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THE CO-THERAPY RELATIONSHIP

Supervision of a Co-Therapy Team

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Supervision has long been seen as basic to the training of inexperienced psychotherapists. However, a growing number of senior clinicians recognize it as a necessity for themselves as well. Some arrange ongoing supervision which they consider as much a part of their continuing education as reading professional books and journals and attending conferences. While this may take the form of the traditional supervisee-supervisor dyad, other common examples of supervision include clinicians in a group supervised by a respected senior colleague and peer group supervision with no designated leader. At least one peer group even meets annually in a distant setting (Shultz and Stoeffler, 1986). This present paper, however, will discuss an additional method of supervision that apparently has been mentioned only occasionally in the literature: a triad consisting of a supervisor and two co-therapists who regularly work together in one or more psychotherapy groups. While McGee (1968 and 1974) described the value and importance of a triadic approach in supervising co-therapists in training, little has been written about what actually goes on during such supervision. It is an approach that offers a unique opportunity to openly expose and work with the interplay of the character strengths and defenses of the co-therapists as they show themselves in the supervisory session itself. It is also an approach that requires a good deal of ego boundary strength in all three participants since the potential for transference distortions is increased by the high degree of interpersonal involvement. Strict adherence to the reality principle and a non-acting-out contract make up the basic foundation that helps keep the focus at all times on the treatment needs of the patients. Properly conducted, this type of supervision can greatly improve the effectiveness of a co-therapy team.

"The relationship between successful co-therapists has some basic parallels with a good working partnership or marriage, it deepens with the successful mastery of personal conflicts..." (Rabin, p. 253). The characterologic and dynamic issues arising in the "marriage" of co-therapists is most usefully dealt with "here and now" during the actual process of supervision. This provides a sort of "instant feedback," illustrating dramatically how they relate to each other during the supervision session itself. "Conflicts arising from the co-therapy relationship are almost always reflected in the therapy group, but, fortunately, they are almost always reflected in supervision..." (McGee and Schuman, p. 34). Basic is the assumption that the ability of the "marriage" partners to communicate in an honest, straightforward way about their interpersonal difficulties outside of the group therapy session increases their ability to communicate with each other and make any necessary corrections during the actual process of practicing psychotherapy. As Reynolds, McWhirter and Jeffries (1984) indicate, one of the reasons co-therapy is often so helpful is because it increases the objectivity and accountability of the co-therapy team. Supervision as described here aims to further enhance the objectivity and accountability of the team.

Two relatively experienced clinicians, David and Elaine, had recently begun to work as co-therapists in several psychotherapy groups in which their patients were involved, in conjunction with ongoing individual sessions. Such combined therapy has been shown to provide a particularly effective setting in which to work with patient character defenses, thus effecting ego-boundary repair (R. Bar-Levav, 1988). Despite years of previous personal psychotherapy, however, both Elaine and David were aware that unresolved characterologic distortions were sometimes "lived out" in their relationship, thus interfering with their work. We agreed that joint supervision was in order and I accepted the responsibility for determining how to best carry this out. To use Alonso's words, the challenge was "to provide a climate that allows for a modification of the parallel process..." (p. 109). That is, the supervisory process would have to make room for the supervisees' character defenses to manifest themselves along with the characteristic manner in which

they relate to one another, and it would have to do so in a manner that focused on impediments to their work with patients without becoming "psychotherapy" for them. I had to foster an atmosphere which David and Elaine would experience as safe enough for them to expose the private workings of their "marriage." My aim was to help them go beyond their fears, embarrassment and shame so that they could be open and spontaneous enough to relate to one another as freely with me present as they would in private and in their groups. If it worked, I would become the "guest," living-in with them as they lived out their "marriage." It would require me to be sensitive to this process and to remain continually aware of how easily it could be damaged by poor timing or harsh criticism. Yet I would have to be free to intrude, pushing my supervisees beyond their comfort level, since the welfare of their patients was at stake.

