THIRD EDITION

Introduction to Psychotherapy

An outline of psychodynamic principles and practice

Anthony Bateman,
Dennis Brown
and Jonathan Pedder

INTRODUCTION TO PSYCHOTHERAPY

Introduction to Psychotherapy has been an essential reference book since its publication in 1979, and is regularly included in reading lists for trainee psychotherapists, psychiatrists and other professionals. It is often recommended to interested lay people and prospective patients. This third edition takes into account recent changes in psychotherapy theory, practice, and research.

'The authors have succeeded in providing an up-to-date and integrated account of the many different forms of psychotherapy without taking sides in some of the controversies which still exist in this field. [Each] is discussed in its historical, theoretical and practical context…. Medical students, general practitioners, psychiatrists, students of psychotherapy, both medical and non-medical, and also experienced psychotherapists will all find it a pleasure to read and a useful and practical guide to modern psychotherapeutic concepts and practice.'

Dr Heinz Wolff, *Group Analysis,* review of first edition

'The overview provided by the book is impressive in its depth, as well as its breadth…. I think this book ought to be recommended very strongly to every trainee within the mental health services.'

Denis Carpy, *Psychoanalytic Psychotherapy,* review of second edition

The authors are all psychoanalysts. The first edition arose from the experience of Dennis Brown and Jonathan Pedder working and teaching together as Consultant Psychotherapists at St Mary's Hospital and Medical School, London.

Anthony Bateman is a Consultant Psychotherapist at St Ann's Hospital, London. **Dennis Brown** works at the Group-Analytic Practice, London and the Institute of Group Analysis, London. **Jonathan Pedder,** until recently Consultant Psychotherapist at the Maudsley Hospital, London, is now retired.

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Anthony Bateman, Dennis Brown and Jonathan Pedder

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FOREWORD TO THE FIRST EDITION

We have often been asked to recommend some introductory text in psychotherapy, and felt at a loss. Freud's papers on technique (1912, 1914) or Bion's (1961) *Experiences in Groups* make fascinating if not essential reading for those embarking as therapists on formal individual or group psychotherapy. Yet we were not aware of any one book—certainly none written by psychotherapists in this country—which answered basic questions such as 'what is psychotherapy about?' This book was born out of our attempts to answer that question and to convey something about dynamic psychotherapy to medical students and newcomers to psychiatry from various disciplines. We have been unashamedly simple in trying to delineate basic psychodynamic principles in Part I. We have described something of the range of methods based on these principles in Part II. We do not say very much about the practice of psychotherapy— that is 'how to do it'—for we believe that this can only really be learnt by embarking on the journey of exploration, either as patient or as therapist under regular supervision.

We are both psychoanalysts working part-time as consultant psychotherapists in a teaching hospital psychiatric unit where all current opinions and treatments in psychiatry are represented. In our view Freud's work and psychoanalysis have provided the spring which has nourished all later forms of dynamic psychotherapy, be they individual or group psychotherapy, marital or family therapy. With the proliferation of new forms of psychotherapy, both within and beyond the fringe of psychiatry, we felt some simple statement of basic aims and principles would help to orientate ourselves and, we hope, others. The psychoanalytic view is, among other things, essentially a developmental one. It sees man against the evolutionary background of his long pre-human and especially more recent primate past; it sees man in his historical and social setting; and lastly, it sees each individual in his

own unique cultural and developmental context, which is our particular concern in psychotherapy. The present can only be understood in terms of the past. The past is ever-present.

Dennis Brown
Jonathan Pedder
St Mary's Hospital, London
1979

FOREWORD TO THE SECOND EDITION

The foreword to the original edition began by explaining that there was a gap in the literature. Before 1979 there were no simple, comprehensive, introductory texts to which we could direct newcomers to psychotherapy. Clearly others were thinking along similar lines. In the same year Bloch (1979) edited a multi-author book describing a range of psychotherapies, and Malan (1979) produced *Individual Psychotherapy and the Science of Psychodynamics* which sums up in vivid everyday language years of working in this field at the Tavistock Clinic. In 1979 Whiteley and Gordon published a comprehensive survey of group methods in psychiatry, and Storr (1979) an account of his own approach to individual psychotherapy. Six years later came Casement's (1985) lively description of the interactional process in psychoanalytic work. This was followed by Symington's (1986) Tavistock Clinic lectures on key contributors to modern psychoanalysis; and Frosh's (1987) exposition of different developments within the psychoanalytic tradition, and their implications for culture. All of these we would recommend to students of psychotherapy at different points in their professional development. Two other books have appeared which are of particular use to lay-people and potential patients: Knight's *Talking to a Stranger* (1986) and *Families and How to Survive Them* by Skynner and Cleese (1983).

