THE APPLICATION OF PSYCHOANALYTICAL PRINCIPLES TO THE HOSPITAL IN-PATIENT.*

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THERE is no need for re-stating, in general terms, the importance of the psychoanalytical contribution to psychiatry. This has been discussed here on several occasions, and possibly more seriously than in any other society of psychiatrists. I am referring to the papers read to this section by Bernard Hart (1), David Forsyth (2) and Edward Glover (3). They form a most interesting introduction into the problem of the relationship between psychiatry and psychoanalysis. Psychoanalysis has not been the main topic of discussion in this section since Edward Glover's address on the application of psychoanalytical principles in psychiatry thirteen years ago. Since then the psychiatric scene has changed out of recognition. We have entered an era of great therapeutic activity. The hospital in-patient with whom we are concerned to-day has been subjected to a variety of physical methods, and the campaign has still not reached its peak of intensity. It is too early, at this stage, finally to assess the therapeutic value of those treatments, but we can say this much already: it is most unlikely that they will save us the trouble of studying mental illness the hard way. Psychiatry cannot afford to neglect any approach that promises to contribute to the understanding of mental phenomena. It is against this background of psychiatric developments that psychoanalysis has again been chosen for discussion here.

Considering that there are a great many activities, and a vast number of problems in hospital work to which psychoanalytical principles can profitably be applied, it would be difficult to attempt a comprehensive survey in the limited time available. I shall try to give you a personal account instead. I want to tell you how much help psychoanalysis has given me in my clinical and research work as a psychiatrist. I am going to talk mainly about clinical observations on mental hospital material, but I shall from time to time take the liberty of commenting on problems that appear pertinent to the subject under discussion. I should like to say at once that nothing is further from my mind than the ambition of setting a standard for the application of psychoanalytical principles in psychiatry. How widely and how deeply these principles will direct and pervade the activities of a psychoanalytically trained psychiatrist will depend not only on the amount of work he is called upon to do, much of which may not lend itself to the analytical approach, but also on his personal leanings and talents. I have no doubt that many of my psychoanalytical

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colleagues would have delved deeper into the unconscious than I did in dealing with some of the problems I tried to elucidate. However, they must not forget that most of the case material in the mental hospital is not accessible to analytical treatment in the strict sense. The psychoanalysis that can be practiced there is in the main applied psychoanalysis.

Dr. Rickman, in his opening remarks, has stated the principles that govern the doctor-patient relationship with admirable clarity. They apply irrespective of whether or not psychoanalytical treatment in the strict sense is attempted. It is true that the basic concepts of psychoanalysis have been evolved in the psychoanalytical treatment of neurotics. However, it is well to remember that most of Freud's contributions (4) to the psychological understanding of the psychoses were based on material that had not emerged in the psychoanalytical treatment of psychotic patients. Such highly important contributions as the papers on paranoia and melancholia, are really examples of applied psychoanalysis. This proves that the psychoanalytical treatment in the strict sense cannot be regarded as the only legitimate source of progress in clinical psychoanalysis. This brings me to another point, the importance of which cannot be emphasized too often, especially among psychiatrists. Even now there is a tendency amongst psychiatrists to judge the significance of psychoanalysis on the basis of its value as a therapy, and to overlook the fact that psychoanalysis has, as Ernest Jones (5) put it, provided psychiatry with an interpretative, dynamic and genetic point of view. I hope that I shall be able to illustrate the applications of those aspects to you. Nevertheless, I want to say a word about therapy.

I have treated with psychoanalysis cases of very severe obsessive illness and anxiety states in hospital. The majority benefited from the treatment, but I do not want to enter into a discussion of therapeutic successes and failures on this occasion. Dr. Rickman has pointed out the complications that are apt to arise when more than one doctor is involved in the medical care of a case in hospital. I can fully confirm his observations. These difficulties which originate from the transference situation, are apt to arise when the doctor who is carrying out the treatment is himself in charge of the ward to which the patient belongs, and is thus responsible for his conduct in hospital, his welfare and his discharge. The fact that the patient is bound to meet the doctor outside the treatment on the ward where he has to share him with others complicates the transference situation very considerably. The institution of the visiting psychotherapists which is being adopted by many hospitals meets those difficulties admirably. They do not arise to any marked degree where only superficial routine psychotherapy is given to in-patients. In that case the fact that the treatment is carried out by the doctor in charge of the ward may even have considerable advantages ; but he has to watch the transference phenomena carefully.