Theoretical Considerations

The term "supervision" embraces a wide range of possible approaches. At one end of the spectrum is the traditional one-on-one meeting of supervisor and supervisee, reviewing a session sentence by sentence with an eye toward better understanding the content of what the patient and therapist are saying to one another. At the other end of the spectrum is a process-oriented approach that occasionally resembles psychotherapy. This approach may begin with actual material brought in by the supervisee from a session. But it quickly moves into the emotional reactions of the supervisee to the supervisor's interventions as he or she challenges the supervisee's character defenses. The aim of this approach is to tease out the elements of the therapist's personality and his or her irrational reactions that limit the effectiveness of the treatment. Underlying this approach is the assumption that countertransference in its broadest sense is the central factor most limiting our work with patients (Mint, 1969, 1978). Of course the goal is not to *treat* the supervisee but to sensitize him to his emotional reactions that negatively influence his work with the patient. (If he is unable to bring these reactions under conscious control quickly, a resumption of personal therapy is in order.) Since this method of supervision challenges the super-

visee's defenses "here and now," it is often anxiety-provoking and can sometimes be quite unpleasant. Nonetheless, this is the approach I have found most useful for myself when I have been supervised as well as for people I have supervised over the past 15 years. But it poses special risks which must be systematically and carefully addressed.

Where is the boundary between supervision and psychotherapy? Salvendy (1993) illustrates how this difficulty is usually handled: "Although contended by some, most supervisors focus on supervision to impart theoretical and practical advice and discuss countertransference only as it applies to the treatment of a particular patient or a specific group interaction" (p. 353), thus avoiding the issue of defining the boundary. However, if two conditions are met, that boundary can be kept clear.

1. **Supervisees must have already undergone enough personal psychotherapy to ensure adequate ego-boundary strength to tolerate the emotional stress of such an approach.** Subjecting one's personality and behavior to scrutiny can be experienced as threatening. Thus, the supervisee must be able to tolerate elevations in anxiety (and other feelings) without losing the ability to observe and reality-test such experiences, and to trace their genetic sources when relevant. When challenges to character defenses elicit anxiety or when transference reactions arise (and both are inevitable), the supervisee can then easily recognize these old reactions and keep them in perspective. This foundation of firm ego boundaries is actually an elaboration of a concept first introduced by Richard Sterba (1934) describing a "therapeutic split of the ego" into "experiencing" and "observing" parts. Thus, regardless of the strength of one's emotions, a clear distinction is maintained between present reality as *observed* by the ego and the feeling reactions *experienced* at the moment which stem from the past.
2. **All parties must agree to a set of ground rules governing the goals, method and limits of the supervisory process.** "A *sine qua non* of the co-therapy relationship is openness at all times, particularly on issues related to the

group psychotherapy enterprise" (McGee and Schuman, 1970, p. 29). In all cases, the reality principle must prevail regardless of how unpleasant the implications. As McGee and Schuman emphasize, "In view of the complexities and demands of the triadic approach to co-therapy supervision, it is suggested that the supervision of co-therapists be based on a 'contract' to assure availability and continuity among all three partners" (p. 35). However, they say nothing further about the specific nature of such a contract. It is clear that a properly delineated agreement provides a powerful tool for maintaining boundary clarity not only in psychotherapy (L. Bar-Levav, 1995 and Torraco, 1993) but in supervision as well. Such a clear understanding serves as an "equalizer," since the supervisor is called to the same standard as is the supervisee (Shultz, 1991). This may provide a useful safeguard against unconscious confusions of the supervisor such as wishes to be admired, to rescue and to be in control (Alonso, 1993). The supervisee, or the supervised co-therapists, must have the right and freedom to challenge the supervisor's judgement at any time, and he or she must accept the burden of seeking counsel elsewhere if necessary to resolve the disparity.

