A Comparison of Individual and Multiple Psychotherapy

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IT IS CUSTOMARY to think of psychotherapy as a relationship between two persons. This restriction of the psychiatrist has been an obstacle to professional growth, and stands in sharp contrast to the practices of medical clinicians. However, in recent years there have been several reports of the successful psychotherapy of a patient by two or more therapists jointly.[1] It is the purpose of this paper to describe and evaluate further certain experiences with such a multiple therapy approach.

This study was done within the framework of what has become known as brief psychotherapy.[2] It is the opinion of the present authors that, in working with a patient, the therapist must provide an opportunity for an intense and intimate experience. When this occurs, the shared factual material is of relatively secondary importance. Such an approach depends to a large extent on the degree of emotional maturity of the therapist. At the same time, Szurek has stated that the therapist enters this professional field "primarily and basically to find a solution to his own conflict."[3] Thus, there is always a greater or lesser gap between the mature functioning required from the therapist and his actual personal needs. Multiple therapy offers one approach to this problem of the growth of the therapist.

The limitations of the therapeutic situation in this study were essentially similar to those of individual therapy which we have described in previous papers.[4] Thus, interviews were postponed unless all persons involved were present. None of the therapists carried any administrative responsibility for patients seen in therapy. No effort was made to acquaint the therapists with historical data before the interviews began, or to inform them of the patient's behavior outside the in-

[2] Carl A. Whitaker, "Teaching the Practicing Physician To Do Psychotherapy," *South. Med. J.* (1949) 42:899-903.
Carl A. Whitaker, John Warkentin, and Nan L. Johnson, "A Philosophical Basis for Brief Psychotherapy," *Psychiatric Quart.* (1949) 23:425-443.

[3] S. A. Szurek, "Remarks on Training for Psychotherapy," *Amer. J. Orthopsychiatry* (1949) 19:36-51.

[4] Carl A. Whitaker, John Warkentin, and Nan L. Johnson, "The Psychotherapeutic Impasse," *Amer. J. Orthopsychiatry* (1950) 20:641-647. Also, reference footnote 2.

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[1] Rudolf Dreikurs, "Techniques and Dynamics of Multiple Psychotherapy," *Psychiatric Quart.* (1950) 24:788-799.
Samuel B. Hadden, "The Utilization of a Therapy Group in Teaching Psychotherapy," *Amer. J. Psychiatry* (1947) 103:644-648.
Gerard Haigh and Bill L. Kell, "Multiple Therapy as a Method for Training and Research in Psychotherapy," *J. Abnormal and Social Psychol.* (1950) 45:659-666.
Malcolm L. Hayward, personal communication, June, 1951.

terview. For example, the therapists had no contact with members of the patient's family. Such family contacts, as well as problems relating to the real world of the patient, were handled by a physician who functioned solely as an administrator toward the patient.

Some of the work described in this study was carried out in a forty-bed psychiatric inpatient service, and the remainder in an outpatient clinic. Twenty-five patients were treated in multiple therapy; the number of interviews in which they were seen ranged from five to about thirty. Some of the patients were offered the choice of working with a single therapist or a group of therapists; other patients were not given this alternative. The diagnoses of patients treated included various types of neuroses, psychosomatic disorders, character disorders, and psychoses. The number of therapists varied from two to ten, but for any given patient, the therapists remained the same throughout treatment. All therapists present were considered to be responsible participants, earlier experiences having shown that the presence of nonparticipants, such as observers or supervisors, precluded optimum functioning. Some of the therapists were experienced, while others were therapists in training.

Responses of the Patients

In general, patients responded to several therapists in much the same way as patients react to individual therapists. In the first interview or two the patient often showed some anxiety about finding his own place in this group setting, as indicated by comments that he had not expected so many people; concern over where he should sit; concern as to whether the presence of several therapists meant that he was very sick; worry over whether the interview would be kept confidential; and so forth. The therapists usually said very little, thus leaving the initiative with the patient. There was no effort to elicit factual information, and no direct questions were addressed to the patient. As in individual therapy, this resulted in increased tension and often in aggressive outbursts.[5]

As the interviews continued, the patient came to accept himself as belonging to the situation, as he does also in individual therapy. He readily sensed differences in the personalities of the therapists, and often tested his capacity to play the therapists off against each other. The patient also repeatedly singled out one therapist as a harsh, punishing figure, while defining another therapist as a soft, warm, giving person. In the multiple therapy situation some patients seemed much more free than in individual therapy to act out their feelings, both positive and negative. The patient seemed to feel that his work with several therapists amounted almost to a cultural acceptance, as if the whole world were with him. He felt safer in his dependence on the therapists as a powerful unit, and less guilty over his sexual or hostile responses. In brief, he acted as though this setting reflected a validation by numbers.[6]

The "ending" of patients in this situation was essentially comparable to that in individual therapy. Some patients did not end simultaneously with all therapists. In such instances the entire group helped resolve the impasse. Another minor difference between this and individual therapy was that, for some patients, the ending seemed more important than is usually the case in individual therapy. Such a patient developed a forceful attitude, as if he had previously been outnumbered but now felt proud of being able to face the group without cringing. In terminating the last interview, some patients first went around to shake hands with each therapist, while others simply said "Goodbye" to the group as a whole.

Experience of the Therapists

Whereas the outcome for the patient was more or less comparable to that of individual therapy, there was quite a dif-

[5] Thomas P. Malone, "Analysis of the Dynamics of Group Psychotherapy Based on Observations in a Twelve-Month Experimental Program," *J. Personality* (1948) 16:13.

