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# Prokaletic Measures Derived from Psychoanalytic Technique

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The purpose of this paper is to report on therapeutic measures which have been used on my Unit at the Maudsley Hospital for several years and have been gradually elaborated with the help of registrars who have learned to apply them under my general supervision. The measures are derived from the therapeutic technique Freud recommended. In 1913, when he reviewed the development of his technique, he said: "In the earliest days of analytic technique we took an intellectualist view of the situation. We set a high value on the patient's knowledge of what he had forgotten, and in this we made hardly any distinction between our knowledge of it and his. . . . We hastened to convey [it] to the patient in the certain expectation of thus bringing the neurosis and the treatment to a rapid end. It was a severe disappointment when the expected success was not forthcoming" (1). Many of Freud's patients in those early days had broken off treatment abruptly after having been prematurely made aware of erotic fantasies they had firmly repressed and forgotten because of their shocking and revolting content. Freud came to the conclusion that interpretations of repressed erotic fantasies should only be given when the ground had been adequately prepared first. "Even in the later stages of analysis," he advised, "one must be careful not to give a patient the solution of a symptom or the translation of a wish until he is already so close to it that he has only one step more to take in order to get hold of the explanation for himself" (1).

But how was the patient to acquire tolerance of the shocking content of his repressed fantasies? Freud found an ingenious way to decondition, as it were, his patients against the shock of his interpretations. He had noticed that patients usually formed a strong attachment to him in the beginning of treatment. This positive rapport made them responsive to suggestions. He therefore had no difficulty in often bringing about an early alleviation of symptoms. Yet he soon realized that such initial improvements were usually followed by disappointing relapses and bitter criticisms. He began to warn his patients not to expect a quick and simple cure. He even found it necessary to avoid all steps that might reduce neurotic suffering while psychoanalysis was in progress. "The primary motive force in the therapy", he said, "is the patient's suffering and the wish to be cured that arises from it. . . . Every improvement effects a diminution of it" (1).

Suffering and the wish to be cured were, however, by themselves not enough to abolish a patient's neurosis. Otherwise there would have been no need for him to seek psychotherapy. An additional motive force was needed. Evidently, the positive rapport with which patients began treatment was such a force. Freud surmised that it came from the instinctual urges of repressed infantile fantasies, which were activated by the start of treatment. The patients regressed in the treatment situation and recaptured at first hopeful infantile fantasies about the benevolent power and devotion of parents; but the fantasies now had the analyst as their object. It was this positive transference which supplied the additional motive force needed in the therapeutic battle against an entrenched neurosis. Freud therefore advised: "It remains the first aim of the treatment to attach [the patient] to it and to the person of the doctor. To ensure this, nothing need be done but to give him time. If one exhibits a serious interest in him, carefully clears away the resistances that crop up at the beginning and avoids making certain mistakes, he will of himself form such an attachment and link the doctor up with one of the imagos of the people by whom he was

accustomed to be treated with affection" (1). Among the resistances that crop up in the beginning are objections to the task of free association or to the analyst's passive role. Among the certain mistakes that have to be avoided by the analyst are the adoption of a moralizing attitude, seeming to act on behalf of a third party (e.g. a spouse), conveying shocking interpretations too soon, or reducing a patient's suffering and thereby his wish to be cured.

However, the honeymoon period of the positive transference reaction at the beginning of treatment never lasts long. Feelings of disappointment emerge sooner or later, co-operation flags, and the patients become critical of the analyst and his methods. Their transference has turned negative. It was Freud's view that this is the crucial moment for the analyst to become active. He must not, of course, get involved in an emotional tangle with his patients or defend himself against their accusations. He must stand aside and analyse the motivations behind the negative transference. His sole therapeutic weapon consists in making his patients aware of the unconscious meaning of the emotional changes that have come over them. This unconscious meaning always has one common component, namely that of resistance to the progress of treatment in order to protect instinctual gratifications and emotional gains which are clandestinely provided by the neurosis. Such resistance interpretations are sure to elicit indignant rejections from the patients, who are only aware of having sacrificed much time and money in order to have treatment, and of having done their futile best to fall in with the therapeutic regime of the analyst.

The patients might, of course, become accustomed to a monotonous repetition of the same resistance interpretation whenever the analyst opens his mouth. Fortunately, he has some other interpretative arrows to his bow. Resistance to the progress of treatment is a transference manifestation which draws its motive force from repressed fantasies. It is these fantasies that provide the analyst with an opportunity for varying his resistance interpretations. There are many such fantasies, but, at any particular time in the course of treatment, he will choose one whose content is not excessively shocking in the light of the tolerance already acquired by the patients. However, it must have some capacity to shock the patients. They must feel challenged by it to relinquish, if at all possible, the resistance manifestation that has been interpreted. For example, the resistance manifestation may consist in the patients being silent during treatment sessions or mentioning only trivialities. At an early stage in the treatment, they might be given the relatively mild interpretation that their behaviour indicated an unconscious fear of becoming aware of repressed sexual fantasies about the analyst. For most patients, it is not too difficult to alter the interpreted, and by implication criticized, behaviour. They now begin to talk about topics in which they know the analyst is interested. However, if the patients are unable to modify the interpreted behaviour they will become emotionally disturbed by the unpalatable implications of the interpretation.

