TECHNIQUES AND DYNAMICS OF MULTIPLE PSYCHOTHERAPY*

BY RUDOLF DREIKURS, M. D.

All forms of psychotherapy where several therapists treat a single patient simultaneously may be considered to be "multiple psychotherapy." Although new in private practice, similar techniques have been in clinic use for a long time. The child guidance clinics which Alfred Adler and his co-workers established in Vienna in 1920 practised not only group therapy, but also multiple therapy.[1] Parent and child were counseled jointly by the psychiatrist and a second counselor, either a social worker or teacher; the client's problems were discussed in his presence by the counselors whenever emotional blocking or resistance prevented a direct approach. Children, in particular, responded more readily when explanations of their behavior and suggestions for possible changes were not directed at them, but were discussed in their presence. Staff conferences in hospitals can also be considered a form of multiple therapy if the attending physician presents the patient and discusses his problems with other staff members. Group therapy often allows the participation of several therapists. Hadden[2] describes the participation of more than one doctor (student) in group therapy as a means of teaching psychotherapy. The writer's own experience in the psychiatric clinic of a medical school has demonstrated the effectiveness of supervised psychotherapy through joint discussions of the instructor with student and patient; each student in training presents his patient, and the supervising faculty member discusses with him the dynamic data evolved during the preceding interview which the student had with the patient. Whitaker, Warkentin and Johnson[3] have experimented for several years with a technique of psychotherapy in which two therapists treat one patient.

The writer's present interest in multiple psychotherapy was aroused by the rather surprising results of two incidents. A very difficult patient with psychosomatic disturbances who had been completely resistant to psychotherapy, even denying the need for psychiatric treatment, responded unexpectedly to a presentation

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of his case to a class of medical students. The group discussion about his case marked the beginning of his co-operation.

The first introduction of multiple psychotherapy into the writer's private practice was the result of an emergency. It became necessary to train an assistant to take over the practice for a contemplated absence of the writer. Each patient was seen with the new psychiatrist, when the patient's problems, progress and difficulties were discussed in a joint session. Afterward the new psychiatrist made a few individual appointments, the results of which were again discussed in a joint interview. This permitted a smooth transfer of all cases under therapy to the new therapist. This procedure proved to be so effective that it was continued after the emergency period and has been continued for the past three years.

In 1931, similar needs, in an emergency situation, had stimulated the writer to introduce group therapy in his private practice. Under the pressure of an overcrowded schedule, three patients were asked for a joint consultation about one specific problem which they had in common. Only one group interview was contemplated. However, the patients expressed such gratification about the result of the discussion that they requested a continuation of these group interviews. Since then, group therapy has been an integral part of the writer's work with private patients, supplementing the individual sessions.

The principal dynamics of multiple psychotherapy are similar to those of group therapy. The methods share a variety of therapeutic factors. One is the patient's position as an observer of, and listener to, a discussion of his own problems, dynamics and attitudes; another is the less than usual personal relationship between patient and therapist and the atmosphere of a more objective approach. A more detailed comparison of the two methods is outside the scope of this paper.

Multiple psychotherapy seems to offer great benefits to the patient, and to the therapist as well. It can be carried out by two psychiatrists of equal experience, as a function of group practice, or it can be maintained as a training arrangement between a senior psychiatrist and his associates. The writer's experience was, until recently, mostly of the latter type. There are probably many ways in which multiple psychotherapy can be applied; it lends itself to various therapeutic procedures and approaches. Whitaker and

his associates[3,4] applied it to psychotherapy based mainly on psychoanalytic concepts. The writer used the Adlerian approach, and his technique was, therefore, adapted to the specific needs of this approach. Characteristic of his technique is the regularity of one joint session with the consultant therapist after each two or three single interviews with the active therapist. (Whitaker et. al.[3] speak of "triangular interviews" and seem to use the consultant psychiatrist only for a limited period of time.)

In the writer's practice the patient is seen initially by the senior psychiatrist, who determines the nature of the problems, makes the diagnosis, and decides whether psychotherapy is indicated. The patient is then assigned to one of the associates. The latter then has two interviews with the patient to gather all the necessary basic information for the formulation of the patient's life style. This requires an investigation of the patient's earliest experiences within his family, his family constellation; it includes his position in the sequence of birth, his relationship to siblings and parents or any other person living in his household, the methods of training, early successes or failures. The recognition of the patient's earliest childhood relationships permits an understanding of his individual approach to others, stimulated by the experiences to which he has been exposed in his formative years. Early recollections offer another means of analyzing the life style or personality pattern of the patient. They reveal the conclusions which he drew from early experiences, his outlook on life, based on his concept of himself and of his role in society.

