

Lecture 10: Psychoanalysis & Psychological Disorders

Housekeeping

- Assignment due next Monday
 - Paper and hard copy please
- Tests here for after class
 - Will try and go over some answers in class

Chapter Outline

1. The psychodynamic perspective
2. Defining, classifying, and diagnosing psychological abnormality
3. Models of abnormality
4. Mood disorders: depression, bipolar disorder

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Why Bother with Freud?

- Ground work for all contemporary theories
- Very comprehensive understanding of psychological problems
 - Tried to explain **all aspects** of human behaviour
- Contemporary theorists tend to distance themselves from it, but he is still very present in all of the work we do

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Defining Personality

- **Personality** refers to the unique characteristics that account for enduring patterns of inner experience and outward behaviour
 - A collection of stable states and characteristics
 - Varies from one individual to another

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Freud and Psychoanalytic Theory

- Based on his clinical practice (seeing patients), he decided that people are influenced by their “unconscious”
 - Developed psychoanalysis—type of therapy based on his theory of discovering one’s unconscious
 - One of the first to state that the parent-child relationship influences how people feel about themselves and how they handle intimacy as adults

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Freud's view of personality

- Personality forms as a result of the struggles between primal needs and social or moral restraints
- Personality is shared by interacting, constantly fighting forces

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Freud's view of personality

- **Conscious**—the thoughts and feelings that we are aware of at any given moment
- **Preconscious**—holds memories or feelings that we aren't consciously thinking about, but can be brought to consciousness
 - E.g., what you had for breakfast yesterday
- **Unconscious**—holds memories or feelings that are so unpleasant or anxiety provoking that they are repressed



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-can't access unconscious
 -we store things in the unconscious because we cannot tolerate those thoughts

The Forces of Personality Development

- Three forces that influence who we are:
 - ID, ego, superego
- **ID:** present at birth, basic instinctual and primal needs
 - Eating, sleeping, sex, comfort
 - **Pleasure principle:** constant strive for gratification
 - (everything with respect to the ID is at least a little bit sexual)
 - Sexual energy (libido) drives the ID

ID is like the last component of personality

The Forces of Personality Development

- **Ego:** develops throughout childhood
 - Wants to satisfy impulses, but in a way that is realistic and concerned about consequences socially
 - **Reality principle:** it isn't always possible or acceptable to have all wants and desires met
- **Superego:** forms during childhood
 - Interested in what is socially acceptable to express openly and what is unacceptable
 - Develops from internalizing cultural values and norms
 - Fixated on morality, social acceptability, etc.
 - "Conscience"

-ego is the thing that helps you act more realistically and functionally

-superego is the polar opposite of ID

-it focuses on anything socially acceptable

Development of Personality: Psychosexual Stages

- Children progress through specific developmental stages
- As they progress, they have new primal needs and experience new social constraints
- They need to reconcile each stage to progress to the next one, or else they get "stuck" and become "fixated"

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Psychosexual Stages

1. Oral (linked to the mouth): 0–18 months, pleasure derived through oral satisfaction
 1. Sucking on a bottle and weaning
 2. IF stuck at this phase: continued dependence on mother, focused on pleasures of the mouth (e.g., someone with a binge eating problem)
2. Anal (linked to anus): 18 months–3 years, area of pleasure is focused on the anal region
 1. Going to the bathroom and toilet training
 2. IF stuck at this phase: excessively neat and orderly, rigid, stubborn

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Psychosexual Stages

3. Phallic (linked to genitals): 3–6 years, seek genital stimulation, attraction to opposite-sex parent

1. Boys focus on penises, women apparently are upset about not having penises (*penis envy*)
2. Oedipus complex: boys have sexual attraction to mother and jealous rage towards father (opposite for girls = Electra complex)
3. Boy worries about penis being cut off (castration anxiety)

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ID wants this but superego is like no

Psychosexual Stages

5. Latency: 6 years to puberty, repression of sexual impulses and identification with same-sex parent

5. No fixations
6. Genital: Puberty–adult, at puberty, latency gives way to experiencing sexual attraction to opposite sex and establishing mature relationships
5. IF FIXATED: sexual dysfunction and unsatisfying relationships

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Anxiety and Defense Mechanisms

