discussed extensively by Boyer and Giovacchini.[10] They present a convincing argument for the possibilities of fostering ego growth and especially the developing of a self-observing facility as part and parcel of the use of psychoanalytic technique with these kinds of patients. (They also discuss the use of parameters[11] and in particular the advantages and disadvantages of an early treatment phase within which a more real and gratifying interaction with the analyst occurs.) Kernberg[6] states that psychoanalysis is the treatment of choice for many patients with intermediate-level character pathology; although he qualifies this by noting that the analysis may be lengthy and expectations may have to be modified. These constitute potent agreements for psychoanalysis as

the ideal treatment for certain of these patients. However, in most cases the people we are describing have neither the motivation, nor, sadly, the money to afford psychoanalysis. With regard to the former, they often want a procedure that yields immediate and direct results or they quickly reject the process. We are then forced even in a majority of those cases where psychoanalysis is indicated, to recommend a more viable and available alternate to the ideal of psychoanalytic treatment.

We intend to elaborate the useful features of the conjoint situation in the discussion below. At this point, it will suffice to say that the presence of the offending party is useful in confronting these patients with their preconceptions about them, and is therefore useful in eroding their defensive use of externalization. In addition, the conjoint treatment can help to instigate what these people require most desperately, that is, a gratifying relationship.

In certain cases the conjoint work also serves as a useful prelude to productive individual exploratory psychotherapy. This sequence is also referred to elsewhere in the literature. For example, family and conjoint treatment have been recommended by Wynne,[12] for situations in which the difficulty has its source in individual psychopathology but is perceived by the subject or subjects as originating in other members of the family. Furthermore, it is suggested that a switch to individual treatment might become useful and appropriate at the point when the individuals involved become aware of the internal nature of their difficulties.

During conjoint treatment, the focus of the therapy is shifted to the interaction between the couple in treatment. The aim is to identify with them the features of the disturbed nature of their interaction and in turn to help them become aware of the determinants of this behavior.[7] Although this focus prevailed in the conjoint treatments described here, the following clinical examples will center largely on the member of the conjoint pair who was originally designated for treatment, and we will attempt to identify the utility of the conjoint work for that patient.

CASE 1. MR. AND MRS. B.

Mrs. B.

At the onset of treatment Mrs. B. was 36 years old. She was a housewife and had a 17-year old daughter and a 15-year old son. She essentially never held a job. She had completed the 11th grade in high school when she dropped out to be married.

By the time of the author's initial contact with her in July, 1970, Mrs. B. was a veteran of seven years of psychotherapy with four therapists and of two earlier hospitalizations. The durations of the therapies had been between one and two years and the usual frequency of visits had been one

per week. The therapies were always terminated when the therapist, usually a trainee, left.

In their reports, the therapists described Mrs. B. as follows:

1. In 1963, on intake, she was described as extraordinarily "demanding, exasperating, insatiable."
2. In 1968, after a year and a half of treatment, "... I found the patient to be extremely difficult to work with...," she is described as "... demanding and incessantly complaining—there has been no real progress in therapy."
3. In 1970, after two years of treatment, "It is difficult to reflect over the past two years and see any significant change in Mrs. B. in any area. I am pessimistic about any significant changes in the future."

Mrs. B. was an extraordinarily demanding woman. Her single, constant interest was to influence her therapist to care exclusively for her. She attempted to justify her constant demands by claiming to be misunderstood and neglected by her husband ("he cares more for others than for me," "he never spends any time with me"), or by invoking helplessness or developing infirmities such as headaches, fainting spells, and complaints of incapacitating anxiety.

When the therapist appeared to lose interest, she would elevate her complaints, and, in the extreme, she would develop some concrete difficulty (somatic, personal), or finally, would act out in retaliation by, for example, getting drunk or threatening to have an affair. Characteristically, in order to please her therapist, she attempted to give him some of the things that she felt he wanted, especially intellectualized insights, e.g., "I am still dependent on my (dead) mother." However, she never showed any interest or capacity to use the therapy for gaining insight into her internal difficulties and ultimately for change.

