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Psychodynamics and Psychotherapy on an Acute Psychiatric Ward
The Story of an Experimental Unit

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The treatment of severely disturbed patients is strengthened in an important way by listening closely to them and by attempting to understand their experience in the depth that is made possible by the use of psychoanalytic concepts. It follows that the practice of clinical psychiatry in the UK would be greatly improved by the introduction of a psychoanalytic and psychotherapeutic perspective into the acute ward. This paper reviews the work done on a ward at the Maudsley Hospital in which this approach was the practice.

The late Sir Denis Hill (1978) averred that an essential quality of a good psychiatrist is the habit of attending to the mind as well as the brain, and applying both neurobiological and psychoanalytic knowledge in every case. He drew attention to the long-existing gap between academic psychiatry and psychoanalysis. This gap is not confined to the UK. Hawkins (1979), reviewing psychiatric education in Western Europe, noted a long-standing and powerful anti-analytic and anti-dynamic core within academic psychiatry in several European countries, and traced its complex origins. He concluded that in many European centres there was a resurgence of interest in the psychodynamic viewpoint, although "the tendency for oversimplification and championing of one approach obstructs the development of departments in which faculties sufficiently expert and appropriately diverse are willing to work together". Others have taken up this theme, using such evocative titles as "Are psychiatric educators losing the mind?" (Reiser, 1988), and "The retreat from patients" (Kubie, 1971). Yorke (1988) has recently examined defects in the training of psychiatrists in the fundamentals of psychoanalysis. Freeman (1989) has commented on the unsatisfactory position of psychotherapy within general psychiatry: he points out that many psychoanalysts have little interest in psychiatry, a trend which impoverishes both disciplines, and suggests that since academic psychiatry is for the most part preoccupied with natural-science methodology and physical methods of treatment, the general practitioner and the public may be forced to turn away from the psychiatrist as a source of helpful understanding of personal illness and seek it elsewhere (Wilkinson, 1988; Croft-Jeffreys & Wilkinson, 1989). Nemiah (1989) has written with clarity about the limitations of phenomenology and neurobiology as guiding principles for the understanding of patients, and referred to the promise offered by seeking correlations between the psychodynamic standpoint and neurobiological observations.

Psychodynamic principles have nevertheless played some part in British psychiatry, largely because of the influence of the therapeutic-community movement (Main, 1946), and a psychodynamic approach is pursued in many acute psychiatric units. Such work tends to focus on the treatment of the individual in relation to the group and the community, and individual and group therapy techniques play an important part in many wards (Whiteley, 1972; Hinshelwood & Manning, 1979; Kennedy *et al*, 1987; Main, 1989). However, Hill's (1970) wish was to integrate perspectives that are too often opposed or polarised. As a first move he postulated that a different type of ward organisation would provide a helpful experience for patients and staff and a basis for integrated practice. To this end he appointed a consultant psychiatrist who was also a trained psychoanalyst to take charge of one part of his in-patient unit, hoping to explore the application of psychoanalytic ideas to a wide range of acute general psychiatric conditions. The aim of this paper is to record some aspects of the practice of this experimental unit for general psychiatric patients, run on psychodynamic principles in the Maudsley Hospital during the years 1975–1988.

Rationale

Some people with psychotic disorders think and talk in a way that seems illogical, bizarre and unintelligible, but their thought processes have a logic and consistency of a different order from normal thinking, an order with its own rules and grammar. This is the logic of a primitive form of functioning, more akin to dreaming, which Freud called 'primary process' thinking. Such regression to primitive ways of thinking may coexist with primitive ways of dealing

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with anxiety. A great deal has been said about these processes, described as splitting, introjection, projection and repetition–compulsion, which may be responsible for states of psychogenic incoherence, depersonalisation and derealisation, and feelings of loss of control of the self. When such a regressive mental state is present, in acute or chronic form, problems of management tend to arise, and a treatment plan aimed at 'normalising' the patient as rapidly as possible with the help of medication may run into difficulties if it is not accompanied by examination of the process of regression.

Psychoanalysts have studied the processes of early mental development and formulated models for thinking about the arrests and deformations of growth that restrict personality development and render the child vulnerable to breakdown in adult life. The writings of Donald Winnicott (1965), Margaret Mahler (Mahler *et al*, 1975) and Melanie Klein (see Segal, 1964; Spillius, 1988; Grotstein, 1981) are widely known. Most psychotherapists would agree with Winnicott in seeing regression in psychotic states as a return to the level of functioning reached at the time when things began to go seriously wrong because traumatic events or conditions resulted in privations and deprivations, causing normal psychological development to be arrested. Winnicott considered this process to be in the nature of an attempt to find a 'facilitating environment' which would provide for the patient that which had been missing in the first place, and allow psychological growth to be resumed.