- These internal conflicts result in anxiety
- But we can't always handle the anxiety- it is too much!
- So we develop methods of keeping the anxiety at bay
- **Defense mechanisms:** unconscious tactics employed by the ego to protect the individual from anxiety

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Defense Mechanisms

- **Repression:** “repressing” unpleasant thoughts
 - “repressed memories”
- **Denial:** refusing to recognize something difficult
 - If someone passes away refusing to acknowledge their death or your grief
- **Reaction formation:** acting opposite to unacknowledged unacceptable impulses
 - Frenemies
- **Projection:** transferring unacceptable qualities or impulses to others
 - E.g., a client who believes she is worthless assuming the therapist thinks she is worthless

-we can repress anything which is unpleasant

Defense Mechanisms

- **Displacement:** diverting impulses to a more acceptable target
 - Beating up a punching bag when mad at your brother
- **Sublimation:** channeling socially unacceptable impulses into acceptable ones

sublimation - if somebody has an impulse to sleep with someone they shouldn't and then they take up knitting. all those impulses they had get channeled to a certain behaviour

Defense Mechanisms

- **Regression:** reverting to immature ways of responding
 - #elbowgate anyone?
- **Intellectualization:** ignoring troubling emotional aspects by focusing on abstract ideas
 - Getting hung up on work details when grieving

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Problems with Freud?

- No empirical support
- Not actually testable
 - E.g., you're repressing desires for your mother... can you DISCONFIRM or CONFIRM something that you're not conscious of?
 - Explain and nothing
- Based entirely on case studies
- Can explain things retrospectively, but not really predict anything
- Small select populations (upper-class Viennese people)
- Sexist and very heteronormative

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Freud Wrap Up

- Three domains of consciousness:
 - Conscious (thoughts we're aware of in any moment), preconscious (things we can access but aren't currently thinking about), unconscious (memories, feelings, thoughts beyond our access)
- Components of personality: ID, ego, superego
- Development involves passing through five psychosexual stages: oral, anal, phallic, latency, genital
- Defense mechanisms arise to help us manage internal conflicts and anxieties (e.g., repression, denial)

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PSYCHOLOGICAL DISORDERS

Psychological Disorders Outline

1. What makes something “abnormal”?
2. Models of psychopathology
3. Mood Disorders
 1. Depression & Bipolar Disorder

WEDNESDAY:
Anxiety disorders, PTSD, Eating disorders, Borderline Personality Disorder, Schizophrenia

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One in Five

- One in five people will have a psychological disorder at any given point in time
- But even if you don't have a psychological disorder, everyone will experience their features
 - Sad, low mood
 - Thoughts of worthlessness
 - Low self-esteem
 - Stress, feeling tension
 - Worrying about what other people think about you
 - Body image issues
 - Difficulties relating to other people

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What Makes Something A Psychological Disorder?

- **Deviance:** deviating from societal norms.
 - Very culture based, value based
- **Distress:** behaviours, ideas, emotions must cause distress to that individual or others

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What Makes Something A Psychological Disorder?

- **Dysfunction:** behaviour that interferes with ability to function

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What Makes Something A Psychological Disorder?

- **Danger:** posing threat to self or others
 - Though violence to others is rare and people with mental illness are more likely to be victims of violence than perpetrators

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What Makes Something A Psychological Disorder?

- **Abnormality and Normality** lie on a spectrum
 - "Eating healthy" → Dieting → Disordered eating
 - Feeling nervous or awkward in social situations → social anxiety disorder
 - Even some occasional hallucinations/delusions are relatively normal
 - You **will** have some of the experiences we discuss, you don't necessarily have a disorder
- **Pathology is contextual**
 - Gandhi has starved himself for long periods of time
 - People have set themselves on fire in protest

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Classifying and Diagnosing Psychological Disorders

- **Symptoms:** physical, behavioural, or mental features indicating a problem
- Clinicians have attempted to examine which symptoms co-occur to identify what may make up a particular mental disorder
- **Diagnoses are human-made**

The diagram shows a collection of symptoms: Worry, Anxiety, Muscle tension, Difficulty concentrating, Irritability, Fatigue, Feeling "keyed up", on edge, Insomnia, Suicidal thoughts, Depressed mood, Loss of interest in pleasurable things, Appetite changes, and Worthlessness. A blue line groups Worry, Anxiety, Muscle tension, Difficulty concentrating, Irritability, Fatigue, Feeling "keyed up", on edge, and Insomnia, with the label "GENERALIZED ANXIETY DISORDER" below. A red line groups Suicidal thoughts, Depressed mood, Loss of interest in pleasurable things, Appetite changes, and Worthlessness, with the label "DEPRESSION" below.