Resistance interpretations thus evoke reactions through the emotional challenge they convey. It is justifiable to regard these emotional challenges as the essential elements in Freud's analytic technique. From a practical point of view, psychoanalysis—at least, Freud's version of it—may therefore be called a "*prokaletic therapy*" (from Greek *prokalesis*, challenge). Freud's explanation of the disturbing prokaletic elements in his technique relies on the patients' difficulty in recalling the interpreted unconscious fantasies or any memories related to them. They have two means of eluding the task of recall. They can alter the interpreted behaviour and thus remove, for the time being at least, any justification for exploring an unpleasant interpretation. On the other hand, if the interpreted behaviour cannot be modified, the task of recalling unconscious fantasies may be transmogrified into a re-living of them in the present life situation, and particularly during treatment sessions. To quote Freud's own words: "The patient does not *remember* anything of what he has forgotten and repressed, but *acts* it out. He reproduces it not as a memory but as an action; he *repeats* it without, of course, knowing that he is repeating it. For instance, the patient

does not say he remembers that he used to be defiant and critical towards his parents' authority; instead he behaves in that way to the doctor" (2) (Freud's italics).

When the re-living and acting out of unconscious fantasies follows on the challenge of a resistance interpretation, Freud speaks of an emotional abreaction which he calls "working through". When the working through is intense, the patients' clinical state deteriorates and their therapeutic resistance increases. Freud is quite explicit about this. "I have often been asked to advise upon cases in which the doctor complained that he had pointed out his resistance to the patient and that nevertheless no change had set in; indeed the resistance had become all the stronger. . . . The treatment seemed to make no headway. This gloomy foreboding always proved mistaken. The treatment was as a rule progressing most satisfactorily. . . . One must allow the patient time to become more conversant with this resistance with which he has now [through an interpretation] become acquainted, to work through it, to overcome it by continuing, in defiance of it, the analytic work. . . . This working-through of the resistances may in practice turn out to be an arduous task for the subject of the analysis and a trial of patience for the analyst. Nevertheless it is a part of the work which effects the greatest changes in the patient and which distinguishes analytic treatment from any kind of treatment by suggestion" (2).

Psychoanalytic therapy therefore has two fundamental practical aims: (*a*) to attach patients to the treatment situation, and (*b*) to undermine their resistance to therapeutic influences. The measures required for the achievement of the first aim are simple. All one has to do is to show interest in one's patients and their special problems, taking care to avoid anything that might antagonize them. These measures are, of course, not a prerogative of Freud's therapeutic technique, but occur universally in every kind of treatment. The measures, on the other hand, which Freud devised for his second aim are typical of his technique. He used resistance interpretations which acted as emotional challenges on his patients. These prokaletic measures differ widely from any employed in forms of treatment in which emotional reassurance is paramount.

We have adapted and expanded Freud's prokaletic measures for incorporation into an eclectic form of treatment that is purely symptomatic and pragmatic. We are satisfied when we can reduce to a minimum the power of psychiatric illness to jeopardize the life of our patients, and their prospects in social, educational and occupational fields. It is our aim to place our patients in a life situation which will stand them in good stead when their illnesses eventually come to an end. Instead of being handicapped by lost years of inactivity and invalidism, they should find themselves fairly well prepared to take their rightful place in society when they have recovered. Many of our patients have been adolescents who present special difficulties even to orthodox psychoanalytic therapy. This was attested by Hellman's findings at Anna Freud's Hampstead Child Therapy Clinic in London. "With many adolescents," she said, "analysis is deprived, to a great extent, of the means of access to the unconscious . . .; play is no longer used to convey the continuous stream of phantasies, and free association is resisted. . . . Communication remains restricted to behaviour and often to carefully censored talk . . . and we may subsequently be faced with considerable surprises." She therefore came to the conclusion that "adolescent patients can, in fact, rarely fulfil the basic requirements of psychoanalytic treatment for any length of time" (3).

We would even go further. We are convinced that it is a mistake to plague adolescents with probing questions. This is often done because therapists feel insecure unless they can glimpse signs of a psychodynamic background that seems plausible to them. The clinical condition of many adolescents can deteriorate dangerously if they cannot escape from the onslaught of tenacious inquiries. Indeed, we have found that a satisfactory relationship can often be achieved only by assuring the adolescents that we do not want to hear from them what they find difficult to divulge or regard as absolutely private.

The primary object of our form of psychotherapy is the same as Freud's: to attach the

patients to our treatment. We also use the same means to achieve this object. We do not only show interest in the patients, we also cultivate a feeling of concern for them as suffering human beings. The term "cultivate" is here used deliberately to indicate that we intentionally foster this feeling in ourselves even with patients who are so contrary, provocative and annoying that our concern is in danger of being swamped by punitive and riddance desires. Our constant awareness that we are dealing with unfortunate and tormented human beings, however disagreeable and irksome they may happen to be, has made it impossible for us to follow Freud's dictum that their suffering is a necessary precondition of successful psychotherapy. We freely use any means, including chemotherapy and electroshocks, to keep the patients' suffering within tolerable limits. We have not found that our treatment is thereby unfavourably affected. We remain concerned with our patients' symptoms and suffering even after the patients have become firmly attached to our treatment.

We plan our therapeutic strategy according to the disease we have diagnosed and the symptoms we have chosen for primary attention. The clinical manifestations which have proved themselves most amenable to prokaletic measures are conversion-hysterical symptoms, therapeutic resistances, and certain non-genital auto-erotic gratifications such as thumb-sucking (in adolescents), overbreathing, some forms of self-poisoning, skin-incision, hair-tearing (trichotillomania), and the like. Occasionally we also score some success in obsessional patients in whom it has been possible to foster a socially acceptable compulsion as a counter-measure against time-wasting symptoms. The effectiveness of our prokaletic procedures is simply measured by their influence on the chosen target symptom. If we cannot abolish or markedly improve the target symptom, we admit failure. We do not presume to know, or to affect, the underlying morbid condition responsible for the target symptom.

A prokaletic interpretation of a symptom is given with the express intention of arousing in a patient such an emotional response as will counteract the symptom. This can be achieved by an interpretation that attaches unacceptable ideas and emotions to the target symptom. The first reaction of a patient is usually a rejection of the interpretation rather than of the symptom. He may hotly affirm that the interpretation is nonsensical or obviously false. The therapist must, of course, avoid the trap of arguing the point. This would ensure the rejection of the interpretation. Instead, the patient's emotional reaction is presented to him as proof of the truth of the interpretation. Why should he otherwise become so upset?

