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Power and goal pursuit in intimate relationships

To what extent do we adopt the goals of our partners in intimate relationships? What influences the extent to which we facilitate our partner's achievement of their goals? Laurin and colleagues reported the results of a series of experiments designed to examine the influence on goal pursuit of relative power in relationships[1].

Previous research had suggested that partners who had lower relative power in a relationship were more likely to prioritize their partner's goals over their own, and more likely to take on their partner's goals as personal goals (referred to as a 'contagion' effect). Low power individuals may be (or perceive themselves to be) more dependent on their partners for both tangible (e.g., money) and less tangible (e.g., affection, love, support) resources, which might act as powerful motivators to attune to and please their partner. However, interestingly, a similar effect has also been reported in other dyads, such as flatmates.

Laurin and colleagues assessed relative power by means of self-report measures, using questions such as: *'I think I have a great deal of power,' 'I can get my partner to do what I want,'* and *'I have more say than my partner does when we make decisions in our relationship.'* Using both couples and individuals recruited from the community a number of experiments were conducted to test their hypotheses that individuals who were low in power were more likely to prioritize their partner's goals over their own, and also more likely to adopt their partner's goals. They also conducted experimental manipulations designed to make participants feel somewhat higher or lower in power, to see what effect this might have.

The first question that probably comes to mind is whether there were systematic gender differences, and reportedly there were not, although the specific ratios of men and women scoring as high and low in power were not reported.

> The authors found broad support for the finding that partners who are low in power are more likely to prioritize and adopt their partner's goals.

The authors found broad support for the finding that partners who are low in power are more likely to prioritize and adopt their partner's goals. One study examined the influence of power in respect to a partner's goals being predominantly prosocial (e.g. wanting to help family or community) or competitive (wanting to beat some rivals). The results suggested that a low power partner was more likely to engage in prosocial behaviours if this seemed to be the priority of the partner, but found almost an opposite effect when the participant was a high power partner—they seemed less likely to engage in prosocial behaviour and more likely to engage in competitive behaviours designed to achieve more personal benefit.

To illustrate these effects Laurin et al introduced David and Danielle. David, who has low power in the relationship, is a keen home cook and gourmand who tends to be a couch potato. Danielle is a fitness enthusiast keen to eat a very controlled 'healthy' diet. 'If David prioritizes Danielle's health goal, he will strive to achieve exactly what she is trying to achieve, which is Danielle's health: That is, he will work to make Danielle a healthier person. If David catches Danielle's goal to pursue health for herself, he will adopt it for himself: That is, he will work to make himself a healthier person.' This can have implications for supporting patients to achieve health and wellness goals.

Attuning to a partner's goals and adapting to them might have benefits in promoting cohesiveness in a relationship. But Laurin et al point out that too much adaptation might have consequences both for the individual (e.g. loss of self-esteem, engaging in activities they aren't passionate about whilst giving up the things they were passionate about) and the relationship (e.g. maybe Danielle really liked that David was different to her and had his own passions), and they strike a note of caution in an unusually colloquial way for a scientific report: *'Changing from a bad-ass cook to a half-assed fitness fan may not be a successful relationship motivation strategy in the long run.'*

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Defence Mechanisms: Our 'iceberg' minds and the lies we tell ourselves....

Book review: 'Why do I do that?'

'Nothing is so difficult as not deceiving oneself' Ludwig Wittgenstein

Sigmund Freud describes the human 'mind' as an iceberg in that 'it floats with only one-seventh of its bulk above water'. Therefore according to Freud; personality and unconscious motivations is underneath what we actually see and that this controls all of our behaviours and our desires. Freud divides the human 'personality' into three parts; these being a) Conscious: things we are aware of; b) Preconscious: all the things we *can* be aware of *if we think about them*; and c) unconscious: the deep hidden place that holds *the true self*. Freud called these the Ego, the Superego and the Id respectively. In brief, Freud describes the Id as our hidden animalistic desires and works on the *pleasure principle* of 'I want it and I want it now'. Freud believed this was the first part of our personality to develop. The Ego develops after the Id and works on the *reality principle* in that it negotiates between the Id and the environment to avoid unpleasant consequences. Freud believed the Ego is what everyone sees as your 'personality'. The Superego is the last to develop and Freud believed it develops through a system of learning about punishment. Therefore learning the difference between what is right and wrong: our conscience as it were.

