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THE ISSUE OF THERAPISTS' COOPERATION IN THE SYSTEMIC AND PSYCHOANALYTIC APPROACH

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co-therapy

systemic

psychoanalytic

Summary

This is the first part of the paper raising the question in what way two therapists cocreate capaciousness with couples and families. Capaciousness allows helpful perspectives and points of view to appear, which were not available before or in different circumstances. The article is an introduction to further deliberation on the question if co-therapy can be useful both for the therapists' work and the patients and in what way co-therapy helps the patients to make a change. The paper contains a description of some selected systemic and psychoanalytic conceptions employed during couple or family psychotherapy. Both the systemic and psychoanalytic theories emphasize the significance of the *difference* – a concept introduced by Gregory Bateson. This article mentions this issue and the next paper will describe it widely. The collected material is the result of individual searches during a long-term psychotherapy practice based mainly on the Milan systemic therapy and taking into account the unconscious dynamics running in families and couple relationships. The article contains practical exemplifications of theoretical conceptions, based on own experiences of working in co-therapy.

Introduction

A characteristic element of my work as a family and couples psychotherapist is work in co-therapy. Cooperation with a second therapist is a common practice in group therapy. Family and couple therapy is more varied. The school of Systemic Psychotherapy and the institutions where I have worked had a great influence on my choice of cochairing the therapy process with another therapist. Initially, I have worked in the Psychiatry Ward of Child and Youth of the Lower Silesian Pediatric Center in Wroclaw. Then, I started working in the Team of Family Therapy at the NEUROMED Neuropsychiatry Center in Wrocław. For several years, I have also run a private practice in which I also work in co-therapy.

The thinking presented by me is rooted in the Milan school of family and couple therapy, which was based in large part on the work of the psychotherapist and cultural anthropologist Gregory Bateson[1]. At the heart of the systemic approach is the concept of circularity, which focuses the therapist's attention on

[1] The most frequently cited works of Bateson: Bateson G. Steps to an ecology of mind. New York: Ballantine Books, 1972; Bateson G. Mind and nature. A necessary Unity. New York: E. P. Dutton, 1979.

relationships instead of a single entity. The systemic approach assumes that a family or a couple are not only a simple sum of individuals but thanks to their relations they create something qualitatively new and different. The British psychoanalyst Mary Morgan notes that ”the relationship of a couple is more than the sum of two people, it is what partners create between each other on a conscious and unconscious level” [1, p. 29]. During my psychotherapeutic practice, I have recognized the need to take into account the existence of unconscious processes taking place in relations between family members. It is also important for me to think about what is happening between the family/couple and the psychotherapists, and to take into account the dynamics of the co-therapists' relationships. Many of the elements of interaction that take place in the three areas I have mentioned are sometimes unnamed, unconscious, and played out in action. The psychoanalytical approach expands my capacity for searching individually and relationally assigned meanings and for developing sensitivity to symptoms of mental life, both for me and my patients in the therapy process.

I will present those theoretical elements that I considered important in my deliberations about the utility and substance of co-therapy, and I will also share how I experience the described phenomena in my meeting with the other therapist and our patients.

Co-therapy in systemic concepts

A crucial step in the Milan school of family and couple therapy was the recognition that the therapist's neutrality and objectivity, strictly consistent with the word, are impossible [2]. The utility of the therapists' sceptical investigating of their concepts was emphasized. On the one hand, assigning your thoughts the status of one among many possible hypotheses arouse a fertile tension and support of genuine curiosity in the therapist. On the other hand, it makes the therapist feel constantly uncertain and insufficient due to the lack of final, unequivocal solutions. It also brings frustration and puts the therapist to contain a multitude of feelings which are derived from constant doubt. I believe that the ability to maintain reflective attention (as opposed to acting in action) towards emerging family stories during the therapy is of particular importance to the psychotherapeutic process.

The Milanese idea of conducting therapy in cooperation with another therapist was supposed to generate more hypotheses, to protect against excessive attachment to the “only right” perspective, and to protect against establishing a coalition with a selected family member. From today's perspective, I would say that the work in co-therapy also increases the possibility of containing feelings related to uncertainty.

