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CONCURRENT THERAPIES: A MODEL FOR COLLABORATION BETWEEN PSYCHOANALYSTS AND OTHER THERAPISTS

Many psychoanalysts treat individuals who are simultaneously in couples therapy or whose partners are in individual therapy. If such cases stall, some analysts may seek consultation from a colleague, though most have accepted the tacit historical prohibition against communication between therapists treating members of the same family. Experience, however, suggests that a certain form of communication between such therapists can have a powerfully enhancing effect on the concurrent therapies. After a review of the literature, the advantages, disadvantages, and impediments to collaborative cross-communication are examined. A model is then presented for use in ongoing discussion between therapists, and is illustrated with two clinical examples. The proposed model centers on the transference-countertransference configurations within the therapeutic field, and serves as an organizer highlighting areas for discussion.

A member of our group reported the following experience: "At a meeting, I found myself seated next to a colleague who was analyzing the spouse of a man I was analyzing. We chatted while avoiding discussing our patients. Toward the end of our conversation I said of his analysand, 'She is certainly dependent, isn't she?' He

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replied, 'Well, she's married to a workaholic who is seldom there for her!' This was the only communication we had about them, even as their analyses continued for many years."

Years later, after surveying colleagues, our group found that some collaborate openly, others do so sporadically, while most avoid sharing information. The discussions that do occur are usually in response to a crisis. Such emergency discussions are difficult, because the lack of prior communication has not allowed the development of a collaborative alliance.

In the past twenty years, those of us treating patients whose spouse or other family members are in treatment with others have struggled with how and what to communicate to these other therapists. Two years ago, one of us (JG) convened our group to study the problem in detail. We discussed cases we had in common and monitored how and what we shared, what seemed to help, and what impeded our collaboration.

Our six-person group is diverse: of the five men and one woman, all are adult analysts, three treat couples in conjoint therapy, and one is a child analyst. Given differences in theoretical persuasion, there have been inevitable differences of opinion. However, a consensus has grown that collaboration between therapists can be quite helpful in certain difficult cases, and that potential threats to the therapeutic alliance and other complicating issues concerning confidentiality and patient reactions can be managed. Additionally, we have discovered and mapped psychological impediments to collaboration in ourselves. With these impediments understood, collaboration could proceed, and it facilitated understanding of the individuals and marriages being treated. As might be expected in any trial-and-error scientific endeavor, some shared communications backfired, some were probably unnecessary, and others were especially valuable. This paper summarizes our conclusions with the aim of specifying the most likely routes to success.

LITERATURE REVIEW

Members of a family frequently participate in a variety of therapies at once—psychoanalysis, individual psychotherapy, couples therapy, group therapy, and psychopharmacotherapy. Despite this common occurrence, there is no research and only limited literature to guide analysts working in concurrent therapy systems.

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Among the early psychoanalysts, some couples availed themselves of individual treatment with analysts who knew each other. There were then no clear guidelines for communication among treating analysts and, given the closeness of analytic communities at that time, there was ample informal communication between analysts treating family members. These communications ranged from simple gossip to serious breaches of confidentiality (Carotenuto 1982; Roazen 1995; Lynn and Vaillant 1998). Deleterious communications, experienced and made public in the literature, contributed to a backlash in which all such communications were seen as countertherapeutic.

Additionally, Freud's original closed-system model of analysis (1917), with its exclusive focus on the patient's inner life, made information obtained from outside sources seem a distracting contaminant of the intrapsychic field.

While there was little in the psychoanalytic literature about analysts communicating, other disciplines emphasized its benefits. Collaboration was established as crucial in inpatient settings (Stanton and Schwartz 1954) and within the child guidance movement (Sperling 1979). In these situations, therapists learned the benefits of pooling data and the dangers of exclusive reliance on information from one patient or one therapist. Instances of patients attempting to split their treating therapists and of therapists induced into such enactments became understood.

Several analytic writers have recently described their experiences of sharing data from multiple therapies (Graller 1981, 1996; Zinner 1989; Maltas 1996; Ehrlich, Zilbach, and Solomon 1997). These writers also emphasized the dangers of triangulation and antitherapeutic splits. Therapists may be cast as adversaries and sometimes act accordingly. Each of these authors addresses this problem. Zinner (1989) notes that splits and enactments are less likely when concurrent therapies are planned, rather than emerging "spontaneously" out of desperate attempts to counter impasses.