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Classifying and Diagnosing Psychological Disorders

- Because diagnoses are human-made, there are different systems of diagnoses (which don't always agree!)
- **International Classification of Diseases (ICD):** World Health Organization
 - Now on their 10th edition. Predominates in Europe
- **Diagnostic and Statistical Manual of Mental Disorders (DSM):** American Psychiatric Association
 - Book says current version is DSM-IV-TR, but DSM-5 actually came out in 2013

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Classifying and Diagnosing Psychological Disorders

- **Diagnosis:** determination that a person's cluster of symptoms matches with that of a particular disorder's
 - Means that people's symptoms are consistent with other individual's symptoms
- Could feel dehumanizing, invalidating, pigeonholing, or become a self-fulfilling prophecy

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The Diagnostic Axes of DSM-IV-TR

- Full diagnostic assessment means gathering information about more than psychological functioning

AXIS-I	<ul style="list-style-type: none"> • Most psychological disorders • "Recognizable point of onset and realistic probability of recovery"
AXIS-II	<ul style="list-style-type: none"> • "Longer-term disorders" (personality disorders and mental retardation) • "Complicates" the axis-I disorder • BS ALERT!!
AXIS-III	<ul style="list-style-type: none"> • Medical problems
AXIS-IV	<ul style="list-style-type: none"> • Major stressors in the client's life (e.g., divorce, death of family member)
AXIS-V	<ul style="list-style-type: none"> • Global assessment of functioning from 0-100

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A note on the multi-axial system

- Many axis II disorders (e.g., borderline personality disorder) DO have a "realistic probability of recovery"
 - Communicating otherwise to patients is damaging
- The notion that an axis II disorder "complicates" an Axis I treatment is problematic
 - Rests on notion that our clients are interfering with our treatments, when really our treatments are not adequate for those clients
 - E.g., trying to treat a spider phobia of a chronically suicidal woman with borderline personality disorder...
- DSM-5 no longer uses this multi-axial system

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Criticisms of the DSM

- Not all disorders are based solely on scientific data
 - E.g., very little research on dissociative identity disorder and yet it still is in the DSM
- Value laden
- High level of **comorbidity**: a person has two or more diagnoses

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Summary

- DSM is prominent diagnostic “bible” for clinicians
 - DSM-5 most recent edition
- Used to have five axes of functioning: axis-I disorders, axis-II disorders, health, psychosocial, and global functioning
- DSM criticized for being value laden, yields high levels of comorbidity

Models of Abnormality

Models of Abnormality

- Different ways of understanding how psychological disorders come about
 - Neuroscience model
 - Psychodynamic model
 - Cognitive-behavioural model
 - Sociocultural model

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The Neuroscience Model

- Views disorders as illnesses caused by a malfunctioning brain
 - Genetic inheritance
 - Mood disorders, schizophrenia, mental retardation, Alzheimer's
 - Too few or too many of certain types of neurotransmitters
 - Insufficient norepinephrine and serotonin in depression
 - Viral infection
 - Fetal or childhood exposure and schizophrenia
 - Hormones
 - Excess cortisol in depression
 - Specific brain structures
 - Huntington's disease and loss of cells in the striatum

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The Neuroscience Model

- Not all problems can be solely explained by looking at brain activity
- Many problems may actually change brain activity rather than the other way around
- Neuroscience model can neglect interplay of biological and non-biological factors
 - E.g., childhood abuse, life stressors, beliefs about the world, classical conditioning

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Cognitive-Behavioural Model

- Prominent model in psychology
- Believes that problems arise from an interplay of problematic thoughts, emotions, and behaviours
- Pioneered by Aaron Beck
- **Two big components: cognition and behaviour**

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Behavioural Principles

- What are the two major learning processes that can play a role in psychopathology?
 - Classical and operant conditioning
- We acquire normal behaviours the same way we acquire abnormal behaviours
- **CC:** Fred almost fell off a roof in his 20s and felt terrified. Now whenever he goes near a roof he feels terror.

