THE INDICATIONS FOR PSYCHO-ANALYSIS*

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IF the standards of psychotherapy approximated to those in vogue in the field of organic medicine a lecture on the indications for psycho-analysis would be a comparatively brief and possibly tedious affair. Since, however, there is no uniform diagnosis of mental disorders, no exact account of the rationale of psycho-analytic treatment and no assented list of the modifications of treatment required in different forms of disorder, it is obvious that before we can usefully discuss indications for psycho-analysis or in other words the scope of psycho-analytic treatment we must arrive at a certain amount of agreement regarding the diagnosis and prognosis of mental disorders and the nature of psycho-analytic therapy.

Before attempting to do so we must recognize a subjective source of bias, which although not unknown in general psycho-therapy is particularly obstructive of progress in the case of psycho-analysis. Owing to the early and widespread opposition with which they were faced, psycho-analysts developed and still maintain a number of protective reactions. Being put on the defensive they naturally buttressed their own position, maintaining, for example, that psycho-analysis was the most radical form of treatment for disorders of varying gravity, and sometimes, if only by implication, casting doubt on the depth and permanence of the results obtained by non-analytical treatment in such cases. To which it may be added that within their own walls, they gave short shrift to any followers who might be tempted to dally with short-term methods of treatment.

This was an unfortunate policy; for like most psycho-therapeutists, the psycho-analyst is a reluctant and inexpert statistician. No accurate records or after-histories of psycho-analytical treatment exist: such rough figures as can be obtained do not suggest that psycho-analysis is notably more successful than other forms of therapy: and in any case none of the figures is corrected for spontaneous remission or resolution of symptoms. In consequence of all this psycho-analysis has developed a so-far unacknowledged mystique which borders on the esoteric, and, like most esoteric products, springs from inferiority feeling. The attitude is in any case as ill-founded as it is aggravating to non-analysts. The validity of psycho-analytic theory never did depend on therapeutic results nor, for the matter of that, does the validity of any other theory of mental function. The fact that a very large proportion of schizophrenics are inaccessible to the ordinary expectant techniques of psycho-analysis does not invalidate psycho-analytical etiologies of schizophrenia. Research and therapy, though frequently combined in psycho-analysis, are clearly different things.

To begin therefore with definitions of psycho-analysis and of psycho-analytic treatment: it used to be said, up to twenty-five years ago, that whoever believed in the existence of the unconscious, in infantile sexuality, in repression, in unconscious conflict and in transference believed in psycho-analysis. Such was the definition of the late T. W. Mitchell, an acute and sympathetic student; and, despite the passage of time, despite increases in the theory of ego-development,

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despite increasing emphasis on the factor of unconscious aggression and a corresponding burgeoning of psycho-analytical terminology, it is still a satisfactory definition, on which criteria of psycho-analytical therapy can also be based. In short we may say that whoever holds these fundamental concepts, understands the processes of mental development by which they are arrived at, has taken steps by personal analysis to eliminate, as far as that is possible, the errors of subjective bias, has learned to apply the technique of association and interpretation and is capable of analysing as far as possible the transferences and counter-transferences that arise in an analytic situation, can call his treatment psycho-analytic therapy.

Of those conditions, the capacity and determination to analyse the transference is decisive when drawing a distinction between psycho-analysis and other forms of psycho-therapy. It was Ernest Jones, I think, who was in the habit of saying that there are only two forms of psycho-therapy, namely, psycho-analysis and suggestion. Although this must appear an unduly sharp saying to psycho-therapeutists who spend a good deal of devoted energy and ingenuity on analysing the material or symptom-formations presented by their patients, it is certainly true in the sense that an analysis which does not analyse the transference is no different from any other form of psycho-therapy: it depends ultimately on the state of therapeutic rapport existing between the psycho-therapeutist and the patient.

General psycho-therapeutists may however take comfort from the reflection that however sharp the saying, it is also two-edged. For should the analyst not succeed in analysing the transference, or should his modifications of technique, e.g. in the direction of active measures or of moral support, prevent his successfully analysing the transference, then his treatment depends for its success or failure as much on factors of rapport as on his analytical activities.

