Psychotherapy Guidebook

Direct Psychoanalysis

John N. Rosen

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DEFINITION

Direct Psychoanalysis is a method of treatment for the emotionally disturbed. It utilizes the insights and dynamics established by Freud and his co-workers, but modifies them in an effort to enhance their therapeutic value with a greater emphasis on treatment rather than investigation. It proffers that the manifest content of the illness is analogous to the cry of a baby, which indicates that something is wrong. With a baby, if the disturbance is corrected, the cry stops and the baby regains peace of mind. With the sick patient, if the disturbance is corrected, the symptoms stop. If the mother simply observes the crying baby — for instance, the loudness of the cry, the redness of the baby's face, the writhings of the baby's body, etc. — it might be excellent research, but would hardly stop the baby's crying. On the other hand, if the mother discovers the reason for the crying and does what has to be done about it, the crying will stop. In order to listen in a meaningful way, a special kind of knowledge is required. A direct psychoanalyst can discover the reasons for the disturbance.

HISTORY

Direct Psychoanalysis began in 1939 with my personal analysis. From my world of internal medicine and pathology my attention was increasingly directed toward psychosomatic medicine, and finally to full-time work in a state hospital and the world of deep psychosis. There I was taught shock treatment and drugs, which were ineffectual and cruel. I heard about a patient with acute catatonic excitement who died and was about to be autopsied. I went to the morgue where the autopsy was performed and was astonished to discover that there was no anatomic cause of death. Death came about from the agonies in the patient's mind. It was said there were other such patients in the hospital that it was just a question of time before they died, and that nothing could be done about it. I went to the wards where these patients were kept and I was surprised to find that they were not out of contact in the sense that I could understand what they said. I treated these patients and they did not die, but recovered. From this initial discovery, that what a patient said made a certain kind of sense, I began to listen over the decades to hundreds of patients and almost invariably I was able to understand the peculiar language of the neurotic and the psychotic. To this body of knowledge, both theoretic and clinical, Paul Federn gave the name Direct Psychoanalysis in order to distinguish it from orthodox and indirect psychoanalysis. Freud said that since the psychosis is like a dream and since we awaken in the morning from a dream, it was his hope that one day a method would be discovered that would awaken the psychotic from his relentless nightmare. Many colleagues

report that Direct Psychoanalysis offers the possibility of doing just that.

TECHNIQUE

There are many different techniques involved in treatment by Direct Psychoanalysis, in large measure they depend on the nature of the case and the varying skills and personalities of different therapists. Since no teaching institution has been able to give us a consistent model for physicians or patients, the Direct Psychoanalytic Institute has abandoned this effort and devotes its attention to those areas where we can standardize and categorize the areas of similarity.

First and foremost, we agree that a hospital is the least desirable place to treat a patient. In this situation, the number of patients, the inexperience of the personnel, and the jealousies and frustrations that are aroused by the attention any given individual gets make therapy exceedingly complicated. Ideally, the place for treatment should be arranged in the best interest of the individual patient. The way my colleagues and I did it during research on Direct Psychoanalysis at Temple University Medical School in the late 1960s was to obtain three row houses, which were then staffed with psychologically trained personnel. There should be three such helpers: one, a woman who acts as the foster mother; the other two should be males, because protection is required both for the patient and the community at large.

There are daily sessions with the therapist in the presence of those responsible for the operation of the treatment unit. This consists of what we call the therapeutic dialogue, where the therapist listens, observes, and uncovers the meaning of what is said and done — usually a crumb at a time, until as much of the whole as possible becomes visible. Over the balance of the twenty-four-hour day, the assistant therapists continue along the lines that the therapist has established so that treatment becomes a continuous process. Here, like the baby we referred to in the beginning, we find that the psychotic has regressed to the earliest infantile levels. This might include such behavior as soiling, wetting, or the inability to feed or clothe himself. Like a baby, the patient must be cared for day and night.

The therapeutic dialogue uncovers the fact that transference (where the client shifts feelings about a significant person to the therapist) and intense resistance will dominate the scene. This, as in conventional analysis, follows the understanding of repetition compulsion. If these are successfully managed, the patient develops a childlike dependence on the therapist and at this positive phase of therapy, education and discipline can begin to be achieved.

Termination takes place automatically when and if the patient regains normal judgment. The family, the patient, and the therapist agree that the patient can be returned to society at large. Since one cannot be sure that the

end point has really been achieved, it is understood that if the patient exhibits unusual behavior, he should either visit the therapist on an outpatient basis or, if necessary, return to the treatment unit.

APPLICATIONS

We have found this method of therapy most useful with people classified as psychotic. It is especially useful in depressives who have already made a suicidal attempt or where the possibility of suicide is present. Obviously, as a precaution, the patient must be guarded twenty-four hours a day or he may very well be lost. The treatment unit is best suited for this protection.

Direct Psychoanalysis can do nothing for a patient who has been lobotomized. The more a patient has been subjected to shock therapy or, to a lesser degree, drug therapy and hospitalization, the more guarded the prognosis becomes. Neurotic patients, particularly those with anxiety hysteria, are the easiest to treat. We have found that hysterics, agoraphobics, claustrophobics, and various forms of psychosomatic fixations are sometimes quickly resolved.