TRANSFERENCE IN BRIEF PSYCHOTHERAPY: EXPERIENCE IN A COLLEGE PSYCHIATRIC CLINIC*

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Psychotherapy with college students is always puzzling, often chaotic, and not infrequently inconclusive in outcome. The adolescent's sense of urgency, and his perception of the present moment as evanescent, strongly influence the treatment process. Much of the literature on college psychiatry has dealt with general aspects of the establishment and functioning of a psychiatric department in a university,[1-3] or has stressed the "differentness" of psychiatric practice with the college population.[4-6] This article is intended to examine the nature of the process of brief psychotherapy with young adults, and to focus attention on transference manifestations in short-term therapy.

An immediate problem arises: Are college students adolescents or young adults? It would seem that some are one and some are the other, and most are a little of both. While it would be inexact to say that college students are overgrown adolescents, it is necessary to recognize the psychosocial grace period in which they live, postponing full adulthood in order to complete their educations.[7, 8] The special social milieu of the college student is as little understood as the psychological growth that occurs within the individual during the four-year college course. Faculty-student interactions, peer relationships, the effect of group standards on academic achievement and concepts of normality, the vicissitudes of the establishment of ego-identity, the influence of membership in deviant groups on personality development—are all little known and worthy of study.

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However, the purpose here is to examine transference manifestations as they appear in brief psychotherapy with college students; to discuss the role of the therapist in dealing with expressions of transference; and to comment on general implications for a rationale of short-term psychotherapy. By brief therapy is meant, a duration of one to 20 hours, most often less than 10 hours. Such abbreviated treatment is usual at college health services;[9] this is

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scarcely a matter of choice (although it has been rationalized as such[10]), but is rather a function of the demand for services and the sparsity of staff. Improvement of psychotherapeutic skills, then, is necessary if a decisive intervention in an acute psychological decompensation is to be made. The sustaining hope—one not immune to doubt—is that such intensive, brief psychotherapy can appreciably better the subsequent life adjustment of the individual; and that even such short-term therapy is superior, in most cases, to usual efforts at reinstatment of psychological homeostasis without professional help. We do not know, really, if college psychiatry—as it is now practised, relying on a minimum number of contacts for each individual—*does* significantly modify the longitudinal life-courses of most patients seen while students. Certainly, many of the problems encountered are serious, as a recent paper by Selzer shows.[11]

Definitions of transference are numerous. Within the framework of psychoanalysis, Karl Menninger defines transference as "the unrealistic roles or identities unconsciously ascribed to a therapist by a patient in the regression of the psychoanalytic treatment and the patient's reactions to this representation derived from earlier experience."[12] A less restrictive definition might be that of Lagache, who characterizes transference as "a repetition in present day life, and particularly in the relationship to the analyst, of unconscious emotional attitudes developed during childhood within the family group and especially toward the parents."[13*]

When we speak, then, of transference in *brief* psychotherapy, we plunge into a semantic jungle. Certainly, transference in pure culture does not appear in such psychotherapy; the brevity of the process, active interaction between therapist and patient, focus on current reality problems, all tend to obscure and distort transference. Nevertheless, idiosyncratic emotional responses in the patient, directed toward the therapist, and relatively independ-

*Freud writes, "The patient, that is to say, directs toward the physician a degree of affectionate feeling (mingled, often enough, with hostility) which is based on no real relation between them and which—as is shown by every detail of its emergence—can only be traced back to old wishful phantasies of the patient's which have become unconscious... Transference arises spontaneously in all human relationships just as it does between the patient and the physician. It is everywhere the true vehicle of therapeutic influence; and the less its presence is suspected, the more powerfully it operates."—Freud, S.: Five lectures on psycho-analysis. In: The Standard Edition of the Complete Works of Sigmund Freud. James Strachey, editor. Hogarth. London. 1957.

ent of the therapist's personality or activity in the hour,* do occur; for want of a better word, these unconscious attitudes, feelings, and expectations, as they become evident in the therapeutic process, will be termed transference.

Although disagreement about terminology is inevitable, the attempt in this paper is to ground brief psychotherapy in psychoanalytic personality theory, and to develop explicit, operational criteria for understanding and influencing the course of such treatment. Several authors have already spoken on other aspects of brief psychotherapy,[15, 17] utilizing a psychoanalytic frame of reference.

