

After Freud

by Alexander Linklater & Robert Harland

On his 150th anniversary, Freud's legacy is being dismantled by the ideas of his greatest challenger, Aaron Beck. Cognitive therapy is now the orthodox talking cure in Britain, and the government wants more of it. But with cognitive science comes a new battle for the meaning of the human mind

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Anyone who has undergone traditional psychoanalysis will know that it is not about finding a cure for an illness, or even relieving the symptoms of one. In this occasionally marvellous, often painful, and sometimes absurd enterprise, the analyst--whether Freudian, Jungian, Kleinian, or Lacanian--does not tell you what it is that you've got, nor does he or she explain how you will get over it. Instead, you embark on a personal exploration during which you find that you don't only suffer from the symptoms you thought you did, but also a range of other conflicts underlying them. The process is classically driven by two mechanisms, and these are essentially all there is to the technique (though not, of course, the theory) pioneered by Freud.

The first is "free association," which means that you say whatever comes into your head during regular, 50-minute sessions--taking place two to five times a week over a period of months and years--revealing themes, links and patterns in your psychology of which you were previously unaware. The second is the "transference," which is what takes place between you and the analyst as you become embroiled in an intimate relationship that is unlike any other you might have outside the consulting room (though it may substitute for an inadequate or absent one). The principle that the relationship is what does the therapeutic work is fundamental to all the so-called "psychodynamic" therapies to have grown out of the Freudian tradition. If the analysis is successful, the outcome of that relationship will change something in your life for the better. Your symptoms will retreat back into deeper conflicts, which you come to accept as the price of being alive.

Psychoanalysis is hardly redemptive, and never promised to be. When early patients of Freud's complained to him that nothing could change the original circumstances which made them unhappy, he agreed--with a caveat: "Much will be gained if we succeed in transforming your hysterical misery into common unhappiness." This is one of Freud's most celebrated remarks, though it appears in *Studies in Hysteria*, which was published in 1895, before he had developed the full psychoanalytic method. But it captures the pessimism--or realism--which threads its way through all Freudian practice. It is one of the peculiar fascinations of psychoanalysis that a method seized upon by so many in the search for self-transcendence should have sprung from a man so captivated by the irredeemability of human nature.

"The crowning paradox of psychoanalysis is the near-uselessness of its insights," Janet Malcolm wrote in the *New Yorker* in 1983. "To make the unconscious conscious--the programme of psychoanalytic therapy--is to pour water into a sieve. The

moisture that remains on the surface of the mesh is the benefit of the analysis." Malcolm was not one of psychoanalysis's detractors. Far from discrediting it, her aim had been to distinguish charlatanism from genuine practice. But American psychoanalysis had by that time reached its baroque period, and was ripe for pillorying. A decade later, the Berkeley English professor Frederick Crews delivered the coup-de-grâce in the *New York Review of Books* with an essay which still stands as one of the most unflinching executions to have been performed on Freudian practice, theory and scientific pretensions.

The seriousness with which disputes over psychoanalysis were being conducted in the 1980s seems to belong to another age, especially in Britain where it has withered more than in either America or continental Europe. The 150th anniversary of Freud's birth has just passed here with low-key, often confused acknowledgment. Part of the confusion arises from the fact that Freudian terminology and concepts remain so ingrained in the wider language. But it is important not to confuse the extravagant mythopoeics of Freudian theory with the rather modest practice of psychoanalysis. Lengthy, complex and expensive, it is conducted mostly in private practices and, in Britain, is confined largely to London. Around 250 accredited psychoanalysts work in the NHS, along with counsellors, art and drama therapists, consultant psychotherapists, and other psychodynamically inclined practitioners. But as a feature of public health in this country, psychoanalysis in its pure form is almost non-existent. It is hard to argue that such an uneconomic method, which makes such conditional claims for what it can achieve, should play much of a part in the big problems facing the NHS in treating mental illness.