It is, of course, not easy for a patient to eliminate a psychogenic symptom that has become a deeply embedded habit. If the elimination of the symptom is difficult, a prokaletic interpretation can only achieve a therapeutic result after a preliminary emotional upheaval, a "working through", that has to be endured by both patient and therapist, and may even have to be rekindled by occasional repetitions, in an abbreviated form, of the challenging interpretation. Because of the emotional upheaval which is intentionally kindled, some words of caution are indicated. The manipulation of the patients' emotions must be kept within manageable bounds. Prokaletic procedures are therefore contra-indicated with severely melancholic patients. The term "melancholic" is here used advisedly to indicate an affective *illness*, and not merely an emotional *symptom*. Patients with depressive symptoms can be prokaletically manipulated with impunity, but with severely melancholic patients there is the risk of aggravated guilt feelings and dangerously increased suicidal urges. Severely melancholic patients need electroshock treatment and antidepressant medication before challenging remarks can be addressed to them.

It must be emphasized that prokaletic measures are not short cuts which can drastically reduce the time spent on patients. A prime requirement on the part of the psychotherapist is patience. In the first place, he must wait until a positive attachment of the patient to the treatment as such and to himself as a person has been established. A particular target symptom is then selected and a preliminary decision made about the most promising prokaletic procedure. The next step is to gain some impression of the patient's emotional

susceptibility to the procedure intended. The initial prokaletic moves are therefore aimed at a reconnaisance of the patient's likely reaction. Only when this has been done, is a deliberately disturbing prokaletic move made.

Care is needed on the part of the therapist to adopt an attitude of sympathy and concern when making emotional challenges. An effort should be made to present a facial expression of serious thoughtfulness. Smiles, even when they are meant to be reassuring, are out of the question at first, though they may be used later, when challenging remarks are repeated. They tend to augment the prokaletic influence. We have made it a custom to preface challenging remarks with the words: "I am afraid that . . ." or some similar phrase.

Mildly challenging procedures can be used with out-patients, provided a positive attachment of the patients exists. Most patients, however, who require seriously challenging manipulations are so handicapped by their symptoms or so difficult to manage that in-patient psychotherapy is unavoidable. As our prokaletic measures are merely palliative procedures aimed at particular target symptoms, but not at the underlying morbid condition, circumspection is imperative. It has been found that therapists who are not theoretically so hidebound that their empathy with patients is side-tracked quickly learn to apply prokaletic procedures with safety. The use of these procedures has become so commonplace on my Unit that there is hardly a patient who is not subjected to an occasional emotional challenge. The resulting emotional reactions have not posed excessive problems to the nursing staff. There has been no increased incidence of patients absenting themselves from our open wards. The number of deaths through suicide has been negligible. Among 500 patients treated on my Unit of 17 beds during the last ten years there have been only two deaths through suicide. One occurred in a melancholic patient who disappeared from the ward and took her life before there had been time to start adequate treatment and before any prokaletic measures had been considered. The other suicide was that of a patient who is described more fully in the first case report of the Appendix and occurred a month after the patient had discharged herself from hospital. In evaluating this incidence of suicides one must take into account the fact that our patients are highly selected and are often admitted because they have made repeated suicidal attempts.

What then are the prokaletic procedures that can be used? The answer cannot be decided *ex cathedra*. It lies in a patient's emotional reactivity rather than in the content of any communication by the therapist. It is true that there are certain procedures that have proved to be generally effective, but they are culture-dependent and could therefore lose their power through cultural changes or too much publicity.

To make prokaletic measures therapeutically effective, they must, of course, be linked to the target symptom. In psychoanalytic technique, this is done by presenting the prokaletic measure as an interpretation of the unconscious origin of the target symptom. Interpretations in terms of perverted sexual urges derived from unconscious genital or pre-genital instincts are among the most powerful challenges. This was indeed one of the discoveries of Freud on which he based his original psychoanalytic technique. Interpretations in terms of aggressive instincts have proved far less successful. In fact, such interpretations tend to sanction an overt display of aggression which can be as undesirable and potentially harmful to a patient as similar sanctions in the field of sex.

Sexual interpretations are, of course, not the only prokaletic measures which can make the interpreted symptoms unpalatable and objectionable to the patients. Many prokaletic procedures are non-sexual in content and yet highly effective. Common among them are a therapist's admission, or prediction, of therapeutic failure.

*Admission of therapeutic failure* is often used when patient and therapist have been feeling dissatisfied for some time with the progress of treatment. It is often surprising to see the effect on a patient of the therapist's regretful and resigned statement: "I am afraid my treatment has failed", or "I am afraid you have been unable to respond to my treatment". Before the

statement, the patient may have been engaged in a pessimistic recital of complaint after complaint. The therapist's statement halts this recital and turns the patient into an optimist who tries to comfort his doctor by a hopeful enumeration of all sorts of signs of improvement. A more powerful variant of this prokaletic procedure is the announcement that treatment may have to come to an end since it has not been successful. We have even gone so far as to actually interrupt treatment for a definite period of time. The announcement of the possible end of treatment is a device that has been modelled on a suggestion by Freud. He said about it: "I have employed the method of fixing a date for the termination of analysis . . . and I have also inquired about the experience of other analysts in this respect. There can be only one verdict about the value of this blackmailing device (*sic*). The measure is effective, provided that one hits the right time at which to employ it" (4). However, we differ from Freud in that his announcement was inflexible and ultimate, whereas ours is made dependent on a continuing lack of improvement. It challenges the patient to show progress—or else.