A further case exists: should the analyst's interpretations be consistently inaccurate then quite clearly he is practising a form of suggestion, whatever else he himself may call it. It follows then that when analysts differ radically as to the etiology or structure of a case—as they nowadays do with increasing frequency —one side or the other must be practising suggestion. Since analyses, in private practice at any rate, tend to be lengthy, seldom less than two years and frequently of four years' duration it can easily be imagined how powerful the force of such analytical suggestion must be.

Regarding the question of modification of analytical technique it is obvious that the necessity for such modification depends on how widely the analyst casts his therapeutic net. For it is clear that if one attempts the analysis of, e.g. drug addicts, psychopaths and psychotic cases, the situations existing during crises do not usually permit continuance of the expectant technique used in the psycho-neuroses and equivalent states. It can however be fairly claimed that, provided the usual techniques of association, interpretation and transference-analysis are followed whenever possible, such modifications as are entailed by the clinical necessities of the case or by the need to safeguard such of the patient's interests as he is for the time himself incapable of safeguarding, can justifiably be called psycho-analysis.

Having arrived at a working definition of psycho-analytic therapy, we may proceed to consider the difficulties arising from variation in classifications of mental disorders and in methods of diagnosis and prognosis. Here I think psycho-analysis may justly be said to have added considerably to our understanding both in diagnostic and in prognostic respects. Although ready to accept most of the clinical distinctions advanced by psychiatry, psycho-analysis

has chosen to adopt a *developmental approach* to these clinical data. In the first place it regards all adult disorders, most adolescent disorders and a few prepubertal disorders (notably the obsessional neuroses) as end products, the predisposition to which is established during the first five to six years of life. The nodal points in maldevelopment, mostly unconscious to be sure, are termed fixation-points, which vary in number, depth and scatter. Following the theory of fixation-points, psycho-analysis has arranged adult mental disorders in accordance with the developmental level to which the mind regresses when faced with precipitating factors of frustration or traumatic excitation or both. Thus to take a few instances, anxiety hysteria is regarded as having an etiology based on disturbances at the fourth and fifth years of mental development when genital anxieties constitute the main pathogenic factors and repression is the main defence, the obsessional states as having fixation-points about the three to four year level when pregenital factors are decisive and defence is mainly reactive in type, and most psychoses as products of maldevelopment occurring during the first three years of life when both libido and ego development are exceedingly primitive. Classifications on this basis have not yet been worked out for various intermediate or transitional conditions but there is every prospect that a fairly accurate hierarchy of pathological elements based on developmental criteria will some day be established. Alcoholism and some types of psychopathy for example illustrate transitional forms lying between the neuroses and the psychoses.

The validity of this developmental approach is borne out by two circumstances of considerable therapeutic significance. The first of these concerns the degree of ego disorder and the second the degree of "transference potential" or "accessibility" as it is often called. It is in accordance with theoretical considerations that the more profound mental disorders, having early and scattered fixation-points, should show greater instability and lack of synthesis of the ego than, for example, the neuroses. For therapeutic purposes, this factor can best be described in two ways, first, by the degree of capacity of the ego to withstand stress and trauma, and, second, the degree of capacity to make accurate reality estimations. It is obvious, for example, that if the faculty of reality-proving is gravely disordered, there is little prospect that the ordinary techniques of expectant analysis will be effective, if indeed they are even applicable.

Similarly with the transference factor. The earlier the fixation-points the more tenuous the positive transference bond and the less accessible the patient is to that opening-up process of analysis which depends on a working transference. In this connection it is useful to recall that Freud originally designated the hysterias and obsessional states as "transference neuroses" and that psycho-analysis achieved and still achieves its greatest number of successes in this particular field. In illustration of the value of the developmental approach and of the practical (therapeutic) significance of ego-synthesis and of "transference potential", we may consider the fact that whereas the hysterias are readily accessible to analysis, cases of "pure" obsessional neurosis (i.e. unmixed with hysteria) are extremely difficult to resolve and commonly require a lengthy analysis, up to four years in many cases. This can be understood partly in terms of the earlier fixation points of the obsessional states, and partly the ambivalue of the transference. It is much better understood if we reflect that the obsessional states, behind which we can sometimes detect in the unconscious depressive or even paranoid layers, seem on the whole to protect against psychotic regressions. Although they may persist and expand up to the forties, they rarely regress to a psychotic state. Their refractoriness to analysis is thus

seen to be a function of their defence of the ego against further regression.

