Module:
Mental Health in the Community

Week 4
Psychosocial approaches to care in the community

Topic 1
Psychological approaches I: Individual therapies – Part 1 of 2

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Lecture transcript

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Before we start thinking about psychological and psychosocial approaches to mental health, it's useful to spend a couple of minutes exploring the definition of mental health and mental illness in the current socio-economical context. It is quite important because over the years there has been a shift, and we look at what that shift has meant in the next couple of minutes. So in the previous lectures, you have explored the changes in the conceptualisation of mental health over the centuries, and this is also reflected in the current DSM-5 definition of mental illness.

The DSM-5, which is the handbook for diagnosing mental disorder, defines mental disorder as, 'a clinically significant disturbance in cognition, emotional regulation, or behaviour that indicate a dysfunction in mental functioning that are usually associated with significant distress or disability in work, relationships, or other areas of functioning'.

Now, as I said, this definition is important because, as I just mentioned, over the years there has been a shift from a more compartmentalistic way of thinking, to a much more holistic approach that actually emphasises that psychological distress is multifactorial, and that can present itself in many different aspects, and it can have an impact on several areas of a person's life. So, for example, if we look at the DSM definition, there is an acknowledgement that the disturbance can be both in cognition, emotional regulation, or also behaviour, and that the disability or the distress can actually appear in very different formats, and it can have an impact in an individual's ability to work or an individual's ability to form or maintain relationships or in other areas of functioning.

Now, this is important because actually, earlier psychological approaches to mental illness were not so forthcoming in considering multiple factors. Many, instead, focused only on one main aspect that was believed to be responsible for the development of psychological distress.

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So, for example, the psychoanalytic model-- which is the theory of the development and the organisation of personality that guides psychoanalysis and which is a clinical method that was used for treating psychological distress-- had a very different approach.

Now the psychoanalytic theory was first laid out by Freud in the late 19th century. It has actually undergone many refinements since his work, and its validity is now widely disputed or often also rejected. It adopts a deterministic view of human nature and argues that human beings are actually driven by irrational forces, biological and instinctual drives, and also unconscious motivations. Now given these assumptions, the psychoanalytic model focuses and really emphasises the need to

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explore the unconscious.

Now, Freud argued that human beings are dominated by two basic instincts. He spoke about Eros, which is the sexual drive or the creative life force, and Thanatos, which is the opposite force, which is the death force or destructiveness force. Eros represents life, it represents creativity, it represents growth. Thanatos represents destruction and death. According to Freud, we fight constantly in order to balance these energies.

Now, in order to understand the psychoanalytic stance in respect to the aetiology of mental illness, it's really important to consider Freud's approach to the development of personality, which argues that personality is shaped through sexual stages. During each stage, a child is presented with a conflict between biological drives and social expectations. Successful navigation of these internal conflicts will lead to mastery of each developmental stage, and ultimately, to a fully mature, healthy personality. When an individual fails to navigate these stages or becomes fixated at a stage, unhelpful behaviours can develop. And, for example, we'll have a look at the chart in a minute, and we'll see how individuals can actually get stuck at a certain point, and how that can give rise to psychological distress.

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So if we look at this chart, for example, the first stage is the oral stage. That goes between birth and one year old, and the erogenous zone is the mouth. Successful navigation of this stage will lead the child to move on to the next stage, which is the anal stage. However, the failure to successfully navigate this stage will actually lead to consequences, and the consequences can be an overly aggressive personality or an overly passive personality; and that, in itself, can result in either a passive, gullible, immature, or manipulative personality.

Similarly, the anal stage, which is the second stage that goes between the age of one and three years old, the erogenous zones are the bowel and bladder elimination. Failure to successfully navigate this stage can result in either an obsessively organised or excessively neat personality. If the individual gets stuck at the anal expulsive stage, then the personality results in a reckless, careless, defiant, or disorganised personality.

And so on.

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Freud's psychosocial theory of development sets the ground for how our personalities develop and for possible causes of psychological distress. However, it was only one of five parts of his overall theory of personality. In fact, he also believed that different driving forces develop during these stages. So for example, Freud argued that the personality consists of three different elements: the id, the ego and the super-ego.

The id is the aspect of the personality that is really driven by internal and basic drives and needs. These are typically instinctual, such as hunger, thirst, and the drive for sex. The id acts in accordance to the pleasure principle in that it really avoids pains, and it seeks out pleasure. It wants whatever feels good at the time, with no consideration for others.

So for example, if we think about a child or a young infant, when an infant is hungry, the id wants food. And therefore, the infant cries. When the infant needs to be changed, the id cries. When the infant is uncomfortable, in pain, too hot, too cold, or just wants some attention, the id actually cries. They id doesn't care about reality. It doesn't care about the needs of anyone else, only about his own satisfaction. And so again, if we think about babies, they don't care if their parents are sleeping, relaxing, eating dinner, or bathing. When the id wants something, nothing else matters.

