THE PRESENTING CONTEXT FOR COUPLE TREATMENT: SOME GUIDELINES FOR ENGAGEMENT AND BOUNDARY MANAGEMENT

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This article proposes that several guidelines can be helpful in engaging and managing boundaries when interviewing couples. Also, preliminary strategies can be matched effectively with the presenting configuration as couples come to marital therapy. There are a variety of contexts, and several of them represent some challenges and difficulties to ensure that therapy gets off to a good start, and proceeds more smoothly past potential boundary traps.

Before beginning, I would like to state a fundamental distinction that I use in the management of boundaries of information. In a therapy contract involving more than one individual, where there is stated verbal consent to share necessary information so that therapy can proceed, I state the difference between PRIVACY and SECRECY.

PRIVACY can be any confidential information that, in my opinion, does not directly or indirectly bear upon the therapeutic contract.

SECRECY is information, the withholding of which, could affect or undermine the workings of therapy. Thus privacy can be permitted, but secrecy must not be tolerated.

As with every rule there can be exceptions in limiting cases, but I have generally found that this is a sound guideline in marital counseling.

Now that this guideline is established, let's begin with a list of presenting contexts, with some comments or guides suggested for each.

A. INDIVIDUAL OR FAMILY THERAPY BROADENS TO INCLUDE CONJOINT SESSIONS

1. **An individual client has a spouse who can be engaged to support the individual therapy plan.** In virtually all the individual therapy I do, I encourage my client to invite their spouse or significant other to support whatever objectives we are working toward in the therapy plan. This is especially helpful with overcoming phobias or sleep disorders. Often in cases referred for anger management, I have the spouse come in almost from the onset ostensibly to help the identified client, but indirectly influential in the non-identified spouse in terms of altering their interaction patterns in conflict situations. In contexts where one member of a couple agrees to be the identified client, engagement is generally easier, in that there is less symmetry and blame escalation. With less defensiveness, it is easier to work in systemic ways to shift interactive sequences and ascribed meanings. Boundary management is generally quite easy as well, with the primary focus and obligation being with the identified client, and less need to provide balance of time and attention

to the spouse. Perhaps the only difficulty can occur with an overly intrusive or potentially controlling spouse, especially if the identified client has had a previous history of blurred or intruded boundary violations. Obviously, if there is potential harm to that spouse the therapist has the obligation to establish and maintain safety procedures and frequent monitoring. In these circumstances the therapist's acts to be protective of the client can lead to triangulation traps and coalitions potentially slowing or compromising the integrity of therapy. Care plus firmness are guiding principles here.

2. **An individual presents with a problem in which the majority of instances occurs in relationship with their spouse.** As the therapist redirects the client to focus on themselves rather than blaming or attempting to change their spouse, it can become increasingly obvious that a conjoint therapy contract may be the most effective and efficient way to proceed. At this point the therapist may propose a shift in the context of therapy, and must advise the individual about the implications of sharing information and emphasis within the couple rather than the individual. Of course, we are assuming that the spouse will take part if invited. Often, extraordinary efforts may be necessary to provide an atmosphere of balance in the engagement. Sometimes I will need to see the spouse several times alone to establish rapport and a new and separate therapeutic alliance before starting with the couple conjointly. I acknowledge that the second person into conjoint therapy is often at a perceived as well as sometimes real disadvantage that needs to be addressed and counterbalanced. Conjoint therapy with an entirely new therapist is often the best solution to provide a fresh start. This is especially important in situations in which prior individual therapy discussed sensitive confidential issues. If the original client wishes to disclose this information at the outset of conjoint therapy, and issues of safety have been addressed and adequate provisions made, then perhaps conjoint therapy can proceed with the same therapist. The crucial distinction of privacy vs. secrecy applies here. That is, if the therapist feels compromised by potential coalition due to confidential individual information, referral to another therapist for conjoint therapy is strongly advised.

3. **After beginning with family therapy, in which concern for a child was the primary original motivator, a subsequent shift into conjoint therapy of the parents may be indicated as the most effective and efficient path towards effective family functioning.** If the therapist or parents come to this conclusion mutually, then the couple may be seen in some sessions, the child or children in other sessions, or any other subgrouping that seems appropriate. Provided that the welfare of the family and the well-being of the children is kept in mind, such subgroup sessions generally go well. The couple is seen under the auspices of promoting teamwork in parenting communication. The couple is still not regarded as a marital unit unless they specifically request it and both agree to focus on their marriage per se. There is still the delicacy and adeptness required to handle boundaries of information appropriately, and here the privacy-secrecy distinction applies quite helpfully. Sometimes, however, the shift is quite difficult if either parent wants to blame the other for family misery, or if either parent wants to disguise the obvious secret that they despise their spouse and want out of the marriage as soon as the youngest child is of a certain viable age. These are very difficult cases, again requiring skillful handling by the family therapist, or likely, referral to another therapist to handle the conjoint sessions.