My experiences with systematic psychoanalytical treatment of psychotic conditions in hospital are scanty and inconclusive. You know that Freud has expressed the view that those patients are not accessible to psychoanalytical treatment, as they are unable to form a stable transference relationship. This has not deterred a number of psychoanalysts from attempting psycho-

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analytical treatment of psychoses in hospital. It is clear that in the treatment of psychotic conditions, the analytical method has to be modified, and the technique advocated for those cases has much in common with child analysis. I am not a therapeutic enthusiast, but I see no reason why attempts at psychoanalytical treatment of selected psychotic cases should not be made by properly trained psychiatrists, especially under hospital conditions. Such studies are likely to yield interesting material, and are most unlikely to do harm. There are other reasons why such work could be very important. It would, for instance, be most interesting to study in this way selected cases before and after leucotomy. I would expect such investigations to cast some light on the effect of the operation on psychotic conditions. They could verify and elucidate certain clinical impressions, such as that leucotomy changes the schizophrenic from an introvert into an extravert. Such investigations could be very profitable even if they were confined to patients who had not made sufficient improvement to leave hospital.

I think I ought to say here a few words about the psychoanalyst's attitude towards current physical treatments. It is perhaps as well to distinguish between his attitude as a scientist and as a therapist. Psychoanalysis as a mental science is based on biological concepts. The prominence that it gives to the instincts implies that mental illness can be influenced by physical means without the detour over psychological mechanisms. It is therefore, quite natural that psychoanalytically trained psychiatrists have co-operated wholeheartedly in the administration of physical treatments, which are not incompatible with psychoanalytical principles. However, methodologically, and in the underlying approach, they are, of course, extreme opposites, and it is not unnatural that some psychoanalysts have expressed themselves strongly against their use. In a discussion on the application of psychoanalytical principles in mental hospital, it is perhaps not inappropriate to try to understand that attitude. The psychoanalyst views abnormal behaviour as manifestation of a struggle between conflicting forces, and he regards many of the most spectacular symptoms as indicators of a healing process. In his attempts to intervene therapeutically the psychoanalyst tries to modify and harmonize those forces, to change their direction and their objectives, and thus help the patient to adjust to reality. The psychoanalyst believes in the power of love and reason. In spite of everything that has been said to the contrary about him, he is an optimist and a humanitarian. How can it be otherwise, since he constantly discovers the child in all of us, especially in those suffering from mental illness?. The psychoanalyst is fundamentally a strategist. He feels about the more violent forms of physical treatment the same as a highly trained military strategist must feel about atomic warfare. One may disagree with him, but his convictions deserve respect especially if they are recognized as honest prejudices (6). They can do nothing but good if they remind us of an approach to mental suffering that will always rank as a great scientific and human achievement.

Psychoanalysts have not been unmindful of the fact that full analytical treatment is available to only very few, and some have tried to evolve shorter methods. The most recent systematic attempt on those lines is that of

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Alexander and French (7), but for the sake of clarity, those treatments which do not use the analytical technique had better not be called psychoanalysis.

Schilder (8) was guided by psychoanalytical principles in elaborating his method of group psychotherapy. In this country, Bion and Rickman (9), and especially Foulkes (10), have made valuable contributions to the theory and practice of group therapy based on analytical principles. That treatment is the subject of intensive research in many places, and I have no doubt that important developments will come from this new method which has already widened the scope of psychotherapy in hospital considerably. Like individual psychoanalysis, it encourages free play of emotional forces by the adoption of a group association method. I have practiced this technique with mixed groups of recoverable patients in mental hospital, and found it most interesting, and helpful. Kräupl (11) has recently reported on work with similar groups. Like everybody brought up with the concept of the individual interview, I had to overcome a certain resistance to that kind of treatment myself. I fully agree with those who have pointed out that in the group situation, certain behaviour features emerge which individual treatment alone might not have brought to light.

I do not want to discuss group therapy beyond saying that, as in individual treatment, the method has to be modified when one is dealing with psychotic subjects. The psychiatrist conducting the group has to be more active, and to intervene more often than in groups consisting of neurotics only. Conducting such a group demands considerable psychiatric and psychotherapeutic experience. I have found it particularly helpful in cases of schizophrenia entering a remission. Often the group situation acted as a stimulant for the individual interview. On several occasions the patient's reactions in the group situation helped me in arriving at a correct assessment of their improvement, usually proving that the patient was really better that I had assumed from the individual interview. My fear that psychotic patients would talk about their delusions in the group spontaneously did not materialize. It was surprising how discreet they were in this respect, and how open in other respects.