Graller (1981) noted how referrals for marital treatment allowed work on "split transferences"[1] that were reduced in the marital therapy

[1]We use the term *split transference* as shorthand to indicate situations in which patients unconsciously represent others so that one person is seen as more or less "good" (gratifying, understanding, competent, etc.) while another is seen as correspondingly more or less "bad." Typically the spouse/partner and his or her therapist are cast in the roles of bad objects, while patients represent themselves as victimized and their own therapists as gratifying. Such defenses are termed "split transferences"

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and so allowed the individual analyses to progress. This collaborative work required effective communication between the marital therapist and the individual analysts.

We agree with Maltas (1996), who contends that in many concurrent therapies communication between therapists is unnecessary, since healthier patients integrate the different therapy components without special assistance. By contrast, her paper focuses on a case where the patients' defensive acting out recruited their individual therapists into overidentification with them, so that their analyses stalled and the analysts worked at cross-purposes. Although Maltas's attempts to broker collaboration between the therapists failed, she was able to make progress by showing the married couple how they had unconsciously created the standoff.

Graller (1998) in his discussion of Maltas's paper emphasized the benefits of therapists trusting each other so as to allow discussion and integration of transference and countertransference data.

Ehrlich, Zilbach, and Solomon (1997) presented an example of collaboration and used the term *transference field* to describe the interweaving of unconscious fantasies among patients and therapists. The case they present illustrates how detailed communication between therapists can unlock resistances to deeper analytic work.

TO COLLABORATE OR NOT

When therapists contemplate possible collaboration, the chief concern should be the impact on the analytic process. While this paper presents our experience of the benefits of collaboration, it is important to consider contraindications. The principal danger is that the therapeutic alliance will be damaged. This can happen if sensitive material is injudiciously shared and patients feel betrayed. In anticipation of this problem, we request patient approval before a collaboration, and determine any specific information our patients wish not to be revealed.

Another concern is that the analytic focus may shift from the intrapsychic to the external. In fact, the most common situation neces-

partly because they serve to separate desired and feared aspects of objects, while defending against their explicit elaboration in analysis. Such intrapsychic defenses routinely have powerful interpersonal consequences, as the other persons involved are induced to play out their assigned roles. To the extent that such role induction "succeeds" (Sandler 1976), interpretation of such projections becomes difficult or impossible.

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sitating collaboration is the patient's defensive use of external events (marital problems) to avoid an intrapsychic focus. Nonetheless, patients should be told explicitly that the goal of collaboration is to further the examination of each patient's psychology, rather than to manage current problems.

A related concern is that the conflicting goals of individuals (and their therapies) preclude collaboration between therapists. It is true that the specific goals of marital partners may conflict; indeed, disagreement and an inability to see common goals is the very stuff of marital therapy. However, to the extent that patients are committed to improving their marriages, rather than using marital therapy to achieve a less painful exit, the underlying goals of the therapies need not conflict. To the extent that analysts or patients are indeed working toward conflicting goals, collaboration can help make this explicit; working out conflicts that patients may have around decisions to be made in their lives outside the treatment is not the goal of collaboration, which focuses solely on improved comprehension of psychological and marital dynamics.

While collaboration between analysts does not inherently conflict with individual agendas, patients may have fantasies that it does. We therefore tell patients that the process may elicit dreams and fantasies about the collaborating individuals that can be usefully explored.[2] Some patients may be upset by what seems a replay of caretakers insensitively planning behind their backs, while others may be overstimulated by fantasies of wished-for dependent care. Paranoid patients may lose trust in their analysts if *any* information is shared, while patients with extreme narcissistic vulnerability are sometimes unable to tolerate the injury they anticipate from the exposure required by collaboration. More generally, analysts should consider on a case-by-case basis whether consultation is likely to evoke unworkable transferences that would damage the analytic alliance and process. Such a likelihood is a contraindication for collaboration. In some of these situations, collaboration can be deferred until an improved therapeutic alliance makes it possible.

While analysts are understandably concerned about dangers to the treatment process, we find that factors involving the patient less

[2]Actually, fantasies about the treating analysts exist in what Ehrlich, Zilbach, and Solomon (1997) have termed the expanded *transference field,* whether they confer with one another or not.

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commonly present roadblocks to collaboration than do concerns centering on the analyst. Some of the latter are relatively superficial and external: lack of guidelines for conducting collaboration, lack of rationale for a process that breaks with tradition, concerns about not being reimbursed for the time spent, and difficulty finding time for case review. We will address the first three later; as for the fourth, we suggest that time spent in collaboration will be repaid by improved patient outcomes.

