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Introduction to Psychotherapy

An Outline of Psychodynamic Principles and Practice

SAMPLE CHAPTER

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adult mental health problems and personality disorder. But the link between childhood experience, the attachment process, and adulthood is complicated. Studies of low-risk groups have failed to identify any simple relationship between insecure attachment, for example, and behavioural problems in middle childhood. By contrast, studies of high-risk groups have been more successful in finding a relationship between insecure attachment and externalizing problems (e.g. aggression, poor peer relations) in the school years and between ambivalent attachment and anxiety disorder in adolescence (Raikes & Thompson, 2006). The effects of attachment trauma may be mediated through failures in the development of mentalizing, which is discussed on p. 82.

Finally, the question for clinicians is how attachment theory and research contribute to the practice of psychotherapy itself. Psychotherapy is, at its base, an attachment relationship. We will discuss this in the final section on the therapeutic alliance (see p. 68) but first we consider models of the mind. How the mind functions is highly dependent on the attachment relationship and the context in which the developing infant and child finds himself.

MODELS OF THE MIND

We need some sort of working model of the mind as a framework within which to organize our experience, much as we need a map when embarking on a journey in unfamiliar territory. It is probably in this area of the theories of psychic structure, or metapsychology, that most disagreement has arisen among the different psychodynamic schools. It must be remembered that these are theories or models of how the mind works; we should expect constant revision of such theories in the light of advances in our understanding of man, comparable to the revisions in other scientific fields such as in the theories of the structure of matter or of the nature of gravitation.

Freud revised his own theories several times, although fundamental to his thinking and that of other psychodynamic schools is the idea of different psychic levels. Here there is more than a hint of Freud's neurological background and the influence upon him of the neurologist Hughlings Jackson. At first (in the 1890s) he described the psychic apparatus simply in terms of *conscious* and *unconscious* levels. Next (in *The Interpretation of*

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Dreams, 1900) came his topographical theory with the idea of conscious, preconscious, and unconscious realms. Consciousness would correspond to what we are immediately aware of at any given moment. The preconscious would include all those memories or sense impressions, of which we are not immediately aware, but which can fairly easily be brought to full consciousness. The unconscious would include repressed memories and sensations, which are not so readily available, as well as more primitive impulses and fantasies (p. 14).

In 1923 (in *The Ego and the Id*) Freud introduced his structural theory with the now familiar concepts of *super-ego*, *ego*, and *id* (ego and id corresponding roughly to conscious and unconscious respectively, and super-ego approximating to conscience). This is a much more complex theory than the previous one. The conscious, preconscious, and unconscious labels of the topographical theory describe different levels or areas of experience. The structural theory is a hybrid that attempts to combine biological, experiential, and interpersonal dimensions. For example, by id is meant the basic biological aspect of the psyche, the inherited instinctual and constitutional aspects which we share to a large extent with other higher primates. It recalls Darwin's closing words in *The Descent of Man* (1871): 'Man with all his noble qualities . . . still bears in his bodily frame the indelible stamp of his lowly origin.'

The ego (corresponding roughly to consciousness) is concerned with rational thinking, external perception, and voluntary movement. It may be noted that there is some correspondence between such ego functions and cortical activity (in neurophysiological terms). The former are mostly waking functions, concerned with external reality, and are largely suspended in sleep. Other functions such as defence mechanisms (p. 28) operate at a more unconscious level, but are also relaxed during sleep and fatigue or under the influence of drugs and alcohol. The ego is at the centre of object relations, both as they are represented in our inner world and met in the outer world. The ego is the mediator between the needs and demands of the inside world and the realities and opportunities of the outside world. In performing this refereeing task it has to heed the super-ego, which is roughly equivalent to conscience, both in its conscious and unconscious aspects.

The super-ego is built up from the internalized representations and standards of parental figures from infancy onwards, with contributions from later relationships with teachers and other

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admired or feared figures. We can distinguish further between the more primitive and punitive aspects of the super-ego ('Thou shalt not . . .') and the more positive ego-ideal or those precepts we may try to follow. The primitive super-ego and the ego-ideal are somewhat like the Gods of the Old and New Testaments, respectively. It must be remembered that not all the operations of the super-ego are conscious. We may think out for ourselves, as adults, our attitudes to major issues of the day, such as abortion, euthanasia, etc., but more frequently in many (often trivial) ways, such as queuing in shops, we operate according to the less conscious dictates of conscience. Indeed, society could hardly survive without them. Difficulty arises when the unconscious super-ego (unnecessarily) represses feelings and impulses which may then give rise to symptoms, as in the case of the paralysed left arm of the young woman who wanted to hit her therapist (p. 19).