Moreover, we often intensify a patient's attachment to the treatment as such by using drugs in association with the therapeutic interviews, which enable anxious patients to talk more easily. For this purpose, we give, at the beginning of one or, at most, two sessions per week, an intravenous injection of diazepam (Valium) usually 5 mg., sometimes 10 mg.; or of methylamphetamine hydrochloride (Methedrine) usually 5 mg., sometimes 10 mg. We have been careful to exclude from this drug-assisted psychotherapy patients who, in the past, have shown tendencies to become addicted to cigarettes, alcohol or drugs. On the whole, it seems that the anxiety-dominated patients whom we regard as suitable candidates for drug-assisted psychotherapy are not prone to become addicted to the drugs that are customarily prescribed for them, with perhaps the sole exception of barbiturates. It is often surprising to see how these patients, after discovering the beneficial effect of alcohol on their phobias, yet anxiously fight shy of using it for this purpose.

The intravenous injections of diazepam or methylamphetamine attach the patient to the treatment situation rather than to the personality of the therapist. This makes it easier for him to overcome the periodic change of therapist which is often unavoidable at teaching hospitals. The patients are not attached to the drug injections *per se*, but insist on having the attention of their therapist in the subsequent treatment session. There is thus no gain of time here. On the contrary, we have had to continue this form of treatment for years until the patients eventually matured enough to free themselves from therapy-dependence. When drug-assisted treatment does not progress satisfactorily, particularly when patients fail to improve enough after several months and cannot maintain themselves in employment outside the hospital, they are prokaletically informed of our fear that treatment has failed and will have to be terminated. This often has the desired therapeutic result. When this cannot be achieved by the patient, treatment has indeed failed and is brought to an end, at least for the time being.

Drug-assisted therapy is often used in patients whose symptoms constitute auto-erotic gratifications of a perverted and non-genital kind. In this category fall many of those difficult patients who inflict skin wounds on themselves by cutting or burning, or who frequently take overdoses of drugs in suicidal bids of the risk-taking variety to which Stengel (5) has drawn attention. These patients sometimes respond, even without drug assistance, to the prokaletic information that their symptoms can be viewed as perverted forms of masturbation. This is often readily accepted as plausible because the patients are consciously aware of the tension-reducing and gratifying consequences of their self-damaging behaviour. The challenge may therefore have to be stepped up after a time by reference to the pregenital components in their symptoms. Those who continue to take overdoses may have to be given interpretations of oral intercourse and of the semen significance of the swallowed tablets. Even then, prokaletic interpretations by themselves often prove in-

effective in the long run so that drug-assisted psychotherapy becomes necessary, combined with the eventual challenge of therapeutic failure.

*Predictions of therapeutic failure* are particularly applicable, when patients request a special form of treatment which we regard as either innocuous or doubtfully effective. The announcement, "I am afraid this treatment will not help you" usually elicits a strong and beneficial desire in patients to prove us wrong. If they succeed, we readily admit having been wrong. Common are also prokaletic predictions of failure on the patient's part. They are especially called for when it is desired to prevent a patient from producing a symptom that habitually occurs in a particular situation. They may then be called "prophylactic predictions". A typical example is the remark: "I am afraid you will have a blackout again (or heated argument or panic attack, etc.), when you meet your friend (or go home or return to work, etc.)." Prophylactic predictions have proved very successful when it has been possible to couple them with casting doubt on an attribute or aptitude of which the patient was justifiably proud. For example, an intelligent, gifted and ambitious student, who was scared to return to university after a depressive illness from which she had only partially recovered, was told: "I am afraid you will never return to university, as you are not up to the work there." A week later, she was back at her university working as hard as she could. Since then, whenever she has passed an examination, she has come to tell me the good news and receive my congratulations, to which I always added the, to her, gratifying rider: "I had not expected it." She is still in psychotherapy as an outpatient, but her professional future seems assured.

Our prokaletic procedures have sometimes been criticized by colleagues as dishonest because they withhold from patients the truth. We do not think that there is much, if any, substance in this accusation. However, i. is a challenge to which we are obliged to rise as inevitably as our patients.

As far as prokaletic interpretations go, we largely follow psychoanalytic precept. Yet we have to admit that we do not share the conviction of some faithful psychoanalysts that their own particular school of psychoanalytic thought embodies some ultimate truths. In our opinion, psychoanalytic theories rely on intuitive insights into the minds and motives of other human beings, insights which, as Karl Jaspers (6) has convincingly argued, can be neither true nor false in any objective sense. They are merely intuitively plausible. What is even more ruinous to any claim to their truth is that contradictory insights can be made equally plausible. That is why Freud had to assume that contradictions exist side by side in the unconscious mind. Modern logicians could have told him that, starting with contradictory premises, there is no theorem that cannot be proved true or false, according to requirements.

But Jaspers is an *Existenzphilosoph* with transrational tendencies. His pronouncements on science and scientific truth might be regarded as suspect. Let us therefore quote a philosopher of science. Karl Popper (7) has defined scientific theories as those which can be refuted by empirical evidence. As long as a theory can thus be shown to be false, it has a claim to scientific status and may be accepted as presenting at least an approximation to factual truth. On the other hand, theories which are all-explanatory and cannot therefore be refuted by empirical evidence have no scientific status. Yet they may still contain some truth. In Popper's own words: "If a theory is found to be non-scientific, or 'metaphysical' (as we might say), it is not thereby found to be unimportant, or insignificant, or 'meaningless' or 'nonsensical'." When considering the theories of Freud and Adler, he has this to say: 'There [is] no conceivable human behaviour which could contradict them. This does not mean that Freud and Adler were not seeing things correctly: I personally do not doubt that much of what they say is of considerable importance, and may well play its part one day in a psychological science which is testable." We like to associate ourselves with this view, and suggest that we have no means today of deciding what the true elements in psychoanalytic theories are. We cannot therefore know whether the interpretations we

convey to our patients are true or not. Yet, in our opinion, they have a pragmatic value that depends on their prokaletic power and the therapeutic reactions they can evoke. It would be rash to squander this value for this or that theoretical reason. The charge that we do not tell our patients the truth cannot be levelled at all at our prokaletic admissions of therapeutic failure. Such admissions state a truth that is not only a plausible intuitive insight, but is supported by objective evidence, however regrettable that evidence is in view of our therapeutic efforts.

