

Preface

The Roman philosopher Lucretius is famous for writing an extended poem titled *On the Nature of Things*. It contains sections on a wide range of subjects, such as the movement of atoms, the cosmos, time – and a great deal of psychology.

Among Lucretius's writings on the mind and behaviour is a description of what happens when people fall in love. He observes that the besotted frequently become agitated and stirred up by insatiable desires. Sexual union, often passionate and violent, results in only temporary relief, because lovers always want more of each other. Lucretius seems to be describing an addiction. He uses language that suggests that falling in love is a little like becoming ill or, even worse, going mad. Love, he says, is like an unconquerable disease and lovers waste away from wounds that can't be seen. They are lovesick: weak and neglectful of responsibilities, they behave foolishly and fritter away fortunes on excessive gifts; they become jealous and insecure.

After describing all these symptoms, Lucretius employs a device that many stand-up comedians use. He subverts our expectations to make us laugh. He says: That's what love's

like when things are good – just imagine what it's like when things get bad. All of a sudden, he is no longer a classical philosopher but a friend or drinking companion.

Lucretius proceeds to tell us what happens when love goes wrong. Lovers become delusional and lose the power to make objective judgements. They experience a kind of ongoing hallucination. Ordinariness, or even ugliness, is perceived as outstanding beauty. They can't keep away from their beloved, and everyone else in the world becomes insignificant. Lovers become abject and helpless, and what pleasures they enjoy – sensuality, mutual delight – serve only to limit them. The goddess of love, Lucretius warns, has sturdy fetters.

It's interesting, even remarkable, that a Roman philosopher, dead for over two thousand years, can supply us with a description of lovesickness that we all recognise. In this respect, it doesn't seem that human nature has changed very much since classical times. But Lucretius doesn't stop there. He refines his argument and makes a distinction between love going well and love going wrong – love that is normal and abnormal love. In a more general sense, the whole discipline of psychiatry is predicated on this division: the identification of abnormal individuals within the wider, 'normal' population.

In fact, the symptoms that Lucretius associates with love going well are only marginally less dramatic than the symptoms he associates with love going wrong. This suggests a continuum of increasing severity, rather than a real difference between normal and abnormal. I doubt Lucretius had particularly strong views on this issue, and the distinction

he makes might appear in his poem only in order to make his joke work.

Lucretius described the lovelorn as fools. Indeed, the tone of his verse is quite contemptuous. He invites us to laugh along with him at their folly. It's an attitude that many may share. There's a certain amount of questionable pleasure to be had from watching other people making fools of themselves, but when we mock the lovelorn, we do so either as hypocrites or automatons. Who hasn't acted foolishly – or at the very least conspicuously out of character – when in love? Only those who renounce society or repress their emotions are immune.

We know almost nothing about Lucretius. Saint Jerome tells us that he committed suicide when he reached his middle years. It is thought that he had been driven mad by a love potion. Perhaps he should have taken lovesickness more seriously.

She was clever, successful and horribly depressed – an opera singer with a very considerable talent. As is often the case with depressed patients, she was also extremely irritable. She told me what sex felt like with her husband: 'I feel like a blow-up doll,' she said, forming an 'O' with her mouth and stiffening her limbs. Then, suddenly, she looked at me as if she'd only just noticed I was sitting there. Her eyes narrowed. 'Why do you do this?' she demanded. My answer was thoughtless and trite. 'It's my job ...' I should have known better and didn't get the chance to elaborate. She was expecting something more insightful from a psychologist. 'All this misery and unhappiness,' she exploded. 'Day

after day – listening to people’s shit – listening to my shit! What kind of person does this for a living?’ Then the fire went out of her eyes and I could see her sinking into a quagmire of self-loathing. She made a feeble, apologetic gesture. ‘It’s okay,’ I said. And I gave her a better answer – although it was still incomplete and a little disingenuous.

Why *did* I become a psychotherapist?

The saccharine and safe answer is that I wanted to help people. And that would be true. But this is so obvious as to be completely uninformative. A little like asking a fireman why he chose to join the fire brigade only to be given the flat answer, ‘To put out fires.’

For as long as I can remember, I have always been attracted to hinterlands, fringes, twilight places and oddity. As an adolescent I would consume volumes of weird fiction and horror, largely because these genres typically explored the darker recesses of the mind and bizarre behaviour. As I matured, this fascination with oddity (and particularly psychological oddity) became something less prurient and somewhat closer to intellectual curiosity. But it remained, in essence, unchanged.