Klein's work in particular has extended our understanding of psychotic states and of the early precursors of later vulnerability (Segal, 1981). Klein believed that conflict between destructive and constructive ('reparative') processes is an inescapable feature of all human existence, a conflict that is never entirely solved (Rey, 1986). For reasons of biological inheritance or traumatic early experience, or both, the potential psychotic may enter adolescence and adult life exposed to particular risks. Emotional attachment and the recognition of dependent needs may bring back the original conflicts, with catastrophic consequences for one's capacity to relate to the real world. Klein's model of the transition in the course of development from an immature ('paranoid–schizoid') to a more mature, realistic and responsible state of mind (the 'depressive position') has greatly influenced psychotherapists who are attempting to work with very seriously disturbed patients. It has also led to a more optimistic view about the psychotherapy of psychotic patients.

Regression and 'repetition-compulsion' can be seen as the response to the environment of the patient with disturbance in sense of reality and capacity for relating to the self and others (i.e. disturbed 'object relationships'). A supportive environment is one in which he or she is contained, understood and helped towards a better level of functioning. In the course of these interactions with the environment, the patient may re-enact various patterns of earlier relationships and expectations with respect to those who have become currently important. These 'transferences' may be detected in behaviour towards staff members as well as towards an individual psychotherapist, who become the target, or 'container' (Bion, 1967) of these 'projections'. Looked at in this way, much disturbed behaviour can be considered as the raw material on which the professionals have to work, material with important diagnostic, prognostic and therapeutic significance.

Disturbed behaviour in the patient may disturb the helper. Contact with a psychotic patient can upset any person of sensitivity, and this is especially so for the professionals, who may experience feelings of helplessness and frustration in their endeavours to understand and help. Sometimes the less obvious processes of transference exert the most disturbing effects. Experienced professionals will not feel personally gratified or affronted by loving and pleasing or abusive and hateful aspects of the psychotic patients' behaviour that are part of the illness, but their human feelings are inevitably aroused, sometimes painfully. To be treated as a devil, a criminal, an angel, a seducer, a bad parent or even as a part of the patient's own mind, and to be able to turn such a situation to the therapeutic advantage of the patient, requires skill and experience which can be helped by recourse to the concept of 'counter-transference'. Professionals' comprehension of the mental mechanisms involved, their capacity to tolerate uncertainty and to learn by experience will protect the patient from inappropriate responses and treatment procedures. It will also form the basis of therapeutic milieux where individual, group and family psychotherapy and behavioural methods can be employed in treatment plans suited to the individual patients' own particular needs and capacities. In such milieux, medication is regarded, at least in the first instance, as an often indispensable agent for reducing anxiety and thought disorder to a level where more rational 'secondary process' thinking can be sufficiently restored to allow contact and exploratory communication with the patients.

Without some basic knowledge of these fundamental processes and mechanisms the workers may be seriously handicapped in their attempts to understand the patient and create a therapeutic milieu. When making the attempt they may be

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confronted with further stress if their colleagues are unable to recognise and understand the nature of the methods employed.

The assumptions underlying in-patient care on the experimental unit can be summarised as follows.

(a) All patients, irrespective of diagnosis, stand to benefit from the best possible assessment, within which psychodynamic exploration in depth plays an essential part.
(b) All patients display patterns of behaviour which may be understood psychodynamically, to their advantage.
(c) All patients should be considered as possible candidates for individual psychotherapy until proved otherwise, whatever their diagnosis. Those who are not accessible will usually find an ongoing supportive relationship helpful, but with availability of therapists, very few patients would be found totally unsuitable for some form of dynamic psychological treatment.

Resources

A ward of 22 beds was assigned to the experimental unit and the associated unit, each unit having 10–12 patients. Bed occupancy over the years was 80–90%. There were usually 18 nurses assigned to cover two day shifts and one night shift seven days a week. Seven were trained (RMN) mental nurses, three were nursing assistants, six were mental nursing trainees and two were student nurses in general nursing training. When the ward was fully staffed the average nurse/patient ratio was 1:5, and the two units received approximately equal amounts of nurses' time. Each unit had several sessions of social worker time; a full-time occupational therapist shared by both units also had a considerable commitment in the main occupational therapy department. A clinical psychologist was attached to the associated unit (one-third time), often with an assistant psychologist. The experimental unit did not have its own psychologist, though we believe that a psychologist trainee in analytic psychotherapy would have greatly added to its strength.

When the patient was discharged the policy was to maintain contact throughout the transition to care in the community. For the first weeks after discharge patients often attended the ward on several days weekly: this facility for including day patients in groups and other ward activities proved invaluable and caused little difficulty in practice, although space was severely restricted.

