This chapter aims to describe the key contributions that psychoanalytic theory has made to our understanding of the mind.

The practice of psychiatry and the development of psychological treatments rest upon how we understand the mind and emotional life. As clinicians working with patients with difficulties in how they feel, relate and think we need an understanding of psychic life in healthy and more disturbed states, just as practitioners of physical medicine need to understand bodily processes in sickness and in health.

Since the late nineteenth century psychoanalytic theory has provided a platform from which a series of models of the mind have evolved. An underlying and fundamental tent of this approach is that most of mental functioning occurs at an unconscious level; a finding now widely supported within psychology and neuroscience [1]. The unique contributions of a psychoanalytic approach seek to elucidate and to understand the form and nature of these unconscious processes, both in healthy and more disturbed states of mind. Furthermore, clinical techniques derived from psychoanalysis such as free association and dream interpretation are specifically aimed at identifying unconscious mental processes and psychoanalysis has a great deal to offer a systematic study of the unconscious. Although the terms psychodynamic or psychoanalytic tend to be used in association with psychotherapeutic treatment, a psychoanalytic approach refers to a school of thought able to provide insights into the workings of the mind far beyond the treatment approaches derived from it.

The limits of rational thought and considered volitional action in explaining emotional life are blindingly evident from the complexities, extremities and non-common-sensical nature of much of human behaviour. Being driven by powerful emotional forces which we may struggle to fully know or to understand is intrinsic to human life. Our need to love, to connect and to relate contrasts with acts fuelled by hatred, cruelty and alienation. We can function in both highly creative and deeply destructive ways and a coherent model of mental life requires the capacity and vision to address this paradox. Psychoanalytic thinking draws upon the intensity and passion of early life, when the infant’s survival is dependent upon his ability to secure a nurturing attachment, and to regulate and to manage his primitive terrors, as the starting point from which to consider the management of psychic energy throughout life. In taking a developmental perspective psychoanalysis seeks to identify the influencing factors determining how we feel, relate and behave from infancy and throughout life. This enormously ambitious project provides a means to consider how the internal world is formed at an individual and unique level, and also how we behave in groups and within society.
The development of psychoanalytic theory has a fascinating history involving the evolution of ideas seen as provocative, enlightening, disturbing and controversial within the contexts of the times within which they have emerged. This chapter will introduce some of the key ideas and thinkers contributing to this body of work. Additional reading will be recommended at the end of the chapter for those who wish to further their explorations of this rich and complex subject.

Despite differences in emphasis and at times conflicts about key ideas, all schools of psychodynamic thought are concerned with both unconscious and conscious aspects of mental life and the interplay and tensions between them. A defining belief of a psychoanalytic perspective is that the unconscious forms a vast substructure underpinning the conscious mind and exerting pressures and influences upon it; all behaviour and subjective experience is therefore seen as having unconscious determinants.

Sigmund Freud: The Neurologist and Pioneer of the Unconscious

_Sigmund Freud, 1900 [2]_

Sigmund Freud (b. 1856, Freiburg, d. 1939, London) trained in medicine and neurology; his early research interests lay in the area of brain damage linked with aphasia. He realised the limits of the mechanistic localisation-based theories in understanding the cases he saw and his first published book _On Aphasia_ represented an early attempt to incorporate a dynamic and psychological model of the mind into the world of neurobiology [3]. His rejection of an anatomical brain model as adequately explaining his patients’ symptoms was further fuelled by the cases he observed under the care of the renowned neurologist Charcot in the Salpêtrière asylum in Paris in 1885. He became deeply interested in the study of hysteria, recognised that paralyses, physical maladies, dreams and parapraxes of the patients he encountered could only be explained by models of disturbance of psychological function and that mental function could not be located within an anatomical structure. Furthermore, he recognised these symptoms as expressions of experiences consciously forgotten which could be remembered under hypnosis, a striking realisation captured by his words ‘hysterics suffer mainly from reminiscences’ [4].

Freud’s private practice as a neurologist enabled him to study patients and their symptoms in detail. The case of Anna O, a young woman who presented with a host of physical symptoms including a cough, paralyses, disturbances of speech and sight and fainting fits after her father’s death, led him to conclude that traumatic experiences can be repressed and continue to reside in an area of the mind which is entirely unconscious, yet these experiences make their voices heard by re-emerging as symptoms. If the trauma can be remembered and spoken about – a process he called _catharsis_, there is no further need of the physical symptoms that resolve accordingly. This formed the basis of what he referred to as _the talking cure_. Drawing on his background in physical sciences Freud developed the idea of a mental apparatus that, in common with other bodily systems, aims to maintain a steady homeostatic state against internal psychic energy that is seeking discharge. He saw the mind as being dominated by instinctual drives to ensure basic needs were expressed and met which he considered as largely residing in the unconscious – a vast substructure underpinning the volitional conscious mind and with a distinctive nature and functioning [5].
As a scientist Freud continually modified his ideas on the basis of clinical observation and experience, leading to a series of theoretical models and emergence of developing clinical techniques. His early work included the use of hypnosis, which he later abandoned in favour of free association, or encouragement of the patient to speak openly and freely about whatever comes to their minds. Free association has been called the fundamental rule of psychoanalysis and assumes that everything that emerges in thoughts and communications has meaning. Further clinical techniques followed such as dream interpretation, the neutral stance of the therapist and a way of listening, all of which sought to access and to tune into the workings of the unconscious as they reveal themselves in everyday life [6].