[6] Reference footnote 5.

ference for the therapist. Since the responsibility for the patient was divided or shared, the presence of colleagues offered each therapist a great deal of support in the performance of a difficult and threatening task, especially with psychotic patients. On the other hand, inexperienced therapists were afraid that they would not make a favorable impression on their colleagues. They were tense, lacking in spontaneity, and overly intellectual in their participation. On occasion the beginning therapist was afraid that he might seem to "hog" the patient, or felt that the other therapists were leaving him out and were "stealing" the patient. At times, one or another of the inexperienced therapists was blind to what was going on, and interrupted the therapeutic process by injecting into it his own personality in an inappropriate manner. In this way, a "hungry" therapist would sometimes divert the effort of the group from the patient to himself, thus abandoning his therapeutic function and using the interview to get help with his own emotional difficulties. A learning therapist's occasional inability to maintain his therapeutic potential sometimes resulted in an impasse with the patient.[7] When this occurred, one or more regular interviews with the patient had to be devoted to helping the inadequate therapist, before the work with the patient could proceed.

Perhaps the worst that occurred was that, in some instances, the therapists fought each other through the patient, or else used the patient to disagree with each other. For example, one therapist said to the patient, "You must feel guilty about the way your father died." Another therapist promptly disagreed, saying, "That isn't really important to you now, is it?" In this instance the two therapists were actually arguing with each other, but not honestly and directly. Thus, they cancelled each other out, with the result that each therapist seemed less useful to the patient. However, there were also certain points when the therapists, even though they did not agree on the approach to the patient, sincerely respected each other. In such cases the patient himself indicated what was valid for him, and in this way provided the therapists with a new basis for working together.

The difficulties described above, though genuine enough, did not seem nearly so important to the participating therapists as the gains derived from this approach. After his initial adjustment to the situation, the individual therapist often felt a new warmth in working with colleagues. He was less hesitant to take new steps in his therapeutic effort, because he felt certain that his co-therapists would protect the patient if it seemed necessary to do so. There was an increased responsiveness to the patient, made possible in part by the fact that some therapists "heard" statements made by the patient which had been missed by other members of the therapeutic group. Therapists repeatedly spoke of an increase in their capacity to work with individual patients, which resulted from working with other therapists.[8] One infers that their intimate contact with colleagues both promoted their personal growth and increased the scope of their therapeutic function.

Problems arising from the treatment of the patient as such were discussed in the interview situation itself. By contrast, problems relating to the therapists were regularly taken up in the hour following the therapeutic interview. In this way, training and research interests were assigned to a time when they would interfere the least with the treatment of the patient. Disagreements about the over-all method to be used, as well as specific differences between therapists, were resolved in a free discussion after the interview. This time also provided an opportunity for the ventilation of interpersonal tensions which were unrelated to the patient. The entire group participated in these struggles for a more adequate personal and working relationship. It was always understood that, when such a dis-

[7] Lois Koren, Victor Goertzel, and Mona Evans, "The Psychodynamics of Failure in Therapy," *Amer. J. Psychiatry* (1951) 108:37-41. Also, reference footnote 4.

[8] Hadden, reference footnote 1.

cussion became therapeutic for one of the therapists, this "therapy" was limited to that hour, unless the therapist "patient" specifically asked for additional therapy at another time.[9]

It was agreed from the outset that only therapists who themselves had had therapy should participate. Even with this prerequisite, the pressure of the situation made some of the therapists sufficiently uncomfortable to interfere with their function. As the study progressed, it became apparent that the intensity of the relationship between the patient and the therapeutic group could not exceed that existing between the therapists themselves. This observation led to the formulation of the following preliminary criterion for successful multiple therapy: Would each participating therapist feel free to be the therapist or patient of any other therapist in the group?

Conclusions

Multiple therapy is described here solely as a method of treatment. Its use for training and research as such is not discussed.[10] As a psychotherapy for neurotic and psychotic patients, this approach was found to have the following characteristics:

(a) The patient has the opportunity to avail himself of greater support and more intensive help when he is working with several therapists simultaneously.

(b) In comparison with individual therapy, multiple therapy produces more therapeutic pressure on the patient, and sometimes leads to a more effective and powerful ending of the therapy.

(c) The contrast in the positive and negative feelings expressed by the patient toward different therapists is sometimes quite marked; and this contrast seems important, because it offers the patient an increased incentive to work through his positive and negative relationships simultaneously.

(d) When the therapists first start working together, the stresses in their relationships with each other are frequently a distinct hindrance to effective therapy. Multiple therapy highlights the problems involved in establishing a group, and puts pressure on each therapist to become more mature in his functioning.

(e) As the relationship of the therapists to each other becomes more intimate and secure, they develop a greater therapeutic capacity in their individual work with patients.

(f) Multiple therapy offers a successful method of doing "elbow-teaching" in the training of psychotherapists.

(g) This approach offers opportunities for research on the nature of the process of psychotherapy.

(h) The personal growth of the therapists and the corresponding increase in their enthusiasm for psychotherapy are the major by-products of this method. This is not surprising since control work in psychoanalytic training is also known to round out the analytic candidate's own didactic analysis.

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[9] Whitaker, reference footnote 2.

[10] See Hadden, and Haigh and Kell, reference footnote 1.