Anxieties stirred by the prospect of consultation with peers are the most important impediments to collaboration from the side of analysts.[3] Our most convincing demonstration of this is that we have repeatedly observed such anxieties in our own group, despite our intellectual commitment to exploring the collaborative process and our many positive experiences with it.

Sharing one's work risks the exposure of errors, oversights, lack of understanding, idiosyncratic countertransferences, and other feelings about one's patients. When sharing their work, analysts risk real and imagined criticism and loss of respect. Such fears are intensified by the privacy of our work. Doubts about efficacy and proper technique may result in fantasies that other analysts could do better with the same patient or couple.

While such anxieties are commonplace, they can be partially counteracted by anticipating the benefits of consultation. Specifically, while fears of being shamed by peers or of revealing unflattering fantasies about spouses and collaborating analysts can impede collaboration, such fantasies are also keys that can unlock impasses. When this happens, analysts experience not the fantasied injuries but real relief from the pain of work that was not progressing.

The most important advantage of collaboration is that several analysts can bring more creative and synthetic power to understanding of the individual and marital dynamics. Anticipation of a discussion with another analyst encourages a review of transference and countertransference themes, which improves understanding, especially in areas that remain puzzling and disturbing.

When analysts collaborate, both differences and similarities of opinion can be helpful. Differences stimulate critical thinking and

[3]Racker (1968) is perhaps the first to note the anxieties stirred by transferences toward other analysts, while also pointing to their diagnostic value.

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attempts at integration, while agreement on fundamentals strengthens conviction about being on the right track.

In addition to pooling data from different perspectives, collaboration can uncover analysts working at cross-purposes. It can expose latent agendas, transference splits, unconscious enactments, and power struggles in the treatment system. Patients' successes in inducing misconceptions or oversimplifications in the minds of their analysts provide fertile ground for study. Collaboration often helps clarify the reality of the other analyst, including validating occasions where patients have accurately reported analyst limitations or biases.

When successful, collaboration reduces the pressure on the therapists. Feeling part of a larger therapeutic team, each therapist can focus better on the work at hand. A related, if serendipitous, benefit of collaborative work is that it is invigorating. Some of the stress of being a psychoanalyst arises out of the isolation in which the work is typically done. Very often our loneliness abates, giving way to increased vitality, when we work with others contending with the same cast of characters.

A COLLABORATIVE MODEL

The collaborative model we now present has two primary and overlapping goals. The first is to allow communication between therapists so as to deepen their understanding of the treatments. The second goal is to solidify collaboration as a bulwark against the split transferences and enactments that can undermine the treatment efforts of the individual therapies.

The model addresses both goals by focusing attention on understanding (1) transferences to the therapists (the transference neuroses), (2) spouse-to-spouse transferences (the "marital neurosis"[4]), and (3) transferences of the therapists, to each other as well as to the

[4]The "marital neurosis" is a transference-like constellation which, by analogy with transference neurosis, develops over time in the course of a marriage. It is distinguished from a healthy marital fit in which the partners bond successfully, work as a team, resolve conflicts, and handle common regressions in each other. By contrast, when things do not run smoothly, some couples demonstrate areas of "neurotic fit," empathy fails, and conflicts remain unsolved. The "marital neurosis" is the result of mutual and interlocking spouse-to-spouse transferences, and is the shorthand term we use to designate this maladaptive unconscious process.

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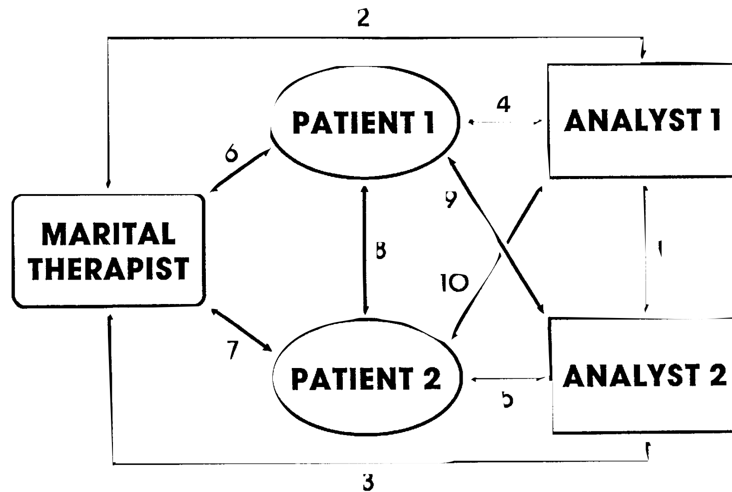
patients. These various transference relationships are shown in the diagram.[5]



The transference and countertransference frame of reference provides therapists a template and a shared language in which to discuss historical information and dynamic understandings of their patients. This focus on the various transferences helps forge a collaborative alliance among the therapists as it brings to light and mitigates transference distortions that interfere with working together.