We have already said that the structural theory is a hybrid. The id is more of a biological concept that refers to the instinctual processes within a single person. The super-ego is an entirely different sort of concept, which moves away from one-person psychology towards family and social psychology. It is a concept which implies an interpersonal dimension including others in the external world who become internalized and set up as internal representations or images. These internal images people our dreams, but may be externalized and experienced in our ready response to myths, fairy stories, and drama. Such images are not exact representations of real past external figures, but, coloured by our feelings towards them, may become exaggeratedly good or bad objects. This process has been particularly emphasized by the followers of Melanie Klein (Segal, 1964). These idealized and denigrated figures become the heroes and demons of our dreams and mythology.

From the 1920s onwards there was a movement in theory-building away from models involving physical notions of psychic energy, towards more interpersonal models involving relationships between people. The object-relations theorists (Fairbairn, 1952; Guntrip, 1961; Winnicott, 1965; Balint, 1968; Greenberg & Mitchell, 1983a) whom we have already mentioned (p. 42) were an example of this movement.

The term *object-relations* theory is ill-defined despite its significant influence in psychotherapy. Greenberg and Mitchell (1983b) undertook a definitive assessment of the concept and suggested it

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was a theory concerned with the relationship between real, external people and the traces they leave in the mind of the other in terms of internal images, relationships, representations, and emotions. During childhood we build up images of our relationships with our parents, family, friends, and important caregivers. These develop in complexity over time. We internalize a representation of the relationship we have with them, that is, we lay down a memory of the interactions and the emotions associated with them. These representations gradually become mentally active internal working models which guide us in future relationships because we can use them to predict interactions with others. When people vary from our internal expectations based on previous experience, we become more alert and wary because the interaction does not map easily onto an internal representation. We look for reciprocity between external and internal and avoid jarring clashes which create anxiety.

From an object-relations perspective there is neither a need to consider the balance of the ego, super-ego, and id nor a requirement to consider basic motivational drives. Nevertheless practitioners have tended to combine models with the result that, over time, mixed models of the mind have become predominant. For example it is accepted, as we have suggested, that patterns of objects relations are shaped by the early interactions with the caregivers, that they become increasingly complex through the stages of development, and that they may be distorted by aggressive drives as well as external experience.

With the development of object-relations theory, psychoanalysis has moved increasingly towards an experiential perspective in terms of understanding the interaction between the patient and therapist as a representation of their internal object relations. In other words, what happens between the patient and therapist is a residue of the patient's relational past, an enactment of his internal object-relational states, and indicative of how he forms his current relationships. The focus of therapy has therefore become the relationship rather than an understanding of the interaction between forces. In the next section we consider this in more detail in relation to the transference (see p. 70).

Self-psychology, or self-object theory (p. 138), is a further development of object-relations theory and conceives of the self as over-and-above ('super-ordinate') the tripartite division of ego, super-ego, and id. In developing a strong and resilient self, we need

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others not only as sources of gratification and as objects to rely on and internalize, but also as self-object mirrors of ourself. The self is envisaged as having two poles, leading from modified grandiosity to realizable goals. An adequate self thus feels good about itself, and when disappointed and 'narcissistically wounded' does not fragment and resort to 'narcissistic rage' or denial and self-destructive behaviour. Attempts have been made to integrate self-psychology with object-relations theory (Kernberg, 1975; Bacal & Newman, 1990).

By placing *relationship* at the centre of human experience, self-psychology has more in common with object-relations theorists such as Fairbairn and Guntrip than with classical Freud and Klein. However, as Bacal and Newman have pointed out, Freud foresaw the central role of an object-relations perspective, perhaps even the self-object function of others and, even further, possibly attachment theory itself. In a footnote in *Three Essays on the Theory of Sexuality* (Freud, 1905, p. 224) he tells a story:

> I once heard a three-year-old boy calling out of a dark room: 'Auntie, speak to me! I'm frightened because it's so dark.' His aunt answered him: 'What good would that do? You can't see me.' 'That doesn't matter', replied the child, 'if anyone speaks it gets light'. Thus what he was afraid of was not the dark, but the absence of someone he loved; and he could feel sure of being soothed as soon as he had evidence of that person's presence.