The team of therapists and patients form two subsystems: the therapist subsystem and the couple/family subsystem. A system is understood as a network of relationships and mutual connections created by its individual elements. The team is composed of at least two therapists. The Milan model implements a method of therapy, during which ”a part of the therapeutic team works directly with the family, and the rest observes the course of therapy through a one-sided mirror” [3, p. 395]. Psychotherapists became aware that

during the therapy, they were co-creating a new system with the family. Bogdan de Barbaro and Szymon Chrząstowski in their book "Postmodern Inspirations in Psychotherapy" emphasize that "what the therapist perceives in the family he works with, depends not only on the real functioning of this family but also on who the therapist is, what his knowledge and experience is, what values he shares, etc." [4, p. 47]. Working in co-therapy and the technique of working with a one-sided mirror serve to ensure that at least one of the therapists is less involved in the interaction with the family, *i.e.* in its communication patterns. Observing the sessions from a distance aids the co-therapist maintain their separate thinking and enables the emergence of new ways of looking at the difficulties brought by patients, and enables the emergence of new ways of understanding it. Moreover, the one-sided mirror helps (openly and with the consent of the patients) to invite more people to cooperate without their overwhelming impact on the family/couple; for example, inviting a supervisor, or enabling trainee psychotherapists to assist. Currently, the technology of electronic devices gives more opportunities to build a wider team because one can use videotransmission, *i.e.* an electronic version of a one-sided mirror. The co-therapist or co-therapists share their observations and hypotheses during the break of the meeting with the therapist who is in direct contact with the family, so that he can then share this information with the patients. This part of the psychotherapy session is called an intervention. This name reveals the initial thinking of the therapist as someone who is an expert bringing about a change in the family system. The form of intervention and its legitimacy are subject to reflection and critical discussion. Some therapists working together in the office directly raise their thoughts to the conversation with the family and its members can comment to on an ongoing basis.

Various factors are influencing whether therapists decide to use the one-sided mirror in their work. One such determinant is the way in which patients experience using it. Sometimes, they have a feeling of artificiality and sometimes, they report that they feel as if they were "being auditioned." An invisible therapist may be perceived as a hostile person who hides his intentions. Therefore, in addition to the theoretical concept, the use of a mirror may be determined by the predispositions of therapeutic teams and the predispositions of families/couples. Taking into account the individual psychological conditions of a given family/couple, it is always necessary to consider how the psychotherapeutic process is influenced by the presence of an invisible therapist observing the therapy from another room.

The decision to have therapists work together with the family, without using a one-sided mirror, is a move to increase transparency in relationships. Therapists are then not seen as experts who are "talking behind the backs of patients." The development of this method was proposed by Tom Andersen [5], a Norwegian psychiatrist and psychotherapist, who created a model of the work of a reflective team in which more than one co-therapist participates. In the Polish language, there are two meanings of the word *reflective*: *thoughtful* and *mirror*, *giving feedback*. It is useful when members of the team share outright their varied perspectives, thus reflecting the dilemmas faced by the family and proposing various alternative views. After that, the family can comment on what they heard. This method is an expression of the belief that the same reality can be

described in many versions, each of which is equally empowered. This helps family members to talk to each other in such a way and on topics that they have not previously thought of.

"Reflection team: it submits only reflections, emphasizing that each member can only have their own subjective version of the whole and […] there is no version that can be said to be objective or final. […] They believe that they can only create an opportunity for a temporary structural union, mutual participation, and exchange of ideas. […] They can be useful only if the conversation stimulates their curiosity" [5, p. 17].

Tom Andersen and his colleagues extended the possibility to figure out as many alternative descriptions as possible. To this end, they retraced the session records and wondered what other questions could be asked and what statements of family members were omitted, unnoticed. During group supervision, I often use this opportunity to see different perspectives. Usually, there are many comments and suggestions.

