Concurrent Therapy, Countertransference, and the Analytic Third

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Concurrent therapy, where individual and group therapy are done at the same time, has been the subject of research from the early 1970s, focusing mostly on practical issues. It can take the form of combined therapy, when the same therapist is doing both the group and the individual therapy, and conjoint therapy, when one therapist is the group psychotherapist and another is the individual one. This article focuses on the countertransference of the therapists in the conjoint therapy model. While combined therapy exposes the individual therapist to intensive criticism from the patient and from aspects he or she has never expected, conjoint therapy exposes the individual therapist more to the criticism of the colleague and not of the patient. In addition, this article suggests the analytic third and the relational approach as a frame of reference for understanding concurrent therapy. The therapist and the patient create an intermediate space that is neither individual nor group therapy and co-construct a new relationship to which they react.

KEYWORDS: Concurrent therapy; combined therapy; conjoint therapy; countertransference; analytic third; relational and intersubjective approach.

INTRODUCTION

Since the first article on combined therapy (Wender & Stein, 1949), over 120 articles and books have been published on the topic. From the early 1970s to the middle of the 1990s, articles about concurrent therapy appeared occasionally in professional publications (Alonso & Rutan, 1990; Bernard & Drob, 1985; Caligor,

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IDEOLOGY OF CONCURRENT THERAPY

Group and individual psychotherapy can be seen as complementary if group therapy is seen as a facilitative technique that takes place within the individual therapy. However, it is important to note that the two therapies do not share the same goals or techniques. In individual therapy, the focus is on the patient's internal world and their personal experiences. In group therapy, the focus is on the group dynamics and how the patient relates to others.

CONCURRENT THERAPY

Concurrent therapy has two forms: individual therapy and group therapy. Individual therapy involves a one-on-one relationship between the patient and therapist, while group therapy involves a group of patients working together with a facilitator. The two forms of therapy are often used together, with the individual therapist and the group therapist working in collaboration.

SHORT REVIEW OF LITERATURE

The concept of concurrent therapy has been explored extensively in the psychotherapy literature. Freud (1921) introduced the concept of the analytic third in his work on countertransference. Taylor & Gueda (1995) also discussed the role of concurrent therapy in the history of psychology. Fielding & Bock (1995) examined the practical issues of doing therapy concurrently, and the article by Ratan & Alonso (1998) addressed the question of whether the patient would benefit from concurrent therapy.

Taylor & Gueda (1995) most of them focused on the practical aspects of doing therapy concurrently. Their work has been covered in previous articles, but it is still relevant today. Their focus on the concept of the analytic third suggests a new frame of reference for this modality, relating concurrent therapy to the concept of the analytic third.
A Clinical Vignette

A 37-year-old man came to individual therapy complaining about dissatisfaction with his life. He worked in a high-tech company but did not feel that he loved his job or that the rest of his life was satisfying. He was unhappily married and had a girlfriend who was also quite frustrating and disappointing, betraying his trust. In addition, he felt that he could not terminate his relationship with her, and his responses to his therapist's attempts to help him were quite frustrating. The therapist usually felt quite helpless and, after a few sessions, he gave up trying to help him. However, in the next few sessions, the patient began to change. He became more helpful and less helpless, and his responses to the therapist's interventions were more helpful. He began to express his feelings more openly, and the therapist was able to help him work through his problems. After a year of therapy, the patient felt much better and was able to terminate his relationship with his girlfriend. He began a new relationship with a therapist who provided more help and support. After two years of therapy, he returned to therapy, basically with complaints about his situation. He was able to function more effectively and to communicate more effectively with his therapist. The therapist agreed to continue therapy, and the patient was able to make significant progress. He developed a good relationship with the therapist, and the group met more frequently. The patient's progress was quite noticeable, and he developed a strong and supportive relationship with the therapist. He was able to make significant progress in his relationship with the therapist, and he was able to develop a strong and supportive relationship with the group. He was able to make significant progress in his relationship with the therapist, and he was able to develop a strong and supportive relationship with the group. He was able to make significant progress in his relationship with the therapist, and he was able to develop a strong and supportive relationship with the group.
to the group strengthened and more willing to work on it. From the drawn combined therapy arouses the question of boundaries: What is suitable for individual session? What is kept secret from the group? How much of what should be discussed in the one-to-one situation? What should be brought to the attention of the individual therapist in the group?