The Therapeutic Function

Let us assume that a genuinely motivated young person, with an acute disturbance of psychological homeostasis, consults an empathic, competent, and experienced psychotherapist; that a contract for psychotherapy is made; and that a secure helping relationship is established. Let us assume, further, that this patient begins to display attitudes and feelings in the therapeutic hours that suggest the reawakening of archaic ways of relating, either in fact or fantasy, to significant persons in the past. What then?

The literature on short-term psychotherapy often stresses what is termed "reducing transference."[18] Such maneuvers may serve only to keep the transference out of the therapy, and in effect prolong, rather than reduce or minimize, transference distortions. Transference is often discussed as though it were at best a nuisance in short-term therapy, so that it may be prematurely suppressed, driven under cover and made temporarily inaccessible to therapeutic attention.

Whitaker and Malone advance a different concept of the proper technical handling of transference. They write, "In brief depth therapy, the emphasis shifts from an objective analysis of the historical determinants in the patient's behavior to a contemporary participation and response to the patient's behavior during the interview. The therapist accepts, as a point of departure, the notion that all of the patient's therapeutic participation is essentially symbolic in character. He further accepts the fact that in

*Attributes of the therapist do, of course, materially affect the psychotherapeutic process. If a patient is interviewed by different examiners, each dyad is unique, and the patient presents himself as a "different person" in each transaction, as reflected in both process and content.[14]

brief psychotherapy the patient condenses all of his transference relationships into his emotional involvement with the therapist."[19]

Menninger, in discussing analytic technique, describes lucidly a conceptual model of the therapeutic process in analysis. Understanding of childhood experiences, of contemporary environmental reality, and of the analytic situation (e.g., transference), with connections made between the three areas, comprises what he calls the "triangle of insight." He writes, "insight is the simultaneous identification of the characteristic behavior pattern in all three of these situations, together with an understanding of why they were and are used as they were and are."[12]

Is such a model applicable to brief psychotherapy? The author holds that it is, and will describe three cases in illustration.

These particular cases were chosen because in each the patient introduced transference expectations in a different manner, and because the therapeutic technique differed in each process. The common denominator of the cases was that the model of the therapeutic process was essentially that outlined by Menninger, conceptualizing a triphasic and interrelated transaction that ideally should clarify for the patient the unconscious connections between present reality, genetic past, and therapy.

Clinical Examples

After several months of experiences in the psychiatric clinic at the Student Health Service, Dr. A. was aware of the accelerated tempo of change—both regressive and reconstitutive—that characterizes college psychiatry; he had overcome the initial excitement of dealing exclusively with highly verbal, intelligent, introspective, and motivated patients; was again able to use his clinical judgment to see pathology clearly, and to plan a realistic treatment program; and was beginning to become aware of the strong counter-transference feelings generated in him by dealing with many young, attractive, sexually vigorous, provocative, and impatient young people. In other words, he was sobering up after the intoxication that a hospital psychiatrist experiences when first working with college students. At this point in Dr. A.'s career, Miss N. asked for an appointment, and saw him a few days later for her initial interview.

Case 1

Miss N., 19, a sophomore in the College of Arts and Sciences, asked for help in understanding her relationship with an irresponsible, arty, Bohemian young amateur actor, whose future seemed dim. She had gone with him for several years, to her parents' consternation; at times she tried to separate from him, at times she clung to him with a lyrical and romantic intensity. In the first few hours, she dealt with the present reality, describing her feelings for this young man, detailing her many attempts to break away from him, and the causes for failure, and telling of her parents' reactions to her love affair.

With the support of the therapist, she then began to talk of her childhood. She described her mother as a chronically depressed, complaining woman, who was often bedridden. The father was pictured as an alert, aggressive man, who wore his wife's suffering as proof of his own strength. The patient always felt that a woman's life must be tragic and painful. She wanted to be, not like her mother, but like her strong father—who, however, left her behind with the sick mother while he went off into the world of men. She began to see, in therapy, that her choice of an unmasculine man—one who would not expect her to be a woman—was an expression both of her own confused sexual identity, and of her anger at her father who had preferred the sick and unlovable mother to her.