Before regular work with David and Elaine could proceed, it was critically important that our understanding of the contract be explicit. Standard issues such as meeting times, financial terms and confidentiality were quickly resolved, but other issues required clarification. Since psychodynamic and characterologic forces not clearly recognized by the two were repeatedly limiting the effectiveness of the team, it was explicitly agreed that the goal would be to address these personal difficulties directly. What would keep this process from becoming psychotherapy? Our most important guiding principle was our mutual agreement that the clinical needs of patients always come first. Both co-therapists agreed that if their perceptions of a patient's treatment needs differed, they were committed to pursuing the issue diligently until the reality of the situation was clear to both of them. Such a commitment assumes the

epistemologically obvious: despite personal blind spots and other limitations, there is in fact only one reality. The commonly held but nonetheless adolescent idea that there can be more than one reality is merely an intellectual defense intended to minimize anxiety. As in other realms of medicine, the personal discomforts or preferences of the therapist/doctor must come second to the needs of the patient. With respect to supervision this means that all areas of a therapist's living and personality must be "on the table" (R. Bar-Levav, 1997). That is, therapists must be willing, in principle, to openly address, scrutinize and reality-test their feelings, fantasies and thoughts about each other and their patients.

While such candor commonly stresses the personal boundaries of supervisees, such a clear understanding of contractual and ethical obligations to patients helps in the difficult task of attending to the treatment needs of patients rather than the personal needs of therapists. On occasion, anger might flare or tears might be shed, but overall the supervisee is expected to limit emotional expression, keeping the focus on how his character affects the patient's treatment.

As supervisor of this co-therapy team, I carried a heavy burden. What I did with them would affect the lives of each of their current and future patients. Above all, I had to ensure that I would not *add* to the difficulties they brought to me. And yet the very nature of the work we three would do meant I had no formula to follow. Unlike classical supervision that aims to correctly understand the latent content of process notes, these meetings with David and Elaine were experiential, making room for a lively interaction of three personalities. As a therapist's character influences his effectiveness, my own character would affect how we lived together in these hours. I expected to experience anxiety from time to time, as I might not see clearly what was going on between them, nor know how to best help them with it. My sensitivity and diagnostic acumen would be tested as I watched the process unfold, and my creativity would be drawn upon often since I would be forced to decide where to go next. But it was always clear to me that wherever we were going, we were going there together, and the guidelines we would follow — our fundamental agreement to abide by the

reality principle — made it likely we would arrive at the truth, sooner or later.

The Supervision

As I invited David and Elaine into my office for our first meeting (described from David's point of view in the paper that follows), I realized the first thing necessary was to make clear to David and Elaine that I was not a repository of answers but would instead challenge them to find answers themselves. To help them become a more effective co-therapy team, my goal was to help them work together more effectively and not depend on a third party, an outsider. I took note of the fact that Elaine spoke first, in an emotionally flat and intellectualized manner, about their goals. As with patients, *what* she said was far less important than *how* she said it, as was the fact that she spoke first. I formulated a hypothesis that this was typically how it was when David and Elaine discussed their patients, with Elaine tending to take the lead and to speak in an intellectualized and somewhat emotionally distant manner. When Elaine finished there was a brief pause, and then David spoke haltingly about why he thought the co-therapy supervision would be helpful. Both were probably anxious and therefore character defenses were expressed in Elaine's emotional "flatness" and David's "halting" speech. Neither David nor Elaine made reference to their relationship with one another or to the fact that there seemed to be no reaction on the part of either one to what the other had said. They seemed to speak as independent creatures who had no relationship with one another. In all likelihood, they tended to discuss anxiety-laden issues about their patients this way too. It was also likely that when things were emotionally pressured in the group they operated this way as co-therapists. When I noted this by saying, "You both act like the other person isn't in the room," Elaine and David both looked confused. While we had all understood that their relationship would be examined, none of us could have known how directly and immediately this would occur.

