Psychotherapy

It’s Individual Psychotherapy—
So Why Meet with the Spouse?

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Early in my career, I received some practical advice from an unexpected source, advice that over the years has proved invaluable. The source was a senior psychoanalyst and the occasion was our initial supervisory discussion of my first psychoanalytic case. After he heard the details of the patient’s problems, my supervisor said: “Well, of course, as part of this evaluation, you will want to meet with your patient’s wife.”

This sounded heretical and antithetical to all that I had heard in the lecture room about how to conduct psychoanalysis. “Why?” I asked, “he hasn’t suggested there is a problem in his marriage; he says he wants to understand his reactions of rage. Are you supposed to see a spouse of a beginning analysand? Won’t it confuse the transference?”

My mentor’s response was clear. I would be hearing about his wife for the next 4 or 5 years. There was no telling what I might learn by having a personal look, and it would help enrich my sense of the patient and the world in which he lived.

In our work with children or adolescents, meetings with the family are usually routine. When treating patients with severe mental illness or those with suicidal or homicidal ideation, involvement of family members is a natural part of the evaluation and treatment process. In writing about the psychiatric interview and history-taking process, Sheiber includes a section about meetings with relatives and friends but it is in the context of those who choose to accompany the patient to the interview. His thrust is primarily how to manage the immediate situation. My supervisor had a different referent. He was suggesting that meeting with a patient’s spouse should be a routine part of the initial evaluation process of all analytic and psychotherapy patients, regardless of whether or not there were any specific clinical indications.

In my meeting with this patient’s wife I did not uncover any hidden secrets, but I did develop a more three-dimensional picture of his life. The insights I gained were very useful over the time we worked together. For one thing, I found that his wife had a genuine affection for her husband. She described his gentle nature with their children and other areas where he expressed spontaneous kindness and concern. His “black side,” as she called it, confused her. His angry outbursts were intimidating to someone with her shy and somewhat introverted nature; nevertheless, she was confident about the overall positive nature of their alliance. This knowledge of her commitment to the relationship provided a useful background during her husband’s work in analysis. As he delved deeper into this “black side,” with all of the attendant pain, depression, and confusion, I knew that when he left my office, he was returning home to an atmosphere of warmth and security.

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This pattern of meeting with a patient’s spouse or significant other continues to be a routine part of my initial evaluation of most new patients. The information gleaned is sometimes quite unexpected and frequently useful—and never detrimental. There is considerable variability in the type of information that emerges. Sometimes I learn that the relationship is relatively solid and will provide a source of support and growth during the psychological work ahead. Or I may find that the relationship is shaky and can be expected to be turbulent during the course of treatment. At other times, I learn that the relationship is fragmented, nonsupportive, and may soon dissolve.

CASE EXAMPLES
The following brief case vignettes give a sense of the range of information that may emerge from such meetings.
Case 1

For many years, Mrs. A had been seeing a psycholo-
gist for mild recurrent feelings of depression. When
the psychologist relocated to another city, he sug-
gested she see a psychiatrist since her depression was
becoming more severe and medication seemed indi-
cated. During our first meeting, I said: “When I am
first getting to know new patients, I like to have a
chance to see them at least once with their spouse.
This helps to enlarge my picture of their world. It is
also helpful to hear how one’s family experiences the
problems.” She was quite agreeable.

However, on her return visit, she announced that
her husband refused to come in. “Is it a problem for
you,” I asked, “if I telephone to ask him myself? That
way I can clear up any misunderstandings he might
have about why I want to see him. Sometimes hus-
bands or wives anticipate that they are going to be
blamed for whatever problems exist. They don’t real-
ize that I truly want to learn what life is like for them.
If your husband will come in, he may be able to help
the two of us appreciate more about your problems.”
She gave me permission to telephone her husband. I
was surprised to hear his response: “Listen,” he said,
“I can’t stand her or her depressions. When she isn’t
depressed, she is erratic, outspoken, and babbling all
over the place with enthusiasm. I can’t stand that
either. When she gets over this depression, I am out
the door. If you want me to come in and tell her that,
I will. However, I don’t think it will help. On second
thought, even if it did help, I don’t want to do it and
I won’t.”

Although the telephone call did not result in my
meeting the spouse in person, it was still extremely
illuminating. I had heard about a potentially manic
aspect of the patient’s functioning that she didn’t rec-
ognize in her present state. I had also learned that the
husband, whom his wife described as warm and sup-
portive, was not going to be around for long. And
indeed, later, when she recovered from a severe manic
episode, he was no longer there.

