A PHILOSOPHICAL BASIS FOR BRIEF PSYCHOTHERAPY*

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This is a report of the use of a variation in the process of brief psychotherapy, that of two therapists treating one patient. This method has been used experimentally for three years. It has seemed valuable in teaching the art of psychotherapy.

The immediate objective of the procedure was to develop the capacity of the therapist. This aim is in agreement with Dr. Betz of the Johns Hopkins University, who has said that "the dynamics of psychotherapy are in the person of the therapist." The long-range objective was to develop concepts that would facilitate the teaching of psychotherapy.

The experimental method consisted of having two therapists conduct jointly the entire course of a patient's treatment. It developed from an effort to share with each other the emotional experience of the therapeutic interview. At first, the second staff member sat in on the interview as a visitor and as a critical observer. It was difficult to overcome the threat and embarrassment which the therapist felt at having a second staff member observe him in a deep emotional relationship.

The second therapist, however, soon became dissatisfied with his rôle during the interview and was allowed to participate more actively. This did not seem to disturb the therapeutic process. In fact, treatment was often augmented by the participation of the co-therapist. It seemed to make little difference whether he supported or disagreed with the therapist or the patient, or expressed his feeling about their interrelationship as he saw it. The co-therapist often saw and utilized inferences or cues which otherwise might have been overlooked, so that the treatment process was facilitated. A disadvantage of the method was that the presence of the co-therapist seemed to restrict the capacity of some patients to verbalize, but this did not appear to affect the therapeutic effectiveness. A patient might have verbalized more psychopathology to an individual therapist than he did in the presence of a co-therapist, but participation with the two appeared to hold greater significance for him.

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This technique led the therapists to challenge each other following the interviews, especially in relation to the feeling tones. It soon became evident that, to function smoothly, the two therapists had first to resolve their immediate relationships to each other.

The give-and-take during and after these interviews was emotionally charged for both therapists, and thereby made possible a more complete perception of the therapeutic process. Because feelings were discussed and evaluated, the verbal content was seen in better perspective. They struggled to resolve the many differences which arose in their functioning. The unconscious overtones of one therapist were repeatedly picked up by his colleague; and, periodically, it seemed as if whole new vistas were opened up in their professional insight. Instead of building up a false intellectualization, their free association helped each to see more of his own emotional functioning in the interview. This highlighted the differences between them and made for professional growth.

The remainder of this paper will be concerned with the elaboration of three principles and how they relate to the functioning of the therapists themselves: (1) The therapists should be directive in developing an emotional relationship with the patient. (2) They should consistently refuse to participate in the patient's real life or its decisions. (3) A "healthy counter-transference" is the crucial force in treatment.

Concerning the first of these three conclusions, the therapist—in developing an emotional relationship—is dominant in setting the stage for the treatment process. He attempts to restrict the interview-situation so that the patient cannot use the ordinary means of social communication and must search for a new way. This atypical situation is intended to facilitate the release of deeper forces in the personality, such as aggression or sexuality, and to create a dream-like atmosphere within the interview setting. The emotional warmth of the therapist serves as anesthesia to help the patient suffer through the "operation" of integrating his personality. It is vital that the therapist give the patient enough warmth to make his ordinary defenses less of a barrier in the office interview situation. The abstract nature of this type of interview, and the inability of the patient to apply any of it directly to his behavioral living, forces the patient to search for ap-

plication to his subjective living and thus to begin changing himself instead of conversation or behavior.

One specific technique for denying a social relationship in the interview is the use of silence on the part of the therapist. Such a silence must not be merely a retreat from the interview. Silence may force the patient to experience the uniqueness of the situation and its directional orientation. It demonstrates that the therapist will not take the initiative at that point. Whether he feels hostile or accepting, silence focuses the emphasis on the patient's fantasy life. Silence increases the symbolic power of the therapist. All this observation is valid if the therapist overcomes the temptation to use the silence for his personal fantasies, rather than to increase the therapeutic pressure on the patient. Subsequently, words usually carry a deeper emotional charge and it is easier to avoid the impotence of an intellectual therapy.