In conjoint therapy, when the difference of approaches between the therapist is too big, they might not be able to collaborate, which might create a split and block the progress of therapy. Patients, too, might create a situation where their work in the group is meaningless and "empty" by bringing all the energy to the individual therapist, thus stopping the working through in the group and avoiding immediacy in the here-and-now interaction.

We will suggest later that working through the parallel processes that intersubjectively between the individual and group therapists in a thin line, for example, a supervision group, can help identify splitting processes; continuing and interpreting in this space, split and projected parts of the self can gradually be reintegrated. Lipsius (1991) provided practical guidelines to avoid a split between modalities and achieve a harmonious balance, and he described the confidentiality of individual sessions without draining the group. Aloth-Ruten (1990) examined some of the advantages and disadvantages of co-treatment, addressing contraindications for some patients. Taylor and Gaets described some ethical and legal issues involved in concurrent therapy and its precautions for the group therapists. Bromfield and Pfeifer (1988) illustrate the potential benefits and risks of the combined approach to treating co-thereapy, in a comprehensive review of concurrent therapy, focused multiple transfences developed in groups concurrently with the support of individual sessions, all in therapeutic regressive situations.

COUNTERTRANSFERENCE IN CONCURRENT THERAPY

Freud (1912) held the view that the patient’s early experiences and inner conflicts could generate intense emotional responses in the analyst, which might distort the analyst's analytic stance. This idea suits a so-called one-person psyche point of view or, at most, a dyadic psychoanalytic context. The psychodynamic approach has moved further from the idea that countertransference is an obelisk that needs to be resolved by the therapist alone. Winnicott (1949) distin between subjective and objective countertransference reactions; the latter can co to therapy if explored because they reveal the patient's dynamics. Reciprocal intersubjective and relational approaches (e.g., Aron, 1991) claim that transference and countertransference are co-constructed, and thus their source is no longer a person alone (whether patient or therapist) but is co-created in the interplay space between them. For our purposes we will follow the broader defini
The therapist and patient both react to the new construct created by concurrent therapy. Each responds not only to elements in the individual or group setting, but also to the new format, the innovative space that is formed. They combine both modalities, require some adaptation from both therapists and clients. In the process, the therapist becomes more sensitive when moving from one session to group meetings. If the therapist becomes more interested in the group's experience and collaboration, the client might also engage more constructively with the group. We suggest that the therapy is facilitated by the therapist's capacity to work through issues of competition and envy in the dyadic session, as well as with colleagues and other therapists. The therapy involves individual, group, or family therapy, or their combination, and the therapy is more effective when the therapist acts as a facilitator of the group's process. The therapist's role is to help the group develop a sense of community and cooperation, and to support the participants in the group.

CONCURRENT THERAPY AS THE THIRD SPACE

The central thesis of this approach is that the specific context of the group situation is the focus of the therapeutic process, rather than the individual patient or the dyadic relationship. This is achieved through the group's ability to create a new context that is different from the individual and group sessions. The therapist's role is to facilitate this process, rather than to direct it. The group itself becomes the leader, and the therapist becomes a facilitator. The group's ability to create a new context is achieved through the group's capacity to work through issues of competition and envy in the dyadic session, as well as with colleagues and other therapists. The therapy involves individual, group, or family therapy, or their combination, and the therapy is more effective when the therapist acts as a facilitator of the group's process. The therapist's role is to help the group develop a sense of community and cooperation, and to support the participants in the group.

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each of the therapies (individual and group) are experienced in a new co-created space that is beyond the simple addition of the two types of therapies. This space is conceived as a new arena for the individual, the group, and, even more, for both of them. Individual and group therapy complete one another in the concurrent model and generate a new therapeutic space—a space that reminds us of Nitsun's (1996) idea of the indivisible unity between the individual and the group in an ongoing process of flows and failures of communication.

