

Evolutionary biology demarcates the territories of specialist psychotherapists and general psychiatrists.

by John Price

## 1. The role of the specialist psychotherapist

In this pair of essays, I am going to present a radical and speculative view which I hope will act as a basis for discussion.

Psychotherapy can be looked on as dealing largely with the problems of low, labile and fragile self-esteem. An evolutionary view of self-esteem helps to clarify the type of psychotherapy needed for different problems. We think that human self-esteem evolved out of resource-holding potential (RHP) and social attention-holding potential (SAHP) which are self-constructs relating to capacity for agonistic and prestige competition, respectively. Behavioural ecologists tell us that it is advantageous to both individuals and groups to have a wide variation in competitive ability. In humans, this variation in life-long self-esteem is effected during two critical learning periods, using signals from parents in early childhood and from peers during adolescence. During adult life, it is also advantageous to have the capacity for variation in self-esteem, and this is largely brought about by mood change. The psychotherapy needed to deal with these adult changes in self-esteem should be the province of the general psychiatrist, and in the next essay I give three examples from my own practice. To rectify low self-esteem induced during childhood and adolescence requires a re-creation of the archetypal situation during therapy, and this should be the province of the specialist psychotherapist.

### The individual therapist

In his recent monograph (Stevens, 1998) and elsewhere, Anthony Stevens has made the case for specialist psychotherapy when there has been "frustration of archetypal intent" in the parenting of the child. The child whose archetype of the "good parent" is not activated by either of the real parents suffers from a serious developmental defect, and this can be remedied by dynamic therapy in which the developing relationship between the therapist and patient is vitally important, in that it recapitulates the parent/child relationship, but in a healing form. It provides a "corrective emotional experience" (Knobloch & Knobloch, 1979) in that it makes up for something that should have, but has not, happened during childhood. It could be looked on as an extreme form of psychological kinship therapy (Bailey and Wood, 1998). Such taking the role of the parent is a matter for the specialist psychotherapist, and usually the general psychiatrist has neither the skill nor the time for such a task. It could be argued that it does not matter what the patient and therapist talk about, just as it does not matter what a father does with his son in establishing the father/son relationship; the therapist could talk about sex, power or dreams, in the way that a father could take his son to football, or fishing or tell him stories. Provided the therapist has the qualities of the good parent, and a forum for interaction is provided, the content may be of subsidiary importance.

In the developing self, and in the formation of self-esteem, there are two sensitive learning periods in which outside influences may be crucially important in either inculcating a good sense of self or, alternatively, leading to a damaged self and lifelong low self-esteem. The first is the parental influence during infancy and early childhood, discussed above; the second is the adolescent peer group. These are two archetypal situations. The archetypal quality of the parent/child experience can be inferred from the ritualised way that parents stand around a young child and give great whoops of admiration as the little person overcomes some trivial obstacle to its progress. From an evolutionary view, the gain is set very low in this activity. The resource acquiring properties of high adult self-esteem have no doubt led parents to maximise this opportunity to inculcate high self-esteem in their children, so that any child who does not get what, to an outside observer, appears to be excessive parental boosting, is liable to result in below average self-esteem. At the other tail of the distribution are those children who receive the message from their parents that they are intrinsically evil and should never have been born. And other children fail to get the boosting because the parents are absent or dead. As a result of this varied parental input, some children come to think of the world as their "oyster", and others feel the need to apologise for their very existence.

The reason for this variation is given by evolutionary game theory. A population of hawks is not evolutionarily stable, and can always be infiltrated by doves (Maynard Smith, 1982). We can equate the dove with the person suffering from life-long low self-esteem,

who never fights back and is always willing to take a subordinate position. For some reason, which it would not be appropriate to discuss here, some parents are motivated to turn one or more of their children into doves, and they do it by withholding the praise that the majority of children get, or, even more effectively, by putting their children down. These children then remain doves for the rest of their lives, even if they never meet a hawk; after all, they have an internalised hawk who takes the form of their "hostile dominant self" (Gilbert, in press) who bullies them relentlessly year after year, keeps them "up to the mark" and ensures that they perform a devoted lifetime of service to others.

