Origins of psychology

This month marks the centenary of the birth of Alfred Adler. To celebrate the anniversary, Dr. Avis Dry provides a layman's guide to the pioneer study and thought of Freud, Jung and Adler whose work provided the basis on which all modern psychological practice is built.

So firmly linked are the names of Freud, Jung and Adler as the Great Triumvirate of the early psychoanalytical movement that the centenary of the birth of 'Alfred Adler in 1870 raises questions which concern them all. What are the main findings of the movement? Where do these theorists differ from Freud and each other? What significance has their work now for the psychiatrist and his professional allies, for the patient and his relatives?

This can be seen more vividly against the background of previous work in the middle and late nineteenth century, which were active years in the development of psychiatry and of all medical science. In Germany, the foundations of 'clinical psychiatry' were laid, and the hope of the time, inspired by the advance of physical and biological science, was to find definite, organic causes for mental illness.

In France a different line was being pursued. Building on the work of English physicians who had used hypnotism as anaesthetic during surgical operations, before the advent of chloroform and ether, French doctors discovered remarkable cures of blindness or paralysis could sometimes be achieved by suggestion under hypnosis for which no organic basis could be found.

At this point, in 1885, Sigmund Freud began work on medical psychology. Forced to abandon his first career choice—research in physiology—for lack of money, he turned to private practice in neurology. He collaborated with Josef Breuer, who had already discovered that encouraging a patient to 'talk out' troubles during the hypnotic session, had more success than simple hypnotic suggestions of improvement.

Freud soon abandoned hypnosis. He argued that it would be better to carry out the 'talking cure' with the conscious co-operation of the patient, and substituted the method of 'free association', asking the relaxed patient to say whatever came to mind—however unsuitable or trivial it seemed. The patient could not continue for long without coming up against a 'blocking of associations' which was invariably found to conceal painful or embarrassing memories, often sexual.

The free association eventually led back to childhood. Freud was startled to find how often sexual assaults seemed to have occurred early in his patients' lives and still more startled to find that, where it was possible to check, the assaults were imaginary. He declared the material was nonetheless important—the patients, as children, had wanted these things to happen and had lived them out in fantasy. From this he developed his well-known theories of the Oedipus Complex (in boys) and Electra Complex (in girls).

Contrary to the officially held view, he maintained that sexual urges did not begin at puberty with the maturing of the sex organs, but are present in the child from the age of 3-5 years and are directed toward the parent of opposite sex with corresponding hatred for the same-sex parent. After a so-called latency period, from about five to eleven years old, these love/hate conflicts return at puberty.

As starting points for free association Freud frequently used dreams since, during sleep, the repressing forces arising from the need for social conformity are relaxed. Even in dreams repressed feelings cannot be allowed to enter consciousness directly because the dreamer would awaken very disturbed. Hence the need for symbolism. To Freud the dream symbol always represents a more primitive object which would be too disturbing if it appeared in consciousness without disguise. For instance, although acknowledging that personal circumstances must be taken into account, he lays down a general rule that long, thin objects such as umbrellas or walking sticks—represent the male sexual organ and round or hollow objects the female genitals.

Freud's libido theory is difficult to understand for the general reader and the academic psychologist alike. Together with his follower Karl Abraham he built up a system of types—the 'oral types' who, having enjoyed undisturbed pleasure in suck-
ing at the breast, are optimistic and dependent, and those who, having experienced suckling difficulty, are impatient and demanding. There are also two 'anal types'—those who, having sought praise for punctuality and cleanliness in toilet training, in adult life are dependable and orderly, and those who, having found pleasure in wielding power by withholding faeces, become obstinate and parsimonious.

During the same period Freud worked out his therapeutic approach. He received declarations of love from men as well as women patients but concluded that the patients were not really attracted to him but rather transferred to him emotions experienced in earlier relationships within the family. He decided that, if the analyst refused to respond to emotions he would see the conflicts of the patient's past unfolding and the patient, gradually acknowledging them as childish residues, would be freed to pass on to other things.

After 1914 Freud renamed and modified his earlier classifications of conscious, unconscious and repressing forces, and spoke of the 'Ego', largely conscious, which mediates between instinctual demands and the regulations of society, and the 'Id', that part of the individual's own make-up, with a larger unconscious component than the Ego which, from early children, has represented or incorporated social taboos.

In the period 1900–10 a small band of workers—Jung, Adler, Sachs, Rank, Ferenczi, Abraham, Ernest Jones—had gathered around Freud. Among them Adler and Jung were the chief dissenters.

