

A Defect in Training

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The effectiveness of specialised work in any branch of medicine cannot depend alone on the personal and professional qualities of the entrant into the field. It demands extended and systematic training, not only in the clinical speciality itself, but also in those many disciplines that bear upon it. In the course of his or her studies, the trainee psychiatrist is expected to further his acquaintance with the relevant basic medical sciences (especially neuroscience), and with organic medicine (particularly neurology), and with the application of these to his field of study. His understanding of these and many other subjects, including genetics, biochemistry, sociology, epidemiology, and statistics, is indispensable to his professional development. Extended clinical experience will teach him something of the day-to-day applications of these studies to psychiatric practice in a wide variety of circumstances. He may also acquire knowledge of such specialised areas of work as mental retardation and forensic psychiatry. Although he will be aware of his many limitations, the well-trained consultant will draw, in his general clinical practice, upon these various fields of knowledge with a justifiable measure of confidence.

But there is one basic discipline in which many psychiatrists will feel unable to profess true expertise. That discipline is psychology. Certainly, the examination syllabus will demand some knowledge of what is loosely called dynamic psychiatry, as well as of some of the more important and relevant contributions of academic psychology. The trouble is that this diverse and disparate information is rarely brought together in a wider context of psychological understanding; it does not form part of a reasonably coherent and cohesive body of knowledge. This lack of an integrated psychological grasp, whether of so-called normality or pathology, is often recognised by the psychiatrist himself, who may, in this respect, feel something of an amateur. For some, this recognition is subliminal, but others are uneasily aware of their disadvantage, and feel compelled to use what is often, at best, an uncomfortable and uncertain eclecticism. Indeed, such an awareness may grow steadily from the earliest days of their training.

Glover (1958) pointed out that in the absence of a systematic psychology, those who deal with the distress of mental illness can only achieve professional

peace of mind through the capacity to treat and effect improvement in those patients who are amenable to available therapeutic measures. But they are otherwise denied the confidence that can come from *understanding* their patients from a psychological point of view, *whether those patients are treatable or not*. It should perhaps be added that professional satisfaction may be achieved through research, but from the standpoint of clinical practice, Glover's argument must stand. Furthermore, its validity is not affected by questions of aetiology: the organic dementias, the aetiology of which is unquestionably organic, provide a case in point. The psychological dissolution that accompanies the organic process still needs to be understood from the point of view of a disciplined psychology, and, in particular, one that takes cognisance of evolutionary and ontogenic processes. Nurses and fellow professionals who bring an understanding of this kind to bear on the management of even the most difficult patient may do so with an increased tolerance, which may itself bring a therapeutic benefit.

Psychology and psychoanalysis

The question at once arises: on what kind of psychology is a more comprehensive and coherent understanding to be based? Pond (1986) discussed this central issue; noting that psychologists of both behavioural and 'dynamic' orientations were making well-recognised contributions to various psychological therapies, he emphasised that what was lacking was "a better theoretical conceptualisation". The biggest advances were being made in cognitive psychology, while the psychology of emotions and personality structure, in spite of their crucial importance, lagged behind. Pond argued that the relationship of psychopathology to clinical psychiatry/psychology should resemble that of somatic pathology to clinical medicine. Psychopathology was restricted to two well-developed approaches: one of these was the descriptive *phenomenology* commonly identified with such German psychiatrists as Karl Jaspers, and an important influence in the clarification of diagnostic formulations, while the other was *dynamic psychopathology*, mainly identified with the work of Freud and his colleagues. Within psychiatry, their

works had provided a coherent theoretical framework. Pond suggested, however, that the “whole conceptual system” had “one fundamental and fatal flaw”: it depended on the assumption of psychic energy that could be “expressed, directed, and changed with ageing and illness, and which depends in some way on the physical facts of sexuality and aggression”. But unlike physical energy, which could be defined in terms of mass and velocity, there was no way in which ‘psychic energy’ could be measured. Freud’s theories could never have “any connection with the brain as understood by neuroscience”. Yet paradoxically, psychodynamic theory remained “by far the most important and effective contribution to psychiatry of this century” and was “only now, and only to a limited extent, being supplemented by theories that owe more to contemporary general psychology”.