Group therapy on analytical lines is of great help in assessing how much of the social personality is preserved, especially if combined with a certain amount of individual treatment. It is hard work, but worth while. Like every psychotherapeutic technique, it is not congenial to every psychiatrist.

One of the advantages of group therapy is the possibility of having another colleague present at the sessions, if possible, as an active participant. This means that it can be learnt by direct observation, and considering the difficulty of teaching psychotherapy this is an important point.

So far, I have been concerned with some of the applications of psychoanalytical principles in the treatment of the hospital in-patient. There are other applications about which I do not intend to speak, such as the various methods of achieving abreaction with the help of drugs.

Having given some examples of the application of psychoanalytical principles in the treatment of the mental hospital patient, I would now like to refer to the importance of those principles for the understanding of abnormal behaviour and symptoms. But we cannot expect psychoanalysis to

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explain any of them fully and from every angle. There is no method of approach, however indispensable, that can by itself solve all the complex problems of mental phenomena.

Let us take but one instance—*folie à deux* will serve ; let us restrict that concept to the adoption of psychotic thought contents by a person who is not himself suffering from mental illness. The occurrence of this condition is usually regarded as due to increased suggestibility on the part of somebody who lives in close community with the psychotic subject. Lack of judgment owing to low intelligence, and constitutional predisposition have also been blamed. These explanations are far from satisfactory. *Folie à deux* belongs no doubt to the suggestive phenomena, but this statement only begs the question. It does not help us to understand why it happens in an individual case, nor are the victims particularly suggestible in their relations to others. The cases I studied were far from unintelligent. Common predisposition, even if it could be proved in all cases, could not explain the identity of the delusions in paranoid cases. In fact, paranoid patients are far from suggestible, and we know that psychotics living together in hospital over many years hardly ever adopt each others' delusions. To understand the *folie à deux*, we have to investigate carefully into the relationship between the persons concerned, their personality make-up, their conscious and, if possible, their unconscious tendencies, and the nature of the thought contents transmitted. I made such investigations with Hartmann (12) in a series of cases, all of *folie à deux*, and all with paranoid states. The mechanism underlying the process is that of identification as understood by Freud. Under normal conditions, gross identification does not take place in adult life, but it is all-important in childhood. We found that in those cases a strong tendency to identification had developed out of feelings of guilt which caused the passive partners of the group gradually to sacrifice reality. That strong sense of guilt had, in those cases, grown out of the feeling of having failed sexually and socially, and also out of repressed aggression towards them. The contents of the delusions, too, proved significant. They were ideas which could be traced as unconscious fears in the passive partner's mind. The adoption of the delusions meant sacrifice and punishment. We also turned our interest to the active partner of the group, the one from whom the delusions originated. We found in every case a character type with marked sadistic features, demanding the sacrifice of complete identification, and deriving strength from the fulfilment of those demands. When finally the spell was broken, and those who were the victims of their suggestive power freed themselves from the delusions and regained their independence, the condition of the paranoid patients deteriorated, and it appeared that with the loss of unity with the others, their resistance to complete withdrawal from reality failed rapidly. This suggested that their eagerness to make others share their delusions had been the expression of a defence reaction against the threat of isolation. This is only a poor sketch of what we found in those cases. Instead of accepting the apparently obvious, namely, that the man who takes over his wife's delusions is just more than usually gullible, we uncovered a constellation of conflicting forces which had been at work over years, and finally resulted in

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the sacrifice of reality. This may not be the whole story, but it is at least part of it. The method of investigation in those cases was careful exploration by psychiatric interview.

The discovery of a certain mechanism underlying abnormal behaviour in a number of cases does not mean that that mechanism is the only one that can cause it, and we have to be careful with generalizations. However, once one has established a certain dynamic constellation in a pathological case, however rare, it is often not difficult to recognize it in its milder forms, e.g. it can be said that our observations in the cases of *folie à deux* might be of help in the understanding of some other suggestive phenomena.