As far as our prokaletic predictions of therapeutic failure are concerned, it would be rather pretentious to say that we know the truth of future events, but are dishonest enough not to reveal it to our patients. We certainly do not claim prophetic insight. Intuitive insight into other people's minds and motives is quite enough to claim. When it comes to the truth of future events, we cannot pretend to know it; we only claim to *believe* that one truth is more likely than another one. However, like most gamblers on future events, we have learned the truth—a known, certain, and objective truth this time—that our beliefs in the most likely truth of future events cannot be relied upon. It seems to us that honesty demands the admission that our prognostic beliefs in the most likely outcome of clinical manifestations have quite often been disappointed. We have therefore no scruples in disregarding our unreliable beliefs in the most likely truth of future events, when therapeutic considerations require it. For therapeutic reasons, we deliberately adopt a prokaletic Jeremiah attitude, even when we happen to hold more or less sanguine beliefs or convictions.

Such deviations from a believed prognosis have been the stand-by of doctors throughout the ages. Their deviations were, however, usually complementary to ours. We deviate from a belief in a favourable prognosis by expressing a gloomy opinion. It is the more usual medical practice to deviate from a gloomy prognosis by expressing a favourable opinion. The general aim of doctors is to reassure their patients, ours is to challenge them to prove us wrong. If reassurance had been successful, the patients would never have come to us. Even laymen know how to apply reassurance.

We intend our prokaletic predictions to have a self-falsifying effect. In this sense, they are comparable to predictions publicized and believed in a community at large. Such widely believed predictions have what Karl Popper (8) called an "Oedipus effect" of a positive or negative kind. I have suggested elsewhere (9) that such predictions should be called "self-verifying and self-falsifying beliefs". In the Oedipus saga, the prediction of the Delphic oracle led to a belief that was self-verifying in that it initiated a series of actions which led to the predicted events. As an example of a self-falsifying belief we may quote widely believed predictions that the Wall Street crash of 1929 will be repeated because a similar wave of excessive stock exchange speculation has occurred. These widely believed predictions have so far been self-falsifying because they have called forth strong counter-measures. Popper has argued that, on account of the general validity of the Oedipus effect, a plausibly argued and widely believed dynamic analysis of a past historical situation is a poor guide to the outcome of a similar situation at a later time, because the belief that history will repeat itself sets into motion social processes which support the self-verification of the belief in the case of a favourable outcome and its self-falsification in the case of an unfavourable one.

In the dyadic society consisting only of a therapist and a patient similar processes are active. The same is true, of course, of the slightly larger societies of therapeutic groups. The interpretation of the psychogenesis of a symptom is analogous to the dynamic analysis of a past historical situation. The only difference is that the interpretation implies a belief that history has already repeated itself. Freud's original intention in interpreting transference manifestations of therapeutic resistance had been to achieve a self-verifying effect in the sense that the patients would confirm the interpretation by the recall of relevant, but previously repressed, memories. This, he hoped, would lead to a self-falsification of the interpretation in the sense that the interpreted manifestation would vanish and thus demonstrate that history

no longer repeats itself. However, he found that there was often no self-falsification in that sense, and that any self-verification that occurred was only partial, in that the patient did not confirm the interpretation by a recall of relevant memories but only by acting them out in an emotionally disturbing manner.

In passing it may be mentioned that any psychiatrist who finds himself threatened with a physical attack by a patient should avoid prokaletic remarks with a self-falsifying impact. To tell such a patient: "You would not dare attack me", might be famous last words. A preferable alternative is to accept the patient's aggressive emotions but to think aloud, mentioning some unconscious possibilities that might explain them. The aim is to cause such self-reflection in the patient that his "native hue of resolution is sicklied o'er with the pale cast of thought".

It must be stressed that our therapeutic interference is, of course, never exclusively prokaletic. Indeed, challenging interpretations, as well as challenging admissions or predictions of failure, are only sparingly given. For the most part we use what may be called "guiding interpretations" which have the purpose of directing the patients' attention towards a particular field of self-exploration. The information thus obtained supplies useful material for our intuitive understanding of the symptoms and therapeutic reactions exhibited by our patients, and for the later application of prokaletic measures. Reassuring procedures, chemotherapy and electroshocks are not neglected either and are employed, particularly during difficult periods of emotional upheaval. Whenever a patient has succeeded in overcoming an interpreted symptom or therapeutic resistance, we briefly express our appreciation of his achievement. For the patients, the greatest praise lies in our admissions of having been wrong in believing that their symptoms and therapeutic resistances would prove too obstinate for their determined opposition to our gloomy prognostications.

Experienced psychotherapists will not find it difficult to make use of prokaletic measures of a suitable kind at suitable times. Yet, to amplify this report, three brief case-histories are appended. To eliminate, as far as possible, bias and memory distortions in their presentation, only such information was used as had been recorded at the time by the registrars who carried out the actual psychotherapy.

## Summary

Freud's psychoanalytic technique takes as its main target transference manifestations which resist the progress of treatment. By interpreting the unconscious, and therefore shocking, psychogenesis of these manifestations, the patients are challenged to counteract them as much as possible. The term "prokaletic" has been introduced as a synonym of the term "challenging".