Hence the scene was set for the exploration of this vast territory; the unconscious aspects of the mind to which Freud devoted much of his subsequent career. Although in parts controversial, challenging and, in common with all great advances in understanding, modified by later discoveries, it is remarkable how much Freud’s ideas have contributed to our understanding of mental processes. Like Darwin and Einstein, Freud changed the paradigms through which we understand ourselves – the modern world is familiar and comfortable with the concept of unconscious processes and how they may affect our emotional and social functioning. More contemporary discoveries within neuroscience support his finding that the vast majority of mental life occurs at an unconscious level.

In keeping with his medical training, Freud’s ambitions lay in developing a general theory of the mind from which pathology could be understood. But he was interested in more than just illness; he also sought to understand the breadths and depths of human functioning at its most creative and destructive, from the individual to societal level, from sadism to war, from infancy to schizophrenia; the scope of his work was vast and his writing prolific.

Freud’s evolving models of the mind followed his shift in thinking from the anatomical to the psychological. His earliest topographical model divided the mind into three parts – the conscious, the unconscious, serving as a reservoir of instinctual urges and repressed memories, and the preconscious, representing areas of the mind requiring attention and prompting to make themselves consciously known. However, the topographical model ran into difficulties and in 1923 Freud introduced a major revision with the structural theory of the mind in which the conscious, unconscious and preconscious are all understood as dynamic, fluid qualities of mental processes as opposed to discrete areas of the mind. The structural theory divides the mind into the id, the ego and the superego in which mental processes are grouped together in terms of their functional significance [7].

Within Freud’s structural theory of the mind the id is entirely unconscious and holds the basic instinctual urges such as aggression and sexuality. (More recent findings from the developing world of neuropsychoanalysis dispute this as the affective states from them seem to be conscious [8].) Psychological processes of the id are primitive and entirely different to rational thought. Referred to as primary process thinking the mental life of the id knows no shame, guilt or inhibition and operates entirely under the reign of the pleasure principle. In the magical land of primary process thinking logic is disregarded, opposites can co-exist without conflict, external reality is ignored and instant gratification of all urges and appetites with avoidance of all pain and discomfort is the aim, resorting to hallucinatory wish fulfilment or magical thinking to avoid frustration. Primary process activity is evident in the play of young children, revealed in glimpses in mental and verbal slips and more fully in dreams and psychosis. The id was referred to by Freud as the seething cauldron of unacceptable impulses such as the desire to kill or insatiable cravings for sexual satisfactions.
Unimpeded by input from perceptual organs about external reality, the id functions under the sway of its own wishes and appetites.

Instinctual urges and the vast resource of psychic energy seeking discharge from the id require active management and are censored by the superego which functions as a conscience, repressing what it considers to be morally unacceptable and supporting the ego in making realistic judgements and decisions. Freud conceptualised the superego as socially conditioned and developing from the internalisation of parental attitudes and approval. The ego has the task of mediating between external reality, the superego and the needs and demands of internal needs and urges. The ego strives to function in keeping with the reality principle, ensuring both executive thoughts and motor actions are able to negotiate and manage the expectations, opportunities and limitations of the external world while also relating to the appetites and needs of the id.

The ego develops as the central aspect of the psyche; it comprises both conscious and unconscious aspects and is the seat of thought. Ego structures are informed by the perceptual organs about external reality; it controls motility and is tasked with managing the passions of the id, which it does with varying degrees of success. Balancing the primitive appetites and survivalist instincts of the id alongside the pressures of the superego, which can be unduly harsh or tolerant, is a precarious task for both the individual and for social groups and behaviours. Freud wrote about the tension between these processes on the world stage and how in Europe the First World War showed that the deep human instinct to kill overwhelmed the use of negotiation and diplomacy [9].

Hence our psychological functioning is constantly challenged and informed by pressures from the unconscious, which contains the most primitive and survival-oriented drives and urges, and from the prohibitions and limits of the superego which strives to regulate them. According to Freud the mind’s ability to function depends on the balance between these different forces, most of which are beyond conscious awareness. An overly powerful superego, for example, can lead to punitive ways of seeing oneself, excessive self-criticism and self-inhibition, while an excess of id, or an ego too fragile to manage the forces of id, means the ability to function in keeping with the demands of external reality is threatened.

