# SOME METHODS AND PROBLEMS OF PSYCHOTHERAPY.

By W. L. NEUSTATTER, M.B., B.S., B.Sc., M.R.C.P.,
Assistant Medical Officer, Out-Patient Department, Maudsley Hospital.

THE objects of this paper are twofold : they are, on the one hand, to give a straightforward description of psycho-therapeutic procedure for those who are unfamiliar with its more technical aspects, and, on the other, to discuss specific problems which have arisen in the course of clinical work, and which might be of interest to other therapists.

## TYPES OF TREATMENT.

Broadly speaking, the types of treatment adopted may be grouped under two heads :

(1) Methods of overt suggestion.

(2) Procedures of an analytical nature.

The first group includes hypnotism and relaxation (with and without direct suggestion for recovery), and allied methods. The latter group may be subdivided as follows :

(*a*) Psycho-analysis in the Freudian sense, one of the essential features being that the analyst plays an entirely passive role.

(*b*) Psychological analysis. By this I mean methods in which the patient's symptoms are explained to him in the light of their apparent ætiology. Free association is little used, or not at all, but the patient is told to describe his life, and to discuss his feelings and attitudes to intimate matters, people, etc.

(*c*) A method founded largely on that of Stekel, which I have found most useful. Dream analysis and free association are used, and the transference situation is analysed, but the analyst does not play an entirely passive role. Where advice appears necessary it is given, and if persuasion seems justified it is used.

Before proceeding to enlarge on the methods enumerated above, it would be as well to digress to give an account of the first interview with the patient. This is necessarily common to all the procedures, and such important decisions regarding diagnosis, prognosis, and above all, treatment, have to be made at this meeting, that it can usefully be described in detail, before proceeding to discuss the individual psychotherapeutic methods.

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## The First Interview.

Taking the history is very much like taking any other history. To say that it should be followed by a physical examination is redundant, but as this is always stressed, even by psychiatrists of the most unassailable standing, it is impossible to omit reference to it without the doubt arising that a psychotherapist will neglect such an elementary procedure.

The patient should be asked to state his symptoms, and to tell his story in his own words. The usual questions should be asked about sleep, appetite, loss of weight, suicidal tendencies, early childhood and family history. Leading questions, however, are best kept to a minimum, and should be put from the point of view of making a diagnosis, and not of establishing the ætiology of the condition. My reasons for saying this are twofold: (1) An attempt to establish the ætiology at one sitting is frequently misleading, and (2) to do so means attempting to penetrate just those problems which may be most difficult for the patient, and this may be therapeutically harmful. For instance, the patient may be distressed by the behaviour of his father, who, we will assume, is a drunkard. He will have some scruples about revealing to a stranger this "skeleton in the cupboard". To drag the information out of him at this early stage may be of use in revealing to the examiner one of the ætiological causes, but is so doing of any therapeutic value? What is of importance is that the patient should feel relief in unburdening himself. The matter he reveals is of little consequence; in fact, trivial incidents frequently have the greatest emotional content. Yet this object can only be attained if the material is revealed spontaneously, or at least willingly. Where it is produced unwillingly, it may even have a prejudicial effect, the patient—not without reason—being upset by the lack of tact shown by the examiner.

There are occasions, when time is short, where the therapist, hoping that he has the patient's confidence, may, and must, deliberately risk putting his finger on where he thinks the patient's sore spot lies. The success of this method will depend on the therapist's intuition and experience, and on his tact in making the point. It will also depend on the patient's insight and his trust in the therapist. With all these variables there is a considerable gamble.

At the first interview I believe it is much better to play the role of silent listener, reading between the lines to attempt to gain information about the patient's attitude towards himself and his surroundings. I particularly avoid asking leading questions of a sexual nature, which are often needlessly embarrassing, and the answers often untruthful.

In dealing with neurotic patients who are particularly sensitive, it is specially necessary to give the impression of being very understanding at the first interview. At the same time this should not be done at the expense of expressing opinions, because, although a patient may voice one opinion on a subject, he may underneath be prepared to hold a brief for the other side. If

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the therapist comes down on one side or the other he will find himself in a " Heads I lose, tails you win " position. This is especially so when the patient's attitude to other people is in question. It is very necessary for the patient to feel that the therapist is not a critic. I always say to the patient, " We are concerned here with discussing causes of behaviour. I am only concerned with matters from a medical aspect, and not from a moral one ".

