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AN HISTORICAL OVERVIEW OF PSYCHOTHERAPY

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Early views of mental illness

Since the earliest recording of human culture there has been evidence of human mental and emotional distress and also ways to explain and alleviate it. Responses have ranged from demonisation and execution to some form of 'treatment'. Hippocrates in the third century BC considered that mental distress must have a physical cause. However the predominant view in most cultures has been to define mental disturbance in terms of spiritual distress and the task of healing it has been seen as belonging to the realm of priests and of shamans who used trance states to effect emotional healing, for example through 'soul retrieval' (Ingerman, 1991).

The predominant Christian view of mental distress has been to regard it as caused by evil spirits, or as possession by demons. From the thirteenth century, the inquisition of the Catholic church defined people with deviant behaviour as possessed or as witches, and persecuted them. In 1487 *Malleus Maleficarum* (*The Witch Hammer*) was published. It attributed abnormal behaviour to satanic influences and specified the diagnosis, behaviour, trial and punishment of witches and provided a basis for the torture of people with deviant behaviour. Loss of reason was seen as a key diagnostic feature, and many hundreds of thousands of mentally disturbed individuals (suffering from what we would now think of as psychosis, and even depression) were tortured and put to death. Most of those who suffered were female and the authors of *Malleus Maleficarum* considered that 'All witchcraft comes from carnal lust, which in women is insatiable' (Tallis, 1998: 5).

It is also likely that some early Christian visionaries and saints suffered from mental illness. For example Joan of Arc may well have suffered auditory hallucinations. Interestingly she was both burned as a witch and, later, sanctified by the church – perhaps an indicator of the ambivalent and confused view of mental disturbance. The

last execution of a witch took place in Switzerland as late as 1782 and it was around this time that more humane views of mental illness were emerging.

The beginnings of care and treatment

In Europe, alongside the religious view, there has also been the approach of containing the mentally ill. In 1247 the priory of St Mary of Bethlehem was founded in London. It later became known as Bethlehem Hospital (or 'Bedlam') and from as early as 1377 it was used to house 'distracted persons'. Treatment there was nevertheless based on the idea of possession by demons, resulting in the punitive and neglectful treatment of inmates.

At the time of the renaissance there is evidence of debate as to whether mental disturbance was a spiritual or a physical and medical problem. A well-known example of this may be found in Shakespeare's *Macbeth* (published in 1599). The doctor observes Lady Macbeth's troubled sleep-walking and responds:

> 'This disease is beyond my practice …
> … Unnatural deeds
> Do breed unnatural troubles; infected minds
> To their deaf pillows will discharge their secrets.
> More needs she the divine than the physician' (*Macbeth*, V. i.)

thus placing mental disturbance firmly in the hands of spiritual care. He also suggests that problematic or traumatic events can lead to mental distress. When the doctor reports to Macbeth he receives the challenge:

> Cure her of that.
> Canst thou not minister to a mind diseas'd,
> Pluck from the memory a rooted sorrow,
> Raze out the written troubles of the brain,
> And with some sweet oblivious antidote
> Cleanse the stuff'd bosom of that perilous stuff
> Which weighs upon the heart? (*Macbeth*, V. iii.)

However the doctor washes his hands of the problem:

> Therein the patient
> Must minister to himself' (*Macbeth*, V. iii)

Although Macbeth is clearly articulating the idea that mental distress has a cause and potentially a cure, this was, at the time Shakespeare wrote, a novel idea and the doctor here evidently does not regard healing the mind as within the province of medicine and science.

The implication is that talking (confession) with a priest is what is needed, and that there is no magic pill to cure such distress. This debate is still current, and while we now have effective psychotropic medications, the role of human relationship and contact through talking is acknowledged by both medicine and religion as being highly important in resolving distress and maintaining well-being.

In 1586, just 13 years before *Macbeth* was written, the first medical book about mental illness, the *Treatise on Melancholy* by a physician called Timothie Bright, was published. It contained descriptions of what we would now call depression or mood disorder, and may well have been a source for Shakespeare, particularly for Hamlet. In 1632 came the publication of Burton's *Anatomy of Melancholy*, and this included both descriptions and treatments (diet, exercise), based on earlier medical views. Burton wrote in order to relieve his own melancholy and considered it possible to alleviate this distress.