Nevertheless, the steady interest in our book leads us to believe that it is of continuing value. It is regularly included in the reading lists for trainee psychotherapists, psychiatrists, and other professionals, and it is often recommended to interested lay-people and prospective patients.

It was meant as a brief and simple introductory overview of the many forms of dynamic psychotherapy and their origins in and links with psychoanalysis. It traces the similarities and differences between individual, group, family, and social therapy and some of the 'newer' therapies. In updating we have continued the original aim, taking into

account developments since 1979, including valuable new additions to the literature for those who want to read further, with an expansion of the sections on selection and research. We have touched on shifts in the social climate and impending changes in the organization of psychotherapy practice and training in the United Kingdom.

We wish to thank Dr Robin Skynner and Dr Don Montgomery for their comments on family therapy and gender assignment respectively; and Mrs June Ansell for her ready and efficient help with the manuscript.

Dennis Brown, Institute of Group Analysis, London
Jonathan Pedder, Maudsley Hospital, London
1991

FOREWORD TO THE THIRD EDITION

Our first edition appeared in 1979, the second in 1991. The book has maintained its place on reading lists for trainee psychiatrists, psychotherapists, and counsellors. Interested general readers and potential clients have found it a useful overview of the increasing range of psychotherapies available today. So far it has been translated into nine languages. Yet psychotherapy itself is developing, and we want this to be reflected in a third edition for the new millennium. The original authors (DB and JP) therefore invited AB to join them in rewriting the book. He is already an established teacher and writer, as well as an experienced clinician within the NHS from which both DB and JP have now retired.

The passage of time has not lessened our belief that psychoanalysis provides the basis of all dynamic psychotherapies: individual, group, family and couple, and social; and that many of the 'newer' therapies owe their basic ideas to some aspect of psychoanalytic theory and practice. Since the first two editions, some such therapies have declined, others have become more prominent. Behaviour therapy, essentially non-analytic, has largely given way to cognitive-behavioural therapy (CBT), now a major part of the psychotherapeutic armamentarium, especially within psychiatry. Having earlier differentiated itself from psychoanalytic therapy, in its more recent development CBT has become closer in its methods to the psychodynamic, analytically-based therapies. There has been further development in other therapies such as interpersonal psychotherapy, cognitive analytical therapy, and conversational therapy. These have developed out of the search for brief forms of therapy, considered in more detail in this edition.

One effect of the rise of CBT and other therapies has been to stimulate more outcome research in all therapies including psychodynamic therapy. This is in line with a more serious

questioning of the cost-effectiveness of different therapies, especially the longer-term therapies which are often needed for radical change and sustained personal growth. We welcome such questioning and have extended our section on selection and outcome. Changes in emphasis in modern understanding of therapeutic relationships are reflected, along with recognition of changes in society and the patterns of the individual's relationships with others. Consideration is given to current issues such as the proliferation of counselling, the recovered memory controversy, and the increasing influence of attachment theory in therapy and research.

We wish to thank Dr Harold Behr and Dr Stuart Whiteley for their comments and suggestions regarding the sections on family therapy and social therapy respectively; and Mrs June Ansell for continuing practical help with the manuscript.

AB, DB, JP

PROLOGUE

What is psychotherapy? It is essentially a conversation which involves listening to and talking with those in trouble with the aim of helping them understand and resolve their predicament.

Mrs A. went to her family doctor complaining of bouts of tearfulness and acute attacks of panic and anxiety. She considered herself to be happily married and could not account for her symptoms. Her doctor regarded them as the manifestations of a depressive illness, that is to say of some physical disease process of presumed, but as yet undiscovered, biochemical origin. He prescribed various anti-depressants in turn, but these had little effect; rather Mrs A. began to feel that something dreadful was happening to her which nobody understood and that perhaps she was even going mad.

Are there other ways of trying to understand such problems?

When an alternative point of view of her predicament was sought, the following aspects of her life and its history emerged. Her symptoms had begun when her only child (a daughter) was 6 years old. At that time Mr and Mrs A. had been discussing the possible need for their daughter to go away to a boarding school because of their remote situation in the country. It seemed likely that Mrs A. was far more depressed over this projected separation than she herself had acknowledged. Moreover when Mrs A. herself had been 6, her parents had separated and she was sent to live with an aunt, so that the possibility of separation from her daughter in the present had re-awakened the heartache of her own separation from her parents at the same age—long ago. When Mrs A. reviewed her recent experiences in relation to the past within this suggested framework, her tearfulness and anxiety began to make sense to her and to resolve. She no longer felt prey to some mysterious and frightening disease process beyond her control, but began to recognize herself as a dis-eased person, discomforted by a situation that only too painfully reminded her of the past.