So we are left with a vague impression that, while the practice is impractical, the theory still contains a blueprint of how the mind works. Perhaps Freud was similar to Darwin (whom he admired), providing a model which would later be refined by scientific developments. In fact, the better analogy may be with Marx (whom he did not admire)--hugely influential in the 20th century, but with little evidence for his "scientific" theories.

The whole scheme of both Freudian theory and practice was left to its own internal disputes through most of the last century. There was the split with Jung and Adler over childhood sexuality, and after Freud's death the argument between Anna Freud and Melanie Klein over the relative significance of the mother and father, but there was limited interaction with other scientific disciplines. And while developments in genetics advanced the Darwinian cause, they did the opposite to the Freudian one. They lent new impetus to the long-established tradition in medical psychiatry of searching for the biological bases of mental illnesses.

Meanwhile, from the 1950s, pharmacological developments--principally antipsychotics, tricyclic antidepressants, and the rediscovery of lithium--had provided the biggest breakthrough in managing the symptoms of severe mental illness in history, dramatically reducing the populations in mental hospitals. Pharmacological successes were largely a process of containment rather than cure. But they clearly established the biochemical component in severe mental illness, and from the 1980s and 1990s, idealistic hopes grew for identifying the genetic origins of conditions such as schizophrenia and bipolar disorder (manic depression).

Freud did not claim that psychoanalysis was capable of treating profound or psychotic mental illnesses, and he never denied that the foundations of human psychology were material and biological. But a genetics of the human mind--which viewed madness as the downstream biological effect of a genetic disorder--threatened to flood into even the areas he did consider to be available to therapeutic intervention. More damaging still for the Freudians were the increasingly detailed and sophisticated classifications of mental illnesses, which completely re-categorised the hysterical or neurotic symptoms that Freud had observed and attempted to explain. In 1980, in a dramatic move that sent shocks of both glee and horror through American psychiatry, the word "neurosis" was struck out of the third edition of the *Diagnostic and Statistical Manual of*

Mental Disorders--never to return. The American bible of psychiatric diagnosis had effectively declared that the key mental phenomenon on which Freud based his ideas did not exist.

And if the news from biologically-inclined psychiatry looked bad for Freudian theory, the message from neuroscience was worse. The 1990s was the decade of the brain. Language, memory and voluntary action had been mapped out in their particular locations. With the discovery of functional neuroimaging, an increasing number of mental operations could be watched in real time. Motivational and emotional states were shown to have a specific underlying brain circuitry. We began to learn about what happens in the pre-frontal cortex, the hippocampus and the amygdala, and there didn't appear to be any particularly useful correlation with an id, ego or superego.

And what of the unconscious, and the mechanism of repression? Without these, there can surely be nothing foundational left in the Freudian system. What we know for certain is that most of the brain is not conscious; but this does not mean that the subconscious pathways of cognitive science amount to the same dynamic region of conflicting desires that Freud postulated. It simply tells us the obvious, that the brain conducts most of its operations without our being aware of them. The non-conscious mind may even have turned out to be less of a mystery than the conscious one. It is consciousness that cognitive scientists find hardest to locate rather than what lies beneath it. And if we want myths to explain our strange drives, we can as well go to the evolutionary psychologists for their tales of prehistoric survival strategies as to Freud for his psychosexual dramas.

Even the idea of repression, the last stronghold of Freudianism, has been dismantled over the last 30 years. After a shock or trauma, someone may be unable to process a memory, which gets blocked, or comes back in nightmare or flashback form. But this may be understood as the brain's failure to process terrible events, rather than the repression of forbidden desire under the strains of civilisation. Freud's model of repression emerged not just out of 19th-century Viennese society, but out of the age of the steam train. Science is always hypothesised through the meta-phors of the day. Freud viewed man as being under pressure from his inner furnace, blowing off steam. Now, we are more likely to imagine ourselves like the interspersing windows of a computer screen, in which operations take place simultaneously and the hard drive of our brains runs the software of our psychology.