Despite these acknowledgements of the role of treatment, the predominant approach to mental distress continued to be incarceration and physical restraint. Patients might be chained or manacled, and treatments included blood-letting, whipping and immersion in cold water. Furthermore, in the seventeenth century the behaviour of mentally deranged people was considered amusing and Bethlehem Hospital was open to the public who could take a tour and view the inmates as a form of entertainment. John Evelyn described a visit in his diary in 1657: 'several poor miserable creatures in chains; one of them was mad with making verses.' Hogarth's 1735 picture of Bedlam shows the kind of scene these tourists might have see in. Mental illness was still viewed as a kind of degeneracy, and the picture was intended as a moral lesson warning against debauched behaviour.

Later in the eighteenth century the idea that people suffering mental distress needed humane care began to emerge. Public visiting to Bedlam was curtailed in 1770, although it continued in some form into the nineteenth century. The first ever law to ensure the humane care of people with mental illness was passed in Tuscany in 1774, and in 1792, the first humane care for people with mental illness in the UK was provided by William Tuke, a quaker, who founded the York Retreat. Here patients were less restrained and confined, a healthy diet was provided and treatment included giving patients activities such as farm work (the beginnings of occupational therapy). Similarly, in 1794 Pinel introduced humane care at the asylum of La Bicêtre in Paris. He took the view that:

> The mentally sick, far from being guilty people deserving of punishment
> are sick people whose miserable state deserves all the consideration
> that is due to suffering humanity. One should try with the most simple
> methods to restore their reason. (cited in Tallis, 1998: 8)

Pinel in his *Medico-Philosophical Treatise on Mental Alienation or
Mania* (1801) developed what he called 'traitement moral', which
involved talking gently with the patient, offering warmth, and
restoring hope – elements that research now demonstrates are central
to effective psychotherapy.

The emergence of psychological diagnosis and treatment

In 1766 Franz Anton Mesmer published his ideas about what
he called 'animal magnetism', seeking to account for mental distur-
bance as a result of physical forces. His 'animal magnetism' may
best be understood as a kind of 'life force' and he conceived illness
as an interruption of the natural flow of this 'subtle fluid'. His treat-
ment system, known as mesmerism, was a precursor of hypnosis,
which, in turn influenced the development of psychological treat-
ment and particularly psychoanalysis (Ellenberger, 1970).

During the nineteenth century the medicalisation of mental ill-
ness progressed as modern scientific medicine evolved. The idea
that mental problems may have physical causes was supported by
the development of microbiology (for example the connection
between syphilis and the mental condition of 'general paresis'),
establishing a trend of seeking physical and biological causes for
emotional problems. This approach was reversed through the work
of Charcot (1882) who, at the Salpêtriere hospital in Paris, began to
look at psychological causes for physical symptoms. He believed he
had identified a condition he called 'hystero-epilepsy', based on a
group of patients who appeared to have both epileptic symptoms
and 'hysteria'. It emerged that the epileptic convulsions were the
result of suggestion and induction (hypnotism) due to the fact that
these apparently 'hysteric' patients, were placed on the same wards
as the epileptics. Once these patients were separated from the
epileptics, and their initial concerns (for example distress, anxiety,
family conflicts) were individually explored, their epileptic symp-
toms disappeared. Charcot developed treatment based on counter-
suggestion to address what we would now call conversion disorders.
The focus on the symptoms was redirected to looking at real-life
concerns with a focus on solving these problems.

Sigmund Freud and psychoanalysis

Charcot's lectures and demonstrations of his new hypnotic treatment were attended by the young Sigmund Freud, around 1885. Freud, who had specialised in neurology, had begun to be interested in hypnotism and psychological treatment. Contact with Charcot further developed Freud's interest in psychology and the nature of neurosis which in turn led to his development of psychoanalytic theory and practice.

Sigmund Freud (1856–1939) emerged in the context of the nineteenth century post-enlightenment preoccupation with the development of rationality and science. Religion, spirituality and romanticism were equally powerful aspects of his culture, however they were being scrutinised and questioned with a scientific eye. The publication of Darwin's *The Origin of Species* in 1859 represented an unprecedented upheaval in Western culture as beliefs about God and the nature of human beings were radically called into question. In focusing on human psychology, Freud was grappling with understanding scientifically the nature and workings of the human soul. Science was moving into the domain of human emotional and mental suffering, which had hitherto been configured in spiritual terms, as soul-sickness; and into the domain of healing, which had been the preserve of pastoral care.

