17.6 Psychodynamic concepts and mental health

FREUD AND THE CAUSES OF MENTAL HEALTH PROBLEMS

A number of Freudian psychoanalytic concepts have been applied to explain the origin of mental disorders:

- **Repression of traumatic events** – traumatic experiences, especially in childhood, may be repressed and become a later source of unconscious anxiety. Freud concluded that neurotics suffer from reminiscences (memories).
  Evidence – research on traumatic events leading to dissociative states like fugue (where people forget their previous life and start a new one) or multiple personality disorder (where a person may have different personalities that are unaware of each other's existence due to amnesic barriers) supports the possibility of repression and its effects.
- **Sublimation into somatic symptoms** – underlying anxiety may be symbolically expressed in physical symptoms as in hysteria. Hysteria, as it was understood in Freud's time was a medical term applied to patients who seemed to be suffering symptoms of disorder to the nervous system (e.g. pain or temporary paralysis or blindness), for which no *physical* neurological cause could be found.
  Evidence – Freud presents numerous case study examples of his patients' hysterical disorders as evidence, e.g. Anna O.
- **Regression** – the disorganised and delusional thinking of schizophrenia may result from a regression to a self absorbed state of 'narcissism' in the early oral stage where the irrational id dominates and there is no well developed ego to make contact with reality. Depression may also result from regression to an early state of dependency due to a loss in later life triggering the emotional effects of a more serious childhood loss.
  Evidence – many studies have supported the idea that early parental loss and childhood trauma are correlated with later mental disorder, but are not able to tell whether repression and regression are the causes.
- **Displacement** – unconscious anxiety may be displaced onto external symbolic objects and situations, resulting in phobias.
  Evidence – Freud regarded the case of Little Hans as good supporting evidence for this.

FREUD AND THE TREATMENT OF MENTAL HEALTH PROBLEMS

Traditional psychoanalytic therapy involves first identifying the unconscious source of disorder (such as the blockage of id impulses or the repression of traumatic experiences) and then trying to relieve the blockage by making the unconscious causes conscious. This is not easy since the patient is not only unaware of what is causing their problems, but will show resistance to the therapist's attempts to interpret them as the ego tries to maintain its defences.

1 **Identifying the problem** – Freud used three methods for unrooting the unconscious causes of disorder:

- **Free association** – thought associations expressed from the client to the analyst without inhibition could contain clues regarding the source of unconscious anxiety. Pauses in, or drying up of, associations meant unconscious resistance was being met.
- **Dream analysis** – which Freud regarded as the 'royal road' to the unconscious. By unravelling the disguised symbolism of the manifest content of the dream (what was remembered), the latent content (what the dream actually meant) could be revealed.
- **Behaviour interpretation** – Freud believed that both normal (e.g. slips of the tongue) and abnormal behaviour were due to unconscious causes which could be carefully deduced from what people said and did – "He that has eyes to see and ears to hear may convince himself that no mortal can keep a secret. If the lips are silent, he chatters with his finger-tips; betrayal oozes out of him at every pore" (Freud 1901).

2 **Producing improvement** – this is achieved by:

- **Catharsis** – Freud originally thought that discharging the emotion (psychic energy) associated with repressed impulses or traumatic memories brought about improvement, but what seemed more important was that the unconscious conflict was brought out into the open for discussion. This is where transference is important.
- **Transference** – the process whereby unconscious feelings of love and hate are projected onto the analyst. These feelings provide a basis for identifying, accepting and discussing the analyst's interpretation of the problem.
- **Insight** – Freud regarded this as the crucial therapeutic element since it increases ego control over revealed unconscious causes.