Mitchell (1996) and Ogden (1994) described personality in terms of different levels that are dialectically interconnected. Clinically, we can see the same person bringing different aspects of his or her internal world, from different levels of personality, into individual or group therapy. Following this, transference processes unfold as multiple transferences toward participants and therapists. Working on the split projections and bringing back the projected contents to their source by the therapists in a less pathogenic way leads to a better internal integration inside the patients. The concurrent model of psychotherapy generates a common potential space through integration of the two modes of therapy, which enables verbal, nonverbal, interactive, and intersubjective elements to unfold. According to Ogden (1994), all these elements represent those unconscious thoughts and feelings that block the discourse of therapy.

According to de Maré, Piper, and Thompson (1991), individuality does not exist in void or in isolation from the world—it is being forever forming and transforming itself through mental awareness as a continuous dialogic experience with the others. We can say that the self is in a continuous process of transformation and creation through interaction. The significance of individuality rests not so much in its separate uniqueness as in its unique way of being part of the world, hence the therapeutic function of dialogue, which transforms the self. De Maré et al. (1991) claimed that only when a system is structurally altered can a permanent change occur. Following their idea, we can see the transitional space of dialogue as the central vehicle that moves systems, and organic systems as well. When such a dialogic space is established, change occurs.

What is the place of internal change in the process of analysis (individual or group), and how is it related to the therapist's attitude toward healing and curing? Our therapeutic position places healing in a transitional space created by, and further allowing for, a relational framework, including the vertical intrapsychic parameter and the horizontal interpersonal one. From this therapeutic position we can see the interplay between individual and group analytic therapy (including the interaction between therapists) as a new entity, allowing split aspects from the past to be reconstructed in the new interaction. It is the interaction between all the parts in the system that contributes to the integration of the self: between the individual therapist and the patient, between the group members, but also between the two subsystems of individual therapy and group therapy (as well as between the two therapists).

Weinberg and Tønder (2004) mentioned the therapeutic function of it especially in groups. In concurrent therapy, mirroring receives a wider perspective. It is not only the reflection of the patient in the eyes of the therapist, or the self reflected by members of the group through image and behavior is also the different reflection of the patient in the two settings and the interactions between these. On the basis of the view that primary identity is a mirroring experience, in combined therapy the previous dyadic projective a triadic form of mirroring, and a cycle of projections and introspections is thus triadic kind of mirroring enables the individual to become more aware of her/his unconscious elements.

Our view of change challenges Freud's (1930) deterministic view that present and future as being formed by patterns from the past. According to the conceptualization of the analytic third, therapy is not only exca the past, but it is reconstituted in the repetitiveness of the patient and therapist. The past is co-constructed by patient and therapist in the analytical field asymmetrical relations. The past is reconstructed to serve the present and selective recalling and co-creation in the analytic third. This co-construct individual session, in group therapy, and in the third combined space between and beyond them allows for what Bollas (1987) called psychic intensity to The therapist's role is not only to listen to the patient. It is also to experi to be "invaded" (Greenson, 1960) by the patients' deepest communicative communications are being transformed in the analytic third, in which the entity is co-constructed. In this entity, which is the subject of analysis, the therapists are in a dialectical interaction of co-construction and mutual recognition and negation of one another.

So the question of change is conceived in Ogden's (1994) analytic th ongoing co-creation of the living past through dialectic processes of identification, recognition, and negation of therapist and patient. The analyt is co-created in the transitional space between therapist and patient, in the dialectical relationship.

Applying this approach to concurrent therapy, we can say that this therapy is not only individual and group therapy together, but also both of they are experienced by patients and therapists in the analytic third. Th the interactions in concurrent therapy are the combined interactions betwee and individual therapist, the interaction between patient and group, the c of the group conductors, and the co-therapy interaction between group co and the individual therapist (when it exists).