There are many other forms of abnormal behaviour which the application of psychoanalytical principles has helped to elucidate. I found the psychoanalytical approach most valuable in studying fugue states with the impulse to wander (13), and a variety of other psychopathological phenomena. Psychoanalytical knowledge, especially in its dynamic aspects, has helped me in the study of the interplay between obsessive-compulsive symptoms on the one hand, and depressive and schizophrenic reactions on the other hand. It enabled me to understand how interaction between abnormal mechanisms of different dynamic qualities, the one tending to disintegration, the other to preservation of the personality, is apt to modify the clinical picture, and the course of the psychotic process in individual cases. After I had established those observations on a considerable case material (14) with the help of psychiatric methods, I discovered to my satisfaction that Edward Glover (15) had come to similar conclusions in his psychoanalytical work. I think that such studies are of great importance to the psychiatrist. Prof. Kallman (16), the eminent American geneticist, has recently pleaded for concerted investigations into all the factors which are apt to modify or to nullify the effects of hereditary predisposition. The psychoanalytic approach, with its emphasis on dynamic as well as environmental factors, can be of great value in the study into such problems.

I have given you some examples of the applications of psychoanalytical principles to the clinical material that we meet in the mental hospital, and I hope that I have been able to demonstrate the value of the psychoanalytical approach. Psychoanalysis has contributed a great deal to the knowledge of psychotic mechanisms and to the understanding of psychopathological products such as hallucinations and delusions by deciphering their unconscious meanings. It is a pity that workers in the mental hospital who have the ideal material for such studies at their disposal have taken so little serious interest in those problems.

In a discussion such as this, it is not out of place to devote a few remarks to the significance of psychogenetic propositions in psychoanalysis. They attempt, as Hartmann and Kris (17) have pointed out, to establish a causal relationship between the individual's retreat pattern in conflict situations and early impressions in which the pattern was gradually formed. In other words, "they try to answer the question when that particular form of reaction was learned or adopted first, and why a certain conflict was solved in a certain manner." You see, psychoanalysis may be able to describe how a condition

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under observation has grown out of a person's past, but may not necessarily be able to say why it has done so. This applies particularly to the psychoses. The conception of psychogenesis, therefore, does not imply that a condition which we can trace back to its roots in early childhood is necessarily caused chiefly by environmental experiences at that period. But that is exactly the idea that most people have of psychogenesis. To psychoanalyse a patient means to them to set out to find certain environmental experiences or constellations which are solely responsible for the illness. This is a misconception of psychogenesis.

Psychological understanding of a mental illness from the psychoanalytical aspect does not even exclude the possiblity that it is an organic disease. On the other hand, the organic nature of an illness does not imply that it cannot be influenced psychologically. I am referring to some psychosomatic conditions. Viewed from this angle, the difference between physiogenic and psychogenic is not fundamental, but we must not over-rate the impressionability of the organism by psychological means. Whether it will fall to the psychoanalysts to give the final answers to the question of the cause of mental illness we are unable to say, but psychoanalysis will certainly be indispensable in helping to formulate the problems and to shape the answers.

From what I have said about the biological foundations of psychoanalysis it is clear that it is not incompatible with any other scientific approach to mental illness. Masserman (18) and his school have shown by their experimental work that the psychoanalytical and reflexological approach can be co-ordinated with great profit. It is felt by many that the neurological approach to mental illness from which they expect the final clarification of its mysteries is incompatible with psychoanalysis. The view has been expressed that the occurrence of complex psychopathological symptoms in cases of organic brain lesion has proved the futility of psychoanalysis. I would like to demonstrate to you that, on the contrary, psychoanalytical knowledge can be of help in the elucidation of certain symptoms of organic brain lesions. In entering the precincts of neurology I am not aware of any trepidation, nor do I feel that, to gain admission I have first to try to raise one or the other mental phenomenon to the dignity of a reflex. Having been brought up as a "Neuropsychiatrist" and having had the great good fortune of training under Paul Schilder, I see no difficulty in combining the neurological and the psychoanalytical approach.

When post-encephalitic sequelae were first studied, the occurrence of obsessive-compulsive symptoms, especially during the oculo-gyric crisis, aroused considerable interest. I studied a series of such cases, and was able to make some interesting observations (19). In those patients, the organic illness had caused an impairment of the equilibrium between the libidinal and destructive tendencies, resulting in a constellation not unlike that found in obsessional illness. I pointed to the interesting fact that obsessive-compulsive phenomena had been described only in such cases of brain lesions in which those parts of the brain related to the control of instincts were affected. It does not, of course, follow from these observations that obsessive-compulsive symptoms are always due to organic lesions, but it does mean that the

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anomalies in the instinctual sphere to which they are related may sometimes be due to such causes.

