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The Unseen Spouse: Pitfalls and Possibilities for the Individual Therapist

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Individual therapists often hear a great deal about our patients' spouses or partners, and naturally develop ideas and beliefs about that unseen other and about the causes of any relationship difficulties the patient reports. Not uncommonly, therapists can lose touch with the fact that their impressions of an unseen spouse are constructions that have emerged from the transference/countertransference field, based on only partial or limited information—not veridical truths. They can then talk with the patient about his or her partner or relationship issues in ways that can ultimately do both patient and spouse a significant disservice and perhaps distract from the patient's own issues and analytic goals. This paper discusses several factors that seem to contribute to the development of this problematic dynamic, including various qualities of the transference/countertransference field, and offers suggestions for avoiding or reducing it. Clinical material is used to illustrate key points.

INTRODUCTION

A psychoanalyst colleague I like and respect called about referring a couple. “I see the wife,” his message explained. “She's bright, insightful, interesting, really uses the

individual treatment very well. I think you'd really enjoy working with her. She's married to a man who … [pause] … ah … loves her, I think, but is very narcissistic and extremely limited emotionally, just not capable of the kind of emotional intimacy she needs. She's been severely depressed for some time and we've discovered in our work that most of it stems from her marriage and her husband's inability to relate with the level of emotional depth she needs." He sounded so definitive that I wondered if he might have met the husband or seen the couple at some point, but I learned later he had not.

As might be suspected from the title of this paper, when I began with the couple I developed a very different conceptualization of the husband and the reasons for the couple's difficulties. I eventually came to believe that my referring colleague's impression of his patient's husband as emotionally incapable was at best only "part of the elephant" and at worst quite inaccurate and damaging to the marriage, the marital treatment, and ultimately both partners. The accompanying view of the wife as primarily the unfortunate victim of an emotionally limited husband—rather

than an active co-constructor of her marriage—was similarly problematic and may have distracted both analyst and patient from important analytic work of the wife's. By the time I met the couple, these beliefs were long-standing and very firmly entrenched in both the wife and her analyst and thus very difficult to question, deconstruct, and alter.

This scenario is all too familiar to couple therapists—perhaps much more so than most individual therapists/analysts realize.[1] Individual therapists frequently

hear a great deal about our patients' spouses or partners[2] and naturally develop ideas and beliefs about that person and the causes of the couple's difficulties. For a number of reasons to be discussed next, individual therapists (including me when I am in that role) can lose touch with the fact that our impressions of and beliefs about an unseen spouse are not veridical truths but constructions based on only partial or limited information. Even the most seasoned, sophisticated, and thoughtful clinicians can fall prey to this dynamic, in which they seemingly forget that their impressions of the spouse are based only on information that has been filtered through their individual patient's transference or subjectivity as well as their own. They can then begin to speak about the patient's partner or relationship issues in ways that can ultimately do both patient and spouse a disservice and perhaps distract from the patient's own issues and analytic goals.

During a conversation with the wife's therapist (held with the couple's consent[3]), I found myself defending the husband of this couple and reminding my colleague that he had never met the man or watched the couple engage with each other. “OK, OK,” he eventually exclaimed in semi-exasperation, “I realize I only have her side of the story. Of course I only have what she tells me, but still, I have to say *something* when this guy hurts her or disappoints her once again, as he has for so many years now! What else can I say when she tells me these terrible things?!” Although feeling somewhat exasperated myself until that point, I suddenly felt more empathic with his frustration and recalled times I had been in his position as the individual therapist.

This paper emerged from that moment. What *is* best for individual therapists to do when our patients complain about apparently terrible mistreatment by their partners? How can individual therapists respond empathically and helpfully without inadvertently contributing to a set of

ultimately problematic constructions of the spouse or neglecting important individual analytic work? Contemporary psychoanalytic theory, with its emphasis on the complexity and co-created ——————————————————

[1] Evidence that this problem is fairly common includes the frequency with which it comes up in discussions among couple and family therapists. Every couple therapist I know has a story similar to mine, in which they felt a couple treatment they were conducting was significantly impeded by the presence of inaccurate (or only partially accurate) constructions of an unseen spouse by one partner's individual therapist/analyst. Gerson (2009) and **Maltas (1998**) have written of similar situations (discussed next), and the problem has been discussed on the listserv of the Couple and Family Section (Section VIII) of APA's Division 39. Finally, at a recent discussion hour sponsored by Section VIII, I read aloud only the first few lines of this paper, just up to the point when the referring analyst paused before describing his patient's (unseen) husband, when to my surprise the room of 25 to 30 couple therapists burst into the laughter of recognition. After only two sentences, they had already correctly guessed where the analyst's phone message—and my paper—was heading.

[2] I use *spouse* and *partner* interchangeably, since the points made apply equally to married and unmarried, gay and straight couples.