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Behavioural Principles

- Susan was very sick with a stomach virus and lost 10 pounds. Everyone in her environment told her she looked amazing afterwards, so Susan started to try and lose more weight. She eventually became so preoccupied with her weight that she developed anorexia
- Jennifer has panic disorder and borderline personality disorder, everytime she had a panic attack her parents would sit with her and soothe her for hours. She started having more and more panic attacks.

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Cognitive Perspective of CBT Model

- Pioneered by Albert Ellis and Aaron Beck
- Distorted ways of thinking lead to painful emotions and problematic behaviours
- We all have beliefs about ourselves and the world that help us organize our experiences
 - Some beliefs are helpful and others are not, and some beliefs are more and less based on reality

"I'm a loveable person!"	"I'm worthless unless I'm thin"
"I'm capable of changing things in my life!"	"Nothing I do makes any difference or matters."
"I can cope if something goes wrong!"	"If I'm not in complete control, everything will fall apart and I won't survive."

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The Cognitive Perspective

- Beliefs about the self: Worthless/worthwhile, loveable/unloveable, competent/incompetent
- Beliefs about the world: World is predictable and good, world is unsafe, world is full of terrible people, world is ultimately full of good people, world is out to get me

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Cognitive Distortions

- Distorted ways of thinking that do not accurately reflect reality and tend to influence our well-being
 - We ALL do this!
- E.g., someone you know walks by you and doesn't say hi... possible conclusions?
 - "She probably doesn't like me" → feel sad/shame
 - "She's such a b*****" → feel angry
 - "She probably didn't have her glasses on" → meh

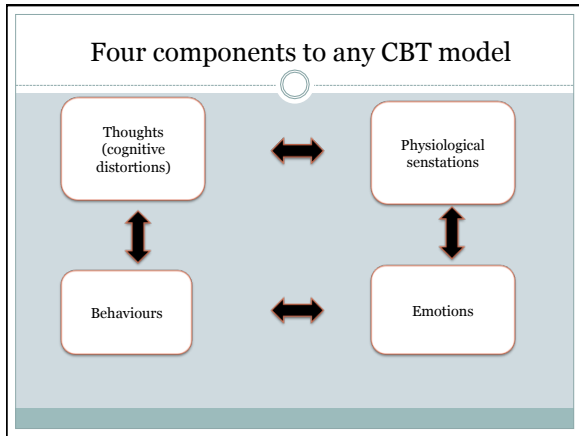
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Cognitive Distortions

I'm not the best so I must be the worst

Cognitive Distortion	Explanation
Selective abstraction	Focusing on negative details or events whilst ignoring contradictory or positive ones
Overgeneralization	Creating grand conclusions or "rules" based on a single incident or event
Catastrophizing	Exaggerating a minor setback until it becomes a complete disaster
Personalizing	Taking responsibility and blame for all unpleasant things that happen
All or none thinking	Seeing everything in terms of success or failure

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The Psychodynamic Model

- Underlying, perhaps unconscious psychological forces cause conflict
 - Rooted in Freudian theory
 - Fixation—being trapped at an early stage of development due to traumatic childhood experiences
 - Unsupported by research

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The Socio-Cultural Model

- Society's characteristics can cause psychological harm
- E.g., women are twice as likely to become depressed than men...
 - What are some possible reasons?

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Sociocultural Model

- Socioeconomic class:
 - Higher rates of psychological disorders among those with lower socioeconomic statuses

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Sociocultural Model

- Cultural factors (or, rather, factors that cause societies to respond oppressively to various cultural groups)

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Aboriginal and First Nations Groups

- Up to six times more likely to commit suicide than non-Aboriginal Canadians (Kirmayer, 1994)
- Up to six times more likely to be incarcerated (Health Canada, 2003)
- 25% of Aboriginal adults report sexual abuse, 15% report rate (Health Canada, 2003)
- High rates of many mental health disorders
 - Depression, alcoholism, drug use problems
- Histories of serious government-based oppression
 - Residential schools

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Chander and Lalonde (2003)

- When Aboriginal groups had received land claim negotiations with government, taken control of education, and services in their community (fire, police, child welfare) and when there is a physical structure in community dedicated to heritage, youth suicide rates were the lowest in Canada
 - But they are the highest if they are not in place
- These problems seem clearly linked to systemic oppression

