Mill suffered from a major depressive breakdown when he was 20 years old. The first ray of light broke in upon his gloom when he was reading some memoirs in which the author relates his father's death:

"the distressed position of the family, and the sudden inspiration by which his, then a mere boy, felt and made them feel that he would be everything to them - would supply the place of all that they had lost" (Mills 1873).

Mill records that he wept at this affecting account, and clearly that it was because the book made him able to feel emotion again that he started to improve in spirits. A comparable turning point occurs in Coleridge's Ancient Mariner when the protagonist finally feels empathy for fellow creatures (in his case, sea-snakes), and is at that moment relieved of the burden of his depressive guilt (symbolized by the albatross). Mills' 'bibliotherapy' marked the end of his affect phobia and he could begin to experience the emotions of sadness, grief and anger which, ironically, his depression had blocked. Another interpretation would be that this passage made him aware that sons can sometimes aspire to replace, or even surpass, their fathers; and this realization helped him to feel less inadequate. Some patients recount similar experiences when listening to music, or watching films that resonate with their own situation.

Mills upbringing clearly demonstrates that a child may receive the most devoted attention from his parents but fail to acquire a proper sense of his own value. And both Churchills life and Mills demonstrate that great achievements may in part come about because an individual, who in early life believed himself to be inadequate, is driven to make especial efforts to prove the contrary.

Anxiety

Inevitably, going to see a therapist is anxiety provoking. Will the therapist understand me? Is it safe to lay bare my hang-ups, conflicts and shameful secrets? Can I rely on her not to gossip or laugh about me? Will she be there for me when I want her, or will she be on holiday at the crucial moment of need?

All these are normal, healthy and expected feelings. We need anxiety to stay safe, and to tell us whom to trust, when to hold back. Just as sadness and grief are normal responses to the loss of a loved one, so fear is an adaptive and protective response to external threat, helping us avoid danger. But if fear is a good thing, anxiety-disordered patients suffer from too much of a good thing. They are overwhelmed with anxiety rather than unable to benefit from it. In this chapter we shall look first at anxiety disorders in general, and then focus on one in particular, obsessiveness.

Freud on anxiety

As in depression, where the source of the loss is veiled (although almost invariably present if one looks in the right place), in anxiety the source of the threat is often obscure. Thus anxiety and depression have in common either the absence of an obvious stimulus, or a seemingly disproportionate response to a trivial one. To account for this, Freud put forward two radically different theories of anxiety. In his first attempt (Freud 1905) he argued that since in anxiety disorders there is no evident external source of fear, the source must lie within: people are made anxious by their inner feelings - in his model predominantly sexual or aggressive. These id-impulses are repressed, and the result is anxiety. But Freud later saw that anxiety can result not just from the presence of threat, but also from the absence of someone with whom to mitigate and modulate that threat:

'Missing someone who is loved and longed for is the key to an understanding of anxiety' (Freud 1926).

Here the cause of anxiety is to be found as much in the absence of a protective relationship as the presence of a threat. Bowlby (1973) argues that we appraise external threat not just for its intrinsic danger, but its danger in relation to the presence or absence of appropriate protection. In the absence of a secure base, a child alone is wise to treat strangers with suspicion; if accompanied, the child can rely on the mother to evaluate the stranger and, with the help of her visual cueing, afford to be more exploratory and forthcoming.

Attachment theory

A basic postulate of attachment theory is that anxiety is a normal, expected and adaptive response to physical or emotional separation from a secure base. Anxiety becomes pathological when relatively trivial separations trigger intense anxiety responses. From an attachment perspective this can be understood in terms of early developmental experience which instigates expectations of abandonment and/or difficulties in managing anxiety when in the presence of a base whose capacity for security provision is sub-optimal.
Secure children become anxious on separation, stop playing, express angry protest, are soothed and reassured on reunion and will then return to exploratory activities. If the commitment of the caregiver (e.g. due to maternal depression) is intermittent, partial, or in the rare but pathogenic circumstances where the caregiver is also the source of threat, defensive or compromise processes necessarily come into play.