[3] A discussion of the advantages and disadvantages of this kind of collaboration between psychoanalytic clinicians is beyond the scope of this paper, but I essentially concur with Graller and his colleagues (2001; also cited in the next section), who examined the issue in a two-year study group. They concluded that collaboration between therapists who are treating spouses concurrently is often very helpful, although contraindications must be carefully considered. They have proposed a useful psychoanalytic framework to guide the collaborative process.

nature of interactions and relationships, can help shed light on these issues and provide a useful framework from which to think about and begin to answer these questions.

LITERATURE REVIEW

The development of strong opinions by the individual therapist/analyst about a patient's spouse (or another of the patient's objects) has been discussed intermittently in the

literature beginning as early as 1926, when Deutsch noted the potential impact of the analyst's reactions to the patient's objects on the treatment and the free development of the transference (Deutsch, 1926). **Racker (1968**) later distinguished between the analyst's identification with aspects of the patient's personality (concordant identification) and identification with the patient's internal objects (complementary identification).

Building on Racker's work, **Jacobs (1983**) discussed the analyst's emotional reactions to actual others in the patient's current life, rather than only to their internal objects. He noted that “each patient brings to the consulting room a world of people … a cast of characters worthy of a Chekhovian drama” (p. 624), to which the analyst naturally responds with strong emotions. The paper gives several examples of the analyst's emotional reactions to the patient's objects (including their parents, children, bosses, and spouses/partners) having an inadvertent negative effect on the treatment, at least until the analyst became aware of the problem. In one example, Jacobs meets an analytic patient's mother and is surprised to experience her far more positively than he had expected given his patient's portrayal of her. He attributed such situations to “the analyst's unconscious identification with his patient and his consequent adoption of the patient's view of his objects” (**Jacobs, 1983**, p. 627) and to a process in which the patient's descriptions stimulate “the reemergence of the analyst's own affectively charged self- and object representations” (p. 627), which become linked with those of his patient.

Gerson (2009, p. 12) referred more specifically to the problem I raise here. In her discussion of transference in couple and family therapy, she described a referral phone call that is remarkably similar to the one I opened with. In her vignette, the wife's individual analyst describes his

patient's husband (whom he presumably has never met) as “quite schizoid and antagonistic, constantly berating her in an obsessive way for small failures” (Gerson, 1996, p. 12) and states that his real reason for referring the couple is to get the husband into individual treatment. The couple therapist later experiences the wife as withdrawn, resentful, and self-righteous and sees the husband's nit-picking as a symptom of his fruitless efforts to make contact with her.

“It is tempting for the couples therapist to simply conclude that the referring analyst is a muddled clinician,” Gerson (2009, p. 13) noted—a temptation I admittedly succumbed to in my more exasperated moments with my referring colleague, at times using even stronger terms than “muddled.” She suggested that rather than judging or criticizing our colleagues when this dynamic occurs, we should instead ask how it is “that a patient becomes so convincingly a certain kind of person within the analytic transference–countertransference matrix and yet appears quite otherwise within another intimate relational system” (Gerson, 2009, p. 13). I very much agree but suggest that we also ask how, within the analytic transference–countertransference matrix, the therapist/analyst becomes so convinced that an unseen spouse is a certain kind of person—especially when that therapist typically thinks in a more speculative, relational, or constructivist manner.

Recent evidence of the enormous amount of information that is processed, stored, and communicated through the implicit system (**Shimmerlik, 2008**) or enactive domain (**Lyons-Ruth, 1999**)—outside of conscious awareness—can

also shed light on this phenomenon. Shimmerlik illustrated in detail how implicit messages sent between a couple and their therapist (outside of their awareness) resulted in a repeated pattern in which the wife would unknowingly waylay or truncate her husband's emerging affective experience by intensely experiencing and expressing the affect he was just about to access, thereby shifting the focus away from the husband onto herself. Clearly, neither partner could have adequately described this implicit enactive process to their individual therapists. **Shimmerlik (2008**) cautioned at the end of her paper,

> As analysts I believe it is crucial that we know that we often do not have access to aspects of our patients' experiences that are enacted outside of our consulting rooms. Just knowing that we do not know can leave us open to a more complex frame from which to understand the experience of our patients. (p. 387)

Several papers on collaboration between therapists/analysts treating spouses in concurrent treatments (**Ehrlich, Zilbach, & Solomon, 1997**; **Graller, 1998**; **Graller et al, 2001**; **Maltas, 1998**; **Zinner, 1989**) refer to the phenomenon raised here, although it is not the focus of the papers. Advocating for increased collaboration between individual and couple therapists (especially in stalemated cases), Graller and his colleagues discussed case examples in which they saw the individual therapist as having unconsciously overidentified with his or her individual patient and joined the patient's negative view of the unseen spouse. They reported that in case discussions, the husband's and wife's individual analysts became quite angry and blaming toward each other while attempting to discuss the case, thereby enacting the couple's dynamics (**Graller et al., 2001**). **Maltas (1998**) similarly described a case in which the husband's analyst, the wife's analyst,

and the couple's therapist (Maltas) disagreed so strongly about the couple's problems that repeated attempts at collaboration between the therapists were unsuccessful. She eventually successfully educated the couple about the differences between individual and couple treatment and about how they had contributed to the split between their therapists.

