AN EXPERIENCE WITH PSYCHOANALYTIC PSYCHOTHERAPY IN SINGAPORE

D S G Kong

SYNOPSIS

The treatment of nine patients with neurotic disorders using psychoanalytic psychotherapeutic techniques were described in this paper. Treatment was based on the analysis of transference to the therapist and to significant others in the patients' life. Differences with traditional psychotherapeutic practice in the West highlighted include the use of behavioural techniques and the long interval between sessions. These were related to social and patient factors prevailing here. The results of therapy were in the majority of cases improved psychological and social functioning. It is argued that there is a need and a place for psychoanalytic psychotherapeutic techniques in local psychiatric practice.

SING MED J. 1988; 29: 327-331

INTRODUCTION

Although psychoanalytic theory and concepts has been popularised in Singapore largely by American writers and paperbacks, psychoanalytic psychotherapy as a technique of treatment do not appear to have been utilised by psychiatrists here until recently. Indeed some form of psychotherapy may have been used in the local context, but these can hardly be conceptualised as psychoanalytic in approach. By and large, psychiatry in Singapore is biological in orientation with an emphasis on medical treatment. This is inevitable given the large number of psychotic patients and the small number of practising psychiatrists.

The practice of psychoanalytic psychotherapy locally is not without difficulties. Most of our patients sought the help of doctors because of some physical or psychological symptoms. Therefore when there is improvement with significant reduction of symptoms, patients often question the need for more sesions and further therapy. Further to attend for psychotherapeutic sessions meant frequent time off work regularly and this is often not tolerated by employers and colleagues. The fear is obvious that their frequent psychiatric consultations may led others to infer that they are psychotic with its attendant social stigmatisation.

The question that obviously arises is whether there is a need for a psychoanalytic approach to treatment? For psychotic patients, the mainstay of treatment will be mainly pharmacological. In neurotic and related disorders, the present treatment modalities available are probably inadequate. The majority, mainly treated by chemotherapy, is likely to benefit from psychological techniques such as supportive psychotherapy or behavioural therapy, as a very few would probably be offered. The time is now opportune to describe and evaluate such techniques including psychoanalytic techniques in the local setting. As far as psychoanalytic techniques are concerned, there had not yet been any description of techniques, psychopathology or evaluation within the local context. This paper is therefore a report of the author's clinical experience with psychoanalytic psychotherapy over a period of 4 years and an evaluation of that experience. This paper also sought to confirm the view that there is a need for the application of such techniques in non-Western countries like ourselves. (eg. 1) To establish such a need, it must be demonstrated that psychiatric disorders encountered must be amenable to conceptualisation within a psychoanalytic framework and that the application of psychoanalytic techniques lead not only to symptom reduction but also to an overall improved psychosocial functioning. That patients with such disorders do seek for psychological treatment is evidence of such a need as well.

Department of Psychological Medicine
National University Hospital
Lower Kent Ridge Road
Singapore 0511

D S G Kong, MBBS, DPM, MRC Psych,Senior Lecturer

A modified version of this paper was presented at the Recent Advances in Psychiatric Treatment — 1st International Conference. San Francisco, U.S.A., 14-19 September 1986

PATIENTS

The clinical material used in this paper consisted of 9 patients treated by the author over a period of 4 years. All but 2 were female. Their ages ranged from the early twenties to the thirties. Four were married and all were Chinese except for one Malay. Their clinical diagnoses by ICD-9 nosology were: 2 anxiety neuroses, 3 neurotic depression, 2 cases of anxiety with depression and a case of conversion hysteria with depression. The period of treatment of these patients thus far ranged from 9 months to 42 months as they commenced treatment at different times. To date, most had at least 12 months of therapy which are still ongoing except for one case.

METHOD OF THERAPY

The techniques used by the author was set within the broad framework of object-relations theory informed by existential values of meaning, responsibility and hope.[2] The general approach has been to explore feelings and emotional responses, understanding it psychodynamically using techniques similar to that of Goldberg et al.[3] Emphasis is placed on the analysis of transference to the therapist and to significant others in the patient's life. Therapeutic effort was also directed at resolving intrapsychic conflicts and the correction of distorted reality testing.