All the necessary data can be collected in two individual interviews, after which a joint interview is arranged between patient and both psychiatrists. The material obtained so far is presented and its significance discussed in detail. The patient may correct information if he finds the facts are misrepresented, or he may add some points. The main part of this interview is a discussion by both psychiatrists, defining the style of life of the patient. Following this, the patient is again seen by the active psychiatrist who reviews with him the conclusions of the first joint interview. He then investigates the patient's other experiences within his family, his school life, sex development, adolescence, social relationship and work experiences, up to the current problems and conflicts, with special emphasis on the "crisis situation" which brought on the

present symptoms. An understanding of the basic life style is used as a key to clarify past and present experiences.

After each two to three interviews, the material brought up is reviewed in another joint session. Generally the therapist who conducts the single interviews and sees the patient each time (the active therapist) decides on the frequency of the consultative joint interview, which should be arranged not less than every fourth interview; otherwise, the smooth co-operation between the two therapists may be endangered. In certain cases, particularly if the patient develops a negative attitude toward the active therapist, the other therapist may take over the active work. In this case the former active therapist takes on the role of the consultant therapist and is called in for joint interviews within the same intervals. Thus a wide flexibility is attained, and the therapy can be adjusted to various needs as they arise.

The advantages of multiple psychotherapy apply to all four phases which characterize dynamic psychotherapy. They may overlap or coincide; nevertheless, they imply different therapeutic mechanisms. The four phases are: (1) the establishment and maintenance of the proper interpersonal relationship between patient and therapist (the "transference" of the psychoanalytic approach); (2) an investigation of the patient's problems and the inner dynamics of his personality structure ("analysis" in the wider sense of the word); (3) the helping of the patient to understand himself (generally called "insight"); (4) the stimulation of the patient's reorientation to effect a change of his attitudes, outlook, goals and approaches—the principal purpose of the therapy. Multiple psychotherapy offers advantages in each one of these four fundamental steps.

1

The *relationship* between patient and therapist is greatly affected by the efforts of two therapists. The patient's willingness to accept a second therapist depends greatly on the self-confidence of the therapist arranging for such a procedure. Resistance was found only among the earliest patients, while serious reluctance to accept the procedure is rarely encountered today. If present, reluctance generally persists only until the first joint interview; after the patient has experienced in it the full advantage of this procedure, he is generally willing to accept both therapists. This willingness continues unless the patient becomes antagonistic

toward one of the two therapists. In these infrequent cases, hostility may be directed as frequently toward the active therapist as toward the consultant. The dynamics which lead to the resistance are always discussed in a joint interview in which the therapist not directly involved can always clear up the situation. It has always been possible to re-establish the normal procedure of multiple therapy, although the roles of the active therapist and of the consultant may be shifted.

The participation of two psychiatrists in his treatment strengthens the patient's confidence and increases his willingness to accept interpretations. It leads to an atmosphere of greater objectivity, where the personal bias of any participant can be more easily recognized and dealt with. This more objective and impersonal atmosphere does not hinder, but rather enhances, the progress of the therapy. This has some significance for the phenomenon of transference. It seems to indicate that the emotional attachment of the patient is *not* a pre-requisite for progress. Multiple psychotherapy does not preclude an emotional involvement of the patient with one or the other therapist. A strong emotional attachment to one therapist often reveals itself through the patient's resistance to the other. As already indicated, such situations are immediately met. Discussion and interpretation of the underlying dynamic factors either re-establish at once an atmosphere of more casual objectivity; or the therapist not involved takes over for the time being. In this sense emotional positive involvement is met in the same way as antagonism and opposition. Sometimes an apparent antagonism to one therapist is only a cover for the patient's desire to continue his main work with the therapist to whom he feels emotionally attached. Such aims generally retard the progress of therapy. As a rule, they indicate a drive for control of the situation, rather than a special need for emotional satisfaction. Critical examination and evaluation of the transference dynamics under multiple psychotherapy may produce significant data on the importance and the dynamics of transference in general.