History. Mrs. B.'s mother had divorced Mrs. B.'s father when Mrs. B. was one year old. Her mother was only intermittently available thereafter, and for varying periods Mrs. B. had been cared for by her grandmother. Finally Mrs. B. was placed in an orphanage at four and a half years of age and was not returned home until she was seven and a half years old after her mother had remarried.

Mrs. B. remembered her mother as strict and demanding. For example, Mrs. B. was given almost no social privileges. Instead she was made to administer to her mother's needs. For example, she was often made to get up at night or to remain home from school when her mother was upset or was suffering from one of her many somatic complaints. In addition, in spite of her efforts to please, Mrs. B. felt that her mother favored her stepfather, and, ultimately, her half-brother who was ten years younger.

Although Mrs. B. resented her mother's fickleness, her main effort was to gain a secure and favored position with her. In fact, Mrs. B.'s entire adult history can be understood as variations on this theme. As a child, she tried exceptionally hard to please her mother, and did her best to under-

mine her two male competitors. As an adult, she stuck closely to her mother and thwarted any interest her husband had in developing a more separate existence with her.

Mrs. B. followed through and accepted therapy at our clinic only eight months after her mother's death in April, 1966. She was definite in relating her wish for therapy to the loss of her mother. In her words she wanted a our treatment,

Individual Therapy with Mrs. B. Several months after the inception of our treatment, I began to consider a revision in the treatment strategy. The previous therapists had warned about Mrs. B.'s total inability to use therapy for the purpose of insight and change, and this had already been somewhat confirmed in the new treatment.

This process involved two phases. At first, it was decided to take a less interactive, more neutral, and more exploratory stance than her previous therapists. Essentially, the aim was to avoid interacting with Mrs. B. in any way that she could construe as directly gratifying. It was hoped that this would shift the focus of the work from the external to the internal. Furthermore, her incessant complaints about the hardships of her life and the disinterest of her husband were treated as a resistance to exploring her own psychology.

In reaction, Mrs. B. escalated her demands. She continued to see therapy as a real situation in which she was engaged in a day to day struggle to win her therapist's support and affection. Also, she continued to feel victimized, primarily by her husband. As a result, after five months of treatment another change in strategy was instituted. At this point the decision was made to bring Mrs. B.'s husband into treatment.

Mr. B.

Mr. B. grew up on a farm. He was the youngest of seven siblings. From the time of his early childhood his mother had selected him as a special child, and attempted to use him as an emotional substitute for her alcoholic husband. In addition, she redoubled her hold on him through strict religious teachings and obligations. His position in her life was further elevated at age ten when his mother divorced his father, and his brothers went off to war. In spite of his show of devotion to his mother, Mr. B. increasingly found the relationship to be stifling and ultimately emasculating. At age 17, he left home to join the Navy, and following this first move away from his mother he rarely returned for visits.

Conjoint Treatments

Mr. B. presented himself at the onset of treatment as a hard-working and well-intentioned husband who, because of his long hours at work, had

little time to spend with his family. He felt justified in resenting his wife's insatiable demands that he spend more time and be more involved with her and the family. However, he had difficulty confronting her with these feelings directly, and instead, out of guilt, emersed himself in his work in order to compensate for his resentment. (The parallels to his relationship with his mother are obvious.)

Mrs. B. spent most of her time during the early phases of the conjoint treatment attempting to maneuver the therapist back into individual treatment with her. She attempted at first to demonstrate, along with her husband, how useless the conjoint arrangement would be.

This was interpreted as a resistance to involving herself in and exploring her relationship with her husband. In reaction, Mrs. B. became increasingly direct in expressing her resentment at having to share the therapy with her husband. As a result it was possible to make certain clarifying observations. From Mrs. B.'s interaction with her husband, and in spite of her claims to the contrary, it became clear that she had absolutely no interest in improving her relationship with him or accepting his support. She very much needed to maintain the position that he was and would always be unavailable to her. She did this in order to justify the demand that the therapist continue to give her special consideration. She seemed to feel that without this justification, and without active coercion of the therapist, that he would lose interest in her.