B. THE COUPLE PRESENT TOGETHER AS A COUPLE PROBLEM

1. **The couple can present themselves in a crisis of betrayed trust upon the disclosure or discovery of an extramarital affair.** There have been many books and thousands of articles dealing with how to handle this common and distressing presentation. To this body of knowledge I will attempt to add some of my experiences in engaging these cases.

As with virtually all first sessions with a couple, I present the format of 45 minutes assessing them conjointly, then 10-15 minutes with each spouse privately, then about 30 minutes with both working together to map out a provisional map

of therapy. I explain and invoke the distinctions between privacy and secrecy, but say that sometimes it is helpful for the therapist to know private statements about current individual motivation to save or leave the marriage. I tell both partners together to not tell me any secrets and affirm the same rule again in our private sub-sessions.

I tell the offending party that he or she must put the extramarital lover on ice for at least 6 months while we work on giving the marriage a chance to heal. If the offending partner works in the same office as the extramarital person, then I work with the couple to devise a code of restrictions on their actions for the next 6 months, so that their conduct will be beyond reproach and "business only, no closed doors" basis. Any violation of this code will be interpreted as potential sabotage to the intent of the therapy contract, and a further breach of trust. I realize that this is stricter than other solution-focused therapists, such as Michelle Weiner-Davis, but it provides the best chance for the rebuilding of trust in the absence of further violations.

One further cautionary note involves "emotional affairs" in which there is deceit and duplicity, but the offender totally swears it was not sexual. As Frank Pittman points out, likely the worst betrayal was not necessarily sexual, but a violation of the shared and private emotional intimacy of a committed monogamous couple. Sometimes what happens 3 months into the therapy, is that the offending partner finally owns up to the fact that it was a sexual affair, but the offending couple broke it off when they were overwhelmed with guilt, and have been "close friends" but not sexual since. This story is not as uncommon as I first thought. It is distressing to the couple, especially the betrayed partner, because the tender bonds of trust were just beginning to heal. Usually the couple gets through this painful impasse. The offending party later justifies the earlier not-full disclosure as "If I had told her it was a sexual affair before we came to therapy, she would have dissolved the marriage with no chance for reconciliation." While I have not been pleased with such deceit, their spouses often confirmed that such would have been the case, so stepwise approximations of honesty can sometimes prevail. I sometimes pre-empt such situations by telling my clients that I am always willing to work with the best approximations of honesty that they can present to me. The closer to honest they are, the more effective I can be as their consultant, that's all.

2. **The couple can present themselves in a crisis of another sort, such as death, severe illness, chronic unemployment, or some other condition that renders one or both partners almost disabled.** These situations may be difficult in that the partnership of the marriage may have rested upon the assumptive contract of sustained emotional or financial contribution. Usually, because the couple are presenting together, the contract for reestablishing trust and partnership under a new set of circumstances is quite likely. The couple will need to grieve the losses, reset expectations, accept some limitations, and make provisional plans to deal with the new realities of their lives. Reframing with future hope and attributions of individual and couple resources guide the therapy.

3. **The couple can present with addiction in one or both parties.** Seldom is it a case of both in the same phase of readiness at the same time. Usually, if both are addicted, the marriage has not survived or is in a severe spiral of mutual destruction. Usually in these cases, one of the partners is ready; the other is not ready to change. Twelve-step models and larger support groups and community support are often necessary to secure before undertaking such a difficult contract. In the case of a single addiction , systemically-oriented solution-focused therapy may suffice if both members of the couple are motivated and persistent in promoting positive change, including systemic reaction loops as the symptom bearer escapes the addiction.