It is essential to be alert to the transferences and collaborative difficulties due to differences in analyst gender, age, education, and hierarchical status in the mental health community. Different attitudes about important life issues (e.g., saving the marriage, extramarital affairs, proper amounts of "assertiveness," etc.) may also become manifest and be usefully discussed.

We usually begin our collaborations by focusing on either the analyst-analysand transference-countertransference relationships (4, 5, 6, 7) or on the marital neurosis (8). After this the "unseen relationships," those between each patient and his or her partner's analyst (9, 10) and between the various therapists (1, 2, 3) can be approached. These

[5]The diagram sketches a therapy system including two patients concurrently in psychoanalysis and couples treatment. The model can be applied also to instances where one spouse is in individual treatment while both see a couples therapist, or both are in individual treatment without conjoint therapy.

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unseen relationships invariably contain important transference projections that before collaboration will have been largely inaccessible.[6]

In anticipation of meeting with colleagues, analysts should review their patients' histories, character styles, defenses, strengths, problems, and goals. Analysts should be especially cognizant of the thoughts they feel inclined *not* to share.

These principles can be seen in operation in the following two cases. In the first, we present a typical situation with two individual psychoanalysts and a marital therapist; in the second, the collaboration of the two analysts made concurrent couples work unnecessary.

Case 1

Two years after divorcing their first spouses and one year after they married, both Mark, a thirty-eight-year-old businessman, and Jill, his thirty-six-year-old wife, entered psychoanalysis.

Mark complained of depression and reported angry outbursts at his wife that followed visits with his two adolescent children, who lived with his ex-wife. These outbursts were disrupting his marriage to Jill, whom he blamed for not bonding with his children. The blaming, so typical of couples in distress, was only much later understood as a complex defensive structure. At the time, Mark's persistent complaints about his wife rendered his analyst powerless. Mark rarely reported dreams, and rejected suggestions that he examine other sources of the rage he directed at his wife.

Mark's pertinent history revealed an overworked and absent father. His long-suffering and lonely mother had spent many hours with him and his two younger brothers in a custodial rather than interactive manner. His first marriage had ended because of his intolerance of his wife's depression following her mother's sudden death. As his wife regressed, Mark's anger escalated because he viewed the depression as controllable and manipulative.

Despite many academic and social successes, Jill had become frustrated, guilty, and depressed in her first marriage when she found herself unable to become pregnant. After four years of infertility

[6]Another paper could usefully explore the complex differences in transferences between people who have or who have not "seen" each other. One frequent pattern we have observed with spouses and their therapists is that "never having seen" tends to foster more negative characterizations, while "having seen several times" can blind therapists to "harder to see" problems that can emerge over time.

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workups and treatment, her husband "fell out of love" and abruptly divorced her, leaving Jill feeling bereft, as she had felt when her father was away on his frequent business trips.

After eighteen months both analyses were stalled, as Mark and Jill were unable to get beyond relating the events of their angry confrontations. At that point, Mark's analyst referred them for marital therapy. The marital sessions were dominated by Mark's anger at Jill's inability to bond with his difficult children. His attacks and her problems connecting with his children magnified her low self-esteem and elicited her anger at his lack of appreciation for her efforts. Their angry feelings were intensified by their misunderstanding of psychoanalysis, as both assumed that "catharsis" and "expression of feelings" would suffice to resolve their marital problems.

When the addition of marital therapy failed to deepen the analyses—each remained mired in repetitive complaints about the other—the analysts decided to meet with the marital therapist with the aim of achieving greater understanding.

The initial meeting of the three therapists revealed two angry analysts overidentified with their patients.[7] While the analysts knew one another, they had never discussed a case like this face to face. Mark's analyst joined Mark in blaming Jill for being passive-aggressive and lazy. Jill's analyst was angry with Mark and his analyst for encouraging Mark's counterproductive expressions of anger, and hoped that Mark's analyst would control Mark's "verbally abusive outbursts."