Symptoms that patients bring to doctors may often be the expression of unacknowledged feelings in the present, which remain hidden because of painful associations with the past. One of the central aims of this book will be to try and provide a framework within which to understand such problems and begin to approach them psychotherapeutically.

PART I
PSYCHODYNAMIC PRINCIPLES

INTRODUCTION TO PSYCHODYNAMIC PRINCIPLES

It is widely agreed that about a third of all patients who go to their family doctor have primarily emotional problems. About half of these will have a recognizable psychiatric condition, but only one in twenty is referred to a psychiatrist (Goldberg and Huxley 1992). A still smaller proportion will be referred on for formal psychotherapy in the National Health Service. However, psychotherapy at varying levels will be appropriate for some patients at each of these stages. We will discuss these different levels and types of psychotherapy in further detail in Part II. The term 'psychotherapy' is used in both general and special ways; it includes forms of treatment for emotional and psychiatric disorders that rely on talking and the relationship with the therapist, in contrast to physical methods of treatment (such as drugs and electroconvulsive treatment (ECT)).

Most psychotherapy in the general sense is carried out informally in 'heart-to-heart' conversations with friends and confidants. 'Everyone who tries to encourage a despondent friend or to reassure a panicky child practices psychotherapy' (Alexander 1957:148). Wellworn sayings such as 'a trouble shared is a trouble halved' make sense to everyone. Such help is more likely to be sought in the first instance from the most readily available help-giver, such as a friend, family doctor, priest, or social worker, rather than from a psychiatrist or psychotherapist. In the medical field, the art of sympathetic listening has always been the basis of good doctoring. There has been a risk that this might be overshadowed by the enormous advances in the physical sciences and their application to medicine, which have resulted in an increasing attention to diseased organs, to the relative neglect of the

whole dis-eased person. In the last generation, interest has shifted back again to the individual as the focus of stress in the family and community, and psychodynamic principles have helped to illuminate this interest. While many acute and major forms of psychiatric disturbance are best treated by physical methods, many less acute forms of neurotic and interpersonal problem are helped more by psychotherapeutic methods. We shall take up this issue further in Part II, particularly in discussing Levels of psychotherapy (p. 82) and Selection (p. 189).

Historically there have been two major approaches to psychotherapy in the special sense, competing with varying mixtures of rivalry and cooperation. These are Psychodynamic Psychotherapy, which has its historical origins in Freud's work and psychoanalysis; and Behavioural Psychotherapy, which involves an application of learning theory and stems from the work of Pavlov on conditioning principles. Here we are principally concerned with psychodynamic rather than with behavioural psychotherapy (though see p. 84). Basically the approach of the behaviourist was that of a physiologist or psychologist studying the patient from the *outside*. He* was interested in externally observable, and preferably scientifically measurable, behaviour, and in manipulating (by suitable rewards and punishments) deviant or maladaptive behaviour towards some agreed goal or norm. Behaviour therapy has now been modified and developed and joined with cognitive science to form cognitive-behavioural psychotherapy. We discuss this on page 168.

The dynamic psychotherapist is more concerned to approach the patient empathetically from the *inside* in order to help him to identify and understand what is happening in his inner world, in relation to his background, upbringing, and development; in other words, to fulfil the ancient Delphic injunction 'Know Thyself'. Dynamic psychotherapy has been the major influence in the field of mental health, and has appealed more to doctors, social workers, and those psychologists immersed in the complexities of relationships with patients or clients; and to patients wishing to understand themselves and their problems rather than to seek symptomatic relief alone. Sutherland wrote:

* Where the sex of the therapist or patient is not defined by the particular circumstance described, he or she is referred to, for convenience, in the masculine gender throughout this book; such references should be taken to imply male or female.

> By psychotherapy I refer to a personal relationship with a professional person in which those in distress can share and explore the underlying nature of their troubles, and possibly change some of the determinants of these through experiencing unrecognized forces in themselves.
>
> (1968:509)

(Those unclear about the respective training and role of psychiatrists, psychologists, psychoanalysts and psychotherapists, will find them briefly described in the appendix.)

It will be our contention that all forms of dynamic psychotherapy stem from the work of Freud and psychoanalysis, which has produced many offshoots. Jung and Adler broke away before the First World War to found respectively their own schools of Analytical Psychology and Individual Psychology. Between the wars Melanie Klein and Anna Freud, applying analytic ideas to the treatment of disturbed children, developed Child Analysis. During the Second World War, Foulkes and others explored the use of analytic ideas in groups and developed Group Psychotherapy. Since the Second World War further developments have included family, couple, and social therapy. Rogers in the Encounter movement, developments such as Bioenergetics, and other forms of humanistic and integrative therapy have been seeking new ways of encouraging direct interpersonal contact to help free people from a sense of isolation and alienation from themselves and others. (Some of the links between these developments are traced in the 'family tree' of Figure 10 on p. 188.)