In part, by demonstrating contradictions between Mrs. B.'s claims and her husband's behavior, and in part, by enlisting Mr. B.'s observing ego and helping to free him from his part in the pathological interaction, it slowly became possible to demonstrate these discrepancies to Mrs. B. The work with Mr. B. was, of course, a major feature of this treatment; however, it will not be a focus of this presentation.) Furthermore, it was possible to illustrate to her how her concerns about being deprived and overlooked were precisely the same that she had experienced with her mother, and in this context to make the statement that, although these concerns may have had some realistic basis early in her life, under the current circumstances, they were quite irrational.

As expected, the pace of this work was painfully slow. Every progressive move was matched by retraction and an accusation. Mrs. B. easily felt she would be overlooked and cheated. However, with time Mrs. B's whining and nagging slowly declined. She focused less on the therapist and became more directly involved in experiencing and exploring the relationship with her husband. As this occurred, after about a year of conjoint treatment, many of the affect-laden issues of disappointment and feared deprivation which had previously characterized the relationship with the therapist were experienced and explored in the relationship with her husband.

In addition, as this work proceeded and Mrs. B. came to feel more optimistic about the relationship with her husband and less desperate in her need to cling to the therapist, she began to develop some tenuous

friendships and became interested in part-time work managing a small snack shop (this unfortunately failed after several months because of interpersonal difficulties which developed between Mrs. B. and her partner). It is noteworthy that with this development she also began to experience a new kind of anxiety, namely, a concern about her capabilities and related anxieties about potential humiliation. At this point, she felt she needed help to take forward steps. She was engaged in what might be termed a "developmental task." Her concerns seemed more genuine, and as a result, at times her husband responded empathically.

After a year and a half of conjoint treatment, a transfer to a new therapist became necessary. After some initial testing of her new therapist in an effort to see whether she could again seduce him into a directly gratifying relationship the work with the B.'s proceeded much as it had previously. Progress was signaled by such events as Mr. and Mrs. B. vacationing together for the first time in many years (six months into the new treatment), and Mrs. B. making the decision to donate time to a volunteer organization (one year into the new treatment). It is also noteworthy that within the first year of treatment Mrs. B. came to better understand her relationship with her deceased mother, and its repercussions for her current life. A major event in the treatment occurred when she was able, for the first time, to recognize with bitterness how cheated she had felt by her mother. Following this, her outward devotion to her memory of her mother decreased noticeably, and she showed a more vigorous interest in her husband and her outside life.

CASE 2. THE D. FAMILY

The D.s were seen in once-a-week therapy for two years and seven months. For the first year, the sessions were attended by the D.'s son, G., age 16, Mrs. D., age 51, and Mr. D., age 49. The treatment had originally been requested by Mr. D. for his son, in spite of the fact that for years Mr. D.'s wife and medical doctors had been suggesting that he seek treatment, and, more recently, the same suggestion had been made by a juvenile court worker who had some contact with his son. Mr. D. was concerned that his son was "defective and becoming perverted," and he was feeling frustrated in his efforts to regulate G.'s life. G. left treatment at the end of one year when it became clear that his alleged difficulties were largely the externalization of Mr. D.'s problems and reflected a displacement of the animosity which existed between Mr. and Mrs. D.

Mr. D.

At the time of the referral, Mr. D. was unable to appreciate his own immense, progressive feelings of inadequacy. He had returned to college at

age 31 in the hope of making something of himself. His wife supported him financially through these years. However, as was characteristic of him, Mr. D. quit college shortly before finishing because of a sense of "discouragement" and some feeling that his physical health was failing. He then went to work as a laboratory technician. Two years prior to referring his son for treatment, he suffered a serious heart attack, and afterward did not return to work. Rather, he became more isolated and eccentric and fanatically involved himself in his hobbies, mainly collecting things and reading.

Mr. D. was the older of two children. His father had died when Mr. D. was seven years old. His mother was described as having been highly volatile, domineering, and often brutal and sadistic. She had frequently cursed and beat him. At age eight, soon after the father's death, his mother suffered a nervous breakdown. As a result, the two children were placed in a foster home for at least several months.

Mr. D. developed a tremendous hatred, but at the same time, fear of and need for his mother. There are indications that Mr. D.'s father had been a rather distant figure before his death. In spite of this, Mr. D. secretly believed that if his father had lived, he would have offset the influence of his mother and given him what he had needed to be a success.