Another Clinical Vignette

A 33-year-old male, Henry, with a long history of depression, enters with diverse complaints. Among other complaints, he was socially iso.
for years had no intimate relationship with women. He built his own blue-collar business and was doing OK financially but felt a lot of pressure that caused him dissatisfaction with his work. He avoided returning phone calls to customers, perceived their requests as burdening demands, but still could not argue with them. In addition, he was tardy (sometimes in months) with sending bills. We will focus only on these last issues to describe the subject of the analytic third.

After a year of individual sessions, some of the depression symptoms were alleviated, but there was no progress in his social relationship and especially no change in his avoiding contact with women. Exploring his difficulties at work led to the conclusion that Henry was seeing the requests of the other as demands because he did not know how to take care of his own needs and could not say no when facing these requests, anticipating conflicts and rejection if he tried to stand on his rights. The only way to avoid the burden of automatically adjusting himself to the other was to passively resist by not answering phone calls or evading the customers. Although these factors were thoroughly examined in the individual sessions, it had no impact on his behavior: He continued avoiding dealing with work pressures.

His therapist suggested that Henry join group therapy, which the therapist was leading, thus moving into combined therapy. Until that point, Henry’s attitude toward the therapist was somehow indifferent, keeping a safe emotional distance on one hand but showing a lot of trust in the therapist’s professional judgment and his recommendations. On the basis of this (almost blind) trust, he agreed to join the group, even though he did not understand for what purpose.

In the group meetings Henry was usually quiet and passive but still interested and involved in the events, so that when people related to him or asked for his opinion, he always had something meaningful to say. The group members came to like him and included him in the discussions. Gradually, he developed warm and close relationships with most of the group members, especially with men.

What caught the therapist’s attention was the difference between the attitude that Henry manifested in the group and in the individual setting toward the therapist. The more Henry felt safe and comfortable in the group setting, the more he seemed to tease the therapist, subtly questioning his authority and decisions, sometimes embarrassing him in front of the group. In the individual sessions Henry continued to present an attitude of ultimate trust toward the therapist, unaware of the sharp gap. He also argued that he could not understand why other group members related to the therapist as a father figure and emphasized that he was not seeing the therapist as a father at all. The therapist suggested that they look together at the differences between Henry’s attitude toward him in the group and in the individual sessions and at this constellation of both group and individual treatment, thus constructing a way to relate to the analytic third. He also encouraged Henry to pursue further his teasing approach in the group, suggesting that this must be important for Henry and that exploring reveal something hidden so far.

This exploration took place not only in the individual sessions, but also in the group and with the help of other group participants, who pointed out ways Henry quietly and almost unnoticeably challenged the therapist’s leadership and also suggested motivations for his behavior. It came out that Henry had a domineering-abusive mother and an untrustworthy father, who protected him but was too weak to stop his wife’s aggression. As a result, Henry developed a deep mistrust in authority, but fearing retaliation, he needed to hide his attitude. His automatic trust in the therapist was a reaction to defense. In the safe atmosphere of the group he let himself reveal this mistrust, without even being aware of the different attitudes. The therapist suggested to explore this issue and his encouraging Henry to continue teasing pacified Henry’s fears of retaliation and created a new safe arena through these complex issues: the space of the analytic third.

The surprising result was that Henry started dealing with his colleagues differently. Although it still was uneasy for him, he no longer their phone calls; refused to do things that did not suit him, either being another professional opinion or because it was personally uncomfortable for him; and, from time to time, entered into conflict with clients. In a few months his financial outcome improved dramatically, too.

This example portrays how the therapist and patient co-construct the third as the subject of analysis. In this vignette they could observe the new reality created by adding group sessions to the individual ones and ruminate on the implications of the patient’s different behaviors in the two settings. This exploration took place in the individual and group space, but in an imaginary intermediate area belonging neither to the group sessions nor to the individual ones. The change was the dialogue that developed between the therapist, the group members, and the specific patient, along with accepting and empathetic interactions.

CONCLUSIONS

As a treatment of choice for different categories of patients, concurrent therapy can be addressed in terms of potential for change. The question is what woul⾏more effective change. Individual and group processes can be well understood and explored through concurrent therapy. Change in concurrent therapy is enhanced through the contributions of an analytic third, where dialectic processes of mutual identification, recognition, and negotiation of therapist and patient unfold.