However, despite their apparent diversity and different theoretical formulations, we believe that all schools of dynamic psychotherapy hold in common certain key concepts. These basic concepts are briefly introduced now and each is expanded in later sections of Part I.

People become troubled and may seek help with symptoms or problems when they are in *conflict* over unacceptable aspects of themselves or their relationships. This is contrasted with the traditional medical model where symptoms are viewed solely as an expression of disordered anatomy and physiology.

Aspects of ourselves, which so disturb us that they give rise to *anxiety* or *psychic pain,* may be consciously rejected, and become more or less *unconscious.* We all employ a number of *defence mechanisms* to help us deny, suppress, or disown what is unacceptable to consciousness; these may be helpful or harmful.

Unacceptable wishes, feelings, or memories may arise in connection with basic *motivational drives.* The different psychodynamic schools may disagree over how to categorize human drives or as to which are the more important and troublesome—for example, those associated with eating, attachment, sexual, or aggressive behaviour. However, the central importance of conflict over drives and their derivatives remains.

Again, although *phases of development* have been conceptualized in a number of different ways, it is widely agreed that how we handle our basic drives begins to be determined in infancy by the response of others to our basic needs and urges, at first our mother and subsequently others of emotional significance (father, siblings, teachers, etc.).

It is in *models of the mind,* or theorizing about the structure of the psyche, that greatest disagreement has arisen. Freud revised his theories several times. At first he saw the psyche simply in terms of Conscious and Unconscious levels; later he introduced the concepts of Super-ego, Ego, and Id. In more anthropomorphic terms, Berne (1961) has written of the Parent, Adult, and Child parts of each one of us. Yet running throughout is the idea of different psychic levels, with the potentiality of conflict between them.

Aspects of the *therapeutic relationship* will be the last of the theoretical principles dealt with, and it naturally leads us on to the area of practice. We will distinguish between the therapeutic or working alliance, transference, and counter-transference.

HISTORICAL BACKGROUND TO DYNAMIC PSYCHOTHERAPY

Before developing each of these concepts further, let us take a brief look at the historical background, where we are much indebted to Whyte (1962) and Ellenberger (1970). Although it might be broadly true to say that all modern forms of dynamic psychotherapy— whether psychoanalysis, individual or group psychotherapy, family or marital therapy—stem from the work of Freud and others at the turn of the century, it would not be true to say that Freud 'invented' psychotherapy.

The idea of a talking cure through catharsis of feelings is at least as old as the Catholic confessional, and current idioms such as 'getting it off your chest' testify to the widespread belief in its value. A work on Aristotle's concept of catharsis was being much talked of in Vienna in the 1880s and may have influenced Breuer and Freud.

Nor is there anything revolutionary in the idea that we are often in conflict with our feelings, wishes, and memories. In 1872, a year before Freud entered university, Samuel Butler wrote in *Erewhon:*

> there are few of us who are not protected from the keenest pain by our inability to see what it is that we have done, what we are suffering, and what we truly are. Let us be grateful to the mirror for revealing to us our appearance only.
>
> (Butler 1872:30)

Writers down the ages, who have attempted to penetrate the complexities of human motivation, have known this intuitively. Shakespeare, for example, recognized unconscious conflicting wishes in *King Henry IV Part II:*

> *Prince:* I never thought to hear you speak again.
> *King:* Thy wish was father, Harry, to that thought.

Pascal (1623–62), in his *Pensées,* knew that 'The heart has its reasons, which reason knows not.' Rousseau (1712–78) wrote: 'There is no automatic movement of ours of which we cannot find the cause in our hearts, if we know well how to look for it there.' Writing in the 1880s Nietzsche anticipated Freud: "'I did that" says my memory. "I could not have done that" says my pride, and remains inexorable. Eventually the memory yields' (Whyte 1962).

Freud's achievement, combining the gifts of a great writer and scientist, was to address these ideas to a medical context, in such a way that they have since been given continuing and increasing, if at times faltering, attention. Yet, as we have said, Freud did not invent psychotherapy any more than Darwin invented evolution. Darwin too had his forerunners; yet it was the added impetus of the evidence he collected for his new causal explanations of natural selection that gave fresh weight to already current ideas on evolution.

