APPLICATION OF PSYCHOANALYTIC PRINCIPLES TO THE TREATMENT OF IN-PATIENTS IN MENTAL HOSPITALS.*

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This paper has been written with the intention of illustrating the application of psychoanalytic principles to the treatment of in-patient psychotics by reporting the treatment of a female manic-depressive patient by psychoanalysis at the Cassel Hospital during 1936–38. Unfortunately no reports of intensive in-patient psychotherapy of psychoses in this country have been published. Little prolonged intensive psychotherapy of psychoses has been carried out in hospitals, apart from the Cassel Hospital, where for many years the staff was sufficiently numerous to allow most patients to have daily interviews of significant length. In the United States experimentation has been much more active. Recently Fromm-Reichmann (1947) has reviewed many of the problems encountered in the several Mental Hospitals where psychoanalytic methods of treatment are actively pursued. Rosen has reported daring and courageous experiments. He has reported (1946) the treatment of acute catatonic excitements by psychoanalysis—his chief innovation being the long interview. With one patient the first interview was 16 hours with a break of half an hour. He has reported (1947) favourable results from treating 38 male and female schizophrenic patients, the ages of the patients ranging from 15–49, the duration of illness before treatment ranging from 1 month to 27 years, and the duration of hospital residence ranging up to 11 years. The average daily hours of treatment ranged from 1 to 12, and the duration of treatment ranged from 3 days to 11 months. In my opinion the New York Psychiatric Institute which encouraged Rosen's experiments has fostered a technique about which much more will be heard.

The literature contains no reports of patients treated psychoanalytically in hospital with which I can compare the material I am reporting. Kaufman (1937) reported the successful treatment in hospital of two late-life manic-depressive depressions by psychoanalysis, but the technical problems dealt with by him differed greatly from those encountered by me.

My patient was 20 when treatment began in 1936. She was a first child, and was breast-fed for about one month. She sucked strongly; but obtained little, and often screamed herself to sleep. Owing to this she was weaned to the bottle, which she sucked well. The screaming ceased. At the age of 6 or 7 months she spoke a few words, and before 2 years was using complicated words and sentences. Her bowel and bladder were trained quickly and early. Solid foods were refused for some time, and she remained difficult about solid food for several years. By about 15 months she was weaned from the bottle to semi-solids. She put no toys to her mouth. Her further development was uneventful. A sister was born

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when she was a toddler, and two brothers were born later. At 10 she had whooping-cough and mumps, and her tonsils were removed. At 11 she had measles and bronchitis. Her menses began at 16. No emotional reaction or change in her personality were observed in regard to any of these events. She progressed steadily through school, but was never considered to be doing her best. After finishing secondary school she went to College, both her parents having had a similar education. At college she met a woman whom she admired and to whom she wrote letters. This friend noticed that she was becoming more tense and depressed, and suggested that she should go to the Institute of Industrial Psychology for advice regarding the type of occupation which would most probably suit her. She was told that tests done there showed her to be of exceptionally high intelligence, and she was advised to seek medical treatment for her emotional state. The late R. D. Gillespie, whom she consulted, considered that she was on the verge of a serious depression, and advised treatment at the Cassel Hospital.

Her disposition had always been sociable with her family, but she was shy with new acquaintances, especially men. She never discussed her feelings, and under no circumstances showed any intense emotion. Until her going to college, piano playing had been a great interest. She gave it up because she felt she was not making any progress. During the few months preceding the beginning of treatment she helped at home while her mother was convalescing from the effects of an operation.

On admission to hospital she was tense and fidgety. She seemed to be continually on the verge of tears, but wore a forced smile. She did not speak much, and when talking spoke slowly and in a low voice. She complained of being fed up and of not knowing what to do. On being questioned she said that depression had been increasing for as long as she could remember and that, during the previous few years, depression had been worse. She stated that twice during the previous year she had seriously contemplated suicide by poisoning. Her physical condition was generally good. Her weight had decreased considerably during the previous year.

It was considered justifiable to attempt psychoanalysis as an experiment. During the progress of the analysis the following marked changes in interviews and in her adjustment to the hospital situation occurred. During the first weeks of treatment she was usually silent. During the next months she was almost absolutely silent; and during analytic interviews and for some time after interviews an anergic stuporous state and abnormal sleepiness occurred. Her occasional slight movements furnished material which allowed the analysis to progress. After about seven months' treatment emotional outbursts began to occur—at first at the end of interviews and later during interviews. At first these outbursts were "convulsive" and vaguely directed, and the type of affect was difficult to recognize. At times it appeared to me as if she were going to have a *grand-mal* convulsion. Such spells, which at first began at the end of interviews, lasted up to forty minutes, making it necessary for me to remain with her until she was able to leave the room without much difficulty. She had to be held at times, and the help of two nurses was required, owing to her strength.

