PSYCHOTHERAPY.

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THE present war has occasioned sudden and notable changes in many aspects of medicine. Psychotherapy is no exception. The war has come at a time when this branch of treatment is receiving a greater measure of acceptance by the profession than ever before. And the war has brought with it a challenging demand for shorter treatment and—if it may be—more permanent results. Thirty or forty years ago psychiatry complacently limited itself to environmental and custodial measures. Since then a gradual infiltration has taken place whereby the psychiatrist accepts an active therapeutic commission. Much of this change is due, directly and indirectly, to the work of Freud, which shook into animation both clinical psychiatry and academic psychology. The interdependence of these three departments of mental science has by no means reached completion. Nevertheless, psychotherapy can look back on a growing contribution to psychiatry, initiated to a large extent in the Great War, and now multiplied many times by the demands of totalitarian warfare.

A good deal has been written on the value of superficial psychotherapy. McLaughlin (1942) describes a routine for R.M.O's. at sick parade which aims at detecting the maladjusted young soldier. To this end he gives him a simple talk on his difficulties in order that he may the better adapt himself to army life to avoid drifting into a breakdown. Hubert (1941) discusses acute nervous illness in active warfare under the three headings of anxiety, hysteria and psychosis. For the recoverable, as opposed to those diagnosed as chronic, he advocates a speedy return to duty. He uses sedation, and follows it up with psychotherapy directed to the general nature of the condition rather than to the individual's reaction. His intention is to enable the patient to tolerate army discipline as soon as possible. Snowden (1940) elaborates a system of group instruction applicable to service patients, but more suitable for civilians. Analysis is avoided as too lengthy. A preliminary history is taken by an assistant, and that is followed by a single diagnostic interview. In this interview investigation is directed to certain main aspects of life, childhood, school life, adolescence, work, marriage. The patient is then drafted into a group. Eight lectures, each lasting twenty minutes, are given. After the lecture the group discuss among themselves. Then the M.O. sees each member of the group for five minutes. Stress is laid on the importance of not giving more time to one patient than another. Satisfactory results are claimed.

Another system of group psychotherapy is described by Wender (1938) as applicable to psychoneurotics and mild psychotics. His aim is to use the new environment and social contacts in the hospital to adjust former family and social conflicts. These are visualized by the physician in analytical terms.

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The patients are divided into groups of, say, eight, and as far as possible on the same level. A series of lectures is given, supplemented by individual work. The group discuss the subject-matter of the lectures, but only within the group. It is claimed that this impersonal approach helps patients to make a personal application of various psychological mechanisms. The doctor, of course, occupies a father-figure position and regards the ensuing rivalries as useful. Furthermore, patient to patient transferences can be utilized to reduce the transference attitude of dependence on the physician.

In studying these various techniques of superficial psychotherapy it is noteworthy that some (e.g. McLaughlin) invite a father-transference situation and utilize it for suggestive and persuasive ends, while others (e.g. Wender and Snowden) limit or evade the transference situation by the group technique. This utilization of Freudian theory without recourse to psycho-analytical technique is stressed by Rickman (1939), who points out how much advantage the general practitioner can gain by interpreting the psychosomatic factor in disability in terms of Freudian theory. Again Wolfe (1939) emphasizes the benefit to all concerned which can accrue by the general use of a psychotherapist in conjunction with the surgeon or physician directly responsible. He would not limit the work of the psychotherapist to accepted psychosomatic disorders, but would assign him an essential role in the cure of all patients. Daniels (1940) takes a similar line to Rickman in relation to psychosomatic disorders in general practice.