Personally, I tend to work with a second therapist without a one-sided mirror and without a structurally separated summary at the end of the session. Currently, in my psychotherapeutic work I use both: a structure based on working with a one-sided mirror and working with another therapist in one office together with the patients. When it comes to using breaks for discussion taking place in a separate office – depending on the context, I use this option or comment on an ongoing basis, without a break. I maintain the stability of the structure for a given family/couple. This is partly the result of the diverse requirements and possibilities of the places where I work. It determines, among others, such variables as the frequency of meetings and their duration. This is also partly a result of what the therapists cooperating with me are ready for and of my own research, which attempts to find what is useful for my patients. In the case of 50-minute sessions, the intervention takes place essentially without a break for discussion. Moreover, when working without a one-sided mirror, the activity of the therapist transcribing the session is usually more involved in the relationship with the patients than when working with the mirror, so various issues are taken up on an ongoing basis without a separate intervention. Although I am more comfortable when sharing the therapists' thoughts and observations during the meeting, there are some sessions in which I am relieved to be able to talk to another therapist and collect my thoughts during the meeting but without the presence of patients, *i.e.* to use a classic intervention. On the one hand, I really appreciate the brisk, direct contact with patients. But on the other hand, it is sometimes difficult to me to keep my own, discrete thinking during the session in the meeting with the family/couple, and in such cases, psychotherapeutic techniques come to the rescue, for example in the form of a break intended to construct an intervention.

In my therapeutic practice, I experience co-therapy as a tool that supports my thinking about the therapeutic process, and also increases capacity for an authentic meeting with patients. I will allege a part of one family consultation, in order to share what is happening in me as a therapist. During this session, I felt like an uninvited guest. I had difficulties to contain the vision of my patients as the ones who had come for therapy and who experienced me as an intruder. It was as if my questions were too insistent and overwhelming. I worked with the patients in the office together with a co-therapist who wrote down the session and joined

the course of the session whenever she felt interested. I felt responsible for maintaining the communication and the structure of the session, while the other therapist could experience *evenly hovering attention*[2] and remain in the state that Checchin postulated in his writings, that is, *irreverence*[3] to her thoughts. Being sceptical of emerging hypotheses is associated with the ability to take the attitude of Harlene Anderson's *not knowing stance* by the therapist. Thanks to this particular attitude of the therapist who "does not want to know too soon," curiosity is maintained. "Anderson believes that the therapist's curiosity stimulates the client's curiosity. It becomes a catalyst that enables the process of change, as the client becomes curious about how his experience can be understood in various ways" [4, p. 82]. However, the implementation of these ideas in practice can be very difficult because the above postulates do not exempt the therapist from a good knowledge of the concept. Being placed "next to" the ongoing "action" helps to reduce the pressure of "knowing" and maintaining dialogue, and thus allows one to sometimes see the situation from a different perspective, which often allows getting out of some impasse. During the meeting, we took a break to talk about the session without the presence of the patients. We wondered about the significance of my curiosity, the feeling of being rejected, and why the family might experience this curiosity as excessive. Is it inadequate to the topic raised by the family, or perhaps inadequate for the current stage of development of the therapeutic process? Or, perhaps, do the questions make too much of a difference between my vision and how my patients perceive their situation? Is my curiosity a symptom of excitement, and if so, is it caused by something in this family? Or maybe is it in me and concerns my personal stories that arise precisely in this particular situation? After a moment's thought, we decided to make a hypothesis about centripetal tendencies in the family. We assumed that maintaining a communication that excludes people from outside the family was their way of keeping balance. In such a situation, the therapist, although invited by the family, is perceived as someone who invades its boundaries, invades the culture of talking (the culture understood as an inexpressible principle about what you can talk about and what you can not). The discourse with the other therapist helped me get out of my resentment caused by the attempts to exclude me from the relationship, and it also helped me to realize how much I fear offending the members of this family with "wrong" questions or comments. It made me feel more at ease with my patients and less affected when they expressed their sceptical, negative attitude towards therapy. Together with the patients, I was able to carefully name the feelings of dislike and seek understanding for them.

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[2] "Colman's chapter argues strongly that the couples therapist needs to maintain evenly hovering attention if she or he is to understand the personal meanings" after: Fonagy P. Foreword. In: Clulow C, ed. Sex, Attachment, and Couple Therapy: Psychoanalytic Perspectives. Warsaw: Fundament Publishing House, 2016, p. 20. In another position, Colman invokes the Bion notion *reverie*, which is necessary to understand and process the patient's projection. In: Colman, Marriage as a psychological container. In: Ruszczyński S, ed. Psychotherapy With Couples Theory and Practice at the Tavistock Institute of Marital Studies. Warsaw: Ingenium Publishing House, 2012, p. 87.

