The approach to psychotherapy with mental patients described in this paper is eclectic (19), using therapeutic procedures of several schools of dynamic psychology. I find, however, the techniques of the Adlerian school most helpful in reaching the patients and in lifting them out of their psychosis.

From Adler's *socio-teleological* holistic point of view (12) a functional psychosis appears as a severe mental disturbance of an individual who feels hurt and defeated by the world around him and therefore, in a mood of utter helplessness and despondency, has retreated from a dreary reality into a protective shelter, the insane asylum. Living in a world of fantasy, the psychotic patients are social shirkers, but not aware of their hidden aim which is to dodge social responsibility. Accordingly, I do not treat the mental illness, let alone pathological symptoms, as such, but rather make a massive concentration on the whole individual with his mental illness. I then treat the unique personality in its total intra-mural and extra-mural environment, as far as I can get hold of it (17).

In order to make the basic principles of the psychotherapy I practice better understood, I should like to present briefly a concrete case assigned to me for individual treatment, and to insert these principles and some theoretical remarks, set off by indentation, where these become pertinent. The patient was a female who had been admitted to the State Hospital for the first time in 1950, diagnosed as "schizophrenic reaction, paranoid type." Her progress and regress were currently discussed with the supervising psychiatrist in charge of her ward.

**The First Interview**

After browsing in her chart, I saw the patient, whom we shall call Loma, a thirty year old married woman, high-school graduate, the mother of three children, rather short in size, but of average good

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1Paper read at the Annual Meeting of the North Dakota Psychological Association in Grand Forks, North Dakota, on May 20, 1955.
looks. As she had been helped by psychiatric convulsive therapies and also by group therapy to some extent, she was more or less in contact with reality. When in starting to establish an initial rapport I routinely reassured her that she was “not brainsick, but just confused in her mind,” she tried to embrace me. I explained the value of individual psychotherapy “for all of us” (6). I told her that I would be glad to help her with her most intimate problems as I had done with numberless fellow-beings for decades. I also reassured her that everything she would confide would be kept in inviolate professional confidence (“you may be sure, Lorma, I'll take it into my grave”). Lorma sensed my genuine respect for her as an individual and my deep sympathy for her as a suffering human being. Thus, a satisfactory therapeutic relationship was soon established. Upon my encouragement she started to speak out about what was bothering her most.

During this part of the interview I functioned in the manner of Rogers (16) as a patient-centered, empathetic, permissive, non-directive psychological counselor, i.e., I was accepting, recognizing, and clarifying her feelings and not the content of her report.

Lorma was very happy when I asked her to write a letter from my dictation to her husband asking him to come to see her psychotherapist. I added in my handwriting “in your and your children’s interest” (9). I also suggested that he might bring along his oldest boy (10), the reason being that I had found a mention of the boy’s pre-delinquent behavior and felt that he needed professional help in time. Lorma experienced great relief in the first session. For, on leaving, she asked “Why is it, when you speak out, you feel better? I now feel better.”

**Case History**

After the first interview, with the image of the patient in my mind, I studied her personality from the chronological recordings in her chart. My notes may be excerpted as follows: Let us say, born in California, Baptist, married at 19 years to a farmer who was stationed as a soldier in her home town during World War II ... Paroled in 1951 and returned to the hospital; paroled in 1952—returned; paroled in 1953, fourth admission in March 1954 ... She had been doing odd things since 1948 ... Tendency to day dreaming ... Her feelings are easily hurt, particularly when her husband would go to church dinners and leave her alone at home ... She threatened to shoot herself ... One
day she fired a shot from the barn to scare her husband... She says that her husband and in-laws have not been friendly to her... She does not like to be in a crowd... Her husband said that a lady neighbor was scared of her. He complained she would stay up until 4:00 a.m., drink coffee, and smoke... She was also going to liquor stores... Lorna said that her in-laws accused her of chasing with other men while her husband was in the Army 1942 to 1945; mother-in-law called her a "hell cat," husband was disgusted with her... Her girl Caroline, 9 years old, said: "Mom, I hate you, because of you I have that navel mark."... After electro-shock therapy and insulin-coma therapy it was recorded: "prognosis for her getting well is poor."