Ellenberger (1970) has traced the ancestry of dynamic psychiatry from its origins in exorcism, and its evolution through magnetism and hypnotism. In primitive times, disease, both psychic and somatic, was commonly thought to be due to possession by evil spirits. Healing was expected to follow exorcism and such treatment was naturally in the hands of religious leaders or traditional healers, such as a shaman, witchdoctor, or priest.

Alternatively, it was thought that disease might arise from infringement of taboos. Then again cure was expected to follow confession and expiation. Healing by exorcism and confession have both played a part in the Christian tradition. However, with the rise of Protestantism, the Catholic monopoly on confession weakened. There was an increased interest among lay-people and some doctors in the idea of the 'pathogenic secret' formerly disclosed only to priests at confession. Thus, by around 1775, the time of the last executions for witchcraft in Europe, exorcism as practised by priests such as Gassner (1727–79) gave way to new techniques (which we would now call hypnotism) stemming from the work of the physician Mesmer (1734–1815). We might now find Mesmer and his disciples fanciful in their theories about magnetic fluid as an explanation for what they called magnetic sleep, but increasing attention was being paid to such phenomena. The similarity between magnetic sleep and natural somnambulism (or sleep-walking) led to its being first re-named artificial somnambulism, and later hypnotism.

Towards the end of the nineteenth century there was further acceleration of interest in all sorts of psychic phenomena (which we would now see as different examples of dissociation within the psyche), such as hypnotism, spiritism, mediumistic trances, automatic writing, and states of multiple personality, all of which suggested split-off unconscious psychic processes. Phenomena that were formerly thought to be caused by possession and therefore to be cast out by exorcism, were now attributed to unconscious agencies to be reached and revealed by hypnosis. Accounts of possession were replaced by clinical accounts of multiple personality. In 1882 the Society for Psychical Research was founded in London to examine such phenomena. In the same year Charcot gave an important lecture to the Academy of Sciences in Paris, which brought a fresh respectability to hypnosis in medical circles, and helped to dispel some of the scepticism psychiatrists had felt towards it.

Throughout the century there was an increasing interest among writers in such phenomena, particularly that of dual or multiple personality, a well-known example being Stevenson's 'The Strange Case of Dr Jekyll and Mr Hyde', published in 1886. By the 1880s there was also considerable interest in the importance of repression of emotional and instinctual life in determining human conduct. For example, Schopenhauer (1788–1860) had already anticipated psychoanalysis; in Freud's own words, 'not only did he assert the dominance of the emotions and the supreme importance of sexuality but he was even aware of the mechanism of repression' (Freud 1925: 59).

Benedikt (1835–1920), a Viennese physician known to Freud and Breuer, was among the first medical men to show that the origin of neuroses, and especially hysteria, often lay in a painful pathogenic secret involving sexual life. Nietzsche (1844–1900) emphasized the importance of instincts and their sublimation, of selfdeception, and of guilt feelings arising from the turning inwards of impulses which could not be discharged outwardly. In literature and drama, Dostoevsky and Ibsen were exploring the theme of passions that lurk below the surface and dictate the actions of men who may deceive themselves that they are rational beings. Ellenberger (1970) refers to this as the 'unmasking trend' that was prevalent in the 1880s. Ibsen's father had been a miner and his tomb bears a miner's hammer put there by his own son to emphasize how he had continued the mining tradition of digging away at what lies below the surface—similar to the archaeological metaphor that Freud was fond of using.

Sigmund Freud (1856–1939) was born at Freiberg in Moravia (now part of Slovakia and named Pribor); when he was a child of 4, his family moved to Vienna. At school Freud had some leanings towards the law, but, as he wrote in his autobiography, 'the theories of Darwin, which were then of topical interest, strongly attracted me, for they held out hopes of an extraordinary advance in our understanding of the world' (Freud 1925:8). He was later to consider that, following Copernicus and Darwin, he had himself delivered the next major blow to man's self-esteem and view of his central position in the universe. It was on hearing Goethe's essay on Nature read aloud just before he left school that he decided to become a medical student.

He entered medical school in Vienna in 1873 but did not qualify until 1881 because he spent some time working in Brucke's physiology laboratory while considering an academic career. This was a time when the rational hope was high that the ills of mankind would yield to discoveries in the basic physical sciences. Brucke had pledged, 'No other forces than the common physical and chemical ones are active within the organism' (Jones 1953:45). Freud shared that hope early on and to some extent never quite abandoned it, since he later predicted the more recent vogue for drug treatments in psychiatry.