It is not at all evident that a "corrective emotional experience" should be possible during therapy. After all, by the time the patient comes for treatment, the critical learning periods are over. The parents, and the peer group, have lost their power to affect self-esteem. So how can a therapist do it? It is, I think, one of the great empirical findings of the psychotherapeutic movement that such a possibility exists. The parent/child archetype can be resurrected in therapy and it appears in the regression of the patient to a childlike form of behaviour and in the transference. The patient feels to the therapist as a very young child feels towards its parent, and so re-enters the archetypal situation, and this allows the therapist to boost the patient at a very primitive level, by paying attention to what the patient says, giving respect, taking the patient seriously, and in general, treating the patient as someone of great value. This, I think, is why it is useful for the patient to be encouraged to remember and talk about early childhood; the value lies not in the retrieval of "repressed" memories of nursery conflicts, but in helping the patient to regress to an age at which the parental archetype is active, and so allow it, amazingly, to alter its first message from "You are a worthless person" to "You are an important person." To orchestrate such a scenario of regression and transference is a highly skilled matter - it is a task for the specialist psychotherapist and should not be undertaken by the general psychiatrist.

#### The group therapist

Let us turn now to the second critical learning period for self-esteem. The archetypal quality of the peer group experience is revealed in the way adolescents cohere into gangs and feel intensely about their acceptance by their peers. Some "make it" but others are rejected and they too are doomed to lifelong low self-esteem. Often they become highly successful people who compensate by their achievements for their basic feeling of "not having made the grade". In these cases, too, it is possible to have a "corrective emotional experience" and do a rerun of what was not completed during adolescence. The adolescent peer group is re-created in the therapy group.

As with the parent/child archetype, so too with the adolescent/peer group archetype: it can be opened again during therapy, but it requires group therapy rather than individual therapy. The group members represent the peer group, and the therapist represents parental authority. The therapist prevents the group from discussing adult matters, like current affairs, and so the group interaction descends to the typical chaotic and apparently senseless discourse of the adolescent peer group. But this, together with rebellion against an apparently unsympathetic therapist, seems to help regression of the group members to the adolescent stage at which acceptance by their peers can activate the archetype. It is also helpful if there are other groups with which the index group can compete in typical adolescent fashion, although this may be difficult to arrange on an out-patient basis. The skill of re-creating this adolescent scenario is a specialist matter and should not be undertaken by the general psychiatrist, because, of course, if it goes wrong the patient may get a reinforcement of the original message that the peer group does not want them (there are not many rejecting individual therapists, but there may well be rejecting therapy groups). On the other hand, it may be useful during training for the general psychiatrist to experience "group therapy"; I, for one, would otherwise not have believed it possible to feel such love for fellow group members after meeting together once a week for six months.

In summary, evolutionary biology predicts a wide variation in self-esteem in any population of competing individuals, and it appears from observation that this variation is induced during two critical learning periods during ontogeny, one in early childhood in which the variation is induced by differential parental messages, and the other in adolescence, when further variation is induced by differential messages from the peer group. It is a surprising but empirical fact that these learning periods can be re-entered during a therapeutic situation in which the original archetypal relationships are re-created. To create such therapeutic situations is a highly specialised task, and defines one arena in which the specialist psychotherapist should reign supreme, and into which the general psychiatrist enters at his or her peril.