Neither a comprehensive social history nor a diagnostic psychological study based on a battery of tests (20) was available in her chart of 1950. Yet I found material enough recorded in the course of her four admissions to the hospital to make a tentative evaluation both of her pre-psychotic personality (3) and of the emotional stresses which might have precipitated her mental breakdowns (12).

**Medical Therapy**

We, non-medical psychotherapists, do appreciate convulsive and drug therapies although they are admittedly not a cure in themselves. These medical therapies are rather effective adjuvants to psychotherapy, as they bring about, as a rule, a considerable, though temporary, reduction of the crippling anxiety of the patient. Sometimes they have the function of a catalyst in making a resistive patient accessible to psychotherapy, at a time when we cannot afford tireless and arduous efforts to use the proven techniques for breaking resistance to psychotherapy. But as long as a mental patient, more or less recovered from his psychosis as a result of convulsive and drug therapies, does not understand the why's and wherefore's of his mental crack-up, at least to some extent, his intra-psychic and inter-personal conflicts still exist. If he is again exposed to the external emotional stresses in his family and community life, he will rarely be able to handle his devastating anxiety without professional help. It is, therefore, up to psychologists with training in psychotherapy to conduct psychological therapies within their professional limits, i.e., to conduct individual psychotherapy and supplementary group therapy with mental patients under regular psychiatric supervision.
On the basis of the available information, I could not accept the impression of the group therapist that our self-centered patient “was not interested in her children.” However, I could agree with his feeling that “the patient disliked her husband very much.”

In the group sessions, Lorma, whose schizophrenic process was in recession at the time, still allied herself with another female patient who used the group as a captive audience for her delusions of “snake therapy.” This other, more psychotic, patient was tenaciously clinging to the delusion that “live big pregnant snakes were vaginally inserted in her.” In the third session I had with Lorma, when I had some therapeutic reason to see the other patient at the same time, Lorma, to my surprise, enjoyed this delusion of “snake therapy.” But she was quick to accept my interpretation on the etiology of such delusions (5, 15).

Because of the critical shortage of persons trained and experienced in individual psychotherapy with mental patients, we must resort mainly to group therapy at our hospital. However, I know from experience that group psychotherapy with all its merits often cannot reach an acutely psychotic, let alone a chronic patient in his or her sorest spots. Such patients feel a special need for privacy, and they are entitled to it, when they are expected to speak out about the traumatic experiences which precipitated the total collapse of their defense organization. Just think of the understandable resistance to discussing frustrations in sex life, not to mention sex deviations, in a group of persons who do not experience the same difficulties in this painful area. I feel, therefore, that each mental patient should receive at least a small amount of individual psychotherapy at first, prior to group therapy, and then along with it. Such a combined approach can build up the sick personality more effectively and quickly than group therapy classes alone, over a period of months or even years, can possibly do. In group therapy the specific problem of a patient is often either dealt with on the edges only or goes unnoticed at all.

If the confidential material elicited from the patient in an individualized approach, is currently shared with the group therapist, it will considerably promote the latter’s understanding for the group member concerned, and will enable him to focus the group discussions on specific problems.
INDIVIDUAL THERAPY

In the second interview I first focused on some points which needed clarification, before I returned Lorna’s chart to the office. For instance, reassuring her that “all the foolish things she had done were to me nothing but psychological mistakes” (2) etc., I asked her: “Just to understand you better, Lorna, why did you jump off the roof ten feet high?” Her answer was: “I was scared because I was in the room alone.” This response revealed her terrific struggle with the powerful affect of disintegrating anxiety (7). It was a warning to me that I had to proceed very guardedly and sparingly with interpretations to such an anxiety-ridden patient.

Then I started the therapeutic work proper, i.e., to build up the sick personality by stressing her strong points, again and again in each session and in all variations (11). I also started gradually to interpret her shortcomings and faulty mechanisms of adjustment. Lorna welcomed individualized treatment of her psychic wounds in the most sensitive areas.