Using Freud's psychoanalytic technique as a model, prokaletic measures have been elaborated. They have proved successful especially with conversion-hysterical symptoms, therapeutic resistances, certain self-indulgent practices, and some obsessional symptoms. Caution is needed with severely depressed patients, who may respond with aggravated guilt feelings and increased suicidal urges. The main prokaletic measures are challenging interpretations, and admissions and predictions of therapeutic failure. Guiding interpretations, reassurance and appreciative remarks are also employed and are if necessary combined with chemotherapy and electroshock treatment.

## Appendix

*Patient A.* A girl who had suffered from strong sexual fears since puberty developed recurrent tensions, depressive preoccupations, obsessional anxieties and histrionic emotional outbursts at the age of 22. Three months later, she made two suicidal attempts by swallowing aspirin tablets. This led to her first admission to the Maudsley Hospital under another consultant. She improved quickly and was fit for discharge a fortnight later. There followed a period of out-patient psychotherapy which was supervised by an orthodox Freudian analyst. Seven months after her discharge, she tried to gas herself; she was then put on anti-depressant medication. Four months later, drug-assisted psychotherapy with intravenous sodium amytal was begun. After her second injection, she had a disturbing histrionic outburst and had to be re-admitted to hospital. Again she improved quickly and was discharged after a month. She returned to her secretarial job, and continued her out-patient psychotherapy for almost three years. Then there was an incident in which she burned her left hand with a cigarette, and six months later she made another suicidal attempt by taking an overdose of sodium amytal. It was not a determined attempt

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(neither were her previous ones), but it led to my being asked to admit the patient to my Unit.

Psychotherapy and anti-depressant medication were started, but were without effect. The patient remained very tense and depressed. A course of twelve electroshocks caused no definite improvement either. In the following two months, she injured herself four times by cutting or burning. Eventually, she was given the prokaletic interpretation that we were afraid that her self-injuries were a form of perverted masturbation in which she acted out a fantasy of defloration. There were no further self-injuries in the subsequent six weeks. Then she had to change her therapist, and the next two months saw six episodes of self-injury. Our next prokaletic move was to tell her that we were afraid our treatment was a failure, as evidenced by her self-injuries, and that we might be forced to discontinue it. In the following three months, she burned her hand on only one occasion, though on another occasion enjoyed a vicarious form of self-injury by successfully encouraging another patient to cut herself. However, she improved enough to return to outside employment and she was discharged eleven months after her admission.

Two months later, however, there was a relapse. She had to stop work and asked for re-admission. The first four weeks in hospital were relatively uneventful, though she bought razor blades on several occasions and complained of a continual urge to cut herself. Prokaletic interpretations of the masturbatory significance of this urge seems to have kept it in check. Then the patient hit on a ruse that defeated us. She told us of a new urge: she wanted to pour petrol over herself and set herself alight. The newspapers were full of such reports at the time and we feared their suggestive influence on the patient. We took an unusual step and decided on a bargain. She had to give us a promise in writing that she would not attempt to set fire to herself. In return, we sanctioned her attempts to obtain relief of tension by cutting herself. However, we also decided to give her drug-assisted psychotherapy twice weekly with intravenous methedrine.

There followed an orgy of ten incidents of slashing in the next seven weeks. We then challenged her by admitting therapeutic failure and considering the termination of the methedrine injections. This was effective. There was one last episode of slashing the day after our challenge, but that was all. She did her best to co-operate, found herself a secretarial job, and even asked to have her scars removed by plastic surgery, as she felt certain she would never cut herself again. Unfortunately, her recurrent tension states interfered with her employment. She could only keep her jobs for short periods. We therefore resolved, four months later, on another prokaletic move. We expressed our doubts about the efficacy of her methedrine injections in view of her inability to remain in constant employment. Eventually, we did in fact stop the injections. This led to a very challenging manoeuvre by the patient. She showed the Ward Sister a syringe and an empty methedrine ampoule and claimed to have injected herself. Unfortunately, we succumbed to this challenge. We had always feared the spectre of a patient becoming addicted to methedrine injections after having been initiated by us, and we decided not to give the patient any more methedrine injections. The patient seemed to accept this, but her clinical condition deteriorated so that another course of electroshocks became unavoidable. A few weeks later, she discharged herself, and as she could no longer support herself in London, she returned to her parents in the provinces. We were against this move, as we feared that conditions in the parental home might prove detrimental. We arranged to continue seeing the patient once a fortnight. However, after a month at home, she committed suicide by self-poisoning. In retrospect, we feel that we might have kept the patient in treatment, and alive, had we continued her drug-assisted psychotherapy.

*Patient B.* A girl of 21 with an adolescent mood disorder and a hysterical gait disturbance. Her father was a heavy drinker and there was much parental disharmony. On one occasion, the parents had separated. Mother and children had lived with another man for a while. At 13, the patient became very critical of what she regarded as her parents' lax morals. She became devoutly religious, and has since devoted most of her spare time to religious activities mainly of a social kind. She set a high moral standard for herself, and did her best to suppress sexual feelings. She has no memory of ever having masturbated. Her inclinations are heterosexual, but she has never indulged in any intimacies. Before her illness, she was a good-looking, intelligent, cheerful, and sociable girl. At 18, she became friendly with an older man, and left the parental home to be more independent. However, she soon terminated the friendship, ostensibly because her friend belonged to a different religion which made marriage unthinkable to her.

Soon afterwards, she developed blackouts. They occurred, for the most part, in the church which her former male friend continued to attend. During the next three years, several neurological investigations were carried out which were all negative. Then her mother fell ill and had to have an operation. Three weeks later, after another blackout in church, she found herself unable to walk. This lasted five days and was followed by a hysterical gait and a depressive mood disorder, which led to her admission to my Unit. On her arrival, she was depressed, tense, and morose. She could walk, but her gait caricatured that of a drunkard who staggers wildly from side to side.