A practical difficulty I have come across at this juncture is the question of how much reassurance to give the patient. It is necessary at the outset to rid him of feelings of shame about his symptoms, but occasionally such reassurance is interpreted as a reason to avoid treatment of which he is feeling frightened, especially if analytic treatment is to come in question. A feeling of discontent with himself, I think, furnishes the patient with a valuable drive.

I therefore say to the patient that other people have similar troubles, and that he need not be ashamed of his symptoms ; but if I have the impression that the patient is going to seize on this as an excuse to himself to avoid an issue, I emphasize the inconvenience of his symptoms to him. Where, however, the patient is so ready to catch at straws to avoid treatment, the prognosis is correspondingly, though not inevitably, bad.

Another question concerning reassurance is this : Is the patient to be given a hearty and unhesitating assurance of betterment, or is a more cautious prognosis more advisable ? Again this has to be a matter of judgment. If a patient appears suggestible, encouragement and reassurance are called for. With the hypercritical, introspective type I say something as follows : " I have treated cases like yours before with good results ; you will see how you get on for yourself. The proof of the pudding is in the eating ! " Should I contemplate an analysis, I add : " The method I am going to use does not depend on suggestion, but on undermining the structures causing your trouble." My experience is that these patients are very convinced of, and even a little proud of being unsuggestible. Consequently, if they are assured that they are not going to be treated by suggestion, the suggestive features of the treatment will be enhanced.

In spite of telling the patient that he will see the results of treatment for himself, he will fairly soon repeat the question of how he is and how he is going to progress. This is a natural and legitimate question, but unless the therapist stands firm it will be asked repeatedly and needlessly. I therefore reply that my answer is no different from what it was, and that the patient can see for himself how he is progressing. It is very undesirable that the patient should feel that he can take up time by the repetition of purposeless questions.

Finally, it is as well to remember the gulf that exists between the mind of the patient and the sophisticated outlook of the therapist soaked in Freud. If this is borne in mind, such pitfalls as utilizing the initial consultation to put leading questions to elicit if the lady up from the country, depressed by her



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husband's infidelities, is really a repressed homosexual will be avoided. I have heard of this being done; the patient not only failed to return for treatment, but refused to see the doctor who sent her as well!

## Indications for Treatment.

Having taken the history, the essential problem is what is to be attempted in the way of treatment, and which of the methods enumerated is to be used.

This is a difficult question to answer, as there are no clear-cut indications. It appears to me to depend on the following factors:

(*a*) The nature of the patient's complaint.

(*b*) The patient's psychological make-up, i.e., his intelligence, his attitude to his illness, his suggestibility, etc.

(*c*) The time available.

(The therapist's own predilections will obviously also play a part; but as only an analysis could be expected to change these, the matter is too complicated to discuss.)

It is simpler to take the points out of order:

(*c*) As regards *time*, if this is limited, then an analysis is automatically put out of court. Similarly, lack of money makes analytic treatment impossible in private.

(*a*) Regarding *the nature of the symptoms* complained of, from my own experience I should be inclined to proceed as follows:

*Obsessionals.*—I should use an analytic method in most cases, as I think it will be agreed that they are bad cases to treat by suggestion, hypnosis or persuasion. Where, however, the obsession is so bad that the patient continually reiterates his complaint, I do not think a lengthy method like analysis would be justified, as it would probably be ineffectual. Where there is compulsive behaviour after treatment is well under way—say at about the end of a month—I should insist on the patient making a conscious effort to stop the acts in addition to the analysis. Where analysis is not possible or effective, suggestion can be tried. I have had a certain amount of success with it. Where nothing else can be done, the patient's lot can be somewhat ameliorated by trying to persuade him to accept the symptoms as a disagreeable—very disagreeable—occurrence, but to attempt not to be troubled by the content of the obsession, and not to fight against allowing the ideas to enter his mind.

*Anxiety states.*—Again, possibly with a predilection, because analytic methods have to my mind certain secondary advantages which are discussed later, I should be inclined to give analysis a trial. I should try it for about a month, going on to three months if there is any sign of response, but if by then there is no further improvement, I should change to another method.