No one has fully explained the great riddle of how flesh became thought, but it is now perfectly possible to piece together a working model of the mind from neuroscience and cognitive psychology that contains no oedipal conflict, no thanatos or eros, no pleasure principle, no ego and--decisively--no unconscious. We may be emotionally attached to some of these ideas but, scientifically speaking, we don't need them.

Does this mean that the big dream of the talking cure inspired by Freud has been swept aside by a biology of the mind? Far from it. Despite the development of increasingly refined pharmacological treatments, new drugs do not work much better than the old ones. At the front line of psychotic disorders, the beneficial effects of medication are often accompanied by devastating side-effects. Having made its big pharmacological leap, psychiatry remains largely a process of diagnosis, risk assessment, containment and care. Almost nothing has yet come of the great hope of the 1990s that--as with Huntington's and Alzheimer's disease--the genetic sources of mental illness would be revealed. For the moment, the big themes of mental illness have been distilled into "gene-environment interaction," the old question of how a person's life-circumstances trigger and shape his biological predispositions, and vice versa.

There is one model of the mind, however, complete with its own particular brand of therapy, which has been gaining a

slow ascendancy over the last 30 years. Cognitive psychology has suffered from few of the problems that Freudian theory faced as it confronted developments in biological psychiatry, genetics and neuroscience. Observational and experimental by habit, it is the relatively new science of cognition--the mental functioning that processes information--and since its inception in the late 1950s it has increasingly integrated itself with neurobiological and computer-oriented conceptions of the mind.

And the talking therapy which came out of cognitivism--cognitive behaviour therapy (CBT)--now has more research poured into it on both sides of the Atlantic than any other in history. The drops on the surface of the CBT mesh appear to be swelling. "It works," is the mantra you will hear practitioners repeat with a cool certainty that is quite distinct in tone from the old fervour of the Freudians. Not that "working" means the same as "curing." More specifically, CBT has done what no other therapy has managed to achieve to the same degree, which is to develop an empirically grounded method and a base of evidence to show that it is distinctively effective. And, unlike traditional psychoanalysis--based principally on theory, authority and patient anecdote--CBT is able to claim that it is scientifically testable.

Aaron T Beck, the father and architect of cognitive therapy, made his own personal break with the Freudian tradition unintentionally. Beck was an assistant professor of psychiatry at the University of Pennsylvania Medical School when, in 1959, he began to conduct some modest research into psychoanalysis. Having completed a fellowship at the Austen Riggs Centre in Massachusetts (which, today, is the only authentic psychoanalytic hospital in America), Beck wanted to provide proper evidence for Freudian ideas--to convince "hard-headed" psychologists. So he focused his research on an area of psychoanalysis with which everyone was familiar: dream analysis. The hypothesis he tested was the basic one that depression is caused by inverted hostility: aggression unconsciously turned against oneself. The Freudian assumption behind this was that the type of thought that takes place in dreams must be qualitatively different from that of waking consciousness--because dreams reflected unconscious motives.

But the more Beck examined patient responses, the more something obvious began to dawn on him. Most of his depressed patients were not actively seeking failure, either consciously or unconsciously. The dreams themselves seemed merely to confirm what the patients said when they were awake. Perhaps, Beck reflected, there was a simpler explanation: "that the person sees himself as a loser in the dream because he ordinarily sees himself as a loser."

With this little shift in perspective, Beck began to take a path away from the entire model of the Freudian unconscious, with all its motivational and instinctual drives, towards one in which the conscious mind was the key. As he told the British psychologist Paul Salkovskis in 1990: "If you take motivation and wish fulfilment out of the dream, this undermines the whole motivational model of psychoanalysis. I started looking at the model all the way through, and... it did not hold. Once I inserted the cognitive model, I saw no need for the rest of the superstructure of psychoanalytic thinking."