We regarded it as our first therapeutic task to alleviate her depressive tension with antidepressants and mild tranquillizers. At the same time, we built up in her a positive attitude to her doctor. After about three weeks, we decided that the time had come to interfere with her hysterical symptoms. We planned to give her the mildly challenging interpretation that her gait indicated she had unconsciously identified herself with her father in one of his drunken bouts. However, the patient anticipated us. In the next session, she talked at length about her father and mentioned categorically that she had never seen him drunk. Her doctor felt that, in these circumstances, there was no sense in giving the intended interpretation. A week later, we tried a different tack. This time, she was told that

her hysterical gait indicated an unconscious identification with her mother. It symbolized her mother's vacillation between husband and lover. The patient blandly replied: "I cannot see any connection. I am not a bit like my mother." She was not at all emotionally stirred by the interpretation. It had failed as a challenge. However, it served as a guiding interpretation as it elicited from her a description of guilt feelings for having felt so critical of her mother and so antagonistic to her.

We waited a fortnight before we attempted another prokaletic interpretation. The patient was then told that she derived sexual pleasure from her stagger which announced to all the world the unconscious meaning that she was ready to fall for a man. This time, the challenge worked. She was angry. It was nonsense to think that about her gait. At the end of the session, on leaving the room, she had a blackout. Next morning, she complained that her legs felt so heavy that she could hardly get out of bed. She was irritable and her gait very bad. A week later, the interpretation was repeated and combined with a prophylactic prediction. She was told: "I am afraid you cannot lose your staggering gait because there is some sexual satisfaction in it for you." There was the same angry rejection again.

We decided to make subsequent interviews less stressful for her by giving her an intravenous injection of 5 mg. of methedrine at the beginning of every second of the bi-weekly interviews she had. Once or twice, we also tried 5 mg. of intravenous Valium (diazepam), but this proved less effective with her. During the first methedrine interview, she mentioned little of relevance. The next day, she asked for a special interview to tell her doctor that she had not liked the injection and had felt angry that he should feel she was enjoying her symptoms. At the same time, she showed the first inkling of wishing to rid herself of a hysterical symptom. However, it was not the gait disturbance that we had selected as our target, but her blackout attacks. She confided to her doctor that, during those attacks, she often has the feeling of putting it all on. The doctor's response was that he was afraid she also derived sexual satisfaction from her blackout attacks and would find it hard to get rid of them. This time, her reaction was less angry and more tearful. A week later, she asked: "Do you mean by sexual satisfaction a desire for love and affection?" She had always felt that her family had little affection for her. At one time, she had had a strong desire to have a baby to whom she could give all her affection. She even developed a habit of looking into every pram. But she realized that she could not possibly have an illegitimate child. "It would have killed my mother." She had no further blackouts.

A week later, i.e. about 10 weeks after her admission, she woke up and found to her delight that she could walk without a stagger. It was like a miracle, and she attributed it to her having been able to confide in Christ the night before. We agreed with her, as we had no desire to claim any credit or to undermine her strong religious faith. However, our concurrence acted on her as a challenge. She read into it a threat that her treatment would soon come to an end. When she was reassured on this point, she wanted to know why she had been told her cure was due to her religious faith. Without our treatment, there would have been no cure. Her doctor declined an argument, but told her it was far too early to speak of a cure. She agreed. Her gait still felt peculiar; it was like walking on foam rubber. However, she was optimistic and was already looking for a job.

She remained elated for a few more days. Then her depression returned with a vengeance. She felt miserable, especially in the morning. We stepped up her anti-depressant medication and stopped her methedrine injections. There was no improvement. After a fortnight, she begged us to give her electroshock treatment. We agreed, but combined it with a prediction of therapeutic failure, saying that we were doubtful about the effect of electroshocks on her. She had three treatments. After each, her staggering gait returned for a few hours. This decided us to discontinue electroshocks, a decision that turned out to have been wrong.

It was now four months after her admission. The electroshocks had produced some improvement of mood, enough for the patient to find herself a job. We resumed her methedrine injections and avoided disturbing challenges. She stayed at work for two months. At first, she enjoyed it, but she was not eating properly and was tired in the evening. Then she developed panic attacks, and eventually her morning depression was so bad that she could no longer carry on with her job.

At that time, her doctor's six-monthly allocation to my Unit came to an end and he had to hand over the patient's treatment to his successor. The patient's depression was deepened by this change of doctor. She appealed to the doctor who had been treating her so far to continue seeing her psychotherapeutically. He agreed, but, as usual, predicted a possible therapeutic failure. He also applied our modification of Freud's blackmailing device by telling her that, if there was no therapeutic progress, it would show that there was no special advantage in his continuing to treat her and he would have to hand her over to a new doctor. The patient was confident that she would improve, but asked for another course of electroshock treatment. This was given. She again had short-lasting returns of her gait disturbance after each shock, but we carried on this time and gave her twelve treatments. The result was fairly good. Her mood picked up, especially in the evenings, her eating improved, and she formed a friendly relationship with a man attending her church. At that point, her periods became abnormally frequent. She was concerned, and asked for a gynaecological investigation by a specialist. We did not think this justified and gave her a prokaletic transference interpretation that we were afraid she had developed erotic feelings for her doctor and that these were responsible for her desire to be genitally manipulated by a doctor. She withdrew her request for a gynaecological investigation, saying she did not want to lose her virginity in this way. However, she began to inflict superficial incisions on her arms and wrists. This reaction was removed by the prokaletic interpretation that the incisions provided her with sexual pleasure and indicated her desire for defloration.

Our next plan was to give her some guiding interpretations of a sexual kind in order to encourage her to speak more freely about her sexual feelings and fantasies. Her doctor's countertransference caused a slight holdup here, but he soon succeeded in conveying the desired guiding interpretations. The patient responded by a greater readiness to discuss sex. Her menstrual rhythm also righted itself. However, when sexual feelings were actually aroused in her relations with her man friend, she still panicked and kept him at arm's length. She needed some reassurance at that point and we told her that we fully understood how difficult it was for a healthy young woman like her to bring her normal sexual impulses under the control of abnormally strict moral principles.