Freud saw psychological symptoms as expressions of unconscious conflict between unconscious urges and conscious behaviour. He referred to this as psychic determinism – that our feelings, thoughts, behaviours and symptoms are inherently filled with meaning how is beyond conscious awareness. As he wrote in 1895 ‘dreams are never concerned with trivia’ [2] – we may like to see ourselves as rational and in control, or at the mercy of random and arbitrary experiences, but in psychodynamic theory our internal and experiences and the situations we find ourselves in are full of meaning. The best jokes for example may have some primary process in them and often have an aggressive component, the laughter discharging the underlying aggressive wish. Freudian slips in speech and the forgetting of undesirable realities may all be signs that a wish from the unconscious has gained entry into the conscious mind in disguised form, so the lapse is far from meaningless and may reveal powerful unconscious urges.

In Freud’s early work with patients with conversion disorders he found that the repressed knowledge of childhood sexual trauma seemed to be the foundation of his patients’ symptoms, which became known as the seduction theory [10]. This emphasised the causative impact of abuse in adult cases of hysteria and obsessional neurosis and placed trauma and nurture at the heart of his early theories. However, for reasons not fully elucidated, but seemingly linked to the frequency with which sexual material emerged during
his work with his patients, Freud turned his attention to developing ideas about childhood sexual curiosity and urges, abandoning the seduction theory. This remains one of the most controversial areas of his work with far-reaching consequences for psychoanalysis. Criticisms followed that the child’s actual experience and the prevalence of childhood sexual abuse was denied and neglected in his subsequent theories [11]. However, Freud’s ideas about childhood sexuality led to his discovery of key concepts such as the transference, repetition compulsion, and personality development. Freud saw infantile sexuality as different to mature adult sexuality and described stages of psychosexual development, meaning that different areas of the body become the focus of instinctual sexual energy or libido, depending on the prevailing developmental preoccupations [12]. Hence in the first year or oral stage satisfaction via feeding means the main source of pleasure is the mouth, the anal stage (1–3 years) refers to the acquisition of bowel control through toilet training and the genital stage (3–5 years) refers to anxiety about the genitals and recognition of difference. Each stage has its associated nature and functions and if not satisfactorily navigated the individual may become fixated at certain stages with implications for character development (it has become common parlance for example to describe people as being ‘anal’ in keeping with this idea).

Freud used material from his own dreams to further his understanding of the unconscious and discovered strong feelings of love for his mother and jealousy towards his father in this analysis. He believed these to be universal themes and linked this discovery to the Oedipus Myth in which Oedipus unwittingly kills his father and marries his mother. Freud saw this myth as capturing a universal developmental challenge and central to psychological development – the unconscious rivalry and murderous wish towards the same sex parent, with a desire for exclusive ownership of the other. The term Electra complex was used to describe a similar constellation of unconscious desire in girls. Freud thought that oedipal issues come most overtly to the fore between three and five years of age, such as may be expressed in acceptable form by the ‘daddy’s girl’ type behaviours of a daughter or ‘mummy’s little man’ of a son. He considered that the development of healthy superego function depended in part on a satisfactory resolution of anxieties linked with oedipal urges, allowing adult sexuality to be enjoyed within societally accepted parameters and at the same time free from excessive inhibition.

Although issues arising from oedipal urges and anxieties continue to play a central role in psychoanalytic theory, there have been marked departures and developments from this earlier model – most strikingly by Melanie Klein. Recognition and negotiation of triangulation in relationships and the experience of exclusion is seen as a key developmental challenge, alongside the universal longing for the exclusive love of another and intense hatred when this is denied.

**Defence Mechanisms**

*Humankind cannot bear too much contact with reality*

*T S Eliot*

The struggle for the ego to manage instinctually based urges, and the demands and challenges provided by privations, losses, frustrations and traumatic experiences in external reality means the mind needs to be able to manage potentially overwhelming urges, emotions and anxiety. To preserve its capacity to function the mind has developed a wide range of defence mechanisms – in essence these are the mind’s tactics employed against the
pressures of unacceptable desire or unbearable experiences and are mobilised in response to anxiety. Defences are unconscious, universal, constantly in action, and adaptive. They allow the ego to think by titrating contact with both painful reality and primitive impulses from the id.

In more extreme forms however defensive functioning can develop into more problematic behaviours, distortions of reality or psychological symptoms. The latter may develop when an unacceptable urge from the id, or an experience repressed beyond conscious knowledge, cannot be adequately defended against, and a compromise has to be reached between the unconscious forces and the failing defence – usually this means that the unacceptable impulse or experience may present in a sufficiently disguised form to be consciously acceptable. This can become the basis of a neurotic disorder, phobia, psychosomatic complaint or conversion symptom. Defensive organisations can also become excessively rigid and dominate mental functioning to the extent they become entrenched in the personality, such as in obsessional, anankastic or borderline personality organisation.

Defence mechanisms are historically categorised in relation to the stage of development when they are most commonly prevalent, although all forms can continue to be operative throughout life; they overlap and are interdependent on one another – we all operate under the influence of a community of defensive activities that relate to and inform each other. The immature defences for example are most frequently deployed in infancy and early childhood and are also powerfully operative in psychotic and borderline states. The more mature defences are generally seen as more adaptive and also importantly as the source of much or man’s creative endeavours in channelling the energy from id impulses towards alternative means of expression. Table 1.1 illustrates some common defence mechanisms, based on Freud’s early conceptualisations, but added to and modified by subsequent psychoanalysts.

