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Psychoanalysis and the Treatment of the Psychoses*†

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Psychoanalysis is not regarded as having a significant part to play in the treatment of the psychoses. This view has been strengthened by the ease with which the phenothiazine and other drugs may bring many psychotic symptoms under control. Nevertheless, there are psychiatrists who believe that psychoanalysis, in its classical form or suitably modified, can benefit patients suffering from psychoses. The issues which have been raised by these claims are still the subject of controversy among psychiatrists and psychoanalysts. This paper is not concerned with details of the different kinds of analytical treatment which may be recommended for patients. Such an account would be inappropriate in the circumstances of current psychiatric practice in the United Kingdom. Instead attention will be focused on the way in which psychoanalysis can be integrated into therapeutic regimes presently employed in mental hospitals.

Principles of treatment and patient management should be based on knowledge of causes and of the pathological process which gives rise to the symptomatology. In some physical illnesses this is possible and rational therapy can be prescribed. It is still beyond the scope of psychiatry, in which treatment remains empirical. In recent years the concept of psychoses as disease entities has been subject to considerable criticism. This has culminated in the theory that mental derangements are nothing more than special modes of existence. The existential approach is the reaction to the mechanistic theories of psychosis which have held the field for so long, and indeed continue to do so in academic circles.

Fifty or more years ago Adolf Meyer (1910), August Hoch (1915), and MacCurdy (1925), rejected the brain disease theory of psychosis and advocated the concept of reaction types. This was the beginning, for the clinician at least, of the recognition that the symptoms of a psychosis must be viewed primarily in the context of abnormal psychology rather than in terms of a pathophysiology—however important this might be from a research standpoint. The adoption of the psychological model was a pragmatic step which in no way precluded the role of genetic or metabolic factors in the development of the illness. It merely asserted that explanatory concepts of a psychological nature, being closer to the clinical phenomena, provided a better means of understanding both the illness and the individual. It did not exclude the possibility that psychoses are diseases but diseases of a different nature from those which disturb somatic functions.

An explanatory psychopathology is confined to the use of psychological concepts. This can be a serious shortcoming if taken to an extreme. It then bars from consideration other factors which may play a major role in leading to a predisposition to the illness. This limitation can be overcome by following a psychobiological approach which emphasizes the unity of mind and body and the interplay which occurs between psychological and organic factors.

Freud's original observations on the neuroses were ordered and interpreted in accordance with a conceptual framework which had been designed for neurological disease. He went on to divorce mental events from the central nervous system and gave up attempts to understand these events on physical grounds. Freud (1900) constructed a model in which dissolu-

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tion (Jackson, 1894), was replaced by regression. While this model was a psychological one, a place was found for the biological element through the theory of instinct. Initially it was this theory which allowed Freud to give representation to constitutional and hereditary factors in mental life.

The Theory of Psychosis

Basic to the theory of symptom formation in both neurosis and psychosis is the libido concept. This was introduced to describe the instinctual forces which underlie the sexual needs with their drive toward objects and their special aims. Object cathexis or cathexis of the self refers to the investment of external objects, their mental representations and the representations of the self with libido. The libidinal cathexis of objects and the self has both qualitative and quantitative aspects. The quality of the libidinal cathexis will depend on whether the libido has an instinctual expression or whether, as a result of sublimation, it is concerned almost wholly with social and environmental adaptation. The quantitative aspects of the libidinal cathexis will be reflected in the intensity of needs and the strength of object attachment.

The psychoanalytic theory of psychosis presents an explanation of symptomatology and abnormal behaviour. It assumes the presence of a predisposition to the illness created by hereditary factors on the one hand and adverse environmental influences on the other. The intense anxiety which so frequently appears in psychotic states is regarded as the expression of an inner danger which has been created by drive arousal. The heightened drive may follow frustration, loss or disappointment.