Therapy is conducted in a consulting room that catered for both physicians and psychiatrists. The room is furnished simply with an examination couch and basic furniture. The patient is seated facing the therapist sideways. The couch is

never used except when hypnotic techniques are applied. Psychotherapy is normally offered after a period of treatment when it was considered that a psychodynamic understanding is likely to be beneficial. The result is that patients when first started on psychotherapy would be on some medication and still would be for at least quite a while into therapy.

Frequency of Sessions

Experience with local patients indicated that the orthodox rule of weekly sessions was for many patients an unattainable ideal. This became apparent when the author began to admit patients into long-term psychotherapeutic work. Patients invariably and repeatedly requested for longer intervals in-between visits. The reasons given for this request were inevitably related to their work. They had difficulty in getting time off work, more so to see a psychiatrist so frequently besides being not obviously symptomatic. Non-working patients plead the cost of attendance and transport as reasons for not coming more frequently. Only in two cases was it possible to see the patient weekly. In most cases, the frequency of visits settled to one session every 2 or 3 weekly.

However as therapy proceeded, there would be occasions where because of therapeutic breakthrough, more psychological work needed to be done. During such time when there is more psychodynamic change, the patient after persuasion would normally agreed to be seen at least 2 to 3 weekly for a period of at least a fortnight or three weeks. For some the frequency of sessions was achieved by impatient sessions daily.

The impact of such variability of interval in-between sessions would be a greater interplay of psychological factors. In particular, the request for a longer interval may be a manifestation of resistance. This is a definite limitation and difficulty, although not all patients all the time made that request. In one case where the patient repeatedly requested for a longer interval was the interpretation of resistance made. This was substantiated when she eventually terminated because of transference difficulties.

Psychotherapeutic Evaluation

The psychotherapeutic treatment of patient is preceded by a psychodynamic evaluation of the patient. This preliminary investigation would provide the framework for a psychodynamic reconstruction of personality and emotional development and the evolution of psychopathological symptoms.

> **Case 1:** TKI, male, 20 years, was inducted into National Service. Four months after his induction, he developed an anxiety state with a severe tremor. He was referred to a physician where he was investigated for endocrine disorders. When these were negative, the possibility of an anxiety state was considered and he was referred for a psychiatric evaluation. Although he was on a moderately high dose of anxiolytic, his symptoms did not completely remit. A psychoanalytic evaluation was initially unsuccessful, but repeated focussing on life events finally uncovered the following which indicated the presence of an oedipal conflict underlying the neurosis:
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> 1. Both parents were harsh and punitive in their discipline,
> 2. He was living with both of them then working abroad when at the age of 6 years, he was sent home to Singapore for his education. On his return, a persistent stomach pain that he had for some years disappeared until his parents moved back home and he returned to live with them.
> 3. A change in language stream while in secondary school as a result of educational policy changes led to poor academic performance, persistent parental criticism and an anxiety state lasting some 3 years.

The above case highlighted the biological orientation of medical practice in which both doctor and patient are engaged in a search for an organic cause to symptoms and a physical remedy for them. Psychological explanations are often rejected or undervalued with the assumption that such an explanation implied either madness or constitutional weakness both undesirable. From the developmental viewpoint, psychological causation and psychodynamic conceptualisation allowed an understanding of any psychiatric psychopathology for psychological intervention purposes. Thise case certainly responded to a psychoanalytic approach combined with a behavioural anxiety reduction technique.

Intervention techniques

Techniques used by the therapist to help the patient included most of the techniques described in the literature including construction, the demonstration of recurring patterns in the patient's life, confrontation and clarification. Because local patients usually are inhibited and unable to verbalise their feelings as a result of their upbringing, they therefore needed help to do so. Furthermore as a result of denial and repression of negative affects, identification of affective responses are also handicapped. As a result, in the early stages of treatment, the therapist would verbalise for the patient in a hypothetical way and allow the patient to refute or confirm that verbalisation. Using this techniques, patient's feelings were clarified and identified as to their nature and direction. Sometimes the rage experienced by the patient is so generalised that even the tentative expression by the therapist on behalf of the patient is not recognisable by the patient at all initially. The patient quoted below is illustrated of this:

> **Case 2:** TPL, female, 33 years, first presented with a suicidal attempt when because of problems with her husband and in-laws developed a severe depression. Attempts at trying to resolve the conflict by relatives led to family meetings in which the father-in-law insisted that he was right and did all in the interest of the family. Faced with such an overwhelming assault on her ego defences by authoritarian figures, her own conflicts with parental figures were reactivated. After her depression symptoms subsided, she developed hypomanic symptoms and this alternation of depressive and hypomanic spells continued for 24 months. During this period, she was admitted for inpatient treatment 3 times and supported psychologically throughout by a psychodynamic understanding of her conflicts. Inspite of the fact that she readily provided material of a historical nature of rows and disagreements between herself, parents and now in-laws, feelings attached to those events were consistently denied. Yet she experienced severe tension and anxiety, persistent insomnia and sometimes homicidal and suicidal feelings (she was able to acknowledge them). When encouraged to talk about her feelings, her response had been consistently: "There is nothing wrong, so I don't know what to talk about." "There is not much to talk about, I do not know where to begin. I don't even know what I'm feeling, how do I talk about them." Statements like above would be made in a detached manner indicative of the way her emotions were denied and repressed.

Use of Hypnosis

Hypnotic techniques was also used as an adjunct to psychotherapy partly to facilitate the gathering of affect-laden historical material, and partly to evaluate the effect of these events on ego functioning. By the use of such techniques, material which might be difficult to access because of repression and denial was made available for thearpy.

> **Case 3:** LML, a 38-year old professional was seen by several psychiatrists for multiple suidical attempts and diagnosed as a case of personality disorder with depression. She was described as attention-seeking

and recommended for compulsory admission as a result of her suicidal behaviour. She was referred for psychotherapy as "an interesting case of an otherwise artistic lady with skills in poetry and painting." Her poetry however, appeared to be lacking in depth and feeling. Initially at each session, she was weepy and depressed and unable to progress beyond comments of inability to cope. Under hypnosis, she was able to relate that when she was two years of age, her father disappointed that she was a girl, married another wife and fathered a son. When news of the boy and the affair reached the family, there was a series of rows in which both parents made threats at one another. Although the father dropped his second wife subsequently, the mother herself after some years carried on a liaison with another man in which the patient as a child was both a witness and accessory. The effects of these events in the childhood years had long-term consequences. Because of her father's desire for a son and she was the only child, the father's desire was introjected and she identified herself with her father seeing herself as male in outlook. As mother was seen as inadequate and threatening, her oedipal conflicts was resolved such that she should supplant her mother in her father's affection. She therefore perceived herself primarily as female, wicked and capable of and a party of her mother's "wicked deeds". Her depression then was the result of a harsh, critical superego and an ego incapable of trusting relations. These clinical material was thus made rapidly accessible because of the hypnotic technique used.

Interpretation of Dreams

Dreams have powerful and symbolic meaning and their interpretation is one of the cornerstone of psychoanalytic treatment. Similarly for most local people, dreams can foretell the future, warn of disasters and affect our lives in significant ways. Bad dreams are never told particularly when they implied a "change of luck". Thus one patient felt very guilty about not warning her mother of a dream she had in which her mother was given an object that symbolised death. Her mother subsequently died in an accident and she became very depressed as a result.

It is possible that this is one of the reasons why many people reported no dreams or were reluctant to report them. It could well be true that patients may have actually had forgotten their dreams as most people do, and therefore little dream material was available for analysis. The case reported below however seemed to indicate that this may not be the case with actual dream material being consciously denied even when requested for.

> **Case 4:** LYM, female, 34 years, had been having nightmares in which there were severe rows between herself and her mother. Over a period of time, these nightmares slowly changed into scenes of her getting out of control, becoming mad, and attacking her mother in a frenzy of homicidal impulse. Yet throughout this period she consistently denied having any dreams. Finally when the anxiety provoked by the nightmares became intolerable, she requested the therapist for help to stop her from having such nightmares. When asked why she did not report the nightmares earlier on, she replied "I did not want to talk about it because my dreams were all so evil."