## Learning the capacity for hedonic symmetrical relationships

Another candidate for group psychotherapy is the individual who is unable to enter into hedonic (friendly) symmetrical relationships. Evolutionary biology is informative on this issue. If we look around at our fellow primates, we find that the capacity to form hedonic symmetrical relationships is exceedingly rare. As human beings we are expected to relate to other as equals in many social situations, and we expect people to do it as a matter of course, but it is, in fact, a very surprising and rare capacity. Adolescence is again, probably, the arena in which the capacity is formed. Some people come out of adolescence with equal friends; others do not, and they have learned the pernicious "Potter Principle" that "whoever is not one up is one down" (Peter & Hull, 1969). These latter are what has been termed authoritarian personalities (Adorno et al., 1950; Maslow, 1943). Their social life is based on the social hierarchy. They are either grovelling or sneering. Their self-esteem seems very variable as it depends on whether they are looking up or down the hierarchy. Looking upwards, they feel inferior and regard others with deference; looking downwards, they feel superior and regard others with contempt. They are behaving like non-human primates; indeed, like any non-human group-living terrestrial vertebrate.

An example of this type is the case of Mr Silver described by Horowitz (1997, Chapter 1). He wanted to enter into cooperative partnerships with peers at work, but was unable to do so; he had a pathogenic belief that "I must be superior or I will be inferior and rejected; if I am not superior, I am scared of being left alone." The fact that Horowitz does not discuss the possibility of group therapy for Mr Silver is another justification for applying the evolutionary perspective.

The members of a therapeutic group are assumed to be of equal status. Any attempt by members to adopt an inferior or superior role is part of "group process" and represents material for the therapist to work on. It is more difficult to do this in individual therapy because the relationship between patient and therapist is not, and never can be, symmetrical; and so the individual therapist has to work with the patient's relationships outside the therapeutic setting.

---

Evolutionary biology demarcates the territories of specialist psychotherapists and general psychiatrists.

## 2: The psychotherapeutic role of the general psychiatrist

### Introduction

This essay is about the difference between psychotherapy as practised by the general psychiatrist (or clinical psychologist) and psychotherapy as practised by the specialist psychotherapist. Surprisingly, evolutionary biology can throw light on this apparently highly detailed and technical matter. There is a tendency in the multidisciplinary team in the UK for the psychiatrist to attend to medication and legal issues, while any brief psychotherapy that is done is carried out by a clinical psychologist or nurse; for long-term psychotherapy, the patient is referred to a specialist psychotherapy department. There are probably two reasons for this. One is that psychotherapy is time consuming and nurses are cheaper than psychiatrists for management to hire. The other is that the existence of specialist departments of psychotherapy tends to spread the myth that psychotherapy is something requiring specialist training over and above that of the general psychiatrist. This in my view is unfortunate for both psychiatrist and patient.

When patients come to the psychiatric out-patient clinic, their lives are usually in a mess. The mess is aggravated by the psychiatric symptoms themselves. There is usually a positive feedback interaction between psychiatric symptoms and adverse life events, such as loss of job or spouse, excessive drinking, and social withdrawal, in that these life events both cause and result from psychiatric symptoms, particularly depression. And like Hamlet, their melancholy unfits them to deal with the situation that caused the melancholy in the first place. Some of these patients have previous good adjustment, others have always had chronic low self-esteem and/or various pathogenic beliefs or behaviours. These patients make up the bread and butter of the general psychiatrist, and their optimum management usually involves both antidepressant drugs and brief psychotherapy.

One evolutionary view that helps to analyse these cases is the idea that depression evolved as part of social hierarchy behaviour, either to prepare the patient for low social rank, or to accommodate the patient to a lower than desirable rank after a fall in rank order has occurred (Price et al., 1994). Therefore, although all sorts of adverse life events may trigger a depressive episode, humans are especially sensitive to ranking

stress; i.e., the perception that social rank is being, or is likely to be, lost or in some way jeopardised. Logically, there are three sources from which ranking stress may arise: from an equal, from a superior and from an inferior. The worst ranking stress is associated with a rank reversal - when a former despot has to bite the dust and grovel to a new boss. Before the first world war, a Norwegian schoolboy called Thorleif Schjelderup-Ebbe noted that this stress caused a severe depressive reaction in the hens on the farm where he spent the school holidays (Schjelderup-Ebbe, 1935; Price, 1995). The same occurs in many other species. My first case describes a situation in which a tyrannical father's position of dominance was usurped by his daughter, who very much rubbed her father's nose in the dust.