She was able to leave the hospital after about twelve months and is continuing her drug-assisted psychotherapy as an out-patient. Once she is securely settled in the community again, we plan to reduce the excessive strictness of her superego gradually by prokaletic interpretations of the Oedipal fantasies and fears responsible for it.*

*Patient C.* A girl of 16 with a severe obsessional neurosis. She had been a thumb-sucker all her life and had responded with severe temper outbursts to the birth of her only sibling, a brother. Her obsessional symptoms began with her menarche at 14. She had to pass her tongue across her teeth, searching for painful spots. During the summer before her admission, she had spent a holiday with her father in Germany, while her mother had taken the brother to the seaside in England. In Germany, the compulsions had become so bad that she had to return to England prematurely. On returning to school, she found it impossible to concentrate on anything but her compulsive tooth-searching. Until then, she had had an excellent school record, shining particularly in linguistic subjects and music. Now she was so distraught at school that she could not pay attention to her lessons. Eventually, she refused further attendance at school. Her whole day at home was occupied with compulsive rituals which were interspersed with periods of thumb-sucking and destructive temper outbursts. She tyrannized the whole family. Any attempt to influence her elicited screams, aggression, and suicidal threats. A psychiatrist suspected schizophrenia and recommended hospital admission.

At first, she could only be kept in hospital with the help of fairly large amounts of tranquillizers and antidepressants. However, she quickly settled in and became popular among the younger patients on the ward. She formed a positive transference to her doctor in a very short time (and also to all the other doctors who have since treated her). She was an easy conversationalist and talked with obvious relish, but quite impersonally, about any subject, including her family and sex. Her symptoms soon improved. After three months, she only carried out rituals lasting about half an hour before going to bed.

However, she obstinately refused to return to school. She was therefore given her first challenge: that she enjoyed being in hospital, that she derived some satisfaction from her neurosis, and that she did not want to get better. The patient could not intellectualize this prokaletic communication in the same way as she had done with guiding interpretations before, but felt hurt. She agreed to take a violin examination, but, soon after she had passed this, her clinical condition deteriorated. She isolated herself in the ward and sat about openly sucking her thumb. Her rituals now became rather complicated and took up several hours in the morning and at night.

We decided on an attempt to reduce her self-indulgent and ostentatious thumb-sucking by the prokaletic interpretation that her thumb had to her the unconscious meaning of a penis. Her immediate response to the interpretation was quite unexpected. She said that a girl in the ward had given her the same interpretation the night before, but she had not believed it. Neither did she believe us; it was only one of our challenges. (The patients did, of course, know about our challenging interpretations and we had no reason ever to deny them. The patients' knowledge did not prevent them from reacting as we had intended them to do.) Her doctor admitted that he had chosen this interpretation as a challenge, but he believed it to be true none the less.

The result was that she avoided thumb-sucking during the day and in full view of others. A week later, she remarked spontaneously: "I keep thinking of what you said about sucking my thumb, but I cannot say any more." She sometimes resumed thumb-sucking in later sessions, when she wished to annoy her doctor. However, on those occasions, he merely nodded his approval and indicated that we did not want to deprive her of all her sexual pleasures.

In the weeks that followed she was encouraged to discuss her feelings for her parents, particularly her father with whom she had a very close relation and who was excessively concerned about her. Only guiding interpretations were given, which she usually discussed with intellectual zest. When she spent week-ends at home, prophylactic predictions were used that there would be scenes and temper outbursts. In consequence, her home visits were so peaceful that her father began to write us grateful letters from time to time.

After six months in hospital, she still showed no interest in any school subjects. A prokaletic admission of therapeutic failure was therefore made, and it was indicated that we were considering terminating her treatment in hospital. She was annoyed, sucked her thumb at the therapist and remarked that she had no intention of going back to school. Yet two days later, she went to see one of her teachers and it was arranged that she would be back at school in about a fortnight. However, there were still some hurdles to overcome. She developed a compulsive reading difficulty. Every sentence had to be looked at as a whole image, paying equal attention to the black letters and the white around them. Then she had to look at every word separately, including all punctuation marks. Finally, every passage had to be read several times. No wonder she did not return to school when the fortnight was up. Moreover, her behaviour in the hospital became

* The patient has since improved so much that she decided to terminate her psychotherapy.

extremely provocative and annoying. Yet her doctor was full of prokaletic understanding and sympathy. He understood that she did not want to get better. There was too much masturbatory pleasure in playing about with her rituals. She exploded: "I hate you. Oh I could say the nastiest things. You don't think I like being here in hospital, do you? But I will prove you wrong. I will go back to school."

Yet nothing happened in the next three weeks. Her behaviour remained as bad as before. Eventually she said: "You tricked me into saying I would go back to school." She was told that it was probably best if she did not return to school; she was not sufficiently intelligent to achieve the scholastic success to which she had aspired in the past; if she did return, she would only prove us right and end up as a failure. Ten days later she was back at school and three months later she was able to be discharged from hospital and go back home.

Ever since then, for more than four years, she has remained in out-patient psychotherapy. Her rituals have not disappeared, but they have remained restricted to the privacy of her bedroom and bathroom. Occasionally they have become worse and taken up too much time. She was then always given a reminder of our prokaletic prediction of scholastic failure, namely that her rituals only became worse because she did not want to admit that it was her inadequate intelligence that interfered with her studies. These challenges have always succeeded so far. Her intelligence and scholastic ability are her most prized possessions. Any doubt cast on them mobilizes all her energies to disprove it. She is now at university and has been very successful in examinations. Her antidepressant and tranquillizing medication had had to be continued throughout her treatment; she would be too tense and anxious without it.

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