The consultant (MJ) devoted approximately 20 hours weekly to his work on the unit. A senior registrar shared his/her time equally between the experimental unit, the associated unit and one other unit elsewhere in the hospital. Registrars from the Maudsley rotational training scheme were attached to the unit for six months. Supervision of patient groups was provided by members of the out-patient psychotherapy unit (two hours weekly).

Procedures

Selection procedures were the same for both units. The major source of referral was the Emergency Clinic, a 24-hour 'walk-in' clinic serving the whole of the London area. Forensic, drug-dependent and psychogeriatric patients were directed to specialised units, and all others came to the general-intake units, including these two. Most of these patients were in a first or subsequent acute psychotic episode. A smaller number (about a quarter) were specifically referred to the unit from outside. These patients, with psychotic, severe neurotic and personality disorders, had usually received extended periods of treatment elsewhere. For patients from the Emergency Clinic there was no specific selection procedure, but for the elective admissions a careful selection process was operated. This involved close study of past psychiatric notes, and an interview with each patient to decide whether benefit was likely to accrue from a psychotherapeutic approach. The attempt was made to clarify the patient's expectations and determine whether he/she could tolerate the dormitory accommodation and overcrowded living conditions while attending groups and occupational therapy and complying with the procedures involved in primary nursing. For patients with severe personality disorders it proved important to consider whether admission might precipitate a severe regressive process, with acting-out behaviour which could prove too much for the unit to manage. This assessment process was time-consuming and only undertaken when admission in the near future seemed possible. Consequently, many requests for assessment of apparently suitable patients had to be turned down because no vacancy was available. A small waiting list was maintained, patients being seen meantime as out-patients. Important family conflicts were usually disclosed in these cases, and demonstrated the importance of involving the family from the outset wherever possible (Davison, in preparation).

It was held that mental mechanisms characteristic of the psychotic patient would also play an important part in patients with severe personality disorders. Mixing such patients was in principle welcomed, and seen as potentially beneficial to both groups.

The goal was to suit the treatment procedures to the particular needs of the individual patient (Alanen *et al*, 1986) within a psychoanalytic perspective, and to plan a long-term programme. Early discharge was not a primary objective. The average length of stay increased over the years as staff became confident in the methods and convinced of the severe limitations of the 'quick turnover' style of care. In the later years the average length of stay was nine months, varying from a week to a year. A few patients with personality disorders stayed into a second year, and readmissions, though uncommon, were sometimes predictable, and often necessary and useful in the process of 'working through' crucial conflicts in personal relationships.

About 150 patients were treated over 13 years. ICD-9 diagnoses of the first 112 were schizophrenia (27 patients), other psychotic conditions (15), personality disorders (34), and miscellaneous, including anorexia nervosa, neurotic disorders, and hitherto unsuspected organic disorders (36).

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A research anthropologist, himself a psychotherapist, investigated the structure and function of the unit within the ward and the hospital over a two-year period. He explored the philosophical and socio-political implications of the approach of the unit, and the destabilising effects of attempts to integrate conventional and psychoanalytically-inspired treatment philosophies. He concluded that this attempt to overcome fundamental epistemological differences illuminates a prevailing crisis in psychiatry to which little attention is being paid (Williams, in preparation).

Psychotherapy resources were poor in comparison with those in some other countries, but generous in comparison with the average for the UK. Where formal individual psychotherapy was undertaken, it was usually carried out by successive psychiatric registrars in training. Their enthusiasm might compensate for their relative lack of experience, but their departure at the end of the six-month rotation period was disturbing for patient and staff alike. Application of the 'nursing process' (Ritter, 1989), with emphasis on the attachment of a primary nurse, allowed a style of nursing reminiscent of that practised at the Cassel Hospital (James, 1984), although the patient population and the psychiatry practised were different. The out-patient psychotherapy unit provided experienced supervisors for patient groups, and individual or group psychotherapy for selected patients after discharge from the unit. In later years the services of an experienced family therapist became available. This proved to be a valuable asset, and strengthened the view that early involvement with the family of the acute psychotic patient may be an important part of a treatment plan.

The first contact with whatever family members were available was usually made by the nursing staff. The psychiatrist interviewed family members whenever possible and obtained information necessary for the formal assessment of the case. Where more detailed or prolonged family involvement seemed appropriate, this was undertaken by the social worker. Social workers of experience and psychodynamic sophistication were particularly informative and gave much help to other members of the team.