The withdrawal of interest in external objects and their representation in the mind is interpreted as an attempt, by repression, to diminish this danger by reducing the strength of the drives. The appearance of forms of relating, attitudes to the self and modes of sexual behaviour which are similar, if not identical, to those found in early childhood are regarded as caused by a regression which affects the libidinal cathexis of the self and objects. The libidinal cathexes, having regained their instinctual quality because of the failure of sublimation, seek out means of satisfaction or they are the cause of severe anxiety. The content of much of the symptomatology is attributed to the revival of the disturbing childhood events and reactive phantasies which partially contributed to the predisposition to the illness. Cases have been described where a connection between childhood experience and delusional content has been demonstrated (Niederland, 1959).

The further development of the clinical picture will depend on whether or not the initial withdrawal of cathexis from objects is maintained, and on whether or not the detached cathexis is concentrated entirely on the self or on memories or phantasies of significant relationships and events. It is the concentration of primitive libidinal cathexis on the self which causes the pathological egocentrism, the morbid self-love and the magic thinking.

Where the delusions and hallucinations have a sexual content some patients regard them as a form of persecution. This tendency results from the action of projection on the libidinal drives. The patient disowns the sexual or aggressive affect and attributes its initiation to someone else. In both categories of patients—those in whom the libidinal cathexis is predominantly self directed and those in whom it finds substitute objects in a psychotic reality—there will always be some libidinal cathexis ready to attach itself to external objects. It is therefore always possible to find evidence of a residual capacity for object attachment. This may be tenuous, and may only find expression under special conditions. It is easily overwhelmed by the self-preoccupation and the delusional content.

In other cases the object cathexis remains but possesses a primitive quality. The subjects are interested in others only as they serve a need of the moment. They are impatient and greedy; when frustrated they become aggressive. Object relations are further characterized by a tendency to merge self representations and object representations. This leads the patient to attribute to another his own thoughts, wishes and feelings. At the same time he assumes the manner, behaviour and even identity of the latter. These

transient identifications may appear in patients who are overactive and in those who are not. These primitive forms of object relationship exist contemporaneously with omnipotence of thought and other signs of a pathologically exaggerated egocentrism.

Descriptive psychiatry, basing itself on Kraepelin's classification, distinguishes the schizophrenias from the manic depressions. The former present an autistic withdrawal, disturbance of affect and thinking, hallucinations and delusions. The latter manifest a psychomotor overactivity or retardation together with elation or depression of mood. When classification of illnesses is founded on symptoms alone difficulties arise because many patients present phenomena belonging to both clinical entities. Attempts have been made to reconcile these seeming inconsistencies by postulating the existence of schizo-affective states and mixed manic depressive psychoses.

The psychoanalytic position is that the nature of the symptoms will depend on the extent of the regression and on the influence of forces antagonistic to the expression of the drives. These forces comprise anxiety and guilt. Anxiety, guilt or both lead to psychomotor inhibition. When these affects are minimal there will be no check on the drives, and a symptom complex characterized by psychomotor overactivity will appear. This may emerge in an illness in which autism, hallucinations and delusions are the leading features. Similarly persecutory delusions and self-preoccupation may arise in a case which earlier had exhibited psychomotor overactivity or retardation. The symptoms which arise in the individual case can be best understood if they are regarded as depending on the speed and the extent of the regression, the activity of the drives which have escaped from repression and the influence of anxiety and guilt.

The Metapsychological Profile

A systematic psychoanalytic classification of clinical data has recently been introduced by Anna Freud (1963) in the form of a metapsychological profile. Freud used the term metapsychology to describe the theories and concepts of psychoanalysis. The libido theory and the concept of cathexis are illustrative examples. The purpose of the profile is to order clinical material in accordance with the psychoanalytic concepts appropriate to the abnormal mental state under examination. Profiles can be outlined at any stage of an illness—at the onset, during treatment, in states of remission and in chronicity.