Knowledge of psychological mechanisms discovered by psychoanalysis has helped me in the study of the body image, of the symptom of unawareness of physical disability and of such primitive phenomena as echo-reactions. Schilder and Pötzl have pointed out that certain features in aphasia could be understood in the light of mechanisms described in psychoanalysis, and this is not surprising. If we assume that psychoanalysis has something to say about the structure and functions of the mind, there is no reason why it should not be able to throw light on those functions when they are impaired by organic lesions.

I hope I have not digressed from the subject of our discussion. It is true, I have left the in-patient behind for some time, but I have been talking about his problems and have tried to contribute to the understanding of principles the wider application of which would make the mental hospital an even more interesting place than it is already.

Psychoanalysts do not claim a monopoly for their approach in psychiatry. They do claim, however, that for a great number of psychiatric problems, theoretical and practical, their approach is indispensable. I am looking forward to the time when more psychoanalytically trained psychiatrists will work in mental hospitals, and take part in the great work their colleagues are doing there. How and to what extent the psychiatrist who is not psychoanalytically trained can and should apply psychoanalytical principles is a very important question, but it lies outside the scope of to-day's discussion. I would only like to say that he should refrain from doing so, without having given careful preliminary thought and study to those principles.

Some of you may feel it a bit unfair that I have dwelt at some length on the misconceptions existing among psychiatrists about psychoanalysis, but have not even mentioned the misconceptions that exist among psychoanalysts about general psychiatry. They are very considerable, and would need much more time to discuss than I have at my disposal. I can assure you that those among the psychoanalysts who have general psychiatric experience are doing their best to help their colleagues towards an understanding of the psychiatrist's problems.

Psychiatry and psychoanalysis have too long been divorced from each other. The benefits that would come from closer co-operation, based on mutual understanding and respect, would be very great indeed.

References.

(1) Hart, B. (1932), *Proc. Roy. Soc. Med.*, **25**, 188.
(2) Forsyth, D. (1932), *Proc. Roy. Soc. Med.*, **25**, 1200.
(3) Glover, E. (1935), *Proc. Roy. Soc. Med.*, **28**, 695.
(4) Freud, S., *Coll. Papers*, Vols. III and IV. London.
(5) Jones, E. (1938), *Papers on Psychoanalysis*, 495. London.
(6) Winnicott, D. W. (1947), *Brit. Med. J.*, **1**, 688.
(7) Alexander, F., and French, T. M. (1946), *Psychoanalytic Therapy*. New York.
(8) Schilder, P. (1938), *Psychotherapy*. London.
(9) Bion, W. R., and Rickman, J. (1943), *Lancet*, **2**, 678.
(10) Foulkes, S. H. (1946), *Lancet*, **1**, 303.

https://doi.org/10.1192/bjp.94.397.773 Published online by Cambridge University Press

(11) KRÄUPL, F. (1947), *J. Ment. Sci.*, **93**, 613.
(11a) *Idem* (1948), *Ibid*, **94**, 77.
(12) HARTMANN, H., and STENGEL, E. (1930), *Jahrb. Psychiat.*, **48**, 164; (1931), *Arch. f. Psychiat.*, **95**, 584.
(13) STENGEL, E. (1939), *Brit. J. Med. Psychol.*, **18**, 250; (1941), *J. Ment. Sci.*, **87**, 512; (1943), *J. Ment. Sci.*, **89**, 224.
(14) STENGEL, E. (1945). *J. Ment. Sci.*, **91**, 166.
(15) GLOVER, E. (1930), *Brit. J. Med. Psychol.*, **10**, 226.
(16) KALLMAN, F. J. (1945), *Lancet*, **2**, 445.
(17) HARTMANN, H., and KRIS, E. (1945), *The Psychoanalytical Study of the Child*, **1**, 1. New York.
(18) MASSERMAN, J. H. (1946), *Behaviour and Neurosis*. Chicago.
(19) STENGEL, E. (1934), *Jahrb. Psychiat.*, **52**, 236.

https://doi.org/10.1192/bjp.94.397.773 Published online by Cambridge University Press