**Freud and Transference/Countertransference**

The processes of transference and countertransference refer to how the minds of people interact and impact on one another through unconscious means. These are ubiquitous processes that inform our perceptions and responses to others and allow us to intuit about another’s state of mind. In infancy when at our most dependent and vulnerable, the mind is exquisitely sensitive to the reactions and responses of others; this is key to survival. The quality of these early essential and nurturing relationships powerfully affects our unconscious expectations of, and responses towards others. These early templates continue to be added to and modified throughout life and are present to varying extents in all our interactions and relationships. Someone with secure and nurturing early relationships for example may respond to an angry interaction with calmness and confidence, whereas if early life has been characterised by neglect and fear then the perception of threat may be more easily triggered and the response may be to feel threatened or paranoid. Freud recognised and named the transference in his early work, initially seeing it as a form of resistance against therapeutic change, later seeing it as a potential path to unconscious material. Use of the transference and countertransference remain cornerstones of psychoanalytic technique, although as ubiquitous processes the power and effects are not confined to the consulting room and powerfully inform how we perceive and respond to others at an unconscious level.
<table>
<thead>
<tr>
<th>Primitive/Immature defences</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repression</td>
<td>The unconscious forgetting of what is unbearable to know about</td>
</tr>
<tr>
<td>Denial</td>
<td>Refusal to accept a threatening reality</td>
</tr>
<tr>
<td>Projection/Projective</td>
<td>Expulsion of any thoughts, qualities or feelings which the individual rejects about himself</td>
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</tr>
<tr>
<td>Idealisation/Denigration</td>
<td>Seeing something or someone as all good, perfect and the Attribution of entirely bad qualities to another</td>
</tr>
<tr>
<td>Regression</td>
<td>Reverting back to an earlier stage of development to avoid responsibilities, demands and conflicts associated with current stage of life</td>
</tr>
<tr>
<td>Acting out</td>
<td>Taking action to avoid painful affect</td>
</tr>
<tr>
<td>Reaction formation</td>
<td>Assuming an attitude diametrically opposed to a repressed wish</td>
</tr>
<tr>
<td>Somatisation</td>
<td>The location of emotional tension or pain into the body and focus of concern becoming on physical symptoms</td>
</tr>
<tr>
<td>Schizoid</td>
<td>Avoiding relating to others and substituting gratifying fantasy</td>
</tr>
<tr>
<td>Dissociation</td>
<td>Temporary loss of awareness of reality, state of extreme detachedness, loss of memory and loss of identity e.g. in extreme trauma</td>
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<table>
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<tr>
<th>More mature defences</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Displacement</td>
<td>Avoiding conflict by expression towards a substitute person or object</td>
</tr>
<tr>
<td>Identification</td>
<td>The qualities of another person become part of one’s own identity</td>
</tr>
<tr>
<td>Identification with the aggressor</td>
<td>Becoming the threat oneself to master fear of being the victim</td>
</tr>
<tr>
<td>Introjection</td>
<td>Internalising the qualities of another to avoid awareness of loss</td>
</tr>
<tr>
<td>Intellectualisation</td>
<td>Use of theoretical abstract concepts in order to manage and distance oneself from painful feelings</td>
</tr>
<tr>
<td>Isolation of affect</td>
<td>Separating an idea from its accompanying affect to make it more acceptable</td>
</tr>
<tr>
<td>Rationalisation</td>
<td>Justification made to explain away a thought, feeling or experience unbearable to know about</td>
</tr>
<tr>
<td>Sexualisation</td>
<td>Turning an encounter or experience into an exciting and sexualised experience as a defence against intimacy and anxiety</td>
</tr>
</tbody>
</table>
Freud has been hailed as one of the great thinkers of all time and has been a hugely influential figure on our cultural, societal and clinical landscapes. He was however a man of his times and many of his ideas have been considerably modified by subsequent theorists. He did not tolerate dissent and some of his early collaborators fell out of favour. He has attracted criticism including from leading feminists for his rather limited theory of the sexual development of women, and he had little to say about the role of mothers or of the importance of early nurture; he admitted he did not understand women very well. He did however make a huge contribution towards understanding the struggles and conflicts inherent in emotional life, highlighted the significance of unconscious mental processes and linked the biological with the complexity of psychological life. Having witnessed the horrors of the First World War, and fleeing the Nazis for London during the second, he did not pull back from a full and frank appraisal of all the urges, creative and destructive, and the cruelty inherent in human behaviour and was entirely committed to seeking ways to understand all aspects of the mind. In emphasising the importance of ego function in controlling the impulses of the id he provided psychological ways to understand the danger when thought breaks down and is replaced by action fuelled by primitive urges seeking gratification. As part of his legacy he left a metapsychology of a scale unmatched by any other model.