With present reality and genetic past in the process, transference made its appearance. In the fifth hour, Miss N. told of this dream:

"At this big orphanage there were two little girls. One of them was as sweet and pretty and nice as a little girl can be. The other was kind of mean and had red hair. This man came to adopt a little girl. Finally he took the sweet little girl. The mean girl cried and cried, because he didn't love her and nobody did; she felt just terrible. But in a few days the man brought back the nice little girl because he didn't like her after all. And that's the way it ended."

Unprepared for such a rapid development of transference (and not having recognized earlier signs in the patient's behavior or verbalizations), the therapist handled his own anxiety and indecision by commenting on the dream in a vaguely empathic way. However, the patient rushed on to talk about other matters, and he allowed her to leave the dream undiscussed; he did not relate

the expectations expressel in the dream to wishes or fears experienced by the patient in therapy.

The next hour, Miss N. came in bright and smiling, told with great conviction how much better she was feeling, and explained that she had broken with the boyfriend. She said repeatedly that she actually just needed a friend, someone to talk with in a relaxed, friendly manner. She was charming and gay throughout the hour. The therapist did not challenge this socialization of the treatment process, nor did he in his mind or during the hour relate her being such a "nice little girl" to the dream of the previous week.

A week later, the patient came to her appointment, determined to end therapy, stubbornly insisting that her problems were solved. The therapist agreed to a termination, without commenting during the hour that this must be the "bad little girl" of the dream (although supervisory hours had alerted him to the likelihood of such acting-out behavior).

The goal of the short-term process, in the minds of supervisor and therapist, had been to allow Miss N. to gain some understanding of her behavior as symptomatic of deeper conflicts about sexuality and dependence; to help her perhaps to examine some of the anger toward her parents which she was expressing by her actions; and to provide her an experience with a helping process, and thus reinforce her motivation for treatment. It was hoped that she could be referred to a psychiatrist in private practice for long-term psychotherapy at the end of the school year. However, inability to help the patient deal with transference problems—to complete the "triangle of insight"—resulted in the termination of therapy short of these desired goals. The therapist hesitated to use the dream material to deal directly with the transference pattern. The underlying Oedipal concerns would not have been accessible to interpretation at that point; but certainly the patient's concern about pleasing and displeasing could have been dealt with, relating the dream thus to therapy, current reality, and childhood experiences. But with this opportunity lost, Miss N. proceeded to demonstrate in the therapy her sense of the futility of trying to please anyone, and displayed by her charm one week and her stubborn rebellion the next, the intensity of her ambivalence for the parents.

In this first case, then, transference feelings were expressed by the pre-logical, symbolic modality of the dream; and lack of under-

standing or interpretation by the therapist resulted in the patient's translating her unconscious fantasies into action.

In essence, she said to the therapist: "I am sure that this relationship will be as frustrating to me as my relationship with my father was. Even if I am a good little girl, and you seem for a while to love me, you will soon reject me and I will be as unhappy as the bad little girl, who at least is able to express her anger. It's all so hopeless." The therapist's answer was to remain passive and neutral; by this young woman, his behavior was probably seen as aloofness and disinterest. Neither charm nor provocativeness moved the therapist from his emotional dead center. Miss N. gave up, her transference distortions of the therapist unchallenged, her characterological maneuvers still ego-syntonic, her treatment a failure.

Case 2

Miss C. was referred to the author because of an acute, moderately severe depression. Her dilemma was much the same as in the preceding case: She was attached to an emotionally unstable, academically unsuccessful, homosexual student, and suffered from recurrent anxiety and guilt because of sexual experiences with him. The depression which brought her to the psychiatric department was precipitated in part by a serious argument she had had with her parents, who disapproved of the young man; but in even greater part, by a series of solicitous letters she had received from her father following the argument, in which he asked what he could do to help his poor, unhappy daughter, whom he loved so dearly.

In the first interview, she talked at great length about the conflict between the rigidly moralistic values of her parents, and her own newly-adopted identity as a free-thinker and a religious and moral liberal. This struggle for identity was crystallized in the relationship with the neurotic, sexually confused young man, so unlike her parents in every way. She talked feelingly about her desire to please her father, who loved her so, but expressed her determination not to "give up and buckle under." As she developed this theme, the psychiatrist commented, "It looks like you can't please both your boyfriend and your daddy at the same time." She was startled by this comment, but her behavior in the hour changed markedly: The anxious, frightened, lost little girl disappeared, and

she became much more composed. An agreement was reached to complete a psychiatric evaluation.

