SOME OBSERVATIONS ON INDIVIDUAL PSYCHOTHERAPY WITH PSYCHOTICS

BY DORIS MENZER, M. D., CHRISTOPHER T. STANDISH, M. D., AND JAMES MANN, M. D.

Interest in treating psychotics with psychotherapy is relatively new. The reluctance to treat them stemmed in part from the difficulties arising from the patient’s defenses and resistances. Patients were regarded as withdrawn and inaccessible, and it was the rare therapist who could retain his enthusiasm in the face of the indifference shown by some patients to the therapist and the inconsiderate and even violent behavior shown by others entailing a great deal of verbal and physical abuse. Discouragement resulted also from the difficulty in understanding the meaning of the language and symbolic behavior of some patients.

Further distance was placed between the patient and the therapist by the general feeling that the prognosis in psychoses was poor and that therapeutic efforts were doomed to failure. Freud’s paper on narcissism further contributed to this general feeling by stating that it was impossible to establish a transference relationship with a psychotic because of the patient’s narcissistic withdrawal. Since transference was regarded as the essential therapeutic tool, the conclusion was obvious that psychotic patients could not be treated. When it was more recently shown that transference could be established with psychotic patients, interest in psychotherapy of the psychoses was reawakened. It was shown by a number of workers that therapeutic results could be obtained.

Early in the present writers’ experience in psychotherapy with psychotic patients it became apparent to them that many of the difficulties in treatment stemmed from the therapist’s own personality. Confronted with the intense feelings of the psychotic, whether they be rage, disappointment, or panic, the therapist very soon becomes aware of his own discomfort, which sometimes may become so distressing that it necessitates termination of treatment. In some cases it may lead to an enforced loss of interest in this type of work. In another paper, the writers have attempted to deal with this question more thoroughly and have indicated that the discomfort of the therapist is based on feelings of frustration, anxiety, hostility and guilt, which in turn stemmed from a reawak-
enning of old repressed conflicts in the therapist. To summarize, the general reluctance to treat psychotic patients can now be viewed as arising from the nature of the patient's illness and the great stress that this illness places on those who attempt treatment.

The program in psychotherapy was introduced at Boston State Hospital about three years ago, and was oriented not only in the direction of the difficulties presented there by nature of the patient's illness, but also by the problems arising from the stress placed on the therapist. Staff conferences were instituted for discussion of treatment. They were oriented primarily around the interpersonal relationship between the doctor and patient. The difficulties arising in this relationship were soon found to be shared as common experience. Spontaneous discussion of these difficulties helped to overcome the frustrations, fears, doubts and hostilities of the therapist. Such discussions were often helpful in carrying on in a difficult treatment situation. Different technics and approaches were explored in an attempt to find methods to deal effectively with difficulties arising from the patient's defenses and resistances. Some of these methods proved helpful; others were discarded. The prevailing atmosphere of spontaneous discussion served to overcome the resistances of the staff who were reluctant to begin—so that at the present time every member of the staff is engaged in some psychotherapeutic endeavor. Individual case supervision with the clinical director reinforced the aims of the staff conferences. In these sessions the therapist had the opportunity to discuss some of his more intimate problems arising in the treatment situation. The growing realization of the therapist's understanding of his own personality as an asset in working with psychotic patients has led many members of the staff to undertake personal analysis.

At this point the writers would like to present their more specific observations. They will first deal with difficulties in starting the therapeutic relationship arising from defense mechanisms, resistances and transference phenomena of patients. From a therapeutic standpoint the patients could be divided roughly into three groups: (1) The overactive and assaultive patients who drive the therapist off; (2) the withdrawn or mute patients who keep themselves inaccessible in this way; (3) the patients whose behavior lies between these two extremes. These last form the largest of