I’ve worked in many different settings, including in some very large, rambling hospitals. In every instance, when the opportunity arose, I would escape the busy, pristine ‘front of stage’ areas – reception, outpatients, wards – stray off the major thoroughfares and wander around basements, neglected corridors and empty offices. Sometimes I would stroll through eerie, silent places for some time without encountering another soul. On one of my excursions, I found what appeared to be an abandoned operating theatre with

a ceiling constructed of glass panels. Much of the glass was broken and autumn leaves were scattered on the tiled floor. In the centre of the space was an antiquated machine with white enamelled surfaces. It was vaguely telescopic, mounted on a wheel-shaped base and festooned with levers. I felt as if I had stepped into a novel by H. G. Wells or Jules Verne. On another occasion, I discovered a room lined with dusty shelves and on each of these were rectangular Perspex containers in which slices of human brain were preserved in formaldehyde. It was a haunting image – like a library of memories. In the grounds of a Victorian asylum I came across a tiny museum that contained a collection of art works by former patients. I was the only visitor. A custodian appeared – a diminutive, alert woman – who immediately demanded to hear my views on the effect of hot weather on homicidal behaviour.

Symptoms must have causes. They can be produced by abnormalities in the brain, neurotransmitter imbalances, repressed memories, or distorted thinking. But symptoms are also the end point of stories. For me, psychotherapy is as much about narrative as it is about science or compassion, perhaps even more so. The awkward truth, which I couldn't reveal to the depressed opera singer, was that I found the day-to-day misery of psychotherapy tolerable because I liked listening to the stories – especially those that were touched by strangeness and explained the occurrence of unusual or striking clinical presentations. My uneasy conscience is salved, in this respect, by the fact that I stand shoulder to shoulder with some very august company.

The practice of psychotherapy has long been associated with storytelling. Anna O., the very first patient to be

treated using a procedure that eventually became psychoanalysis, entered an altered state of consciousness during which she would tell Josef Breuer (Freud's avuncular patron and collaborator) stories that reminded him of those written by Hans Christian Andersen. These formed an integral part of her treatment and prompted her to describe Breuer's approach as the 'talking cure'.

People are living story books. Talking cures open the covers and let the stories out.

The core of this book is a series of true stories about real people, all of whom I saw for psychotherapy because they experienced significant distress attributable to falling in love or being in love. Most of their problems were emotional, sexual, or a combination of the two. Romantic love, as Lucretius suggests, is almost always linked with physical desire. The clinical phenomena I describe (the symptoms, feelings and behaviours) are authentic; however, I have disguised my patients to ensure anonymity.

The very earliest poems were composed in Egypt over three and a half thousand years ago – exquisite love songs that describe the despair of lovers as a malady. Early medical texts also conceptualise falling in love as an ailment. The second-century Greek physician Galen described a married woman who couldn't sleep and who started acting strangely because she had fallen in love with a dancer. Lovesickness was considered a legitimate diagnosis from classical times to the eighteenth century, but it more or less disappeared in the nineteenth century. Today, the term 'lovesickness' is employed as a metaphor rather than a diagnosis.

When love-struck individuals voice their complaints, the best they can usually hope for is a little sympathy and a wry, knowing smile. Teasing and ridicule are also common responses.

But lovesickness is not a trivial matter. Unrequited love is a frequent cause of suicide (particularly among the young) and approximately 10 per cent of all murders are connected with sexual jealousy. Moreover, there is a view that intermittently gains currency within psychiatry and psychology that troubled close relationships are not merely associated with mental illness but are a primary cause.

I have often found myself sitting in front of lovesick patients whose psychological pain and behavioural disturbances were equal in severity to any of the cardinal symptoms of a major psychiatric illness. Such patients are usually embarrassed to disclose their thoughts and feelings, having internalised the prevailing view that lovesickness is transitory, adolescent, inconsequential, or ridiculous. This couldn't be further from the truth. The emotional and behavioural consequences of falling in love can be enduring and profound. I have seen conventional lives unravel on account of wild passions; I have watched people suffer prolonged agonies because of rejection; I have accompanied individuals to the verge of psychological precipices – dark, fearful places – where I sensed that an infelicitous word or maladroit turn of phrase might be enough to propel them over the edge; I have seen patients listening to the siren call of oblivion, attending to its promises of release and eternal rest, even as I endeavoured, sometimes desperately, to persuade them to step back. I have watched people hollowed

out by desire and yearning diminish to a fading iteration of their former selves. On none of these occasions was I ever tempted to offer a wry, knowing smile.