The maintenance of a proper and friendly relationship between patient and therapist is also facilitated by the differences of the personalities of the two therapists. Each one has different personality traits, some of which are beneficial, some detrimental, in dealing with a particular patient. In almost every case, these vari-

ations of personality tend to supplement each other. If one trait in one therapist disturbs his relationship with the patient, certain supplementary characteristics of the other therapist come into play almost automatically, intensifying the effectiveness of the team.

2

The *analysis* of the dynamics of the patient benefits from the consultation between the two therapists. The chances of inaccurate conclusions are diminished; so are the dangers of overlooking certain aspects. While, by and large, a more experienced therapist contributes more, it is not unusual at all for a junior associate to point out mistakes and omissions. Divergent opinions are openly expressed before the patient. Such differences of opinion have no detrimental effect on the patient; on the contrary, he appreciates that a sincere effort is being made and finds it easier to accept final conclusions. Too often during individual therapy is a patient inclined to feel that the interpretations given are unfounded, even though they may be correct. The discussion between the therapists clarifies to him such interpretation; it is more convincing to the patient and offers a substantial guarantee of an objective evaluation of facts. Whitaker et. al.[4] suggest also a frank discussion of the two therapists in the presence of the patient, if one has difficulties during the therapy and reaches an impasse. His experiences confirm the observation that the patient appreciates an open admission of difficulties.

3

The discussion between the two therapists helps the patient to gain an *understanding of himself*. Emotional blocks often invalidate or preclude direct interpretation; not acceptable interpretation may even lead to argument and increase the resistance. Joint interviews are much more effective in such situations than individual sessions, which may force the therapist into a prolonged period of passivity. In the individual session, the therapist may have no chance to bring up his point and sometimes may find it even difficult to interrupt the patient's flow of emotionally-loaded speech; in the joint interview, he is in a completely different situation. The most distressed, anxious and restless patient is willing to listen while the two therapists discuss his problems.

The effectiveness of "listening in" has been observed in child guidance centers. The writer has pointed out[5] that most parents get greater insight into their own problems by listening to the discussion of similar problems presented by others. Similar observations are made in other fields. Lazarsfeld, Berelson and Gaudet[6] have observed that passive participation in conversations, i. e., listening to the discussion of others, seems to play an important part in changing and forming opinions. Moreno[7] introduced in psychodrama the figure of the "auxiliary ego" who, in a "mirror technique," helps the patient to realize his own position and attitude. The United States Army in its report on experiments made in regard to soldier's opinions[8] states that "giving the strong point for the 'other side' can make an argument more effective at getting across its message." In the writer's joint interviews the discussion is often arranged in such a way that one therapist presents the patient's point of view, his private logic, while the other offers an interpretation and evaluation.

Gaining insight and reorientation is a learning process. It requires repetitive, but also highly-varied, presentation of the material to be learned. As each therapist uses a different and varied approach based on his personality, the combined efforts of two therapists increase considerably the effectiveness of the learning process.

4

The period of *reorientation* seems to be considerably shortened through multiple psychotherapy. Various factors may contribute to the faster progress which has been observed. Some have already been mentioned: The patient's ability to comprehend and to accept insight is increased through the varied approaches; emotional blocks or disturbances in the personal relationship to the therapist are more easily recognized and more quickly resolved. The joint interviews are much more dramatic, and impress the patient more, than a sequence of individual interviews. The periodic recapitulation of the material obtained and of the progress achieved makes considerable impression on the patient. The monotony of repetition, often unavoidable in a series of individual interviews, is interrupted by the constant change of scene. During individual therapy, therapist and patient may become deadlocked in a point of investigation or discussion, and the therapist may find it difficult to extricate himself. The joint interviews al-

ways offer new angles and bring the situation into proper focus.

While the benefits which the patient derives from multiple psychotherapy seem obvious, the advantages for the therapist may depend on the method and approach which is used. A completely non-directive approach as implied in Freud's original form of psychoanalysis and catharsis, and more recently in the "client-centered" approach of Carl Rogers, may not need the support and the subjective relief which the therapist with a more active approach derives from multiple psychotherapy.