It is my experience that those anxiety states where overt feelings of fear, such as tachycardia, feelings of faintness, nausea, are pronounced, are not

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greatly benefited by analysis. Relaxation, with the suggestion of betterment, may bring about relief, though patients usually have to continue to attend at regular intervals of a week or a fortnight.

Where there is a general state of emotional tension, and where the patient experiences emotion in relating certain events accompanied by slight bodily twitching, I think a definite relief of tension comes about through abreaction and talking, and these cases do well from analytic treatment. Similarly, where there are obvious sexual phantasies in women—often very clear from their dreams—the translation of these symbols and the discussion of the phantasies may relieve nervous tension, though it may be replaced by overt sexual feeling, which in its turn may prove a problem of its own.

Cases which—for want of a better term—are often classed as anxiety states, in which the patient complains of tight feelings in the head, feelings of giddiness, pains in the body, are in my opinion poor subjects for psychotherapy of any sort. Apart from a general inquiry into their history, I do not think analytic methods of much use, nor are these patients the type that understands or appreciates this method of treatment.

In cases where there is a specific anxiety, say in regard to going out alone, after some weeks or months the patient must be persuaded to conquer it. It is useful to suggest to the patient that while they are doing this they shall picture themselves lying at ease in the consulting-room, and thus divert the mind from their anxiety feelings, except, of course, when they are crossing the road!

*Hysteria*.—Suggestion and persuasion are the accepted methods, though all hysterics are by no means easily suggestible. With hysterics I should be guided more by the make-up of the personality (*vide infra*) than the symptoms, though I should on the whole favour persuasive methods.

*Psychoses*.—A depressive state, an advanced paranoia or other advanced psychosis, would appeal to me as unsuitable for psychotherapy. (Freud, it is interesting to note, does not consider psycho-analysis of use in psychoses, or at any rate in a psychotic phase.)

As it may sound rather ambiguous to state categorically that I should not use psychotherapy for psychotics, it may be of advantage to define what I mean by psychotherapy in this connection. I should define the term as an attempt to modify psychological states by the adoption of some specific psychological method. The emphasis should be laid on the "modify" and the "specific methods". There is a tendency to regard psychotherapy as anything which influences a patient's condition through psychological —and not physiological—channels. A bottle of coloured water may bring about improvement through its psychological effect; a conversation on his own premises may temporarily pacify a paranoiac; and five minutes' conversation may console a normal person, but I do not think that the term "psychotherapy" is usefully employed to include such simple procedures.

It might be better to coin a new term with a specific meaning, such as

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"psychotherapeutic methods". By this we should imply that a definite psychological *technique* is used with the idea of removing or modifying a symptom, i.e., it might be demanded (*a*) that the method should be able to succeed where the "bottle of medicine" has failed, and (*b*) that it should produce greater permanence in the result. I confess I shirk the issue of defining the latter accurately, but I think that symptoms should, in the absence of specific aggravating factors, remain in abeyance for some months at least.

A psychological technique might include the use of physical methods—such as apparatus—specifically intended to have a suggestive effect on the patient. It would obviously include definite procedures such as an analysis, hypnosis and relaxation with suggestion, but when it comes to methods which can be applied by anyone with a flair for influencing others, such as persuasion, a more difficult point arises. Here the "horse-sense" so beloved by some members of the profession (and others) may be all that is needed, but I submit that a "little horse-sense", however beneficial, lacks the technical quality which makes it a therapeutic method.

While obviously any definition of anything so controversial as psychotherapy is bound to contain flaws, and to be open to criticism, if we adopt the definition given it does settle the point as to whether psychotherapy is indicated in, say, the case of psychoses. Conversations with psychotics may be beneficial and may temporarily modify behaviour, but personally I should not consider this to be psychotherapy.

(*b*) *The patient's make-up.*—I should be guided by the following: If the patient were of the doubting, introspective, obsessive type, not able to relax, inclined to worry, and unable to accept advice, I feel an analysis would be the best possible line of approach.

For an analysis I think a patient needs the following characteristics: He must be intelligent enough to understand what is being attempted, sufficiently pliable to be able to accept new ideas, and patient enough to give the method a chance. Above all, he must have ample psychological insight to enable him to perceive his own feelings and the relationship between them.

On the negative side, he must not disclose a history of great instability, i.e., continual change of employment, as for instance, almost complete inability to control his impulses (a history of little serious attempt to stop them would strike me as worse than the actual occurrence of impulsive acts), etc. In cases like these I should fear undesirable incidents during the analysis, and would certainly want the patient in hospital.

