

The Three Person Field: Collaborative Consultation to Psychotherapy

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In this short paper we would like to introduce you to our work at the Center for Collaborative Psychology, which we recently founded. The guiding ideas are archived in Steve Frankel's two published books (1995, 2000), his coming book on therapeutic conjunctions, and his journal articles (e.g. 1997, 1999). One of the main techniques, which we call the "three person field," was developed in a four year project carried out by Philip Erdberg and Steve Frankel. There Phil provided collaborative assessment with more than 30 of Frankel's psychotherapy clients, in many cases conducting followup interviews and retesting at 6 to 12 month intervals. There was never an instance when, by client testimony, the work of the treatment was not furthered by this procedure.

Our philosophy follows tightly that of Stephen Finn and Constance Fischer, whom, ironically, we have just met. The client is a collaborator, with therapist and client continually integrating new information, in pursuit of identifying and working toward the client's latent goals. The client's stated, manifest goals are continually replaced by a more authentic, collaboratively arrived at, picture of what the client wants and needs. The subjective nature of the therapy situation explains why the collaboration is necessary, as the two participants approach, but never reach, a full understanding of their therapy project. We remain cognizant that attempts to understand and influence another person in therapy are never objective; the therapist's needs, biases, mood, and past, as it has become internalized, are always interacting with the client's. This is the human part. The humanistic part rests on the observation that for therapy partners to work together successfully, the client needs to feel understood and cared about. The two are engaged in a project reaching to the center of the client's experiential life and, if they are successful, critically influencing its future.

Our workspace is a bit different from Finn's and Fischer's. Steve Frankel is a psychiatrist and psychoanalyst, always the therapist in these, at times, long term, cases. Diane Engelman, a clinical psychologist, is almost always the consultant. Our assessment and treatment model is organized around the place of collaboration between therapist and client, and between the therapy dyad and a psychologist consultant, in the assessment and treatment process. Although both Finn and Fischer hold joint meetings with therapist and client, their meetings focus on collaboration between client and evaluator. This difference arises because we have made assessment and clinical consultation to the therapy a standard part of our therapy protocol, required for all therapies conducted through the Center.

First we will describe how we work at the Center, and then provide a clinical example.

The Center for Collaborative Psychology

At the Center, in addition to conducting the psychotherapies we have described, we offer comprehensive psychological evaluations, referral, and treatment monitoring, as well as professional training to psychotherapists and their clients from the community, all informed by our collaborative model. We are interested in trouble-shooting any complex, psychologically relevant, problem involving the question of what a client needs to improve his or her life. At times, by their request, we temporarily enter into other people's therapies as consultants, when client, therapist, or both, seek a new perspective to enliven their work, or want to determine whether the therapy is productive and might require revised treatment strategies. Frequently, this consultation to the therapy is repeated as the therapy progresses. One way to think about this process is that it gives both therapist and client a chance to air their questions and doubts, and helps them both to be accountable for progress in the therapy. Always adhering to collaborative principles, client and therapist, in an interpersonal partnership, strategize personal change, in an effort that is focused and goal-oriented, as well as psychodynamically informed. Problems are identified, evaluated, and solutions collaboratively derived. In our work at the Center we take a broad based approach to problems, often involving disciplines beyond psychotherapy. When indicated, we seek feedback from nontherapist consultants, for example an educational consultant or an expert in psychopharmacology. Clearly, this model of conducting therapy clashes with the traditional psychodynamic practice of keeping the therapy field free of figures from the client's outside life, thereby highlighting the client's irrational, transference productions. The use of outside consultants to the psychotherapy expands the objective of the work from insight-oriented psychological change to strategizing solutions to a broad range of life issues.