At times the provision of nursing staff was sufficiently stable to allow the organising of pre- and post-discharge groups to smooth the passage of patients into the community. On discharge an individual nurse who had known the patient in hospital, but usually not the primary nurse, was assigned as a 'key worker', with the aim of maintaining regular contact for as long as proved necessary, and offering a safety net during crises, and a trustworthy 'listening ear', with the possibility of a brief re-admission to the ward on a 'guesting' basis if the nurse deemed it necessary. This service proved particularly valuable in the case of those who had proceeded to individual out-patient psychotherapy, since it supported the psychotherapist in his or her treatment of patients who might otherwise have been regarded as too difficult for psychotherapy. Some patients eventually received long-term psychoanalytic psychotherapy and a few (six in 13 years) were referred for formal psychoanalysis: of these, all but one did well.

Special attention was paid to the psychodynamic milieu by attempts to elucidate the nature and meaning of the tensions developing in relationships between patients and staff. The identification and clarification of such conflicts often threw new light on the difficulties that patients had for long been experiencing in their personal relationships: these difficulties had sometimes clearly played a part in the development of their illnesses. A large group, consisting of the whole community of patients and available staff, met at the beginning of each day, and small groups were held twice weekly. These small groups were conducted by doctors and nurses who were themselves supervised. The groups were relatively unstructured, dealing with immediate issues – such as why patients had needed admission, tensions in the ward, setting boundaries and limits – and sometimes dealing with such basic issues as loss, attachment, mistrust and rivalry. Each patient was assigned a primary nurse and two associate nurses: thus the unavoidable absences of particular nurses were manageable. A weekly staff group was conducted by an experienced psychotherapist from the out-patient psychotherapy unit. This was intended not to provide psychotherapy for the staff but to elucidate the psychodynamics of conflicts arising between staff members. It was often found that these conflicts had their roots in both the pathology of the patients and the staff members' personal attitudes and difficulties. This group often provided useful diagnostic information, and in addition reflected the pressures from external sources within the hospital itself and within the National Health Service during a period of conflict and frustration. The attempt to work in a new way, in many respects very different from conventional practice, caused many problems for the staff, but with the help of the staff group these could usually be resolved.

The function of the nurse was continuously re-defined, as were the objectives of treatment and the care plan, and Cawley's formulation of "levels of psychotherapy" was found helpful (Cawley, 1983). Supervision was organised to reduce the stress of responsibility and the impact of patient transferences. Conflicts of roles between nurses, doctors, males and females, occupational therapists and social workers were discussed openly and thus effectively reduced to manageable proportions. The nurses functioned primarily as reality-oriented figures, accepting patients in a non-judgemental manner, but always attempting to arouse their interest in the meaning of their behaviour and subjective experience and the relation of these to recent and past life, and thus to propose a view of their illnesses as problems of adaptation to life circumstances and not simply as unavoidable biological misfortunes. Although the nurses did not aim to be psychotherapists in any formal sense, their work was often effectively psychotherapeutic, and at times succeeded in enabling patients to assume some sense of responsibility for their condition and their future.

A new post was created for one senior nurse as a specialist in psychodynamic liaison throughout the joint hospitals, while another undertook an extensive revision of the Maudsley nursing handbook, adding a more psychodynamic perspective (Ritter, 1989). The traditional pattern of 'nurses care and doctors treat' no longer applied, and when things were going well there was an impressive sense of co-operation and enthusiasm, with participation by all members of the team. It became clear that it would

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be unreasonable to expect that nurses of high quality who might be attracted to such interesting work should be asked to persevere without properly organised support, on-going training and sensitive recognition of their stresses and responsibilities.

All the members of the team met in a weekly ward round, in which the consultant interviewed each patient at various stages of his or her time in the ward. Before such an interview, an hour was devoted to a detailed review of the essential data. The registrar presented the history, noting the circumstances which had led to admission, subsequent events, and the resulting assessment of the case. Then the nurses reported their observations and interactions with the patient, and the occupational therapist and the social worker followed suit. A composite picture of the patient emerged. As individual members of the staff became more experienced, their reports became more searching and reflective (see Freeman *et al*, 1958).

The consultant interviewed the patient for half to one hour, exploring current experience and its origins as fully and deeply as possible (Jackson, 1986). The aims of this interview were threefold: to explore the patient's psychopathology, to make him/her more accessible to the staff, and to allow the formulation or review of a treatment plan based on individual needs (Alanen *et al*, 1986). A nurse accompanied the patient back to the ward and then returned to report on further conversation with the patient. At this point the team members, together with a small number of selected visitors – often experienced professionals from overseas (who with the patient's agreement had utilised a one-way screen) – discussed the case for an hour, focusing on what the interview had revealed.