## Methods of Suggestion.

There is not a great deal to be discussed in this section, as no novel methods have been used, nor has the technique differed from that adequately described in books on the subject.

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The method I adopt is to spend a few sessions inquiring into the patient's history, etc., and in attempting to establish a transference. (The question of transference is discussed subsequently.) Treatment consists in telling the patient to lie down and relax completely. After a minute or two, he is told to concentrate on feelings of numbness and heaviness, which I suggest he will feel in his legs, and which will gradually steal all over his body. When the patient has relaxed I sometimes make suggestions to him that he cannot move his arm or leg. In patients where this is successful I use it as an argument to impress them that I now have a degree of control in which they will respond to the suggestions I am going to make. I often say that the symptoms are going to be reduced in frequency and intensity, elaborating this idea if necessary.

A useful device, I find, is to suggest that when the fears arise the patient will be able to "shunt his mind off them", that this will get progressively easier, and that by doing so he will find himself calm instead of frightened. With some patients I have found it beneficial to say that the symptoms *must* disappear, and that there is no question about it. I also encourage patients to continue their relaxation exercises at home.

### Procedures of an Analytic Nature.

#### (*a*) *Freudian Analysis.*

As I am not a member of the Freudian Psychoanalytic Society, I am not in a position to discuss the detailed intricacies of a Freudian analysis, though the technique has a good deal in common with the method of Stekel (described below), which I use, except that the Freudian analyst is far more passive (*vide infra*).

The essential features of a full Freudian analysis are that the patient attends five sessions a week, the treatment probably lasting at least six months, and possibly for several years. During treatment the patient lies on a couch, and is instructed to allow his mind to wander and to say everything that comes into his mind, without reservation, in whatever order it comes. The analyst plays an entirely "passive" role. He interprets the material produced by the patient according to psycho-analytic theory, but he gives no advice, nor does he in any way exert any authority or interfere with the patient's life or behaviour—at least in a full analysis. The reason for this is that any interference by the analyst is considered harmful to the transference situation. The transference is discussed further on.

This brief description of the Freudian method is included for the sake of completeness, and in order to assist those readers who are unfamiliar with its details in following some of the points discussed further on.

#### (*b*) *Psychological Analysis.*

There is little need to enlarge on what was said in the definition.

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(*c*) "*Stekel's Method.*"

This is the method I use. It is similar to psycho-analysis, but the patient usually comes three times a week, though it may be twice, but rarely four or five times. As stated previously, a certain amount of advice may be given; dreams are made use of; and the method may be combined with persuasion or suggestion.

The following is a detailed account of what occurs, using this method:

At the first session it is necessary to give the patient some indication of what is to be done. I try to give the patient a very brief explanation of the theory, avoiding the use of technical terms as far as possible. I find it difficult to avoid using the word "unconscious", but I am not fond of it, as it so often leads to patients making remarks, such as "That is my unconscious at work", or "I feel (or think) that unconsciously, doctor". The objection to this is not purely a philosophical one of a contradiction in terms, but the more concrete objection that in doing this the patient is escaping the problem, as it is only another way of saying, "Yes, it may be so". I always insist that the patient commits himself to agreeing or disagreeing with what I tell him.

For purposes of explanation, I resort to similes of the patient's troubles, comparing them to the dangerous iceberg which only shows a small part of its ugly structure above the surface, or make references to steam under pressure, and other obviously useful comparisons.

After this I ask the patient to tell me his life-story as far back as he can remember, urging him to give as much detail as possible. Most patients do this badly, especially in describing their childhood and their relationship to members of the family. On the other hand, I once saw a patient who had been told to write down his history, and who confessed with shame that he had not completed the task, he was tired by the time he had got to his tenth year, by which time he had run into a hundred pages!

After the first session, several sessions are devoted to talking along general conversational lines, after which I go on to use free association, with or without the use of dreams. The patient is told to lie down and to try and let his mind drift, just as it does before going to sleep, not to direct his thoughts, and above all to say everything that comes into his mind. If he has dreams I take out certain particulars and ask him to start his free association from those, stopping him when he appears to have got to what I consider an important point. This is open to the obvious objection that it is quite unscientific; the only answer appears to be that therapy is not research, and that the therapist must make his decisions as a general physician does, by emphasizing what he considers important in his findings, and disregarding what he considers to be inessential.