In its place, Beck developed a form of therapy that directly addressed the thoughts and beliefs that patients had about themselves, viewing disorders of mood as a by-product of dysfunctional thinking. In CBT, there are no thanatos and eros battling it out, just negative and positive cognition. Out of Freud's fatalistic view of human nature, Beck stepped forward with optimistic rationalism. He viewed depression as principally a cognitive distortion, and treated it by getting patients to reorganise their routines, reprocess their memories, restructure their thinking and challenge their negative beliefs about themselves.

In Beck's "schema," behaviour, cognition and mood are intimately associated, and each can affect the other. Even where the biological component of a mental illness is evident, CBT looks to ameliorate the dysfunctional thinking that goes with

that, and thus perhaps also alleviate the underlying biochemical disorder. As Cory Newman, director of the Centre for Cognitive Therapy in Philadelphia, says: "If medication works bottom up, CBT works top down." It is a method that proceeds by observation and experiment. Since Beck's pioneering work in the 1960s and 1970s, CBT has developed slowly but surely, building up a portfolio of disorders for which it is effective, and for which it has evidence to demonstrate its effectiveness--principally anxiety, depression, trauma, obsessive compulsive behaviour and eating disorders.

The basic tool of CBT research is the same as that applied to the testing of new drugs--the randomised controlled trial (RCT). This means that a particular therapy for a particular disorder may be tested against both other treatments (drugs, or another type of therapeutic treatment) and a placebo (no significant treatment). Hundreds of large-scale RCTs in Britain and America have, since the 1980s, increasingly shown not only that CBT has a high success rate among the less severe mental disorders but also that it can sometimes be a useful complement for the treatment of major psychotic illnesses, when applied in conjunction with medication.

So what happens when the door closes and you are alone with the cognitive therapist? For a start, there is no couch. You and the therapist sit opposite each other, and the therapist will be explicit about what he or she is trying to do. First a questionnaire will be filled in, and you will be assigned a score, indicating the severity of your condition and providing the basis against which any improvements will subsequently be measured. The therapist may provide a thumbnail sketch of how emotional and rational parts of the brain work, to give you a sense of an explanatory theory behind the therapy. In order to establish your personal history, there will be a process of what is known as "Socratic" questioning--not so much an intellectual pursuit of truth as a way of establishing how you think about yourself. A technique called "down arrowing" may be used to test your beliefs. If you have panic attacks, you may be asked to consider which thoughts trigger the attacks, and consider whether these thoughts make sense. If you can down-arrow to "core beliefs"--seen as underlying mood states--you may be able to change a feature of your thinking which automatically comes up with a self-critical belief such as, "I am a bad person." If you cease to think you are a bad person, your distress should be alleviated. Approaches differ for different disorders. If you have lived through a traumatic event, with subsequent memory loss, you will be asked to describe as much as possible in order to "re-process" the experience. A great deal depends on the skill of the therapist, of course, but it is meant to be a technique in which therapists can be systematically trained.

Sessions will most likely take place once a week, with homework exercises, such as writing a "thought diary," to perform in between. Cognitive therapy does not have to be long and laborious, and it does not have to delve into the dungeon of childhood memory. Twelve or 16 sessions are now considered sufficient to help with the average depression. A good relationship between the therapist and the patient is considered vital, but only so that the therapy can be effectively implemented. Cognitive therapists talk about a doctor-patient "alliance." There is no need to get embroiled in a murky, Freudian "transference."

Cognitive behaviour therapy is now the best-researched, most medically accepted talking cure in the western world. Efficient, easily teachable and scientifically testable--it is easy to see the appeal of it for a large, cash-strapped system like the NHS. One of the curiosities of cognitive therapy is that while it was developed in America, the place it has really taken off is Britain. In the US it competes within an open market of other therapies, including the psychodynamic ones which inherit the Freudian tradition. In Britain it has become academic orthodoxy.

The National Institute for Clinical Excellence (Nice), which independently assesses findings from research and recommends treatments, now states in its guidelines that CBT should be available as an option for almost all mental disorders.

