BRITISH JOURNAL OF PSYCHIATRY (1998), 173, 279–280

https://doi.org/10.1192/S000712500015130X Published online by Cambridge University Press

Psychodynamics, narrative and 'intentional causality'

JEREMY HOLMES

Young doctors are attracted into psychiatry for two main reasons. They see the brain and its disorders as one of science's last frontiers and want to be part of the current revolution in neuroscience. At the same time, many are also drawn to the humanistic aspect of the subject, realising that the opportunity to listen to patients and their stories is, with the possible exception of general practice, unique to psychological medicine. The clinical aspects of these two facets of our discipline are tested in examinations by expecting expertise in phenomenology and diagnostic accuracy, and the capacity to arrive at a 'psychodynamic formulation'. But what is meant by 'psychodynamic' and what is its scientific and philosophical basis? The purpose of this editorial is to point to some recent developments in cognitive science, attachment research, and philosophy which suggest possible answers to these questions.

PSYCHODYNAMICS AND NARRATIVE

The starting point of most clinical encounters is the patient's narrative – the life story sufferers describe which encapsulates their difficulties, their view of themselves and their history. This story is usually both descriptive and explanatory, containing "when . . . then" and "this . . . because" statements. In scientific medicine the latter are usually ignored: it is the patient's job to describe a sequence of events, the doctor's to offer an explanatory framework which ties them together. A classic illustration is the discovery of trisomy in Down's syndrome. Until 1959 both doctors and parents of babies with Down's syndrome believed that the condition resulted from trauma in pregnancy, since many parents reported such events, whereas parents of normal babies did not. Once trisomy was established such narratives were seen to be irrelevant, except insofar as parents needed to be reassured that their child's condition was not their fault.

But in everyday life narrative explanations are widespread. 'John felt sad because his dog had died', 'Sally was angry because John had forgotten their wedding anniversary', or, to give a clinical example, 'Jane could not catheterise herself to relieve her urinary retention, because it brought back memories of sexual abuse from childhood'. Narrative explanations are part of a network of representations of the self and the world which provide a causal map which guides action and enables social relationships to run smoothly. We need to know who we are and where we come from if we are to relate effectively to others. The EARS – expectations, assumptions, rules and schemata – of cognitive psychotherapy are examples of such representations which influence behaviour, and, if dysfunctional, can lead to psychological difficulties.

The essential quality of a narrative account, as opposed to a conventional scientific explanation, is that narrative depends on human agency. This provides the link between narrative and psychodynamics. Psychodynamic explanations are stories about agency which extend beyond the conscious awareness of the protagonist. A patient may have become depressed rather than merely grief-stricken following his or her mother's death because he or she unconsciously holds themself responsible for her demise, based perhaps on unexpressed resentment towards her having remarried when they were young or because she favoured another sibling. For Freud, symptoms were narrative fragments, which without the notion of the unconscious were inexplicable, but once placed in the context of unconscious wishes and desires, fell into place. These stories are causes, even if in Down's syndrome they are not (Roberts & Holmes, 1998).

A similar analysis can be applied to systems theory (Bateson, 1973) which sees families as governed by rules of which the individual members may be unaware, for example the need to maintain proximity at times of stress, which is a fundamental property of the attachment behavioural system (Holmes, 1993). This can be used to explain, for example, 'over-involvement' between parents and people with schizophrenia in 'high expressed emotion' families (Leff & Vaughn, 1985) – the more disturbed the patient, the more activated is the attachment system. The parent and the patient are motivated by forces of which they are unaware, whose dynamic is crucial to the maintenance of the illness.

Thus, psychodynamics, in the sense of narrative accounts of behaviour based on human agency, whether conscious or unconscious, is a property of the three main branches of psychotherapy: cognitive, psychoanalytic and systemic.

NARRATIVE AND ATTACHMENT THEORY

If narratives encode meaning, and if science's starting point is the capacity for measurement, can such meanings be measured? Recent attachment research suggests that they can. Main's Adult Attachment Interview (AAI; Main, 1995) takes recordings of psychodynamic assessments and subjects them to linguistic analysis. Four clear patterns of narrative style emerge: secure–autonomous, insecure–dismissive, insecure–preoccupied and insecure–unresolved. Each reflects a particular pattern of talking about oneself and one's experience, ranging from the coherence and comprehensiveness of the secure–autonomous style, through the affective restriction of avoidance and structurelessness of preoccupation, to the logical breaks and inconsistency of disorganised narratives.

The relevance of this to the present discussion is two-fold. First, Main's work suggests that the way people talk about themselves is a manifestation of an inner representation of self–other relationships. Second, these representations derive from early parent–child interaction, and are highly predictive of future interactions between themselves as care-givers and their own children (Fonagy *et al*, 1995). Narrative patterns are thus both an effect of parental handling in childhood, and a cause of future patterns of relationship with intimates.

https://doi.org/10.1192/S000712500015130X Published online by Cambridge University Press

'INTENTIONAL' AND 'NON-INTENTIONAL' CAUSATION

These findings suggest as Bolton & Hill (1996) put it 'meanings can be causes'. They distinguish between two types of causality: 'non-intentional causality', of which trisomy in Down's syndrome would be a good example, and 'intentional causality', which they see as unique to biological systems, whether operating at a physiological or a psychological level, and having the properties, among others, of 'set goals', purpose, being driven by information rather than energetics and being active rather than passive. By linking what appear at first sight to be purely psychological phenomena with other biological processes such as homeostatic mechanisms and visual pathways in mammals they open up an important discussion of the relative balance between intentional and non-intentional causes within psychiatry. In Down's syndrome what was mistakenly thought to be a result of intentional causality was shown to result from non-intentional mechanisms. The reverse error is equally possible. There are many aspects of psychiatric work in which intentional causality, and therefore psychodynamic factors, play a significant part, and ignoring them would mean missing an essential aspect of the field. Life events research in depression shows that it is the meaning ('contextual threat') of the event to the individual that determines whether or not it is depressogenic.