4. **The couple can present themselves in a crisis of symmetrical control struggles, emotional and perhaps physical abuse.** These situations are especially difficult for the therapist to provide reasonable balance in engagement and the

monitoring of communication within and sometimes outside the sessions. Sometimes the couple is locked into a death-spiral of blame and a desperate win-lose paradigm. The therapist typically starts with a Time-Out Agreement and safety measures to set a safety-net provision for the couple if they are to remain living together while working on solving their issues. Community violence-prevention and safety resources such as safe houses are discussed with provisional action plans assigned. Anger Management Programs can be delivered conjointly or even separately if necessary at the start. Again the privacy-secrecy guideline is frequently invoked, and the therapist has to be extraordinarily adept at managing invitations to triangulate the therapy. Be extremely careful if you write letters or emails (not recommended) to the couple. The usual response to any email is to say it will be discussed in the next session. Sometimes such invitations can be snares for future divorce proceedings in which the marital therapy itself was a ruse to gain positioning advantage. Even when you state at the outset that therapy will not be used in court, they both know that if you are subpoenaed by a court, you must comply and testify as ordered. Although this situation is extremely rare, there are a few people in this world who actually attempt to use the marital therapy context in this way. Pre-empt and discourage these tactics by being scrupulously balanced from the outset of therapy. Most couples will then settle down, and realize that human needs and insecurities underlie their need to display anger, and that mutual win-win solutions can emerge to meet these needs.

5. **The couple can come to therapy at a shift point in the family life cycle, such as failure to demonstrate loyalty to the new couple bond against family-of-origin loyalty demands, the birth of the first child, leaving home of adolescents, or empty-nest pre-retirement phases of development.** These cases are usually the easiest to deal with, because the MFT literature is full of books and articles to guide you through these situations with roadmaps of well-charted territory. Also, they have in common the attribute of normalizing painful adjustment experiences as living solvable processes for which a tradition of hopeful resolution can prevail.

5. **The couple can come to therapy to seek help with blended family issues.** Blended families are high in complexity and adjustment difficulties, loyalty issues, and child management empowerment issues (which parent is empowered to deal with which children, especially in years 1 and 2 of the blend). There are usually financial issues as well, with complicated formulae for child support and visitation schedules. While these complexities impinge heavily on the couple, most often they are seen in the context of family therapy. Obviously, boundary management and balance by the therapist are strong considerations in the conduct of the therapy.

6. **The couple can come to therapy to seek help with intimacy and fear of commitment issues.** These situations often arise when either partner has some emotional baggage and fear of intimacy based on unresolved issues from childhood or previous negative experience in relationship. The other partner (most often the wife) is likely getting fed up waiting for the spouse to "make up their mind" or "grow up emotionally." I often find it hard to preserve my balance to offset the tendency to side with the wife, especially when the couple is under the influence of patriarchy, and gender issues contaminate underlying fears of commitment.

7. **The couple can present with sexual problems.** Once biological or mechanical complications are ruled out, specific problems in the arousal and orgasm phases readily lend themselves to specific sex therapy interventions. Possibly more subtle and complex are discrepancies of sexual desire. Desire phase disorders involve many interactions between sex and love and relationship and intimacy themes that are interwoven in the fabric of relationships. Effective therapy involves combinations of communication, emotional expression and validation, as well as behavioral interventions to address rather than downplay the physical aspects of sex therapy.

8. **The couple can come to therapy saying "We have grown apart" or "We just can't communicate."** This situation may be difficult, in that these problem patterns have likely persisted for over 6 years, with both partners denying and

avoiding, hoping that the difficulties would resolve themselves. They have likely become closed off to each other, each trying to immerse themselves in other activities, like career, raising children, sports or hobbies, support networks, etc. They have come to a place of "living together, but feeling alone." They are often so emotionally dead and non-responsive that they are reluctant to allow themselves to feel or love again. The thought of further disappointment or desolation is too painful to risk. Thus they proceed slowly through hesitation and partial measures, easily knocked off recovery course if their partner does not reciprocate their half-gestures. Sometimes these marriages arrive "dead on arrival" and the marital therapy is merely a preliminary ritual for external purposes to convince other relatives and friends "Well, we even tried couples counseling, but it just didn't work out." Occasional individual sessions may help to understand if there is enough motivation and the glue of mutual respect and attraction to work with. If there is enough, then patient encouragement in an incremental solution-focused approach will take them through their reluctances. Gottman's guidelines are especially helpful with these couples to restore the rediscovery of each other as vital people worth connecting.