So how do these three personality layers co-exist? Freud believed the ego mediates between the superego and the Id to keep the 'peace' for best optimum outcome. This would look like something like this:

Id 'I want that now!'

Superego 'Good people don't think about those things. For shame.'

Ego 'Okay let's try to compromise...'

Freud thought of the Id and the Superego as equally 'destructive' in that each push down the Ego with demands and assumptions. Freud concluded that these two personality layers are therefore intricately involved in controlling what is intimately our true selves. What is stressed by Freud here is that most of this tug-of-war is unconscious. Interestingly people can have over-developed Id's and Superego's - but this is a whole other paper. I can offer up a simple example of each however: Donald Trump and Judge Judy...

Freud describes how the constant flux and tug-of-war of the three layers of our personality translates into what he called psychological *defence mechanisms*. In brief, the Ego tries to protect itself from threatening thoughts and feelings from the conflict between the Id and the Superego. Thus, Freud states that psychological defence mechanism are our unconscious 'lies' that we maintain to help us keep unpleasant thoughts and feelings secret from ourselves. A very elaborate form of self deception. Freud states 'sometimes when we're confronted with an idea or feeling that we find too painful or morally unacceptable, we ward it off, pushing it into the unconscious. It's not a deliberate decision; it happens outside of awareness, in ways that are often automatic.'

Freud identified nine psychological defence mechanisms however over time more have been identified by other psychodynamic thinkers such as Alfred Alder, Anna Freud, Melanie Klein and Donald Meltzer who all agree that psychological defence mechanisms are 'the lies we tell ourselves to evade pain' and lessen the struggle inherent in the human experience that is a) needing or desiring contact with other people and depending upon them; b) coping with difficult, painful emotions and; c) feeling confident about who we are and our personal worth in relation to others. So, in a sentence; the 'unconscious caries all the thoughts and feelings we either find too painful to bear, or which conflict with our morality and values and undermine our self image.'

Before I move on to the book review; it is noteworthy to direct you, the reader, to an interesting article from M.C. Anderson et al from St. Andrews University in Scotland who is using the principles of neuroscience to biologically verify defense mechanisms. So impressive is this study; Christof Koch referrers to it as 'neuroscience meets psychoanalysis'. ...

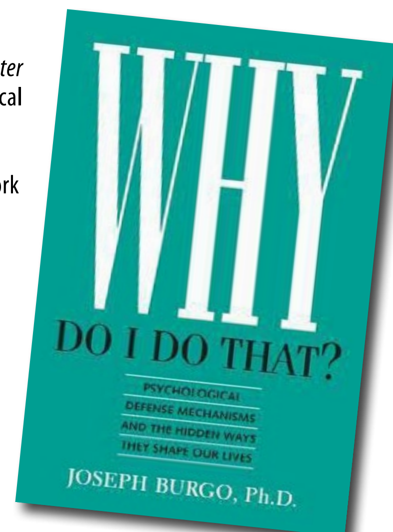
In his book; *Why do I do that?* Dr. Jospeh Burgo, a psychoanalyst of thirty years, adapts the basic strategies of psychodynamic psychotherapy to guide the reader in a 'self-exploration, highlighting the universal role of defense mechanisms in warding off emotional pain.' In brief, Dr. Burgo has broken the 'psychoanalytic' mould and written a *self-help* book on defense mechanisms and according to the critics; a damn good one. Dr Burgo explains; 'our defense mechanisms...distort our perceptions of reality—in both our personal relationships and the emotional terrain within us....when our defenses become too rigid or entrenched, they may prevent us from leading a full and satisfying emotional life.'

In brief, Dr. Burgo has broken the 'psychoanalytic' mould and written a self-help book on defense mechanisms and according to the critics; a damn good one.