I tell the patient to write out his dreams, advising him to jot down notes before rising from bed in the morning. This has the dual effect of making the patient remember his dreams, and, by giving him a slightly uncongenial

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task to perform, making him realize that treatment is something to be worked at, and not to be regarded only as an interesting side-line confined to the hour in the consulting-room.

*Difficulties of Association.*

The majority of patients have great difficulty with free association at the start. The difficulties are fivefold: (1) The patient is unaccustomed to allowing his thoughts to wander without control to order. (2) He feels foolish at producing a pot-pourri of thoughts without any apparent rhyme or reason. (3) He thinks certain thoughts too trivial to mention. (4) He declares his mind goes a blank. This, of course, is not actually so, but he does not recognize the thoughts which are of a trivial or perceptual nature. Though this blankness is often determined by emotional inhibitions, it must not be lost sight of that patients do differ in their introspective ability as well.

(5) Apart from this, patients nearly always keep something back, such things being revealed only after weeks or months of treatment. These may not be of very great moment, but obviously must be something of which the patient has felt ashamed to tell.

The difficulties in associating must at first be met by instances and explanations of what is desired, because it is not always quite clear to the patient. After this it is largely a question of winning the patient's confidence so that he is not afraid to say what is in his mind. Apart from true resistance, with certain patients there is a good deal of what I suppose should be dignified by the name of "resistance", but in plainer language consists of a more or less vague dislike of the proceedings.

Such patients come to treatment with a mixture of hope and curiosity that something may occur, but this is not enough to make them do what is unpleasant. Once this is apparent, the therapist has to be quite firm and outspoken, and point out to the patient that if he wishes to go on with treatment he has got to make the requisite effort.

*Posture.*—As stated above, once free association is started, I get the patient to lie down, or to sit reclining with his back to me. This method has the following advantages:

(*a*) In the recumbent attitude it is easier for the patient to allow his thoughts to drift.

(*b*) The patient is not distracted by the therapist.

(*c*) It is far less tiring for the therapist—an important point when he has many patients to see.

(*d*) The patient may hesitate to say things outright to the therapist's face, and is very much on the *qui vive* for any change of expression or gesture on the part of the latter, thus making it impossible for him to relax at all.

Patients frequently protest at having to lie down, as it makes them feel

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foolish. The position also often gives rise to sexual thoughts. This unusual posture may cause difficulty, but on the other hand, by forcing sexual phantasies to the surface, it may help to break the ice on what is usually a delicate subject for the patient.

## TRANSFERENCE.

In certain cases, after an analysis has proceeded for some time (it may be a few days to a few weeks), the patient begins to develop an attitude in which, broadly speaking, he (or she) develops feelings either of an affectionate nature or of hostility towards the analyst. The feelings may vary from mild liking, or dislike, to feelings analogous to love or hate, their intensity differing according to the individual.

The essential feature of a " transference feeling ", I should say, is that it must be irrational, and subjectively, not objectively, determined. A certain degree of like or dislike is bound to exist towards the doctor, as soon as the patient becomes acquainted with him, just as it exists for anyone else. But where it has a mainly rational foundation, i.e., the doctor is liked because he has shown sympathetic understanding, or disliked because he was hurried, brusque, and terse, then I do not think this feeling can legitimately be ascribed to the transference. Obviously there must be a subjective element present, as all our attitudes are of necessity to some extent subjectively determined, but equally obvious is it that we should retain our sense of proportion, and not regard every action of the patient as primarily subjective.

What is meant by transference is perhaps illustrated best by one or two instances :

(1) *Positive transference.*—A woman patient brings along a dream of seeing a sailor whom she wants to hug her. " *Sailor* " makes her think : " He had on a blue suit—like you wore the other day, doctor." " *Hug* " makes her think (with embarrassment) of being hugged by the doctor. At the same time hugging reminds her of how her father hugged her.

As the doctor has not made any advances, the theory of this is that feelings relating to her father are now being " transferred " to the doctor.

This paper is not concerned with theoretical implications. It is enough to state that these situations do occur, in which, for no objective reason, patients develop feelings for the analyst which are analogous to feelings felt towards some person who was of emotional significance to the patient in childhood.