Concurrent therapy has clinical, theoretical, ideological, ethical, and organizational implications. The context and timing in which concurrent therapy is generated...
interplay between the patient’s personality makeup and the dynamics of the ongoing individual or group therapy. Patients with borderline or narcissistic disorders that are referred to concurrent therapy can benefit a lot from each format. Difficulties in processing preoccupations or narcissistic issues; massive anxieties in a one-to-one-situation; operation of primitive defenses such as denial, projection, and splitting aroused in individual therapy—all these favor referral to simultaneous group therapy. In the group these patients experience social interaction and relatedness through development of multiple transferences, resonance to issues of reality perception, and participants’ support through identifications. On the other hand, patients that are only in group therapy might experience overwhelming emotional stress and the need for another therapeutic place, in which issues aroused in the group can be dealt with in privacy and in depth, and therefore they are referred to individual therapy.

Behind concurrent therapy hides an ideology. It encompasses the individual in all aspects. In the individual setting the patient can explore in depth the intrapersonal issues, vertical transference, and work through past events with their impact on present difficulties. The group format facilitates unfolding interpersonal issues, multiple horizontal transferences, and the patient’s social world. The whole situation enables manifestations of different roles in life, from intimate dyadic relationships to complex social situations. On the other hand, this special therapeutic modality complicates the countertransference picture. It makes the individual therapist more exposed, but while the combined therapist may react to stepping out of the relatively safe isolated one-to-one space, being exposed in a social situation, therapists in conjoint settings react more to being exposed in front of their colleagues than in front of their individual patients.

The therapist and patient react to the new construct co-created by concurrent therapy. They relate to the intermediate area, which is neither individual nor group alone. The transitional space of dialogue created in the analytic third is the central vehicle enhancing change. Thus change is created by a continuous dialogue on all possible levels of the new system.

When therapy is done in an institute, we suggest that concurrent therapy is useful in forming the professional and cultural climate of the psychotherapy institute and the staff supervision group and that it is also influenced by them. The combined and conjoint therapists create in their work a space of an analytic third in which the psychic elements of the patient’s world and their own converge. This space enhances the containing potential of the whole situation and leads to an ongoing transforming influence on the psychotherapists and patients.

An interesting question that has not been explored enough yet is what happens in the situation where some people in the group are in combined therapy with the group therapist, some are in conjoint therapy with another therapist, and some are only in group therapy. This situation creates a variety of difficulties, including envy among the group members and comparison between different therapists evoking different countertransference reactions in the group therapist different attitudes toward patients who are “mine” and those that are “not mi.

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The Integrated Model (Individual and Group Treatment) of Cognitive-Evolutionary Therapy for Outpatients with Borderline Personality Disorder and Axis I/II Comorbid Disorders: Outcome Results and a Single Case Report

A. Ivaldi, G. Fassone, M. T. Rocchi, and G. Mantione

Integrated cognitive-evolutionary therapy (CET) models (double setting and group therapy [DS-CET] and individual CET [I-CET]) were compared of dropout and improvement of symptoms in outpatients with personality and/or axis I/II comorbidity. Persons 18–60 years of age with personality (mainly borderline personality disorder [BPD]) and/or axis I/II comorbidity w to choose a treatment regimen (n = 129). DS-CET consisted of 2.2-hour group and 2 1-hour individual sessions per month. Individual CET consisted of 1 individual session per week. Both regimens lasted for 24 months. Symptoms a adjustment were evaluated with Global Assessment Functioning (GAF), Be and Symptom Identification Scale–32 (BASIS–32), and Quality of Life Index

Information on history of treatment and on motivation toward the current self-harming behavior, and substance abuse was collected at 0, 12, 18, and 24 of treatment. Twenty patients were excluded from the study because they un other forms of CET (individual and drug cotherapy). The control patients h severe symptoms, worse overall functioning, more previous hospitalizati higher previous dropout rates and were more likely to have BPD. The current rate was lower for the DS-CET group (n = 85; 19% vs. 65% for controls, n =

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