The book is presented in three parts. The first part introduces the reader to the unconscious mind and the role this plays in psychological defense mechanisms by excluding difficult emotions and thoughts from consciousness. It is in this section that Dr. Burgo introduces the three primary psychological concerns at the 'heart of human experience' as introduced at the beginning if this article (here they are again in brief a) bearing neediness; b) tolerating intense feelings; and c) developing a sense of personal worth and value). Dr. Burgo extends this explanation by reminding the reader these *human concerns* are 'normal human needs' and that 'navigating them well means learning to tolerate [the] intensity, both pleasurable and painful.' Dr. Burgo spends the rest of the first section discussing the human emotional landscape and specifically those emotions us humans have the greatest difficulty with: anger, fear, hatred, jealousy, shame and envy. Importantly, Dr. Burgo eloquently concludes that *being human* means 'accepting ... a wide range of emotions we can't avoid' and helps the reader accept this simple, but challenging truth using science, research and therapist experiences.

The second part explores primary psychological defense mechanisms chapter by chapter with exercises to help the reader identify their own defenses at work. Dr. Burgo discusses repression, denial, displacement, reaction formation, splitting, idealization, projection, control, rationalisation and passive-aggressiveness. What stands out in this section of the book is the depth that Dr. Burgo undertakes to discuss the above psychological defense mechanisms. He doesn't just hand out flash cards with target words on them: he introduces layers and extended concepts for each one.

For example, he discusses psychological defense mechanisms in relation to *character* formation; the usefulness of a psychological defense mechanism and how they can be woven into our every day life; how one psychological defense mechanism can work alongside another psychological defense mechanism; how psychological defense mechanisms and certain emotions can *collude*; Cultural influences on certain psychological defense mechanisms; introduction and discussion on sub-types of certain psychological defense mechanisms; and psychological defense mechanisms and personality disorders and certain psychopathology such as



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narcissism and anxiety.

After each chapter, Dr. Burgo walks the reader through a intelligent check list that looks at that specific defenses emotional vulnerabilities; self-esteem presentation; and hierarchy of needs and dependencies. Each psychological defense mechanism discussed also comes with a set of exercises to help the reader becomes *aware* of each defense at work in their everyday lives. Finally, each chapter ends with a *Now What?* section that asks the reader to reflect on their awareness and insights with encouragement.

The final part offers the reader guidance on how to 'disarm' your defenses and to be effective at coping with the unconscious emotions and thoughts behind them. Dr. Burgo reminds the reader that psychological defense mechanisms are tenacious and won't go away 'simply because you've come to recognise them.' He reminds the reader that defenses are *mental habits* that have been 'etched into the neural connections and pathways of the brain' and that its more about learning how to navigate those habits effectively through your emotional world. Despite the rapid evolving frontiers of neuroscience; we do know that because psychological defense mechanisms are formed during development they will effect the brains circuitry in lasting ways. So, the final section of the book is about learning how to develop techniques and being mindful that the old defense *habits* 'will always pose a problem because they've been around much longer.'......and so the reader embarks upon a journey of change.

Throughout I found the references to research, neurosciences, and evidenced practice lent more kudos to the book in addition to Dr. Burgo's commitment to the *human truth* in that sometimes life means suffering and anyone who says differently is selling something. In fact, the following statement from Dr. Burgo captures the essence of any therapy: 'only by coming to know yourself very well, to recognise your trouble spots and the characteristics ways you cope with them, can you start to grow. Only then can you develop new skills and capacities that help you better navigate your emotional world.'

Are your psychological defenses helping you lead a richer, more comprehensible and satisfying life?

Melinda Barone
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Using psychotomimetics for depression: a delicate balance

It is well established that we have a massive ongoing problem with the limited efficacy of our current pharmacological approaches to depression. The oft-quoted STAR*D study, for example, reported that treatment with citalopram at a final mean dose of 42mg resulted in remission for only 36.8% of study participants, whilst switching to another agent (bupropion, sertraline, venlafaxine XR) or augmenting (buspirone, bupropion) was associated with remission in only a further 25% to 35%, respectively (Rush et al, 2006).

It is also the case that we have not seen compounds with entirely novel mechanisms of action (ie. different from those that increase serotonin and/or nor adrenaline in the synaptic cleft) being brought to market: agomelatine (a melatoninergic agonist with post-synaptic serotonin 5HT2c receptor antagonism) is the stand-out exception, and it has never received PBS reimbursement in Australia.