The negative appraisal is as important as the positive, and Pond was not alone in his failure to accept the notion of psychic energy: like other workers in the field, he appears to confound a conceptual model with a statement of objective reality. But Freud himself was very clear about the distinction. Outlining his first conceptual model of the mind in ‘The interpretation of dreams’ (1900), he said that he saw no harm in devices of this kind, providing the scaffolding was not mistaken for the building. Concepts can always be modified when they are insufficiently serviceable, or even discarded once they cease to be useful, as Freud himself pointed out. Indeed, he did not hesitate to modify and supplement his topographical model of the mind when fresh developments made such changes imperative (Freud, 1911, 1915*a*, 1915*b*, 1917). When clinical and theoretical considerations called for more radical changes, his tripartite or structural model of the mind (1923) reflected the need to adapt to these necessities: concept ought not to be confounded with objective substance.

Neuroscience and psychoanalysis

The assertion that Freudian theories do not and cannot have any connection with neuroscience seems to be largely based on this misconception. If the charge were true, it would be a weighty indictment, and for that reason alone it merits further attention. In fact, the psychoanalytical model of the mind and the contemporary understanding of brain functioning share an important common root; it is worth stepping back into history to put this issue into its proper perspective.

Freud was a neurologist and neuropathologist before he was a psychoanalyst. The importance of

his work on infantile cerebral palsy (Freud, 1891*a*) has always been acknowledged, but his book *On Aphasia* (1891*b*) was in advance of its time (Jelliffe, 1937; Stengel, 1953; Jones, 1953) and was long ignored by most neurologists. It shows the deep influence of Hughlings Jackson, the significance of whose work was not otherwise recognised for half a century (Head, 1926; Luria, 1980), but its historical position is now secure (Luria, 1980; Sacks, 1985). Freud was in total agreement with Jackson’s rejection of the predominating and would-be precise cerebral localisation hypothesis, that was so well in tune with the associationist psychology of the day. Jackson’s clinical observations led him to break new ground and to consider nervous functioning in terms of a complex ‘vertical’ organisation. According to this hierarchical model, the process of dissolution in nervous disorder led to two kinds of symptom. The pathological, or negative symptoms resulted from the loss of higher levels of organisation, whereas the positive symptoms were not in themselves pathological, but resulted from the operation of more archaic but persisting structures, which were only revealed as an evolutionary or ontogenetic process was set in reverse.

Jackson’s observations had two historical consequences. The first, and more immediate, was their influence on Freud’s psychoanalytical thinking, which can be readily discerned in his concepts of fixation and regression and of the part played by these processes in the formation of neurosis. The importance of Jackson’s views on ‘The factors of insanities’ (1894) for Freud’s thinking about psychosis has been discussed by Freeman (1969). The second consequence, and the more delayed, was their influence through Head and others on modern neurology and, ultimately, on the contemporary understanding of the working brain (Luria, 1973, 1980), with its concepts of functional systems and primary, secondary and tertiary areas of higher cortical functioning. However different their orientations and interests may be, there is no good historical reason why neuroscientists and Freudian psychoanalysts should view each other from positions of isolation.

The divorce is more apparent than real. Solms & Saling (1986), in a timely paper on the relationship between the two sciences, have pointed out that Freud’s (1895) own attempt to construct a neurological model of the mind resulted, in effect, in a psychological model in disguise. The outcome was abortive; Freud changed his approach, and if he could have had any say in the matter, his manuscript would never have been published. Nevertheless, he never abandoned his belief that one day neuroscience

would offer a firm basis for a psychoanalytical psychology, but in the meantime, felt obliged to accept Jackson's (1884, 1894) insistence, in the light of contemporary knowledge, on the distinction between psychological and neurological states and to adopt, with some regret, a purely psychological model of the mind.