This perspective fits with our humanistic orientation. We agree with the familiar explanations about how psychotherapy produces change, for example, insight obtained through work with transference and countertransference, revisions of pathogenic object relations, the client encountering new relational configurations. However, our view is that to be engaged and to change optimally the client needs to know the therapist wants to help and will do so in any way that is constructive, and that the therapist respects the client's wisdom and is comfortable enough to regularly yield to the client's authority. We hold that authenticity and the probability of therapy having a desired impact are carried to new heights under these conditions.

The Assessment and Collaborative Consultation Process

The referral and assessment process has many of the elements Fischer (1970, 2000, 2001) and Finn (1996a, 1996b) describe for collaborative and therapeutic assessment. A major difference is that the consultation is targeted to therapy where a therapeutic disjunction (Frankel, 2000) has been detected or where intermittent treatment monitoring has been agreed upon. Both therapist and client need to develop trust in the evaluator, enabling him or her to become a member of the therapy team, able to provide a fresh view of the therapy. The two work with the consultant, collaboratively integrating his or her ideas into their working model of the therapy. Clearly, this process may require more meeting time than when only the client and assessor are involved.

The consultation procedure works as follows. (1) Client and therapist separately formulate questions for the consultant. These questions are consolidated into one document and submitted to the consultant. (2) The client and consultant meet together, the consultant having at least a phone conversation with the therapist, or all three meet for one or more initial visits. (3) The psychologist consultant begins to develop a clinical impression of the client, based on the

questions asked, and selects psychological tests he or she believes will provide some of the elucidation that client and therapist are seeking. (4) The testing is administered according to the therapeutic assessment method described by Finn and Fischer (1997), in this case directed by the task identified for the tester by therapist and client in dialogue. The collaboration, at this point, may occur between the consultant and the client or therapist alone, or, when the testing is completed with client and therapist together. (5) The consultant writes a report in the style described by Finn (1996) and Fischer (1994, 2000, 2001), designed to be useful and personally accessible to client and therapist, providing the feedback and/or advice requested. (6) Usually the consultant meets with client and therapist together, a final collaborative step in the process. The consultant structures these feedback and collaboration sessions so that they also provide the kind of time-limited therapeutic intervention described by Finn and Fischer (1997) for the therapeutic psychological assessment process.

The target of this intervention is likely to be the therapy, but it may primarily be for the therapist or client individually.

Clinical Example: Max

In this collaborative evaluation, Philip Erdberg is the psychologist consultant. Max was one of our original "three person field" study cases.

Max, at age 68, came to Steve for help overcoming his inability to speak in public. He was impressively successful as a business man and the parent of three grown children. Born in prewar Rumania, his family was forced to flee twice, finally to central Russia. The family was always struggling economically and running. That era came to a jolting end at age 16 when the Nazi's invaded his Russian town and Max's father and oldest brother were shot to death while Max watched from a loft in a barn. Max escaped into the woods, losing track of his brother, confirming two years later, when he returned to the town after the war was over, that the whole family had been killed. Those two years were spent with the "Partisan" resistance, every moment facing death as he and his colleagues blew up trains and conducted a campaign of counterterror, some surviving, most not.

After two post-war years of living in Spain and France and making a living smuggling black market goods into Russia, Max lied about his citizenship and managed to get permission to immigrate to the United States. Always enterprising, he rapidly moved his business from a tiny specialty food store where he discovered the promotional value of giving free samples, to owning and operating huge shopping centers. Small in stature, Max, his English always heavily laced with his Rumanian-Yiddish accent, had become a giant. That is, a giant to everyone but himself. To himself, he was always a "greenhorn" the kid who dropped out of school in the fourth grade, reprimanded by his older brother who was clear that Max had been a fool to leave school so early.

Max was anything but a typical psychotherapy candidate. But his wife had been helped by a therapist and he thought he might as well try it. What was there to lose, and secretly he had wanted special attention from a male ever since childhood.

Max and I met for several months, Max's reticence unnerving to me. I took a history, asked a lot of questions about how he felt, and even made a few suggestions about how he might be more confident in public. That's when he asked me questions like, "why do I shake so much, something to do with nervousness don't you think Dr. Frankel?"