The resistant or ambivalent child's anxiety levels are hyper-roused as she becomes clingy and exploration-inhibited for the sake of the security provided by the inconsistent caregiver. By contrast the avoidant child dampens down anxiety, thereby achieving a measure of security even from somewhat rejecting caregivers. The disorganized child faces a difficult approach/avoidance dilemma and may resort to various pathological self-soothing measures to reduce anxiety and build up an illusory world of self-sufficiency.

Klein

Melanie Klein (1935) postulated that the infant in the early weeks and months of life suffers from persecutory anxiety. Klein, like Freud, concentrates on the 'enemy within.' She imagined the infant to have a prae-natal Oedipal sense of being usurped by the father in the mother's affections. The consequent frustration and envy leads to the defensive projection of these potentially disruptive emotions into the mother, which are then seen as persecutory.

For Klein the presence of a 'good object' is the main mitigating factor in overcoming anxiety. The role of the good object is to neutralize the anxiety aroused in the infant by his or her projected hatred and aggression.

But this in turn stimulates a second cycle of anxiety generation. To the extent that one is able to love, the idea that one might damage the loved object with one's aggression becomes unbearable. One is now prey to depressive anxiety. Here initiation flows from separation - 'making good' the imagined injury by acts of generosity, construction and repair. In Bion's (1970) extension of Klein, the role of the good object now is to contain the projected aggression, to hold it and name it without retaliation or comprehension, and eventually to hand it back, when the child reaches a sufficient level of maturity for this to be tolerable.

All this is clearly relevant to the work of the therapist, whose job is to be the secure base the patient turns to when anxious. Since anxiety inhibits exploration it is only when the patient feels safe that he can be expected to start thinking about himself and his inner world.

The therapist is alert to ways in which she may disturb this trust - latenteness, unexplained breaks due to illness, preoccupation with her own worries - all these may precipitate fear and withdrawal in the patient.

An aim of therapy is to foster the capacity to mentalise (Holmes 2010). The anxiety sufferer is encouraged to move from a non-mentalising 'teleological' perspective (e.g. 'If I go to the supermarket I'll get a panic attack') to begin to think in interactive relational terms ('If I go to the supermarket on my own I may lose a sense of who I am and panic, since I have always relied on my mother or husband to be there for me and give me reassurance').

There is also a negatively reciprocal relationship between mentalising and anxiety - the more anxious one is the less easy it is to 'think.'

The anxiety-aggression cycle

A useful working hypothesis in the therapy of anxiety disorders is that behind every manifestation of anxiety there lies unexpressed anger, and behind every act of aggression there is latent anxiety. From an attachment perspective, separation triggers anxiety, which in turn stimulates angry outbursts in attempt to re-establish attachment. But this, as Klein suggests, may then trigger a new round of anxiety, based on the fear that the object may be damaged by one's 'demandingness' leading to more anxiety, further aggression, and so on.

The caregiver of the securely attached child is able to accept the child's angry protest, to see it for what it is, soothe the anxiety which underlies it and so assuage anger - a gentle answer turns away wrath. The anxious patient needs to learn that it is OK to feel angry and that the object of their anger will listen and survive an angry attack - as Winnicott memorably put it: 'hello object, I just destroyed you' (Winnicott 1971). A major component of Busch, Milrod and Sandberg (2009) evidence-based treatment model of panic disorder is based on working with unexpressed aggression.

Role of control

The two fundamental defences in anxiety disorders are a) avoidance and b) control. But in the absence of a secure base, internal or external, both are doomed to failure. The world's vicissitudes cannot be entirely avoided, and we live in an inherently uncertain universe, so complete control over the unexpected is impossible.