Finally, **Gurman and Kniskern's (1978**) finding that patients in individual therapy were more likely to divorce than were those who chose marital therapy is also relevant to the present topic. The study's numerous methodological issues (e.g., patients chose their treatment modality, so people already leaning toward divorce might have been more likely to choose individual treatment, while those who chose joint work may have had a greater desire to stay together; **Sander, 2006**) require that its findings be interpreted cautiously. However, results are consistent with anecdotal reports and leave open the possibility that the higher divorce rate in the individual treatment group could have been at least partly due to individual therapists developing negative conclusions about or impressions of their patients' spouses or marriages—which then negatively affected the marital relationships and their outcomes.

The present paper seeks to build on this previous work by focusing specifically on the tendency of individual therapists/analysts to form strong opinions about an individual patient's unseen spouse or relationship and to lose touch with the limited nature of the data on which they are basing their opinions. It begins by examining factors that appear to contribute to the development of this dynamic, then moves to a discussion of how individual clinicians may mitigate its occurrence and be most helpful when individual patients complain about their partners or relationships.

THE DEVELOPMENT OF PROBLEMATIC CONSTRUCTIONS OF THE UNSEEN SPOUSE

What factors influence how the patient's descriptions of his or her partner are construed and taken up by the therapist/analyst, or how the patient's significant other lives in the analyst's mind? The problem I describe emerges from the complex transference/countertransference field involving the patient and his or her history and psychology, the therapist and his or her history and psychology, and the intersubjective field that is created between them. A number of factors seem to contribute to its development, including the following:

Positive transference-countertransference bond: Ironically, the individual therapist's negative constructions of an unseen spouse—and sense of these as unreconstructed fact—may be an unfortunate side effect of an otherwise very positive treatment. That is, the problem tends to occur when the attachment between individual therapist and patient is strong, when the therapist very much likes and cares about the patient, and when the patient's experience of the therapist is very positive or idealizing—all of which were true in the opening example. These factors are generally associated with a positive, effective treatment relationship, yet positive regard for the patient can also leave the therapist/analyst prone to underestimating the patient's role in marital difficulties.[4]

Positive transference/countertransference treatment relationships tend to bring out the best in patients (and therapists), so in these situations the individual therapist often has not experienced the patient at his or her worst and may not be easily able to imagine that side of the

patient. Often the therapist/analyst is being experienced very positively, while the spouse is experienced very negatively—the “split transference” described by **Graller (1981**) and others. From the perspective of the intersubjective systems theory of Stolorow and his colleagues (e.g., Stolorow, Bransdshaft, & Atwood, 1987), in these cases the patient is experiencing the therapist/analyst primarily through the lens of the selfobject dimension of experience, as a source of selfobject experience, while the spouse is experienced primarily through the lens of the conflictual-repetitive dimension of experience, as alarmingly similar to previous disappointing others.[5] Even in rockier treatment relationships that involve more negative transference, the protected, asymmetrical, helping-based treatment relationship still often does not trigger the same intense, painful reactions and interactional dynamics that marital or other romantic relationships do. Patient and therapist may therefore naturally conclude that since their analytic relationship works so well, any problems in the marriage or relationship must be more the spouse's fault than the patient's.[6]

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[4] Just as good parents are naturally protective of their children, it is natural for caring, emotionally connected therapists to want to protect their patients from perceived harm—in this case, harm seemingly caused by the spouse or the relationship. At times this protective pull can cause therapists to subtly or not-so-subtly encourage patients to leave a relationship that appears harmful, rather than encouraging them to examine in depth the multiple factors that might be contributing to the harmful interactions.

[5] A similar split transference dynamic often also occurs with extramarital affairs. The unfaithful partner often experiences his or her spouse primarily through the lens of the conflictual-repetitive dimension of experience while the new partner is experienced almost solely through the selfobject dimension of experience, at least initially.

[6] In the context of more negative transference–countertransference between patient and therapist, the opposite pattern can occur. When the therapist is the brunt of the patient's anger and/or in the throes of negative feelings

toward the patient, he may then more easily understand and identify with the imagined experience of his patient's *spouse*. Without more information about the systemic processes of mutual influence at work (discussed next), the therapist so identified with his patient's spouse is then more likely to underestimate the spouse's role in the marital problems and overestimate the patient's.

Finally, the more immersed the therapist is in the patient's inner world, or the more he or she sees the world through the patient's eyes, the more true or real the patient's perspective can begin to feel. While feeling deeply understood and having one's feelings shared or agreed with is obviously beneficial to patients, problems can develop if clinicians become so empathically immersed in their patient's experience that it begins to feel like objective "reality," rather than simply that patient's particular subjective experience. This may be a particular risk for self-psychologically informed therapists (including me), given our emphasis on empathic immersion/inquiry into the patient's subjective experience. However, the problem occurs with therapists of all theoretical persuasions, as discussed below.