There were ups and downs in the therapeutic process. Lorna’s relapses were a result of the delay of her husband in coming to see her and her therapist. Our paranoid (14) patient had the unvoiced feeling that her therapist, too, might side with her husband. Without relying on her outward cooperation, I repeatedly had to restructure the therapeutic relationship, since a strong rapport is indispensable for any success in psychotherapy. As Lorna’s mood was varying, often from session to session, I had to adapt my procedures to the degree of her accessibility in a given session. Here I can hint only the main features of my work with her.

The pathological material brought out in twenty short sessions may be summarized as follows: The patient was suffering from a morbid inferiority complex because of her short size, the low socio-economic background of her parents, etc. (1, 8). Let me just state a trilling idea she was possessed with. In the very first session, when asked about what was bothering her most, she stated: “You know, I did not have a church wedding” (11). In a more or less incoherent way she was somewhat apologetic, in the following sessions too, because her parents could not afford a conventional wedding, and the like. She admitted rankling feelings of jealousy and envy, when she compared the financial state of her parents—without mentioning that they were living on public relief—with the higher socio-economic status of her in-laws (“You know, I always wanted to have a fair chance in life... my sister-in-law said, ‘all you married Clifford for was his money,’ but it is not true... you know, he does not feel he is good-looking, but...”).

She complained, in a circumstantial way, about derogatory remarks of her female in-laws about her and her parents, and, in a roundabout way, about lack of social status in her community; she could not live up to her strongly maintained exaggerated aspirations and was somewhat paranoid towards a lady neighbor.

While she occasionally spoke of her lovely children, she did not mention or evidence any longing for them; however, she gladly accepted my interpretation of this attitude being a defense mechanism (13) (“you are just wrapped up in your own worries like a tight cabbage... but I’m sure, you do have motherly feelings for your kids”).

There was projective material enough to bear out our assumption that Lorna was sexually not compatible with her husband, in spite of her spontaneous protestation to the contrary. In this very sensitive area of continuous tension in her marital life I connived deliberately with her persistent efforts to sweep her severe problem under the rug, instead of facing it.

Under the pressure of our heavy case load we cannot afford long-term reconstructive psychotherapy, but I want to justify my procedural deviation to illustrate that my planned approach, while goal-directed (1, 12), psychotherapy should not be conducted in a theoretical vacuum. We have to proceed along practical lines and see our patients in relation to their family constellation and their social environment (9, 10). In other words, we have to be realistic in re-educating our patients for a return to their specific reality of life.

In the case of Lorna I felt: If her marriage were childless, I would have encouraged her to speak out frankly about her relative or absolute frigidity which is mainly due to her strong masculine protect (3). I would have left it to her to draw the consequences of her insight into her sexual maladjustment to her husband. However, as there were three children, the youngest five years old, I felt that I ought not dig up repressed material in order to get to the neurotic nucleus of her sex problem. Weighing the pros and cons I felt there were valid reasons not to break up the home for the children and the patient. Therefore, I manipulated her on the premise that I would succeed in changing the rejecting attitude of her husband who did not want to have her
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paroled to him any longer ("You see, Lorma, while marriages are made in heaven, they have to be lived on earth, sometimes under a sacrifice in the interest of small children who need both parents ... Look, for teen-agers marriage is surrounded with an aura of romance, but a mature woman prefers a good mate to a romantic date—and your husband is a responsible breadwinner ...").

I resorted in this case to persuasive re-education, reminding the patient from time to time that I, for one, believed in marriage being a mutual task (6) with the will towards unity on either part for the sake of the children. However, I did not impose my set of values on the patient as I always added: "and you will do what is good for you." Actually, I followed her lead, for Lorna with her practical intellect did not want to lose her place in the home of her children. She also preferred the economic security of a housewife to living in the home of her destitute parents and working for other people to make a living.

COUNSELING THE RELATIVES

Lorma’s parents, when asked, were quick to come for an interview. Their information was valuable, and justified my tentative plan to return Lorma to her husband and children rather than to her well-intentioned but helpless parents.