Anna Freud

Anna Freud’s younger daughter, Anna (b.1895, Vienna, d.1982, London) became a leading figure in the psychoanalytic world, and a pioneer in child psychoanalysis. From her extensive experience she developed further ideas about ego development and the defences, emphasising the interplay between the internal and the external worlds, and first described the defences of identification with the aggressor and altruism [14]. The Anna Freud Centre in London remains as testament to her ideas and clinical contribution.
Carl Jung

*Until you make the unconscious conscious, it will direct your life and you will call it fate.*

Carl Gustav Jung (b.1875, d.1961, Zurich Switzerland) was a psychiatrist who worked with Bleuler in schizophrenia research before developing a close collaboration with Freud. Despite the excitement and closeness of their early relationship, developing differences in theoretical approaches led to the irrevocable breakdown in their professional and personal friendship, a schism with repercussions lasting into contemporary times in terms of limiting potential cross-fertilisation of ideas. Jung felt that in addition to the psychic structures that Freud had identified there was a spiritual dimension to internal experience that had central importance and which could not be reduced to Freudian drives. Jung emphasised the importance of **symbolism** in our individual and **collective psyche** finding common themes in myths from around the world. He postulated a **collective unconscious** populated by **archetypes** – universal themes of meaning that lies beneath and transcend our personal ego structures.

Jung’s thinking was profoundly influenced by **synchronicity** – the concurrence of an event and an inner experience, which are connected by a sense of meaning for the individual experiencing them. He introduced the concept and his personal experience of these meaningful coincidences in everyday life led him to the conclusion that there was a **causal order** that linked the inner world of the mental with the outer world of the physical through their meaning.

At the apex of Jung’s hierarchy of archetypes is the **Self**. The Self is a mysterious concept that can be understood in prosaic terms as the best possible version of ourselves and which involves a unification of the conscious and the unconscious aspects of the psyche. Jung coined the term **individuation** to describe the death rebirth process and psychological transformation that marks the transition from ego to Self in advanced stages of ego development. The **anima** (and its masculine version the **animus** occupied a central role in Jung’s model as the archetypal feminine that has to be owned and integrated by ego structures for individuation to progress [15].

Jung was considered one of the great thinkers of the twentieth century although his ideas have been less influential in modern psychiatry and psychotherapy. He described his own **confrontation with the unconscious** in his autobiography and how the material that emerged in this personal crisis shaped his subsequent work, referred to subsequently as a creative illness [16]. Jung thought of psychotherapy as a developmental journey of psycho-spiritual maturation and Jungian depth psychology provided for many a modern method of accessing the spiritual power of the deep psyche at a time when traditional religion was losing its relevance.

Melanie Klein

*The study of the adult neurosis led Freud to discover the child in the adult, the study of children led Mrs Klein to the infant in the child* [17].

Melanie Klein (b. 1882, Vienna, d. 1960, London) further developed ideas about unconscious processes from her groundbreaking psychoanalytic work with infants and young children. While Freud extrapolated backwards from his work with adults in developing ideas about early development, Klein used her understanding of infantile and primitive psychological processes and raw states of affect to generate ideas about adult psychic life. She placed early emotional experience as central to the development of adult psychic life. Klein’s
direct observations of infants with their mothers, and perhaps her own experiences as a mother herself, led to the recognition that the mother’s state of mind provides the primary emotional environment for the child – and of the child as being *relationship seeking* from birth. This heralded an intense interest in early experiences of care in psychoanalysis and a huge advance in our understanding of emotional development and the role of early relationships.

Klein had an extreme gift for recognising how children use play to create scenarios in keeping with their conscious and unconscious preoccupations. She developed the play technique; using a selection of toys and drawing materials children would be encouraged to play freely in their therapy sessions – seen as the equivalent of free association for adults. The child’s play was recognised as being full of meaning, the toys and activities representing key figures and emotional issues in symbolic form, and as worthy of the same level of serious consideration by the analyst as the verbal expressions and dreams of adult patients. She recognised how anxieties, emotional urges, Oedipal issues and conflict were expressed and to an extent worked out in this way. This gave access to the unconscious world of the child and both confirmed some of Freud’s findings while adding some unexpected new discoveries about the unconscious.

Klein differed from Freud in seeing the infant as seeking to communicate and to relate to others from their earliest days, not simply to satisfy instinctual needs. From this viewpoint she saw feelings, both emotional and physical, as being experienced in terms of a relationship with another in early life. She used the term *object* to refer to the people to whom the infant primarily relates. According to Klein in infancy this relating is towards parts of the other – their lap, breast, arms etc., and these have not yet been put together in the infant’s mind to form a whole person. She wrote of the breast as representing the nurturing capacity of the other [18].

After birth the infant is no longer cocooned within the regulatory homeostatic mechanisms of the mother’s bodily processes and is faced with an external reality in which he is separate and has to find ways to secure his own survival. He faces hunger, cold, frustration and aloneness for the first time and is entirely dependent on care in order to live; he is not able to move, feed or protect himself. Klein recognised the intensity, desperation and passion with which the infant seeks to relate and also how he interprets all his experiences in relational terms – every feeling is experienced in relation to another. Fortunately for the infant the mother’s state of mind is usually exquisitely tuned into the intensity of his need and the nature of her response is key to emotional development.