CBT is still a "hard to get" therapy, with waiting lists of up to nine months. But cognitive therapists now constitute the biggest single group of psychotherapists in the NHS, and this is just the beginning. For some time now, Richard Layard, the economist and Labour peer, has been arguing we should train 10,000 further therapists in CBT. He points out that there are 3.5m people in Britain suffering from mental health problems, and 1m of them receiving incapacity benefits. The cost of training and employing therapists, Layard argues, would not only reduce the £10bn cost of the benefits, but offset the cost of prescribing antidepressant medication, provide better long-term outcomes for patients and make society happier.

The government is listening. Two CBT pilot schemes have been announced by Patricia Hewitt--in Doncaster and Newham, east London. The areas have been chosen partly because of the high proportion of people claiming incapacity benefits, a third of whom are thought to be suffering from depression. These schemes will set out to show that therapy can get people back to work more effectively than medication. If they are successful, there is a good chance that, over the next decade, Layard's dream of a cognitively driven NHS will come to pass, and Britain will be the world's principal incubator of Aaron Beck's method.

This is not to be sniffed at. To varying degrees for varying conditions, CBT can be shown to help people. No other form of talking therapy possesses anything like an equivalent base of evidence for this, and clearly a publicly accountable system like the NHS should take it very seriously. Other things besides CBT can help people, however. Some of those who come from the Freud-based psychodynamic traditions argue that where the research is done, they too can demonstrate effectiveness. The most important of such figures is Peter Fonagy, professor of psychoanalysis at UCL and head of the Anna Freud Centre. (See Fonagy's debate with Lewis Wolpert, *Prospect* November 1999.) Fonagy is viewed by some psychoanalysts as a kind of apostate for abandoning key classifications (he is happy to view the unconscious as just a handy metaphor) and for accepting the idea that psychotherapy should be submitted to the tools of evidence-gathering. But Fonagy's approach is more likely to preserve the life of the Freudian tradition than any other, and his capacity for conducting and assessing research is not questioned, even by the cognitivists.

Fonagy has no desire to argue against CBT. He simply maintains that the Freudian tradition provides an alternative means of understanding the effect of the therapeutic relationship and the tragically long-term difficulties of coping with most mental illness and human unhappiness. While the Nice guidelines find favourably for the long-term benefits of CBT, a recent Health Technology Assessment study into the long-term outcomes of cognitive therapy trials in Scotland found the effects of CBT in anxiety disorder being eroded over time, and none of the effects on psychotic illnesses being maintained at all. Fonagy's criticism of cognitive therapy is that it is "marketed as an antibiotic when really it's an aspirin."

In one condition--personality disorder--Fonagy provides evidence drawn from meta-analyses of various studies conducted over the last seven years that show psychodynamic therapies doing as well as CBT. But David Clark, professor of psychology at the Institute of Psychiatry, points to findings from different comparative studies in the Archives of General Psychiatry that show CBT doing better. How much can definitively be concluded from such studies is far from clear. Freudian therapies are always going to face a handicap in the research race, because what can't be fed into a data set is the "active ingredient" in psychodynamic therapy--the patient-therapist relationship.

But even for cognitive therapists, who consider the relationship to be a delivery method rather than an active ingredient, research trials can be more ambivalent than they like to admit. Some critics of the CBT trials have described the process as

"garbage in, garbage out--with precision in the middle." In other words, the data generated by the answers to the questionnaire the patient is given before and after therapy may be processed scientifically, but how closely does this data reflect real psychological states? It's the same problem faced by pollsters and social scientists, but the CBT research comes out looking more like medical fact than perhaps it should.

What's more clearly telling is that, particularly in personality and bipolar disorder, leading CBT practitioners are quite happy to admit borrowing a few ideas from the old Freudian cellar. In America both Judith Beck (Aaron's daughter, and director of the Beck Institute) and Cory Newman at the Centre for Cognitive Therapy describe how they use some techniques taken from psychodynamic therapy when exploring childhood problems. And even in Britain, a pivotal figure like David Clark at the Institute of Psychiatry, does not rule out the value of other approaches. "Do I think CBT is uniquely the best therapy across all these disorders?" he asks rhetorically. "We don't have the evidence to claim that."