C. ONE MEMBER OF A COUPLE CAN PRESENT A WISH TO SAVE A FAILING MARRIAGE

1. **"My wife sent me here. She says I have the problem and maybe you can fix me."** "No, she refuses to come into treatment. I don't know why she is so unhappy." My first thought in these cases is severe communication and denial problems, and likely gender issues. But first I need to redress some of the imbalance, usually by asking the wife to write a letter to me, the contents of which I will discuss with the husband. Most wives are more than happy to oblige, so we start from there. I am still unsure if the wife will welcome the asked-for changes and relinquish her blaming stance. Eventually, as husband changes wife comes in to assist and promote the process with conjoint sessions. Of course there are many ways to entice the absent partner into at least one session with the therapist. Many of these strategies, described by Milton Erickson and Jay Haley, are almost coercive, so I seldom invoke them unless I feel stuck without the input of the absent spouse. Usually, working with the identified client is sufficient and respectful.

2. **The Runaway Wife Syndrome.** This pattern is so frequent that Michelle Weiner-Davis presents it as a common pattern in her book The Divorce Remedy. Basically, wife tries hard in the early years to state her emotional needs and try to manage the emotional climate of the marriage. After largely raising the children while her husband becomes workaholic and more emotionally withdrawn, she raises her demands and he increasingly withdraws. Finally she gives up and plans her eventual escape when the children are "old enough." (usually in their mid-teens). During this incubation of close to a decade, husband becomes relieved and complacent, thinking all is well because the nagging has stopped. Then one day, seemingly out of nowhere, she drops the bomb and says she wants to leave. He feels shocked and devastated. He desperately tries to hold on, but for her, it's "too little, too late." Once again, there can be gender issues clouding role expectations, intimacy scripts, nag-withdraw patterns, and his desperation to change to save the marriage and the family, to which by now he has become increasingly attached. He thinks that his attempts to support her initiative to gain employment, find an apartment, or set up her dream business venture will be appreciated by her, and sometimes this is so. However, more often than not, she scornfully reacts to his attempts to further "control her" through patriarchy. She just wants to break away and be herself for a change. The therapist engages with the desperate husband and takes on a difficult task of helping him try to rescue the marriage unilaterally. It can be done, but the odds are against a quick and effective solution to years of problems.

3. **"Help! I'm trapped in a toxic marriage!"** Here one spouse feels they have no options within the marriage. Although they are mostly on their way out, a part of them is interested in a survival strategy to stay on mostly for the sake of the children. They have largely despaired about the potential for love and emotional intimacy, and feel emotionally dead. The husband and children refuse to take part in treatment, but won't stand in the way of wife seeking her own counseling. This situation is slightly different from the first context, where one spouse is sending the other to therapy. When a spouse comes for strategies to fulfill her own needs and autonomy, the possibilities for single-spouse therapy are more promising, though still less efficient than conjoint therapy. Here the therapist guards confidentiality about the systemically-oriented individual therapy more carefully, strategizing with the client what disclosures are to be

made with the family and when and how. Still, the focus is on what the individual is prepared to do about her predicament. Minimal time is used to ventilate about the unbearable conditions at home.

D. USE OF INDIVIDUAL SESSIONS DURING A MARITAL THERAPY CONTRACT

1. **Family-of-Origin Issues can sometimes be resolved more effectively in individual sessions.** The ability of a client to talk succinctly and candidly about family of origin can be enhanced with individual sessions. There is no need to think about their spouse's reactions or possible interference and emotional clutter. One the other hand, including the spouse does add the possibility of an external frame of reference or reality check on longstanding perceptions and family distortions. Generally, however, a few individual sessions, or even F.-of- O subgroup sessions might be an effective and efficient way to resolve some of these embedded issues. Later, conjoint update sessions can be convened to report and elaborate the couple implications of progress in individual work.

2. **Some instances of PTSD arising from incidents preceding the marriage or outside of the context of the relationship can be handled with individual EMDR sessions.** In these situations, the guideline usually involves an assessment of whether the spouse's presence would be a helpful support or a complicating distraction from the resolution of the issue. A good example is occupational stress in the career environment of a police officer involved in a difficult arrest or accident scene.

E. CONJOINT CONSULTATION FOR SEPARATED COUPLES

Conjoint consultation is provided for relationship partners, usually married, who have recently separated, or who are about to separate if the issue of commitment is not resolved. The key questions have to do with stated and implicit agendas, the viability of the relationship, and the quality of life resulting from sustained deadlock and its resolution.

The role of consultant is rather delicate in these situations, requiring careful engagement, balancing, contracting, boundary management, normalizing, and a commitment to a solution focus in a win-win paradigm.

Summary. This article has presented some possibly useful guidelines for engagement and boundary management in couple counseling that the author has used in various presenting contexts of treatment. It is hoped that they are heuristic for useful discussions in training courses in marital therapy.