This exhaustive procedure sometimes had a temporarily disturbing effect on the patient, but the longer-term effect was never seen as harmful. Indeed, it was usually seen as helpful to the patient and staff, although not intended to be a psychotherapeutic session. The event was the focus of the psychoanalytic input from the unit and provided an important learning exercise for all concerned. It demonstrated mental mechanisms in action and brought life to theoretical concepts such as splitting, projection, transference and counter-transference. These concepts would then become understandable by direct experience and were shown to have useful practical significance.

The boundary between psychotherapeutic understanding and psychotherapy proper was often blurred because most registrars chose to see many of their patients for a formal weekly session in addition to the more informal daily contacts. Sometimes this indvidual psychotherapy was a continuation of the work of a predecessor, and sometimes registrars carried on with one or two patients after discharge, perhaps for a year or more. Thus the provision of psychotherapy was somewhat haphazard, and supervision by the senior registrar and consultant was rarely close. The most disturbed patients were of necessity being treated by the least experienced psychotherapists.

The experience of working on the ward inspired a textbook of nursing (Ritter, 1989), a PhD thesis in social anthropology (Williams, in preparation), and several papers (Jackson & Jacobson, 1983; Ritter, 1984, 1985, 1988; Jackson & Pines, 1986; Jackson *et al*, 1986; Jacobson *et al*, 1986; Jackson, 1986, 1989, 1991; Brown, 1988; Jackson & Tarnopolsky, 1990).

Some important considerations

A number of inter-related difficulties arose, all associated with the practice of dynamic psychotherapy in a ward for disturbed in-patients. There were difficulties in setting limits with patients showing disturbed transferences and behaviour. Conflicts were aroused among staff and within the patient group, especially relating to the 'special' patient selected for individual psychotherapy. The whole enterprise was sometimes idealised by staff and by other wards in the hospital, where the ward was often accused of elitism (see Kernberg, 1976; Menzies, 1988). The consultant who interviewed the patient and endeavoured to make some relevant explanatory comment did not have to live with disturbed patients all day, and sometimes became the target of secret resentment, often veiled by idealisation. It became clear that it was necessary to include a skilled conductor of the staff group, not directly involved with the ward. For long periods no such person was available and at such times stresses mounted among nurses. Periods of severe disturbance could generally be managed on the ward through intensive nursing and appropriate medication, but when these exceeded the available resources, the patient's treatment was disrupted by the need for transfer to the intensive care unit elsewhere in the hospital, where the patient necessarily moved into the care of another team. However, contact between the nurses on the two units was generally good enough for some sense of continuity to be preserved. When an out-patient already in psychotherapy was admitted during a breakdown, considerable efforts were made to allow the psychotherapy to continue. This arrangement created problems of its own where the 'outside' therapist was faced with the issue of establishing adequate communication with the nursing staff. Individual therapists and nurses varied in their ability to cope with this separated rather than integrated mode of care. When the registrar in daily contact undertook the individual psychotherapy of a patient, the issues of combining general clinical management activities with the psychotherapeutic role came to the fore. At times it was possible to separate management from psychotherapy, but usually the realities of daily work made it necessary for the registrar to undertake both activities.

As a result of these considerations, disappointments and failures were part of everyday life. Nevertheless, the enthusiasm and morale of the staff were high and rates of absence through sickness were low. Nurses valued their time on the ward, although the unavoidable movement of nurses within the hospital often prevented continuity. Maintaining a stable core of experienced nurses whom the patients could come to trust remained a problem. Absence of experienced psychotherapists was a handicap, counterbalanced to some extent by the enthusiasm and flexibility of the trainees.

Therapeutic outcomes

A correct scientific appraisal of therapeutic outcome would have called for detailed scrutiny of clinical features

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(including psychodynamic variables), therapeutic procedures and follow-up data for a consecutive series of patients, preferably with a control group. Such an enterprise would have required the concerted efforts of a multidisciplinary team appointed specifically to carry out blind studies using specially designed criteria and scales for measurement. We did not have the resources either for this or for examining results according to a simpler scheme. Even routine follow-up was difficult because there is an ethical problem: many ex-patients do not wish to talk in depth, or even at all, about intensely unhappy periods in their lives. Consequently, this paper does not attempt to provide hard data in the shape of indices of success or failure of the unit; much less does it offer a system for clinical audit. At this stage we can offer only impressionistic and qualitative conclusions.

It was usually possible to help the patient who had repeated schizoaffective breakdowns and had been maintained on long-term neuroleptic drugs. Often the circumstances of the first breakdown and the associated psychodynamics had not previously been investigated in detail. A comparable situation arose where chronically disturbed patients, often in middle age, had long histories of inadequately resourced psychiatric care. Serious attempts at psychotherapy were possible with a few manic–depressive patients who had had a long chronic and disabling illness, and in these encouraging results were achieved (Jackson, 1989). It was difficult to avoid the conclusion that given an effective containing milieu and the provision of sufficiently skilled psychoanalytic psychotherapy, a high proportion of psychotic patients could be helped towards stability.