Clark cites Aaron Beck's own, half-joking description of CBT as being "whatever works." This suggests the pragmatic, incremental, non-dogmatic, altruistic and scientific side of the new talking cure at its best. It may have plans to roll itself out across Britain and the world, but only if and when "it works." In the meantime, Fonagy and followers will be able to argue that parts of Freudianism work too.

The problem with cognitive therapy is not one of method but one of meaning. No one pretends that cognitive therapy has created a wider culture, in the way that psychoanalysis did. CBT is designed to modify the mechanics of the mind--to give people symptom-improvement exercises--not to produce a language of human experience. That constitutes both its achievement and its limitation.

As they spread out of the realm of research and development into the wider world, some cognitivists--including the 85-year-old Aaron Beck himself--are keen to give a sense of something deeper at work in the idea. And the place they go for affirmation is, interestingly enough, Buddhism. An idea of "mindfulness" is seen to connect CBT with Buddhist doctrines of acceptance. The cognitive model does not need to postulate an identity-holding ego amid a network of neural processing, and this sits well enough with the Buddhist principle that the self is constituted out of a series of illusions, which may be extinguished on the road to enlightenment.

But this fanciful pairing has got nothing to do with the scientific method that cognitivism relies on. It ignores a glaring contradiction that the practice of Buddhism does not encourage talking about your problems. Many ordinary Buddhists hold by a belief that misfortune is accounted for by actions taken in a previous lifetime, and high Buddhist teaching is scarcely similar in tone to the active, positive psychology of the cognitivists. We recently asked the supreme patriarch of Cambodia's Dhammayutta order, His Holiness Bour Kry, what he thought of using western trauma therapies in one of the most psychologically afflicted countries in the world. His response was as follows: "The Buddhist way is not to worry about the past. You have to relax and calm down, don't think about it. In Buddhism, nothing just happens. It's part of karma. In the west you express things more. In Cambodian culture, people keep things inside, they don't talk. It's a different way of doing things. It's not to do with the knowledge of scientists, it's cultural."

The culture that has produced the world's top talking cure is western, rational and scientific. And, so long as it is understood where the philosophical parameters lie, it can rightly make claims for being effective. However, what it is structurally incapable of doing is explaining, or describing, the phenomena of experience--whether sane or mad. The set of psychiatric diagnoses that attempt to classify mental illnesses are seen, through the lens of CBT, as a variety of cognitive malfunctions. Its ambition is to improve mental functioning. Anything outside that field is cognitively meaningless.

For example, the famous depressions of Abraham Lincoln and Winston Churchill would have to be seen as cognitive problems they had to overcome, rather than agonising yet meaningful states of mind that told them something about the world and shaped their actions as unifier and warrior. Looking at the dreams of Beck's depressed patients, the cognitive therapist must see only positive or negative--functional or dysfunctional--beliefs. This is an advantage if a patient is coming to the therapist simply trying to change the symptoms of his or her illness. It is a difficulty, on the other hand, if the patient needs to understand his or her experience as part of who they are. If a manic depressive is being tormented by religious delusions and comes up with a quotation such as "condemn not, lest ye be condemned," who is more likely to help: the therapist who sees just a dysfunctional belief, or the one who is able to grasp why the patient is using that phrase?

Freud's favourite novel was *The Brothers Karamazov*. Dostoevsky's vision of the inherently perverse, self-destructive drives of human nature made sense to Freud, and he sought to find a language that was commensurate to those urges. He got much of it scientifically wrong, and he famously misinterpreted some of his own patients. But the ambition was to articulate the conflicts to which the human mind is subject, and from which it may never escape. Little may remain of his classifications, or his model of the unconscious, but there are those both inside and outside the psychiatric profession who understand that suffering may contain meaning, and that the relationship between people is the engine of human change; and Freud remains one of their pioneering influences.

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