The agoraphobic person avoids exposure to anxiety by staying within the confines of his home. The behavioural treatment approach is to help the sufferer to expose himself to fears of the outside world, in the presence of trusted other - the behavioural therapist. As we shall see, obsessive-compulsive disorder suffers attempt to control anxiety by rituals and ruminations. Again, learning to tolerate anxiety and uncertainty in the presence of a trusted other - through, for example, 'response prevention' in the case of obsessive hand cleansing (where the behaviour therapist literally stands over the patient and forbids him to wash his hands more than once after going to the toilet) - is the essence of therapy. Similarly when the source of the threat is one's own thoughts, as in the case of the young woman discussed on page 23 who had morbid fears of harming her relations with her thoughts, one needs a trusted other, or the internal representation of one, to be able to tolerate and normalize one's thinking.

Learning to tolerate ambiguity and uncertainty is a crucial feature of the psychotherapeutic process. The patient will observe the therapist's tentative formulations, will see her tolerating not-knowing, probing and exploring possibilities on the basis of a trust that solutions will be found. Informal cognitive challenge is as integral to psychodynamic work as it is formalized in CBT. One patient with a fear of flying was helped when his analyst, in contrast to the usual reassurances that flying is far safer than crossing the road etc pointed out, seemingly without undue anxiety, that it is indeed the case that aeroplanes sometimes crash, albeit very rarely. With the help of a secure base, uncertainty and the reality that every contingency cannot be controlled become tolerable.

For a psychoanalytic psychotherapist, working with patients with anxiety disorders presents a particular challenge because the patient is usually manifestly distressed and often on a desperate search for an 'answer' to their feelings of panic, somatic symptoms etc. A convincing case can be made for a symptom-reduction strategy preceding psychodynamic exploration of the meaning of symptoms, in that the greater the patient's state of arousal, the less likely he will be to be able to reflect or free-associate. Hence meditation or mindfulness training, yoga etc can be recommended in parallel with psychodynamic therapy.

However, the analytic therapist can all too easily get caught up in symptom-chasing, rather than sticking to his or her last - a regular, reliable, predictable and accepting therapeutic relationship, helping the patient to tolerate and mentalise transference...
anxiety, and using cognitive processes to down-regulate panic by giving meaning to symptoms.

A woman in her late 50s had been prone to anxiety for most of her life, for which she had had a number of only partially successful short-term treatments, including CBT. She was now asking for help with incapacitating anxiety symptoms following a series of life events which included the deaths of both her parents and a close friend, retirement from her job as a local government officer, and the re-homing of a puppy which she had felt unable to manage, despite as a childless woman, having built huge hopes around this 'baby'.

Outwardly controlled and calm, she said that inside she was in extreme physical pain due to muscle tension and feared constantly that her symptoms of anxiety would take over and she would collapse into a 'shaking babbling mess'.

She described herself as having been moulded by a mother who, frustrated herself, wanted her daughter to be everything she herself had been unable to achieve. She felt throughout her childhood that her mother's approval turned almost exclusively on top exam grades and fulfilling her expectations.

In the initial conversations there seemed an urgent need to help the patient control her symptoms. Adopting a cognitive model, mood diaries and suicide and physical pain rating scales were suggested. She dutifully brought back beautifully constructed spreadsheets showing the variations in her symptoms. She described a number of agonizing moments during her week and questioned the therapist about various techniques for managing anxiety she had found via the internet.

On the fifth session she arrived apologetically confessing that her printer had scrambled the rating scales and handed over a sheet of incomprehensible numbers.