The name of Freud is so closely identified with psychoanalysis that it is often not appreciated that he had an established reputation in several other fields before he ever came to his psychoanalytical discoveries when he was in his forties. As a medical student he had already done original work in neuro-histology; as a neurologist he had made important contributions and written on aphasia and on cerebral palsies

in children; and he had been associated with the introduction of cocaine, as a local anaesthetic, into ophthalmology.

Freud felt that he encountered some anti-semitic prejudice in his ambition to achieve a university post. He had been engaged for some time and, impatient to get married, determined to set up in private practice in Vienna as a neurologist. Before doing so he obtained a grant to visit Charcot in Paris in 1885.

Charcot at that time was giving grand theatrical demonstrations of neurological cases, amongst which there were hysterical patients with paralysis, anaesthesia, or bizarre gait. Freud noted that Charcot could create, by hypnosis, conditions identical to those arising spontaneously in hysterical patients; and that, furthermore, the pattern of the disorder followed the idea in the patient's mind rather than any anatomical pathway (as seen in true neurological lesions). He therefore concluded that, if hysterical disorders could be created by hypnosis, perhaps they arose spontaneously by autosuggestion—in response to an idea in the patient's mind of which he was *unconscious*.

Freud returned to Vienna and married in 1886. In his private neurological practice he found the usual proportion of hysterical cases. At first he used hypnosis as a treatment in an attempt to dispel the symptoms by suggestion. Through his association with Breuer, with whom he wrote the *Studies on Hysteria* (Breuer and Freud 1895), he found that, by putting patients into a light hypnotic trance and encouraging them to talk freely, memories or ideas might be revived that had become repressed and unconscious because unacceptable to conscious ideals. Hence the 'talking cure', as one of Breuer's patients called it, was born.

Freud soon abandoned hypnosis as a direct method of intervention and not long after gave up using it even as a lubricant to talking, relying entirely on *free association* (p. 113). The couch remained in psychoanalysis because of its original use by Freud the neurologist, and its convenience to Freud the hypnotist. He himself slowly withdrew from the position of active examining doctor beside the patient, to that of accompanying ally on a voyage of self-examination sitting behind him. He thereby rescued the neurotic patient from the public theatre of Charcot's demonstrations, where only external appearances counted, and created the private space of the analytic consulting room where hitherto unmentionable and unacknowledged aspects of man's inner world could be faced. Symptoms that had been taken for meaningless by-products of as-yet-undiscovered somatic processes could be viewed afresh as meaningful communications about inner states of conflict.

THE CONCEPT OF CONFLICT

The idea of conflict over unacceptable aspects of the self is central to the psychodynamic point of view. Indeed, the very expression 'dynamic' itself was borrowed by Freud from nineteenth-century physics to convey the idea of two conflicting forces producing a resultant third force acting in another direction.

So long as medical students were only taught anatomy and physiology (or their subdivisions, such as histology and biochemistry) it was natural that doctors should try to understand their patients' complaints as symptoms of disordered anatomy and physiology and, therefore, treat them physically. But there is widespread agreement that about one-third of all patients presenting to doctors have primarily emotional problems which cannot be understood in this way, with much resulting frustration to both patient and doctor. It is a romantic view to think that this is some new phenomenon due to the pressures of modern life; Cheyne, a London physician, writing in 1723, estimated that one-third of his patients had no organic disease.

If we bear in mind (as in the case of Mrs A., see p. xiii) that patients' complaints may not be symptoms of a discrete disease caused by an external agency alien to the person, but indicative of a conflict in someone who is dis-eased or alienated from a part of himself, we may be better equipped to understand the puzzling complaints of some people in distress. The discovery of micro-organisms in the last century was a vast advance in the understanding of disease, but also satisfied man's need to blame forces *outside* himself (an updating of devil theories of disease) rather than accept responsibility *within* himself. The importance of conflict in human distress is not only relevant to psychiatry, but to the whole field of medicine. If a child complains of abdominal pain, this might well be symptomatic of a physical disorder such as appendicitis; or alternatively might be the child's way of saying that he does not want to go to school for some reason that he cannot acknowledge or admit for fear of adult reactions. A woman who complains of dysparunia (pain on intercourse) may have a painful somatic lesion such as a cervical erosion; or not want intercourse, but feel unable to say so. The problem may lie in her relationships rather than in her body. The level at which the conflict operates may be relatively conscious or deeply unconscious.

A young single woman went to her family doctor complaining that she was disgusted with her nose. He took this in a literal and

> anatomical sense and sent her to a plastic surgeon, who felt there was little abnormal with her nose and referred her for a psychiatric opinion. She herself then said that when she had first gone to the doctor she had felt that she was merely disgusted with her nose (the underlying conflict was still deeply unconscious). Now she had begun to realize she was really disgusted with herself (the conflict was reaching consciousness) and particularly because of what she called her lesbian feelings. One might go further and say that some distaste for her own sexuality and genitalia had undergone displacement upwards and become focused on her nose.