Length of treatment: The problem may be more likely to develop in longer-term treatments. Most therapists begin an individual treatment with an open mind about the patient's spouse and the causes of any relationship problems the two may have, well aware that they are hearing only the patient's subjective, transference-colored experience of the partner and that any marital problems are co-created by both parties (although not necessarily symmetrically). Over time, however, as the relationship with the patient deepens, the patient improves and changes, and the therapist has heard more and more about the spouse, a gradual drift can occur. Individual therapists

can come to feel that they know this (unseen) person quite well and have a great deal of data to support their impressions—rather than simply a great many examples of their individual patient's transference-colored experience of the spouse and many examples of their own reactions to these descriptions. While these can sometimes lead to impressions of the spouse that are on target and fair to the spouse—impressions that fully incorporate the co-created nature of the relationship—very often this is not possible.

It is important to note that this issue can occur even when the individual therapist is aware of *some* of the ways his individual patient is contributing to marital problems—which my referring colleague turned out to be. “I know she can be difficult,” he acknowledged, and described his understanding of how his patient contributed to the couple's problems, which I generally agreed with. However, this awareness seemed to make him more confident in his opinion about the patient's husband's narcissism and emotional limitations—as though it was evidence that he was operating from an objective or unbiased viewpoint, rather than caught in a transference–countertransference collusion or enactment. All individual therapists may be somewhat susceptible to this conscious or unconscious belief and need to remind ourselves that having some understanding of a patient's potential contributions to the marital system does not mean that all of our impressions of or conclusions about the unseen spouse are necessarily unbiased or accurate. (Of course, couples therapists are not necessarily unbiased or “accurate” either—which is one reason collaboration between individual and couple therapists can be useful—but at least couples therapists have met and experienced both partners.) One corollary to the issue of treatment length, on a different note: when one member of a couple has had significantly more individual treatment than the other, the successfully treated partner

may understandably reason that the relationship problems must be largely due to the other's lack of comparably successful individual work. Therapists are not immune from this (conscious or unconscious) assumption. Yet while individual treatment can certainly be extremely beneficial and often does improve patients' relationship functioning, it of course does not make their marriages any less mutually and reciprocally co-constructed.

Therapist's experience in conjoint modalities: The amount of couple and family therapy the therapist has done —or participated in as a patient—may also affect the extent to which

he or she is vulnerable to losing touch with the limited nature of the data about the unseen relationship that is available in individual treatment. The powerful experience of conducting or participating in couple or family sessions can forever change the way therapists hear and respond to material from individual patients about their spouse or family members. “After so many incredible experiences of hearing the exact same interaction described from two very legitimate and valid but completely different perspectives, it has just become so ingrained in me that whatever one person tells me is only one side of a many-sided story,” one couple therapist put it. Therapists who do a lot of joint work—or who have had a positive experience of conjoint treatment as a participant—are certainly not immune to slipping into the problematic dynamic being described, but overall these experiences may make them less prone to it.

Theoretical perspective: Although clinicians of any theoretical orientation are vulnerable to the problematic transference–countertransference dynamic being

discussed, I believe that the therapist's theory can affect the frequency with which it occurs. For example, neo-Kleinian therapists, with their focus on unconscious fantasy and projective and introjective processes, may be less likely to take up the patient's descriptions of the spouse as “accurate.” Other “one-person psychology” theories might make the clinician more receptive to viewing the pathology as located in an individual (such as the patient's spouse) rather than in the intersubjective matrix the two co-create.

Theoretically at least, a contemporary relational or constructivist perspective should make the problem less likely to occur. When responding to an individual patient's complaints about his or her spouse, clinicians operating from a two-person, systems, intersubjective or relational framework (e.g., **Mitchell, 1993**; **Stolorow & Atwood, 1992**) would hopefully focus on the ongoing processes of reciprocal mutual influence between the partners. Those influenced by the tenets of nonlinear dynamic systems theory or complexity theory (e.g., **Coburn, 2000**, **2002**; **Weisel-Barth, 2006**) would typically view both partners' behavior as affected by a multitude of unpredictable influences within and outside of their awareness (and the therapist's). More aware of how much we don't know, relationally-oriented therapists “hold our theories lightly” (**Orange, 1995**)—including, hopefully, theories about the patient's spouse or the causes of reported relationship difficulties. Finally, the extent to which the therapist holds a concept of multiple selves or a view of the self as having multiple self-states that are context dependent (Bromberg, 1998; **Davies, 1996**; **Mitchell, 1993**) is relevant as well. When listening to a description of a patient's spouse acting, for example, in a self-centered, unempathic, and narcissistic manner, the therapist with this view will hopefully wonder whether there might be sides of the spouse other than those the patient is describing—as well

as sides of the patient other than those the therapist knows—and in what contexts those might emerge.

For example, I experienced the husband in the case previously described as narcissistic, entitled, and righteously indignant when he was feeling threatened or triggered, which was most of the time. We eventually jointly labeled this his “Clint Eastwood” or “tough guy” side. Yet a surprisingly emotionally vulnerable and responsive “softer” side emerged when he felt adequately understood and responded to and when his wife or I were gentler or more vulnerable with him. His wife typically didn't notice this side of him because she was still reeling from the assaults of the tough guy, and because (as we discovered) she disliked that more vulnerable side of him, which she often experienced as pathetic or distastefully needy. This, of course, reduced his willingness to reveal it to her.