Perhaps the most ambitious of the group techniques is that of Bierer (1942). He describes his system as applied to a series of 70 cases in a mental hospital. He claims that of those not discharged so far only four had a bad prognosis. In his system he combines direct psychotherapy, organized social activities and occupational therapy. The personal approach is a modified Adlerian one. The emphasis is on the patient's " general attitude," rather than on his need for insight. Early memories are reviewed with the object of illuminating the " general attitude." Bierer divides his patients into three categories which correspond roughly to Adler's sex, society and work. He then proceeds to deal with the main line of maladjustment. So far from utilizing the Freudian transference he replaces it by an " aim-transference." This is reinforced by an attempt to subject the patient to an " aim-experience " or an actual experience of success in thwarted individuals. It is to be noted that many psychotherapists and other physicians too have resorted to methods of this practical character in the process of " socializing " their patients. The Freudian school has in general deprecated such methods on theoretical grounds. Others have deprecated them because of the obvious difficulty of discriminating between the frustrations that can suitably be dealt with by an " aim-experience " and those which cannot be so dealt with. For instance it must be obvious that with many patients the most immediate desire or need must be for a sexual experience; obvious ethical problems present themselves at once. However, Dr. Bierer makes it clear that what he calls " situational treatment " comprises *impersonal* methods devised by the psychotherapist and his assistants, based on an analytical diagnosis shared by the staff but not known to the patient. It follows therefore that ordinary occupational therapy as provided by the

hospital is merely "institutional" treatment as opposed to this "situational" treatment. The technique of situational treatment includes a club, study circles, concerts, etc.

Another method of environmental treatment based on superficial psychotherapy is that of Maxwell Jones (1942), who has developed it in the treatment of effort syndrome cases. To combat the fixed idea of heart-disease, the author began by giving a series of group talks in the presence of the nurses. These were not very effective. Theoretical knowledge of the structure and function of the nervous system had little therapeutic effect. Then the direction of treatment was turned to the patients' affective attitude, and talks with nurses, specially coached for the purpose, were instituted. In this way improved results were obtained.

Carver (1942), in referring to the affective attitude, points out that the present war has shown up, not so much conflict between self-preservative and patriotic ideals, as the complacent acceptance of entirely selfish standards. He suggests that the need for psychotherapy emanates from imperfect education and attenuated ethics.

Maclay and Whitby (1942) claim that 76 per cent. of their "war injury" civilians were enabled to return to work by persuasion, suggestion, re-education and explanation.

At a symposium devoted to "Direct Psychotherapy in Adolescence" the following therapeutic principles were laid down:

(1) The formation of a strong, positive transference.
(2) Direct discussion of difficulties with explanation of their significance.
(3) Some adjustment of environment.
(4) No strict analytical treatment.

Perhaps the most important contribution to superficial psychotherapy that has appeared in the period under review is Stekel's work (1940). This fertile writer produced his most important book in 1940 only a year before his death. It is called *Technique of Analytical Psychotherapy*. In it he lays down in uncompromising terms his acceptance or repudiation of the main Freudian tenets. As a seceder from the Freudian school his work is less known than it deserves to be. The following excerpts from the preface give a clue to the line he adopts:

"It was reserved for Freud to patent . . . his brilliant discovery, and to establish an iron-bound system of analysis. . . . Psychoanalysts will often analyse into their patients things which have no relation to or bearing upon the latter's fundamental troubles. . . . We must at length admit that the patient is an actor, playing to himself as well as to us, and that he may be able to outwit us. . . . After 30 years' experience of analysis, I no longer believe in the overwhelming significance of the unconscious. . . . Such analysts fail to recognize the nature of the spiritual conflict from which the patient suffers. . . . The discovery of all these things is work for an intuitive artist, endowed with imaginative insight which will enable him to feel his way into what may be the extremely complicated psyche of his patient. . . . Within a couple of months I can always discover whether the analy-

sand's desire for illness exceeds his desire for health. . . . Analysts must adapt themselves to the idea of short periods of treatment. But will they be able to do so? Non-medical analysts are in even greater peril. Freud has thrown the weight of his authority in favour of 'lay analysis.' He should not have done so. . . . The danger of analysis lies in the 'transference.' . . . Orthodox Freudian analysis will not endure. . . . Freud himself has begun the retreat in respect of the anxiety problem. . . . A science in which the Master's utterances have become dogma is more of the nature of religion or sectarianism than of science and is doomed to destruction. . . . The medical analysis of to-morrow will have to . . . establish an undogmatic, unprejudiced psychoanalysis."

The observant reader will have noted that while Stekel demands the "establishment of a science," he simultaneously claims that the analyst must be an intuitive artist. To be consistent Stekel should admit that psychotherapy is partly a science, partly an art, while the Freudians, to be equally consistent, should discount entirely (as some do) the intuitive or artistic factor in analysis.