JUNG AND THE CAUSES OF MENTAL HEALTH PROBLEMS

Jung generally agreed with Freud's interpretations of hysterical neuroses, but thought his theory of schizophrenia too incomplete. A number of Jung's analytical psychological concepts have also been applied to explain the origin of mental disorders:

- **Individuation and growth** – If a person is not able to proceed in their growth then neurosis will develop. Unlike Freud, Jung believed neurosis was caused by ***present rather than past problems***, which only trigger memories of similar troubles from childhood as a result. Neuroses were even sometimes a result of the spirit of the times.
- **Balance** – Mental and behavioural disorder, like dreams and personality traits, are the result of ***imbalance*** in the psyche. Jung believed excessive introversion might lead to complete withdrawal from reality and schizophrenia, while excessive extraversion may lead to hysteria.
- **Compensation** – Since symptoms are the result of compensation, they can often be regarded as serving a ***positive function***, indicating deficiencies and ways in which a more healthy and balanced set of behaviour or attitudes could be achieved in the future. Jung believed that even schizophrenic delusions were attempts of the mind to create new explanations of, or ways of seeing, the world.
- **Archetypes and complexes** – Since the self is not one personality but many, Jung saw the fragmentation of schizophrenic and dissociative disorders such as multiple personality as differing only in extreme (quantitatively not qualitatively) from 'normality' (a term Jung disliked). Problems may result from the imposition of complexes and archetypes, e.g. infatuation with a member of the opposite sex usually involves the projection of the archetypical anima or animus upon them, leading to an exaggerated view of their perfection.

JUNG AND THE TREATMENT OF MENTAL HEALTH PROBLEMS

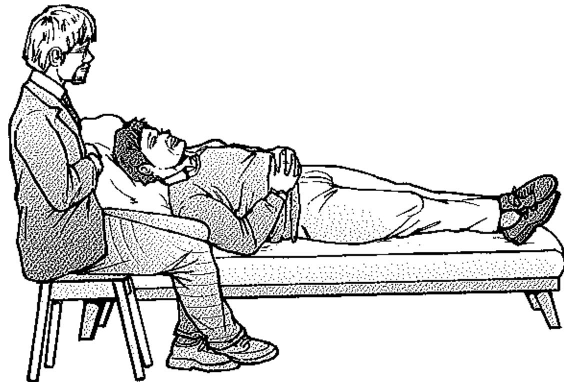
Jung's therapy was more of a face-to-face (Freud sat out of his client's view, Jung sat opposite them), co-operative and joint process between therapist and client, both seeking answers to the problems. Analysis was less frequent, partly to ensure patients did not lose touch with their everyday lives, and aimed to restore balance and meaning to the client's life. Balance could be restored by bridging the gap between the conscious and unconscious through creative and imaginative activities (such as painting and play) or imaginary dialogues with archetypal figures, and by engaging in activities *opposite* to a dominant attitude (introversion/extraversion) or function (thinking, feeling, intuiting, etc.).

17.7 Traditional psychoanalysis

The debate over the effectiveness and appropriateness of psychodynamic therapies was first sparked off by criticisms of Freudian Psychoanalysis. Many attacks were made on Freud's underlying psychoanalytic theory and methodology, and this naturally led people to question whether a therapy based on such disputed foundations could be worthwhile. Since Freud developed his therapeutic techniques, many other psychodynamic therapists have developed their own variations of the therapy that often differ in important respects from traditional psychoanalysis, and all should not be tarred with the same brush. It is instructive, however, to look at some of the issues surrounding the debate over just how effective and appropriate Freud's therapy is, since the debate is more complicated than it appears.

WHAT ARE THE AIMS OF PSYCHOANALYSIS?

Aims – The notion of a cure, according to Freud, involves not merely eradicating symptoms but identifying the deeper, underlying unconscious mental causes of disorder and dealing with them as best as possible. However, since Freud regarded all humans as neurotic to some extent his notion of a cure was very modest, to 'turn neurotic misery into common unhappiness' by providing the client with more self-control – 'where id was, there shall ego be' (Freud, 1933). Freud discovered the unconscious causes of disorder by interpreting the symbolism of his clients' behaviour, dream reports and free associations. The process (cathartic and transference) of revealing the hidden causes of their behaviour and above all the insights Freud provided regarding them provided the relief of anxiety and ego control required to improve their condition.