#### Illustrative cases of ranking stress

(Case histories deleted for reasons of confidentiality)

#### Three forms of ranking stress

These three cases illustrate the three social situations in which ranking stress may occur in relation to another person. In the first, former dominance was lost and the father was forced into a subordinate role. In the second, the son was already subordinate, but was forced to accept behaviour on the part of his father which was outside the limits informally agreed in their relationship. In the third, an equal relationship deteriorated into a subordinate relationship due to a misunderstanding on the part of the other, who thought she was in a supervising role; it is noteworthy too that her behaviour was not overtly aggressive, but it derived its catathetic (putting down) effect from the fact that it was behaviour normally shown by superiors to subordinates, and therefore assumed a rank difference which was not accepted by the patient.

I have not described any cases in which ranking stress occurs in relation to the group as a whole, as when an artist receives bad reviews, or a politician fails to get re-elected or when someone undergoes a "degradation ceremony" such as a criminal being convicted and sentenced by a court. These situations relate to failure, not in agonistic behaviour, but in a more recently evolved type of social competition which we have called prestige competition (Gilbert, Price & Allen, 1995). Nor have I included any cases in which depression occurs in response to a situation which predicts ranking stress, such as when the lady of the manor is bereaved and has to give up her house and titles to her daughter-in-law (see Price, 1998).

The goals and aspirations of humans are extraordinarily diverse and unpredictable (Nesse, 1998). In each case it is necessary to determine what is important to the patient. At the same time, one can keep in mind the simpler case of the chacma baboon, all of whose rewards and incentives depend on social rank, so that the one goal to seek is a rise in rank, and the one disaster to fear is to be overtaken by the baboon who ranks below. The self-esteem of the baboon is not much different from its fighting capacity or resource-holding potential (RHP). It may be significant that Abraham Maslow, who discovered the great human variation in self-esteem, started life as a primatologist, and once remarked that a dominant monkey is more similar in behaviour to another dominant monkey than to itself when subordinate (Maslow, 1940).

#### A note about the evolution of variation

In this argument, I have postulated evolved mechanisms (critical learning periods) for causing variation in self-esteem. This may give the reader pause for thought. One can imagine the evolution of a trait (because it is adaptive) but how can one envisage the evolution of variation in a trait? To whom is the variation adaptive? It may seem adaptive to the high self-esteem person, since dominant people are in a position to acquire and hold on to resources; but how can it be adaptive for the low self-esteem person? There are at least three possible answers to this problem. One comes from evolutionary game theory, and depends on the fact that a pure high self-esteem strategy may not be "evolutionarily stable" in that it can be infiltrated by a mixed strategy containing both high and low self-esteem people (Maynard Smith, 1982). This depends partly on the fact that self-esteem is subject to negative frequency-dependent selection, in that the payoff for high self-esteem becomes less if everyone else has high self-esteem. It pays to be a dove if everyone else is a hawk, but if the majority of the population are doves, the hawk does very well. Aldous Huxley appreciated this fact, and portrayed it in his novel "Brave New World", in which an expedition composed entirely of "alphas" has a poor outcome.

Also arising from evolutionary game theory is the possibility that low self-esteem may be a "contingent" or "best of a bad job" strategy, adopted when social circumstances are unfavourable (e.g., the family is low-ranking) or the phenotype is deficient in some way. Both these conditions are likely to lead to the learning of low self-esteem, both from parents in early childhood and from peers during adolescence.

Another possibility is group selection (Wilson, 1997). Groups with large variation in self-esteem form more stable hierarchies and are therefore better able to compete with other groups. Shakespeare appreciated this fact, and portrayed it in his play "Troilus and Cressida", in which Ulysses attributes the Greek failure to capture Troy to an unstable hierarchy of command. Burgess (1970), introducing the text, writes (p. 185): "Ulysses, giving his opinion on the Greek failure to take Troy, blames it on the Greek failure to maintain order. There is a hieratic pattern in the universe, which men, for the sake of communal health, must be willing to imitate:

"Take but degree away, untune that string, and Hark!  
What discord follows.