We are still a long way from understanding the relationship between the nervous system and psychological functioning, but psychoanalysis and what has come to be known as neuropsychology need not be the strangers they are sometimes held to be. For both, the sequence of events that leads to the development of the individual (ontogeny), and the evolutionary development (phylogeny) that it recapitulates, goes beyond the biological and includes social and cultural factors handed down from generation to generation in the child-parent relationship, however much this may be modified in any given case. Both underline the importance of intra-personal as well as interpersonal factors in psychological development, although Freud's use of the concept is wider and more extensive. The two disciplines are complementary, and Luria's fine synthesising work on language and cognition (1981) indicates how much a comprehensive study of thinking would have to gain were it to draw on such central Freudian concepts as those of the primary and secondary process. Luria himself emphasised some common ground between psychoanalysis and his own cultural-historical approach (Cole, 1979). But Solms & Saling (1986) are surely right in stressing the "deep-rooted compatibility between Luria's neuropsychology and Freud's psychoanalysis" and that "it will be beneficial for both sciences if they were to collaborate on issues of common interest".

Mind and body

Unhappily, though, that common interest is far from universally perceived. Eisenberg (1986), in a paper tellingly entitled 'Mindlessness and brainlessness in psychiatry', draws attention to the defects of a psychology that behaves as if the brain were of no particular consequence, but points to the comparable error incurred when impressive advances in the understanding of brain functioning in psychiatric disturbance leads the less critical enthusiast to disregard or even disown the existence of mind. Eisenberg is perhaps less than fair to psychoanalysis, but his point is a basic one. The dispute – or more correctly, the dialogue of the deaf – between so-called organicists on the one hand and, on the other, the psychological solipsists who seem to regard physical matter as a mere emanation of mind and psychologue

about everything, is an unnecessary and wasteful one. Yet it survives at a time when, for example, our knowledge of the role of neurotransmitters in the aetiology of manic-depressive states is continually expanding, while psychoanalytical understanding of the psychological processes involved is, for all its deficiencies, becoming more firmly based (Freeman *et al*, in press).

In the United Kingdom this false dichotomy is reinforced from two sides. The first is the reaction of fellow professionals against the 'medical model'. Understanding people's bodies is one thing; understanding people is another; doctors have an elaborate training in the one, but have no special claim to expertise in the other – or so the argument goes. They cannot deny the justice of the claims of nurses and occupational therapists, let alone of psychologists, to an authority that is at the very least comparable and in some respects even greater. Over the years, an increasing sensitivity to these criticisms has led many doctors appropriately to welcome multidisciplinary understanding and care, but inappropriately to surrender the medical model altogether. From the standpoints of both psychology and medicine, the result has sometimes been disastrous. When no one has a psychology, *everyone* has a psychology: the multidisciplinary approach becomes uni-disciplinary, and Everyman his own psychologist. Conversely, though, surrender of the medical model has tended to put psychiatry into the hands of those who disclaim the rights of the body to have any special part to play in the genesis or perpetuation of 'mental' illness.

Some practical implications

The fact has to be faced that a reasonable acquaintance with systematic, developmental psychology is not easily attained: it cannot be picked up piecemeal. Many psychiatrists in training learn much from consultants and fellow professionals who have a special psychological concern with their cases or an interest in psychotherapy. But to try to teach by case supervision alone is to try to drive a cart without a horse. Training must also be systematic.

It is not at all clear that the appointment of psychoanalytically trained consultants in psychotherapy has done as much towards meeting these needs as it could have done. Psychiatric colleagues understandably look for an appointee who will supervise juniors in psychotherapy and assess patients for suitability for individual or group treatment. They do not usually look for someone who will teach psychoanalysis as a theory of mind (as opposed to a method of treatment) which has

important applications in the broader discipline. Yet my own experience as a consultant in the health service convinced me that this is precisely what is required – if not always what the student asks for or what he thinks he wants. More often than not, the search by clinicians is for psychological treatability, not for psychological understanding.

Yet a decision on appropriate treatment or management can only be based on reasonably accurate diagnosis, and this demands a psychological diagnosis as well as a formal nosological one. Conversion hysteria and monosymptomatic hypochondriasis, for example, might present with superficially similar symptoms, but a psychological understanding of these two conditions would explain why the one *might* be amenable to psychotherapeutic techniques, while the other would be utterly refractory. A somatic pathway habitually involved in the discharge of psychic excitation, though, would be different from both and might have no specific psychological meaning other than a secondary one. These examples could be multiplied, even when restricted to fairly discrete physical presentations. Complexities of this sort are sometimes avoided by the use of a term like ‘somatisation’, or imprecise reference to a ‘psychosomatic’ condition, but such terms are of little conceptual or practical help, and should perhaps be avoided (Yorke, 1985).