EFFECTIVENESS

Freud's own patients – It has been suggested (e.g. by Webster, 1995) that Breuer and Freud may have misdiagnosed their patients and that many who were supposedly cured through psychoanalysis, including Anna O, continued to show their symptoms after treatment by it. Some patients would have probably been classified as suffering from organic, physical disorders today, such as forms of epilepsy (Anna O), Tourette's Syndrome (Emmy von N, Freud's first hysterical patient treated by psychoanalysis) or even tumours (M-I, who died from a tumour of the stomach, had her stomach pains diagnosed as hysterical by Freud).

Criteria of success and the causes of psychoanalytic effectiveness

This is difficult to assess since psychoanalysis aims to change the unconscious processes that cause disturbed behaviour. However

1 unconscious progress may not always produce immediate observable changes (this affects the criteria and measurement of success)

2 unconscious changes can not be measured and may not be responsible for changes in behaviour.

Lacking an objective goal for therapeutic success, Freud's therapy essentially involved retrieving information about the patient until a cause could be found, but the only way the problem memories could be identified was when talking about them coincided with improvement in the patients symptoms. Freud stated "I accustomed myself to regarding as incomplete any story that brought about no therapeutic improvement". Since psychoanalysis took so long, the symptoms may have spontaneously recovered (disappeared on their own) and the 'story' being recalled at the time could just have been coincidental.

Effectiveness studies

Eysenck (1952) found that psychoanalytic therapy had lower success rates (44%) than alternative psychotherapies (64%) or spontaneous remission (72%). This finding has been hotly disputed, because of its very high spontaneous remission rate (some research suggests 30%) and criteria for success. When the criteria are changed, psychoanalytic success rates improve. A meta-analysis of general therapeutic success rates by Smith and Glass (1977) shows that psychoanalysis is more effective than no therapy at all for most people, but has slightly lower success rates than other therapies. Sloane et al (1975) found psychoanalysis was most effective for clients with less severe problems.

APPROPRIATENESS

Who can benefit? – Rather than asking 'should people undergo psychoanalysis?' a better question might be '*who* should undergo psychoanalysis?' Freud applied psychoanalysis to a range of disorders such as hysteria, phobias and obsessive compulsive disorder (e.g. the 'Rat Man'), yet it seems more appropriate for minor neuroses and anxiety disorders, with more intelligent and articulate clients. Freud himself argued psychotic disorders could not be treated because they lacked insight and the ability to form transference attachments to the therapist (although psychoanalysis with schizophrenics has been attempted in combination with drug therapy). In addition free-association may be inappropriate for obsessive-compulsive patients and transference may encourage further dependency in depressed patients.

What are the costs and benefits? – Psychoanalysis offers a therapy distinct from most other therapies and, using certain criteria, can produce progress and self-reports of improvement (although the latter, as with all therapies, may just reflect the patients' and therapists' justification of the time and effort they have committed). In terms of costs, the need for long-term analysis makes psychoanalysis very expensive and time consuming, although shorter versions have been developed, e.g. Malan's Brief Focal Therapy. Ethically speaking psychoanalytic therapy can be distressing for the patient (some say it can be counter-productive for schizophrenics because of its emotional stress) although it is not the only therapy with negative side effects. In terms of therapist-patient power and control the therapy involves complete trust in the interpretations of the analyst. Because of the concept of unconscious resistance, the therapist may directly or indirectly discourage the patient's right to withdraw from therapy since refusing or leaving therapy could indicate ego defence to progress in uncovering hidden truths.

17.8 Psychotherapy – cognitive therapies

AIMS OF THERAPIES

To cure or alleviate the underlying mental causes of disorder by restructuring the maladaptive thought processes that are causing it. Cognitive therapies aim to alter the way people think about themselves and their environment, to prevent illogical or irrational thoughts and to enable thought to control behaviour and emotion. Cognitive therapists concentrate on current thinking.

TECHNIQUES

There are a variety of cognitive behavioural therapies that differ in technique and directiveness. All, however, aim to alter thought processes (the cognitive part) and monitor the effectiveness of this on everyday behaviour or in role play situations (the behaviour part).