The general's disclaimed  
By him one step below, he by the next,  
That next by him beneath; so every step,  
Exampl'd by the first face that is sick  
Of his superior, grows to an envious fever  
Of pale and bloodless emulation  
And 'tis this fever that keeps Troy on foot,  
Not her own sinews. To end a tale of length  
Troy in our weakness stands, not in her strength."

Group selection has been a controversial subject in evolutionary theory, but has not been entirely discredited (Stevens and Price, 1996; Wilson, 1997).

So, it is adaptive to have a different self-esteem from everyone else, and there are mechanisms for ensuring that this difference occurs. In this sense, variation in self-esteem is unlike other types of human variation, like introversion/extraversion (Price and Stevens, 1998). Here it probably pays to be like everyone else; and the variation probably exists because introversion is selected for in one type of habitat, and extraversion in another. Therefore there are no mechanisms for creating variation in introversion/extraversion - no critical learning periods - and the variation appears to be largely genetically determined. This is why, ever since the pioneering work of Maslow (1940), we have been aware of the enormous variation in human self-esteem, and why psychotherapy is largely concerned with self-esteem management, rather than with other types of human variation.

#### Conclusion

In dealing with common psychiatric disorders, we are dealing with an evolved self-esteem management system, deriving phylogenetically from the RHP management system of our "reptilian" ancestor. With depressive, dysthymic and other personality disorders associated with low self-esteem, we are dealing with lifetime variation in self-esteem. This variation is induced during two critical learning periods during childhood. To alter this variation in later life is possible but difficult. It requires the re-evocation of the original archetypal situation either in individual psychotherapy or group psychotherapy. To achieve this requires the skills of the specialist psychotherapist.

With depressive and anxiety disorders, we are dealing with short-term adjustments in self-esteem. What is required here is to co-ordinate the activities of the triune mind so that all levels are either escalating or de-escalating, resulting in resolution of whatever ranking stress led to the original de-escalation (Price, 1998). The patient needs to deal with the situation at the highest mental level, so that there is resolution in the form of victory, withdrawal/submission, escape from the situation, reframing, submission for arbitration, etc. De-escalation by the "reptilian" brain needs to be replaced by a rational strategy (Price et al., 1994). This is a task which can be performed by the general psychiatrist, but still requires the application of great psychotherapeutic skill, partly to identify the conflict of importance, partly to help the patient to talk about it frankly, and partly to help the patient to give up those goals, aspirations or parts of the self which were unrealistic and so causing trouble.

With the help of guides to brief psychotherapy (e.g., de Shazer, 1988; Fisch et al., 1982; Horowitz, 1997; Ryle, 1990; Weissman & Markowitz, 1994) and more specific guides to psychotherapy along evolutionary lines (e.g., Glantz and Pearce, 1989; McGuire and Troisi, 1998; Stevens, 1998; Stevens and Price, 1996; Weisfeld, 1977) and having had a training in the various forms of family therapy, the general psychiatrist should be equal to the task.

#### References

- Adler, A. (1929) The Case of Miss R.: The Interpretation of a Life Story. Translation and introduction by Eleanore and Friedrich Jensen. New York: Greenberg.  
Adorno, T., Frenkel-Brunswik, E., Levinson, D. & Sanford, R. (1950) The Authoritarian

Personality. New York: Harper.

Bailey, K.G. & Wood, H.E. (1998) Evolutionary kinship therapy: basic principles and treatment implications. British Journal of Medical Psychology, 71, 509-523.

Burgess, A. (1970) Shakespeare. London: Jonathan Cape.

de Shazer, S. (1988) Clues: Investigating Solutions in Brief Therapy. New York: W.W.Norton.

Fisch, R., Weakland, J.H. & Segal, L. (1982) The Tactics of Change: Doing Therapy Briefly. San Francisco: Jossey-Bass.