(2) *Negative transference.*—A man patient of mine, physically strong, of a rather dejected, retiring personality, who felt a lack of interest and success in life, at about the sixth session began to complain that the analysis was no use. He admitted he disliked it. He then confessed, with much embarrassment, that I had annoyed him in three ways : I used the phrase " Do you see ? " too often, also the phrase " I mean " ; and when I had asked him what came to his mind the previous session, I appeared to speak sharply about the association

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he gave. " I thought it was very unfair." None of these seemed very convincing reasons why he should dislike the analysis or myself so much, so I got him to associate to "*Do you see?*" " I.C. My brother wrote those letters on a W.C." In this closet the patient had some sexual experience as a child, of which he was rather ashamed. "*I thought it was very unfair.*" " I used to think it unfair that my mother paid more attention to my brother than me." This was brought out with a good deal of feeling, and he told me how inferior he used to feel about his brother. After he had told me this his hostility for myself and the analysis evaporated (for the time, anyway), and he saw how irrational it had been.

These are illustrative instances of transference. There is no doubt that the phenomenon occurs, and that patients appear to derive relief after the situation is worked out.

Why the situation works itself out in this way, and not directly, is difficult to say. The fact remains that with some patients the transference does occur. It is a mistake, however, to suppose it occurs with all patients, for with some it never appears, and in these an analysis along straightforward lines is very difficult.

Patients will sometimes ask transference questions; that is to say, " Do you think this very serious ? " or " How am I getting on ? ", in circumstances where there is no obvious reason for putting these questions. Some analysts make it an invariable rule never to answer questions, although the patient may be making use of this question to relieve his anxiety, or to avoid continuing some theme (I had a woman patient who would ask a question nearly every minute), it is equally obvious that there are times when these questions are perfectly genuine.

I do not see why the therapist should always act as though he were devoid of any judgment; I consider he should answer or not according to the circumstances. I do make it a rule, however, not to answer questions in the middle of free association, but to treat them as part of the associations. The patient is told that any question to which he wants an answer must be put at the end of the session.

Some other points of interest are as follows :

*The passivity of the analyst.*—Although some schools hold that the analyst should be entirely passive, I believe it is necessary for him to be an authority. This does not mean that the patient is to regard him as someone to be feared, but the patient must realize that he is expected to co-operate and conform with rules of treatment laid down by the doctor.

Many neurotics (often with good cause) have a strong dislike of authority. If, therefore, they are face to face with a certain amount of discipline, it will bring out this attitude. Without it there is a type of patient who will regularly come late, miss appointments, and get satisfaction out of doing this instead of getting on with treatment.

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It may be argued that this interferes with the free play of the transference situation. Quite possibly it does, but it appears to me that it is possible to take short cuts in treatment, in which case the interference with the transference situation is not of such vital importance. Besides this, in quite a number of patients very little transference, if any, occurs.

*Duration of Treatment.*

This is one of the most important practical considerations, and one of the hardest questions to answer. I usually tell the patient I will try to give him a definite answer when I know a little more about him, i.e., after three or four sessions. After that my time-limit varies from two to three times weekly, for a period varying from one or two weeks, to approximately six months. I am inclined to agree with Stekel, who thinks that a definite end-point is an incentive to the patient; that if a cure be not effected then, it very likely will not be brought about by a longer treatment; and that in long analyses the analysis becomes the neurosis.

*Abreaction and Understanding in Analysis.*

With regard to analytical procedures, in doing analysis it has always struck me that there are two separate factors at work: the intelligence and the emotions, varying according to the type of patient. It also seems to me that one of the essentials of an analysis, as opposed to other methods, is that it should bring about a release of emotional forces. The intellectual explanations given would appear to be of apparently little importance, except as aids to bringing about this state of affairs. I rather stress this point because a good deal is heard about the role which "understanding" plays in bringing about a cure. Understanding, in itself, seems to me to have little to do with it, unless by "understanding" we mean an emotional revelation or something corresponding in intensity, and as self-evident quality to Descartes' "Cogito, ergo sum".

