PATIENT-THERAPIST RELATIONSHIP IN MULTIPLE PSYCHOTHERAPY. II

Its Advantages for the Patient

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Multiple psychotherapy as a routine method of treatment is of very recent vintage. The term itself was first used by Dreikurs to designate a specific type of therapeutic relationship in which more than one therapist treated a patient simultaneously.[1] The technique had been used previously for training purposes,[2] to resolve certain types of difficulties in treatment,[3] and subsequently as a method of research,[4] but not as an established procedure in office practice. A recent paper by the writers describes the advantages accruing to the therapists using the multiple approach.[5] The present paper will be devoted to discussing the value of multiple psychotherapy for the patient undergoing treatment.

Contrary to expectation, the writers have found that their patients accept multiple therapy very easily. At first, many are reluctant and others somewhat suspicious. The best way to overcome this resistance is to start multiple therapy immediately by establishing the roles of the two therapists at the beginning of treatment. The writers' findings are that once the patient has experienced the technique, he sees its value and accepts the approach. In fact, many patients express satisfaction that more than one person is concerned with their welfare. They feel that they are receiving more service and more variety. Multiple therapy, moreover, prevents the patient from feeling misunderstood or abused by one therapist, in that he can always discuss such apprehensions and feelings in the "multiple session." He is, consequently, less fearful of antagonizing the therapist and can "open up" with a greater feeling of security.

This discussion of values for the patient might be prefaced by pointing out that anything which helps the therapist possesses the possibility of being beneficial to the patient. Consequently many of the points which were made in the authors' previous paper[5] may apply equally here. However, there are, in addition, some aspects of multiple therapy which bear more directly upon the patient.

A.

Patients often enter treatment with the feeling, whether it be expressed or not, that the therapist is or should be a powerful person. He should be both omnipotent and omniscient. They exhibit the feeling that the therapist should, figuratively, wave a magic wand and cure them completely and near-instantly. Many request pills or hypnosis or shock treatment—some quick-acting technique. Many do not necessarily want to learn anything about themselves; they just want alleviation of their symptoms. They often ascribe ideal qualities to the therapist and rebel against the idea that the therapist is ungodlike—a human being who makes mistakes, who also has problems. Such concepts are counteracted when two therapists disagree, for the disagreement destroys the projection of omniscience onto the therapist. It makes, of the therapists, not superior beings (human or otherwise), but human beings with perhaps a superior knowledge of psychological dynamics, who are interested in helping the patient to arrive at a new understanding of himself with a subsequent reorientation in his behavior.

B.

True learning is an *experience* rather than a mere *accumulation of "facts."*[6] This experience is provided by multiple therapy in various ways. It permits the introduction of two personalities with two different approaches to whom the patient can react and with whom he can interact. In this fashion, he learns to modify his expectation about people. His fallacious perceptions of social interaction can be pointed out and evaluated on the spot. He can work out his own interpersonal conflicts in his interaction with the therapists. For example, the writers have observed situations in which the patient works out his attitudes toward authority by making the senior psychiatrist a father figure and by, simultaneously, attempting to set up a sibling rivalry situation with the junior therapist. The expansion of therapeutic roles can thus aid materially in the resolution of certain prominent conflicts which trace their origin to the formative years of family life.

Patient A. was the older of two brothers. His father was physically weak, a poor provider, who played a subordinate role in the family. While the younger brother resembled the father, the patient was able to overrun him, being the confidant and helper of mother, and assuming a protective attitude toward his brother.

He was in competition with all men he encountered, trying to elevate himself above them. In therapy, he rebelled against the senior therapist whom he put in the role of his father, and was constantly surprised to find himself unable to push him down. The junior therapist was cast in the role of the brother, with the patient attempting to remain one step ahead and resenting the therapist when the latter could hold his own.

The introduction of fresh viewpoints keeps the therapy from getting into a rut and allows the patient to select, to compare, and to assess the material that is discussed in his presence. In fact, even such a simple procedure as one therapist's rephrasing of the other therapist's remarks can make the material more understandable, and, consequently, more acceptable to the patient. The patient may gain new insights from the "correction" of one therapist by the other, as has been pointed out previously. Certainly, the probability of interpretations being accepted is greater when one therapist independently validates the opinion of the other.

Further, multiple therapy permits the patient to be both spectator and participant. He can be the subject of the discussion and at the same time a more objective viewer of the proceedings. One patient described it as "like watching a ping pong game, only you're the ping pong ball." The patient can observe one of the therapists, for example, play his (the patient's) role and evaluate himself without becoming so emotionally involved that he cannot assess his behavior accurately. It is not implied here, however, that this lack of emotional involvement does not permit a corrective emotional experience for the patient. Much of his own resistance is minimized, since he can perceive the purpose of his resistance in the playing of roles by the two therapists.

Patient B., a college senior, an only child, who became discouraged in his efforts "to be a genius," had become thoroughly pessimistic during his senior year in college, when he was confronted with the intense competition and the uncertainty of his future. However, he was unable to recognize the defeatist and pessimistic attitude he had assumed. During a multiple interview, the active therapist assumed the patient's role and "argued" with the consultant, using all of the patient's rationalizations which seemed to justify his defeatism, while the consulting therapist offered interpretation of the actual motives involved. The patient became able to recognize his motives and his reluctance to participate in

life, and became aware of his own resistance against facing his actual and unfounded attitudes. This was a turning point in his development of better social orientation and of an increased ability to function in school.