[3] The concept of *irreverence* and the concepts of *knowing* and *not knowing stance* are developed by Bogdan de Barbaro and Szymon Chrząstowski in chapters 2 and 3 in their book entitled: Postmodern Inspirations in Psychotherapy. Krakow: Jagiellonian University Press 2011, pp. 41-85.

The experience of being straight away with the family does not always allow us to be constantly aware of significant facts about the family's life. In a conversation with three or four family members, it is difficult to keep individuation. Usually, as a therapist, whether I like it or not, I join the unconscious functioning of the family. This can be reflected after the session during the supervision or discussion with the other therapist. Considering the significance of feelings and communication is of great importance for the feedback provided by the therapist and has consequences for further family meetings. The therapist becomes involved not only in the way the family communicates, but also in the emotionally coloured meanings given to reality. The inner world of the family takes the form of obviousness and undeniable truths and, thus, the form of appraisal that often turns into accusations. This creates rigidity in thinking and creates a feeling of deadlock and no way out. It often happens that during a session, the therapist experiences many difficult feelings related to helplessness or the inability to establish contact and cooperation with the patient. Being able to discuss your experiences with a co-therapist turns out to be helpful in many ways. It helps in recognizing and naming feelings, or in enduring and finding connections for them. For example, a co-therapist who is not the object of an attack by patients, may, thanks to greater separateness (sometimes expressed by separation with a one-sided mirror), better separate the reality of the couple's/family's internal world from the external reality. Thanks to this, the co-therapist can support by his different vision a therapist who is ventured in the relationship with the patients.

In the example above, I and the second therapist pondered the reason why the family was omitting some of my questions. I wanted to share my feelings with the patients and explain this incomprehensible situation to me. What I wanted to say is that I feel they are reluctant to share information about themselves. At first, this may seem like a feedback but at the same time, it would be an accusation, a complaint, a suggestion that the family is hiding something. Saying these words would help me to shed the uncomfortable feeling of not being accepted. However, it does not seem that it would be beneficial from the point of view of the psychotherapy process. The presence of a second therapist and knowing that I could consult her helped me to postpone my reaction and see the situation from a distance. We decided that the family centrality hypothesis could be useful and we formulated a message whose task was to test this hypothesis and help the family to reflect on it independently. "*The second therapist drew my attention to the fact that at some point, I stopped talking to you about your free time. I am wondering why. And I thought to myself that maybe that's not something you often talk to people from outside of your family."* The further conversation showed that the parents in this family, along with the increasing difficulties in the relations with their children, withdrew from social meetings in favour of focusing on home relations. The parents were closed to the possibility of seeing various perspectives, and the difficulties in the functioning of their children deepened. This modus operandi is probably rooted in their family history, and it is possible that it was once very useful for the family, perhaps helping to maintain cohesion or identity. If the co-therapist had openly commented on the therapist's conversation with the family during the session, it could have also become a useful experience for patients, and their reaction could provide many valuable thoughts and ideas for psychotherapy. The co-therapist could say, for example: *"I noticed that you* [the therapist] *have withdrawn from the subject of spending free time,*

and you [the family] *have not taken it up. How is it for you to talk to other people about yourself?"* Patients react differently when they notice that therapists have different perspectives or that they are commenting on one another.

To sum up, work in co-therapy is conducive to multiversion, as the other therapist may have different feelings, concepts, and hypotheses. It is conducive to a critical analysis of what is happening during the session. The difference between therapists helps to keep the curiosity going. In a situation where the session is chaotic and specific patterns do not emerge from it, and the therapist feels lost and helpless, the second therapist can be really helpful to not take rash decisions, hasty, defensive hypotheses that adversely affect the psychotherapy process. In addition, family/couple members have the opportunity to observe the relationship between co-therapists, *i.e.* how they react to each other, to their comments.