A few case histories illustrate the range of problems and outcomes.

Case 1

A 26-year-old woman had been admitted for numerous psychotic episodes over ten years, becoming deluded, muddled and at times catatonic. Always diagnosed schizophrenic, she responded to conventional treatment but relapsed within weeks. Psychodynamic exploration revealed a profoundly disturbed relationship with her very intrusive mother, a severe problem of rivalry with a younger sibling, and a markedly passive and timid character. The treatment plan focused on family and individual psychotherapy within the ward-group milieu, where she spent two periods of six months. She gradually became able to recognise and tolerate some of her dreaded aggressive feelings; her relation with her mother improved strikingly; and after a further 12 months of weekly individual psychotherapy as an out-patient, she was discharged. She maintained personal contact with the ward staff for a further year. At follow-up five years later she was found to be symptom-free, without medication, with two children and a happy married life.

Case 2

A young woman doctor of high intelligence became incapacitated by a recurrent manic–depressive disorder soon after passing her final examinations. She spent five of the next six years in hospital, with frequent dangerous self-poisoning, and responded only briefly to medication (including lithium) and ECT. Eventually, leucotomy was considered, but psychotherapy was suggested as a last resort. She had a family history of manic–depressive disorder and a disturbed relationship with both parents and three younger siblings, dating from early childhood. During two years of in-patient treatment on the unit she required intensive nursing care for many months. Couple therapy with her husband and group therapy on the ward helped to an extent, but she made no fundamental improvement until intensive individual psychotherapy could be provided. After two years she was discharged, on lithium medication alone, and continued as an out-patient with a new therapist. In a mildly elated though essentially mourning state following the death of her father, she was admitted to another unit, where ECT was begun but after one application was discontinued at her own insistence. She left hospital within a fortnight and has remained well ever since. Her therapy has continued without incident for a further two years and she is re-training to resume her long-interrupted career in medicine.

This patient, whose case is reported in detail elsewhere (Jackson, 1989) but not yet concluded, needed long-term intensive individual psychotherapy before her deeper destructive motivations could be identified, and her strong reparative wishes mobilised. Without the containing and therapeutic milieu such treatment would have been impossible. Her case also demonstrates that it may take a very long time to work through conflicts and achieve stable personality growth. This task requires patience on the part of the supportive nursing staff, and a high level of commitment to the endeavour.

Case 3

A 32-year-old man had developed a crippling obsessive–compulsive state in his late adolescence, of sudden onset following a dream in which he killed his mother by cutting out her liver. His guilt was of delusional proportions and his obsessive sanctions and countermeasures against damaging or contaminating people and things were equally restricting. After much unsuccessful treatment a leucotomy was performed, leaving him with a small neurological deficit and little symptom relief. After ten years of severely restricted existence he was admitted for consideration of a second leucotomy, and was referred for a trial of psychotherapy as an in-patient. He was able to make use of the therapeutic milieu and began to risk emotional attachments, and very slowly to work through his fears of the dangerous consequences of loving and hating, and his dread of his intensely destructive feelings of jealousy. He stayed for a year and continued for four years in once-weekly psychotherapy as an out-patient. This phase of treatment was conducted by an experienced social worker and a psychiatrist seeing him on alternate weeks, concentrating on his real-life problems and his inner conflicts respectively. He required no regular medication, and was eventually able to engage in full-time work consistent with his high intelligence. After therapy was terminated, he remained

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stable and made what seems to be a happy and appropriate marriage.

Although this patient was not formally psychotic, he made extensive use of 'schizoid' mental mechanisms (Rey, 1979), a feature also characteristic of the 'borderline' patient.

Case 4

A young nurse with a borderline personality disorder with transient paranoid psychotic episodes, was admitted in a state of severe anxiety and depression with suicidal intentions. Psychotherapeutic exploration revealed that she had chosen her career in order to have the opportunity of laying out dead bodies. Her main wish was really to be a mortuary attendant, and she wished to die in order that her life would enter the corpse and resuscitate it. In her psychotic episodes she believed her body was invaded by insects; she had nightmares of being full of maggots and was recurrently afraid to eat. Her complex psychopathology appeared to derive from her murderous jealous feelings towards younger siblings, whom she also loved and wished to protect and re-animate. She discharged herself and was readmitted frequently over a period of 18 months, but with the continuing support and understanding confrontation by the nursing staff her acting-out subsided. In the occupational therapy department she became able to give symbolic expression to her destructive and creative impulses and revealed an unsuspected sensitivity and talent in sculpture. She finally resumed her nursing career, with greater insight into her motivations and a better capacity for relationships.