The construction of a profile brings together relevant clinical and other information. The programme was initially designed to study the developmental aspects of neurosis in children (A. Freud, 1963). Later it was applied to adult cases of neurosis (A. Freud *et al.*, 1965), and most recently it has been adapted for the psychoses (Freeman, 1970). The first sections of the profile deal with such topics as the symptomatology, the history of the illness, the circumstances attendant on the onset, the previous personality and the family history. This information is supplemented where possible by data obtained from relatives, friends, social workers and nurses.

From this point on the profile diverges from the standard forms of psychiatric case taking. The clinical phenomena—the surface manifestations—are now related, as far as this is possible, to the patient's inner, unconscious mental life. The form and content of his relationships with others, the manner in which he perceives himself and the condition of his sexuality are scrutinized in terms of the libido theory. How far do they express a disturbance in the distribution of libidinal cathexis between self and objects? Has the quality of the libidinal cathexis altered and have the sexual drives regressed from the genital to pre-genital levels? The same phenomena are examined from the standpoint of conflict and defence. Can they be regarded as the outcome of a conflict between libidinal or aggressive drives on the one hand and conscience on the other? Are they the result of the action of specific defensive manœuvres?

A profile describes the phenomena which arise from the effects of regression, details the manifestations which result from the action of the drives, libidinal and aggressive, and provides an assessment of the connections which

exist between conflicts, anxiety and guilt on the one hand and the symptomatology on the other. Note is made of the effects of regression. It may be confined to object relations, extend to the self, to the sexual organization and to conscience. The content of conflicts, the specific form of anxiety and the defences are detailed. Special attention is given to affective phenomena not only in their descriptive aspects but also in their relation to conflict and defence.

The construction of a profile is only possible on the basis of an extensive knowledge of the patient and his illness. This knowledge can be gained through daily interviews with the patient and the observation of his behaviour by nurses and occupational therapists. During this time information may become available about childhood and adolescent relationships, experiences and phantasies which may have contributed to the predisposition to the illness.

Relevance of the Profile for Management and Treatment

The information provided by a profile adds a new dimension to the management and treatment of a psychosis. At present treatment is almost entirely limited to the administration of psychotropic drugs and electro-convulsive therapy. Their maximum impact is on the acute symptoms of the illness. Anxiety is diminished and symptoms lose much of their intensity. It is only in a certain number of cases that these beneficial changes are accompanied by a restoration of the pre-morbid level of social, occupational and personal adjustment.

A profile contains data which can be used to formulate an explanatory psychopathology on which recommendations can be made regarding the management of the patient while in hospital and after discharge. The profile can also be used to decide which patients might respond to intensive psychotherapy, if such treatment were considered to be practicable. Sufficient to say that the process of profile construction often leads to the creation of a psychotherapeutic relationship between patient and psychiatrist, nurse or social worker.

Through the examination of profiles it becomes apparent that the similarities which exist between patients are surface phenomena. Symptoms which seem identical in form are associated with quite different mental contents, forms of relating and defence mechanisms. Illustrative is the case of the catatonia symptom complex. The inattention, disinterest and negativism mask different mental states. In one case libidinal cathexis is concentrated on the self as object so that real objects only exist to provide the immediate satisfaction of needs. In another the patient retains an intense attachment to a love object lost years previously. Here the libidinal cathexis is invested in memories of that object. In yet another case there is a firm attachment to real objects, the catatonic signs being related to a conscious homosexual conflict. Hypertonia, catalepsy and negativism prevent the patient from any form of homosexual contact or from masturbation with a homosexual phantasy.

Psychotic illness is almost invariably initiated by some form of mental stress (Bleuler, 1968). This applies equally to the onset of the illness and to relapse after remission. Yet knowledge of precipitating events contributes only marginally to the problem of causation. There is still limited understanding of the factors which contribute to predisposition. That extraneous circumstances, insignificant as they appear to the outsider, may lead to the outbreak of illness suggests that a closer scrutiny should be made of both the actual events and the patient's inner reaction to them.