Although psycho-analysts like most other psycho-therapeutists concentrate a good deal of their energy on the classical psychiatric disorders, they have also turned their attention to two other large psychopathological groups, viz. the so-called character disorders and the psycho-sexual disorders. Both types of disturbance are commonly found in association or conjunction, as in marital difficulties; and it is tempting to suppose that both groups are also capable of sub-division according to developmental (predisposing) levels. Although plausible in theory, this correlation between developmental layer and pathological end-products is much more difficult in character cases and sexual disorders than it is in the case of psychiatric "symptom-formations", where the clinical symptoms afford relatively easy means of identification. This is easy to understand. A symptom-formation carries on it the hallmark of its origin: a character disorder does not have the same developmental hallmarks, a psycho-sexual disorder still less.

Fortunately for diagnosticians there are many exceptions to this rule. An obsessional character for example is so close in pattern to an obsessional neurosis that it is not hard to find common developmental origins, and where homosexual or anal-sadistic sexual perversions are accompanied by obsessional characteristics it is not difficult to suppose that they too spring from roughly the same level. On the other hand the condition of impotence may occur as frequently in the psychoses as it does in persons of an anxiety type and diagnosis of its clinical importance can be effected only on the strength of accompanying characteristics or symptom-formations.

Despite these difficulties there are considerable diagnostic, prognostic and therapeutic advantages to be gained by ordering symptom-formations, character disorders and psycho-sexual difficulties in roughly parallel series and by establishing rough *states of equivalence* between the three groups. Perhaps the best illustration is afforded by those transitional states that lie between the psychoses and the psycho-neuroses. Analytical examination of alcoholism for example, shows that these states can be divided roughly into four groups; those that show a predominantly projective character, veering towards persecutory feeling and reaction; those in which there is a depressive basis to the addiction; those in which obsessive (compulsive) tendencies predominate; and those in which the periodic bouts of alcoholism coincide with excessive anxiety and/or inferiority manifestations. Running parallel to the persecutory type of alcoholism are certain forms of active homosexuality associated with strong contamination fears; the psycho-sexual manifestations etiologically equivalent to the depressive types of alcoholism fall mainly in the inhibited group, and express themselves commonly in impotent forms of homosexuality: obsessional types of alcoholism find their psycho-sexual parallel in fetichism; and anxiety types of alcoholism correspond with the familiar forms of psycho-sexual impotence which have however a strong latent homosexual disposition.

Correlating the same three groups with character difficulties, we find the persecutory type of alcoholism corresponding with severe difficulties in social adaptation, querulence, suspicion, aggressiveness and incapacity in social relationships, the depressive type corresponding with chronic incapacity and lack of success in work, the obsessive type with obsessive indecision in life and work, and the anxiety type with marked social inferiority.

As has been admitted, these correlations have not been very fully worked out, but already they enable us to arrive at useful prognostic assessments. The obvious difference in therapeutic response between the persecutory and the

anxiety type of alcoholism can also be detected in the equivalent character and psycho-sexual disorders. It is important to be clear about this, otherwise the whole problem of indications for analysis is liable to be confused. Unless we make such etiological distinctions, it is in fact impossible to give a straight answer to the simplest questions, such as, "Is psycho-analysis indicated in alcoholism?" Similarly with the equally simple question "Is psycho-analysis indicated in impotence?"; the answer is of course "It depends on the underlying states of disordered defence". Again, although psycho-analysis obtains some of its best results in the treatment of anxiety hysteria, he would be a reckless prognostician who would recommend it in the case of monosymptomatic phobias without first of all examining the character structure to see whether this belongs also to the uncomplicated hysterical group or whether there is evidence of larval psychotic reaction, as there often is.