Beck's cognitive restructuring therapy

Beck's therapy (Beck *et al.*, 1979) involves the identification and restructuring of faulty thinking as a collaborative process between the client and therapist. The therapist challenges the client's assumptions by gently pointing out errors in logic and contradictory evidence in their life and letting the client decide for themselves whether their thinking is accurate.

Ellis's rational emotive behaviour therapy

Ellis's therapy (Ellis, 1962) involves identifying generalised irrational and false beliefs (such as 'I must be successful at everything I do' or 'I must be liked by everyone') and forcibly persuading the client to change them, often through reality testing, to more rational beliefs.

Meichenbaum's self-instructional training

Meichenbaum (1975) assumes many problems are caused by negative, irrational and self-defeating inner dialogues – individuals may talk themselves into maladaptive behaviours with internal thoughts such as 'I can't do this' or 'something is going to go wrong'. The therapy identifies these maladaptive inner dialogues and gets the client to substitute them for better inner statements such as 'I can do this' by verbally repeating them until they become internalised, natural, and self guiding.

Kelly's personal construct therapy

Kelly's (1955) therapy is based upon his theory of personality. The client's personal constructs (ways of seeing the world) are identified through the use of the Repertory Grid technique and then altered or 'loosened' so they become more accurate or functional.

APPLICATION

Cognitive therapies have been applied to treat a variety of mental disorders including:

- **Depression** – Beck's therapy aims to correct the cognitive triad of negative thoughts about the self, the environment, and the future.
- **Anxiety disorders** – Beck's therapy and attribution training have been used to counter panic attacks and phobias.
- **Impulsive children** – Meichenbaum's self instructional training has been used to internalise dialogues of self-control.
- **Stress** – Meichenbaum has also applied his ideas to stress management in industry.
- **Schizophrenia** – Cognitive therapists, such as Beck, have even tried to help schizophrenics cope with, if not remove, their delusions and hallucinations.

EFFECTIVENESS

With depression, cognitive therapies have been shown to be just as effective as drug therapy – some studies have even reported higher success rates. Perhaps more importantly, lower relapse rates are gained if cognitive therapy is used in conjunction with medication.

Anxiety disorders also respond well to cognitive behavioural therapy although some research indicates that they are not superior to pure behavioural techniques, such as systematic desensitisation in some cases.

APPROPRIATENESS

Ellis's therapy is more forceful and directive than the others, but generally cognitive therapies aim to empower the patient with self-control strategies. Although cognitive behavioural therapies emphasise thought processes, they do tackle all aspects of a problem and are thus more complete in their approach. As Ellis's (1993) 'ABC' principle illustrates, many therapists assume that an activating event (A), such as being rejected for a job, directly causes an emotional consequence (C), low self-esteem. However, in reality it is often the intervening belief (B), such as 'I am suitable for all jobs', that is responsible for the emotional effect.

17.9 Difficulties assessing treatment

DIFFICULTIES ASSESSING EFFECTIVENESS

WHAT DO WE MEAN BY AN EFFECTIVE TREATMENT?

To consider how effective a treatment is, one must first define what its aim is. Some treatments aim to 'cure' the individual (e.g. flooding for phobias) while others seek only to alleviate or control the disorder (e.g. drugs for schizophrenia).

One major problem, however, is that different therapeutic approaches have different ideas about what constitutes a 'cure' – for behavioural therapists the removal of maladaptive responses may be sufficient, but for psychoanalysts an underlying unconscious solution must be found, regardless of current behaviour. Indeed, given Freud's quantitative views on abnormality, we may all be neurotic to some extent and so a cure may only involve 'reducing neurotic misery to common unhappiness'.

Relapse rates must also be considered when assessing effectiveness – how long should a cure last?

HOW DO WE KNOW WHEN WE HAVE CURED?