Co-therapy in psychoanalytical concepts

It seems that the Milan school perfected its psychotherapeutic technique mainly in working with families, and psychotherapists working with couples used the same techniques and concepts. In Tavistock, UK, on the other hand, where the idea of couple and family psychotherapy was developing since the 1940s, therapists paid more attention to understanding the interactions between partners in a relationship. The beginnings of the Tavistock Institute of Marital Studies date back to 1948, when Enid Balint and colleagues founded the "Family Discussion Bureau." The therapists cooperating with each other were rooted in various currents of psychotherapy but each member of the Institute's team received training as a marital psychotherapist. "The binder of the group – whether trained for individual practice or not, their orientation being Jungian or Freudian – is the primary interest in the interactive process, in intrapsychic and interpersonal object relations, which manifest themselves most powerfully and intimately in the nature of the couple relationship" [6, p. 18]. The therapeutic goal of the facility was formulated as increasing the clients' insight into unconscious motivations shaping their personal relationships. The Institute drew from the Jungian perspective, the work of the British object relations school, and the work of Klein and Bion. In creating the Clinic, group cohesion was important but it did not mean its homogeneity. It seems that the therapists' experience of differences among themselves is also an important aspect of the utility of co-therapy. As in the Milan school at the Tavistock Clinic, the concept of therapist "neutrality" was challenged. "In simple terms, it is hardly possible to be working with a patient without, to some degree, consciously and unconsciously, becoming involved in the relationship and, therefore, affected by the patient" [6, p. 29]. Initially, individual sessions of each partner were conducted there. Then, the individual therapists of each partner met each other to discuss the couple's work. After some time, the sessions turned into joint meetings of two patients and two therapists.

At the Tavistock Institute of Marital Studies, the essence and meaning of co-therapy work was seen in creating conditions for the unconscious difficulty of a couple to be placed in a pair of therapists so that they would gain access to it. When therapists understand ”what has been put in them unconsciously by the patient couple through projective identification – only then the patient couple are able to do likewise.” [6, p. 31]. Many times the insight obtained is conveyed by therapists in the form of verbal interpretations, and sometimes the experience of therapists is conveyed in the form of non-verbal communication. However, it is not uncommon that the realization of significant processes taking place in the couple's relationship is successful only after the therapists unconsciously play some kind of exchange in their couple. Therefore, therapists cooperating with each other need to stop at it, talk and reflect together on the sources of feelings and impulses that motivate them to act. If cooperation in a therapeutic couple develops, it is possible to jointly discern whether the emerging difficulty results from personal emotional experiences and life experiences, or whether it is some kind of reflection of the unconscious dynamics of the couple with which the therapists work. Becoming aware of this in one's own psychotherapy and supervision is an essential tool for every therapist. Christopher Clulow quotes the words of Susanna Abse, who believes that “it is through acting-out, and through the counter-transference of the therapist, that access may be provided to what cannot be thought and known about” [7, p. 38]. Provided that therapists are capable of reflecting on these plays.

For example, receiving a cotherapist's comment as attacking or critical of my perspective can sometimes be the result of transferring unconscious patient dynamics to our relationship. This type of play requires joint consideration of whether its source is in the therapist or in the patients' experiences. A therapist can convey his feelings straight away during the meeting with patients (although for emotional reasons, it is not always possible) and use it as a therapeutic tool. For example, one could say: *“You know, for a moment it seemed to me as if your thought was understating and invalidating my idea. It stung me a lot. A nasty feeling.”* And to the members of the family: *“I wonder if this is something you also know from your report? How do you feel when your partner has a different point of view? How do you deal with situations of difference?” “As if“* are crucial words here, the use of which recognizes the subjectivity of my feeling and opens me up to hearing the perspective of the other. Such a tool can be useful, for example, when a couple unknowingly collaborates to not make their hatred aware. By remaining in the layer of literality of the words spoken, you can feel helpless in the face of the reported problem. Partners complain about something but the problem seems unsolvable. Various kinds of emotional movements in cooperating therapists are a valuable lead that they can make use of. As I mentioned before, in such cases it is important to recognize what these feelings are and where they come from. They can flow from me, they can flow from what is real between the therapists, and they can flow from the couple/family. It is certainly helpful to talk openly with your co-therapist about your love and hate feelings. When I became acquainted with Bion's concept of broken connections K, L, H (knowledge, love, hate) [8], I realized that quite often I instinctively resent a different opinion of my therapist colleague, and sometimes maybe even feel hatred. Because it is different, not mine. The possibility of experiencing hatred (H+) and taking responsibility for it may not be pleasant but it ultimately allows you to