Eric Berne, in *Games People Play* (1966), has given a popular account of a serious psychodynamic school in the USA known as transactional analysis (see p. 221). His use of the concept of 'ego states' representing the adult, parent, and child parts in each one of us is a particularly graphic way of expressing psychic structure in terms which will also be helpful when considering the phenomenon of transference in the next section. If we consider the different levels of the psyche (Figure 1) as described by psychoanalytic and transactional analytic theory we can discern: a rough correspondence between the primitive child part of us and the id; a closer correspondence between the ego and the adult, rational, reality-orientated part of us; and the closest correspondence of all between the super-ego and the parent within ourselves. Among the advantages of using these terms is that they have immediate meaning to

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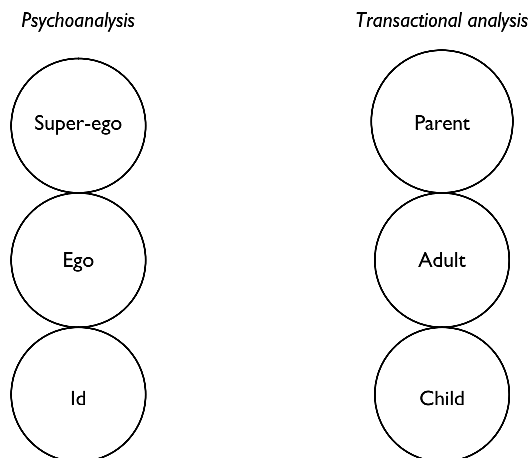

Figure 1

most people. To speak of conflicts between super-ego and id may be thought to give a scientific ring to discussions amongst professionals but would make little sense to most patients; to talk of conflicts between the parent and child parts within us makes sense to most people.

We have emphasized repeatedly the notion of different psychic levels and, in particular, the frequent dualities which ran throughout Freud's thinking and appear also in other psychodynamic formulations (Table 3). For example, Freud contrasted conscious and unconscious; ego and id; secondary process thinking (rational and logical) as characteristic of consciousness and primary process thinking (illogical and irrational) as characteristic of the unconscious; the reality principle, which dictates the workings of the ego, and the pleasure principle dictating the id. There may be conflict between the present and the past and between culture and instinct. There is a conflict between the outer world or external reality and our inner world or psychic reality. Jung wrote of the contrast between the persona or mask which we present to the world and the shadow or darker side of our nature which we wish to hide. Winnicott (1960) and Laing (1960) have written similarly of the false self which hides the inner true self. In Berne's terms the adult obscures the child.

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Table 3 Dual levels of psychic structure

Conscious	Unconscious
Ego	Id
Secondary process thinking	Impulse
Reality principle	Primary process thinking
Outer world	Pleasure principle
External reality	Inner world
Present	Psychic reality
Culture	Past
False self	Instinct
Persona	True self
Adult	Shadow
	Child

Table 4 Dual levels of awareness between self and others

	Known to self	*Unknown to self*
Known to others	A Public self	B Blind self
Unknown to others	C Secret self	D Unconscious self

We have specially emphasized how this way of thinking in terms of different psychic layers or levels is common to all psychodynamic schools. Sometimes there are things we admit to ourselves but hide from others; sometimes we also hide things from ourselves. This is common human experience which any theory of the psyche has to meet. Table 4 (modified from Luft, 1966) illustrates how such dual levels of awareness within the individual relate to similar dualities between people in everyday life.

As will be discussed in Part II, psychotherapy involves information being communicated from C to A (self-disclosure), from B to A (contributions from others), and from D to A (in more intensive treatments).

So far we have tended to speak of personality dynamics as self-contained, the ego working to integrate the diverse pressures from id, super-ego, and external reality as perceived by the sensory apparatus of the individual. This model portrays the individual as essentially isolated, with the external world represented by images and memories based upon interpretations of his experiences. Although this model is extremely useful in explaining *intrapsychic*

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phenomena, it has limitations when we come to more complex *interpersonal* phenomena. This is not surprising; scientists have long been discovering that events cannot be fully understood without taking into account the environment or setting in which they occur. Just as the malfunctioning of an organ may be part of the distress of the whole person, so a malfunctioning individual may be part of a whole family in trouble, or a family disturbance may be part of a social malaise. A disturbance may permeate all three levels: for example, a child may develop abdominal cramp which keeps him off school so that he can remain reassuringly close to mother, who is depressed and talking of suicide because of her husband's inability to get employment.