While it became increasingly clear that both analyses were stalled because complaints about the other spouse crowded out self-examination, forceful and convincing interpretation of these dynamics was blocked. One important impediment was that the analysts covertly agreed with their patients. Like their patients, they were irritated and

[7]Readers will correctly wonder why in this and the next case the analysts were more taken in by their patients' accounts of things than was the marital therapist. Certainly this is not always the case, and is something we try to guard against. While we offer some data on this score here, and some speculations about analyses that go this way, a detailed account of this frequent phenomenon of analyst induction and collusion is beyond the scope of this paper. Doubtless the answer in any particular case resides in some complex mix of patient pathology and analyst disposition. Additionally, the circular dynamics of the marital neurosis tend to bring out the worst in each spouse, so that analysands' complaints to their analysts about spousal behavior will often present convincing instances of the spouse's pathological fixations. In any event, we assume that analytic readers have encountered this situation, become stuck in it, found it difficult to extricate themselves, and would be interested in the possible solutions we offer.

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hoped that the meeting would magically rescue the analyses by controlling the other partner's behavior.

The analysts voiced their feelings of frustration, their fears that the marriage would fail and that the analyses would never get to bedrock issues. After some ventilation and sharing of information, they experienced palpable relief and guarded optimism. However, while this initial meeting was cathartic and somewhat helpful, it was not enough. Both analysts remained too invested in blaming the other spouse.

(*Relationships 4,5,8,9,10:* Collaboration revealed the unconscious overidentification of each analyst with his patient and a resulting countertransference to the unseen spouse. However, the initial collaborative effort failed to solve the impasse, since both analysts resisted examination of their countertransferences to the unseen spouses and to their analysands.)

In retrospect, the dominant pathology at this point was Mark's, his powerful resistance having backed his analyst into a position of therapeutic powerlessness reminiscent of his ineffective parents. This latent transference-countertransference configuration was concealed by Mark's having successfully induced his analyst into the more superficial role of pseudo good object.

At the next meeting Mark's analyst was less defended and revealed his frustration at his inability to control Mark's outbursts by interpretation. He was feeling so discouraged that he was considering putting Mark on medication and switching to twice-a-week psychotherapy. However, he thought that his patient might feel rejected and punished, a feeling that would evoke images of his father. Mark's analyst became aware of his unconscious collusion to "be there" for his patient and not step into the depriving father's shoes. After further discussion, the analyst also realized that he was enacting the role of the patient's passive, lonely, and long-suffering mother as he listened to endless complaints without being able to improve things.

(*Relationships 1,2:* The husband's analyst's ambivalence about meeting was based on his reluctance to reveal embarrassment and guilt to his colleagues about the ineffectiveness of the analysis. *Relationships 2,3,4:* The persistent effort by the marital therapist to continue the collaboration allowed the clarification of the transference-countertransference configuration between the husband and his analyst; the reenactment of the maternal transference and the fear of the negative father transference could now be understood.)

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As a result of the second meeting, the husband's analyst made the following interpretation to his patient: "I suppose my inability to help you with your anger and marital problems reminds you of your caring but ineffective mother." This recognition that the crucial latent transference was maternal led to deeper insights. As the husband's analysis shifted toward understanding his anger toward his mother, the spousal transference lessened and the analytic work resumed. For example, Mark could now see that his attacks on his wife for not "bonding" with his children were fueled by his anger at his mother's similar failure, and concealed his own difficulties connecting with them in depth. Viewing Mark's problem connecting with his children as based in part on his never having experienced such relating (a developmental arrest), the analyst recommended that Mark read the books his children read and that he play board games with them. Mark was able to manage this, and in the analysis could work through the pain it elicited. Eventually he was able to expose himself as a he had felt as a boy—sad, self-deprecating, unworthy of love, painfully naive, and alone in the world.

Without her husband's attacks to distract her, Jill got back on track in her own analysis. Her defensiveness lessened, allowing her to analyze lifelong feelings of undesirability and unworthiness.

The couples therapist was now able to show each partner how Mark's angry outbursts had been part of a "neurotic fit" between them ("the marital neurosis"), serving the unconscious needs of both spouses. In Jill's case, Mark's attacks met her unconscious need for punishment, and distracted her from concerns about motherhood. This topic had been simultaneously too hot to handle and too easy to dismiss when Mark had attacked her for limitations with his children. Jill's masochistic acceptance of her husband's anger could also be seen as based on her fear that he would abandon her as her first husband and father had. From this point on, Jill's analysis deepened as it became disentangled from the marital neurosis.