Similarly, when I met with the wife alone on occasion,[7] I felt much more connected with her and experienced her very much as her individual analyst had described in his initial message—as open, engaging, self-reflective, and so forth. In contrast, when her husband was present, especially if he was even mildly angry or critical, it was as though an entirely different person emerged. She would either shut down completely, becoming frozen, paralyzed, and vacant—almost catatonic at times—or would become enraged, bitter, hostile, and attacking (once throwing her shoe across my office), both sides of her that her individual analyst had never witnessed and was very surprised to learn of. These behaviors both triggered—and were triggered by—the worst in her husband, resulting in a

vicious cycle of co-created mutual selfobject failure that both partners experienced (and described to their individual therapists/analysts) as caused by the other.

In addition to illustrating the dangers of developing constructions of an unseen spouse based on only one side of the story—or one side of the patient—this example supports the contemporary relational/intersubjective view of behavior as co-created and emergent from an intersubjective field, and of people as having different self-states or self-organizations in different contexts. However, although the therapist's theory may play a role in some cases, the problem I describe occurs with therapists of all theoretical persuasions—including committed constructivists—which brings us to the most significant influence on the problem.

Transference–countertransference dynamics: Finally, as previously noted, the development in the therapist/analyst of strong feelings about a patient's unseen spouse emerges from within the transference–countertransference field created between them. Becoming unconsciously allied with one's patient in negative constructions of an unseen spouse can be an intersubjective collusion or enactment reflecting unconscious pulls from both the therapist and patient.

For example, the analyst's relationship history and psychology may make him particularly prone to experiencing the patient as victimized by the partner and himself as protector or rescuer. This dynamic can have an eroticized aspect in some cases, or can be motivated by grandiosity or narcissistic needs. The patient may likewise be drawn to or gratified by this configuration for similar reasons.

The therapist's acceptance of and adoption of the patient's view of the spouse can also be primarily defensive—a way to allow both therapist and patient to avoid examining and facing painful feelings. This could include

the avoidance of negative transference toward the therapist, or of having the therapist become the bad object. The phenomenon could also involve what Stolorow and his colleagues (**Stolorow & Atwood, 1992**) have termed an intersubjective conjunction, in which therapist and patient have such similar unconscious organizing principles that they go unnoticed as worthy of examination and analysis.

Jacobs (1983) detailed a case in which the therapist adopted his patient's idealized perception of the patient's son, such that the therapist pictured the child (whom he had never met) in particularly glowing terms. Exploration later revealed that the therapist had conflicted and ambivalent feelings about his own son who was about the same age as the patient's son. His unquestioning adoption of his patient's idealized image had allowed both therapist and patient to avoid these more difficult, conflicted feelings. A similar dynamic can occur when the patient's negative presentation of the unseen spouse is adopted and even heightened by the therapist. Doing so

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[7] A discussion of the pros and cons of meeting with partners individually as part of couple therapy is beyond the scope of this paper, but one of the advantages of doing so is the opportunity for the therapist to experience the individual partners in a different context and thereby get to know a different side of each.

may allow the therapist to avoid looking at conflicted feelings about his or her own spouse or marriage—or at his or her own role in co-creating their marital dynamics, for example.

The therapist's relationship history is of course likely to be reactivated when a patient is in the throes of a similarly painful marriage or relationship. Has the therapist ended a relationship and been glad she did so—or not left one and

wished she had? Is the therapist the child of parents who divorced—or who stayed together when he wished they hadn't? These and other aspects of the therapist's relational history will obviously affect how he hears and responds to his patient's relational complaints.

Last, the complex intersubjective field of analyst–patient–spouse is especially ripe for enactments involving triangulating or Oedipal dynamics (as is the field between two partners and their couple therapist). The history and psychology of any or all members of these triads could contribute to a tendency for two of the three to ally against the third.[8] Any member may have reasons to prefer triangular or oedipal scenarios and avoid more complicated quaternary structures (such as one including a couple therapist, to be discussed next) or post-oedipal scenarios, especially if those are more unfamiliar or anxiety provoking. For example, the therapist may have a narcissistic investment in remaining the patient's primary object.

In the case just presented, the wife had grown up aligned with her mother in both idealizing and feeling intimidated by her father. Her intense idealization of her individual therapist paralleled her idealization of her father, and aligning with her analyst in devaluing her husband was similar to ways she and her mother had been allied in their experience of the patient's father as intimidating, dominating, critical, and emotionally unavailable (although still idealized in many ways). Certainly the patient had not felt protected by or sided with by her father, so having her analyst view her husband as more limited than she and as more the cause of their marital problems was in many ways a very positive, powerful, new or corrective experience—one that she unfortunately experienced me as disrupting when I saw her husband and their relationship dynamics differently.