So much for the symptomatic aspects of the problem, but symptomatic criteria alone do not resolve the many difficulties attendant on making a prognosis. Nor for the matter of that is it possible to give an exact prognosis by estimating, however shrewdly, the transference potential. A patient may appear and in fact be quite accessible to a psycho-analytic approach, yet the analysis may miscarry or end in stalemate simply because in the process of diagnosis, too little attention has been paid to the total function of his mind and in particular to the factors of primary and secondary gain.

Now the primary gain, that is to say, the part played by the symptom-formation in maintaining however inefficiently and at whatever cost to the individual the dynamic balance of the mental apparatus, or in simpler terms in avoiding a break through of unconscious conflict, is not easy to estimate during preliminary examination. One may in all cases suspect that it is powerful enough, particularly where the form of the symptom-formation suggests either a reinforced masochistic predisposition or a defence against acute sadistic conflict or again violent psycho-sexual anxiety. The primary gain in some depressions, in most obsessional neuroses and in many forms of hysteria or marital disorder is extremely hard to deal with, but it is rarely possible to estimate it with accuracy until after a probationary period of analysis.

Secondary gain is quite a different matter. There should be no great difficulty in estimating already at consultation whether by virtue of his neurosis or other disorder the patient succeeds in securing a favoured situation in his family environment, or is able to conceal his deficiencies from himself, or whether his conditions of life are such as to maintain a high level of frustration which keeps a symptomatic regression alive. When, for example, an anxiety hysteric within, say, ten years of the climacteric is caught in a loveless marriage from which, owing to her obligations as a parent, she is unable to free herself, it is foolish to suppose that psycho-analysis or for the matter of that any form of psycho-therapy will liquidate even the simplest forms of phobia. When a latent male homosexual finds himself in the middle forties still unmarried and without adequate male friendships it is equally foolish to suppose that his working inhibitions will respond to however dextrous an analysis. Nor should we expect the multitudinous fifty-year-old anxiety depressions automatically to respond to a therapy which depends ultimately on an analysis of the transference and on the capacity of the patient to face squarely the emotional deficiencies of his life. Fortunately it is not hard to estimate the nature and strength of secondary gain, for, as a rule it is equal and opposite to the precipitating factor.

Summing up the prognostic situation, we may say that roughly there are

three factors to be taken into account; first, the depth of symptom-formations in which constitutional, predisposing (developmental) and precipitating (immediate) elements have to be assessed; second, the degree of transference potential, which must have a sufficiently strong positive side to withstand the stress incident to the uncovering of unconscious conflict (here the primary gain factor operates); and, third, the strength and persistence of the precipitating factors which determine in turn the strength of secondary gain. Where no major symptom formations are present and the disorder lies in malfunction of the ego and super-ego, i.e. in the character structure, prognosis is not so easily arrived at but can be estimated roughly in accordance with the total characteristics of the ego and the degree of primary and secondary gain; where the disorder takes the form of inhibition or perversion of function, particularly in work and love, the prognosis is again variable but can be roughly estimated by an examination of ego-characteristics and by such minor symptom-formations as may accompany the inhibitions and give some clue to their depth.

Although in principle the groups of factors we have considered cover the prognostic field, there are some items of sufficient importance to call for special mention. The factor of age for example is of more importance in psycho-analysis than in any other form of psycho-therapy. As has been pointed out earlier the hallmark of analysis is in the last resort the analysis of the transference, but analysis of the transference is not only a test for the analyst, it is a pretty searching test of the patient's capacity to free himself from fixations as well as from symptoms. With increasing age this feat is more difficult to compass. Non-analytical therapies in which transference support or exploitation is the rule have no such difficulties to face and consequently can be applied more readily to cases of advanced age. Despite these difficulties psycho-analysis which was originally confined mostly to the under-forties is now freely applied up to the sixties. Owing however to the factors of regression and of secondary gain it is doubtful whether many analyses of persons over the age period of 45 to 50 are ever completed in the strict sense of the term. After this age the strength of the precipitating factors is in most cases the decisive prognostic test.