Psychotherapy emerged as the child of religion and science, and Freud, as a doctor and as a Jew, held within himself the tensions of the relationship between these 'parents'. Although Freud was not a practising Jew, and indeed viewed religious belief as a form of neurosis (Linke, 1999) the religious/spiritual core of Judaism is inevitably a part of his heritage and its influence may be discerned in the evolution of psychotherapy. Given his medical training, Freud was concerned to establish the scientific credibility of psychological treatment, and specifically psychoanalytic theory. He faced the perennial problem of translating clinical experience with unique, individual patients into empirically valid theory and practice. The tension between the art of healing relationship and scientific accountability is as evident in Freud's work as it is in current debates about the evidence base for psychotherapy.

So Freud sought to locate his theories in a medical model of sickness and treatment. Initially he collaborated with Breuer, using hypnotic techniques to work with patients who suffered with hysterical conversion symptoms. Freud's early theory (1895) was based on the case of 'Anna O', a patient of Breuer, and a number of women with

similar difficulties (Freud and Breuer, 1895/1974). Anna O suffered from a range of physical symptoms for which no physical cause could be found, and also had mood swings and a form of hallucination. She named the treatment 'the talking cure' because it involved her entering a hypnotic state, in which she would speak about her symptoms and make links between specific symptoms and feelings, previous occurrences, and, ultimately specific forgotten emotionally traumatic events from her past. Once these links were identified, the symptoms disappeared (Freud and Breuer, 1895/1974). The hypothesis was that traumatic events had been repressed into the unconscious mind, and the hysterical symptoms were signalling their presence. By retrieving and 'talking them away' the symptoms could be resolved. Later, instead of hypnosis, Freud developed the technique of 'free association', in which the patient lies on a couch and verbalises whatever thoughts come into their mind, without censoring or seeking logical connections. From these beginnings he developed key concepts including the role of the unconscious mind, the idea of defenses, particularly repression and resistance, and the role of analysis or interpretation.

Freud's efforts to work within a scientific paradigm led him to seek 'objectivity' and this may lie behind his approach of making the therapist the neutral 'scientific instrument', the blank screen, which receives the productions of the patient: 'the physician should be opaque to the patient and, like a mirror, show nothing but what is shown to him' (in Tallis, 1998: 41).

The concept of the unconscious mind was also explored by other students of Charcot, notably Janet, whose *L'Automatisme psychologique* published in 1889 pre-dates Freud. However Freud developed this idea, formulating a cohesive (albeit complex and evolving) theory of the unconscious mind, and this is perhaps his greatest contribution, both to psychotherapeutic theory and to human culture and self-understanding. Freud formulated a theory of mental difficulty that accounted for overt mental (and sometimes physical) symptoms as being related to aspects of experience that have, because of their traumatic nature, been split off from conscious awareness and repressed so that they are held in the unconscious mind.

The idea that hysterical symptoms and neuroses had their roots in sexuality had existed since ancient times, when it was believed that they were caused by the movement of the uterus around the body. Although this view was discredited, many doctors, including Charcot and Breuer, held the view that sexuality was nevertheless in some way relevant for their patients. In the nineteenth century,

female sexuality, if its existence was acknowledged at all, was seen as unacceptable and problematic. Thus it was revolutionary for Freud to move away from the trauma theory described above and develop his theory of the role of libido (sex drive) in human psychological functioning. It was in keeping with the cultural norms of the time for Freud to hypothesise that psychopathology must arise from the repression of sexual needs and feelings.

Freud noted that many of his patients reported sexual experiences from childhood, and he initially took these to be factual memories. However he eventually abandoned this view and developed his theories of infantile sexuality and psychosexual development (1905). This theory was only slightly less shocking in his day than the idea that adults were sexually abusing children in their care. More recently Freud has been criticised for defining his patients' reports as fantasy and denying the possibility that real abuse might have taken place (e.g. Miller, 1981/1985).