The therapist intuitively felt that this was a message to be heeded, and decided to change tack. He said that she was far more expert than he in techniques for managing anxiety-symptoms, and indeed that he would be interested to learn from her more about them. He said that he saw her skills in helping her to understand the deeper meaning of symptoms, and that the best way to do this was psychoanalytic psychotherapy, and invited her to ascend the couch. Within minutes, or so it seemed, and certainly within a few sessions, she was far more able to manifest both in the transference and in her relationship with her husband, not mention her mother, the anxiety/aggression cycle that kept her trapped. She felt angry with the therapist for failing to rid her of her symptoms and for, like her mother, expecting her to 'achieve' with her charts and rating scales; angry with her husband for his 'stubbornness' about domestic matters; angry with her mother for the conditionality of her love. At the same time, and in the same breath as expressing discontent, she would immediately back-track, excusing the therapist by saying he was doing his best, her husband for having his own problems, and similarly excusing her mother. This punch-pulling 'strategic defence' (Malan and Della Selva 2006) – based on a fundamental fear of abandonment – meant that she never felt confident enough to express anger and to know that her object would survive. The job of therapy was both to redress that and help her to begin to mentalise this bind.

This patient illustrates both persecutory and depressive anxiety. She had a fundamental sense that the world was a dangerous place, and that only avoidance or control would mitigate its dangers. Such people need to learn to trust the universe first in the presence of a secure base, and then with an inner confidence that they can successfully negotiate the pathway between risk and desire. Her task in relation to depressive anxiety was rather different. Here the need is to lessen an omnipotent sense of one's destructiveness. Control is an issue, but in a different way from the persecutory anxiety sufferer: Those with depressive anxiety often are over-controlling of others rather than themselves, compulsively caring towards their objects, vainly attempting to mitigate the effects of their imagined destructiveness. Their need is to learn to tolerate the ambivalence that is integral to all relationships, and that 'good-enoughness' rather than perfection is the goal, and that a degree of failure is inevitable, but not necessarily catastrophic.

Tracking the differences between the various categories of relational anxiety is important. Severity is an equally important dimension. Severe childhood disturbance may permanently compromise anxiety and hormonal neural pathways, leading to chronic hyper-reactivity when faced with minor stress or ambiguity. It is important for the therapist to recognize how deeply ingrained maladaptive stress responses may be in such cases.

Obessionality

Persons with obsessioninal personalities are meticulous, scrupulous, accurate, reliable, honest, and much concerned with control, order, and cleanliness. Many of those who have made outstanding contributions to Western culture exhibit these traits. Indeed, most people of considerable intellectual accomplishment need to be somewhat obsessionall to achieve their results. Who would not choose to be operated on by an obsessionall surgeon who counts his swabs in and out of the operating field? On the other hand, a GP who tears up a dozen prescriptions before handing over the final version is to be avoided, especially if one is in a hurry. Only when these traits become exaggerated into compulsive rituals or tormenting thoughts do we speak of obsessionall neurosis.

Freud described his own personality as obsessionall, and once said to Jung that, if he were to suffer from neurosis, it would be of the obsessionall variety. He described obsessionall personalities as:

'noteworthy for a regular combination of the three following characteristics. They are especially orderly, paranoic and obstructive' (1913).

A minority of people with obsessionall personalities may go on to develop obsessive-compulsive disorder. These take the form of unwanted thoughts which intrude upon the patient's consciousness, or ritual actions which the patient feels compelled to carry out against his will. The line between pathology and normality is often hard to draw. If a man exhibits occasional anxiety as to whether he has closed his front door or turned off the gas taps, we do not take this too seriously, for we have probably experienced the same phenomena ourselves. But if he always has to check the door and the taps ten times before he leaves the house, there is clearly a problem to be thought about. Writers ought to be meticulous in their choice of words; but those who, like Dorothy Parker, say 'I can't write five words but that I change seven' are in difficulties. However, the majority of obsessionall patients referred to dynamic psychotherapists exhibit traits and behaviour which are not more than slight exaggerations of valuable aspects of the obsessionall personality, scrupulosity, reliability, self-control, and honesty. They seek psychotherapy because of tension and anxiety, or because of difficulties in interpersonal relationships.