This idea of conflict is not just a fanciful one dreamt up by man to understand himself. Ethologists now well recognize its importance in understanding animal behaviour. A bird exhibiting territorial behaviour may approach another aggressively at the edge of its territory, then become afraid, retreat and go on to repeat the pattern of approach-avoidance conflict several times; or it may turn aside and begin pecking at the ground as an indirect outlet for the aggression. This behaviour, which ethologists term re-direction, psychoanalysts call displacement (p. 25).

Which aspects of the self give rise to such conflict? We shall discuss this at greater length in the section on motivation; but a common misrepresentation of Freud is to assume that he attributed all problems to sex, and thereby to dismiss psychoanalysis as culture-bound to bourgeois Vienna of the 1880s, and not of general relevance. Indeed Freud found that many of his female hysterical patients were suffering from sexual conflicts, but it is instructive to quote his actual words about this:

> In all the cases I have analysed it was the subject's sexual life that had given rise to a distressing affect…Theoretically, it is not impossible that this affect should sometimes arise in other fields; I can only report that so far I have not come across any other origin.
>
> (1894:52)

Since then we have indeed come to recognize the immense importance of conflict 'in other fields', for example, aggressive feelings, which may be turned against the self (in depression and suicidal attempts) or

converted into psychosomatic symptoms (such as migraine or hypertension) (see p. 27).

Depression itself, or the grief that follows bereavement, or some other loss vital to self-esteem, may not be consciously acknowledged but find outlet instead in physical symptoms. This commonly occurs when a patient presents symptoms at the anniversary (possibly unacknowledged) of a bereavement.

It should not be thought that all forms of psychiatric disturbance can be explained as the result of conflict. There is almost certainly a considerable genetic predisposition to functional psychoses such as schizophrenia and manic-depression. There are also some rare forms of organic psychosis caused by physical cerebral dysfunction, e.g., by brain tumour or vitamin deficiency. In conditions such as border-line psychoses and profound character disorders, we are dealing with early 'harm inflicted on the ego by endowment, environment and vagaries of internal maturation, i.e., by influences beyond its control' (Anna Freud 1976) which impair the ego's strength and therefore its capacity to contain and manage primitive anxieties and impulses. Many forms of trauma, including early separation and loss (Bowlby 1973, 1980) and the many forms of child abuse (Bentovim *et al.* 1988), are increasingly recognized today. Early traumas have been shown to influence development and the later effect of trauma has been demonstrated in studies of survivors of the Holocaust and other disasters (Pines 1986, Kestenberg and Brenner 1986, Menzies Lyth 1989, Garland 1998).

The concept of conflict is of especial importance in understanding neurotic disorders, where we are dealing with the internal damage which the Ego in the later course of development has inflicted on itself by repression and other defences. Neurotic conflicts ultimately orginate in personal relationships during a person's formative years, which become internalized and determine the sort of relationships formed with others thereafter; though the outcome may depend on what is happening in current close relationships, as will be discussed especially in considering Family and Couple Therapy (p. 138).

UNCONSCIOUS PROCESSES

Aspects of ourselves which conflict with consciously held ideals may be denied, suppressed or disowned and become more or less unconscious. It is preferable to think in terms of *different levels* of consciousness and use the word unconscious as an adjective rather than as a noun. We then

avoid implying that there is a mysterious realm 'the unconscious' which is quite separate from the rest of the mind.

Something may be unconscious merely because we are not aware of it at a particular time—for example, the colour of our front door at the moment of reading these lines; or because we find it easier to function by suppressing disagreeable feelings or painful memories, though we might easily be reminded of them. These levels Freud called *preconscious.* Alternatively an idea may be unconscious because it is actively repressed owing to its unthinkable nature—a memory, fantasy, thought, or feeling which conflicts with our view of ourselves and of what is acceptable, and which would cause too much anxiety, guilt, or psychic pain if it were acknowledged. This level Freud called *dynamically unconscious.* Repression may weaken at times so that previously unconscious mental contents become manifest, usually modified by defensive elements—for example, during sleep in the form of dreams, at times of stress in the form of symptoms, or in the emergence of apparently alien impulses under the influence of drugs or alcohol.

The idea of different psychic levels parallels that of different neurological levels, with higher centres controlling and inhibiting more primitive ones which, in turn, might find expression if higher controls were relaxed. Freud, with his own neurological background, had always been impressed by the saying of the neurologist Hughlings Jackson (1835–1911): 'Find out all about dreams and you will have found out all about insanity.' In dreams and insanity we get the most direct insight into deeper levels of the psyche. Our idiom 'I wouldn't dream of it' seems to imply the idea of several levels—that is, there are things we would dream of but not do; then, more deeply, things we would not even let ourselves dream of.