My personal reactions to Max were contradictory. I liked him. Strangely, given his difficulty talking with most people, I found him easy to talk to when we limited our conversation to subjects like politics and his physical health. In contrast, Max was absolutely impassive when it came to personal matters; no, he didn't feel much of anything; no, he had no suggestions about the basis for his 'shyness' or what we might do about it. And, at the end of each session, Max, emotionless, simply walked out, leaving me feeling depleted; never a, "goodbye."

The following is a partial chronicle of the ongoing collaborative assessment process that provided the information Max and I were missing, and kept us on track for the next six years. Because of space limitations only a small portion of the assessment process is recorded here.

1. The first referral - Oct. 1994

The list of questions (abbreviated):

(a) Dr. F.'s question and reflections

1. In spite of his impressive financial success as a developer and having raised three grown children, Max finds himself burdened with inhibitions. These have been present for the greatest part of his life. It is still a question whether they originated when he was a child or during the period following his escape from his village at age 16 just before the Nazi's exterminated the Jews there and during the subsequent war years. Dr. F. and Max have different opinions about the source of Max's difficulties and therefore about how to address them therapeutically. Dr. F.'s emphasis is on the traumatic effect of the sudden extermination of Max's family, and then his being suddenly forced into the role of fugitive and terrorist. Max feels that his inhibitions are old problems dating from early childhood and not the consequence of later events. He is also concerned that calling up these events is painful and wonders about the value of doing this.

a. These inhibitions include nervousness about speaking in public, and a tendency to devalue his accomplishments when with other people.

b. Max worries about decisions he makes, even little ones, about people he cares about, especially his children, and about being identified as being too critical of others. Altogether these tendencies result in his not being clear and decisive about his opinions.

c. When considering the above set of concerns Dr. F. notes that Max is intelligent, thoughtful and guided by the highest standards of integrity.

(b) Max's Questions

1. Max feels the inhibitions come from childhood. ("Why was I so shy in school, refusing when my brother wanted me to belong to a political organization?") People who have been through what I have usually emerge a hero and confidant, but not me. I assume the old anxieties explain this. 2. Max wonders if something can be carried unchanged from childhood. He notes that problems have been perpetuated, for example, "I kept to myself and didn't take partners, so people don't know the real Max."

The Consultant's Report

After meeting with Max and me initially, and having three sessions with Max alone where they

talked and he administered psychological tests including the Rorschach and TAT, Dr. Erdberg wrote the following letter-report to us. I (Steve) also had a phone conversation with him and we all met together after we received the report.

Dr. E.'s letter to us follows:

I appreciate your involving me in your therapeutic work. This memo briefly summarizes my findings. I would be happy to provide whatever elaboration might be helpful after you have had a chance to review it. For the sake of convenience I'll address myself to Max.

1. The issues of how you relate to others have been troubling you for years. My testing suggests that you are insightful, innovative in your approach, and able to put subtle data together in new and reliable ways. Although I think you have some awareness of the substantial extent of these talents, it has been difficult for you to get much pleasure from the success they have brought you. Part of these difficulties comes from a pervasive shyness that makes it hard to "boast" in public and part come from uncertainty as to whether pleasure about accomplishments is appropriate. You are open to considering new approaches to this very old problem, and I think it is an important area for therapy.

2. Shyness has been a problem for you since early childhood. One of your stories, a response to a picture of a young boy sitting alone on a doorstep, provides a good example:

"That's me. A Russian village. The kid is sitting out on the porch. He looks worried. He needs a pair of shoes. And the building was not built right. He's troubled by something."

For a very long time you've felt worried that aspects of yourself placed restrictions on your ability to succeed and required that you had to take a defensive position. That has not been the case, and the conflict between these long-held concerns and the reality of your life continues to trouble you. I think that is a very important target for therapy, allowing the level of pleasure you so clearly have earned.