(*Relationships 4,5,8:* Collaboration freed both analyses from their external defensive preoccupations, and had synergistic effects on each analysis. *Relationships 6,7,8:* The marital therapist's input was helpful as it fostered an understanding of the neurotic fit between the couple and their reenactment of interlocking unconscious needs.)

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Case 2

Robert, a thirty-nine-year-old depressed man, was referred for psychotherapy after complaining of underachieving and feeling unappreciated at work and at home. As an architect in a large firm, he felt that his creativity was not being used. A slightly built man preoccupied with bigness, he yearned to design large buildings but was unaware of feeling competitive with his civil engineer father, who had many people working for him on large projects.

There were increasing conflicts with his wife around the care of their three children and the family pets (three cats and two dogs).

Robert's wife Martha, a part-time paralegal, was a bright, thirty-six-year-old woman. The oldest of five, with three younger brothers and a younger sister, she had felt unable to compete with her brothers, who were encouraged in education and athletics. Everyone in her family thought she should have gone to law school. Once she started having children, however, she became consumed by motherhood.

Soon after Robert started twice-a-week psychotherapy, he filled his sessions with complaints about his wife. Many of his problems preceded their marriage, but it was hard to separate these from current issues. So focused was he on his marriage that transference reactions could not be interpreted. Noting the unsettling, ready availability of oedipal themes coupled with high levels of anxiety, chronic low self-esteem, and relentless complaints about the wife (mother), Robert's analyst suspected deeper, more severe psychopathology. Consequently, he encouraged Robert to enter analysis and suggested an evaluation for his wife (after which she began twice-weekly therapy).

Some months later, as Robert's angry defensiveness continued, his analyst contacted Martha's analyst to arrange a collaborative meeting. At the meeting, Martha's analyst described his patient's intense rage at Robert. Although he suspected that the intensity pointed to her lifelong insecurity, he questioned the work of Robert's analyst. In an accusatory tone, he wanted to know why Robert had his sessions at 7 A.M. Robert's analyst explained that this was at his patient's request, since Robert could not take time during his workday. When asked why this was significant, Martha's analyst said that as a result of this arrangement Robert did not have sufficient time in the morning to care for the family pets. This increased Martha's anger at her husband and his analyst.

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(*Relationships 1,5,8,9,10:* The initial collaborative encounter between analysts revealed that the wife's analyst was sympathetic with his patient's complaint and expressed anger at the unseen spouse and his analyst. In addition, the wife's anger was being displaced onto the unseen analyst.)

Because this initial collaboration was simultaneously helpful and incomplete, especially as it revealed important transference resistances between the two dyads, the analysts continued to meet every few months to explore matters further. The wife's analyst became aware of his anger about this difficult referral. He began to understand his temptation to ally with Martha by viewing her problems as external, since this helped him avoid the feelings she evoked in him (e.g., inadequacy and anger over the question of whether he was "giving" or helping her enough). The collaboration helped to expose and neutralize his negative countertransference feelings. However, both therapies remained impeded by the spouses' constant complaints about each other. Though the analysts discussed recommending marital therapy, they decided to defer this.

One year after their initial meeting, the analysts met and discussed dreams, fantasies, and emerging projections. The husband was preoccupied with feeling small and ineffective. He fantasized that his wife's analyst was tougher than he was. He imagined that her analyst could "take her punches like a man," and this made him feel weaker. Simultaneously, he felt hopeful, since Martha's analyst could absorb her attacks, not take them personally, and not get angry with her. He began to wonder about what limited his resilience in the face of her expressed anger.

(*Relationships 4,9:* As the collaboration progressed, an "unseen transference" was aired: that the husband's sense of smallness was stimulated by the perceived strength of his wife's analyst. Awareness of this dynamic facilitated intrapsychic exploration in his analysis.)

On the days of her sessions, Martha noted fewer angry conflicts with her husband. As she felt safer directing her anger at her analyst, and as he "survived," she understood how such attacks served defensive purposes. Now less defensive, she could examine her painful childhood, when she had felt lost in her large family and neglected by her father, who was involved with her brothers. Her analyst now saw her softer side and could understand how sad, lonely, and unappreciated she felt beneath her attacking exterior.