Klein saw unconscious phantasy as the basis of mental life and as evidenced in infancy and in children’s play. Unconscious phantasy differs from fantasy, which is a conscious process of mental retreat into daydreaming in response to frustration. Unconscious phantasy refers to the unconscious mental representation of somatic experience in early life and gives it meaning in relational terms. For example, after a satisfying feed the pleasurable experience of a full tummy may be accompanied by a phantasy of a wonderfully sustaining object held within the infant. Klein also recognised innate destructive urges and feelings of rage and fear, which are unmodified and primitive at the start of life. This includes envy, which Klein recognised as the destructive and to an extent constitutional urge to destroy the goodness of the other [19]. In addition she suggested the infant has an innate unconscious knowledge about sexuality, and the parental relationship. She saw the Oedipal situation as key to the development of the mind and the child as being aware of triangular situations that
he is excluded from in the earliest months of life. She saw issues of aggression, sexuality, omnipotence and attempts to find creative solutions in her observations of children’s play and drawings.

Klein developed the idea of there being two positions of central importance in early life – the paranoid-schizoid and depressive positions [20]. In the first days and weeks of life the infant has to find ways to deal with powerful emotions, and good and bad experiences in the external world, overwhelming anxiety including fear of non-survival, and innate destructive urges. He does this initially through processes of splitting and projection. Splitting refers to a binary division of experiences into good and bad; these are absolute states with no ambiguity or uncertainty. Klein stressed the importance of this for healthy development and as the infant’s first attempt to structure his experiences. By projecting unwanted and troublesome urges and affects into the external world the infant is able to inhabit a benign state of mind in which he can safely settle and feed. However, by projecting aggressive urges outside of the self the external world can become a threatening and dangerous place leading to fear of attack and persecutory anxiety, ideas helpful in understanding paranoid states of mind.

These ideas help to explain the everyday intensity of infantile emotional life, easily observed in the persecuted screams of a hungry baby, signalling a terror that his very life could be endangered, and the absolute bliss and total state of trust after a satisfying feed which may closely follow this – both are absolute and extreme states entirely disconnected from each other in early life. Within these states the baby is relating to both the utterly wonderful and absolutely terrifying aspects of his own internal phantasies rather than the reality of an understood external world. His internal experience has become the entire reality. Through unconscious phantasy the infant experiences his bodily sensations and affects as being caused by benign or malignant objects – a hunger pain for example as an attack from a hostile persecutor who is attacking his tummy. This is also referred to as part object relating – the mother is related to in parts, and there is no connection in early life between the bad/attacking mother who abandons him to persecutors and the loving and nurturing one. The key anxiety in the paranoid-schizoid position is persecutory – having projected fear of annihilation into the world around there is a terror of attack from outside. The term projective identification adds depth to the concept of projection and includes the process by which the object is changed by the projection – so the person who is the target of the projection of hostility and aggression may in turn become angry themselves.

As the infant develops, he starts to recognise the mother who frustrates his wishes and has her limitations is the same as the loving mother upon whom he is entirely dependent – the parts start to come together to form a whole. This heralds the depressive position that Klein saw as evident from three to six months of age [21]. The mother starts to become a whole object in the infant’s mind – with the painful realisation this is also the mother whom the infant has so hated and felt such aggression towards. This allows the development of feelings such as concern, guilt for the infant’s own aggression towards the mother he so loves and needs, responsibility and a desire to make things better through reparation. These are necessary and normal emotions to tolerate and bear – the depressive position is not the same as depression but the associated anxiety in depressive position functioning is depressive in nature and in keeping with both loving and needing the object. Holding both love and hatred together can be difficult to bear.
and to integrate and working this through requires repeated **mourning** as previous positions are given up and reparation is made for the hatred which has been felt. Defences may be launched against the painful work of depressive position functioning. The **manic defence** involves denial of the object’s importance with denigration, omnipotence and avoidance of guilt and **obsessional defences** involve control and repetitive activities towards undoing aggressive acts. Children’s play is rich in material supporting these ideas, using toys as **symbols** to express and resolve themes of love and hatred, aggression and reparation.

Hence Klein described and differentiated between two basic groups of anxieties and defences; the paranoid-schizoid position characterised by splitting leading to idealisation and denigration and the co-existence of extremes of good and bad within the individual, projection and projective identification in which parts of the self are experienced as located in others, and poor integration of the ego in which there is no memory of a good object when absent. In this state of mind there can be confusion between self and other and the ability to symbolise is impaired leading to concrete thinking; there is no ‘as – if’ when paranoid-schizoid functioning predominates.

Hallmarks of depressive position functioning include experiencing the self and others in an integrated way, as having both resources and limitations, being able therefore to hold ambivalent and conflicting experiences in mind. This involves an ability to tolerate mourning and guilt and ownership of one’s own aggression, needs and dependency.