I cannot speak to the possible contributions of the wife's therapist's relational history to the development of his strongly-held negative impressions of the husband in this case, but I had my own unusually strong reactions to him (my colleague), which are similar to those that can occur between therapist, patient, and unseen spouse. At least until the moment of our conversation just described, and to a lesser extent thereafter, I often felt furious with him. I felt outraged and indignant on behalf of the husband, who I felt was being unfairly and inaccurately portrayed, as well as on behalf of the wife, who I felt was being colluded with, misled, and not well served. “Why did he even refer me the case if he was only going to sabotage it?” I complained, to myself and other colleagues. I even wrote much of this paper in the heat of this period.

Much later, I came to see the intensity of my reaction as the result of a complex interplay of my own history and issues, those of my colleague (presumably), and those of the couple.[9]

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[8] As noted earlier, in some cases the therapist may feel aligned with the spouse more than the patient. Much less often the patient and spouse may ally against the therapist.

[9] Things that contributed to this shift include a colleague who commented, “So the individual therapist is overidentified with his patient! What else is new? Why are you so set off by this?!” It also helped that at long last the wife, and to a lesser extent her analyst, incorporated some of my input on the husband and on the wife's role in the couple's difficulties. Most helpful was reading the paper by **Maltas (1998)**, previously cited, in which she understands and empathically manages a somewhat similar situation.

Having grown up with younger brothers I had to stand up for and advocate for at times, and having parents who divorced in part because of issues similar to those of this couple, clearly influenced my strong reactions to the couple

and to my colleague. As I had with my brothers, I defended the husband and advocated for him, seeing him as the underdog facing the powerful duo of the wife and her analyst. I also fought for the couple's marriage, maybe harder than they did at times—maybe harder than my parents had for theirs. I think my outrage and sense of injustice was fueled as well by my empathic resonance with each partner's anger and outraged indignation, and each one's profound sense of having been unjustly treated and deeply wronged by the other. My complaining about the wife's analyst to other colleagues even paralleled the wife's pattern of complaining about her husband to her analyst, family, and friends.

The point here is that strong opinions about an unseen spouse—like my strong opinions of my colleague, who was being only partially “seen” by me—are multiply influenced and emerge from within a complex relational field. They are therefore worth careful scrutiny, exploration and reflection. Increased awareness of the potential influences on these feelings (positive therapist–patient bond, the extent to which the therapist has experienced the patient in the throes of a negative transference, the length of the treatment, the therapist's experience with conjoint work, the therapist's theory, and the vicissitudes of the transference/countertransference matrix) may help individual therapists avoid or more quickly recognize the development of the dynamic being discussed. Frequent consultation and self-supervision with close attention to monitoring for this common pitfall are also crucial.

RESPONDING TO RELATIONSHIP PROBLEMS WHEN HEARING ONLY ONE SIDE OF THE STORY

So how can therapist/analysts best respond when patients in individual treatment tell us how their spouses

hurt them or painfully disappoint them—often in the very way their parents did—without contributing to a problematic construction of the unseen spouse or couple? In addition to closely monitoring for the transference–countertransference dynamics as just described, here are some ideas about responding to relationship complaints when hearing only one side of the story: *Appropriately qualify any statements about the unseen partner or the couple's dynamics*: As I hope is clear by this point, individual therapists should avoid making pronouncements or sharing strong opinions about the unseen partner or the couple's issues, at least without a strong qualifying statement. For example, in situations such as the case I opened with, individual therapists would ideally confine themselves to highlighting and validating how very mistreated and hurt by her husband the patient felt, without adding their own opinions or speculations about the husband's possible issues and pathology. “You so need X, but he does Y and it is so painful for you,” the therapist might say. If he/she felt it important to speculate about the husband's possible pathology or limitations, an appropriately qualified response might be something like, “It sounds like your husband might be very limited emotionally and may simply not be capable of meeting your emotional needs. That's the impression I'm getting from what you're describing, but since I've never met him, don't know what's going on inside him and why, and have never seen the two of you interacting, of course I may well be wrong or there may be a lot more to it. All we really know is that you aren't getting what you need from him at this point, and how deeply painful that is for you.”

Even better would be for the therapist to be clearer about the other possibilities. For example, “He doesn't do what you need, and that's terribly painful for you. Whether he's capable of doing it—or of learning how to do it—isn't clear. Whether there's just something about him, or something about what goes on between the two of you, or some of both—and whether any of those could be changed—all of that we don't know.”

Analyze as usual: Of course, complaints about the spouse should be processed and explored analytically, as with any material the patient presents. They may be most usefully viewed and responded to as we would to dream material: as a window into the patient's internal world, rather than an accurate portrayal of the spouse or external “reality.” It is not that analytically trained therapists/analysts don't know this; it is that, for the reasons just described, they don't always do it.

Possible areas for analytic exploration include but are not limited to the particular meaning for the patient of the behavior being complained about in light of the patient's history, the possibility that the complaint reflects displaced feelings about the therapist, and the meaning of the complaining itself. In many cases behavior by the spouse is particularly upsetting to the patient because it repeats old injuries or reactivates painful feelings from previous disappointments or misattunements—including those with early caregivers and perhaps in the analytic relationship. Finally, as we know, criticism of others may reflect any or all of the following: a need to defend against or avoid painful self-reflection, affect, or intimacy; an effort to feel superior in order to shore up shaky self-esteem; a typical way of engaging others in an advice-seeking/advice-giving dynamic; and/or a sense of self as victimized or helpless, without a sense of agency. These are just some examples of

the kind of material that can go unexplored or underexplored when this problem occurs.