But such revelations are rare in analytical treatment; the understanding which the patient obtains is of an intellectual nature, much as he learns psychology or physiology from a text-book. This plays a valuable part in itself, but is, I think, dependent on the following factors:

Primarily there is a shifting of attention from the disagreeable symptom to something else on the mental horizon, namely, the study of the causation of the symptoms. The fact that this causation is in the patient himself has, moreover, the obvious advantage that, from its very nature, it is more likely to rouse the patient's interest than anything else. Furthermore, the explanation may act as a suggestion in itself. I know of the case of a woman who, on complaining that she had a headache, was told that this was due to the fact that she had not dreamed the previous night. The headache immediately disappeared, and the cure was attributed to the fact that the woman now had

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an understanding of the cause of her headache. The explanation, I may add, was not mine.

As will be seen from the foregoing, I think that explanations along analytical lines are of value, but I think it is important to keep clearly in mind which objective we are aiming at, viz., to try to bring about an emotional discharge, or to give the patient a distraction and a philosophy, and the feeling of being understood that the explanation will give him. The feeling of being understood is, of course, of an emotional nature, but does not correspond to a discharge of emotional energy such as was witnessed on occasions described in the treatment of war neuroses, where the revival of a memory caused an abreaction. Millais Culpin stresses the point that in hysterical blindness the explanation of the reasons why the blindness exists is not sufficient, but the unconscious psychological cause must be brought to light.

From all this it follows that to some extent a different technique must be adopted in cases where it is desired to produce an emotional discharge, from those in which the patient is to be treated along more intellectual lines. In the former case, a situation should be made as real as possible, technical explanations would be kept to a minimum, and matters discussed in everyday terminology. If in his associations a patient comes to some difficult point, I think it sometimes pays to harp on this in the hope that something may break through. My own theory in this type of case is that relief is brought about by a discharge of some kind of energy. Thus it is a well-known phenomenon how restless we feel when a word is " on the tip of our tongue " and eludes us, and how this feeling evaporates the moment the word has broken through into consciousness.

With a good number of patients of the intellectual, introspective variety, little is to be expected in the way of abreaction, emotional crises, or transference. This should be recognized at the outset, and the more intellectual side of the treatment stressed. These patients are interested in the philosophical implications of the theory of treatment, and it may profitably be discussed.

It is desirable, however, to arouse emotion in these patients, if possible, but special devices of technique are needed. I have found some of the following devices of use in this and other types of patient :

*Methods of arousing emotion.*—(1) Indirectly evoking a patient's pride by pointing out to him how he is wavering between his present tendencies and what he wishes to achieve. This indecisiveness is stressed repeatedly, and at the same time the factors holding him back are pointed out to him. Stekel uses the ingenious device of referring to obsolete and undesirable tendencies as infantile. The term is an excellent one ; it has no moral significance, but acts as a powerful irritant.

(2) Telling the patient vigorously that he is complacently accepting what is told him, that he is taking it as placidly as if someone else were under discussion, that he is not making an effort to verify or dispute what is being told to him.

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The patient usually asks, not without reason, what more can he do than he is already doing? This is often difficult to answer, but one has to be prepared to be considered both inconsistent and illogical in the cause of therapy! This is irritating to the therapist, but it is even more so to the patient, and I find that it nearly always has a good effect, as patients usually produce more material at the next interview.

(3) In obstructive cases where the patient is not really pulling his weight, it is beneficial, if not already done, to set a time-limit to treatment. In addition to this, I have occasionally reminded patients that they are wasting their time, mine, and that of other potential patients. On the whole, I do not think such drastic treatment is very good, but I have known it to hasten matters considerably.

On the other hand, I doubt if it be desirable for the therapist to remain too passive. As in everyday life, the patient may respond where he feels it is expected of him, whereas, unprompted, he quite naturally remains unresponsive. Merely analysing the patient's resistance does not strike me as always being enough. The reluctant bather, told that he is hesitating because previous experience has shown him the water is cold, will continue to shiver on the brink; whereas the presence of one critical small boy prepared to yell disparaging epithets will act as a powerful counter-incentive to overcoming his anxiety!

(4) Finally, after a period of sympathetic understanding, it is sometimes useful to force the patient to stand on his own feet by becoming blind to his point of view. Thus, a woman of 24, whom I had been treating for some months, had a good deal of fear and some antagonism towards her mother, with whom she was living. She decided to go and live by herself. Shortly after, she showed me a letter from her mother about which she displayed much emotion, saying how difficult her mother was whenever she wanted to do anything on her own initiative. Actually the letter was quite innocuous. When I pointed this out, the patient became very annoyed with me, and said bitterly that she thought at least I would understand. I remained unsympathetic, explaining that the patient must expect to receive some criticism; that the letter was not as unreasonable as she was making out; and that she had to accept the fact that the world is not populated by saints. Her annoyance continued for a further two treatments, after which improvement, which had been delayed until then, set in rapidly.