A key feature emphasised by Klein and subsequent theorists [22] is that a continuous movement occurs between the two positions and throughout life; we can all fluctuate from more depressive positions of mind in which we function in more integrated ways and with secure senses of ourselves and others to more fragmented states in which we can feel more persecuted and it is harder to hold a perspective and the capacity to think. Klein also opened the idea that psychotic anxiety and processes are present from early life. She contributed significantly to the understanding of the psychological processes underlying paranoia and psychosis seeing these as having their psychological antecedents in early, primitive and normal psychological processes (see Chapter 14).

Klein’s theory of projective identification, in which the mother is used to contain some part of the baby’s emotional state, informed early ideas about the importance of **containment** in psychic development. If the mother is able to adequately contain her baby, to receive him and to feel with him, to process and to understand the projected emotions the infant experiences, he **introjects** an experience of being calmly understood. Over time the infant gradually develops his capacity to do this for himself – to become increasingly independent and **self-contained**. In contrast if the mother appears damaged, overwhelmed, non-responsive or retaliatory, his guilt and despair increase.

Criticisms of Klein include that she focussed too exclusively on the internal experiences of the baby and not enough on external reality, although she did emphasise how the actual state of the mother is key. Her ideas formed the basis of **object relations theory**, giving psychic form to the architecture of unconscious processes, in which the internal world is populated by representations and phantasies about internal and external feelings and experiences, and brought the importance of early life and the quality of early nurture to the forefront of psychoanalytic thinking [23].

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Donald Winnicott

There is no such thing as a baby [24]

This startling statement illustrates Donald Winnicott’s emphasis on the primal importance of the infant–mother relationship, without which the infant cannot continue to exist. He emphasised the importance of the mother’s state of mind, her receptivity and responses towards her baby as providing his entire environment in early life and introducing the term primary maternal preoccupation to describe the infant’s need for a non-intrusive awareness of, and exclusive focus upon his communications [25]. This has been likened to the state of mind of an analyst when listening to their patient.

Donald Winnicott (b. 1896, Devon, d. 1971, London) was a paediatrician and a psychoanalyst who saw thousands of children with their mothers in the paediatric hospital and clinics he ran at Paddington Green Children’s Hospital. He further developed Klein’s object relations theory and saw the emotional and relational aspects of the baby’s environment as key to healthy development. He introduced the term good enough mother as able to provide sufficient emotional holding or a facilitative environment for the infant to explore, organise and satisfy their basic needs – both physical, emotional and relational [26]. Under good enough conditions the baby is able to develop what Winnicott described as a true self with a secure sense of their own identity. However, if the baby’s sense of themselves becomes impinged upon by the mother’s own emotional needs then a false self may develop which colludes with perceived pressure to be a certain kind of object for another – with parts of the true self kept hidden [27]. An example may be an excessively good child with a disturbed mother, who keeps their own angry and aggressive urges concealed although these may be expressed in other ways – or through psychopathology. Winnicott emphasised the importance of play for both adults and the developing child – and the importance of potential space for transitional phenomena to occur towards the infant being able to creatively explore the environment which includes the use of transitional objects, often used to describe a toy or blanket which may be used towards the process of separation from the primary object. He wrote of the importance of an early merged state of illusion in which the infant may creatively feel he can create the breast or required other, and the importance of disillusionment in relinquishing this in order to negotiate weaning and a sense of a separate self. Winnicott also developed ideas about delinquent and antisocial behaviours, described as a sign of hope that actual deprivation in the external environment had occurred and was being protested about [28].

Wilfred Bion

The purest form of listening is to listen without memory or desire [29]

Wilfred Bion (b.1897, India, d.1979, UK) was a decorated tank commander in the First World War and trained as a physician and then a psychiatrist in the 1940s. The two world wars were massive stimulants to the development of his ideas and during the Second World War he worked as a psychiatrist at the military hospital in Northfields where he further developed his ideas. Bion observed from experience in active combat how group cohesion was maintained if men could unite against a common enemy and went on to incorporate group activities and therapy at Northfield Hospital and the Tavistock Institute of Human
Relations in London. He developed further ideas about group processes and group therapy and his ideas about ‘Basic Assumptions’ in groups have been described as the ‘metapsychology’ of groups (see Chapter 11).

After training in psychoanalysis Bion’s achievements continued to be highly original and illuminating. In the 1940s he was one of several hugely talented psychoanalysts to be analysed by Melanie Klein and he became deeply interested in the analysis of psychotic patients. In 1970 he moved to Los Angeles and his work there became powerfully influential in Latin America but became increasingly outside the mainstream of psychoanalyst thought in Europe.

Bion’s major contributions included ideas about the key importance of the maternal environment for development, detailing further some of the processes identified by Winnicott. He described maternal reverie and maternal receptivity to projective identification from the baby as being of crucial importance in allowing the baby to develop their own reflective capacity [30]. His highly original ideas about the psychological processes involved in thinking transformed psychoanalytic theory. He saw thoughts as already existing in the infant but requiring the alpha function of another to come into realisation. This is achieved through projective identification of the unprocessed sensory data or beta elements into the mother who through her own mature processing and state of maternal reverie is able to contain and return them in modified form as alpha elements – which the baby is able to experience as understood thoughts. He called this process container-contained. He applied these ideas to the ability to learn, to psychotic processes [31] and to the psychoanalytic process between patient and analyst, emphasising the importance of how to listen and to be receptive in the consulting room.