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(*Relationships 1,5,8:* Collaborative interaction between the analysts had allowed the wife's analyst to understand the impact of her treatment on her husband, and revealed the defensive function of her anger. Martha and her analyst could now access and come to terms with the profound feelings of emptiness and inadequacy that had accompanied her childhood depression.)

The analysts continued to improve their understanding of Robert's and Martha's dynamics, which lessened the couple's anger and helped to correct their projections and distortions.

A turning point in Martha's therapy occurred when she described a dream in which her animals were out of control "and messed up the living room." Her analyst discussed parts of the dream with the other analyst and was informed of the husband's disdain for the largest dog. Both analysts agreed that the symbolic meaning of the dogs for both partners needed to be understood. The wife's analyst told the husband's that Martha felt instant love and gratification from the dogs because they were immediately responsive.

The wife's analyst was now tuned in when Martha described feeling wonderful whenever the big dog was on a leash and pulled her along. She began to cry and associated to wishes for acceptance by her father and brothers. Martha was then able to tell Robert how much she longed for him, and he was able to respond nondefensively because he had been working on his feelings of inadequacy in relation to the dog and her analyst. He accepted her need for him and was able to spend more time with her, which diminished the tension in the marriage.

(*Relationships 1,4,5,8:* Effective communication between analysts was helpful in understanding and lessening defenses against crucial transferences. The support that her analyst received during the collaborative process allowed him to deal with his countertransference feelings of frustration and anger. It also corrected some distortions and headed off a developing split. For instance, Martha's analyst learned that Robert's analyst did *not* encourage his patient's passive-aggressive behavior. The clarification of the unseen spouses' pathology and transferences helped the analysts traverse the first phase of the spouses' analyses without a referral for marital therapy.)

These cases illustrate how collaboration with other therapists working in the same system can provide a rich case review and experience that facilitate movement beyond a therapeutic stalemate.

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FURTHER REFLECTIONS

Based on our study of numerous collaborative encounters, we have concluded that a lack of therapeutic progress is the primary indication for the collaborative model presented here. In such situations, patients have become stuck on a defensive external focus that does not yield to the usual analytic technique. Often there is a complex blend of neurotic and self pathology that links with similar pathology in the spouse. We then see rageful, needy, and insecure behaviors enacted unconsciously in the regressive marital situation. The confirming and agitating behavior of the partner interferes with analytic interpretation so that diagnosis and treatment of the marital neurosis become urgent. In many instances, psychoanalysis of one or both spouses relieves the marital neurosis. Other marriages remain conflictual, as the marital neurosis becomes a resistance and the primary content of the analyses.

A SEQUENCE FOR APPROACHING IMPASSES

Analysts may use several options in responding to such impasses: (1) They may encourage the patient to communicate more directly with his/her spouse, including sharing insights gained in analysis. (2) They may recommend analysis or individual therapy for the spouse, or couples therapy for the partners. (3) They may seek consultation from colleagues outside the treatment system. (4) They may initiate a limited communication with the other therapist(s). This limited contact should focus on the patients' psychopathology and may be educational or supervisory. Its main value is the validation, revision, and extension of the analyst's dynamic formulations. It may also indirectly challenge or expose "unseen" transferences the various therapists may have about each other and the other spouse. (5) Finally, if these efforts fail to resolve the impasse, a more extensive collaborative process is indicated. The purpose is to develop a collaborative alliance to understand the marital neurosis and its impact on the various treatments.

This sequence of options moves from less to more complex as it brings to bear progressively more powerful methods for resolving therapeutic impasses involving marital partners. The collaborative model described in this paper—with its attendant complications involving confidentiality, boundaries, and general complexity—should be considered the "ultimate" recourse, not a standard method to be applied to all cases.

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Three nuances concerning this sequence of treatment options can be noted.

Sequence of referral. Patients who begin in marital therapy and are subsequently referred for analysis should be differentiated from those in analysis who are later referred for marital therapy. The latter cases tend to be more difficult, sometimes the stalemated variety, while the former are often "satisfied customers" looking for more depth and help than can be provided by conjoint treatment.

Outside consultation. While outside consultation with another analyst is often helpful, its applicability and power is sometimes limited. As concerns applicability, the unconscious splits and countertransferences that are central to the stalemates we are discussing can keep an analyst from seeking outside consultation. In both our case illustrations, outside consultation was not sought, and powerful resistances to case examination were eventually uncovered. While we analysts consciously attempt to examine countertransferences and maintain healthy skepticism when patients describe their external worlds, this is easier said than done. (For a detailed exploration of analysts' transferences to "objects" in their patients' lives, see Jacobs 1983.) Unlike analyses stalemated by overt negative transferences, which call out for consultation, collusive split transferences create an illusion of helpfulness and patient satisfaction, coexisting with warded-off transference-countertransference patterns.