Object loss and the frustration of drive and affect expression are the most common danger situations for those destined to develop a mental illness. These dangers are not specific for any one diagnostic category and are to be found in all psychoses. The loss may be real, as in the case of bereavement, infidelity, a broken engagement or divorce. Or it may be in phantasy, the patient no longer being able to maintain the day dream of a lover in the face of its contradiction by reality. Loss frequently engenders aggression, which in its turn provides a new inner danger for the patient.

Frustration leads to a danger situation when the patient can no longer find an outlet for genital drives or, when faced with the prospect of genital arousal, cannot tolerate the heightened

instinctual tension. In some cases the frustration follows object loss, as when a young man loses his father through death and is left alone with his mother. The proximity of the mother becomes a source of danger. Where there is frustration, pressure of conscience may become a major factor in provoking a danger situation. This is common in young persons during their first heterosexual relationship. In older age groups frustration leads to danger when the libidinal drives have a deviant expression or where there is an actual frustration of genital needs. Here again frustration leads to aggression and an enhancement of guilt. In these cases self reproaches are common and may be accompanied by persecutory ideas due to projection of the unwanted drive derivatives.

Recognition of these inner dangers is of the utmost significance for the management and treatment of the patient while in hospital and after discharge. Those patients whose mental equilibrium depends on the continuing existence of a real or phantasied object relationship can be identified, not only by their own statements but by an investigation into their social and family ties. Social workers have an important role in providing information about the state of the intra-family relationships. Those patients whose illness followed a real loss are discovered to be persons who are unable to contain their drives and affects without the aid of an external object (Jacobson, 1967). The loss of this object leads to a fear of a disintegration of the self and of the environment.

It follows that patients suffering from psychoses present difficult problems of management after discharge from hospital. The patient who falls ill after a phantasy loss may turn cathexis to the hospital itself or to one or other of the staff who undertook his care. The patient may transfer all kinds of expectations from the phantasy object to doctors and nurses. If the expectations are not met, anxiety or depression may follow. When a patient is able to undertake long term psychotherapy such tendencies will become manifest.

The aims of individual analytic therapy in cases of psychosis is to render the patient less vulnerable to inner dangers. This requires considerable intrapsychic change particularly in the sphere of the defence mechanisms. These treatments are fraught with difficulty, so that they can only proceed if the therapeutic relationship is minimally contaminated by psychotic symptoms. On the positive side, such treatments meet the patient's need for a close object tie. In successful therapy this need is lessened when the patient becomes able to direct libidinal cathexis to objects which afford satisfactory instinctual and emotional outlets. On the negative side analytic therapy is limited in its application because of the time commitment, and also because of patients' indifference, lack of insight into the fact of being ill and inability to join in what has been called the 'therapeutic alliance'.

Under current conditions of practice in the United Kingdom the psychoanalytic contribution to the treatment of the psychoses is mainly limited to the provision of psychopathological formulations. Profiles reveal the inner dangers which may confront the patient and the means used to deal with them. It is the patient's residual capacity for relating in an adaptive and satisfying way which will decide the ultimate outcome of the illness. This can only be assessed through observation of the patient's behaviour with his family, in his contacts with the psychiatrist and in his dealings with nurses, social workers and occupational therapists. The aim of the psychiatrist's or nurse's work is not to perpetuate a dependency in the patient but to assist in demonstrating to him how his attempts to deal with his inner dangers leads to a distortion of reality.

The period in hospital can only be regarded as the beginning of the treatment process. The illness has not ended when the patient is discharged, although he may be free of positive symptoms. The potential for relapse is still present, and complete reliance should not be placed on drug therapy. It is at this time, when the patient is at his most vulnerable, that psychoanalysis may be able to make significant contributions to management and treatment.

Summary

The purpose of this paper has been to show how psychoanalysis can participate and assist

in the treatment of patients suffering from psychoses, quite apart from its role in the therapy of the individual case. This participation in treatment regimes becomes possible through the use of Anna Freud's metapsychological profile suitably adapted for the psychotic patient. The material contained in such a profile provides the basis for an explanatory psychopathology which can be employed as a guide for the management of the patient while he is in hospital and after discharge.

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