Some philosophers have objected to Freud's ideas about the unconscious on the grounds that only conscious phenomena should be considered as mental events. Yet the idea of the unconscious had been increasingly discussed throughout the nineteenth century. Psychologists such as Herbart (1776–1841) emphasized the conflict between conscious and unconscious ideas; and the philosopher Schopenhauer (1788–1860), anticipating Freud, wrote: 'The Will's opposition to let what is repellent to it come to the knowledge of the intellect is the spot through which insanity can break through into the spirit' (Ellenberger 1970:209).

As the authority invested in man's idea of God declined in Europe from the Middle Ages onwards, there was a corresponding increase in human self-awareness which reached a particular intensity around 1600.

The word ‘conscious’ first appeared in European languages in the seventeenth century. The dualism of Descartes (1596–1650), separating mind from body and thought from feeling, marked the high tide of this movement with its assertion that mental processes are limited to conscious awareness. This emphasis on rational thinking was one of the forces that led to the Enlightenment of the eighteenth century and many positive achievements in the spread of education and political freedom; but it devalued imaginative and emotional life so that a natural reaction was the Romantic movement of the early nineteenth century typified by poets such as Wordsworth, Keats, and Shelley. The idea of unconscious mental processes was ‘conceivable around 1700, topical around 1800, and became effective around 1900’ (Whyte 1962:63). By 1870 ‘Europe was ready to discard the Cartesian view of mind as awareness’ (ibid.: 165). If anything, Freud made the idea of the unconscious temporarily less popular by his early emphasis on its sexuality.

Perhaps the idea is now so much part of our thinking that no further argument is needed, but evidence in support of the notion of unconscious psychic activity comes from the following sources.

Dreams

Freud always regarded dreams as ‘the royal road to the unconscious’ and *The Interpretation of Dreams* (1900) as his greatest work, of which he wrote: ‘Insight such as this falls to one’s lot but once in a lifetime’ (Freud 1900: xxxii). He drew a distinction between the often apparently absurd manifest content of a dream and the *latent content* hidden behind it by a censorship which could be by-passed by free association. Dreams were the ‘disguised fulfilment of a repressed wish’. This wish-fulfilling function of dreams is a commonplace. Children dream of feasts or treats, adults of forbidden pleasures, or of lost persons or places they long to see again. Dreams may also be attempts to master unpleasant experiences or to solve problems. Rycroft (1979) emphasizes the creative and imaginative aspects of dreaming, rather than just the conflictual and neurotic, and regards dreaming as the non-discursive mode of communication of the non-dominant cerebral hemisphere. The use of dreams in general psychiatry has been usefully reviewed by Mitchison (1999).

Artistic and scientific creativity

Many writers, artists, and composers, in describing their own creative processes, have told of how they feel taken over by some inner force, not entirely within their conscious control. Often the creative process actually takes place during sleep or dreaming. Kekulé, wrestling with the problem of the structure of benzene, dreamt of a snake eating its tail and then immediately saw that the benzene molecule must have a ring structure (Findlay 1948). Coleridge is said to have conceived his poem 'Kubla Khan' while dozing under the influence of opium (Koestler 1964). The playwright Eugene O'Neill claimed to have dreamt several complete scenes and even two entire plays; he urged himself as he fell asleep by saying, 'Little subconscious mind, bring home the bacon' (Hamilton 1976). Mozart described in a letter the vivid experience of his own creative genius when his ideas seemed to flow into him at a rush:

> Whence and how they come, I know not—nor can I force them… Nor do I hear in my imagination the parts successively, but I hear them, as it were, all at once…All this inventing, this producing, takes place in a pleasing lively dream.
>
> (Quoted by Vernon 1970:55)

By contrast to the flash of inspiration experienced by Mozart, Bertrand Russell writes of a slower process of 'subconscious incubation' preceding the final sense of revelation:

> It appeared that after first contemplating a book on some subject, and after giving serious preliminary attention to it, I needed a period of subconscious incubation which could not be hurried and was if anything impeded by deliberate thinking.… Having, by a time of very intense concentration, planted the problem in my subconsciousness, it would germinate underground until, suddenly, the solution emerged with blinding clarity, so that it only remained to write down what had appeared as if in a revelation.
>
> (Quoted by Storr 1976:65)

Apart from the creative activity actually occurring in dreams, dramatists and writers have described how in a waking life too their characters emerge from within them with a life of their own. Pirandello, whose