Throughout his life, Mr. D. tended to deal with his anxieties about his feared defectiveness by taking refuge in his hobbies and ideas for future success, for example, as an artist or politician. It is striking that his schemes and interests were always pursued in isolation and were always abandoned at some point prior to the time that they would reach their fruition. Underlying this pattern was the fear that his productions would embody his underlying defects. By not completing anything, he could, in a sense, deny the existence of these defects.

Mrs. D.

Mrs. D. was the seventh in a sibship of nine. She was the first daughter and apparently was the favorite of her father who died when she was sixteen. She felt guilty about being favored and compensated by becoming zealously faithful to mother. Underneath, she continued to idealize her father and wanted ultimately to meet a man who, like this idealized person, would transform her life. Throughout her marriage, she struck a compromise between her aspirations and her guilt about them. She chose a needy and unattractive man, and mothered him in the same way she had mothered her own mother. Unconsciously, however, she resented having to do this. She wanted her husband to be successful for her and cherish her.

Her son was conceived in anger when Mr. D. disappointed her and withdrew from college. G. was used, thereafter, by Mrs. D. to carry and express her antagonism towards her husband. The relationship between Mrs. D. and her son was intimate and seductive.

On the other hand, Mr. D. displaced much of the hostility he felt

towards his wife onto his son and the "conspiritorial" relationship Mr. D. accused him of having with his mother. He was afraid of expressing these feelings freely towards his wife. Like his mother, she was important and necessary to him. He was afraid of excessively antagonizing and alienating her.

Treatment

Following the evaluation at our clinic, Mr. D., somewhat reluctantly accepted the recommendation for family treatment. (He vigorously denied that it was he who needed treatment.) In our early sessions, he did most of the talking. He accused his son of being deficient and perverted. Alternately and more mildly, he expressed anger and contempt toward his wife for being "weak" and "a disappointment."

Increasingly, especially after G. left treatment, Mrs. D. was able (as she became aware of her real needs and of her guilt about them) to mount an attack against her husband. She felt that he was unreasonably abusive toward her, used her, and provided her with very little gratification. At the same time, she began to do things that were more directly gratifying to her, such as taking trips with a local environmental group and going to a family reunion which her husband boycotted. Simultaneously, as a result of this progressive detachment, she was able, at times, to see her husband as a pathetic and disturbed individual. Under the best circumstances, she was able to communicate this view to him in a constructive way.

For a long time, Mr. D. continued to insist that his claims were realistic. However, as his son became aware of the role that he was playing and eventually left home two years after the treatment began, and his wife became more firm (on one occasion, she even threatened to leave him if he did not stop his fanatical involvement in a political movement), it became increasingly difficult for Mr. D. to sustain his belief that his claims were realistically based.

Progressively, Mr. D. became aware of his sense of inadequacy and hopelessness. He began to talk about how impossible it would be to realize something for himself. At the same time, he became progressively depressed. Previously, the strongest advocate of treatment (with the goal of exposing his son's and wife's deficiencies), he began to feel resentful of it. He found excuses not to come, and he developed somatic complaints.

Along with this, episodically, Mr. D. became more insightful and began to make historical connections. He was able to relate his current sense of inadequacy and futility to behaviors and difficulties of his earlier adult life, such as failure in college. (Previously, he had denied any relationship and had taken a stance which negated any self-exploration.) Finally, he became aware of the significance of his early childhood experience with his mother, and he began to wonder about the significance of the loss of his father. He lamented the fact of his father's death because, in his view, it probably had

deprived him of the only person who might have encouraged and supported him.

As Mr. D. became more aware of his difficulties, he also became increasingly motivated to work these out and understand them through self-exploration. Although he expressed a certain amount of pessimism about whether he would really amount to anything, he accepted the recommendation for individual treatment rather easily.

Although the conjoint treatment continued for about eight months along side of the individual treatment, its utility seemed to diminish. As time went on, it became clear that Mr. and Mrs. D. had a reasonably good grasp of the nature of their personal difficulties and the ways in which these had been transformed into their marital problems. The next step, a more thorough exploration and some degree of resolution of the personal difficulties, could not be made efficiently in the conjoint situation. At this point, continued improvements in Mr. and Mrs. D.'s relationship through the conjoint modality seemed minimal. Mr. D.'s investment had shifted mainly to the individual treatment modality, and Mrs. D. had become increasingly convinced that, under the condition of her husband's present limitations, there was very little to gain in conjoint treatment.

