8. The psychodynamic view and medical models (30 minutes)

(a) Describe the psychodynamic view of the causes of abnormality.
(6 marks)

Tries to understand the forces that motivate behaviour. Freud's psychoanalytic theory is an example of this view. Freud divided the mind into three components: the id (unconscious aggressive and sexual instincts); the ego (the rational and conscious mind); and the superego (the conscience). Conflicts occur because the id wants immediate gratification while the superego takes into consideration moral standards.

According to Freud, psychosexual development passes through oral, anal, phallic, latency and genital stages. Excessive gratification or major conflicts during any of these stages may result in fixation, where the child spends a long period of time at that stage. Mental disorders arise when a person has conflicts and traumas from childhood that remain unresolved. Defence mechanisms reduce the anxiety caused by these unresolved conflicts. These defences include: displacement, projection, denial and repression.

(b) Describe the implications of the psychodynamic and medical models of abnormality for treatment.
(6 marks + 6 marks)

Psychodynamic model:

Psychoanalytical therapy aims to help the patient gain access to their repressed (unconscious) conflicts and traumatic memories, bringing them into the conscious mind. Various methods are used including, the analysis of the symbolic meaning of dream content; hypnosis; free association. Treatment is time-consuming and expensive due to the reluctance of patients to face up to their past.

Medical model:

The assumed importance of biological factors in causing abnormality has direct impact on treatment. Hence, many treatments are designed to alter physiological functioning and body system biochemistry. These include: drug treatment (e.g. tranquillisers, antidepressant or anti-psychotic drugs); electro-convulsive therapy (which involves causing a seizure by passing an electric current through the brain); neurosurgery.
(c) ‘In order to explain eating disorders, research linked to more than one model of abnormality needs to be considered’.

Evaluate the contribution of two or more alternative models of abnormality to an explanation of either anorexia nervosa or bulimia nervosa.
(12 marks)

**Biological model for anorexia:** emphasis is on genetic vulnerability, biochemical abnormality or brain damage. There is supporting evidence for the influence of genes. The risk of anorexia nervosa is greater for those who have a history of the disorder in their families. Theander (1970) reports that 10% of sisters of anorectics develop the disorder themselves. Strober and Katz (1987) showed first- and second-degree relatives of anorectic individuals to be significantly more likely to develop anorexia than a control group of similarly related relatives of non-anorectics. Twin studies have also pointed to genetic influences: Holland et al (1984) discovered a concordance rate of 55% for identical twins (MZs) reared together (100% of genes shared) but only 7% concordance between non-identical twins (DZs share 50% of genes). However, shared environmental influences may be greater for MZs than DZs. Furthermore, the fact that there is not 100% concordance rate for MZs requires that other factors besides genes must be considered.

Hormonal abnormalities may be important: amenorrhoea can occur prior to weight loss, thus suggesting a problem within the endocrine system. Anorexia is related to adolescence- a period of hormonal change. Fava et al. reported abnormalities of the neurotransmitters serotonin and noradrenaline. However, it is not certain if such biochemical abnormalities are the cause or effect of anorexia nervosa.

The hypothalamus is a brain structure that has been linked to anorexia, and there is strong evidence that it plays an important role in regulating eating. Damage to the hypothalamus can suppress appetite as well as causing disturbances to menstruation. However, there is no direct evidence relating specific dysfunction of the hypothalamus with anorexia. It is also difficult to see how any biological model can account for the recent increase in cases of eating disorder within advanced Western societies such as Britain and the USA.

**Psychodynamic model of anorexia:** one view proposes that anorexia reflects an unconscious desire by a girl to stay pre-pubescent. Overdependence on parents may result in the adolescent fearing sexual maturity and independence. Conversely, Bruch (1974) regarded anorectics as being in a struggle for control and their own identity - the pursuit of thinness was seen as a critical part of such a struggle. Bruch considered that there were two main characteristics of parents that made the development of anorexia more likely in their children, firstly, an over-concern with food; secondly, family relationships that did not assist the child in developing a sense of identity. Particularly important was considered to be girls feeling that their needs were secondary to those of their mother.

However, there is a deficiency of experimental evidence to back up psychodynamic explanations and they are not scientific because they are difficult to falsify. As with the biological model, psychodynamic theories cannot account for recent increases in eating disorders. Alternative theories better explain this, such as the feminist perspective. Bemis (1978) suggests that anorexia results from female adolescents attempting to conform to idealised, unrealistically thin female forms portrayed in the media. This is supported by the fact that anorexia is more prevalent in Western societies where thinness is portrayed as particularly desirable. Other models, involving cognitive or behavioural explanations, have also contributed to the debate about the causes of eating disorders.

(Total marks 30)
Answers:

LEVEL: AS

PSYCHOLOGY – Abnormality