Later the emotional outbursts were more definitely either of anger or of love. At this time she was more sociable in the hospital, and became friendly with a younger girl. She began to write letters, and these she brought with her to interviews. Later she brought drawings. At a later stage she was openly depressed and suicidal, and she cried during interviews. At other times her behaviour was excited and playful in a flighty, manic manner. She began to be more active outside analysis and became both more guilty and more actively a nuisance, attempting for a time to make the analysis impossible. She tried to interfere with the treatment given by me to other patients. Still later yelling and screaming accompanied her emotional outbursts, and she began to talk more during interviews. Following this her emotional outbursts became less frequent and less intense. She became more friendly with her family when she went home on visits. A friendship with an older man began, and later she became friendly with several young men of her own age. She secretly depreciated these men. Jealousy became more openly apparent. She began to show more interest in her personal appearance. She commenced making plans for the future, and was more guilty about the real hardship her treatment was causing her family. She decided to discontinue treatment and to start training as a secretary.

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There was marked improvement in every way, including her sexuality. Masturbation had been first described in a letter written after about nine months' treatment. She wrote that she had tied herself up so that on moving she was hurt. She imagined she had a penis attached to herself and was having intercourse with a woman. During the second year of treatment the need to feel pain during masturbation gradually disappeared. Her activities became predominantly feminine. Her masturbation phantasies were then of normal intercourse and included phantasies of pregnancy. She began to think of most men as potential husbands.

The following sketches of important aspects of the analysis will illustrate the content of some of the problems such an analysis presents. Interviews were daily and lasted one hour. For several weeks interviews were prolonged to two hours, as I remained with her until the intense emotion which had begun during the interview ceased.

It was three weeks after treatment began before she was able to lie on the couch. The interpretations of the scanty material obtained during this period allowed the analysis to begin. From work with this and other similar patients I have come to believe that in psychoses, content, which may at first sight seem to be conscious, or at least preconscious, is often deeply unconscious. After more than a year's treatment I became convinced that the behaviour, which had been used as material on which to base interpretations during the first weeks, had been deeply unconscious.

She sat tensely and mostly silently, stating that she was afraid of what I would think if she spoke. I said that she was afraid that I would say something frightening such as had been said to her by others in her life. She said that she felt dead. I said that she wanted me to make her feel alive and not to frighten her as others had. She said she felt inferior. I said that she wanted me to help her lose this inferior feeling. She then caressed her leg and smiled. I said she wished to show me, but was afraid to tell me, that she was pleased. She told me she wanted to scream where I could not see her. I interpreted this as anger at her frustrated desire to show more pleasure than she had shown me by stroking her leg and smiling. I said she was angry partly because I asked her to put all she was conscious of into words, and partly because I had not shown pleasure at the way she showed me her pleasure—namely, by smiling and stroking her leg. I said that she wanted to protect me and herself from all she thought would happen if she screamed at me while she was watching me and I was watching her. She then began to stroke her legs quite tenderly.

She told me a dream:

> " Mother was dead and I had to care for the house. I was to have come here in a day or so. I wanted a husband and a baby, but I couldn't care for the food."

She gave no associations. She was silent and, after a time, asked me not to look at her. I connected the dream thought " I couldn't care for the food " with her difficulty in dealing with the analysis. I informed her that her difficulty in speaking and her wish neither to be watched nor to be heard screaming by me arose because she felt she could only say or show me something bad—something which she thought would make me act to her as others had acted when they had seen her do what she wanted to do or say what she wanted to say. She then became less tense, stretched, yawned and looked sleepy, and turned to the couch. I said that she had decided to sit instead of to lie, being afraid of what would happen if she lay and slept, and therefore could not watch me in order to protect herself. She then got up from her chair and lay down on the couch.

The analysis had begun by using not only the sequence of what she had said, but also by using the few movements and expressions of emotions she had shown. This appears to me to be similar to the minute attention paid in child analysis to the details and the sequence of the child's behaviour as a whole. In fact the work of those who started analysis of infants and children has in my opinion given the most important single impetus to new psycho-analytic work with severe psychoses.