There were many such striking and relatively successful cases. Such patients would have been unlikely to qualify for long-term psychotherapy elsewhere in the health service. There was a good deal of self-injurious behaviour, and suicide prevention became an important concern in the last eight years of the unit's 13-year life. There were two in-patient suicides, though neither occurred on the ward and one was largely accidental.

In cases where therapeutic results were poor, there was a strong impression that this was more the consequence of insufficient resources of uninterrupted skilled psychotherapy, and of excessive external pressures on the nursing staff, than attributable to 'inaccessibility' of the patient. Duration of previous illness was inevitably an adverse influence, though often it proved no bar to progress. However, it became clear that the most desirable time to employ this intensive level of investigation and treatment of psychotic patients was at the time of the first attack (cf. Alanen *et al*, 1986). Neuroleptic medication was prescribed according to the conventional indications, but the aim was, whenever possible, to avoid its use in high dose or for long periods. The objectives of treatment were seen in terms of personal growth and development, with resulting improved control of psychotic manifestations, increased autonomy and sense of purpose, improved adaptation to the realities of the individual's life, and in the most favourable cases restoration to normal living.

Psychotherapy for psychotic patients?

Many people hold that psychotherapy is not an appropriate treatment mode for psychotic patients because it may do harm. This reservation applies to all treatments used inappropriately, and psychotherapy is no exception. Other objections concern the length of time involved, criticisms of its theoretical rationale and the generally poor quality of results in comparative studies (see Holmes & Lindley (1989) for a discussion of these and related issues). Concern with details of formal diagnosis may militate against the recognition that because of the wide variety of psychodynamic patterns to be found in psychotic patients, their accessibility to treatment does not depend primarily on their diagnostic category. Psychotherapy for a patient with a psychotic condition of any severity must necessarily be a responsibility of a hospital team with psychodynamic understanding and interest, and if such a team is not available, it might be thought better not to start. Further objections to psychotherapy may come from families vaguely acquainted with psychoanalytic views about the importance of early parenting in laying the foundation of the sense of identity and recognition of the world of reality (Bowlby, 1953; Stern, 1985). They may feel that they are being blamed, and thus prefer the purely biological theories of psychosis. Moreover, psychotherapy may have a temporarily disturbing effect on a psychotic patient, and this must be handled with skill by an effective milieu team. Finally, it is common to find that those who are most confirmed in the anti-psychotherapeutic position have never actually attempted to work psychotherapeutically with psychotic patients because of lack of interest or opportunity or unfortunate experiences of attempting psychotherapy without adequate supervisory help.

In psychopathology the nature/nurture issue is rarely clear-cut. Even when there is the strongest evidence for genetic aetiology (as, for example, in some cases of manic–depressive disease), the interactions of the individual with the environment crucially affect his/her welfare, both experientially and in relation to the degree of secondary handicap which may ensue. Recurrence and chronicity are not necessarily barriers to psychotherapy for psychotic disorders. But long-term commitment is necessary, and frequent readmissions may be required, being seen perhaps as part of a process of working through and growth over a period of many years.

Much of what we know about the psychodynamics of psychosis we owe to a small number of psychoanalysts and psychotherapists who have pioneered the psychoanalytic treatment of psychotic

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patients, often under difficult circumstances. It is rarely feasible to attempt such treatment of a disturbed psychotic patient purely in an out-patient setting (but see Karon & Vandenbos (1981), and Karon (1988) for an opposing view). The best hope for the future of psychoanalytic psychotherapy for the psychotic patient lies in the establishment of a well organised psychodynamic therapeutic milieu where appropriate medication and other treatment modalities may be used. Treatment begun within this setting, or at least available in times of need, allows for selected patients to have the prolonged psychotherapy that may be uniquely helpful.

Where skilled psychoanalytic psychotherapy is available, good results can be expected. In one series reported (Furlan & Benedetti, 1985), an 80% success rate was claimed in the treatment of 50 schizophrenic patients by experienced psychotherapists for an average of five years, with follow-up from one to ten years. Such an investment of time by highly trained practitioners is unlikely to attract funding from any public mental health service. However, evidence is accumulating that it may be far from unrealistic. Benedetti, a Swiss psychoanalyst trained in the school of Manfred Bleuler, with extensive experience in the psychotherapy of psychotic patients from a psychoanalytic, Jungian and existential perspective, offers significant comments on this topic.

> "Such long-term individual psychotherapy of the psychotic is, however, rare because of the considerable demands made on the time and the training of the therapist. From a very broad point of view it is of scientific but not sociological interest . . . (also it) is successful only in the hands of very well trained and talented therapists." (Benedetti, 1987, p. 52)

However, he continues, it is fully justified.