Freud developed the notion of the pleasure principle – the drive for pleasurable sensation, and he focused specifically on sexual or sensual pleasure. He considered that in normal development, the infant's pleasure focus was initially oral, that it then develops and shifts to an anal focus as the child gains control of bodily functions, and then to a phallic/genital focus at around 3–6 years of age. In relation to this he also identified what he called the Oedipal phase, in which the child's sexual focus is on the opposite gender parent, and reaches a crisis as the child, fearful of reprisal from the same gender parent, gives up and represses the sexual focus on the opposite gender parent. This repression is seen as part of normal development and enables the child to move into the next developmental phase, latency and then to normal sexual maturity. Freud's theory was coloured by the gender perceptions of his day, and was much more clearly articulated in relation to male children than females.

His theory of psychopathology focused on the idea that for some reason the child gets stuck or fixated in her or his negotiation of the early developmental stages, so that the progress towards sexual maturity is interrupted and arrested. In adult life these unresolved fixations may emerge such that unacceptable infantile wishes and urges intrude into the adult consciousness. This generates anxiety and then a need to defend against both the anxiety and the infantile material, processes that may become evident as neurotic symptoms.

Much of Freud's work focused on treatment approaches, including the development of the analytic technique, and the exploration of dreams and of slips of the tongue, as ways to access the unconscious mind and address neurotic problems. He also

developed the concepts of projection and transference fairly early on in his work, as he accounted for his patients' shows of affection and attraction toward him by seeing them as aspects of their past relationships emerging in the present. Later he focused on the trans-ference process as a way to access unconscious material for analysis.

Freud and the therapeutic relationship

Much has been written about Freud's approach to the therapeutic relationship. The stereotypical image of Freudian analysis is of the patient lying on a couch, with the analyst out of sight behind them and saying little or nothing while the patient does the talking. The picture is of the analyst as a neutral 'blank screen' on to which the patient will project his or her experience of the 'other'. While it is true that Freudian psychoanalysts practise the 'rule of abstinence', meaning that they seek neutrality in their contact with the client, Freud, in his 1913 paper 'On beginning the treatment', highlights the importance of the therapist's 'sympathetic understanding' (1913: 140), and the importance of offering interpretations that are timely and well attuned to the client's level of insight and self-understanding. He also speaks of the crucial importance of estab-lishing the patient's 'rapport' with the analyst and also of the patient's attachment to the treatment and to 'the person of the doctor' (Freud, 1913: 139). These statements are significant in that they indicate Freud's awareness that in practice, the *relationship* is an essential aspect of successful treatment, even though he does not fully articulate this theoretically.

The dissemination of psychoanalytic ideas

Between 1910 and 1915 Freud surrounded himself with a group of students, including Jung, Adler, Rank, Reich and Ferenczi. Freud very much saw himself as pioneering a shift in human understand-ing and consciousness, that was as radical and far-reaching as the work of Galileo or Darwin. In this his style resembles the 'rabbinic mode' – perhaps an unconscious element from his Jewish cultural heritage. Freud shared his ideas dialogically with a small group of followers, much as a Rabbi would, retaining a strong sense of his own authority and rightness. In Judaic tradition, this authority is handed down to followers who are committed to upholding the tra-ditions, who become rabbis in their turn. This mode was a great strength in enabling the preservation of Jewish religion and culture. When translated into the establishment of psychoanalysis, it meant that it was difficult for members of Freud's circle to develop and

add to Freud's theory, or revoke earlier ideas, without breaking away and forming a separate grouping. On the other hand, this approach ensured that psychoanalytic theory was established securely and clearly and has survived, both as theory and as practice up to the present day.

It could be argued that this model has profoundly influenced the evolution of psychotherapy. There is a tendency for schools of psychotherapeutic theory to be strongly identified with a single individual, although in fact the theory may often have been developed collaboratively. Furthermore, there has been a tendency until relatively recently for each theoretical school to be intent on ensuring its own survival through rigid and competitive differentiation from other approaches. This has militated against the identification of convergent therapeutic factors, and has also impeded the evolution of and recognition of pluralistic and integrative practice.

The first schism – departure of two key figures: Jung and Adler.

Inevitably the members of Freud's circle began to develop their own theoretical ideas and to differentiate themselves from Freud. The first members of Freud's circle to break away were Jung and Adler.

Carl Gustav Jung (1875–1961) was Swiss, the son of a Protestant clergyman, and deeply interested in both the history of religion and the sciences. He trained in medicine and worked with severely psychotic patients. He was particularly concerned to articulate the links between the psychological and the spiritual, and to locate individual human experience within the universal. He sought to develop a holistic approach, which embraced both 'science' and 'soul'. This brought him into conflict with Freud, who wanted to secure a sound scientific reputation for psychoanalysis, and so Jung broke away from Freud in 1913 to develop the school of psychotherapy that became known as 'Analytical Psychology'.