A description will now be given of some aspects of the analysis of the stupor. Soon after beginning to lie on the couch she began to talk less, and finally only rarely spoke to me for several months. She lay motionless and her expression was blank. It was often impossible to know whether she was asleep or not. All

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movements were very slow. After some weeks she began to touch a small rip in the upholstery of the couch near her left shoulder. I was sitting at her left. She touched the rip—she tucked its edges in, making the hole larger—she folded the edges together, making the hole seem to disappear, and at times she would leave it alone and roll over on her side to her right. Once after touching the edges of the rip and putting her finger in it she suddenly pulled her skirt down as far as it would go and lay on her back. I interpreted this as anxiety about masturbation. I said she seemed to feel that I would stop her masturbating, just as something within her had stopped her playing with the couch. I interpreted her shift to the genital pleasures of masturbation as a defence against the oral anxieties with which she had started the analysis. She became more active with the hole in the couch, but also generally weaker and slower ; and she looked much sleepier at the end of interviews. She continued to be stuporous for some hours after interviews.

The next phase began when she suddenly arose and stuffed some paper into a window which was rattling in the wind. She did this energetically, and seemed to rouse suddenly from a stuporous sleepy state to do so. On lying down she returned to her former state. I told her that this strong reaction to a noise was to prevent it from harming either me or herself in the way which she thought the noises she was keeping in would harm either or both of us if she gave up the defensive weakness and sleepy silence. At the end of the interview she silently and vaguely clutched me, and strong convulsive movements developed. I thought that she was going to develop a *grand mal* convulsion. She seemed to be fighting with herself to hold something in. Her eyes and mouth were tightly closed. She eventually became weak and was shortly able to leave the room. I interpreted her behaviour as showing the contrast between her sleepy, stuporous state of anxiety at my being harmed and my harming her in revenge on the one hand, and her intense anger at my not giving her the help she wanted to ask for on the other hand. I related this to the early period when she felt her parents knew her wishes, although she had not spoken. This phase was followed by her bringing me a letter. In it she blamed me for making her want a husband and a baby. I linked this to the first dream she reported, and said that she was substituting me for her earlier acquaintances through whom she had first known of husbands and babies.

She then wrote of the fear she had had of the way her father had hugged her and kissed her. I said that she had also blamed her father for her wish for a husband and baby, just as she had blamed me for the content of the dream she had told me.

She then yelled loudly :

" I can't speak."
" You make me talk."
" I don't dare speak."

I said these were memories of what she had said when angry and memories of phantasies of talking when frustrated ; for example, when her father wanted her to talk instead of act and when, during the analytic treatment, I wanted her to talk. A dream followed : " I vomited out of a window and was afraid you would touch it." This was linked to the mess that she had told me she was in (which she wanted me to clear up), to the noise she wished to expel (the window in the dream was the window where she had stopped the noise), and to her fear that I, as a useful external person, and the bad internal mess of vomitus would unite.

Her emotional outbursts then became much less vaguely directed and convulsive. They appeared more definitely as attacks of anger, in which she growled, scratched, kicked and bit. The analysis of the details of this behaviour convinced her that in her phantasies vomitus represented the me which she believed she had eaten in the first seemingly vaguely directed convulsive attacks. The wish to eat me now (since I frustrated her as her parents had in the past) became connected with much memory material—both of fact and of phantasy—concerning her parents and also her grandparents.

She became obsessed with the feeling that there was a lump of meat in her throat and, for a time, she was nauseated and was unable to eat much. These feelings became associated with memories of her bottle and memories of her father giving her the bottle. The emotional attacks became less simply attacks of anger and became mixed with love. She energetically tried to bite me in the genital

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region and, when prevented, she tried to bite me wherever her mouth happened to be. This biting was more than an attempt to bite a bit off my body. She stated and wrote that she wanted to eat her way into my body. This behaviour was interpreted as a desire to swallow and control, mixed with or followed by a wish to eat her way into the person attacked and to be eaten by the person attacked in order to preserve this person from being destroyed by her.

Shortly after this she began to write letters about her masturbation and to draw scenes of masturbation. She described a series of women she had secretly admired. As soon as the interpretation was given to her that she wished to control my sexual behaviour from within me, as she had previously tried to control her father's sexual behaviour with her mother, the masculine identification, which had been brought about both by oral incorporation and by trying to eat her way into me lessened. These different attitudes, which had each led to a masculine identification, were seen at the same time. Phantasies of having sucked, bitten and swallowed her father's penis, and of having eaten her way into him and of having been eaten or swallowed by him, all led to a masculine identification—in the first case due to being controlled from within by the man she had taken in, and in the second case by controlling the man she imagined she lived within. She then became able to describe considerable guilt regarding her attitude to several women. It now became possible to link her previous actual indifference to her mother and father to her anxieties about and her denial of her phantasied control over their mutual behaviour to each other.

Her wish to restore to other women what she had taken from them was first seen in a change in the emotional outbursts. She now became more gentle and tender. At first it was seen as a wish to be loving to a man, so that he could be loving to another woman. It was only much later that this was understood in terms of feminine wishes or of a feminine identification.