Gilbert, P., Price, J. & Allen, S. (1995) Social comparison, social attractiveness and evolution: how might they be related? New Ideas in Psychology, 13, 149-165.

Glantz, K. & Pearce, J.K. (1989) Exiles from Eden: Psychotherapy from an Evolutionary Perspective. London: W.W.Norton.

Horowitz, M.J. (1997) Formulation as a Basis for Planning Psychotherapy Treatment. Washington DC: American Psychiatric Press.

Knobloch, F. & Knobloch, J. (1979) Integrated Psychotherapy. New York: J. Aronson.

MacLean, P.D. (1990) The Triune Brain in Evolution. New York: Plenum Press.

Maslow A. (1940) Dominance, Self-esteem and Self-actualisation. CA: Brooks-Cole, (1973 ed. R.Lawry).

Maslow, A.H. (1943) The authoritarian character structure. Journal of Social Psychology, 18, 401-411.

Maynard Smith, J. (1982) Evolution and the Theory of Games. Cambridge: University Press.

McGuire, M.T. & Troisi, A. (1998) Darwinian Psychiatry. New York: Oxford University Press.

Nesse, R.M. (1998) Emotional disorders in evolutionary perspective. British Journal of Medical Psychology, 71, 397-416.

Peter, L.J. & Hull, R. (1969) The Peter Principle: Why Things Always Go Wrong. London: Souvenir Press.

Price, J.S. (1988) Alternative channels for negotiating asymmetry in social relationships. In M.R.A. Chance (Ed.) Social Fabrics of the Mind. Hove: Lawrence Erlbaum.

Price, J.S. (1995) A remembrance of Thorleif Schjelderup-Ebbe. Human Ethology Bulletin, 10 (1), 1-6.

Price, J.S. (1998) The adaptive function of mood change. British Journal of Medical Psychology, 71, 465-477.

Price, J.S. & Sloman, L. (1987) Depression as yielding behavior: an animal model based on Schjelderup-Ebbe's pecking order. Ethology and Sociobiology, 8, 85-98 (Suppl.).

Price, J.S., Sloman, L., Gardner, R., Gilbert, P. & Rohde, P. (1994) The social competition hypothesis of depression. British Journal of Psychiatry, 164, 309-135. Reprinted in S. Baron-Cohen (Ed.) The Maladapted Mind: Classic Readings in Evolutionary Psychopathology. Hove: Psychology Press, 1997.

Price, J.S. & Stevens, A. (1998) The human male socialisation strategy set: cooperation, defection, individualism, and schizotypy. Evolution and Human Behavior, 19, 58-70.

Ryle, A. (1990) Cognitive Analytic Therapy: Active Participation in Change. Chichester: Wiley.

Schjelderup-Ebbe, T. (1935) Social behaviour of birds. In C. Murchison (Ed.), Handbook of Social Psychology. Worcester, Mass.: Clarke University Press.

Sluzki, C.E. and Beavin, J. (1965) Symmetry and complementarity: an operational definition

and a typology of dyads. Acta psiquiatrica y psicologica de America Latina, 11, 321-330. Reprinted in P. Watzlawick & J.H. Weakland (Eds.) The Interactional View. New York: W.W.Norton, 1977.

Stevens, A. (1998) An Intelligent Person's Guide to Psychotherapy. London: Duckworth.

Stevens, A. & Price, J. (1996) Evolutionary Psychiatry: A New Beginning. London: Routledge.

Weisfeld, G.E. (1977) A sociobiological basis for psychotherapy. In M.T. McGuire and L.A. Fairbanks (Eds.). Ethological Psychiatry. New York: Grune and Stratton.

Weissman, M.M. & Markowitz, J.C. (1994) Interpersonal psychotherapy: current status. Archives of General Psychiatry, 51, 599-606.

Wilson, D.S. (1997) Introduction: multilevel selection theory comes of age. American Naturalist, 150 (Supplement), 1-4.