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Other Cultural Factors

- Religions and spiritualities seem to be protective against the development of mental illness
 - Seem to be able to cope better with life stressors, less likely to abuse drugs, less likely to feel isolated
 - Spirituality/religion adds meaning?
- People with small or deficient social networks much more likely to have mental illness
 - E.g., depression can be “contagious” (Katz, Beach, & Joiner, 1999)

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Relationships and Mental Health

- Married individuals have higher life satisfaction than single people
- High marital quality associated with
 - Lower blood pressure
 - Lower stress
 - Lower depression
 - Higher life satisfaction
- BUT! Don't rush into a relationship people in bad relationships are less well than single people (Holt-Lunstad et al., 2008)

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Social Support and Mental Health

- Research suggests that social support acts as a buffer against stressful life events which would otherwise lead to mental illness (e.g., Cohen & Wills, 1985)

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Models of Abnormality Summary

- **Neuroscientific models:** look for causes in brain or biological bases (e.g., genetics)
- **Psychodynamic models:** psychological problems arise from internal subconscious conflicts
- **Cognitive-behavioural models:** examine interplay of thinking patterns with behavioural issues
- **Sociocultural models:** emphasize the role of culture and context in mental health

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PSYCHOLOGICAL DISORDERS

MOOD DISORDERS

Mood Disorders

- Emotions are different than moods
 - Moods last longer
- Key features of mood disorders: depression (low, sad state), and mania (euphoria or frenzied energy)
- Main mood disorders: Major Depressive Disorder, Dysthymic Disorder, and Bipolar Disorder (I & II)

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Major Depressive Disorder

- DSM-5: Five of nine of the below symptoms must be present for most of the day, nearly every day, **for two weeks**

- ★ 1) Depressed mood (e.g., feeling sadness, feeling empty, tearfulness)
- ★ 2) Loss of interest or pleasure all or almost all activities usually enjoyed by person
- 3) Weight and/or appetite changes (loss or gain)
- 4) Insomnia or hypersomnia
- 5) Psychomotor agitation or retardation
- 6) Fatigue or loss of energy nearly every day
- 7) Feelings of worthlessness or excessive or inappropriate guilt
- 8) Diminished ability to think and/or concentrate
- 9) Recurrent thoughts of death, suicidal ideation, or suicidal behaviour

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Different Presentations of MDD

1. Loss of interest in things
2. Increased appetite
3. Increased sleep
4. Lack of energy
5. Slow movements
6. Feelings of worthlessness

1. Depressed mood (cries a lot)
2. Decreased appetite
3. Decreased sleep
4. Fidgety
5. Difficulty concentrating
6. Suicidal thoughts

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Major Depressive Disorder

- Approx. 16% of people will have MDD in their lifetime, and about 5% each year receive the diagnosis (Kessler et al., 2003)
- Women at least twice as likely to be diagnosed
 - Alternative reasons for this other than women get depressed more?
- Waxes and wanes: 50% recover within six weeks and 90% within a year
- But chances of getting depression again increase
 - Likelihood of second depressive episode = 50%, likelihood of **fourth** = 90%

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Would You Consider This a Major Depressive Disorder?

• Jenny is a 41 year old woman. She had a 6 year old daughter, who was killed in a car accident two months ago. Jenny barely has the energy to get up each day, cries most of the day, sleeps for the rest, and doesn't want to eat. She sometimes thinks about her own death.

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Neuroscientific Models of Depression

- There is some genetic component to depression
 - Higher likelihood of developing depression if family member has had it
 - Monozygotic twin: depression in one leads to 46% chance of depression in other
 - Dizygotic twin: depression in one leads to 20% chance of depression in other
- Low levels of two neurotransmitters in brain:
 - Norepinephrine and serotonin
 - Discovered because old heart medications (which lower these NTs) often caused depression

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Neuroscientific Models of Depression

- Most first line antidepressants work by increasing serotonin in the brain
- BUT! Just because increasing serotonin can improve mood doesn't mean that if you have low mood you have low serotonin...
- High cortisol correlated with depression as well
 - Problems with this?
 - Cortisol is a stress hormone... having depression is stressful!