Attachment Theory

*Attachment is a unifying principle that reaches from the biological depths of our being to its furthest spiritual reaches*  
Jeremy Holmes [32]

Further gains in understanding internal emotional experience, the influences upon psychological development in childhood and of how powerfully unconscious psychological processes drive and repeat behaviours were achieved through the work of John Bowlby (1907–90, London) and James and Joyce Robertson in the 1950s. This involved the observation of children and their parents separated in hospital and residential care. Their descriptions and films of distressed children separated from their parents, at a time when parents were routinely advised to leave their children during hospital admissions, have radically changed how we now think about this and how paediatric services are organised, with parents now encouraged to stay with their unwell children [33].

Bowlby emphasised the survival needs of the infant as being entirely dependent upon their attachment to a caregiver; we need to attach securely and to be able to bind this attachment securely in the earliest hours and days of infancy. The success with which this is achieved determines not only survival but the template for all further relating as these early patterns, laid down when the mind is most vulnerable and its sensitivities most heightened, are repeated throughout life in subsequent relationships and psychological resilience. Bowlby drew upon biological and ethological models as opposed to the prevailing psychoanalytic ideas of the time. The realities and limitations of the actual caregiving relationships are brought to the fore and strongly emphasised in attachment theory. The emphasis is on
real-life experiences and the development of robust rating scales to investigate attachment patterns has allowed for systemic assessment and categorisation of attachment patterns, linked with the responsiveness and nurturing ability of the primary caregiver [34].

Key to attachment theory is that security in childhood is relationship specific, security is related to the parent’s sensitivity and response towards the child’s state of mind, and that classification of a child’s attachment patterns at the age of one has predictive power for later psychosocial development. Infant security can be assessed at one year in a standardised test situation, the Strange Situation, in which two brief separations and reunions between the child and the mother are observed [35]. On the basis of the child’s behaviour their attachment pattern can be categorised as shown in Table 1.2.

<table>
<thead>
<tr>
<th>Attachment pattern</th>
<th>Behaviour after separation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secure</td>
<td>Infant seeks proximity and welcomes mother back</td>
</tr>
<tr>
<td>Insecure avoidant</td>
<td>Infant ignores the mother’s absence and return</td>
</tr>
<tr>
<td>Insecure ambivalent</td>
<td>Distressed, clingy, then rejecting behaviour</td>
</tr>
<tr>
<td>Insecure disorganised</td>
<td>Incoherent response – source of safety is also a source of threat with fear of the mother</td>
</tr>
</tbody>
</table>

There is evidence that secure attachment can be protective when faced with adversity in later life and in social relating, and that disorganised attachment can be predictive with regard to later life stress management, and conduct problems [36]. Separation from attachment figures leads to panic, and loss to despair that may be of key significance in understanding depression in adult life [37]. Adult attachment patterns can also be rated and evaluated using the Adult Attachment Interview and it has been shown that there is a high correlation between the parental representation of attachment and the child’s behaviour at one year. Assessment patterns of the expectant mother as rated during pregnancy are able to predict with 70–80 per cent certainty what the attachment pattern of the infant will be at one year, seeming proof of the importance of the maternal environment both pre- and post-natally on psychological development [38].

In addition to changing the culture and practices in child care, institutions, family courts and hospitals, attachment theory has provided a measureable means to address the importance of mother–infant relating in early life, how this is repeated through generations and how this relates to psychological resilience and relationship patterns in later life. It has stimulated a huge amount of research including the work of Peter Fonagy and Mary Target into the ability to mentalize [39] and has demonstrated how powerfully unconscious psychological processes, linked to early experiences of nurture and the mother’s own internal world, drive and repeat behaviours.

**Conclusion**

This chapter has described some of the contributions of psychoanalytic theory towards our understanding of the human mind. There are widely diverging ideas, arguments
and controversies which continue to surround these ideas, as well as highly creative discoveries and research activities proliferating from them. Advances in research in social, cognitive and affective neuroscience confirm the importance of early nurture, unconscious processes and relationships in brain development [40]. Psychoanalysis has revolutionised our understanding of the mind and provided penetrating insights into unconscious mental processes, psychological development, psychic determinism and the limits of rationality in human activity and how we relate. Furthermore, clinical techniques designed to reveal unconscious processes have been specifically developed and modified. While the model continues to be revised and to evolve, psychoanalysis provides the most far-reaching, coherent and comprehensive framework we have in seeking to understand and to investigate the complexity of human emotional life and behaviour. No other theory has come close in aiming to illuminate and to explore the psychological processes underpinning the vast terrain of the mind, to explain man’s destructiveness and creativity, the importance of thought and relationships, and in linking biological need with psychic contents. Psychoanalysis has also formed the bedrock for a diaspora of psychological treatments based upon psychoanalytic understanding, some of which will be described as this collection of essays unfolds.

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