She did not return at the scheduled time, and in fact it was almost four months later that she again came to the clinic, complaining of a recurrence of depression, and inability to resolve her feelings about the boyfriend. In trying to understand the patient's psychological impasse—and the relationship between her conscious dis-identification with the parents; her attachment to the homosexual young man; her guilt about displeasing her father; and her depression—it was assumed that the "cause" of her illness was an unresolved and unconscious erotic attachment to the father. The comments of Anna Freud concerning adolescence are useful in this regard: "... the danger is felt to be located not only in the id impulses and fantasies but in the very existence of the love objects of the individual's Oedipal and pre-Oedipal past."[20] It was assumed, therefore, that before Miss C. could relinquish her boyfriend—who served as a defense against her incestuous strivings, by displacement of libido—she would have to re-experience and resolve in the therapy her erotic fantasies toward her father; in other words, it was assumed at the onset of therapy that transference was crucial for accomplishing a good therapeutic result: to remove the danger from the ties to the parents, and free the patient to find a suitable genital love object.

A psychotherapeutic process was begun, consisting of 15 interviews at weekly intervals. For the first nine weeks, the patient dwelt on the vicissitudes of her current reality, describing her feelings for the young man in a most extravagant and flamboyant way. The therapeutic relationship was a comfortable one; the patient's anxiety decreased and her depression disappeared; and yet little "happened," in that insights were few and minor; the genetic past was not discussed by the patient in her understanding of her present feelings, and attempts to interpret transference feelings were unsuccessful. The style of therapy, then, was supportive, yet a continual pressure was maintained by the therapist to understand present in terms of past, and in relation to therapy.

About the sixth week of therapy, an episode of drinking had resulted in the patient's being placed on probation. Between the ninth and tenth hour, another such escapade got her into trouble with the dean of women. Miss C. called the therapist in great alarm,

asking him to rescue her; the therapist refused, suggesting that they discuss the situation during the next hour.

By the time of her next appointment, Miss C. had convinced the dean that she would never drink again. During the hour, she was silent most of the time; humming to herself; refusing to discuss the events of the past few days, since they were "all over"; and obviously angry. However, she sat most of the hour with the top two buttons of her blouse undone, not discovering this until just before she left. After buttoning her blouse, she looked up brightly and asked, with pseudo-alarm, "You aren't mad, are you?" ostensibly referring to her refusal to talk. The therapist suggested that this concern of hers might be discussed at the next appointment.

She returned a week later, angry, flippant, evasive, circumstantial, protesting her good intentions, denying any concern about her behavior or feelings, and resentful of the university, the dean, her parents, and the therapist. Attempts to focus on the parallel between her feelings toward the therapist and her feelings toward her parents seemed unsuccessful, as did efforts to direct her attention to the inner turmoil of which her behavior was symptomatic. However, in subsequent hours she told of breaking off the relationship with her boyfriend; she talked of her feelings of guilt for the first time, and recognized increasingly that she was not so unlike her parents as she had imagined. Termination of therapy was smooth, with mutual agreement that she was feeling much better and now felt in control of her own life.

Here, then, the patient characteristically focused on the present reality, to the exclusion of past experiences and transference. Persistent attempts of the therapist to introduce these two parameters of experience met with frustration *in the therapeutic hours.* Yet, in a sudden flurry of acting out, the patient found that the therapist was not going to rescue her: she provoked the environment into augmenting her own super-ego control; expressed her anger at the therapist, and behaviorally hinted at unconscious erotic feelings toward him. It was as though she acted out the dilemma the therapist had summed up seven months previously, "It looks like you can't please your boyfriend and your daddy at the same time." Without verbalized insight, the patient was able to abandon her neurotic attachment to the homosexual young man, as no longer necessary to express her anger at her parents. Certainly, she had

no awareness of any Oedipal conflicts; but it would seem that the security of an asexual relationship with the supportive therapist allowed her to abandon her attachment to a devaluated male who was so patently unlike the seductive father.