In another passage we read: "Every individual works by his own lights and in accordance with the inner laws of his own being. Psychoanalysis is a question of individuality and temperament. When I formulate rules that are to decide the analyst's behaviour, it is on the supposition that these rules can be adapted alike to his individuality and temperament and to the character of his patient."

Stekel has introduced a number of neologisms which have met with small acceptance in the psychiatric world. Nevertheless some of them have connotative value. For instance he discards the term "neurosis" as indicating functional nervous disorder on the ground that the conditions treated by the analyst pertain to emotions and not to nerves. He has coined the unattractive word "parapathy." Psychiatrists show no disposition to accept this ill-sounding word in spite of its etymological accuracy. For repression he substitutes "scotomization"—again an unpopular novelty. And there are others. Stekel departs from Freud in his conception of the unconscious in that he uses the term to cover the preconscious as well. It follows therefore that his use of the term "complex" is radically different to that of Freud.

Stekel claims that, as opposed to the passive treatment by free-association, his method is active. By this he means that the analyst maintains the initiative in much the same way as Adler. There is an authoritative or didactic note entirely alien to the therapeutic detachment of the Freudian analyst. Stekel has taken Adler's favourite concept of the patient's "life-line" and turned it into the "life-lie." And when one reads one case-history after another one begins to sympathize with Stekel. The fact seems to be that Stekel's clinical material differed from average clinical material in this country. Stekel's cases, with few exceptions, seem to have been implicated in gross sexual abnormalities or misdemeanours which they resolved to keep back from the analyst. Consequently we have this sort of pronouncement: "An analyst requires the skill of a physician, a detective and a diplomatist rolled into one" (p. 253). Or again: "Day after day I attack the patient's 'system' by storm, showing that he can get well betwixt night and morning, if only he will discard

his fictive aims" (p. 315). But the "system" Stekel attacks seems seldom to be a matter of real repression and complex formation. "All cases have recent conscious conflicts." Indeed Stekel seems to be dealing generally with superficial ethical conflicts in which his detective methods are in constant play. So fundamental a departure from strict Freudian technique can only be justified in the light of results. And by this criterion it would seem that a case has been made out. After all there are only three main lines of departure from psychoanalytic technique if we are to find a short cut that gives satisfactory results both in speed and permanence. One is by hypnotic or narcotic exploration of repressed material. A second is by social readjustment without serious analysis. A third is by "attacking" the patient's mental background as was advocated by Adler and much more fully carried out by Stekel. It is perhaps permissible to predict that the super-psychotherapist of the future will be equally at home with all available methods, and will exercise such unerring diagnostic insight that he will apply in each case the method best suited to it. Certainly the time has come for psychotherapists to cultivate many techniques rather than a single one rigidly applied to every case.

The protagonists of deep psychotherapy are obviously at a disadvantage in a period which is largely influenced by war conditions. As one of us (H. C.-M. 1939) pointed out, the responsibility laid on the medical services, including the E.M.S., was to restore the patient to the *status quo ante bellum*. To embark on deep psychotherapy is to aim at a greater degree of adaptation than has previously characterized the personality. Debenham, Hill, Sargant and Slater (1940) hold strongly that "a neurotic cannot be freed of his neurotic tendencies." They therefore consider that radical psychotherapy is out of the question. Their object is to remove symptoms and to re-adapt the patient to a useful life within the army if possible, otherwise in civilian life. Dillon (1941) deprecates such therapeutic defeatism. Wright (1941) points out that deep psychotherapy is not applicable because the type of case most commonly met with is one who has always avoided occasions of adventure, danger and anxiety. These fitted themselves into civil life, but have nothing on which to construct a proper war adjustment. On the other hand, Burns (1942) points out that he is dealing with the neurotics weeded out of the army who are certainly not adapted to civilian life. The army is letting loose a body of disgruntled neurotics who ought to receive proper treatment.

This discussion opens up the whole broad cultural question of the value of deep analysis and (perhaps more important) its availability. There are, however, many indications in the literature that those who value analytical theory most are—perhaps belatedly—facing the demand for abbreviated technique.

As opposed to the defeatist views of some authors quoted above, we have the optimistic outlook of Wieninger (1938), who considers psychotherapy essential for patients recovering from a schizoid incident or a manic-depressive episode. He relies on psychotherapy to restore insight. To this end he initiates psychotherapy during the acute stage with the object of forming a positive contact between patient and physician. On this he builds later such analytical therapy as is possible. He emphasizes the need of the recovering psychotic for just that interpersonal relationship which he has lost.