The term 'incurable romantic' is more than just an amusing designation – it acknowledges an uncomfortable clinical reality. One of the ardent poets of ancient Egypt tellingly wrote that doctors with their remedies could not heal his heart. He may have been right.

Love is a great leveller. Everyone wants love, everyone falls in love, everyone loses love and everyone knows something of love's madness; and when love goes wrong, our relative wealth, education and status count for nothing. The jilted lord is just as vulnerable as the jilted bus driver. Virtually all the major theoreticians of psychotherapy, from Freud onwards, agree that love is essential to human happiness.

It is my belief that the problems arising from love – infatuation, jealousy, heartbreak, trauma, inappropriate attachment and addiction, to name but a few – merit serious consideration and that the line which separates normal from abnormal love is frequently blurred. I hope that this view will be supported by the sometimes quite unsettling revelations that follow – unsettling, because ultimately, they demonstrate the presence of deep-rooted and universal vulnerabilities that have been locked into our nervous systems by evolutionary processes. The merest spark of sexual attraction can cause a fire that has the potential to consume us. We all share this dormant propensity, which explains why examples of its full expression in the clinic are so arresting and alarming. They give us good reason to reflect on

our own intimate histories and forewarn us of dangers that may lie ahead.

Psychotherapy is a notoriously divided discipline. There are many different schools of thought (e.g. psychoanalytic, gestalt, rational-emotive) and each of these schools is represented by figureheads whose particular approach – while preserving a circumscribed set of basic values and principles – diverges from the mainstream. These departures from orthodoxy range from minor modifications of theory to major doctrinal revisions. The history of psychotherapy is one of internecine strife, schisms, secession and intellectual hostility. One can imagine it represented on a page as a complex tree diagram composed of several trunks and each of these trunks producing numerous branches and offshoots. This process of growth and repeated bifurcation has taken place over a period of just over a hundred years and continues to this day.

It is customary for a book of this kind to reflect the theoretical orientation of the author. Typically, symptoms are interpreted and understood within the context of the author's favoured unitary approach. I have always found allegiance to a single school of psychotherapy unnecessarily limiting as I believe that even the most peripheral innovators in the history of the subject have had something significant or useful to say about the origin, maintenance and cure of symptoms. Thus, the clinical descriptions in this book are presented with commentaries that borrow from many different perspectives.

While psychotherapists have been engaged in their various disputes with each other, they have also been

participating – as a more unified group – in a much bigger, ongoing dispute with biological psychiatrists concerning the ultimate origin of mental illness. Biological psychiatry is based on the assumption that all mental illnesses are caused by structural or chemical abnormalities in the brain. A corollary of this assumption is that biology, being a more fundamental science, trumps psychology. The relative status afforded to biological and psychological accounts of mental illness frequently polarises views, and opponents from both camps are usually committed and vociferous. Once again, I find this debate – in its extreme form – rather sterile.

Even if one supposes that all mental states can be mapped onto brain states, this doesn't mean psychology is invalidated, in the same way that biology isn't invalidated by chemistry, and likewise, chemistry isn't invalidated by physics. Almost everything in the universe can be described in different ways and at different levels, and the mental life of humans is no exception. Multiple perspectives are illuminating and give a more complete and satisfying account of phenomena. Consequently, my case commentaries also include references to biological psychiatry and brain sciences.

He was nineteen, a philosophy student with unwashed hair and an unconvincing beard. The dark crescents under his eyes suggested sleepless nights and his clothes exuded the smell of cigarettes. He had been rejected by his girlfriend and he was exhibiting many of the symptoms of lovesickness described by poets through the ages. His distress and anger seemed to come off his body in rising waves.

'I don't understand how it happened. I just don't understand.' I noticed his foot tapping impatiently. 'Can you give me *any* answers?' His emphasis converted an innocent question into a challenge that also carried with it a subtle slur, the imputation of impotence.

'That rather depends on your questions,' I replied.

His pale cheeks acquired some colour. 'What's it all about? I mean . . . life, love. What's it all about?'

Love and life are often linked together because it is almost impossible to think about life without love. In a very real sense, when we ask questions about the nature of love we are also asking very deep questions about what it is to be human and how to live.

My young patient threw his arms out and kept them suspended in the air: 'Well?'