

# Co-therapy: Two Be or Not Two Be

by Marsha Vanicelli, Ph.D.

I have been doing co-therapy since I began my first group 35 years ago in the McLean Hospital Outpatient Clinic. My love of groups and of co-therapy have gone hand and hand since then. Eighty percent of my group therapy experience has been partnered with a total of 20 male and female co-leaders—with whom I have had 4 very long co-therapy relationships (6-19 years), 8 substantial partnerships (1-3 years), and 8 very brief co-therapy experiences (leading experience groups and institutes at AGPA and NSGP annual meetings).

All but one of these has been a wonderful, rewarding experience that I would happily repeat. And even that one was not without its bright side—co-leading a couples group that continued without any attrition for the one-year term of the group (we persevered and so did all 4 couples!). Although I nearly “divorced” my clinical partner after our first group session, which painfully highlighted serious clinical limitations that would ultimately propel him into a more suitable profession, I learned a lot about tact and enough about self-restraint to keep me out of jail. Equally important, I learned from my experience with him how essential it is for co-leaders, even if they like each other personally (we had met and talked over lunch a few times), to have a good understanding, in advance, of differences and similarities in terms of clinical styles and orientations, as well as strengths and weaknesses (including affect tolerance, need for control, transparency, and activity level). This kind of careful consideration is in sharp contrast to the “arranged marriages” that often occur in training clinics where co-therapists too often are thrown together without the opportunity to discuss any of these issues.

For me, the premise of co-therapy is simple—anything that is pleasurable is more so if shared. That said, there are costs as well as advantages (Rutan & Stone, 2001; Vannicelli, 1992), and I will briefly highlight some of each.

For the group leaders, one of the most important advantages (after the joy factor) is the opportunity to actually get a group going. Mental health agencies are often only able to support a limited number of groups. A leader who wants to “go it alone” may run the risk of competing with other groups and thus not having a big enough pool of patients. Similarly, in private practice two therapists together may have greater opportunities (double the referral base) for gathering a critical mass to begin a group and for keeping it alive than would one therapist alone.

Co-therapy also provides support, in many ways, for the group leaders. Coverage is facilitated for therapist vacations and illness, and responsibility can be shared for notes, billing, and follow up calls that may be needed. The presence of a respected colleague also maximizes the opportunity to discuss clinical interventions and how they may be most usefully worded. Having a supportive partner in the room can be especially useful when transference (and/or countertransference) is unusually hot, or when a leader is under siege by a particularly difficult member or the group-as-a-whole. In these situations the co-therapist can serve as “interpreter” for difficult interventions that can benefit from being restated or clarified, or can provide a warm spot for directing “indirect communications” (Gans 1996) that the leader wants the group to “overhear.”

Along with this, the learning opportunity for co-therapists is a benefit that cannot be overestimated—the growth that comes from watching and being watched, from giving and receiving ongoing feedback, as well as from having another way of thinking about what is transpiring in the group. For example, one of my long-term co-therapists, who is a bit less group-as-a-whole and interpersonally oriented than I am, is especially attuned to intrapsychic aspects of character (self-deficits and narcissistic vulnerability) that adds enormously to the richness of our work together.

For patients there are also many advantages, including the opportunity to watch an effective pair working together, to have two skilled sets of eyes and ears tracking the group process, and to have greater

continuity and predictability by maximizing coverage for vacations and illness. Though in my own mind these advantages clearly outweigh the disadvantages, many skilled therapists weigh in on the other side. Rutan and Stone (2001), for example, note the many hazards and, in general, recommend against co-therapy, arguing that one of the main advantages—reduction of therapist anxiety—is in itself a disadvantage, since it prevents the co-leaders from experiencing the anxiety that their patients must face in entering the group alone. I would argue, however, that being a group leader is a much lonelier role than being a group member, and that having a co-leader does a lot to offset the tug that leaders often experience of wanting to join the group.

Other disadvantages include reduced financial compensation, since most co-therapists charge little or nothing more than what each would charge alone for leading the group, and increased time commitment to allow for conferring with one another before and after each group. In addition, because of the increased exposure of being watched by a colleague, there may be a greater sense of vulnerability. Competitive feelings are also inevitable (the possibility of feeling diminished, or concerns about who looks kinder, smarter, more effective, more giving) as the leaders deal with their real differences as well as ways that they are differentially perceived by group members. In these ways and others co-therapy may rekindle old dyadic issues for the leaders, both from their family of origins and from adult partnerships and marriages.

Clearly the costs of co-therapy, like any partnership, cannot be ignored and need to be carefully considered. But overall, I vote for two minds sharing the excitement and challenges of the group therapy adventure.

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