Conscious, or at least verbalized, insight was a minor aspect of the therapeutic result. However, a conviction that transference feelings toward the therapist did exist—and the patient's behavior must be primarily understood in terms of these feelings—allowed the process to come to a reasonable termination, with relief of symptoms, solution of a current relational dilemma, and the beginning of establishment of an ego identity congruent with the expectations of her parents. Experientially, a process of partial resolution of unconscious guilt and anxiety about her libidinal attachment to her father occurred in the course of the treatment. In this parameter of short-term therapy, then, the basic model of the "triangle of insight" was used as a guide for the therapist's behavior in the treatment hours: a continuing choice of interpretations so as to attempt to make connections between her present relationship with the young man, her feelings for the therapist, and her unconscious wishes toward the father. The patient resolved the dilemma impulsively, by acting out her fantasies of being a bad little girl. The therapist resisted the plea for supportive activity—which the patient would probably have experienced as seductive—and said by his behavior, "I am not like your father. The relationship between us has strict, explicit rules. You cannot provoke me or seduce me. I will try to help you as best I can." Her response, behaviorally and verbally, was "I don't like you. I don't need your help. Besides, I've already gotten rid of my boyfriend. And this summer I'm going home to live with my parents. You know, they aren't such bad people after all, and I'm really quite a bit like them." With lessened anxiety and guilt, increased impulse-control, and a more secure self-identity, the patient was able to terminate treatment.

Almost a year later she again consulted the clinic, complaining of anxiety and occasional mild depression. In the interview it developed that her affection had shifted to a narcissistic, passive, and unhappy, but not homosexual or markedly effeminate, young man. After a romance that was neither as rapturous nor as miserable as the preceding one, the relationship dissolved for obscure reasons. Within a few weeks, she had fallen in love with a divorced

student, whose wife reportedly had treated him badly and had then divorced him. Her description of the boyfriend as a too-good, passive man, long-suffering at the hands of a selfish and child-like woman, sounded like her description of the relationship between her parents; and her fantasies of rescuing the unappreciated man undoubtedly paralleled her incestuous strivings of an earlier epoch. With the return of such thinly disguised wishes, she became increasingly anxious and again sought psychotherapy.

In the brief process that ensued (nine hours over a 10-week period) the family constellation in childhood was explored, and her emotional response to the present reality was clarified; but although it was weakened, her reluctance to explore the transference persisted. Subtle but persistent attempts to connect "Oedipal" themes (wishes for a forbidden man who belongs to another woman) in the genetic past, the present reality, and the therapy dyad resulted in mounting anxiety. The resolution occurred suddenly and unexpectedly: With great anxiety and evasiveness the patient told in the seventh hour of dreaming of walking down a street with her father toward her mother and sister and being angry at her father because he would not give her a wedding ring. Although the meaning of this dream never was completely understood by the patient, a marked relief in symptoms occurred with partial insight. She became able to manage her romantic affair with considerably more maturity and began to have serious doubts about the advisibility of marriage. The end of the school year necessitated a somewhat premature treatment termination, but with considerable relief of anxiety and depression.

In this process, then, a year passed between therapeutic processes, during which the patient acted out and tried to work through her Oedipal strivings with considerable personal growth over the months. Therapy served as a catalyst for the process, with a dream signaling a partial resolution without full conscious insight. Adherence to a model that guided the therapist's activity in the process—to aid the patient in completing the "triangle of insight"—would seem to have contributed to the personality growth and reorganization of the patient.

Case 3

G., a medical student, became anxious during a lecture about psychiatry, and afterward tearfully approached the instructor

asking for help; he was referred to the Student Health Service. In his first hour, he told of symptoms of anxiety and depression that had become worse for two weeks. He spoke angrily of his parents' continuing attempts to control him, despite his marriage a year earlier. He said that he felt in a trap, having moved from a relationship with his parents in which he was frequently guilty and unable to express his anger, into a marriage in which he felt similarly constrained. In the second hour, he changed from talking about his present situation to discussing his past life. He described his mother as a devoted but rather flighty woman, who reacted to his anger by crying and saying he didn't love her. The father was pictured as an aloof, hard-driving man, whom the son had never felt able to please. His wife emerged as a matter-of-fact, reasonable young woman, who had pursued him for over a year while he was interested in another girl; he married on the rebound after the other girl had jilted him.

