

FROM THERAPISTS ANONYMOUS TO THERAPEUTIC COMMUNITY

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Freud conceived the psychotherapy hour as a relationship between a deliberately anonymous therapist and a well identified patient. The arrangement of furniture, the use of the couch, the position of the analyst outside the patient's line of sight, were all contrived to ensure the therapist's ambiguity. The patient was free to cast the analyst in images of parents, to endow him with attributes of significant others, and to react to him as though he were someone else. This was transference, a primary tool of the analysis, and an artificial bond between therapist and patient. Disturbance was created in the transference relationship as the analyst sought the conditions of cure within his experimental setting.

THERAPISTS ANONYMOUS

The analyst found security in his anonymity. His hidden face was able to respond without fear of patient reaction. He could lapse into selective inattention, make notes for a talk the next evening, or permit some idle fantasy to invade his behavior. His countertransference reactions were not known to the patient unless the analyst chose to put them into words. Outside of the session the analyst was careful to avoid social contacts or any extra-analytic relationship whatever. His private life and personality were inviolate.

There were obvious benefits from this therapist role. Detached and observing, the analyst felt himself to be objective. And yet he could not know wherein lay his magic to change another person's behavior. He assumed that behavior change was a function of technique in the service of theory. He assumed that his schooled and knowledgeable responses were the catalyst for understanding. Freud was afraid of his own countertransference reactions: he did not know the limits of his responsibility for his patients.

Responsibility is a by-product of any relationship in which one person tells another about himself. Nor can we easily or always define our responsibilities to other persons outside of the therapeutic hour. It is a rare human being who is consistently aware of his own stimulus-value, of the impact of his behavior on others. Sometimes in retrospect, or guilt, we see vividly the effects we have on others. As a person becomes closer, perception changes even the facts of physical

appearance. We see a different person, one colored by our own personal feelings, highlighted by our expectations and fantasies, muted by our unfulfilled needs. And in any growing human relationship we do assume responsibility for them at least vis-a-vis ourselves. And other persons are changed in this context to conform to our needs and ideals. We invest the relationship and the person with our hopes and our pathologies.

We do not know where a therapist's responsibility ends because we do not always know in our own lives how to be responsible. Responsibility involves relationship without damage to the other person due to insufficient awareness, knowledge and respect for them or for ourselves. Life is a continuous struggle to define our own relationships with others in such a way that needs are met mutually and the integrity of each person remains intact. Therapists assume that they can be responsible and that their patients cannot be responsible. Simultaneously, the bet is hedged, and a panoply of rules is erected for control of objectivity. We hide in anonymity.

THE THERAPIST'S NEW PROFESSIONAL IMAGE

Perhaps we hide because we do not like to consider what we "get" from psychotherapy. Certainly, money is not the primary incentive: more money can be made in other ways. The fulfillment of altruistic needs may be a motive for choice of the psychotherapy profession. Other professions, e.g., nursing, have empirical documentation that passive nurturance is replaced by concern with technical skill, routine, and approval from superiors (4). Psychotherapists probably undergo a similar transition.

Schafer (5) has described unconscious voyeuristic, autocratic, oracular, and saintly motives of psychodiagnosticians. Wheelis (6) has dramatized the needs of psychotherapists. The pursuit of knowledge may provoke dogma or despair; the approach-avoidance reaction to intimacy is often nourished by psychotherapy experience. Such unconventional and socially unacceptable motives stimulate little pride in our professions.

In a general sense persons who seek and remain in any service occupation may be using their skills in the struggle to maintain their own identities and their own humanness. We are all in various ways, with differing understanding, engaged in a willful attempt to preserve what we are, in the face of increasing cultural pressure for standardization, adjustment, and conformity. We have some prospect of be-

coming a faceless, valueless, anonymous middle class. The service occupations which pit human potential plus technical skill against equally human misery are a counterpoise.

The question of value immediately emerges: Is this "bad" if therapists have such personal motives? Is it "bad" for human beings to have to buy compassion, a willing ear, and even understanding? These questions can only be answered in terms of what makes patients "well", i.e., feel more like human beings. In this endeavor the therapist is a model; partial emulation occurs out of respect. The therapist should be close without losing perspective; be genuine without losing objectivity; and be spontaneous without losing technique. And these are not paradoxical. If we as persons are the instruments of our art, we must be willing to assume responsibility within the limits of awareness provided by our own human judgment. This is not magic but a gift of relationship, of closeness, of affect, of love controlled by therapist awareness of both himself and the patient.

THERAPEUTIC INVOLVEMENT

It is more difficult to be a therapist now: we *do* have to like our patients. How can they trust if cold, impersonal dissection is the technique? How can they identify with the therapist as a model unless they trust the person and not the projected image? With less anonymity, there is necessarily less unreal and intense transference, less therapy-created pathology to confound and lengthen the process. We are not all paragons of strength and wisdom. We are frail and human and have to be able to admit relevant weakness to ourselves and to our patients. Two examples may serve to clarify the intent of these remarks.

Several years ago as a lone psychotherapist in university practice, two principles guided my selection of cases: (a) presence of pathology to the extent that continuation in school without treatment was unlikely; (b) strong motivation to accept treatment. One beautiful and frankly schizophrenic girl, after two sessions of seductive behavior, began calling me at home late at night, describing her diaphanous semi-nudity and inviting me over. My immediate reaction was to arrange for a referral to a large, neighboring city on the grounds that her motivation for treatment was inadequate. She left school and the new therapy process was so successful that within two years she had returned symptom-free and married. Although I would not question my judgment in this instance, referral was probably made because I was reluctant to face and work through countertransference problems. And I succeeded so well that it is only years later that I am aware that such problems were involved.