There are several difficulties involved in assessing when a treatment has been effective:

- Generalisability – an individual may appear cured in the controlled conditions of the clinician's place of work, but sometimes relapse will occur when the individual returns to the real world. For example, people exposed to token economy systems often do not generalise their improved behaviour, and alcoholics treated with aversion therapy often relapse when returned to public life.
- Monitoring effectiveness – who decides when a treatment has been effective – the therapist or the client? Both the therapist and the patient want to see success and may therefore make type one errors in assessment. The patient may show the 'hello-goodbye' effect, exaggerating their disorder at the beginning to ensure they are taken seriously, and exaggerating their recovery at the end of therapy out of gratitude. Psychometric tests used to monitor improvement may be unreliable.

HOW DO WE KNOW WHAT MADE THE INTERVENTION EFFECTIVE?

There are many factors, other than those the therapy intends, that could affect recovery, such as:

- spontaneous remission – many disorders disappear themselves, without any treatment and, in some cases, without reappearing again. Estimates of spontaneous recovery vary according to the disorder but overall it is generally thought to occur in around a third of all cases.
- mere attention – it has been suggested that just the increased attention and support from another can lead to improvement (the Hawthorne effect). In addition the expectation of recovery can cause self-fulfilling prophecy.

For the above reasons control groups are needed to test therapy effectiveness, e.g. using placebos in drug testing.

ETHICAL ISSUES OF INTERVENTION

TREATMENT VS. NO TREATMENT

The first ethical decision that has to be made, concerns whether treatment should be administered, given that:

- there is a chance that spontaneous remission will deal with around a third of all cases anyway.
- there are potentially many costs involved in intervention, such as money, time, and side-effects.
- some therapies, such as psychoanalysis, have been accused of being less successful than spontaneous remission.

POWER AND CONSENT

One of the most difficult ethical problems involves the issue of power in the therapist-patient relationship.

- Treatment may be enforced if the patient is sectioned under the Mental Health Act (1983).
- The choice of goals in some therapies is determined by the therapist or the norms of society, not the patient. This is especially relevant in psychoanalytic therapy where the patient has to accept the therapist's interpretation.
- The therapist may deem it necessary to discourage the patient from exercising their right to withdraw – for example when close to the unconscious 'truth' in psychoanalytic therapy, during flooding, or when forcibly restructuring thoughts and perceptions in rational emotive therapy.

SUFFERING VS. SUCCESS

Many therapies involve making decisions between success and suffering. Drugs and electroconvulsive therapies can cause many unpleasant side-effects or even death. However, their use could be potentially very beneficial – preventing greater suffering from the disorder or suicide (especially in cases of depression).

TESTING ON HUMANS

Many therapies have to be tested on humans rather than animals for validity. However,

- should patients be given new treatments whose mode of action is unknown? Even in the case of ECT, which has been used for many years, its reason for effectiveness is unknown.
- should patients be allocated to control groups with no treatment? Should not every patient have the right to the best treatment available?

CONFIDENTIALITY

Should the patient's disorder be made publicly known, given the stigmatising effects of labelling in our society?

17.10 Community care and counselling

CARE IN THE COMMUNITY

WHAT IS IT?

Care in the community involves providing treatment and support for those suffering from mental disorder under **more socially integrated**, naturalistic and less controlling conditions, rather than in long-term institutions, wherever possible.

While those with very serious disorders or those who represent a danger to themselves and others (see 'sectioning' under the Mental Health Act, 1983) may require round the clock care, support and control, others may benefit from varying degrees of these factors. Care in the community can therefore take the form of:

- **Short-term inpatient care** in local hospitals or **residential treatment programs** – these involve high degrees of support, control and/or therapy, but for shorter periods than in long-stay institutions.
- **Half-way houses**, **'family group' homes**, **night-care** or **sheltered housing** – these involve higher degrees of support and less official therapeutic measures, but are still tied to less socially integrated residential arrangements. Individuals can indulge in productive and everyday activities during the day, e.g. employment, but still live with others with mental health difficulties and access to support is usually on hand from health care staff.
- **Home care** (ideally with respite care arrangements), **day-care**, **outpatient therapy** at local hospitals or **drop-in centres** – these involve socially integrated independent residence or home residence with relatives, with some access to therapy.