Eventually, the patient’s husband, whom we shall call Clifford, turned up; but instead of on a Saturday in the morning, as pre-arranged, he came on that Saturday in the afternoon. He was a pleasant, but less good-looking young man who appeared withdrawn and discouraged (8). He complained that Lorma had "stepped out on him," while he was in the Army, and added in a matter-of-fact way that she had admitted it to him. I weathered this storm by pointing out what World War II had done to mankind and how many marriages had gone on the rocks as a result of that scourge of humanity, etc. Then I was very quick to reassure him that there was "nothing wrong in the brain of his wife, just emotional problems of long standing" and, what is more, that their children were in no way impaired in their hereditary endowment. This authoritative statement obviously brought great relief to him. I also made light of the stigma of confinement in a mental hospital. Then, he was given the opportunity to unburden himself of his marital troubles. I was active as a respectful and sympathetic listener. Thus I gained his confidence, too, and having rounded out my picture of this sick marriage, I started to conduct mar-
ital counseling, first with the husband alone. I enumerated his personality assets and Lorna’s. I interpreted their emotional patterns, her weak ego structure, as well as their neurotic power contest in marriage, instead of a constructive cooperation in equal partnership. A repeated light in his eyes was indicative of his “aha’ experiences and new learning (18). Then I pointed out that his wife had this time profited from the extended therapeutic services in our hospital, in order to dispel his doubts about giving his wife another chance. I tried to convince him that Lorna bade fair to make a better adjustment after her fourth parole, as he would henceforth understand her better than before. I reminded him that it was the husband who was still expected to be the anchor holding the home and family steady, and of the true meaning of the marriage vows. “If your wife were bodily weak, I am sure, you would support her; why not help the mother of your children who has grown emotionally weak in marriage to the point of a break-down?” Clifford nodded his head and was favorably impressed with the therapist’s genuine concern over the well-being of his children. He was deeply stirred, when this therapist explained to him why broken homes might sometimes lead to juvenile delinquency (7).

I had hardly reassured him that the occasional stealing of his oldest boy in their home was not yet alarming, when there was a knock on the door of my office. In strutted Lorna with her children, triumphantly laughing. Having spotted the children in their car, she had ignored my friendly order to stay on her open ward until she was called. Her greeting to her husband was anything but affectionate. She seated her three children and looked with a heart-warming laugh alternately at them and her therapist. Taken by surprise, I formed a semi-circle with the mother and father on either side and moved my swivel chair toward the children who enjoyed this truly dynamic approach. I started counseling with them, and it was not hard to convince them that their mother was “really good” and “full of love for them.” They proudly looked at one another as if they wanted to say: “You see, our Mom!” This was the highlight of my therapeutic work with Lorna.

After Lorna had returned the children to the car, I conducted marriage counseling with both partners. I focused on their “mistakes,” but also on the adverse effect of the interference of in-laws in general.

I arranged with Clifford to bring his mother the next time. I wanted to establish a truce, if not peace, between the patient and her
in-laws. Unfortunately, the mother-in-law could not be prevailed upon to come for a joint session and to help remove this particular dangerous source of conflict and tension, in the interest of my patient and all concerned.

The individual psychotherapist is called upon to involve the significant relatives of the patient in the treatment process, by interpreting the abnormal behavior of the patient to them, by correcting their attitude toward the sick member of their family, and by thus laying the groundwork for sound relations between them for the future.

Considering the constellation (gestalt) of all the factors of the case, the individual psychotherapist of the mental patient and counselor of his relatives will be able to arrive at a relatively accurate psycho-social appraisal of the proper environment for the patient after his release. The group therapist cannot possibly do this on the basis of the one-sided verbalizations of the patient during the group sessions. The combination of individual and group therapy, however, will not only speed up the whole therapeutic process, but also warrant the soundest possible planning for the patient to meet his specific needs after his return to his community.

**OUTLOOK FOR THE CASE**

The results of the prolonged counseling sessions were discussed with the supervising psychiatrist. He found the patient quite relaxed and approved of her parole to her husband, since the latter's attitude towards his wife had been changed. Lorma was recommended to the medical staff for release from the hospital.