In the third hour, he told how much better he had been feeling, and how the relationship with his wife and parents had improved. He went on to talk about himself as being at fault, and perceiving others as more critical of him than they were in actuality. Pursuing this actively, the therapist asked how the patient felt about him, and was told that the therapist's attitude seemed, "a cold and impersonal one, like a mathematician who works a problem and enjoys doing it and coming to a solution, but doesn't really care too much about the problem itself." In exploring this area, the therapist commented on how similar this description sounded to that of the father; the patient at first demurred, then dealt actively with this interpretation and came to some realization that his problem of feeling unimportant and unloved was an internal one. However, no sooner had G. verbalized this insight, than he began to act out the conflict in the hour, by becoming extremely self-deprecatory, and presenting evidence that he was really a selfish, resentful young man. It was as if the therapist had said, "Look, I'm not really like your father," and he had said, "Yes, I know," but then had gone on to present himself in an unfavorable light so as to provoke criticism from the interviewer and thus leave his unconscious transference feelings toward him unchallenged.

However, the therapist challenged the self-deprecatory comments instead, meeting each one by minimizing it and commenting on how self-critical the patient was. Finally, the therapist suggested

they talk about G.'s own expectations of himself; he was able to use the remainder of the hour—largely because of the work in the hour up to that point about transference feelings—to discuss productively, and with genuine understanding, his very high goals, his conviction of failure, and his continual self-criticism for not doing well enough. Further, he was able to link these feelings with his inability to feel that he could ever please his father; and finally, that now his father was inside himself, and that he constantly relived internally his relationship with his father.

In the last few minutes of the hour he told of how he could sometimes trick this introjected father, and, by getting completely away from his work and out of town, allow himself relaxation and enjoyment. He ended by telling what a nice guy his father-in-law was, how much easier he was to get along with than his own father. Therapy terminated at this point, since the initial goal had been the relief of acute symptoms. A suggestion was made that in the future he might want to talk to a therapist more, in an attempt to understand further some of the things that had been discussed. He agreed that this might be a good idea, and left after thanking the therapist for the help he had received.

In the process with G., brief though it was, the model of the "triangle of insight" could be followed with considerable ease, because of the patient's psychological-mindedness and the urgency of his need for help. True insight into his own personality dynamics, and relief of symptoms was obtained by the third hour: The goals of brief psychotherapy had been more than attained.

Discussion

In these three examples, understanding of the transference pattern was important in the management of the psychotherapeutic process. Undoubtedly these clinical experiences could be described from any of several theoretical vantage points, and an "explanation" of the process and outcome could be arrived at. It would be audacious to maintain that a plan of psychotherapy based on the principles outlined is the only, or the best, therapeutic scheme; rather, this is intended as an illustration of one theoretical orientation, which is used at the University of Kansas clinic in attempting to understand more fully the process of short-term psychotherapy, to make predictions about the course of individual therapy, and to influence the outcome of such treatment favorably.

Psychotherapy, then, is conceived of as intervention at a point of dilemma; this intervention is seen in relation to the life course of the individual, and assumptions—at present untested—are made about the future adjustment of the individual; a focus is determined in the first contact with the patient, based on a more-or-less enlightened clinical hunch as to what current impasse, external or internal, has resulted in an upset of psychological homeostasis; and a treatment process is entered into. In this transaction, an effort is made to relate present reality, childhood experiences, and therapeutic reality, so as to result in insight which allows change to occur. The examples presented three different processes in which an attempt was made to utilize transference manifestations to complete the "triangle of insight," illustrating the variety of course and flexibility of therapeutic style which is a necessary accompaniment of brief therapy.

It is clear from these examples that verbal interpretations are not always the chief modality of dealing with transference manifestations. Rather, the process is one of active interaction, in which the therapist thwarts the gratification of transference expectations by actively resisting being cast in the transference role assigned by the patient, so that the transference distortions become clearer until they are, perhaps, directly interpretable. This is quite a different technique from the "blank screen" of psychoanalysis, in which the therapist frustrates gratification of transference wishes by his inactivity and neutrality, with resultant regression. In short-term therapy, a much more active role must be adopted by the therapist, and transference must be actively dealt with as it arises, so that regression is minimized. Such activity by the therapist must be similar to what Whitaker and Malone term "a contemporary participation in and response to the patient's behavior during the interview."[20] There is also a similarity perhaps, to the "corrective emotional experience" described by Alexander.[21] Also, the concept of reciprocal interpersonal roles, described by Leary,[22] might be useful in understanding therapist-patient interaction: The patient behaves in such a manner as to evoke a reciprocal interpersonal reflex from the therapist; and because of the failure of the therapist to meet this interpersonal expectation, the patient moves toward awareness of his own behavior and feelings.