Outside consultation in stalemated cases may also be a less powerful intervention than the full collaborative option. Independent consultants may inquire about missing data and underlying countertransference problems, but they won't be able to provide any of their own for review. In cases with significant acting out and splitting of transferences, other members of the system will be especially well positioned to report on warded-off aspects of the case. This phenomenon of therapists working out splits between themselves to the subsequent benefit of their patients was described long ago by Stanton and Schwartz (1954) and is applicable outside the psychiatric hospital when the dynamics are similar.[8]

[8]This conceptualization of collaboration explains why we advocate meeting with other analysts, but *not* with other significant others, say employers. The reason is that while a patient's boss may certainly be the object of important transferences, his or her countertransferences are not impediments to the treatment.

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Earlier collaboration. Because collaboration with difficult, stalemated cases has proven so helpful, we have considered using it sooner in the second referral situation mentioned above—analysts making a referral for marital therapy. We now move more quickly to employ the full collaborative model. We have usually found such consultations extremely valuable. One rationale for the more rapid move to the full collaborative model is that such cases, though common in our practices, are rarely "routine." Although they may not yet be in crisis or stalemate, most of these marriages soon reveal either patients or analysts who doubt the sufficiency of the various therapies.

Such early collaboration is more easily justified to patients as part of a thorough assessment phase in the new treatment modality. It also has the advantage of occurring before an acute crisis, and before strong or unworkable transference or countertransference feelings emerge. These two advantages should be weighed against potential problems of patient trust, confidentiality, and focus which sometimes tip the scales away from early collaboration and toward sharper therapeutic boundaries.

ADDITIONAL RECOMMENDATIONS FOR COLLABORATION

Over the last several years, we have spent considerable time perfecting the details of collaboration. Our overarching aim has been to find techniques that encourage, rather than inhibit, the unfolding of individual analyses. Some of our experience is condensed in the following additional recommendations.

Once we decide to begin the collaborative process, we prefer to conduct initial meetings face to face. Later discussions can occur by phone once an alliance is established. While the frequency of meetings will depend on clinical necessities, these can usually be spaced at intervals of from three to six months.

Patients are asked permission to allow communication with the other therapist(s) to obtain a different perspective and gain new insights. We stress that the therapist meetings will focus on the overall process of the unfolding therapies and that, if the patient so requests, some specific content can remain confidential. Patients are requested to inform us of secrets, fantasies, and extratherapeutic behavior they wish to be kept private. Reasons for this concealment can be explored in the individual analyses. Such reasons, in conjunction

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with fantasies about the analyst meetings, may reveal important analyzable themes.

After meetings, therapists may give their patients feedback about their growing understanding of the therapeutic process. Alternatively, they may say that insights gained in the meetings will be offered when relevant. We inform our patients that they will be charged the customary fee for face-to-face meetings and for extended phone contact between analysts.

CONCLUDING REMARKS

Observations made during clinical practice have influenced the psychoanalytic theory of technique. Experience leads us to suggest that when family members are in psychoanalysis or psychoanalytically oriented psychotherapy concurrently, the traditional technical preference for noncommunication between analysts should be modified. While the essence of psychoanalysis is still the one-to-one, patient-analyst relationship, there are times when informed collaboration is beneficial and possibly essential.

The primary indication for such collaboration is therapeutic stalemate. Such stalemates occur when the marital neurosis is employed as a defense against the development and interpretation of analytic transferences. Spouses provoke each other, which confirms their intrapsychic fears, while analytic sessions remain clogged with accounts of victimization. Transferences to the "unseen" analysts and unconscious role inductions of the treating analysts intensify the stalemate.

In such instances, we have found analyst collaboration extremely useful in unfreezing the treatment. To facilitate this endeavor, we have proposed a model for collaboration that can serve as an organizational map for therapists. The model uses extraanalytic data to assist in testing the reality of patients' presentations. It also aims to interrupt countertherapeutic projections and splitting, expose latent transferences and countertransference patterns, and deepen analysts' understanding of the marital partners in each therapeutic modality. Analysts who once were experienced as working at cross-purposes come to contain and understand the defensive uses of the marital neurosis so as to allow spouses to expose and work through previously inaccessible material.

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