Whatever its causal origin, the obsessionall personality is double-faced: when present in moderation, it is valuable, indeed essential to the more complex pursuits of civilized life. When exaggerated, it is destructive of spontaneity, and may eventually paralyse action. Obsessionallity can be seen as an attempt to defend oneself against feelings of failure and chaos. But, since the world is inherently somewhat disappointing and chaotic, obsessionall sufferers are doomed to disappointment.

This is one reason why obsessionallity is a risk factor for depression. However fiercely we discipline our unruly minds and bodies, there is always much about ourselves and the world we can never entirely control. Even those who dislike the processes involved, need
both to eat and excrete; sex is so urgent a drive that it, too, cannot be entirely subdued. Much of our mental life, from dream to inspiration, is beyond the reach of the will. We have to fit in with our own natures, just as we do with those of other people; and the idea that control over ourselves can ever be absolute is an illusion. In Book IX of The Republic Socrates says that "in all of us, even in good men, there is a lawless wild-beast nature, which peeks out in sleep. People plagued with obsessiveness behave as if the beast was straining at the leash. Moreover, they are apt to assume that other people are similarly constituted; and therefore look on the world as a jungle in which the unseen hosts of Midian are forever on the prowl."

The philosopher Kant is a classic example of a scholar whose whole life was ordered with meticulous exactness. The obsessive scholar's ideal, which can never be wholly realized, is that the world shall be an ordered place in which everything is understood and everything is predictable. Such a world is the vision of the scientist. The progress of science depends upon the invention of hypotheses which, by bringing an ever-increasing number of facts into causal relation with each other and under one heading, impose order upon chaos, and enable more and more accurate predictions to be made. It is the disarrangement of anomalies, of facts not covered by existing hypotheses, which leads to new discoveries and new theories. Anomalies are a form of disorder which spur the scientist on to create a more comprehensive order; just as dirt or disarray may impel an obsessive to arrange and rearrange his room.

The wild beast which obsessives fear is principally an aggressive animal. Although sexual impulses often constitute a part of the forces which obsessives are trying to control, aggression plays a larger part than love in their psychology. Instead of perceiving other people as persons with whom they can make relationships on equal terms, obsessives tend to relate in terms of domination versus submission, or superiority versus inferiority. The weaker the child feels himself to be in relation to authority, or the more dominant that authority is in fact, the more resentment will equal or outweigh the love he feels.

Many people of obsessive disposition show precocious intellectual development in childhood. This is especially true of the type of intellectual mentioned earlier. When such a child perceives his parents as autocratic authorities, he learns to relate to them by means of his intelligence rather than emotionally. In adult life he treats others as if they were authorities who might suddenly become angry; this betokens the persistence of aggressive feelings from childhood, and demands he exercise control over such feelings. In adult life, obsessives tend either to be authoritarian and often irritable, or else unduly submissive. Either attitude is one in which the object is to disarm the other party. Faced with possible hostility, he either conquers or submits. In neither case can he achieve equity and mutual respect.

Obsessional types entering psychotherapy often appear to be especially mild, compliant characters who are anxious to please the therapist and who agree too readily with everything which she may propose. Fear of aggression from others dominates their adaptation to their fellows. They are usually carefully and neatly dressed, in order to forestall any possible criticism of their appearance. They are punctilious in keeping appointments for which they often arrive early. They show gratitude toward the therapist before she has had time to do anything to help them, and are overanxious about causing him any possible inconvenience.

Yet whereas this variety of obsessional is primarily concerned withwarding off the aggression of other people, there is another type who is more concerned with controlling his own. When his defences fail, he becomes naggingly critical, and may be extremely difficult to live with. Tense, irritable, obsessional parents who want to keep everything under tight control extend this wish to those with whom they live. They insist upon cleanliness and tidiness upon locking doors, being polite, keeping up appearances, not offending the neighbours. For such people — popularly known as 'control freaks' — living in a family is difficult. They may be able to order their own behaviour so that things will not 'get out of hand', but they cannot entirely control the behaviour of other people. Their anxiety leads to anger, and it is small wonder that their wives and children rebel against what they feel to be an irrational tyranny.