Jung became interested in personality type and structure. He proposed that individuals have an outer 'persona', which hides the underlying aspects of personality, the 'shadow'. He believed that each person has masculine and feminine qualities – 'animus' and 'anima', and that for the individual to be healthy, these need to be in balance. He identified extrovert and introvert personality types and also considered that it was important for the individual to balance thinking, feeling, intuition and sensuousness.

Perhaps his best-known contribution to psychological theory is his theory of archetypes. Where Freud recognised the patient's symbolism as individual and personal to him or herself, for Jung,

symbols were overarching universal metaphors for human experience. These archetypal symbols, found in mythologies across many cultures, enabled Jung to develop his theory of the 'collective unconscious'. He proposed that alongside personal consciousness there exists a:

> psychic system of a collective, universal, and impersonal nature which is identical in all individuals. This collective unconscious does not develop individually but is inherited. It consists of pre-existent forms, the archetypes … (Jung 1936/1959: 43)

Jung's theory, then, included a wider context – however this was internal, psychological and spiritual, rather than social.

Alfred Adler (1870–1937), on the other hand, developed his theory to emphasise the role of family and social relationships in the development of psychological problems. Adler was born in Vienna and became a doctor. He developed the idea that human beings must be considered as unique individuals in the context of their environment. In this he diverged from Freud's theories based on drives and instincts. Despite these differences he became part of Freud's circle in 1902, although his divergence from Freud led to Adler's departure in 1911, to develop his own psychological theories.

Adler developed an 'integrated, holistic theory of human nature and psychopathology, a set of principles and techniques of psychotherapy, a world view, and a philosophy of living' that represented 'a vigorously optimistic, humanistic view of life' (Stein and Edwards, 1998: 67).

He believed in an innate growth-oriented life-force, and emphasised both the uniqueness of the individual, and the indivisibility of the individual from his or her context of cultural inheritance and community. Thus he considered that a sense of community (Gemeinshaftsgefeuhl) was essential to mental health. He believed that the child's early responses to the family community became a 'prototype' for that person's approach to life, and believed the individual consciously or unconsciously directs his or her own existence. His treatment approach reflected his philosophical differences from traditional psychoanalysis, in being more dialogic, and focusing on changing beliefs, behaviours and feelings with the goal of replacing 'exaggerated self-protection, self-enhancement, and self-indulgence with courageous social contribution' (Stein, 2004: Appx 1).

Adler's perspective was to have a crucial impact on the development of psychotherapeutic theory and in particular the emergence

of the humanistic psychotherapies. Furthermore, his interest in social context resulted in him playing a pioneering role in the development of the child guidance movement.

Further departures from Freud

Sándor Ferenczi (1873–1933) was born in Hungary, became a doctor, and met Freud in 1908 (Hoffman, 2003). However he challenged the Freudian technique of analytic neutrality, which he saw as inimical to psychological healing, and potentially a form of sadistic mistreatment of patients (Maccoby, 1995). Ferenczi's key contribution was in his understanding of the therapeutic relationship. He proposed (1928) that the analyst should be active, authentic and convey warmth, viewing the patient as an equal partner in the therapeutic process. He saw this relationship as a crucial factor in enabling the patient to 'establish … the contrast between the present and the unbearable traumatogenic past' (Ferenczi, 1933: 160 in Hoffman, 2003).

Ferenczi was an early exponent of the role of empathy and emotional attunement in the therapeutic process:

> I have come to the conclusion that it is above all a question of psychological tact whether one should tell the patient some particular thing. But what is 'tact'? It is the capacity for empathy. (Ferenczi, 1928: 89 in Hoffman, 2003)

He believed the analyst should 'use feelings and intuitions as tools, to analyze with heart and libido as well as with intellect' (Maccoby, 1995). He also recommended that psychoanalysts must undergo personal analysis in order to become emotionally self-aware, and that then they could monitor their internal responses (countertransference), seeing this as a resource for understanding the patient. He articulated a core idea that is now central to most psychotherapeutic theories.