My initial hypothesis about the relationship was supported by what occurred in subsequent sessions. David was repeatedly tentative and

uncertain in his presentation and non-authoritative in the positions he took. I confronted his "I'm not sure" response, directly raising the question, "How much does this tentative, non-position taking show in the group?" David's account shows how our initial session lead to Elaine speaking more openly than ever about her disappointment and anger in regard to David's manner. It was clear that Elaine liked David and that she was concerned about hurting him or threatening his masculinity. Nonetheless, within the framework established by our contract, she finally discussed her reactions openly. Furthermore, when these character traits of David exhibited themselves in the group, patients also could either hide their reactions or speak of them openly. Elaine's care not to hurt or "threaten" David would limit patients' freedom to speak as openly as they needed to. Likewise, these patterns in the co-therapist's interactions would be taken in by patients who would be bound to react, either unconsciously or covertly. But they would not be likely to speak openly unless David and Elaine were able to help them to do so. Without such freedom, patients would be unable to examine their reactions to their therapists, and compare and contrast them to reactions to others in the past.

In the first session it also became clear that Elaine tended to be the more forceful of the two as well as the one more likely to speak with theoretical terminology. David, by contrast, was typically more sensitive to the emotional tone of the present moment and was able to empathize with Elaine more that she with him. Apparently Elaine was aware of this strength and appreciated David's sensitivity. But, remarkably, they did not speak to each other about these tendencies. Therefore it was unlikely that they were able to consciously use their knowledge of one another's strengths to make their team work more effectively. They needed to become more sensitive to the ongoing process between them when they spoke to one another in the group. Toward that end I decided not to make reference to the group, but instead focused on the interchange between them here and now. David's account of this session candidly reveals his reactions to Elaine's comments about him. What I noticed as his supervisor was the extreme form of David's physical reaction: a sudden

stooping of his shoulders, a freezing of muscle tone in his face, and a dramatic widening of his eyes which darted about. I assumed he felt suddenly ashamed as if he had been humiliated. I asked him how he felt about what Elaine had said, hoping that he was conscious of his emotions. If he were not, he probably would not be ready to make use of this particularly taxing and sophisticated form of supervision. However, he confirmed in words what was already apparent on his face: "I'm embarrassed and hurt." I pointed out that he looked like someone had "wounded" him and that he appeared as if he didn't "have a brain." While such language may appear to add insult to injury, my aim was not to humiliate David, but to dramatically make two points by speaking more to his "heart" than to his brain. Firstly, his embarrassment and hurt, while real, needed to be *talked about* in supervision, not acted out. Secondly, he urgently needed to recognize the extreme form his physical reactions take (body posture and facial expressions) when he is in the throes of strong feelings. It is necessary to bring such manifestations under conscious control, especially as he practices psychotherapy. Approaching the boundary between supervision and psychotherapy, I actively intervened as the process unfolded here in supervision. When David started to hang his head, I encouraged him to keep his head up and maintain eye contact with me. He responded immediately, and thanked me. My aim was to help him to behaviorally separate his experience of shame from an open display of it, and to maintain a thoughtful, self-respecting demeanor as we addressed these issues. This would not only help David make good personal use of what was now occurring but would also provide him with a model of a therapeutic experience which he could then use to help his own patients maintain their observing ego during strong emotional storms.

David's awareness of his emotional reactions, his sensitivity to his characteristic ways of dealing with them, and his ability to immediately alter his demeanor reinforced my assumption that he had already done extensive work in his personal psychotherapy. Assuming that the genetic roots of these behaviors and his transference to Elaine were evident to him, I asked, "Do you know where all this comes from?" His response was affirmative and emphatic,

confirming that he was adequately prepared for this kind of supervision. If he had not already integrated such genetic connections it would have been necessary for me to conduct the supervision very differently. However, the responses confirmed that the ego boundaries of both David and Elaine were well enough defined that they could make use of this kind of work.

Before ending the session, it was necessary to reflect on how the dynamics acted out between them affected their treatment of patients. Patients bring with them maternal and paternal transferences as well as gender role confusions. But so do psychotherapists. David and Elaine recognized their transferences to one another: David as Elaine's weak father, Elaine as David's domineering mother. To the extent this was being acted out in the relationship between them, not only would the effectiveness of treatment be limited, but it could actually add to a patient's confusion. A weak father and strong mother from a patient's early history could appear to be "duplicated" and reinforced by how the male/female co-therapy team operated (Mintz, 1965). Both understood this clearly and expressed concern and alarm.