Thus the obsessional person's failure to integrate or control his aggressive impulses may lead in either of two directions: toward submission, on the one hand, or tyranny on the other. Extreme submission leads to his virtual disappearance as a separate entity. Extreme tyranny leads to the annihilation of the other, and hence to isolation.

These observations explain how the obsessional defences may be employed against depressive states. If the subject stays close to people, he may become angry with them because he cannot control them; or depression may result from his turning his anger against himself. Alternatively, he may detach himself from people. It is possible to live with a family and remain uninvolved emotionally. When personalities of this kind develop overt symptoms, there is usually evidence of aggression in their psychopathology. Some cannot ascend to a high place, or even travel on top of a bus, without being beset by the thought that they might drop something on passers-by. Clergymen if obsessively inclined, whose profession requires that they be kind and understanding, frequently fear that their words or actions will escape their lips at inappropriate moments, such as when they are preaching. Housewives may anxiously feel compelled to put all food which they serve to their families through a sieve, in case some minute particle of glass might do someone an injury. Such symptoms represent a failure of defence in that the repressed, underlying aggression of the subject is allowed to peep through.

The psychotherapist's task with such people is twofold. First, she must facilitate the emergence of the instinctive impulses against which the patient is defending himself. Second, she must present herself as someone with whom the patient can experiment in trying to reach a new kind of relationship on more equal terms; a relation in which the question of who is dominant and who is submissive is no longer crucial.

Obsessional patients are generally described as difficult subjects for psychotherapy because of their capacity for intellectualization. Since their whole defensive system is one designed not to allow the free expression of emotion, they find it just as hard as dangerous to 'let go' during psychotherapy as they find it in other situations in life. They will be anxious to understand exactly what the utterances of the therapist mean. Often, they will accept her interpretations as likely to be reasonable, without giving any indication that they have struck home in a meaningful way. Such people tend to understand and interpret their therapists with their hearts. Since intelligent patients of this type are often verbally fluent, they are able to use words as a way of distancing themselves from their true feelings, rather than as a means of expression. When the therapist says something which might be expected to produce outrage, like 'You must have wanted to murder your mother!' the patient mildly replies: 'Perhaps you're right. I suppose something of the kind must be involved.'

Such patients become much more accessible when they are depressed. It is often helpful to pick up any tiny instance of spontaneous reaction to the therapist in the here-and-now, since this may give access to the spontaneous feelings which the patient tries so hard to control. It is also useful to explore dreams, since these may be the quickest route into another side to his personality which he is attempting to suppress and banish. Some obsessional patients find that they can let go better through painting and drawing than they can by using words.

Of all patients, the obsessional-inclined are the most likely to persist in psychotherapy even when showing little evidence of improvement. It is part of their problem that they tend
to live in the future rather than in the present. Their habit of anticipating danger leads them to take all sorts of precautions about the future and to be preoccupied with it to the exclusion of the present. While at a cinema or the theatre they may be so preoccupied with imagining how they are going to get home afterwards that they fail to appreciate the performance itself. The same tendency manifests itself in therapy.

Interminable analyses may represent obsessivity in both parties: the therapist as well as in the patient. Cases of obsessive personality combined with mild compulsive symptoms are suitable for psychotherapy and rewarding to treat. However, there are also cases of severe obsessive-compulsive disorder which are beyond the capacity of the psychotherapist to ameliorate, and which are so extreme as to suggest that the causal factors are not purely psychogenic. These are the patients whose lives are so dominated by rituals that they can scarcely find time for any normal living. Some patients of this kind are even more disabled than if they were suffering from chronic schizophrenia.