Another key figure was Otto Rank (1884–1939) who developed an important new theory focusing on the real mother–child relationship, examining the role of the birth experience and the separation from mother in the development of anxiety. He was interested in briefer forms of therapy and in the importance of the real here-and-now relationship in psychotherapy. His work with Ferenczi exploring the nature of the therapeutic relationship culminated in the publication in 1924 of a ground-breaking monograph: *The Development of Psychoanalysis (*Ferenczi and Rank, 1925/1986). Rank visited the US several times before emigrating permanently in 1935. There his

work was influential in the emerging American humanistic and existential psychotherapies.

Following Rank and Ferenczi's work highlighting the interpersonal contact between analyst and patient, Franz Alexander (1891–1964), a Hungarian 'second generation' psychoanalyst, developed these ideas further. He had some contact with Freud, but moved to the University of Chicago. He is perhaps best known for his highly controversial theory, published in 1946, that the primary curative factor in psychotherapy is the emotional relationship with the analyst, rather than intellectual insight. He considered that the analyst should purposely provide a 'corrective emotional experience' in the transference relationship in order to repair the patient's past traumatic relational experiences (Alexander and French, 1946). He acknowledged the influence of Ferenczi in stressing the importance of the therapeutic relationship, and his ideas prefigure those of Kohut's self-psychology and of current humanistic and integrative theories of developmentally needed relationship as an aspect of psychotherapy (e.g. Clarkson, 1992; Erskine, 1993).

Sullivan's interpersonal theory

Another key exponent of the role and importance of the interpersonal, was Harry Stack Sullivan (1892–1949), an American psychiatrist who did pioneering work with schizophrenics and became a psychoanalyst in the 1930s in New York. He gradually moved away from Freudian intrapsychic theories to develop a relationally based theory of personality development. Like Rank, Sullivan viewed the relationship between mother and infant as central to healthy psychological development, addressing both biological needs and also the basic need for security. He thought that early relational security, and 'the mothering one's' own ability to manage her anxiety and convey empathy resulted in the child developing a sense of 'interpersonal security'. Furthermore he considered that 'the tension of anxiety, when present in the mothering one, induces anxiety in the infant' (Sullivan, 1953: 41). His ideas underpin the emergence of 'Interpersonal Psychoanalysis' and 'Interpersonal Psychotherapy' as a body of theory and practice.

These early theorists had a significant influence on the broader development of psychotherapy. Meanwhile the psychoanalytic strand of psychotherapeutic theory continued to develop both in Europe and in the United States. There is not sufficient space here to discuss the many significant contributions to psychoanalytic theory by the 'neo-Freudians' such as Horney, Thompson and Fromm,

or the evolution of psychoanalysis in France by theorists such as Lacan.

British developments in psychoanalysis

In England, traditional Freudian ideas were carried forward by Ernest Jones (who founded The London Psychoanalytical Society in 1913) and Anna Freud. Anna Freud made major theoretical contributions to the development of ego psychology, seeing the ego as developing defence mechanisms to protect from the anxiety resulting from both intrapsychic and external reality-based threats. Thus, while she maintained Sigmund Freud's theories of drive and instinct as central, she did also include external context as a factor.

Her other major contribution was in the development of psycho-analytic work with children during and after the Second World War.

The emergence of object relations theory

A key development that emerged in England was the development of object relations theory. The historical roots of this development go back to Ferenczi's ideas, and were developed initially by Melanie Klein (1882–1960) and later by Fairbairn, Winnicott and Guntrip (the so-called 'English School').

Klein, writing in 1935, focused on the very early phases of child development, revising Freud's views and formulating the idea that the infant, unable to experience self and other as distinct, identifies 'part objects', which are imbued with 'good' and 'bad' qualities according to whether they are a source of pleasure or pain. The infant is not able to experience both good and bad as aspects of the same person, whether self or other, and so splits them from each other, experiencing pleasurable union with the 'good' and terror of annihilation by the 'bad'. Klein called this early developmental phase the 'paranoid-schizoid position'. She believed that the infant copes with the threat of the 'bad' by means of primitive defensive operations such as idealisation, projection and projective identifica-tion. In normal development the splitting of good and bad gradually reduces and the infant is able to perceive self and other as whole 'objects' integrating good and bad. This Klein called 'the depressive position'. In recognising that he both loves and hates one person the infant becomes anxious that his/her own hate could result in loss of the object, and develops the capacity for reparation through the expression of love. Where this process becomes derailed, the child