THE ORIGIN AND DEVELOPMENT OF COMMUNITY CARE

Community care in Britain and the USA developed as a response to:

- the many problems of long-term institutionalisation for the mentally ill (see Rosenhan's 'On Being Sane in Insane Places' study)
- a humanistic questioning of the motives behind institutionalisation (e.g. who does it benefit – society or the mentally disordered?)
- financial pressures to find a more efficient use of tax-payers' money (institutions are supposedly more expensive to run, but of course this depends on the quality of community care provided).

In the USA the Joint Commission on Mental Illness and Health began an examination of state hospitals in 1955 and advised in 1961 that no more large institutions be built for the mentally disordered since their function seemed largely custodial rather than therapeutic. In 1963 President Kennedy advanced the Community Mental Health Centres Act that began to implement the Commission's recommendations.

In Britain the trend towards community care and deinstitutionalisation began later, with the first serious changes beginning in 1980 when long-stay institutions for the mentally disordered were phased out. In 1990, The Community Care Act put into legislation the idea that local authorities should be responsible for community care provision and should encourage private and voluntary agencies to provide domestic, day-care and respite care (for relatives looking after those with mental health problems) services.

EVALUATION OF COMMUNITY CARE

Advantages

- The therapeutic rationale for community care is that more normal living conditions and social integration will encourage greater independence, self-care skills, social skills, self-esteem, and 'normal' and productive interactions, activities, relationships and behaviour, compared to care in institutions.
- The various methods of community care can more flexibly meet individual needs and abilities since mental health problems differ in severity between individuals and over time. Work, friend and family relationships can be more readily maintained.

Disadvantages

- Problems are encountered in assessing, monitoring and financing individuals' mental health needs.
- The difficulties of diagnosing and treating mental disorders as well as insufficient government funding and local authority provision means some individuals may not receive all the support, control or therapy they need without the necessary contact with health professionals.
- Practically, stigmatisation and prejudice against the mentally disordered may make social integration difficult. This is not helped by media publicity of the comparatively rare cases where released mentally disturbed individuals have attacked or murdered others.
- Home care may become unbearably stressful for both relatives and the mentally disordered.
- The above problems may lead to patients dropping out of care/not taking medication and becoming homeless.

THE GROWTH OF COUNSELLING

WHAT IS IT?

According to Nelson-Jones (1982), counselling can be viewed as:

- **A helping relationship** – provided by a counsellor who creates 'core conditions' for therapy through certain skills and attitudes.
- **A set of activities or methods** – based on therapeutic principles derived from psychological theories.
- **An area of special therapeutic focus** – catering for the needs of the less seriously disturbed.

'Counselling psychology is an applied area of psychology which has the objective of helping people to live more effective and fulfilled lives. Its clientele tend to be not very seriously disturbed people in non-medical settings. Its concerns are those of the whole person in all areas of human psychological functioning, such as feeling and thinking, personal, marital and sexual relations, and work and recreational activity' (Nelson-Jones 1982).

THE ORIGIN AND DEVELOPMENT OF COUNSELLING

Counselling developed from ***psychological approaches*** (humanistic, psychodynamic and behavioural learning) that were strongly concerned with how the individual is influenced by, and adjusted to, their ***social environment*** (e.g. family, friends, partner and work relations). Counselling became more distinguished from clinical psychology and psychiatry in the USA and Britain with the establishment in 1947 of the American Psychological Association's 'Division of Counselling and Guidance' and the creation of the British Association of Counselling in 1977. It has become ever more prevalent and has been applied to marital, family, accident, bereavement and educational problems.

EVALUATION OF COUNSELLING

Advantages

Compared with clinical psychology, counselling psychology:

- Focuses more on ***social contexts*** and relationships rather than problems within individuals. Thus counselling may involve relatives and partners not just the individual with problems.
- Emphasises well-being and fulfilment rather than sickness and maladjustment – looking for what is right and how to use it, rather than what is wrong and how to treat it (Super, 1977).
- Is more proactive – it can be applied to prevent or limit the development of problems, e.g. trauma counselling, rather than just responding to already developed problems.

Limitations

- Not always suitable on its own for more severe mental disturbance.