The model of the individual mind can be seen as a system inside a wider system, that of the family, inside another, that of society. These systems are not enclosed in watertight boundaries; they inevitably influence each other. In talking of one person and his impulses, the concept of psychic 'energy' may be useful. When considering the effect of early relationships on the interaction between two individuals, object-relations theory (p. 42) may be more helpful, with its emphasis on the role of internal images or representations of people in the outer world. In discussing more complex interpersonal and social phenomena, notions of communication and information (Watzlawick, Beavin, & Jackson, 1968) are more relevant. The contrasts between these three levels of interaction are more spurious than real. People function on all three levels at once; the isolated individual is an abstraction.

General systems theory (Bertalanffy, 1968) has been developed over the last few decades to study and explain interactions in a wide range of fields from cybernetics to sociology, and more recently psychiatry. A system is a set of interacting elements within a hypothetical boundary which makes it more or less open to mutual influence with the environment; in sociology and psychology this influence is largely effected by informational communication. Systems theory allows us to think more clearly about the well-known fact that a setting determines what happens inside that setting, and that parts cannot be understood without considering the whole, as expressed in John Donne's view that 'No man is an *island*, intire of itself – every man is a peece of the *Continent*, a part of the *maine*'. It helps us to understand self-regulating processes, which depend on control and feedback, and the interaction of cause and effect.

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Traditionally, in the physical sciences, and therefore in medical thinking derived from them, effect was always thought to follow cause and it was considered illegitimate to suggest that the effect might be the cause. The cause of a symptom had to be sought in the physical lesion which resulted in the symptom: for example, abdominal pain caused by appendicitis. However, where there is no physical lesion the effect of the symptom may itself be the cause. This way of thinking – to consider the effect of the symptom in seeking its cause – has often been dismissed as shoddy teleological reasoning. However, as Bowlby (1969) has shown, it is now perfectly legitimate in many complex scientific spheres to think in this way. The trajectory of an old-fashioned cannon ball or bullet will be described by its velocity aim, and so on, when fired. The end is determined by the start. This is the 'billiard ball' universe of Newtonian mechanics. However, in more complex systems, such as a guided missile, the trajectory will be constantly adjusted according to whether or not the desired end point is being achieved. Similarly, in living organisms, complex behaviour is often 'goal-corrected'; abdominal pain, the effect of which is to miss school, may be caused by unwillingness to go to school.

Human beings exist in a series of systems. From the start they are part of a system (the mother–child pair) which is part of a larger one (the family) which in turn is part of further overlapping and concentric systems (the extended family, school, the neighbourhood, the wider community, etc.). These are termed 'open systems', in that their boundaries are permeable to influences from the smaller sub-systems they comprise and the larger supra-system of which they are a part. We can discern hierarchies of systems in which smaller ones are subject to the rules and expectations of large ones: for example, the individual to the rules of the family, the family to those of society. Furthermore, each system contains a 'decider sub-system' with functions of communication, control, and coordination, such as the central nervous system or ego in the individual, the parents in the family, or government in society. In trying to understand phenomena at any level, we have to decide where to focus attention. Can we understand someone's headache or high blood pressure in terms of an isolated physical system, or do we have to include the whole person (body plus mind)? Can we adequately explain an underlying anxiety or rage without taking into account the family network or relationships at work? Finally, can we explain a person's condition fully without taking social

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phenomena into account, for example, whether his social conditions, such as poor housing or unemployment, are contributing to the poor family relationships and thus to his emotional disturbance?

> Observe how system into system runs,
> What other planets circle other suns.
> (Alexander Pope, *An Essay on Man*, 1733)

A systems theory approach allows us to conceptualize the organization of such interacting levels and to clarify where we can usefully concentrate therapeutic intervention. For example, we might not accept a family's view as to who the sick person is. A child brought with bed-wetting or school-refusal may be best helped by looking at the whole family; the arrival of a new baby, mother's depression, or parental discord may need to be considered in order to help the child. Until we look at the wider system we cannot see the meanings and messages, overt and covert, which the patient is conveying or to which he is responding. Unless we look at the whole family, we might be unable to explain why, following treatment, beneficial change in one member leads to a detrimental change in another – for example the husband of an agoraphobic housebound wife becoming depressed when she gives up her helpless role.

Similarly, we may not understand what is happening between the patient and doctor until we recognize that the patient is treating the doctor as though he were somebody from the past, from the earlier family system, as will be discussed in the following section in considering transference.

THERAPEUTIC RELATIONSHIPS

In considering the total doctor–patient or therapist–client relationship, we feel it is helpful to distinguish four elements. These are the *therapeutic or working alliance*, *transference*, *countertransference*, and *mentalization*.

Therapeutic alliance (see Table 5)

The therapeutic or working alliance refers to the ordinarily good relationship that any two people need to have in cooperating over

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