C.

In individual therapy, should patient and therapist not "hit it off," the patient may become discouraged sufficiently to terminate therapy. This occurs less frequently in multiple therapy, since the introduction of a second therapist permits resistances to be analyzed more easily in the multiple sessions before they attain this magnitude. In the event that resistance becomes so great, all such efforts notwithstanding, that the patient's hostility or distrust prevents positive movement in therapy, the patient can be transferred to the other therapist without feeling rejected or discouraged, or feeling that he has to start all over again.

D.

Dependency, as a factor in therapy, provides many crucial problems for the therapist. These dependency problems require solution throughout the several phases of treatment. In the initial phases, the problem for the therapist revolves about the necessity of helping the patient recognize his own responsibilities in therapy. The patient, on the other hand, partly due to his own neurosis and partly because of a cultural pattern which proclaims that the "doctor knows best," seeks to rely on the therapist and to be cured by him. During the middle stages of therapy, the patient may vacillate between dependence and rebellion against it; and even the shrewdest therapist occasionally becomes ensnared in the cleverly-set traps of the patient. In the final phases of therapy, the problem of termination becomes prominent. Here the patient must become convinced that he is "graduating" and not being "expelled," that he is ready to meet the world on his own. He must come to realize that, while he and the therapist have been participants in a good relationship, he can now stand by himself.

Multiple therapy facilitates the resolution of these dependency problems. The "doctor knows best" attitude may be discouraged very early, when detected, by a discussion of this attitude by both therapists. It may be pointed out that while the therapist pos-

sesses certain professional skills, the patient will play a major role in the therapy; and he comes to assume some responsibility for his own therapeutic growth through his participation in the discussion.

When dependence upon the therapist is intensified in the middle stages of therapy, multiple discussions may serve to dissolve this impasse to further therapy. In fact, since the patient deals at the start with two therapists, dependence upon a single person is immediately eliminated. It may be indicated to the patient that he need not rely on any single person, that he can consider "going it alone." The patient may thus be guided from an attitude of dependence to one of interdependence. The writers have found special merit for their method in dealing with those intense emotional reactions to the therapist which are often called transference attitudes. Here, by shifting to the "neutral" therapist, these attitudes may be uncovered and faced by the patient with a minimum of fear or guilt. They may be carefully analyzed and interpreted and the transference dissolved.

Patient C. reached a point in therapy where she seemed unable to communicate with the therapist. She felt she was in love with him but felt guilty for having such feelings. After confessing this love to the therapist, she reacted with shame which, in turn, provided another barrier to communication. She had a number of interviews with the consulting therapist, during which she realized that her attitude toward the active therapist was merely a repetition of her attitude toward her father . After this problem was worked out, she was again able to communicate with the active therapist.

Should the active therapist become ill or take a vacation, the patient's dependency needs are less apt to lead to feelings of "desertion." The absence of the therapist merely means that the patient will be consulting with the other therapist for a longer time than usual.

Since all of these emotional attachments can be analyzed and clarified and viewed with proper perspective, termination can be more easily accepted by the patient. Undoubtedly, there may be some regrets about giving up therapy and some experiencing of doubt about functioning on his own. Nevertheless, the "break" is smoother, for his attachment is to the *situation* rather than to an

individual. While he cannot carry the therapist with him when he leaves, he can still take with him much of what he has learned in the therapeutic experience.

Patient D. had reached the stage in treatment where he understood the basic motivational patterns in his behavior. When he recognized this during a multiple interview, he was asked how much longer he was going to indulge himself in his emotional dependence upon the active therapist. The patient immediately saw that he was now using his relationship with the active therapist chiefly for self-indulgent gratification. He consequently set his own termination date for the near future.

E.

Finally, the interaction of the therapists provides a social situation of paramount importance. It shows the patient a good human relationship where two individuals can and do have an interpersonal relationship based upon mutual respect. He can observe the co-operation of two individuals, a co-operation which transcends competitiveness, "power politics," and prestige-seeking. He can see how this co-operation can exist even when the therapists disagree; and, above all, he may learn that one can be wrong without loss of status. This lesson may indeed be of more far-reaching significance for the patient's reorientation than any interpretations referring to his mistaken assumption that to err implies inadequacy or failure.

This procedure has implications beyond individual improvement. It affects the cultural pattern to which the patient has succumbed when he assumes that deficiency is degrading in our contemporary competitive culture. This therapeutic procedure exemplifies democracy in action.

Summary

In a previous paper,[5] the writers discussed the advantages of multiple psychotherapy for the therapist. The present paper discusses the advantages for the patient. Briefly these may be summarized as follows:

1. Multiple therapy creates an atmosphere which facilitates learning.

2. The patient can interact with two different personalities with two different approaches.

3. Therapeutic impasses are avoided by the introduction of fresh viewpoints, thus accelerating the therapy.

4. The patient may view himself more objectively, since he is both spectator and participant.

5. In the event that the therapist and patient do not "hit it off," the patient does not become a therapeutic "casualty" and is merely transferred to the second therapist.

6. The many problems related to dependency in treatment are solved more easily. These include the responsibility for the self, absence of the therapist, transference reactions, and termination.

7. Multiple therapy is an example of democratic social interaction and is thus a valuable lesson for the patient.

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