So, instead of developing new compounds, interest is being shown in existing chemicals that have signals suggesting utility as antidepressants. Perhaps the most exciting of these is ketamine, an antagonist at the N-methyl-aspartate (NMDA) receptor. The trial data are promising, albeit long-term efficacy remains to be established and safety issues (mostly depersonalisation-type reactions) and the potential for addiction have led to caution being called for in its use. These cautionary messages have not been heeded by some individuals, who offer intravenous ketamine at various clinics around the country and there is much hype about it.

In this scenario, a thorough and balanced review of the whole area is required, and happily this has been provided in a recent report from the American Psychiatric Association Council of Research Task Force on Novel Biomarkers and Treatments (Newport et al, 2015). The authors conducted a comprehensive search for studies of ketamine use in depression and also covered other glutamatergic agents. Ketamine was the most studied, with 12 randomised controlled trials. Some used ketamine as monotherapy, others used it in conjunction with other psychotropics; and in 5 studies it was used as an augmenter of ECT. Most studies were of major depression, with two of bipolar depression. All used intravenous infusion apart from one in which the intranasal route was employed. Dosing was mostly around 0.5mg per kg, which is sub-anaesthetic. Pooled data from the non-ECT studies (n=6) showed an antidepressant effect at 24hours post-infusion (odds ratio for response 9.87 (95% CI 4.37-22.29)) and was robust for patients with both major depression and those with bipolar depression. The benefit attenuated with time, but intriguingly remained significant in the pooled dataset at seven days post-infusion (not for the bipolar patients). Side effects included transient increases in blood pressure and dissociative symptoms. The issue of how to capitalise on these gains and maintain them in the longer term has not been systematically explored but a few open studies have used repeated infusions: further studies with appropriate control interventions, are required. Alternative modes of delivery also need to be explored: the intranasal route seems most simple but only one RCT thus far has used this route of administration.

Of interest is that, whilst ketamine seems to have robust antidepressant effects, at least in the short term, other agents with similar mechanisms of action, do not appear as promising. The Newport et al (2015) paper reports a handful of studies which have used the ion channel blockers memantine, lanicemide and

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nitrous oxide; the allosteric site antagonists traxoprodil and MK-0657; and the glycine receptor partial co-agonists D-cycloserine and rapastinel. Results have mostly been disappointing, suggesting that ketamine's antidepepressant effect might be due to actions not related directly to its activity at the NMDA receptor: it has activity at sigma receptors and also effects on dopamine and serotonin pathways.

Ketamine for depression: not yet for prime time but certainly exciting. And another substance entering consideration is psilocybin: yes, magic mushrooms! In an intriguing open trial, Carhart-Harris and colleagues (2016) gave psilocybin (which is a prodrug of psilocin, primarily a serotonin 5HT2A receptor agonist) to 12 patients with moderate-to-severe treatment resistant major depression and found quite dramatic antidepressant effects at a week after ingestion. In around half of the patients the gains were maintained at 3 months follow-up. Participants reported transient anxiety and psychedelic effects but all tolerated these well (they were in a very supportive environment, with two psychiatrist at hand throughout and mood music as well). Again, exciting findings but of course require replication and controlled experimental studies.

It will be interesting to see how other drugs used for recreational purposes are exploited for psychiatric maladies. Of course there is much interest currently in cannabis and specifically the potential of cannabidiol to treat psychotic symptoms. Keeping an open mind about the potential therapeutic applications of such drugs can hopefully help us advance the field and move on from the current relative stagnation in psychopharmacology.

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Workshop Review—7 May 2016

Interpersonal Psychotherapy for Eating Disorders (IPT-ED)

Associate Professor Elizabeth Rieger

Interpersonal Psychotherapy (IPT) is an evidence-based therapy that is that long with CBT, is covered by the Medicare Better Access Scheme. IPT was initially developed for the treatment of mild to moderate depression (Weissman, 2007). IPT is present focussed, time-limited and concentrates on current interpersonal relationships.