DISCUSSION

The most impressive feature of these two patients is their massive use of the mechanism of externalization. Both were keenly focused on a member of their immediate families and implicated this person as the main cause of their concerns and troubles. This mechanism had the purpose of guarding against the recognition of certain ideas and feelings which were regarded as intolerable. In Mrs. B.'s case, it was the fear that she would be minimally valued by a central, potentially nurturing, figure. In Mr. D.'s case, it was pervasive feelings of inadequacy.

In addition, these people showed a pervasive defect in their object relations. Their early relationships had, in some ways, been deeply disappointing and frustrating. As a result, their sense of trust had been greatly impaired. In their adult lives, they were distrustful of everybody, including people who, on the surface, were idealized and "positive." They were always engaged in a hypervigilent effort to get these people to meet their needs. This can be viewed as defending themselves against a deeper commitment to these people. That sort of commitment would carry the threat of disappointment and ill use.

The implication for these patients' ability to engage in individual exploratory psychotherapy is clear. They were inherently distrustful, and they could not tolerate the recognition of negative features within themselves. As a result, they were both unwilling and unable to engage in a process of self-observation.

In both cases, the introduction into the treatment of the family member or members who were the major recipient of the patient's distortion initiated a process which concluded in self-observation and improvement in the marital relationship. At least three features of this revised strategy can be identified as having contributed to this.

To begin with, the conjoint situation seems to have provided a context in which the therapist could take a strongly neutral and exploratory posture. It allows for this by freeing him progressively from getting involved, even subtly, in the real and gratifying interactions that the patient attempts to foster. This happens, in part (if things go well) because the claims of the patient about the spouse tend to be disconfirmed. For example, on several occasions, Mrs. B. presented herself in the beginning of a session in a depressed, tearful state and on the verge of disintegration. Mr. B responded with confusion and surprise. He would report that just a few minutes previously, she seemed to be feeling quite well. The therapist was able, through the use of Mr. B.'s observation, to strengthen his own inclination to refrain from rushing in and supporting Mrs. B. Under these circumstances, Mrs. B. always quickly reconstituted.

Second, the conjoint arrangement provided a setting in which the patient's claims about the spouse, and in turn, the patient's whole system of externalization could be convincingly challenged. With the spouse present, the patient's claims about him or her can be subjected to direct and immediate scrutiny. This becomes increasingly useful and effective as the spouse frees himself from the pathological aspects of the situation. Ultimately, the patient begins to become aware that these claims are unfounded and gains some recognition that their motivation and source resides in his own pervasive internal discomfort. This function of the conjoint situation can be viewed as a parameter of an individual exploratory psychotherapy rather than a feature of conjoint psychotherapy proper. It is directed specifically at the individual patient, and its objectives could conceivably be achieved by bringing the spouse temporarily into an individual treatment.

Finally, conjoint psychotherapy proper yielded something of importance for these patients. The needs which these people have are infantile in character and, therefore pressing and uncompromising. Characteristically, they attempt to reassure themselves unrealistically that these needs will be gratified by some compensatory person or event outside of their current life situation. This objective was implicit in Mrs. B.'s efforts to exert a special influence with her therapists and in Mr. D.'s resorting to grandiose daydreams and fanatically immersing himself in causes and hobbies which he secretly believed would bring him belated recognition. The conjoint treatment addressed this problem through its introduction into these peoples's lives of the possibility of a more gratifying marital relationship. As a result the stakes in losing the therapist as a "real" gratifying object or in giving up a restitutive fantasy (as in Mr. D.'s case was implicit in his fanatical involvement in hobbies and causes) progressively

tends to diminish. Paranthetically, as a deeper involvement with the spouse begins to develop, certain new difficulties are usually experienced. Both people make intense (infantile) demands on each other, and new anxieties present themselves. The therapist's clarifying and supportive presence during this period is important to stem the enormous pressure experienced by the patients to retreat to old defensive postures, or to act out and flee from the marriage.

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