Behavioural Techniques

One result of the long interval between sessions is that patients sometimes became handicapped by their psychological sypmtoms. Therapy sometimes cannot proceed because of the need for sympton relief. As patients tended to be dependent, they would look to the therapist for immediate relief. Where the symptoms are incapacitating and a hindrance to therapeutic progress, behavioural techniques are employed where possible to deal with them. These techniques were often used with the patient under hypnosis using imaginery material. Below are two cases illustrative of this approach:

> **Case 5:** YML, 32 years, was first seen when a quarrel with her husband married for 6 months, reactivated her paranoid conflicts with both her parents that dated back to her first year of life. She developed a conversion paralysis of both limbs. Supportive therapy initially offered relief from the conversion symptoms but uncovered a severe depressive illness with marked paranoid features. She had a severe phobia for cats which was related to her fear of persecutory parental figures. The phobia was socially incapacitating as she was not able to go out and cope with the presence of cats outdoors. Systematic desensitisation was carried out under hypnosis to reduce the fear to manageable proportion so that therapeutic work was able to move forward.
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> **Case 4:** LYM, the patient mentioned earlier, was initially referred for depression and a severe twitching disorder involving the shoulders, neck and head muscles. The twitching was situation related in that it was worse at home and attending a job interview as well as other non-specific circumstances when she had to interact with people. The twitching was psychodynamically related to her repressed hostility towards her mother and a previous employer who retrenched her. The twitching was abolished by repeated flooding with the feared situation under hypnosis. With the abolition of her twitching, greater time and effort could now be spent on the psychodynamic work of coming to terms with her repressed hostility.

Behavioural Prescription

For the same reasons enumerated above, most patients repeatedly requested for advice on what to do in situations when they have to relate to persons who aroused in them intense anxiety. Again this appeared to be related to their depandency needs. Thus one patient insisted that only the therapist had the "wisdom" to give her a "brilliant strategy" to solve an intractable marital discord. But not all cases required it as the following demonstrates:

> **Case 6:** GPK, 28 years, a teacher in a tertiary institution came after she had underwent treatment with Transactional Analysis. She confided that she had been the unwanted child, neglected by parents and abused by her siblings all of whom she considered to be better than her both academically and in physical appearance. During therapy she still was not able to relate her childhood relationships to her present socially incapacitating behaviour. She repeatedly asked for advice but was able to say:
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> > "Please tell me what to do. I really don't know what to do. (Pause) But if you tell me what to do, I will be just a robot, doing what you advised, and not because I want to do it."

In suitable cases, however, where therapeutic progress would be aided, behavioural prescription was given very cautiously. This requires clinical judgement and the danger appear to be for the therapist to be more directive than is necessary. Like behavioural techniques described above behavioural prescription served the purpose of anxiety reduction. As some degree of anxiety must to be tolerated for the therapeutic progress, the therapist needed to maintain a fine balance between being too directive behaviourally and too passive in his therapy.[4] When offered, the behavioural prescription was given as a series of alternative options for the patient to select that which was ego-syntonic with themselves. The hidden

danger of transference phenomena emerging and interfering with the patient's emotional growth is therefore real. The judicious use of this technique had however been encouraging:

> **Case 3:** LML, after she became aware of her own intrapsychic conflicts and the way they were affecting her relationships, requested help in coping with her mother in view of her hostility towards her. She was advised to feel free in expressing her feelings provided the situation was appropriate. She was also advised to come to terms with her mother and discuss openly her feelings with her. She became more expressive in her relationships and gained in self-confidence and self-esteem. Later, she was able to confront her mother about the latter's "misdeeds" when she was young. Subsequently she again confronted her mother with the way that the latter was manipulating the family with monetary and material inducements and by guilt induction. During this period, she was also more active in therapy and was more forthright in ventilating feelings that hitherto had been denied.
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> **Case 5:** YML, had stagnated somewhat in therapy after her primitive paranoid fears were ventilated. Inspite of acknowledged homicidal and suicidal impulses, these were hold in check by her asserting that "these were sinful, and I do not want to be guilty of them." She was incapable of good object-relations and declared that she had never know how to feel for people. She had intense cravings for emotional satisfaction from female figures including two girlfriends who later disengaged her perceiving her to have homosexual tendencies. She related to male figures including her husband negatively and often have homicidal impulses towards them. Later she became pregnant and delivered a boy. While aware that that the child needed her, she found difficulty caring for him and had nightmares of the child rejecting her. She also felt hurt by the child biting her breast. She confessed she did not know how to love the child. Her own traumatic infancy with a paranoid and aggressive father was recalled and she related that whenever her mother carried her, her father would interfered. She requested for help in coping with the child, and she was advised to play with the child, to make him happy, to do things with him that she would like if she herself had been the child.