## Conclusion.

To sum up, the following are points which would guide me in deciding upon which method of treatment to adopt:

(1) If the patient has time, is intelligent, and has psychological insight, employ analysis, with or without persuasion (e.g., persuading an agorophobiac to commence going out).

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(2) If the patient is suggestible, and has little time, use suggestion and/or hypnosis and/or persuasion.

(3) Where analysis has been attempted, but is unsuccessful, or the patient turns out to be unsuitable, suggestion may be turned to.

For a residue of patients who are unamenable to any of these methods, I use reassurance and medicine, and spend little time at it. I do not think it justifiable to spend long on these cases. There are plenty of cases who need and will respond to treatment, and in psychotherapy, as in other branches of medicine, we should not be too proud to admit that there are a large number of cases who are unresponsive to treatment. Moreover, the problem as to the amount of time the physician has to give personally to his cases is more acute in psychotherapy.

The point is one which raises certain practical issues. Because a patient is unresponsive or unamenable to psychotherapy, it does not mean that his sufferings are not real, or that he is not entitled to sympathy. There is no doubt an inclination to regard unsympathetically the "chronic neurotic" who is apparently making no effort to get well, and there is no denying that even to the psycho-therapeutically minded (provided, of course, they have been sufficiently analysed to be able to be honest with themselves), these patients who remain ill even when they have had the most palpable ætiological mechanisms revealed to them are irritating, boring, and often a great nuisance.

The question arises, though, are these patients really suffering from a complaint arising from unconscious psychological processes and conflicts? When one thinks of the lives that these chronic out-patients often lead, the slums from which many of them come, the constant plotting to make both ends meet, and the strain, the noise and the discomfort under which many of them live, one is tempted to wonder whether it is perhaps not surprising that many of them have *not* got these complaints. I admit this is only surmise, and that neurosis occurs under comfortable circumstances, but it appears a reasonable speculation to attribute to fatigue many of the aches and pains which are referred to psychological clinics for treatment.

If this is the case, then (*a*) obviously these patients are entitled to sympathy, and a sympathetic hearing, and (*b*) elaborate psycho-therapeutic procedure is not justified. For it does seem to me that as a result of psycho-analytic methods becoming fashionable, there is a quite unjustifiable tendency to allow patients to ramble aimlessly on with a sort of ill-defined and pious hope that "just talking" is going to make them well.

In practice, I think the solution is something along the lines adopted at the Maudsley, where cases considered suitable are referred for psychotherapy, while unsuitable cases attend monthly or weekly for some advice and medicine, as in any other out-patients' department. While psychotherapeutic methods are so time-consuming, this seems to me to be the only system which is

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ultimately fair to the very considerable bulk of patients who do need intensive treatment.

One further practical issue arises from this—the tendency to isolate the psychotherapist from the diagnostic side. I think that at clinics the two functions should be combined. Ultimately, the person who does therapy is in the best position to decide which cases (at any rate, for himself) are the most suitable for treatment, while by seeing other cases he will help to retain a broader outlook than if he is seeing only a group of cases specially selected as being probably responsive to treatment. It is a point to be considered if the discussed psychotherapeutic clinics come into being.

In conclusion I should like to add that if at times I have appeared somewhat bold or sweeping in my statements, this has been done with a purpose. It is exceedingly difficult, for instance, to analyse out those factors which would influence one in deciding what form of treatment to adopt. In attempting to define them, one is obviously on controversial grounds, and hard and fast rules are bound to be open to objections and criticisms. Nevertheless it appears to me that it is better to attempt a definite statement at the risk of contradiction than to remain safely non-committal on what appear to me to be some of the practical issues which arise in connection with treatment.

In conclusion, I desire to thank Dr. Mapother, Superintendent of the Maudsley Hospital, as this paper is largely the outcome of work carried out there. I should make it clear that any views expressed are my own.

* For those readers who desire further information and illustrative examples of psychotherapeutic procedure, there is an excellent series of papers by Stekel in the Viennese monthly, the *Psychoanalytische Praxis*.

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