Now due to the instinctual quality of the id, it is very impulsive and is often unaware of the implication of actions. But as the child interacts more with the external world, the second part of the personality begins to develop, and Freud called this part the ego. Now the ego is based on

the reality principle. The ego understands that other people have needs, desires; and it works to achieve the id's wishes in the most realistic ways. It's a bit of a compromiser.

By the age of five, the super-ego develops, Aad the super-ego is the moral part of us that develops due to the moral and ethical restraints that are placed on us by our caregivers and by society at large. So in fact, for this particular quality, many equate the super-ego with the conscience, as it dictates right and wrong. Now, in a healthy person, according to Freud, the ego is the strongest. So it can satisfy the needs of the id, not upset the super-ego, and still take into consideration the reality of every situation.

According to this model of personality, these particular forces should be in a state of dynamic equilibrium, and a lack of balance will actually cause conflict between these parts, and it will cause an individual to suffer from psychological difficulties. And so for example, if the id is out of control, the person will be extremely impulsive. If the super-ego is too strong, the person might be overcritical and rigid, and they might also develop depression.

So when the ego is not in control through direct methods, it can also resort to operating on an unconscious level by distorting reality through ego defences.

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While the ego dwells in the conscious mind, the id and the super-ego dwell in the area of our unconscious. Now Freud believed, as we just said, that the majority of our inner experiences, emotions, beliefs, feelings, and our impulses are not really available to us on a conscious level, and he believed that most of what drives us is actually buried in our unconscious.

However, the unconscious is only one part of the model. Freud also believed that everything we are aware of is stored in our conscience. Our conscience makes us a very small part of who we are. In other words, at any given time, we are only aware of a very small part of what makes our personality. Most of what we are and most of what we know is actually buried and is inaccessible.

Now for this particular reason, Freud's theory has been equated to an iceberg. Where the majority of our urges, needs, wishes, experiences lay under the water's surface, and only a tiny bit lies on top of the water. But there is also another aspect to this model. It is what we would call the pre-conscious level, which is the amount of information that is not readily accessible, but that we can actually retrieve it if we put our mind to it. Now, according to this model, our personality should be in a state of dynamic equilibrium, and a lack of balance will actually cause conflict, and again, will cause an individual to suffer from psychological difficulties.

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Developing from psychoanalytic principles is object relations theory. Object relations theory is a branch of psychoanalytic theory that actually emphasises interpersonal relationships primarily in family and especially between mother and child. Now 'object' means other, and especially a significant other. 'Relations' refers to interpersonal relationships. Now, object relations theory has its roots in psychoanalytic principles.

However, it places less emphasis on biological drives and much more importance on interpersonal relationships. Also, while Freud's theory is quite paternalistic when thinking about penis envy, object relations theory tends to really emphasise more the significance of the mother. There are many other contributors to object relations theory and many are very influential. However, for the sake of this lecture, we will only look at Melanie Klein and Winnicott and their approach to the development of mental distress.

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And so Melanie Klein was post-Freudian, and she was really described as the mother of object relations. She worked extensively with mothers and babies and was particularly interested in the

early causes of psychosis. Now according to her, the first six months are crucial for the healthy development of the infant's ego. Klein suggests that infants suffer a great deal of anxiety, because it's caused by their innate aggressive and destructive instincts. Within 0 to three months, the baby is only able to relate to its mother and the external world in part objects.

Now this is the stage that is called the paranoid-schizoid position. The infant projects out his loving and hating feelings, which can be equated to the life and death instinct. And the infant projects them out into separate parts of the mother or 'the breast', as Melanie Klein calls it. Now the result is that the maternal object is divided into 'bad breast'-- the mother that is felt to be frustrating, persecutory, and is hated-- and a 'good breast'-- the mother that is loved, and felt as beloving, and gratifying.

The good and bad object cannot exist together. For example, when the infant is hungry and the breast appears to meet the child needs, then this is perceived as a good breast. However, should the breast not appear immediately, then the infant perceives the breast as bad, and the infant fantasises its destruction. Now in this phase, the ego is also split, and splitting allows good to stay separate from bad. Projection is really an attempt to eject the bad in order to enable the infant to take in and to hold on to the good enough experience to provide a basis for integration.

Now, it's the mother's continued survival of the child's murderous attacks that allows the infant to eventually progress to the next phase, which is called the depressive position. Now the depressive position is what we should all aspire to and is roughly between three to six months, and it is when the infant is able to relate to objects as whole objects: so good and bad, love and hate. We don't necessarily just love someone, at times they might irritate us; and it's really this ambivalence that characterises this position. So the baby becomes capable of ambivalence. They don't need to resort to splitting anymore. They can both love and hate the object. The infant becomes aware of their own destructive impulses, and fearing the loss of his object's love by his own destructiveness, perceives guilt, and really attempts to inhibit the destructiveness and attempts to reparate. Now according to Klein, these are normal healthy developmental stages. However, a lack of a successful navigation towards them will lead to psychological and psychiatric distress.