Several characteristics of young adults, evident in the cases cited, must be commented on. First, considerable ego regression at the beginning of treatment is usual; this is similar to the regressive swings, the retreats from full adulthood, that characterize adolescence. Second, the rapidity with which strong emotional reactions to the therapist are experienced is characteristic of this patient population; the affective interplay between patient and therapist is intense, and cannot be overlooked in understanding the process. And third, some acting out of transference feelings or unconscious conflict is the rule rather than the exception; the therapist often must tolerate a considerable amount of such behavior, interpreting where possible, actively intervening when necessary, if a truly expressive therapy is to be attempted on a short-term basis.

In summary, then, it is suggested that the process of brief psychotherapy be viewed within the framework of psychoanalytic theory as a technique involving the effective utilization of transference manifestations to complete the "triangle of insight." Further, it is suggested that attempts to understand the transference pattern and to respond—either interpretatively or by attitude—in a therapeutic manner, are important to the outcome of psychotherapy, no matter how brief the course of such treatment.

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REFERENCES

1. Farnsworth, Dana: Mental Health in College and University. Harvard University Press. Cambridge, Mass. 1957.
2. ——: Psychiatry and higher education. Am. J. Psychiat., 109:266-271, 1952.
3. Wedge, Byrant M.: Psychiatry's aid to college administration. Ment. Hyg., 37: 202-209, 1953.
4. Harrison, Robert W.: Leaving college because of emotional problems. Student Med., 4:49-60, 1956.
5. Carlson, Helen B.: Characteristics of an acute confusional state in college students. Am. J. Psychiat., 114: 900-909, 1958.
6. Blos, Peter: Psychological counseling of college students. Am. J. Orthopsychiat., 16:571-580, 1946.
7. Erickson, E. H.: Problems of ego identity. J. Am. Psychoan. Assn., 4:56-121, 1956.
8. Group for Advancement of Psychiatry: Considerations on Personality Development in College Students. Report No. 32. Group for Advancement of Psychiatry. New York. 1955.
9. Gundle, Sigmund, and Kraft, Alan: Mental health programs in American colleges and universities. Bull. Menninger Clin., 20:57-69, 1956.

10. Tolpin, Malkah, and Snyder, Benson R.: Special characteristics of college students seen in psychiatric consultation. Summaries of the scientific papers of the 115th annual meeting of the American Psychiatric Association, Washington, D.C., 1959.
11. Selzer, Melvin L.: The happy college student myth. A.M.A. Arch. Gen. Psychiat., 2:21-26, 1960.
12. Menninger, Karl: Theory of Psychoanalytic Technique. Basic Books. New York. 1958.
13. Lagache, Daniel: Some aspects of transference. Int. J. Psycho-An., XXXIV: 1-10, 1953.
14. Jacobson, Jacob G., and Whittington, Horace G.: A systematic study of the evaluation interview: preliminary report. Psychiatry, 23: 23-44, 1960.
15. Coleman, Jules V.: The initial phase of psychotherapy. Bull. Menninger Clin., 13:189-197, 1949.
16. Myers, Harold L.: The therapeutic function of the evaluation process. Bull. Menninger Clin., 20:9-19, 1956.
17. Reider, Norman: A type of psychotherapy based on psychoanalytic principles. Bull. Menninger Clin., 19:111-128, 1955.
18. Wolberg, Lewis R.: The Technique of Psychotherapy. Grune & Stratton. New York. 1954.
19. Whitaker, Carl A., and Malone, Thomas P.: The Roots of Psychotherapy. Pp. 218-219. Blakiston. New York. 1953.
20. Freud, Anna: Adolescence. In: Psychoanalytic Study of the Child. Vol. XIII: 255-278, 1958.
21. Alexander, Franz, and French, T. M.: Psychoanalytic Therapy. Ronald Press. New York. 1946.
22. Leary, Timothy F.: Interpersonal Diagnosis of Personality. Ronald Press. New York. 1957.