In IPT-ED, problem areas are posited to relate to actual or perceived negative social evaluation as a cause and also a consequence to eating disorder behaviours by affecting self-esteem and emotional regulation (Reiger, 2010). The aim of IPT is the help the client to develop healthy relationships in order to decrease eating disorder behaviours to manage low self-esteem and emotionally regulate.

IPT is a brief therapy with an Acute phase (approx. 8-22 sessions) and the option of a maintenance phase. The Acute phase of is divided into initial, intermediate and concluding phases.

The Initial phase comprises of standard assessment including client suitability for IPT and the development of an interpersonal inventory to identify interpersonal problem areas, formulation and agree on goals for treatment. An interpersonal inventory takes a chronological history of symptoms, life events and interpersonal functioning, helping to identify interpersonal areas associated with onset and maintenance of symptoms. In IPT, interpersonal problem areas are divided into interpersonal disputes, role transitions, grief and loss and interpersonal sensitivity.

The intermediate stage focuses on identifying links between symptoms and interpersonal factors whilst working towards change by interventions such as communication skills training, problem solving and cognitive restructuring.

The concluding phase focuses on end of treatment planning, relapse prevention and goals for further work. Whilst the acute phase focuses on symptom resolution, the maintenance phase focuses on skills review and relapse prevention.

With regards to eating disorder specific IPT (IPT-ED), often interpersonal psychotherapy is included as a component in the gold standard for the treatment of eating disorders, CBT-E. Client suitability for IPT-ED is dependent on multiple factors such as personality characteristics, attachment issues, symptoms, comorbidity, severity and stage of illness. It is a valuable standalone therapy for a number of psychological presentations as well as treatment for eating disorders whereby symptoms are interpersonally focussed.

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MAN UP

Gender, Language and Psychiatry

Recently, the current Australian of the Year, Mr. David Morrison[1] has begun a campaign to ban the use of the apparently discriminatory term 'guys' in Australian workplaces. His campaign has garnered a great deal of attention, both positive and negative in nature.

Whether we believe that the use of the term' guys' has sexist connotations or not, Morrison's campaign is a useful prompt for psychiatrists and other mental health professionals to review the language we use relating to all patients, in particular our female patients. Words are the critical tools of our trade —in making a diagnosis, connecting with our patients and as a part of the therapeutic process.

The power dynamics between the sexes has long been identified to have many facets. Language styles, terms, and grammar have been described by sociolinguists as battlefronts between the genders[2]. It is pleasing to note that masculine pronouns are very rarely used now to universally refer to women and men. This was the correct English grammar until fairly recently. In older text books, all patients and doctors were 'he'. In this vein, there are many common medical terms and phrases used about women that on closer examination are actually quite derogatory.

The phrase 'falling pregnant' is still a commonplace term to describe being pregnant. The term 'falling pregnant' holds reference to the old fashioned concept of the 'fallen woman'—which in turn denoted a woman of low moral values, one who was unmarried and become pregnant. All of this was of course reflective of morality up to the mid-to-later years of the 20th century—now quite some years ago. The term 'falling pregnant' also robs the woman of control over her pregnancy, namely; she 'fell' into it—rather than planned it or wanted it. The term also seems to equate pregnancy with illness; since we describe people as 'falling ill or falling sick.' As well, 'falling pregnant' conjures up odd sexual gymnastics which ended in conception! Overall, the term 'falling pregnant' should not be used if we want to avoid derogatory, archaic and moralistic connotations.

The term 'presenting complaint' is widespread in medicine and psychiatry to denote the key issue that the patient wants help with. However, the term 'complaint' is associated with mainly negative features such as whingeing, whining, and generally being a nuisance. The term 'main issues', 'presenting symptoms', 'key concerns' and many other descriptions work better to highlight why the patient has come to us at this time.

'Girls' is really only appropriate for prepubertal females and when used to describe women in the workplace or adult female patients, is highly offensive. It is equally offensive for females and males to refer to other women as 'girls'. The common description of nursing staff, administrative and other predominantly female groups of staff as 'girls' is not acceptable. Infantilising women patients by calling them 'girls' is disrespectful and disempowering and ultimately counter therapeutic.