draw from *The Other*, even if it takes the form of jealousy. On the other hand, denied hatred (H-) can be turned into non-seeing[4] another perspective, another person, it can be turned into the rejection of the perspective of the other person (or rejection of seeing my own inner world and my own responsibility). It is developmentally adverse because denying hateful feelings and the inability to experience them does not allow to face the other person's distinctiveness and to abandon omnipotent fantasies. Then, hatred can express itself in the destructive form of envy. The therapist may either want to destroy (*e.g.* by devaluing) another therapist, his thinking (because "he cannot have thoughts like I would like for myself") or he attacks himself, his own value, competences ("if someone else has something that I would like to have in me, I do not experience myself as a valuable person"). Therefore, in the work of a psychotherapist (also in work with a co-therapist), it is important to accept your various internal states in order to maintain the ability to experience them and make use of them. They are internal struggles between the self-ideal and reality, between an internal harsh evaluation and lenience.

My therapist colleague, with whom I work, emphasizes the importance of a co-therapist's accepting attitude, who with his tenderness and mindfulness creates a sense of security in the therapeutic couple. It does not mean that in various difficult situations the emotions of co-therapists do not become white-hot. When the co-therapist comments on my conversation during therapy with the words*: "It seems to me that this interesting discussion emerged in order to move away from the dilemma that appeared a moment earlier, but was abandoned..."*, it can provoke very different reactions in me. Sometimes I feel relieved. The conversation with a family or a couple can take the form of a fight for arguments, and the initial curiosity turns into a feeling of disorientation in the tangle of words and feelings.

However, when I have the impression of a well-chosen goal, I have my own plan, then such an intervention by the co-therapist during the conversation surprises me. Sometimes, I have positive reactions like *"oh, that's an interesting point!"* But sometimes, I have an unpleasant feeling of interrupting something important, or even something of great importance, and then the usual *"oh"* turns into *"oh… really!?"* And then I fall silent, admittedly giving space to her thinking, but feeling offended. Sometimes it takes me a while to get out of it. The recognition of whether my reaction comes from within my world (from my transfer of personal experiences) or from the specificity of the family or the family problem can provide valuable clues for further therapeutic work. When patients function competitively, in harsh and critical judgments, there is a high probability that this pattern will reproduce among therapists. Then, completely neutral content, but expressed in a specific form (through the tone of the voice, the choice of words, the moment of uttering them, *etc.*) and heard through the filter of the unconscious, can be experienced by the therapist in a critical way. To make use of my feelings linked with the other therapist, I need to openly bring them into our relationship to discover if they say something about the dynamics of unconscious processes in the couple or in the family. It

[4] In the Polish language, there is a similarity between the word *to hate* (nie-na-widzieć) and *not-seeing* (nie-widzieć).

is then possible to play out a new, different scenario in reality, which may have a reparative function for patients.

Conclusions

My everyday experience in working in the psychotherapy of families and couples, supported by supervision and cooperation with other therapists, prompts me to deeply reflect on how work in co-therapy is useful. I wonder what it is characterized by and under what circumstances it has a chance to provide a space favourable for a couple or family to achieve a specific change. Therapeutic practice constantly provides new dilemmas and provokes searches that go beyond one paradigm.

Both the concepts of the Milan school and the discoveries of psychoanalysis still enrich my thinking and make me more aware of the processes taking place in co-therapy and their usefulness for patients. Questioning the neutrality and objectivity of therapists directs attention to the individual and relational meanings given in therapy. Maintaining the state of curiosity, despite the frustration associated with uncertainty and hypotheticality, is conducive to studying the assigned meanings (both those contributed by patients and the team of therapists). The team of therapists in interaction with the family/couple can be a modelling point of reference for patients. Members of the couple/family have the opportunity to observe the interactions in the therapists' system and react to it in a way that is unique to them. Therapists also observe how they react to each other, which becomes a tool for understanding the dynamics of the pair/family. Therapists maintain a state of curiosity towards one another as well. What arises in the relationship between the therapists is created, *inter alia*, in response to the system of the patients' meanings. Observing and experiencing mutual interactions in the family/couple, in therapists, discovering their meanings, and naming them has a chance to become a feedback link leading to the development of both patients and therapists.

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