LECTURE SEVENTEEN: A CASE STUDY: DOT

It is a truism, of course, that people differ from one another, but it is especially true of deviants. There may be no typical schizophrenic or no typical retarded person, and of all deviants this is especially true of the drug addict. There may be no typical drug addict. We know very little about drug addicts despite all the research that we have done and the many thousands of years that drugs have been available. Today, you are going to watch an interview with a young girl who was a heroin addict. In fact, she may well not be typical. You probably have certain opinions and beliefs about drug addiction, and this interview with Dot may confirm some of them, it may disconfirm others, and it may even create new myths. For example, off-camera, Dot told me about how sometimes, she would give her share of heroin to her boyfriend out of love. She would forego taking heroin so that he could have some. Other drug addicts that I have talked to say, "You can't do that. If you are really hooked, you just can't give your heroin away. You wouldn't want to." So is Dot typical? I don't know whether she is typical or not. There are no truths and no facts here. These myths about people and, if they were to be true, we might call them laws or generalizations, are useful only if we don't know anything about the particular person we are interested in. If you try to make a statement about drug addicts in general, then maybe you will come up with a law that may or may not be true. But as we get to know somebody individually, in their own uniqueness, then we have no use for these laws, generalizations or myths. We can say what is true for this particular person. So, let us begin now by turning to the first part of the interview with Dot.

L: Tell me, how did you first get into taking heroin?

D: Well there are two answers to that - the marihuana ran out and my uncle has been a junkie for 25 years that makes it a lot easier.

L: Did he introduce you to it?

D: No! As a matter of fact, he hit the person who first introduced me to it, and my uncle is very nonviolent. He was quite upset. I was living with my uncle and my grandmother at the time. His friends used to come over and get high with my uncle up in his room, and one of his friends took a liking to me and thought he would do me a favor. He took me over to his house and he turned me on, and I liked it. I went and got my girlfriend and took her over to somebody else's house, and she got high too. We both really enjoyed it.

L: Why you say he "turned you on," what exactly did he do? Did he shoot it up for you?

D: Sure! I'm petrified of needles.

L: Have you ever shot up yourself?

D: Yes.

L: But the first few times he did it for you?

D: Yes.

L: And you liked it.

D: Usually I never did it myself because I am afraid of needles.

L: Did you like it the first time?

D: Yeh.

L: Were you scared?

D: Petrified!

L: Petrified. What about when you introduced your friends, were they ready to be introduced? Or did you have to coerce them?

D: Well, junkies always think that they're the hippest people in the whole world. It was a cool thing to do, and everybody wanted to get high. They wanted to get turned on and everybody was very excited. "Oh, please! Please!" you know.

L: So they asked you?

D: Sure. I don't think that all the stories about the pushers on the streets begging people to turn on are necessarily true. Maybe in some cases it is, but usually a junkie has enough dope for himself, and he doesn't want to give any away to anybody.

L: Why did the guy want to turn you on?

D: He thought he was doing me a favor.

L: Did you ask him to?

D: No.

L: It wasn't that you begged him?

D: No. I didn't beg him. I mean, I wanted to, you know, but I would never have asked.

L: What made you want to? Was it watching your uncle?

D: It was wondering. All my life, I had gotten lectures about the evils of drugs, the evils of heroin, the evils of marihuana - being told I shouldn't do it. That maybe induced me to do it more than ever.

L: What kind of life did your uncle lead? Was it the kind of life that would turn you off or was it exciting?

D: It didn't look exciting. I really respected my uncle. I always have, even though he has really been down and out. He's been in jail a lot of times.

L: Then it wasn't that he lived an exciting life?

D: No. It wasn't that it looked exciting. I just liked to get high. I wanted to get high.

L: Once you took the first dose, were you hooked right then?

D: No, that's silly.

L: What happened? How long was it before you shot up again?

D: Well, that same night. It even sounds like I was hooked. Maybe I was now that I come to think of it. But I can't remember the second time after that. It's all very vague, but it wasn't long after that.