Mosse (1940) describes a technique of deep analysis which is claimed to achieve success in a shorter course. He uses spontaneous paintings afterwards analysed by free association. It is said that the method lessens resistances.

The most startling innovation in environmental treatment has been elicited by the large-scale effects of air-raids. McLaughlin and Miller (1941) describe a method of deconditioning anxious and hypersensivive patients to air-raid noises. Gramophone records are utilized—sirens, A.A. gunfire, dive-bombers, etc. The patient is subjected to several repetitions of these sounds. The responses of pulse-rate, respiration, etc., are noted. After the first session the improving record is shown to the patient with explanations and reassurance. The method can be used to induce abreaction. Good results are claimed after relatively short courses.

Hardcastle (1941) and Mackwood (1941) express approval of the treatment, but Dillon (1941) and Hurst (1941) demur. Dillon compares the procedure to a medicine-man beating a tom-tom. Hurst emphasizes the satisfactory results obtained at Seale Hayne in the last war by simple persuasion and suggestion.

Mira (1939) points out that all neurotic cases gravitate towards the more comfortable environment—soldiers to hospital, civilians to their homes. Mira's approach is in terms of psychiatric classification and disposal to a different environment. It is therefore easy to understand that he has seen no benefit accrue from systematic psychotherapy—indeed he regards it as dangerous because among soldiers it appeared to induce epidemics of psychoneurosis.

The adjuvant use of environment by many psychiatrists, quoted in other sections of this article, should be borne in mind.

Perhaps the outstanding novelty in psychotherapy that has appeared in the last five years is the use of barbiturates for purposes of mental analysis and abreaction. It is to be noted that the use of " veracity drugs " had already been common for some years in Russia as a juridical method of extracting evidence. Sodium amytal was used in America for purposes of narco-analysis as far back as 1929. Horsley was probably the first to make use of the method in this country (1936). Since that time many writers have advocated this method, especially during the war years. The principle is not a novel one, in that many drugs, from alcohol upwards, have been known for centuries to eliminate inhibition and to promote emotional expression. Various forms of barbiturates are in use, notably sodium amytal, evipan and pentothal sodium. Narco-analysis has to a certain extent replaced the practice of hypnoanalysis, made familiar in the last war by Hadfield, William Brown and others. In a leading article in the *British Medical Journal* (1942) it is pointed out that certain advantages, notably the impersonal approach, are in favour of narcoanalysis. It is further pointed out that narcoanalysis obviates the filial-parental relationship attributed by the psychoanalytical school to all hypnotic procedure.

Sargant and Russell Fraser (1938) have suggested a variation of hypnoanalysis by utilizing the transitory impairment of consciousness that is induced by hyper-ventilation. This method has been known in the East for centuries in connection with Yogi practices.

Reitman (1942) recommends the use of sodium amytal on one occasion only. He gives a sub-hypnotic dose and prefers to postpone the session until some

preliminary psychological interviews have been held. He is thus able to direct more fully the course of the narcoanalytic session. He compares the method favourably with hypnoanalysis, especially for the treatment of amnesias. Blyth (1942) also stresses the advantage of the impersonal approach afforded by narcoanalysis. He uses pentothal sodium, and usually administers a preliminary dose of morphia. He describes two types of reaction:

(1) Droning and reluctantly answering questions.

(2) Spontaneous garrulity.

Since he regards the therapeutic objective as reintegration of dissociations, he considers it essential to work over the material with the patient in a subsequent ordinary session. Blyth claims very satisfactory results in effort syndrome. He also uses it for puerperal psychoses, depressions and schizophrenia. Sargant and Slater (1940) approve of the use of sodium amytal for the purpose of recovering lost memories. They used this in a number of men evacuated from Dunkirk with good results. They emphasize the merciful character of the treatment when the memories in question are intolerably painful.