PSYCHODYNAMICS AND PSYCHIATRY

Three brief examples of the practical applications of these ideas will be given: the role of defence mechanisms, transference and countertransference and ways of overcoming patient passivity.

Psychological defence mechanisms enable an individual to maintain mental coherence and contact with a potentially aversive other, while at the same time minimising painful affect. The notion of 'manic defence' in bipolar disorder, a concept which originates in Kleinian psychoanalysis (Bateman & Holmes, 1995), provides some understanding of the common clinical observation that mania and depression frequently coexist: when patients with mania momentarily escape from their manic flight, tears and misery often surface. The story of manic depression is often that of a desperate attempt to escape from underlying sadness.

Delusion formation in psychosis can similarly be understood as an attempt to avoid the psychic disintegration that is characteristic of psychosis (Roberts, 1992). As Freud (1924) put it: "a delusion is found applied like a patch over the place where originally a rent had appeared in the ego's relation to the external world". Current cognitive strategies in psychosis encourage the sufferer to see his or her psychosis in a dynamic fashion – to argue with or ignore voices, to question delusions and to see them as meaningful attempts to deal with unhappiness or to view grandiosity as a compensation for rejection and isolation (Kingdon & Turkington, 1994).

These psychodynamic approaches are not incompatible with 'non-intentional causality'. The origin of the disorder may lie in genes or chromosomes, and so be 'organic' or 'biological', but that in turn will have its impact on systems of intentional causality, that is psychodynamics, via higher functions such as self-reflection and defensiveness.

Psychodynamic understanding also informs the patient–therapist relationship. A key feature of intentional causality, and a basic premiss of psychodynamics, is the view that all parties are active participants in a relationship, whether at a conscious or unconscious (i.e. transferential/countertransferential) level. Patient passivity is a persistent feature of a psychiatry that does not take psychodynamics into account. A purely biological approach might lead the doctor to say to the patient: "you have got major depression – take these pills and all will be well". Psychodynamic perspectives might lead to cognitive strategies along the lines of "your depression makes you feel guilty and responsible for your illness" (mistaking non-intentional for intentional causality), "but in reality you have no more reason to hold yourself responsible for your misery than you would be if you had a broken leg" (appealing to 'intentional' psychodynamic factors underlying the patient's view of her illness); this might need to be reinforced by a psychoanalytically informed comment suggesting links between the patient's mistrust of his or her doctor and therefore dismissal of such comments, and a history of having been sexually abused by their father as a child.

A purely 'biological' approach sees the patient as a passive victim, and may even reinforce that role; psychodynamics suggests ways in which patients may be active participants in their illness, and therefore also, potentially, in their recovery.

REFERENCES

Bateman, A. & Holmes, J. (1995) *Introduction to Psychoanalysis: Contemporary Theory and Practice.* London: Routledge.

Bateson, G. (1973) *Steps Towards an Ecology of Mind.* London: Paladin.

Bolton, D. & Hill, J. (1996) *Mind, Meaning and Mental Disorder.* Oxford: Oxford University Press.

Fonagy, P., Steele, M. & Steele, H. (1995) Attachment, the reflective self, and borderline states. In *Attachment Theory: Social, Developmental and Clinical Perspectives.* (eds S. Goldberg, R. Muir & J. Kerr), pp. 233–279. New York: Analytic Press.

Freud, S. (1924) Neurosis and psychosis. Reprinted (1953–1974) in *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (trans. and ed. J. Strachey), vol. 19, pp. 203–227. London: Hogarth Press.

Holmes, J. (1993) *John Bowlby and Attachment Theory.* London: Routledge.

Kingdon, D. & Turkington, D. (1994) *Cognitive Behaviour Therapy of Schizophrenia.* Hove: Laurence Erlbaum.

Leff, J. & Vaughn, C. (1985) *Expressed Emotion in Families.* New York: Guilford.

Main, M. (1995) Recent studies in attachment: overview, with selected implications for clinical work. In *Attachment Theory: Social, Developmental and Clinical Perspectives.* (eds S. Goldberg, R. Muir & J. Kerr), pp. 407–474. New York: Analytic Press.

Roberts, G. (1992) The origins of delusion. *British Journal of Psychiatry,* **161**, 298–308.

— & Holmes, J. (1998) *Healing Stories: Narrative in Psychotherapy and Psychiatry.* Oxford: Oxford University Press.

JEREMY HOLMES, FRCPsych, North Devon District Hospital, Raleigh Park, Barnstaple, Devon, EX31 4JB. Fax: 01271-311523; e-mail: aaJ64@dial.pipex.com

(First received 14 January 1998, final revision 8 May 1998, accepted 18 June 1998)