There are many other daily terms that find their way into psychiatric interviews, which on reflection, can disempower our women patients. Therefore to stop and think about the impact of words in a professional context is always a good exercise. The old children's rhyme 'sticks and stones will break my bones, but words will never hurt me'—does not hold true. Bullying, sexism, racism and public humiliation all use hurtful words as a major weapon. Such words are very harmful, and cause long lasting damage including the perpetuation or precipitation of mental ill-health.

The old children's rhyme 'sticks and stones will break my bones, but words will never hurt me'—does not hold true. Bullying, sexism, racism and public humiliation all use hurtful words as a major weapon.

So, while the debate continues about whether or not the term 'guys' is offensive to, or exclusionary of women; we can as mental health professionals review our own language through a gendered lens, to really ensure that we weigh our words carefully to provide empowering care for our patients. As Confucius said 'Without knowing the force of words, it is impossible to know more.'

Prof Jayashri Kulkarni

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Suicide—The disease of the older undepressed male

The Chairman of Lifeline Australia, John Brogden, shared an important message in the Sydney Morning Herald with 'The national emergency we can no longer ignore'. As a suicide attempt survivor himself, he grimly noted that 2,500 Australians still take their lives every year—seven deaths per day. He has called for it to be seen as warranting a national campaign, and the need to improve how we understand suicide.

That last point may not appear to be particularly significant, particularly as there is something that should be self-evident about suicide. 'The unfortunate few people with mental health issues are obviously at risk of suicide, which is due to them becoming too depressed'. What's interesting about that sentence, is that none of those components are true.

Firstly, with regards to the unfortunate few—we are now more aware that mental illness is extremely common. A quarter of the population will suffer from depression at some point in their lives. Skepticism then intervenes—how can 25% of the population suffer from such a severe mental health issue? Where are all the people falling off office buildings on a daily basis? Then comes the rather unusual reality that, in the world of mental health, suicide is actually rather rare. And, interestingly, is also on the decline.

Snowdon in 2015 noted that ABS figures indicated a reduction in Australia suicide rates in virtually all age brackets. Multiple international studies confirm that there are two spikes in lifetime risks of suicide—the 18-25 age bracket, and (in men) the 80 years old and above bracket. I work full-time as an old age and adult psychiatrist, covering both high-risk areas, and process approximately 800–1000 cases a year. Yet I encounter a completed suicide approximately once every 2 years. Whenever we get a case it is a tragedy for myself and my teams, but whilst I remember every patient we have lost, I often consider it strange that there are not more we have to remember.

The reality is that, most patients with mental health issues merely suffer in silence and continue. Yet the most interesting—and novel—issue in this is the premise that depression and suicidality are two different things.

Fairweather-Schmidt and colleagues of the University of Melbourne studied 7,485 people and applied statistical analysis to query whether suicidal behaviour was a symptom of depression or an independent construct. What was fascinating, was that their research indicated that the data fitted a two-factor model of depression and suicidality better than a single-factor model—meaning that suicidality was distinguishable from depression.

This fits a number of preceding studies looking at the effectiveness and roles of medication. We have known for a long time that there is a temporary increase in suicidality in the first few weeks of starting an antidepressant before the patient starts to improve in mood—which is why they require monitoring during this period. What has also been known is that there are interesting distinctly 'antisuicidal' properties of certain medications—such as lithium and clozapine.

What this all means is that if a person has a sense of self-destruction, of wishing not to be alive, but is not otherwise depressed, there may be a serious issue—and, most importantly, a reversible issue.

There is another side to this issue, however, when considering the statistics. Whilst it is reasonable to conceptualise suicidality as a separate entity to depression, and this assists the adult psychiatrist in evaluating their patients, we have the unusual issue of the old age spike in suicide. Contrary to popular opinion, older patients have a lower rate of overall mental health issues as they get older. The older patient is less likely to suffer from depression than their younger cohort.

So, in a landscape of declining suicide rates—for whatever reason—as well as the happy reality of improving mental health as one gets better, what leads to this unusual—and persistent—spike in males over 80? Regrettably, this is an area that creates more questions than are answered. Until the research identifies more reasons for this and provides more guidance, the only questions that we can reasonably ask should be posed to the elderly presentation in the admission office. Because there is one trend that occurs to me in thinking of all the patients I have lost. They were all male.

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