> "Statistical indications . . . indicate that prolonged psychotherapy (two to five years) produces the best results, and is especially indicated for certain patients (those who are motivated, productive and living in stable family relationships). Yet it has become evident that the social purpose of long-term therapy is achieved only when it results in guiding principles, experiences and directions that are also valid for the care of most patients. Psychodynamic knowledge gained from the long-term therapy of schizophrenic patients can be applied in combination with medical treatment, in short-term therapy (i.e. lasting six to twelve months." (ibid, p. 18)

In some centres, methods of psychosocial treatment of psychotics which aim at combining individual psychotherapy with group, family and other treatment modalities within the hospital and community appear to be more advanced than conventional practice in the UK (Schulz, 1975; Oldham & Russakoff, 1987; Ciompi, 1984). Such integrated work, within a psychoanalytically informed framework, has long been established (Ugelstad (1979) and others in Norway, and Alanen and co-workers (1986) in Finland). The work of the Finnish task force has so convinced the government of the cost-effectiveness of psychoanalytic psychotherapy in all mental illness that it is now widely available and mostly publicly funded (Pylkkanen, 1989). This work is being carried out by psychoanalytically trained psychiatrists with full clinical control of their units, or working in close collaboration with enthusiastic colleagues. Whether it is desirable or feasible in current or foreseeable conditions in the UK for a psychoanalyst to hold such a position of clinical control is a matter which calls for examination (see Freeman, 1989). However, it seems clear that the psychoanalytically trained psychotherapist may have much to offer in a consulting capacity to in-patient units, even if not in direct clinical charge of the patients (see Hobbs, 1990).

Conclusions

Psychoanalytic ideas bring a different epistemological dimension to the understanding and treatment of severely disturbed patients. They offer a way of understanding psychotic thinking and inexplicable or bizarre behaviour; they amplify the psychotherapeutic component of management; and in highly selected cases they set the scene for more intensive psychotherapy. They also help the worker to achieve some confidence in his ability to understand such patients, even if these should prove resistant to treatment.

The best setting for such work is an in-patient milieu staffed by a multidisciplinary team whose members are interested in finding out whether, and how, psychoanalytic ideas may be valuable in their work. Regular supervision allows the members of such a team to learn by experience, and to explore developments of their traditional roles and the conflicts that inevitably emerge. Perhaps the greatest challenge and opportunity is for members of the nursing staff who wish to expand their psychotherapeutic role without relinquishing their basic nursing identity and special skills, and without feeling a need to become career psychotherapists in order to do useful psychotherapeutic work.

A similar challenge confronts the psychiatrist who wishes to improve his psychotherapeutic skills without having to abandon his role as co-ordinator of a medically oriented psychiatric team. The general psychiatrist, clinical psychopharmacologist, neuroscientist, psychologist, social worker and occupational

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therapist (as well as the nurse) all possess a depth of understanding and wide sensitivities: no less than this is claimed for the psychotherapist and psychoanalyst. What is special about the latter is that he/she works primarily from an epistemological framework in which the logic is directed towards that of the unconscious mind and the primary processes of thought. Psychiatrists who are less interested in psychoanalytic ideas may not find it easy to work with colleagues who are more familiar with this dimension, perhaps with more advanced psychotherapeutic skills but less appreciation of the demands and responsibilities of general psychiatric work.

The therapeutic work of the milieu alone may be sufficient to help most patients. Formal longer-term psychotherapy must be reserved for those for whom it is considered specifically indicated. When this is undertaken, the backing of a well-functioning ward milieu may encourage fully-trained psychoanalysts to embark on such important and seemingly neglected work.

The severely disturbed in-patient needs to be listened to and understood, and the psychoanalytic perspective can add to the skills of even the most sensitive practitioner. Its application is a complex and demanding task, requiring staff of high motivation and willingness to learn from experience. The staff will also accept that it may be a long time before the full implications of working in this way are appreciated.

Are there prospects of introducing psychodynamic principles into the care of very disturbed people living in the community? This question is clearly important for a future in which in-patient units are progressively reduced in size and more exclusively focused on brief admissions for rapid neuroleptic medication and early discharge. Before exploring the possibilities, much preparatory work will need to be focused on the integrated functioning of the multidisciplinary team in a community setting. Can a therapeutic milieu be established for a patient living in the community? This and other questions will relate to clinical and methodological issues as well as logistics and funding. Establishing an in-patient service, complicated enough in itself, seems simple by comparison. It may well be a necessary first step, because the essential features of a milieu are by definition properties of an institutional setting.

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