Case 2

Another patient, Mrs. G, told me her husband was hos-
tile and attacking. Observing their interaction was
like watching the performance of a Eugene O’Neill
play in which a married couple portrays a caricature of two
people living out the attacks, pain, and misery of a
sadomasochistic relationship. Had I not seen the cou-
ples’ performance, I might have thought that my
patient was somehow distorting the situation. I would
have found it hard to imagine the degree of hostility
displayed by the husband being met with such passive
acceptance from the wife. But, having seen the reality,

I was well informed of the type and breadth of the
problem.

The above vignettes describe but a few of the potential ben-
efits that can be gained from meeting with the spouse, sig-
nificant other, or other primary figures in the patient’s life.

STRUCTURING THE MEETING

Timing

It is important to schedule this meeting during the early
part of the evaluation process. This clearly distinguishes
the meeting as part of the process of learning about the
patient and the world in which he or she lives. Other joint
sessions may be arranged later in response to particular
problems, but this one is identified as purely “information
gathering.”

Of course, there are also other advantages to such a
meeting. Having met and talked with you, the partners
usually feel more comfortable asking you for a referral if
the need arises. They may also find it easier to telephone
should special problems occur (e.g., should the patient
start drinking heavily, seem to be taking unnecessary
risks, or causing them to worry in some other way).

Meeting as a Couple

The husband and wife need to be seen together. This
approach has several positive advantages and avoids cer-
tain potential pitfalls. As the patient’s partner describes
situations, the psychiatrist can observe the interaction of
the couple and encourage the patient to react to what is
said, thereby capturing a first-hand glimpse of how they
respond and interact with one another. While observing
the couple sitting together on the couch, the therapist may
observe a reserved distance or, conversely, warmth and
affectionate touching. Sometimes barbs fly back and forth
that appear to reflect real hatred, while, at other times,
one sees a bantering that is a comfortable, though per-
haps not so healthy, way to communicate.

Meeting the two as a couple avoids the possibility that
you will be told things in private that the partner later
demands be kept in confidence. Despite explaining at the
beginning of the meeting that confidentiality is the
patient’s privilege and not the partner’s, misunderstand-
ings in this area still occur and can be troubling for the
developing therapeutic relationship. Seeing the partner
and patient together also avoids any confusion about the
boundaries of the psychiatrist-partner relationship, since
meeting with the partner individually can inadvertently
give rise to the partner’s wish and belief that you will be
his or her therapist as well. Early on, I had a couple of
such experiences when, because of special circumstances,
I met individually with a spouse. For example, one woman
poured out her heart, telling for the first time of her
intense depression and suicidal despair. Then, having told me all of this, she refused to see any psychiatrist other than myself. She was insistent that either I would treat her or she wouldn’t see anyone. After a few joint sessions with her husband, which allowed the intensity of the idealized transference to defuse, she did accept referral to another psychiatrist. However, it was a bumpy road for a while.

Format of the Meeting

First, it is important to put the partner at ease. Although a spouse often welcomes the opportunity to have such a meeting, he or she is usually somewhat on guard, anticipating blame for the patient’s illness or other problems. A “thank you” for coming, a warm and welcoming attitude, followed by setting the stage with a question such as, “Tell me how you see your spouse’s problem,” usually defuses any anticipatory anxiety.

The partner relaxes and launches into the subject with ease. What then ensues is a reciprocal discussion between the patient and spouse about the issues that have been raised. For example, the patient may be unaware of the timing of his symptoms, but his wife can tell you, “When his boss telephones, he’s always agitated, can’t sleep, and he yells at the kids.” Or the husband may say that the problem seemed to start after the patient got her promotion: “She is really brilliant, and I have heard her give terrific presentations, but she started to fall apart since she got the new job with all the added responsibility.”

At some point during the meeting, spouses may begin to hint at troubling aspects of their life and can be encouraged to talk about these as well. By the time the couple leaves, I have often learned something about the partner as well as the patient and the dynamics of their marriage. These meetings are always rich experiences that inform the treatment in many different ways.

CONCLUSION

A review of the literature on “analyzability” written by Bachrach and Leafl in 1978 does not contain any reference to the idea of including the patient’s spouse during the initial evaluation. However, more recently Oldham writes that, in his experience, “it is often useful, when possible, to meet with a spouse or with significant family members for a more complete clinical evaluation.” Our patients don’t live in a vacuum. The important people around them contribute to their turmoil and their support and are an important factor in their disability and their health. Christensen reminds us that marital distress and divorce are not psychiatric disorders per se, but that they take a heavy toll on human welfare. The life of a couple has a tremendous impact on each of the two individuals. Psychotherapists gain valuable insights by looking, even if ever so briefly, into that part of their patients’ lives.

References