Over the next few months, the patterns demonstrated in the first session were repeated many times, confirming my initial impressions of how the team tended to interact, and providing frequent opportunities to call their attention to it. For many weeks there was little in-depth discussion of actual clinical material since the relationship itself was in such urgent need of examination, clarification and correction. Slowly, however, David and Elaine became much more direct with one another and began to notice and correct distortions in the relationship. In time, they found more effective ways of dealing with each other and adjusted their behavior with patients accordingly. Gradually there was room for more clinical material in the sessions.

The case of Jean (outlined by David in his paper) demonstrates how the characteristic behavior patterns of co-therapists typically exhibit themselves during psychotherapy groups. As David and Elaine

talked over their treatment of Jean, the same themes identified earlier came to the surface yet one more time, but with greater emotional intensity. As they reported to me what happened in the group, it became clear that Elaine was reluctant to help Jean express her anger toward David directly. As we talked this over further, it became clear that Elaine had not been honest with David, or with herself, and had therefore not been able to help Jean properly. Finally Elaine expressed her own point of view, voicing the same complaint as Jean: "Sometimes what David says, or how he says it, does sound stupid." Elaine knew that her transferential feelings about her co-therapist obviously should not be expressed openly in the group. But she had never discussed her reaction with David until this meeting, and thus had never assessed the meaning of those feelings.

My experience as we pressed ahead with this delicate issue was very much like that of a house guest who inadvertently is privy to the tensions between a married couple. As I gently pressed Elaine to talk more openly still, she finally spoke about herself with more clarity and emotion than she had in earlier sessions. "Even though I don't feel it, I must still be angry and disappointed with how David is, or who David is to me, and at all the men in my life who have been passive and ineffective." She began to cry as she experienced a piece of her own unresolved personal history being replayed transferentially with her co-therapist. Once again, I was reassured to note Elaine's reference to "who David is to me" since her choice of words indicated her awareness that her feelings had genetic roots. The expression of these kinds of feelings could lead to confusion between David and Elaine if it were not already clear to her what the transferential roots were. In this instance, Elaine's boundaries were tested as a result of my pressing her to speak directly to David, and they held up well as she discovered that David could not only easily tolerate her impatience, but valued and appreciated her directness. The bit of personal working-through David and Elaine did in this session provides a useful example of co-therapists honestly and courageously joining the issues between them.

Conclusion

Examples from actual meetings have been used to demonstrate an innovative approach to supervising a team of co-therapists. This approach tests the ego boundaries of supervisees as their character defenses are challenged. The inner workings of the co-therapist "marriage" are exposed *in vivo* during the supervision, and their impact on patients is revealed. While this process could be confused with psychotherapy, certain basic elements ensure its usefulness: (1) all three parties—co-therapists and their supervisor—must have already successfully worked through most of their character difficulties in their own, personal intensive psychotherapy, and (2) an explicit and specific contract must be in place describing the limits of what does and does not belong in supervision, defining the aim of the supervision, and noting the commitment to strictly adhere to the reality principle. While the process is often anxiety-provoking and therefore somewhat unpleasant for co-therapists and supervisor alike, it nonetheless provides a unique opportunity to systematically remove unconscious countertransferential contaminants from the treatment of patients.

I realize it is a special privilege to supervise clinicians this way, and respect the courage and determination David and Elaine brought with them to sessions. Repeatedly they exposed their vulnerabilities, sometimes experiencing embarrassment, pain, and anxiety as they struggled to live together more realistically and improve their effectiveness in treating patients. As David and Elaine continue to attend to their relationship, their commitment to the reality principle provides patients with a model for rational living since how they live together in the group shows as they work together as a team. Although the difficult work of personal psychotherapy is never completely finished and all our conflicts are never fully resolved, our profession requires a commitment to continually and with determination pursue such resolution.

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