Up to this period there was little indication of improvement in her everyday life, and several of my non-analytic colleagues thought that her reactions furnished an example of analysis worsening a psychosis. My judgment was, however, that the changes in her clinical state were clearly related to a transference situation in the analysis, which was gradually becoming more conscious and was gradually altering. In my opinion she appeared to be in a state nearer normality than before the onset of the analysis. The continuance of and the progress in the analysis itself at this time seemed to me to be indicative of improvement. In the analysis of psychoses progress within the analysis has to be relied on as there may not be any other standards or criteria on which to depend.

After the period described her condition in interviews began to vary much more frequently and quickly. The alternations between feminine and masculine identifications occurred very rapidly. They could be understood in terms of the swiftly changing relationship of the various people and objects in her phantasy.

The following is an example of part of an interview in which such very rapid changes occurred. At a time when, on the whole, suicidal tendencies were prominent, her voice once suddenly became soft and she tried to caress, fondle and tenderly embrace me. She said softly that she could never leave me. Then she suddenly yelled in a state of fear," Don't look at me—you are too nice." This was interpreted as a wish to preserve the image of a loved person by projection—at that moment I represented a loved person. She could only preserve her love by externalizing it. Immediately after this she pleaded with me in sorrow, in a rather vague but intense manner, to kill her. I interpreted this as the wish that the good object, which she had just wanted to preserve, would kill the hating person in order to protect the loved person from the hating person. She at once became more energetic and lost her vague look. She stated sorrowfully that she hated me, that I had no feeling and that I was dead. I interpreted this as a feeling that she could now tolerate feeling both hateful and loving and could tolerate imagining that I was both lovable and hateful. She then said sorrowfully that, if I did not love her, no one would. I related her sorrow to the new position with regard to me, and her hopelessness to the earliest situations of sorrow when she knew very few people, and if they appeared destroyed or unloving, the whole world seemed destroyed or unloving.

In later interviews, when the transference was to a nursing mother and when memory material was closest to the earliest weeks (when, according to her history, she was ill-fed and screamed) she tried to make me wear cushion as breasts, tried

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to expose my breasts, and had phantasies regarding how I could grow breasts. She yelled and choked in her bouts of anger, sucked many objects, and often smiled in her attempts to love, and described oral sensations, which were accepted as memories of feelings in her mouth before she had any teeth. After 18 months' treatment she drew very childish representations of a wild child. In the next interview she tried to draw a mess which she felt inside herself. What she drew was at first a sheet of scribble, but the form gradually changed during about 20 minutes. I interpreted her activity as the wish to remake her mother's breast which she believed she had eaten and to restore it to me in place of her mother. At that moment she became conscious of her drawing as a fair representation of a full-sized breast. Her relief was great, and her associations were immediately of good relationships between mother and child. She then drew a happy baby.

Writing and drawing proved very useful during this analysis. Writing was sent or brought to me from about the seventh month. After the sixteenth month less was brought. I always accepted the writing and tried to read it aloud in interviews and to interpret it if possible as I went along. In general, writing was interpreted as a projection acting as a defence against oral activities. Occasionally it was related directly to the derivatives of play with her stool. Once she wished to write her name on my body, and this could be related to play with her stool. More intense anxieties were analysed in connection with writing being used as a secret and silent defence against oral situations. Earlier in the analysis she brought writing in a secret code and soon afterwards began to bring drawings without writing. She brought mirror-writing and a small mirror which she kept in her hand, thus enabling her to control whether I could read what she had given me by letting me use the mirror.

The drawings were interpreted as the projection of memory and of phantasy material. Associations and descriptions of the drawings were requested by me, but if, as was usually the case, none were obtained, I interpreted them, as far as I could, on the basis of content in connection with the situation at the moment. When she began to draw and scribble during interviews, it was possible to interpret the type of activity and sequence of activity as well as the content.

After discharge from hospital she continued treatment for about 18 months. She was well when last heard from early in 1948.

The preceding outline of the type of patient, the sketch of the general progress during treatment and the few details of samples of the analysis is an attempt to condense several hundred hours' work into a short paper.

This type of psychotic patient ordinarily has a very serious prognosis. Homosexuality, masochistically perverted masturbation, and manic-depressive depression slowly worsening from adolescence to twenty are symptoms usually considered prognostically serious. Nevertheless if time is available, if adequate nursing help is available, if colleagues are co-operative, and if psychoanalytic methods are persistently used, great improvement in such a patient's condition can occur, and material of great value as far as psychopathological research is concerned may become apparent.

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