It is equally doubtful, although for different reasons, whether analysis of young children is ever completed, and incidentally the therapeutic standards are also different from those applicable in the case of adults. In the first place the persistence of symptoms in a modified form need not be regarded as a failure provided there is evidence of strengthened character formation. Secondly the success of a child analysis cannot be satisfactorily checked until an after-history of 15 years has been secured. Indeed in estimating the therapeutic efficacy of psycho-analysis it would be well to exclude all children under the age of puberty and adults over the age of 45-50. In the case of adults whose age lies between these lower and upper limits, an after-history of at least 5 years is essential. Unfortunately it has to be admitted that satisfactory after-histories are seldom forthcoming; consequently our knowledge of the therapeutic range of psycho-analysis is vitiated by unchecked surmise which too often errs on the side of complacency.

We are now I hope in a better position to deal with the main topic of this paper, viz. the indications for psycho-analysis. It will, I hope, also be clear that there can be no question of sub-dividing these indications rigidly in accordance with the clinical group. Nor strictly speaking is there any need to do so. From the therapeutic point of view it is sufficient to subdivide cases into those in which cure can reasonably be expected, cases in which considerable improvement may be anticipated, cases in which only slight improvement is likely to

occur and cases which are not likely to improve except possibly in minor respects. Any notion that psycho-analysis is a panacea or that it should be recommended to every case coming for consultation is obviously absurd and the analyst who proceeds on this preposterous assumption is destined to early disillusionment. From the point of view of analytic therapy therefore, we can divide cases into three main groups, viz. accessible, moderately accessible and only slightly accessible.

The first of these groups is comparatively easy to delimit. It is constituted by the anxiety hysterias, the conversion hysterias, cases of mixed neurosis in which obsessional and hysterical elements are associated, and some cases of anxiety depression of a mainly reactive type. Care should of course be taken not to include in this category mixed neurosis where there is an underlying system of endogenous depression. To these may be added disorders of sexual, social, marital and occupational life which I have described as "equivalents" of a neurotic symptom formation. They include simple impotence, ejaculatio praecox and vaginal frigidity, early marital frictions, facultative bisexuality, anxiety of an inferiority type and phobiac types of working inhibition (e.g. examination anxiety), neurotic confusional states and lack of powers of concentration leading to incapacity to work. The feature of such equivalent cases is that the predominant anxiety arises from the later infantile genital phases of development.

At the head of the moderately accessible group I would put the average organized obsessional neurosis and obsessional character cases. As I have pointed out these are by no means readily accessible to analysis, but on the other hand I cannot think of any other method of treatment which has better prospect of penetrating the structure of these conditions. In this group come also a number of sexual perversions having their roots mainly in pregenital layers of development. Typical examples are fetichism, transvestism, and cases of active homosexuality in persons under the age of 40: the younger the better in fact. Alcoholism and drug addiction having a psycho-neurotic or mildly depressive basis also come in this category. As a rule treatment requires to be combined with a course of abstinence conducted by another physician. However difficult it may be to obtain cure by analysis, it occurs to me that to deal with alcoholism and drug addiction solely by abstinence methods and without any analysis is to leave the patient at the mercy of a psycho-pathological process which he was originally unable to withstand.

The second group also includes cases of phobia formation, conversion hysteria and the equivalents in sexual and social disorder which owing to the operation of an earlier type of pregenital fixation are more resistant to analysis, and to these I would add a number of milder cases of psychopathy under the age of 25.

I am in some doubt whether to include in the second group some cases of endogenous depression. There are certain types of both larval and manifest endogenous depression in which the traumatic fixations at late pregenital and genital levels of childhood have apparently been of greater significance than the more usual oral fixations, and in which in consequence the sado-masochistic predisposition does not offer so much resistance to analysis. Certainly a number of these cases although long drawn out respond satisfactorily, but to err on the side of caution I usually include the endogenous depressions in the third or intractable group.

As in the case of the second group, the third or intractable group includes cases which would ordinarily come in the earlier groups but for evidence of

deeper or wider ego disorder. The best example is afforded by types of alcoholism which cover either an endogenous depression or a paranoid predisposition. The third group also includes cases of anxiety hysteria which appear to have a psychotic sub-structure. Many severe monosymptomatic phobias are of this type, but the main constituents of the group fall under four subheadings, the pure psychoses, the psychotic characters, severe cases of psychopathy, and sexual perversions and inhibitions of an equivalent order, including incidentally some apparently simple cases of impotence and frigidity and a large number of marital disorders. Needless to say amongst the psychoses the endogenous depressions are the most favourable and the pure paranoias the most unfavourable.