Where does our responsibility to our patients end? Certainly not at the point where we feel personal involvement, or fear that we may be human, too. Convenient referral sources are not always readily available. We cannot lightly abandon patients because they neither fit our image of the "good patient" nor because they are inadequately motivated. Lack of motivation for treatment is a complex defense, designed to maintain a precarious adjustment. When we accept a patient who is unmotivated, we are obliged to instill motivation, e.g., create anxiety, or to be outmaneuvered by the patient's defenses into what may be another in a characteristic history of rejection. Whatever choice we make implies obligation. Psychotherapy is a special example of relatedness to people in which the balance for power is obligation.

A second example. A beginning graduate student goes into treatment with a new and relatively inexperienced instructor in a university atmosphere which actively discourages such relationships. After several sessions the therapist decides for valid reasons that he cannot continue to see the student. Other relationships are being affected. He tries to arrange a referral and transfer to a therapist not in the department. The would-be second therapist is characteristically (by reputation) neither gentle nor kind but a hard man who brings countless character disorders to terms with him and with themselves. His image is well known among the graduate students. This is, however, not the prescription for adolescent rebellion, for a seeker of ideal values who cherishes honest communication of feeling in a self-actualizing attempt.

The therapist's reason for referral is an honest fear that he will be unable to control extratherapeutic contacts with the student. He has been misled by his own good intentions. Ethically, he is beyond professional reproach. Para-ethically, what happens to the client if he does not accept the new therapist? He will feel rejected by another authority, repeating the childhood drama; violent and externalized attempts to put the world right, again may be anticipated.

There are no rulebooks to tell us of the effects of extratherapeutic contacts. There are no guides for the subtle milestones that change a client into a person and a person into a friend. I suggest that it is no accident or necessarily outrageous misuse of therapy that results in marriages between therapist and patient or in friendships that continue long after the transference-countertransference reactions have diminished.

RESPONSIBILITY, THE ESSENCE OF THERAPY

As the formal therapist-patient roles break down, so do the protections, the built-in proprieties of technique, couch, and recorder. We have no mechanics for handling the new problems and our human

behaviors take over. Nonetheless, an informed profession does have to ask uncomfortable questions. Is the anonymity, control, and objectivity merely part of the self-protecting rational armamentarium? Do we really presume evidence that our psychotherapeutic roles are different from teaching or friendship roles?

We assume that therapy roles are indeed different. In fact, it is vital to our professional images to make such assumptions. But what does make therapy "work"? On the one hand we are convinced that technique is of minor importance; we agree that the kind of human being the therapist is, may be critical. It is a short step to say that spontaneous liking based on respect for the integrity of the patient within a context of responsibility allows the therapist to reach out and to be effective as a human being without confusing his roles.

Responsibility is the keynote here. The "best" therapists are probably those who have worked through their own human relationships and are responsible. This does not mean being responsible for one's own actions, taking the consequences when judgment fails or one gets caught. It means being aware of one's impact on others *before* the relationship occurs. Foresight, not hindsight, in human relationships is the hallmark of the competent therapist and the mature person.

THE THERAPEUTIC COMMUNITY

The most dramatic evidence for the enlargement of therapeutic responsibility is in the concept of milieu treatment or therapeutic community. An outgrowth of a systematic indoctrination program for psychosomatic patients during World War II, the therapeutic community was an explicit attempt to change attitudes by changing the doctor-patient relationship (3). This was followed by extrapolation of technique to transitional communities for rehabilitation of former prisoners of war (2). Applications are now legion with all psychopathologies.

In a therapeutic community the essential ingredient is a democratization of treatment roles. A large, daily group meeting provides a permissive atmosphere in which everyone, staff and patient alike, is literally treating everyone else. The focus is on solving reality problems within the interpersonal context. The patient thus retains his identity and is able to participate in decisions affecting his welfare in spite of hospitalization.

One implication is that all who are involved in psychotherapy need

treatment in order to function optimally. Smaller group meetings of staff alone enable evaluation of the larger group process and of each staff member's contribution. Since the attention is primarily on the patient, the staff member is involved only as his problems impinge on the treatment process.

Responsibility is extended beyond the treatment hour to every interpersonal contact with the patient. To be sure this is merely a concretization of belief as to what institutional treatment should imply. However, it is but a short step outside of the hospital to the larger community. With the shortage of professional personnel the mental hygiene movement must look to the community. A generation of barbers, bartenders and policemen could conceivably be trained to maximize the therapeutic potential of their contacts with the public. Already psychiatric nurses (1) and aides have major therapeutic roles in hospitals. Utopia, of course, is the establishment of a sane social environment.

SUMMARY

The transition from the psychoanalytic couch to the therapeutic milieu has been a change from the therapist's anonymity to participation as a person with other people (formerly patients) in a living experience. As the therapist becomes identified as a person, transference diminishes. Professional motivations and human values become salient. The therapist must like his patients. This involvement invokes responsibility and a blurring of the limits of the therapist-patient relationship. Responsibility is synonymous with the therapist's awareness of his own personal impact before the relationship occurs. Therapeutic competence is our professional image and ideal. Like individual maturity, however, competence may rest on relinquishing the protections of the traditional therapeutic role in order to assume more responsibility for patients and ourselves.

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