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The other contributor to the object relations theory that we'll look at today is Donald Winnicott. Winnicott also emphasised the vulnerability of the infant and the need for the caregiver to provide a good holding environment. Winnicott speaks of a good-enough mother who develops a state of heightened sensitivity during pregnancy, and that continues to be maintained for some weeks after the baby's birth. When this heightened state passes, the mother has what Winnicott calls a 'flight insanity,' and she begins to be aware of the world which exists outside of her state of primary maternal preoccupation.

However, the good-enough mother continues to provide a predictable, constant, safe, and holding environment. The good-enough mother provides physical care and meets her baby's needs not only on a physical level, but also on an emotional level, and she provides emotional warmth and love. She also protects her baby against those murderous parts of her. Now, Winnicott says there isn't such a thing as a 'baby', and he tries to really emphasise the state of complete symbiosis that the infant and the caregiver find themselves in the early stages of the baby's life.

Now initially, the carer's role is to support that illusion of symbiosis, but then to gradually and carefully allow disillusionment by really failing to adapt to the baby's needs. It is this process that will eventually allow the child to realise their own and the caregiver's individuality, a bit like the 'me' and 'not me' experience. The separation happens through play and through the use of a transitional object, which is the first known 'me' possession.

Now, Winnicott thought that psychological difficulties start early in infancy-- when the environment is not holding and/or when the mother fails to meet the needs of the baby, and when she fails to provide a reasonably attuned caregiving, and she fails to protect the baby from experiencing overwhelming distress, whether that's emotional or physical. Now for this particular reason,

Winnicott has sometimes been criticised for putting mothers on the 'naughty step,' because it suggests that actually when the environment is not holding, when the mother is not good enough, that can lead to the development of a false sense of self which then, in turn, can give rise to emotional distress.

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Another important figure that we need to consider is John Bowlby, and John Bowlby is also a very important person who views the relationship with the caregivers as truly crucial for the development of a healthy individual and/or for the developmental psychological difficulties. Now, his work is probably affected by his own early life experiences and his early working experiences, which have been crucial in shaping his interest in early life relationships. So for example, Bowlby was raised by a nanny, as was customary at the time, and the nanny left when he was four years old, and he spoke of grieving her as a mother figure when she departed.

He was also sent to a boarding school, which was quite customary at the time. But he spoke of this experience as something that he would 'not wish upon a dog'. Now important working experiences prior to his training in psychiatry, were the encounter with two boys: one who was extremely anxious and who was referred to as Bowlby's shadow, because he would follow him everywhere, and another boy who was quite affectionless and really quite prone to stealing. Bowlby noticed that the common thread was the lack of a reliable mother figure.

Hence, he focused his subsequent work with children who had been separated from their primary caregivers through hospital admission and/or with children who had been institutionalised. The result of these observations really prompted him to argue that in order to grow up mentally healthy, the child should experience a warm, intimate, and continuous relationship with his mother. Now Bowlby suggests that human beings have an innate ability to bond with one another, and he coined the term 'attachment' to describe this bond. He described attachment as 'a strong disposition to seek proximity to and contact with a specific figure and to do so in certain situations, notably, when frightened, tired, or ill'. And he spoke of lasting psychological connectedness.

Now Bowlby argued that it was this attachment, which is an innate primary drive, rather than a secondary drive, which was derived by the association of mother with providing for his physiological needs, as psychoanalytic theorists said. He argued that the quality and nature of this bond was crucial for social, cognitive, and emotional development, and it was the basis for the future capacity to build relationships. In fact, attachment theory suggest that the child's attachment experiences with their primary caregiver leads to the development of an internal working model. Now, the internal working model is a bit like a cognitive framework, a prototype for subsequent relationships.

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So for example, if we look at the internal working model, a child's experience of being cared for in early life will become a prototype for the future expectations on how they will relate to others and how others will relate to them. So if their initial experiences are of being cared for and being loved, they will develop secure attachment style, and their understanding would be that individuals are available, they might be caring, they might be loving, and that he, himself, is a lovable and likeable person. They will also develop an understanding of themselves in relation to others as being effective.

Now on the contrary, if their initial experience is of being unloved, rejected, or even abused, they will develop a sense of self of being unlovable and unlikable. They will develop a sense of others as being rejecting, possibly not emotionally available, and they will develop an attachment style which will be insecure and avoidant. Similarly, if there were early life experiences of a caregiver who is overly intrusive, a bit confusing, sometimes available, sometimes not available, then they will develop an insecure attachment style, and they might develop an attachment style characterised by ambivalence and resistance. So according to Bowlby, the causes of psychological distress lies in the early life experiences with the primary caregiver and an individual's attachment style.