It will be observed that no mention has been made in any of these divisions of the expanding group of "psycho-somatic" cases. My reason for omitting these is really to raise a special problem, viz. of cases suitable for psycho-analytically directed therapy as distinct from pure psycho-analysis, which as you know is a lengthy and more or less standardized procedure, involving under the present usages of private practice, a period which, unless curtailed by extrinsic circumstances, runs in the average from 18 months to 2 years, with an average of 5 weekly sessions and involving fees that are likely to tax the resources of all except the well-to-do. The decision to recommend straight analysis in psycho-somatic cases depends on whether the patient also presents neurotic or psychotic symptom-formations or again sexual or social inhibitions or perversions of the kind already tabulated. In such cases psycho-analysis is indicated, but with the same sub-divisions of prognostic groups, mild, moderately accessible and intractable. It should be remembered that psycho-somatic conditions contribute to what are sometimes called patho-neuroses or organ-fixation-neuroses, also that a pure psycho-neurosis can be readily built round a psycho-somatic core. When however no such complications exist the case can well be dealt with by short-term exploratory and abreactive methods, which however I have no hesitation in maintaining should be based on psycho-analytical principles and orientation. For I do not conceal my view that alone amidst the welter of present-day psycho-therapeutic systems, psycho-analysis offers a reasonable theory and etiology not only of mental disorders but of those disturbances of mental *function* (as distinct from "symptom-formations") which follow from states of mental over-excitation of whatever cause.

Having roughly divided the cases that appear most commonly in the psychiatric consulting room into three prognostic groups, it is possible to give an equally rough indication of recommendations. The first group comprises those cases in which psycho-analysis, in my view, ought to be recommended forthwith and with a reasonable expectation of cure. The second group comprises cases in which substantial improvement may be expected but where there is no certainty of cure. In the third group certainty of cure or even of major improvement cannot be expected and should never be promised. It is true that well-selected cases taken from this third group may from time to time give surprisingly good results, but it would be absurd to pretend that on the average more than a mild degree of betterment can be expected.

Nevertheless, as I have suggested in the case of alcoholism, the indications for psycho-analysis should not be determined exclusively by prognosis. No organic physician would refuse to treat a case of rheumatism because it was chronic, intractable and promised at best only a mild degree of improvement. So long as there is reasonable chance of an improvement which could not be obtained more rapidly by some other form of psycho-therapy, it is perfectly

justifiable to recommend psycho-analysis in difficult cases. Particularly in the psychoses, psychotic characters and severe sexual disorders therapeutic failure is an honourable failure which may in course of time lead to an improvement of the therapeutic instrument. Other things being equal, what should determine the recommendation is an objective assessment of the will to recovery as opposed to the primary and secondary gains secured through illness. A favourable balance justifies the recommendation.

A short postscript on lay-analysis. A properly qualified lay-analyst can safely be entrusted with any of the cases listed above with the exception of certain well-defined groups (*a*) cases of somatic disturbance of whatever kind that call for clinical (medical) discrimination, (*b*) cases in which crises may arise involving danger to life. This latter condition automatically excludes the psychoses and psychotic characters. In any case these should be excluded since lay-analysts undergo no adequate training in psychiatry. To be on the safe side it might be desirable also to exclude such cases as call for concurrent sedation and for a decision as to periods of institutional supervision. But of course this difficulty can be overcome provided there exists an adequate liaison between the lay-analyst and the psychiatrist recommending the case. In many instances it is essential for the medically trained psycho-analyst to maintain similar communications. In cases of alcoholism involving complete abstinence the necessity for this is obvious, for the analyst cannot well conduct the abstinence; but also in cases involving supervision it is essential for the analyst to have ready means of support in the event of crises developing which require hospital supervision. The psycho-analyst who throws his therapeutic net widely is faced with frequent uncertainties, anxieties and harassments and it is of considerable moral and professional support to him on occasions of difficulty to know that he has behind him the expert knowledge and co-operation of an understanding psychiatrist.