In multiple psychotherapy, the therapist's frustrations and difficulties, so often experienced in individual therapy, are almost completely absent, or at least are kept to a minimum. Whenever a feeling of inadequacy or discouragement may affect the therapist, the discussion of his therapeutic predicament with his co-worker—in the presence of the patient—may quickly dispel it. The frank, open and sincere atmosphere of such discussion keeps personal pride and concern for prestige to a minimum and dissolves any despair, discouragement or ill feeling on the part of either patient or therapist. There is no question of uncertainty or insecurity left for the therapist. Any personal involvement through occasional concern for his prestige, through a dormant desire for authority, through an antagonism or secret hostility provoked by the patient or his problems, is revealed in the joint interview, is openly discussed—and is dispelled. The open discussion of mistaken attitudes on the part of the therapist, as well as on the part of the patient, permits a stable equilibrium between patient and therapist, and establishes a relationship based on a sense of equality and mutual respect. Such a relationship seems to present the best basis for co-operation and provides the most favorable therapeutic atmosphere.

Multiple psychotherapy has particular value for the training of less experienced therapists. It is probably more effective for didactic purposes than controlled therapy or the use of wire recorders. The training is not restricted to verbal instruction; it is provided in the actual setting through action and practical experience. Learning on the job has been recognized as the most successful training method. The therapist-in-training functions actively and efficiently almost from the beginning.

The combination of more and of less-experienced psychiatrists, of psychiatrists using different approaches, of psychiatrists and

clinical psychologists, may well become a trend in the development of group psychiatry, as Oberndorf[9] pointed out recently. In such a group setting, multiple psychotherapy may easily be practised and be advantageous to therapist and patient alike. The patient would receive the services of highly-trained psychiatrists without demanding their full time. On the other hand, the method would give the senior psychiatrist sufficient time for his other assignments, for teaching, research, etc. This is of all the greater importance at a time when me must think in terms of providing more psychotherapeutic facilities for the population and of arranging the best time-economy for the insufficient number of highly-trained and experienced psychiatrists.

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REFERENCES

1. Adler, Alfred, and associates: Guiding the Child. Greenberg Publ. New York. 1930.
2. Hadden, Samuel B.: The utilization of a therapy group in teaching psychotherapy. Am. J. Psychiat., 103:644, 1947.
3. Whitaker, Carl A.; Warkentin, John; and Johnson, Nan: A philosophical basis for brief psychotherapy. PSYCHIAT. QUART., 23:3, 439-443, July 1949.
4. Whitaker, Carl A.; Warkentin, John; and Johnson, Nan: The psychotherapeutic impasse. Unpublished paper read at the 26th annal meeting of the American Orthopsychiatric Association, Chicago, 1949.
5. Dreikurs, Rudolf: The Challenge of Parenthood. Duell, Sloan & Pearce. New York. 1948.
6. Lazarsfeld, Paul F.; Berelson, Bernard; and Gaudet, Hazel: The People's Choice. Duell, Sloan & Pearce. New York. 1944.
7. Moreno, J. L.: Psychodrama. Beacon House. New York. 1946.
8. U. S. War Department, Report by the Information and Education Division: The effect of presenting "one side" versus "both sides" in changing opinions on a controversial subject. In: Readings in Social Psychology. Henry Holt. New York. 1947.
9. Oberndorf, C. P.: New possibilities in private psychiatric practice. Am. J. Psychiat., 105:589, 1949.

DISCUSSION

By Sybil Mandel, Ph.D., Baltimore, Md.

Dr. Dreikurs' stimulating paper brings to mind analogies in related fields as well as a number of questions.

To consider just two of the analogies, a person who, in the position of school psychologist has served as counselor and, in more recent years, as

mental hygiene consultant in public health departments has become familiar with similar therapeutic teams. In the earlier work, the therapeutic process was observed when students' problems were handled jointly by the clinical psychologist and a teacher who had been oriented in the techniques of Individual Psychology by the same psychologist. As for the second analogy: In the Baltimore City Health Department a few of the public health nurses are beginning to deal with the emotional aspects of child development, helping mothers with problems which have arisen or—through anticipatory counsel—with situations before they arise. When the mental hygiene consultant is called in, a three-sided conference results. As Dr. Dreikurs has implied, this frequently tends to mitigate any vestigial authoritarianism in the nurse's attitude. On the other hand, the mental hygienist must take pains to preserve the positive factors in the nurse-mother relationship.

So much, briefly, for analogies. May I deal solely with one question, the first which comes to mind and which concerns the patient-therapist relationship? Assuming, as many of us do, that, at some time at least during treatment, the patient experiences his relationship to the therapist as that of the infant to the mother-person, can multiple psychotherapy be considered within the framework of such an ideology? It seems to me that the answer is an affirmative one since, in the words of Alfred Adler, "the second important function of the mother is to spread the child's interest" to others in his environment. At what an early period in the infant's life do we see a euphoric response to the sight of a loving father, an older sibling or some other familiar figure? If the emotionally-immature infant can so relate himself, why not the emotionally-immature adult?