The orientation of the therapist largely determines the depth to which the therapeutic relationship can be used by the patient. It is necessary to clarify the functional limits of the interview-situation to reduce the need for conscious techniques by the therapist. The unconscious of the therapist can thereby be released to relate more freely to the unconscious of the patient. Therapy limited in this way, to dealing only with the emotional and symbolic aspects of the relationship, can be adequate in itself to effect a successful therapeutic outcome. The criteria for this success are measured in terms of change in the patient's orientation and not in any overt change in behavior or symptomatology. It becomes apparent that in this sense any patient can be helped.

The second major conclusion reached by the writers is that the psychotherapist should not participate in the patient's "real life." The term "real life" is used to designate everything except material which has symbolic power that is available to the patient for his emotional growth. To minimize the factors which interfered with the development of the transference, the therapists freed themselves of all responsibility in the patient's real life. The more completely the therapist could be a stranger to the patient's real life, the greater was his symbolic power. For example, the therapists refused to allow the interview to become an after-dinner conversation; any social friendship was avoided; and no factual questions were asked. A therapist impaired his symbolic status if

he said to the patient, "Tell me your life history." Instead he might say, "How can I help you?"

The experiment gave evidence that when the therapists reassured the patient, or made any suggestions as to how the patient should live outside the office, or even discussed with him the medical or psychopathological implications of his symptoms, it was a dangerous interference with the psychotherapeutic process. The therapists tried to offer themselves, rather than to demand of the patient, who came already emotionally impoverished. In addition, the therapists did not need to know the psychopathology of the patient and it was not their function to try to find out—because they carried no administrative function.

In this experiment, a separate psychiatrist who was not seeing the patient in therapy, assumed all administrative functions. These included medical, social, psychological and psychiatric work-ups. In some instances, it worked well to relegate the administrative function to the referring doctor. In this manner the struggles of real life did not become issues in the interview, and the therapists were less likely to fulfill the role of the real parent.

The third conclusion is that counter-transference is the fundamental force in brief psychotherapy. Even though the therapist is skillful in excluding real life and in centering the relationship in the emotional area, he may still fail if he has an inadequate response to the patient. An inexperienced therapist often filled the therapeutic role adequately with anxious, child-like patients but had difficulty with the patients who required a greater degree of warmth. When he was unable to give enough warmth, he was in danger of developing a pathological counter-transference. This pathological counter-transference was a basic problem of the inexperienced therapist who tried to learn psychopathology from a patient, or who tried to satisfy some of his own drives. Thus, such a therapist found himself satisfying his need for power by "playing God" or his need for affection by being the boyfriend. This type of counter-transference stands in contrast to "the love that sets one free." To the extent that the therapist took satisfaction from the patient and the relationship, he was rejecting his own role and rejecting the patient as well.

It is necessary to differentiate two types of counter-transference: pathological and therapeutic. The warmth of the mature therapist may well be called a therapeutic or healthy counter-

transference. He brings to each therapeutic situation the capacity and readiness to give. The "giving" of the mature therapist is best described in terms of the feeling the child should get from the parent. The mature therapist is consistently parental. This parental role, as the therapist lives it, includes emotional support, definition of limitations, the capacity to accept aggression and the ability to give without needing repayment.

The experiment was planned to develop a setting which would enable the therapist to utilize this healthy counter-transference to eventuate in a constructive termination of therapy. The more mature the counter-transference, the greater can be the patient's use of his transference in the furtherance of his growth. The adequacy of the counter-transference will be most evident in the degree of motivation shown by the patient in bringing his therapy to a conclusion.

The writers believe that the therapist must have therapy for himself in order to participate emotionally with the greatest number of patients. Wherever the therapist has significant conflicts of his own, the patient may precipitate the doctor into fantasy about himself. If the therapist has had an experience in the patient's chair, he will have some emotional understanding of the patient's role, will feel more secure in helping him suffer, and will be less apt to switch chairs with him in mid-interview.

This experiment in brief psychotherapy was an effort to foster the development of a better therapeutic relationship. It resulted in the formation of a constricted and synthetic interview situation, which seems to help the therapist to meet more adequately the needs of the patient. The therapist can then help the patient break the pattern of child-like attachments and disappointment, which the patient has experienced over and over in his previous life. Once that structure has been broken, by the help of a mature counter-transference which makes possible a constructive "ending," the old pattern can never enslave the patient again to the same degree.

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