Psychotherapy Guidebook

Co-Therapy

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Table of Contents

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DEFINITION

The development of Co-therapy as a valid mode of treating patients in a group setting has accompanied the proliferation of psychotherapeutic techniques since World War II. The word "Co-therapy" itself encompasses a variety of definitions that reflect its process of evolving as a unique form of therapy. An increasing number of articles describing, refining, criticizing, and extending the uses of Co-therapy point to its expanding popularity as a therapeutic technique.

Although Co-therapy has been associated with other names, such as "multiple therapy," "joint interview," "cooperative psychotherapy," "three-cornered therapy," and "dual-leadership" (Treppa, 1971), it is a process with its own definable qualities. Co-therapy involves the use of two or more psychotherapists who work to develop a therapeutic relationship with an individual or members of a group in order to assist the individual(s) to function better interpersonally and intrapersonally. Co-therapists may be of the same or opposite sex; they may belong to the same or different disciplines (e.g., psychology, psychiatry, psychiatric nursing, and social work); one may

be a senior, more actively involved partner and the other a junior, observer partner; or the relationship between co-therapists may be egalitarian. Co-therapy provides an excellent situation in which to teach trainee therapists how to apply their therapeutic skills.

HISTORY

The Vienna Child Guidance Clinic was the scene of the first documented use of Co-therapy by Adler in the 1920s. Reeve attested to the therapeutic as well as educational values of pairing a social worker and psychiatrist to work with patients in the mid-1930s. And Whitaker et al. confirmed in the 1950s that Co-therapy facilitates the therapeutic process; they were the first to report the intensive use of multiple therapy for treating patients.

TECHNIQUE

Before any therapy commences, and as the therapeutic process proceeds, the co-therapists must be able to freely and openly communicate their feelings to each other. Otherwise, the incidence of hostility, jealousy, and anger that can occur between therapists could have a devastating effect on the individual(s) undergoing treatment. The basis of Co-therapy lies in the ability of the therapists to be able to relate to each other in an open and trusting manner, develop a sense of peership, accept each other's opinions,

identify each other's strengths and weaknesses, and deal with criticism in a constructive manner. In addition the therapists should feel approval from each other, feel compatible with each other, and be able to collaborate and settle differences in opinion outside of the therapy sessions. As long as both therapists are using the same therapeutic model, whether it be psychoanalytical, Rogerian, or eclectic, the type of psychotherapy that is practiced with the group or individual is less important.

The co-therapy process generally proceeds through four phases: the therapists must first develop a relationship between themselves and with the patient(s); then each patient's dynamics must be analyzed through consultation between the therapists and open discussion with the patient; the co-therapists assist the patient to understand himself; and finally, the patient is helped to reorient himself to his new self-concept and patterns of behavior (Dreikurs).

Co-therapy allows for a variety of techniques to be employed in the therapeutic process. For example, one therapist can provide support for a patient while the other can zero in on deeply imbedded feelings. Or, if a co-therapy team consists of both sexes, a patient may be able to use the same-sex therapist as a role model while dealing with parental conflicts with the therapist of the opposite sex.

Co-therapy also provides the background for the successful identification and utilization of transference feelings (an emotional attachment) toward one or both therapists. For example, if a patient develops strong transference feelings toward Therapist A, and Therapist A develops countertransference feelings or is unable to identify the occurring transference phenomenon, Therapist B can act as observer and, by identifying the transference, can prevent an impasse and aid both Therapist A and the patient to visualize and deal with the transference.

As with any group, members of a co-therapy group may develop resistance by comparing co-therapists unfavorably, scapegoating one therapist, assuming the role of therapist, using the therapist to perpetrate symptoms, or avoiding relationships with patients of the "other" therapist (Pine). These resistive patterns must be identified by the therapists and can then be used to initiate changes in patient behavior.

Limit setting is another important aspect of both group and individual psychotherapy and is more easily accomplished through the joint efforts of co-therapists than by a single therapist. This has been demonstrated repeatedly in therapy sessions with adolescents and psychotics.

APPLICATIONS

Co-therapy is applicable in a variety of settings and has been used

successfully with schizophrenics, psychotics, and neurotics; with adolescents and college students; with married couples, and increasingly with families. It is used in private practice, in community mental health centers, in psychiatric facilities, and in teaching hospitals for the benefit of student psychiatric practitioners.