Samuel Johnson is a famous example of a person who throughout most of his life employed obsessional defences to control aggressive impulses and to ward off the depression which constantly threatened him. Boswell wrote:

"He had another particularity, of which none of his friends ever ventured to ask an explanation. . . . This was his anxious care to go out or in at a door or passage by a certain number of steps from a certain point, or at least so as that either his right or his left foot should constantly make the first actual movement when he came close to the door or passage . . . I have, upon innumerable occasions, observed him suddenly stop, and then seem to count his steps with a deep earnestness; and when he had neglected or gone wrong in this sort of magical movement, I have seen him go back again, put himself in a proper posture to begin the ceremony . . ." (Boswell 1796).

This clinical description could not be bettered today. We can see how Johnson was defending himself by his obsessional rituals, and what kind of thoughts he was attempting to expel. Johnson was subject to recurrent depression, what he called a 'vile melancholy,' and was plagued by constant guilt. Throughout most of his life he feared insanity. He hated going to bed because, once alone, morbid thoughts were sure to plague him. He was preoccupied with death and said that he never experienced a moment in which death was not terrible to him. He condemned himself for indolence, for having sensual thoughts, for indulgence in food and drink. This marvellous writer and lexicographer, who accomplished so much, wrote of himself, 'I have lived totally useless.'

Johnson is a fascinating and sad example of a man who kept depression at bay with obsessional defences during most of his life, but which failed at times, so that he was precipitated into a slough of despond. It is interesting that Johnson prescribed intellectual activity for a fellow-sufferer who was plagued with guilt. He himself turned to arithmetical calculations in order to divert himself; an early example of 'thought stopping.'

Patterns of Personality

According to the advertising of a well-known manufacturer of trekking equipment, there is no such thing as bad weather - only bad weather gear. Although this chapter could well be entitled 'the difficult patient,' one could equally say that there is no such thing as a difficult patient, just ill-prepared therapists.

Reprise

Before proceeding to discuss some of the difficulties which the psychotherapist may encounter with her more challenging patients, let us summarize the three key tasks which the therapist must undertake: two fairly straightforward, the third more subtle.

Her first duty is to provide a secure, reliable background of personal concern against which the patient can develop. Just as children grow best if they are fortunate enough to live in a stable home in which continuing care is taken for granted, so psychologically troubled patients are more likely to learn to understand themselves and to cope better with their problems, if provided with a secure base in the shape of a therapist to whom they can turn as a caring, concerned person.

Her second duty is to get to know her patients sufficiently intimately to make sense both of their symptoms and personality as a whole - which can be encapsulated in the formulation discussed previously. This involves having a clear picture of how the patient developed from early childhood onwards. Although such understanding does not necessarily abolish all symptoms, nor bring about radical or sudden changes in character structure, it enables the person to stand back from himself, to look at himself, modelled on the therapist, with an eye both critical and sympathetic. This capacity for self-reflection - for self-mentalling (Allen and Fonagy 2006) - is a prerequisite for change. People who seek psychotherapy do so not because they are very different from the rest of humanity, but because they are overwhelmed or demoralized by their psychopathology. When they can stand back from their own personalities and problems, and apply critical understanding to them, they are on the way to some degree of recovery.

The psychotherapist's third duty is more complex. It is to provide the patient with a laboratory in which he can see himself in action in the world of interpersonal relationships. The therapist does this by offering herself as a more or less unknown quantity upon which the patient will project the images of those who have been emotionally significant to him in the past. She then helps patients become aware in the here-and-now of how these images, and the assumptions on which they are based, influence how he currently relates to others. The therapist is both like, and unlike the patient's previous experience of significant people in his life; negotiating this discrepancy is the lever that generates change (Holmes 2012e). For a while he tries to hang onto the old while trying out the new; eventually, all being well, he can let go of past patterns and defences, and trust that new relationships will be sufficiently safe and satisfying to justify the risk involved in change.