Explore the intersubjective context of the complained-about behavior: Although the goal of the individual work is to understand the patient, not his or her spouse, sometimes the most helpful response to a relationship complaint involves drawing the patient's attention to the intersubjective context of the other's hurtful behavior. For example, the therapist/analyst might wonder aloud why the spouse might be behaving in a particular way. He or she could express curiousity about how the spouse might be experiencing the situation and about the presumably multiple factors that might be contributing to or influencing that person's behavior. This is similar in some ways to Fosshage's concept of “other-centered listening” (**Fosshage, 1997**); however, here I am referring not to the therapist listening as the other, as Fosshage suggested, but rather to the therapist encouraging the patient to reflect on and imagine the experience of the other and to consider what might be influencing that experience. The goal is not to analyze (or side with or against) the unseen spouse, but rather to help the patient learn to mentalize about the experience of others (e.g., **Fonagy & Target, 1997**; **Seligman, 2007**)—an important requirement for developing and maintaining satisfying relationships.

As long as the patient's ideas about the partner's experience are understood to be only speculations, and exploring them does not distract from other important analytic work, this can be a very helpful approach in certain cases—especially for patients whose parents did not help them learn to imagine the experience of the other. For patients who cannot yet tolerate couple therapy or whose partners refuse to attend, treating the relationship indirectly may be the best option available, although far from ideal. Some patients could tolerate the question,

“Wow, I wonder what was going on with her (the spouse) that she needed to do that?” from a trusted individual therapist but not from anyone else. Again, therapist and patient must assess the extent to which

this type of focus on understanding the partner is furthering the work toward the patient's analytic goals or distracting from them.

Exploring why the partner might have acted as he or she did often reveals that the patient has been so upset by the behavior or so focused on her own reactions to it that she has not even attempted to understand it from the spouse's point of view, cannot articulate the spouse's perspective in any depth, and/or has not conveyed her own needs and reactions to the partner in a calm, emotionally vulnerable, and nonblaming manner. When partners are able to sustain an empathic, emotionally attuned dialogue about a problem or issue, they often discover the processes of mutual influence through which the problem has been co-constructed.

For example, after empathizing with the patient's complaint that her husband had forgotten her birthday, the therapist eventually wondered aloud what might have been going on for the husband that led to this failure. The patient was initially nonplussed—she had been so full of hurt and pain and so focused on her experience of her husband as “narcissistic” and self-centered that it hadn't occurred to her to wonder about that. The therapist told her it was very understandable that she hadn't yet considered this question since it would naturally be difficult to think about her husband's experience or the reasons for his behavior when she was still feeling so hurt and angry.

This empathic acceptance seemed to help her shift gears a bit and give some thought to the question.

Eventually it became clear that the patient's husband had been extremely busy at work, was feeling unusually stressed and exhausted, and was also very hurt by and frustrated with the patient over her lack of interest in sex. She, in turn, had withdrawn from him sexually even before the birthday incident because she had not been feeling considered, cherished, and emotionally close. Her husband had been unusually busy at work for the previous few months, and the two had not been able to discuss the problem together. Neither had grown up in families in which feelings of neediness or disappointment were discussed openly. Moreover, the patient had grown up in an environment in which she often felt emotionally neglected, just as she was now feeling in her marriage. Making this connection allowed therapist and patient to consider not only how doubly painful these similar experiences would naturally be for the patient but also how her familiarity with the feeling of neglect and perhaps unconscious expectation of it may have led the patient to actively participate in co-creating it through her withdrawal, lack of discussion, and so forth. Had the therapist focused only on validating the patient's experience of hurt and anger over the forgotten birthday—and perhaps questioned whether the husband was capable of the kind of nurturance the patient needed—much less might have been learned about the mutual, reciprocal selfobject failures occurring in the couple and about the patient's part in perpetuating them. Much less might have been learned, as well, about the patient's own issues and themes, the main focus of the individual treatment.

Highlight what the patient does when hurt, angry or disappointed and where he/she learned to do that: When hurt, the patient in the previous example did several things.

She withdrew; she focused on her own hurt feelings and became consumed with feelings of righteous indignation; and she complained to her therapist, her mother, and her friends, but not to her husband. When she did raise a complaint to her husband, she did so in a critical, angry manner that was not empathically attuned to his experience. All of these were responses to hurt and anger that she had grown up with and learned procedurally or implicitly, generally outside of conscious awareness. Individual therapists can draw patients' attention to these patterns and help expand their

awareness of their own implicit relational patterns or procedures (e.g., **Lyons-Ruth, 1999**) and how they may have developed.