3. Testing suggests that this is a very stressful time for you. It is the sort of stress that is often associated with transitions, and I think the opportunity for ongoing support during this time would be helpful. I don't know what scheduling constraints both of you have. My recommendation would be that seeing each other twice a week for this period makes sense.

The Consultant's recommendations to Dr. F. (from Steve's phone conversation with Dr. E.)

Dr. E. feels that "letting the demons out" at this point is a risk. Max has powerful motivation for "leapfrogging" over the traumatic period from about age 16 through his mid 20s. The recommendation is that therapy remains supportive, and situationally oriented at this point. Uncovering therapy is seen as potentially disorganizing. The emphasis in the therapy stance being recommended is communicating that it is safe to be more emotional and to change somewhat. Dr. E. believes the underlying psychological issues have to do with guilt and surviving. The world is seen as threatening, both because it has been threatening, and as a way of assuaging his conscience, keeping himself from being too powerful and successful.

Overall, Dr. E. believes that Max would like to pursue his work with me "on his own terms." Dr. E. plans to recommend that Max come to therapy, at least for a while, on a twice-a-week basis to contain and resolve some of his current stress.

Outcome

Dr. E's recommendations were delivered in a meeting with Max and Steve. He made his recommendations in language Max easily understood, and encouraged dialogue between Steve and Max, as well as among the three of us. Dr. E.'s mission at the meeting was to empower Max to speak up for himself.

In response to Dr. E's recommendations I found myself (Steve) more willing to give Max direct advice. For example, later when he brought up his son-in-law and how he was both a taker and a disappointment, I said to him, "Well, I guess you should make a man out of him." When he hesitated a bit, I rephrased it and said with emphasis that I thought he should make a man out of Howard. He smiled and said, "Gee, that's just what Howard's father said."

Later on, describing the problems we would be working on, I said it was perfectly fine with me to skip the time during the war in therapy, at least for the moment. I then switched my focus to his complaint about not being expressive with his own children. I pointed out that neither he nor his wife, also a survivor of the war, had received much attention during those difficult early years. This was not their fault, because their families were struggling so hard. I said that these experiences probably made him feel doubtful about giving love, and said that both he and his wife probably found it hard to be confident when they were raising their children. Max then perked up and asked me what Dr. E. meant by "insightful." I replied that it had to do with being aware of the connection between events of his life and his current feelings and behavior.

Max then confided that he had dream last night. He was in a city in Europe, which looked like Rumania. The setting is during World War II. He has to sneak around to avoid being identified as a Jew. The dream repeated itself several times during the night. The dream is a good reproduction of what it was actually like. He adds that there were amazing things he and his colleagues managed to do, even under German occupation. When I wondered about sneaking, he said, "We did all kinds of things, at times we even dressed like Nazis. But it stirs up things inside of me to think about it, and I have to go on living and not dwell on the past." I note the theme in the dream is hiding and sneaking and suggest that's what "shyness" is all about, also. I then ask what he might have been hiding if, as he says, he was already "shy before the war." I say, according to Dr. E's report it could not really, as he often guesses, have been a lack of intelligence. He agrees (uncharacteristically), "Because I could do things on my own. At age 14 I was very good at bartering in neighboring towns." At this point Max has his first cascade of memories, all about worrying and hiding both before and during the war.

Reassessment of Max, three years later

The outcome of the first assessment and one check-in during the intervening three years is apparent in Dr. E's summary of the second evaluation. This evaluation was conducted in the same manner as the first one. The text follows:

I wanted to summarize some of the findings from the testing we did recently. I was particularly interested in comparing these current findings with those of November 1992. There are some significant changes, which I think have implications for future planning. For convenience I'll address Max.

You are thinking much more "psychologically" about relationships and the part that both people play in them. As an example, you may remember one of the pictures we used, in which a young boy is looking at a violin. In 1992, your response was:



His parents want him to be a violinist. But he doesn't really love the idea.