To Adler the fundamental drive in life was not sexual, no matter how widely sex might be interpreted, but will-to-power. Having previously been interested in the body's capacity to compensate for organic damage, he applied the same principle to mental life. All children, he said, begin life with a profound sense of helplessness and inferiority which may be accentuated through many circumstances. At first he emphasised obvious inferiorities, e.g. deafness, lameness, ugliness. Later he widened these factors to include unfortunate types of upbringing—pampering, harshness, favouritism shown to others, and accidents like loss of parents.

All individuals try to compensate for their feeling of inferiority—the term 'inferiority complex' is particularly associated with Adlerian psychology. All people are goal-orientated and have three tasks which they must meet—social adjustment, vocational adjustment and adjustment in their love relationships. Successful adjustment must be carried out within the context of inherent community norms, and, since the family is the first community the child encounters, the origins of his life style are to be found in the climate of those early years.

Unfortunately not all adjustments are successful—the individual may over-compensate for difficulties—like the small man who is excessively assertive. Although paying less attention to sexuality as such, Adler paid considerable attention to the problem of adjusting to masculine and feminine roles, using the term 'masculine protest' to cover the excessive brutality of the man who is inwardly unsure of himself in this respect, and the struggle against male domination of the woman who does not see the feminine role as rewarding.

If difficulties in this or other spheres become too great, the individual may retreat into neurotic illness as a means of avoiding situations of which he is afraid, gaining control over others by demonstration of his helplessness. The task of the therapist in Adlerian theory is to investigate the family style, explain to the patient how this has contributed to his individual life style, and trace its ramifications in his evasions, power-seekings and exaggerated goals. The patient must be helped to find the meaning of life in social relationships, i.e. Adler is more optimistic than Freud in his view of human possibilities and more of an educator in his therapy.

After a brief period of enthusiasm, Jung too concluded that Freud had overstated the case for the Oedipus complex, incest prohibition and consequent repression, as factors in the genesis of mental illness and had paid too little attention to the present situation and to future goals. He doubted Freud's technical libido theory and instead adopted the concept of one fund of psychic energy which, when turned inward, produced the introverted type, and when outward, the extraverted type.

Impressed by similarities between the dreams of his patients and the myths of primitive tribes, Jung postulated a 'collective unconscious' as well as a 'personal unconscious'. Both seemed to him less in conflict with consciousness than they did for Freud, and less anxiously 'making it up to oneself' than they were for Adler; instead, he thought of them as unobtrusively redressing the balance of psychic forces which conscious aspiration often tips too far in one direction. In his therapy Jung seems to have been less directly educational than Adler but less detached than Freud.

Criticisms of all these theories can be made. Many admit that, through a wish to remain close to his biological foundations, Freud was too little in his discussion of the oral, anal and genital characters, and insufficiently aware of the extent to which the Oedipus complex can be influenced by social factors.

Observations of child and animal psychology suggest that social needs are either innate or deve
oped very early from a primitive contact need, so that socialisation is not invariably imposed by eternal authority as Freud has assumed. Many subsequent psychologists have considered that aggression—in the sense of destructiveness of self or others—is not a primary instinct but results from frustration of more constructive impulses.

Of Adler it has been suggested that preoccupation with some of the defensive manoeuvres of the ego prevented him from taking account of many Freudian findings which are relevant for the detailed understanding of symptoms, and that the same preoccupation may have led him to leave to the later school of Melanie Klein a reconstruction of the effects of overwhelming anxiety as experienced in the very early days and weeks of life.

Jung, while stating objections to psychoanalysis which have been widely held—anticipating later psychoanalytical work on 'countertransference' by his view that doctor as well as patient is affected by the treatment situation—and producing the theory of introversion/extradversion (which has been a powerful stimulus to exact research, as in the work of Eysenck), does seem to have lessened his effectiveness as a systematic thinker in his later years by wide-ranging use of so vague a concept as the Collective Unconscious. Since all drives and all symbols are apt to be described in Jungian terms simply as 'attributes of the Collective Unconscious' it becomes more, rather than less, difficult to study them in detail.

Despite its colourful phraseology, its early dogmatism and controversies arising out of the highly emotional nature of its subject-matter, psychoanalysis can be regarded as a discipline which reconstructs the development of personality in a scientific way, making use of observation supported by the experimentally established method of free association, modifying its findings as further evidence comes to light and linking up with other disciplines.

What, then, are the main principles established by this discipline? First, a radical change has been brought about in our view of human nature, which is now seen to be less rational and less determined by conscious motivation than was assumed. Secondly, the part played by psychological factors in some forms of mental illness is harder to ignore; psychoanalysis introduced for consideration factors arising from psychological development in early life. At the same time, the gulf between normal and abnormal has been narrowed since so many similar reactions can be demonstrated to occur, less blatantly or with fewer compensating mechanisms, in people without manifest need of psychiatric help.

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