"I'm not sure," I said to an individual patient recently, "but it sounds like once Susan has begun to do something that you know will hurt you, you don't try to comment on it, stop her, or head her off at the pass. It's like you're sort of resigned to the inevitable, so you just shake your head in disgust and watch it happen—then it gets added to that painful list of all the ways she lets you down." After some thought, the patient agreed there was truth in this for him and felt more understood and known by the observation. Further exploration revealed that he had learned this passive stance as a child, when his attempts to interrupt painful scenarios between his parents were not effective. It also eventually became clear that he subtly enjoyed his role as the righteous complainer. Outraged indignation or disgust was a way for him to feel energized and superior and avoid the riskier, less familiar experience of trying to interrupt or alter a problematic pattern. This vignette illustrates how focusing on the patient's response (or lack

thereof) to failures or disappointments by the partner can highlight aspects of the patient's contribution to the co-created marital dynamics.

Refer for couple therapy (wholeheartedly): Last, but not at all least, individual patients presenting with complaints about their spouses or relationships should be encouraged to address those issues primarily in couple treatment. Individual therapist/analysts can help facilitate the referral by describing the kind of information that is available in psychoanalytically oriented couple treatment that is not accessible in individual treatment. The therapist can explain how this information might be helpful to the patient, to their individual work, and to the patient's marriage.

It can be interesting to notice and reflect on which individual patients with relationship difficulties we refer for couple therapy and which we do not, and why. Not referring—or doing so in an only halfhearted manner—may reflect the therapist's conscious or unconscious belief that the patient would be better off leaving the marriage, that the marriage cannot or should not be saved, that the problem is really more in the spouse than something co-created by both partners, and so forth. The therapist may also have concerns about diluting the individual work or becoming less central to the patient if the patient is in a second therapeutic relationship, and/or concerns about collaborating with another therapist, such as competitive or narcissistic issues or anxieties. Finally, therapists who have never been in couple therapy themselves or who did not have a positive experience with it may also be less likely to refer. All of these factors also influence the manner in which the therapist makes a referral and the extent to which any reluctance or resistance by the patient (or reported resistance by the unseen spouse) to the idea is explored and analyzed.[10]

In particular, in my experience individual therapists most often hesitate to refer for couple therapy—or make the referral only halfheartedly—when they believe their patient no longer loves his or her spouse, or when they believe the spouse has a particularly severe individual problem, such as substance abuse or violence. Yet while these are certainly negative prognostic signs, they

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10 I have previously discussed the many legitimate and understandable reasons partners have for avoiding or resisting couple therapy (**Leone, 2008**). These include discomfort with a process that is not a social norm, as well as fears of loss, humiliation, retraumatization, and so forth. As I have stated, when the very valid and understandable reasons for reluctance to seek couples treatment are identified, understood, accepted, and made sense of, previously resistant partners often become more amenable to the idea and more able to follow through.

do not necessarily mean that couple therapy is not appropriate. In some cases, loving feelings can reemerge in people who have fallen out of love, and sometimes the desire to save a relationship can motivate even people with severe difficulties to make changes.[11] Even those who are quite sure they want to end their relationship can still benefit from couple work in many cases, if only to discover things that may benefit them in their next relationship. Patients who end a relationship without a comprehensive understanding of the multiple factors that led to its demise—something not ascertainable in individual treatment alone—are obviously at greater risk of repeating the same dynamics in their next relationship.

Regardless, the major point here is that one partner's individual therapist is not in the best position to assess whether couples work is likely to be helpful or effective. Therefore, I suggest that when in doubt, individual

therapists err on the side of making the referral—as full-heartedly as possible.

SUMMARY AND CONCLUSION

This paper highlights a common problematic dynamic that can have significant negative consequences for patients and their significant others. Individual therapists/analysts who have never met their patient's spouse or seen the patient and partner interacting often develop strong feelings, beliefs, or opinions about their patient's partner and can experience these opinions as solidly supported by evidence rather than as constructions emerging from the transference/countertransference field.

A number of factors appear to influence the development of this phenomenon, including a very positive transference/countertransference relationship, the length of the treatment, the therapist's experience in conjoint modalities, the therapist's theoretical views, the patient's history and psychology, the therapist's history and psychology, and the interaction between the two. By remaining aware of these influences, attending closely whenever we have a strong feeling or opinion about a patient's spouse (or another of the patient's relationships) and seeking consultation when these prove difficult, therapists/analysts can reduce or avoid this problem.

When responding to individual patients' complaints about an unseen spouse, it is important that therapists/analysts remember to remain tentative and to appropriately qualify (as conjectures or hypotheses) any statements about an unseen spouse. The meaning of both the complaints and the complaining should be explored, including the particular meaning of the spouse's behavior to the patient and its intersubjective context, when appropriate. Finally, therapists can also explicitly remind patients of the limitations of the data available in individual treatment

regarding another person or the couple's relationship dynamics. They can inform patients about the potential benefits of conjoint work and can help to interest them in the additional information that might be available in couple therapy. These responses allow therapists to help their individual patients more fully understand and make sense of themselves and their relationship difficulties.

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[11] I am not suggesting couple therapy in all cases of domestic violence, by any means; however, the interested reader is referred to Goldner's work on the treatment of violent couples (**Goldner, 1998**).

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