Now, your response was:

Somebody wants him to play the fiddle. He's not too interested. He doesn't want to do it. He's thinking about it. He says, "Why is she making me do it." (Why did I pick a she?)

Throughout the testing, you showed a much greater interest in thinking about yourself in the context of relationships with others. I think that was difficult for you earlier, and I see this as a very significant new development. In the past, you needed to focus almost entirely on others, and I think that balance is changing markedly. Now, you are able to see things as much more of a two-way street.

We talked some about the possibility of your writing a book about your past. The findings in our current assessment suggest that it's realistic for you to do that. It's a project that I think would help consolidate the gains you've made over the last few years. In that process, I think the work the two of you are doing would move to an important next level.

These test findings are particularly useful in comparison with earlier ones. I'd be happy for the three of us to talk in more detail about them in regard to future planning.

It's a real pleasure to be working with both of you.

Discussion

Max expected he would be a silent, disconnected observer in both the therapy and consultation: the little boy who sat in the back of the fourth grade Rumanian classroom, said nothing, dreaming only of school being out and going along with his older brother to barter for goods. At that time no one noticed how good he had become at doing his part in supporting these transactions, and, for that matter, at taking care of himself.

Having someone like myself, with advanced degrees, take him seriously was enough to begin to boost his confidence. But the risk of trusting me alone to show him the way out of his dilemma was too great, just as it would have been if I had been the only one assigned with him to carry out an act of sabotage behind enemy lines when he first joined the partisans at age 16. My appealing, however, to Dr. E, another authority, for help finding our way [and restore his voice to him] made a big difference, for both of us.

For Max, my (Steve) being meticulous as we made decisions about how to unearth his traumatic past, was enormously reassuring. For me, bringing in a consultant provided the guidance I needed to regulate our pace. It is important to note that I needed to trust the consultant, in a way similar to Max's becoming trustful of me. The success of our first evaluation process was reassuring to me. The fact that therapy went better when I followed Dr. E's advice, made it easier for me to integrate the findings from the second evaluation and become encouraging with Max about taking intuitive in his life and relationships. I caught on to Max's new rhythm and our meetings became jaunty; we could now talk about his wartime experiences, and Max vigorously launched into finding someone who would work with him to write his book.

The book is now finished, but in the last year aging, and his need for a coronary bypass operation, has brought new problems, reawakening trauma based fears of death. It may be time for us to return to our consultant, who remains an important figure for both of us as the

work progresses. I think Max will be quite comfortable involving him again for a brief period.

Concluding Thoughts

It all seems very logical. Clients are human beings, interacting verbally, and especially nonverbally, with the person called the therapist. Clients are teachers, mothers, and engineers; they, like Max, may be fabulously wealthy or philosophically astute about how they lead their lives. When laid out in this way the appropriate division of labor between the two therapy collaborators is unmistakable. Each therapy partner has the corner on what is likely to be correct for the therapy at different times. Or they have a good chance of discovering it together, collaboratively, and an even better chance with an assessment collaboration.

This way of seeing the therapy process seems correct to us. But not to everyone, as Fischer (2000) has so poignantly described in her writing. What is considered "correct" operating procedure in the assessment world, and what is understood to be gospel to traditional positivistic psychotherapists, for example, probably have a lot in common. The heat generated when you give over some of the governance of either process to the client, and place yourself as therapist in a position to bend the rules in response to the client, can be searing; colleagues not only believe that you are wrong, but profoundly misguided as well. This resistance by some colleagues to making the client a true collaborator is hard for us to fathom. But the criticism can be passionate, as occurred recently at an American Psychoanalytic Association meeting where, after Steve gave a paper, a fellow analyst stood up and said, "But you do understand that we don't treat, we analyze."

At the Center for Collaborative Psychology we "treat," and with the collaborative help of the client, and the additional wisdom of our consultants, we do everything we can to help our clients find their way.

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