Diagnosis is a field in which psychoanalysis and general psychiatry can particularly learn a good deal from each other. Indeed, psychoanalytical diagnosis has an important place in the history of the wider discipline. Its application to the psychological assessment of children has been discussed in major contributions by Anna Freud (1962, 1970, 1979), but she was always deeply interested in the psychiatry of adults, and was a regular attender at Paul Schilder’s ward-rounds in the psychiatric clinic in Vienna headed by Wagner-Jauregg. Her approach to nosology is one that encourages the diagnostician to give due weight to possible genetic, constitutional and physical factors as well as psychological ones, taking note of past and present environmental influences, traumatic and beneficial events, successes and failures, and defences and symptoms. Analytic thinking demands that no single item be judged independently of its setting; and although available data at the diagnostic stage will sometimes be unreliable and always be incomplete, they can be organised in a structured and standardised way through the use of a diagnostic schema (Freud, A., 1962). Thomas Freeman (1973) has adapted this schema for use in the *psychological* assessment of psychosis in the adult, while its value as an investigative tool in clinical research has been

discussed and illustrated by Radford *et al* (1972). The use of a psychoanalytic developmental approach can be extended in many directions of major interest to the general psychiatrist, e.g. to the study of anxiety (Yorke & Wiseberg, 1976).

The psychiatric profession is not restricted today to formal psychiatric disorders or to the plain psychological misery that leads a sufferer to seek help. The growth of liaison psychiatry ensures that psychiatric involvement with general medicine continues to expand. The worker in the field has to know something about the impact of physical illness on the psychologically healthy as well as on the psychologically vulnerable; and he must also have regard not only for the illness itself, but for the medical and surgical treatment deemed necessary to combat it. The student of Type 1 diabetes mellitus is well aware of the unhappy psychological impact on a growing child who lives with the threat of coma or death, with dietary restrictions, and with repeated injections, at an age when normal childhood wishes and needs have to be set aside (Moran, 1984). Comparable, if different, problems arise in other forms of chronic physical illness. The psychological impact of such disorders in children should be emphasised because these, above all, compel us to take a developmental perspective, as well as underlining the value of a sound developmental psychology in general medical practice.

The same point can be made from the standpoint of acute physical disturbances and injuries in childhood. Here, the observer is impressed by the importance of the level a child has reached in his physical and psychological development at the time he encounters a physical misfortune. A fractured limb may have unhappy consequences at any age; but for a child in the second year of life, to be trussed up in orthopaedic fetters, when all his drive and inclinations are to be active and run about, and when he lacks the capacity to understand what is happening to him, faces him with a traumatising experience which may have profound psychological effects, long after his bones are mended and he is able to be active again. Here, the trauma of treatment is unavoidable, but rational management demands that it be taken into account. The considerable value of psychoanalytical knowledge has been demonstrated even in the management of almost hopeless conditions, e.g. by Earle (1979) in her work with children facing mutilating surgery in the oncology department at the Middlesex Hospital, London.

Since the demands on the general psychiatrists have never been greater or more exacting, greater experience in child psychiatry should be demanded than is currently the practice in higher professional

trainings, and perhaps consideration ought to be given to requiring some work in paediatric wards. The psychiatrist who works with adults needs to be able to look back to the child behind the grown-up; indeed, that is what a good case history can sometimes hope to convey. Since the child psychiatrist, for his part, needs to look forward to the different developmental outcomes that his child patients may have in store for them, there is a good argument for closer rapprochement between child and adult psychiatry in general, and certainly for a much better balance between them in a comprehensive training programme.

Increasingly, people have come to expect a holistic approach to medicine, and if they cannot find it within conventional services, some of them will look for it elsewhere, or even seek it outside mainstream medicine altogether. For all their importance, empathy and an awareness of patients' anxieties do not in themselves amount to psychological understanding, but in promoting such understanding, psychiatry would be likely to win greater confidence both from other professions and the general public. It would have a better chance of doing so if it took greater note of psychoanalytical psychology, as well as of what Luria (1979) has called "romantic" as distinct from "reductionist" science.

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