We look to Dr. Dreikurs and his colleagues for further study in this field, which is of practical importance not only to psychiatrists but to those auxiliary workers who, to a great extent, are dependent on their findings.

Discussion

By Alexandra Adler, M. D., New York, N. Y.

Dr. Dreikurs' vivid description of his technique of multiple psychotherapy stimulates the discussion of certain problems which have been on many psychiatrists' minds for some time: To begin with: Dr. Dreikurs' method again proves that hardly ever is there *only one* possible approach in medical therapy, that to believe so denotes an error. This has certainly been the case in the field of psychotherapy. We can trace this erroneous tendency back to times as early as the eighteenth century when the unquestionable therapeutic achievements of Mesmer were attributed to the application of one rigid technique exclusively, namely to the use of so-called animal magnetism through Mesmer's magic hand. It took a long time before the essential factors, namely those now commonly attributed to hypnosis or suggestion, respectively, were recognized and separated from all the additional

paraphernalia used by Mesmer. Then again there were long decades of discussion as to whether it was suggestion or persuasion only which should be used in an effort to influence a patient's personality.

Later again, through several decades, our generation has witnessed the development of, and adherence to, a rigid form of psychotherapy. In this form, it was considered essential to have the patient come five times weekly, for 50 minutes each time, in a specific transference setting which postulated an exclusive, close relationship between psychotherapist and patient, without which no success was to be expected. At present, we witness a liberation from rigid attitudes and the application of a flexible approach in many settings. Dr. Dreikurs has stressed the fact that his technique of multiple psychotherapy was used in Alfred Adler's child guidance clinics many years ago. It was there that many observers were greatly impressed by the importance of having the patient realize the social implications of his deviations. When his problems were discussed in a group setting with the teacher, parents and others, the child had his first revelation that he was not fighting a private fight but that the whole of society was implicated. This took his problems out of a small horizon and made them applicable to the other important problems of life. It brought reality closer to the child and did so through the lively experience of group discussion.

My own experience in this field of multiple psychotherapy, with *adults,* leads to the same conclusions as Dr. Dreikurs'. As chief of the psychiatric clinic of Mount Sinai Hospital in New York, I see every patient first before I refer him to the staff for treatment. Whenever a rather difficult problem, such as a question of discharge, arises, or before presentation of the patient at conference, I see the patient again with the physician-in-charge. Here, too, it has happened—though very rarely—that the patient afterward, somewhat defiantly, has said to his physician that what the chief of the clinic had said was exactly the right thing. But such an incident could always be used to advantage for the patient. To see God in one's psychotherapist is quite evidently undesirable and, incidentally, probably happens much less frequently than some psychotherapists think. We, too, occasionally observed lasting improvements after presentation of the patient before the whole staff where everyone was welcome to talk to the patient. This, of course, is possible with psychoneurotic patients only if the staff is well-trained in experience as well as in tact. No patient resented this procedure afterward, though most of them were somewhat reluctant at first when they were asked to consent to a discussion of their cases in their presence with the staff.

One would think that such team work is possible only if the doctors belong to the same school of thought. This, too, proved not essential. In my work with disciples of various schools I have come to the conclusion that the matters which count in the handling of the patient are, in addition to

other prerequisites, extensive experience, intellectual curiosity and a love of the truth. Adherence to any particular school of thought cannot provide any substitute for this. Consequently, in dealing with a well-trained staff, I have never experienced any fundamental divergence of attitude as to the actual handling of the patient, though we may occasionally differ in our concepts as to the causation and psychodynamics of the various specific symptoms. This, however, never interfered with our evaluation of prognosis, choice of certain practical suggestions or handling of acute exacerbations. The procedure of multiple psychotherapy is not meant to supplant any other approach. It should be used in private practice whenever the particular setting—which includes the make-up of patients *and* doctors as well—warrants such application.

Finally, as Dreikurs has stated, the advantages in the training of the young doctor by the more experienced colleague are, of course, quite obvious and, in certain aspects, superior to the use of such devices as listening to sound records, and the like. Multiple psychotherapy demands the active participation of the physician-in-charge in his role as psychotherapist, which active participation, as is well known, is of primary importance in any teaching procedure.