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Cognitive Behavioural Theories of Depression

- What is learned helplessness again?
- **Learned helplessness:** prior experiences with inescapable punishment condition animals to accept punishing consequences in later situations when they could avoid them
- People become depressed because they believe that (1) they do not have control over rewards and punishment in their life, and (2) they believe they're responsible for their helplessness
 - E.g., the client who believed that nothing was solveable

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Cognitive Behavioural Theories of Depression

- **Attribution-helplessness theory:** when events are beyond our control, we want to understand why
 - Internal attribution: assuming it is something about ourselves
 - E.g., this sexual assault happened because I was asking for it
 - E.g., I lost my job because I am not good enough
 - E.g., I lost my son because I wasn't a good enough mother
 - External attribution: assuming it is something about the world being unpredictable
- Internal attributions create feelings of helplessness and subsequent depression

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Cognitive Behavioural Components of Depression

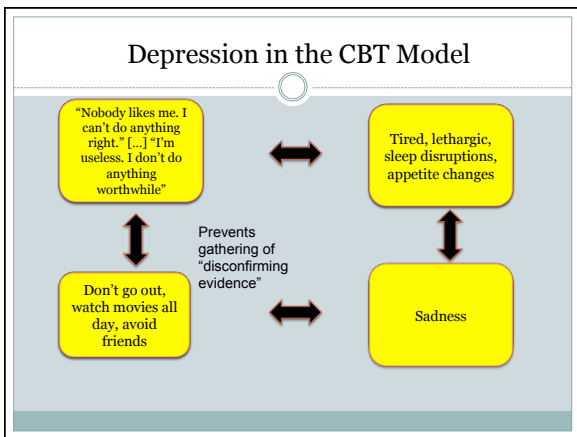
- People who are depressed do not feel like doing very much
- But disengaging from life (e.g., withdrawing from social circles, not doing anything productive) fuels depression
- There are two factors that we need in our lives to prevent depression:
 - Pleasure
 - Mastery
- People with depression lose these experiences, and stop engaging in behaviours that can bring them on

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Cognitive behavioural models of depression

- Dysfunctional thought patterns lead to the development of depression
- **Cognitive triad:** individuals regularly interpret their experiences, themselves, and their futures in ways that will create depressed feelings
 - E.g., working on a task at work "I'm doing a horrible job at this" → "nothing I do is worthwhile, I'm a waste of space." → "it's always going to be like this...things will never get better."
- **Automatic thoughts:** specific quick thoughts that arise and promote depressive thinking
 - "I'm a failure", "nobody likes me", "I'm stupid."

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Cognition in Depressed Subjects

- Depressed subjects
 - Remember more sad events in their lives
 - Are more pessimistic about the future
 - Rate themselves lower

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Depression Summary

- Major depressive disorder characterized by persistent low mood, among other things
- **Neuroscience models:** stress role of serotonin and noradrenaline
- **CBT models:** stress importance of behavioural inactivity, learned helplessness, and dysfunctional thinking
- **Sociocultural models:** stress importance of low social support

Bipolar Disorders

Bipolar Disorders

- Major depressive episodes alternate with periods of **mania**
 - Inflated self-esteem or grandiosity (“I’m amazing. I can do anything.”)
 - Decreased need for sleep (e.g., feels rested after only 3 hours)
 - Quick pace of speech- more talkative than usual
 - Flight of ideas- thoughts are racing
 - Distractibility
 - Increase in goal-directed activity or psychomotor agitation
 - Excessive involvement in activities that can cause painful consequences (e.g., risky sex, spending sprees)

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Bipolar Disorders

- Potential consequences of manic episodes:
 - Spending thousands of dollars on clothes
 - Make down payment on a new house
 - Starting fights on the street with strangers
 - Engaging in risky activity (e.g., walking on the edge of a bridge)
 - Staying up all night working on new projects

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Bipolar Disorder

- Prevalence: up to 2.6% of general population
- Equally common in women in men
- High genetic component- tends to run in families
- Stress also seems to play a key role
 - Major stressors combined with genetic predisposition lead to BiD?

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Bipolar Disorder

- May have systems that are especially sensitive to goal and reward pursuit
 - Systems become “addicted” to reward and goal attainment
 - When overly focused on goal and reward pursuit, develop manic symptoms.
 - When all concepts of goal and reward pursuit are lost, develop depressive symptoms.
- Sleep/wake and eating patterns disrupted in bipolar disorder
 - These kinds of disruptions seem to impact mood
 - E.g., sleep deprivation for 24 hours can produce feelings of euphoria similar to mania

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QUESTIONS?