RESULTS

The treatment of all 9 patients are by no means completed at the time of writing. Yet the application of the psychoanalytic techniques outlined above have had results. There was only one failure when one patient overdosed herself after an attempt to capture the primeval bliss by resorting to her rejecting father failed to materialise. Two patients terminated treatment. One was a male who was active throughout therapy seeking for answers and solutions. When his psychological function improved significantly as a result of changed social circumstances, he left therapy. The other terminated as a result of the anxiety of a transference reaction provoked by the therapist. Unable to cope with it she terminated prematurely although she had earnestly sought treatment in the first instance. Of the remaining still under treatment, all are making steady progress at varying paces.

Overall the results have been encouraging. As therapeutic progress is made, the need for medication is gradually reduced. In 2 of the cases, medication had ceased completely for at least 10 months while others had their medication reduced or taken when needed. Symptomatically, all patients including terminated cases improved in social and psychological functioning. Besides these changes, there are observable changes in personality structure the evidence of which is being gathered.

DISCUSSION

The fact that patients improved clinically over a period of time is evidence that such therapy is indeed effective. However the need for such therapy must be seen in the context of how such patients would have been treated had psychoanalytic therapy not been made available.

In the great majority of cases for neurotic and problems of personality and relationships, drug therapy was probably the main and possibly only means of treatment offered. Some might have been offered and treated with supportive or behavioural psychotherapy by enthusiastic therapists. These would be usually directive and not bear on issues of transference, intrapsychic conflicts or other psychodynamic construct. In a fair number of cases, drug treatment might continued long term, as long as 5 or 10 years. Patients thus become "chronic" and increasingly dependent and described as attention-seeking. They are seen monthly for their supply of tranquilisers on which they are psychologically dependent. However they remained socially handicapped, unable to relate or handle their emotional conflicts as most people would in an adaptive manner. They are in a sense existing rather than living creatively.[5]

In contrast, patients described here and treated with psychotherapy improved significantly in their social and psychological functioning. This improvement after a treatment period of less than 4 years is accompanied by insights into their own personality and intrapsychic functioning. The awareness of psychological mechanisms made available for their own ego psychological resources to confront the daily problems which in the past provoked anxiety, but which is now handled in a more mature and constructive way. The progress of patients described here is more than just the result of consistent concern and empathy by the therapist present though they be throughout treatment.[6]

One issue that is not addressed here is the relative efficacy of psychoanalytic versus behavioural therapy. To the author, such disputes are redundant given the synthesis achieved between the two approaches in brief psychotherapy and in time-limited psychotherapy described in the literature.[7, 8] The method described in this paper has clear behavioral components and is therefore eclectic in approach, rather than purist, pragmatic rather than dogmatic.

Furthermore, the conceptualization of non-psychotic disorders psychodynamically has also help to clarify the psychopathology of local patients. The defenses. utilise by patients such as Case 2 and 3 where isolation, generalisation, denial, repression and control are very evident appeared to be typical of many patients here. Again the clinical picture of patients like that of Case 5 is very much like that of a borderline disorder with infantile features which require a different approach and technique altogether.[9, 10] The object relations of patients when understood in terms of an internal world formed by introjection and projection since young helped us to understand why they are so handicapped psychologically in the first instance. An informed understanding such as described here would be an aid to therapeutic effort and effectiveness.

In the majority of cases, patients were offered the option to have psychotherapy prior to their admission into therapy. Four of them had actively sought and requested for psychotherapy. Five cases not reported here and who requested for psychotherapy were not admitted for a variety of reasons.[11] Two of the reported cases were supported through a prolonged period of psychiatric illness with psychodynamically oriented supportive therapy before being admitted into formal psychotherapy.

In conclusion, there appeared to be a demand among patients for psychoanalytic psychotherapy. More than that,

there appeared to be a need for such psychological treatment for patients crippled by intrapsychic conflicts and whose coping strategies were strained by the stress of environmental crises. It is therefore not surprising that inspite of cultural difficulties in identifying and expressing feelings, the patients were slowly helped to come to terms with their affect and themselves. The need for psychoanalytic or some similarly oriented psychotherapy in Singapore seems to be beyond dispute given the above considerations.

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