Before the war Stungo (1938) had described his variant of the technique. Using evipan he aims at maintaining a pre-anaesthetic state by spreading out the administration over a lengthy period. This is to be contrasted with the technique of using the post-anaesthetic state for the same purpose. Apart from the patience required on the part of the physician for Stungo's method, another difficulty arises in the necessity for having a third person present to take notes. In a more recent communication (1941) Stungo professes to use both pre-anaesthetic and post-anaesthetic states according to the type of case. Like others, he considers it desirable to work over the material so collected in another session of ordinary psychotherapy. Stungo goes the length of claiming that failure to find the psychogenic factor by this method excludes functional disorder. He makes free use of this method for out-patient purposes, stating that the patient is fit to leave in two to three hours.

While many workers stress the impersonal factor in narco-analysis, Dicks (1940) considers that a good *rapport* is necessary. He finds the method has limitations both in overcoming resistance and in promoting abreaction. Felix Brown (1941) recommends evipan narcosis for those air-raid casualties in which hysteria has been produced or old hysteric reactions awakened. Wilde (1942), using pentothal sodium in a series of 50 military cases, claims that 33 were rendered fit to return to duty, 17 were invalided out, and of these half to a satisfactory civil life. He prefers the pre-anaesthetic method after a trial of both. He stresses a point that few writers refer to, namely, the value of the procedure for the diagnosis of borderline psychoses, mental deficiency and epilepsy, and also for the detection of simulation and malingering.

Horsley (1942) recommends narcoanalysis for producing *rapport* in a previously apathetic patient. Burns (1942) compares the condition produced to that which follows many cocktails—the patient is ready to give himself away. Clegg (1942) disapproves on the grounds that no repressed material is elicited by narcoanalysis. He prefers hypnoanalysis, particularly with soldiers whom he regards as good subjects. He considers that narcoanalysis is liable to interfere with the *rapport*, and that the patient is liable to repudiate at a

subsequent interview the material elicited. He does not complain of this experience with hypnoanalysis, but there are some psychotherapists with experience of both methods who would consider such an eventuality as probable in the one procedure as in the other.

Another method that is referred to more or less casually by several writers is prolonged narcosis. This comes under the heading of psychophysical methods. It is a very old method, and in its early form was advocated by McLeod (1908) for the cure of drug addictions. But the bromides which were used originally proved too toxic for the desired duration of the narcosis. However, with the introduction of certain much less toxic barbiturates the method came into vogue again. Soneryl is used by many workers with satisfactory results. It is administered in the form of gr. iij suppositories. The maximum dose in 24 hours is about gr. xviij. The narcosis may be maintained for as much as 14 days. This is a useful technique for acute anxiety cases which are otherwise inaccessible.

This war is unquestionably the first in which the emotions of the civil population have been subjected to demands so similar to those experienced by the armed forces. And yet there is an essential difference generally present —namely, that the soldier can, at least indirectly, retaliate, whereas the civilian cannot. It would follow from this fact, at least on theoretical grounds, that the proportion of anxiety cases developed by civilians would be in excess of that manifested in the forces. It would be hard to establish such a result owing to the wide incidence of bombing raids. On the other hand, what can be established is that among civilians, anxiety and other psychoneurotic manifestations resulted in greater measure from the secondary effects of war than from direct experience of bombing. By " secondary effects " are meant evacuation, family separation, economic strain and occupational problems. Accordingly we find somewhat different conclusions reached by psychotherapists dealing only with civilians and those reached by observers concerned with military, naval and Air Force personnel.

Pegge (1940) describes a regular technique for civilian air-raid casualties. If the patient was unconscious he treated him as hypnotized on the assumption that even in an apparently unconscious state, suggestions could be heard and registered. In every case the traumatic experience was recapitulated in detail. Sedatives were administered, and at the end of three days the patient was either returned to his home or evacuated to a base hospital. Wilson (1940) depends on reassurance and persuasion reinforced by drugs. Dicks (1940) reported good results from abreaction, especially under evipan. Cuthbert (1941) describes a type of civilian case that passes into chronicity for want of any psychotherapeutic help.

It is clear from the above rather contradictory views that no agreed procedure can be expected when psychotherapists are working under the stress of occupational and environmental pressure. The reactions of a soldier discharged differ from those of a soldier who anticipates return to his unit ; the reactions of a civilian in an exposed area differ from those of one in an evacuation area ; the reactions of anyone with a safe home in the background differ from those of the homeless and the indigent.

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