To avoid any misunderstanding, this chronic patient was lifted out of her psychosis, as a result of psychiatric and other therapies now available at our State Hospital. But it was the twenty short sessions of individual psychotherapy with the patient and the counseling with her husband that brought about a social rehabilitation of the patient and some reintegration of the family unit.

Both, Lorma and her husband, need further help with their emotional problems in order to prevent a recurrence of a psychotic crisis. As we do not yet have mental health clinics in the various counties of our state, I arranged with the couple to come for treatment, whenever they could not handle their personal and marital problems unaided. (To date they have not come for professional help in our Outpatient
Clinic where psychologists conduct psychotherapy under psychiatric supervision for a small fee.) To restore a chronically sick woman, such as Lorma, to complete psychological health, one would have to be a miracle worker with a magic wand which could undo in six weeks what life with all its exasperating frustrations and a mental illness in the last five years have done to the patient up to her age of thirty years!

We are well aware of the fact that sending Lorma back to her family at this point for the sake of the three children is taking a risk. I was supported in my recommendation by the following incident. In the session following the joint marital counseling with the couple, Lorma told me, not to my surprise, that her daughter, after leaving my office had exclaimed: “Mom, you have got to come home!” I remembered that this child, obviously affected by the emotional instability of her mother, had once said: “Mom, I hate you.”

SUMMARY OF THERAPEUTIC PRINCIPLES

The *active psychotherapy* which I practice with mental patients is mostly of the Adlerian type and may be summarized as follows.

1. It is conducted under regular *psychiatric supervision*.

2. The approach is *eclectic* in adaptation to the style of life (1, 2) of the patient, not forcing him into the bed of Procrustes of a particular method. Much as we believe in theory, we cannot recommend a doctrinal approach in clinical work with the most disturbed type of patients.

3. The face-to-face interview is focused on the *present* emotional conflicts and future difficulties. We do not let the patient ramble in free associations (1, 12). In view of the unmet needs of many other patients for individual treatment, we simply do not have time to dig out past traumatic experiences more than is absolutely necessary for the interpretation of the dynamics of present behavior. Adler preferred to let the patient sit up in the session. A patient lying on an analytic couch will tend to revel and sometimes get lost in sex associations (13).

4. The patient is treated as an adult and *equal*, not as a childlike dependent in a transference relationship (14).

5. We attempt to correct the patient’s mistaken or distorted concept of his self by interpreting his devastating *feelings of inferiority* and his morbid striving for superiority (1, 2). With mental patients
who have lost all confidence in themselves, we must raise their very low self-esteem and low frustration tolerance to a level where they will muster the courage to leave the protective shelter of the institution for life's harsh reality.

6. We attempt to strengthen the *fellow-feeling* (social interest) of the patient and his sense of social responsibility ("Thou shall love thy neighbor as thyself" and "Am I my brother's keeper?"). Sound human relations are based on genuine good will for any human being.

7. The effort to resocialize (1, 6, 11) the mental-hospital patient as far as possible involves tireless and cheerful *teamwork*, to the fullest extent, not only with the psychiatrist, the head of the treatment team, but also with colleagues, social workers, ministers of religion, occupational and recreational therapists, nurses, teachers, vocational counselors, volunteer workers, and, last but definitely not least, with the non-professional workers who live with the patient under the same roof, so to speak, and can provide valuable clues for our arduous work.

8. Treatment of the patient is combined with active *counseling of the relatives* and other significant persons (2, 9, 10). Only in this way can the pathological factors be grasped in their entirety and social interaction. With the confused or colored verbalizations of a disturbed individual as the only basis, one is liable to make wrong interpretations and faulty plans for the patient's return to community living.

9. An accumulation of knowledge in *socio-economic and legal areas* is particularly useful to a sound concrete planning for the mental patient. In planning for the patient's practising his new modes of adjustment along with and after the termination of the therapeutic process the *economic strategy* is always kept in mind.

10. Psychotic patients, more than maladjusted and neurotic patients, are in urgent need of a "*total push*" treatment *on various levels*, if they are to be kept out of the mental hospital as long as possible.

**References**