L: Do you consider that you were a junkie from the beginning?

D: Oh, no. Nobody ever thinks that they are going to get hooked. My goodness no!

L: Is there a point at which you realized that you were hooked?

D: I think I realized it a long time before I ever thought about it. I realized that I was, but nobody ever thought that they were, even people who had been doing junk for a long time.

L: Why do they do that? Why do you deny it?

D: Because you always think that you can be on top of the drug whether you can be or not. You always say, "Oh, no! I'm not going to get hooked. I can be on top of it. I can control it."

L: What do you mean "be on top"?

D: Control. Control yourself. Control it.

L: And looking back, do you see that you were on top of it?

D: No, I couldn't have been or else I wouldn't have done a lot of the things that I have done.

L: Can you think why an addict maintains to himself or herself that he or she is on top of it?

D: Well, maybe it's got something to do with what I said before, about junkies thinking that they are hip, they're with it, and what they are doing is really cool. Maybe that's got something to do with it.

L: Did there come a point when you realized that you weren't on top of it?

D: Yep, and that's when I started screaming. You always got high with people, usually, and I'd start screaming and ranting and raving. "What am I doing to myself? What am I doing to myself?"

L: How did your friends react?

D: They threw me out. "Get that out of here."

L: Why do you think they threw you out?

D: Because that was verbalizing what they thought.

L: I see, and that was a threat to them, having you verbalize it?

D: They just didn't need me around to tell them what they already knew, and they didn't want to hear it.

L: That's interesting. That implies that, when you're high on heroin, there is a certain way you are supposed to behave. There are some things you are allowed to do and some things you are not allowed to do.

D: Sure, that's right. There's nothing worse for a heroin addict than being around a speed freak.

L: Why's that?

D: Because a speed freak will sit there and talk and rant and rave, run around the room. That makes you nervous, makes you sick, and that's no good. They don't want people upsetting them.

L: Have you ever tried any other drugs besides heroin?

D: Sure!

L: Speed?

D: Once was enough.

L: You didn't like speed. Why?

D: Well, it makes you much crazier. It makes your teeth rot. You can feel your teeth rot. You can feel your brain cells falling apart. I'm a nervous person as it is, and I didn't need any more nervous energy.

L: So the effects of speed didn't fit with the kind of person you are?

D: Right.

L: What else have you tried?

D: All psychedelics. Except for peyote.

L: How do you feel about those?

D: I remember when I first started taking psychedelics (long pause). I'm trying to think back. That was also a hip thing to do. I was in Buffalo, New York, as a matter of fact, and I don't think psychedelics really permanently damage you. I don't know. Nobody knows! But I think they have a tendency, you know, to make any warped behavior more warped.

L: The pleasant feeling that heroin gave you when you shot up, were you running from another kind of feeling? Was your life bad? Were you under stress?

D: I had no idea what I was doing at all.

L: But it wasn't that you were trying to escape some kind of depression or misery or anxiety?

D: No. I was depressed because I didn't know what I was doing. I didn't want to go to college. I didn't want to work. I didn't know what I wanted to do, and it was something to do.

L: And the mood it induced put those worries to rest?

D: Sure! That's what heroin does.

L: Why don't you need it now?

D: Because I'm not depressed?

L: Are you asking me?

D: No. Maybe I am. I don't know. I don't need it now because I know how bad it is for me.

L: But the mood it induced, is there anything that gives you that mood now? Or have you just lost that need?

D: No. It's almost a euphoric mood; it takes away all your troubles; it cuts off this part of your head completely. (Points to top-half of head)

L: So you never get into that state now?

D: No. Not like that.

L: Is it, as if you have put that experience aside, and you've given it up?

D: Well I haven't given it up, because it's part of me, but I've given up the drug.

Why did Dot take heroin in the first place? First of all she mentions that the fact that it was forbidden made it intriguing. I think that that is true of many behaviors for people in today's society. If a thing is forbidden, illegal or sinful, it gives it a certain attractiveness. You feel special if you are doing it, an extra thrill from the secretiveness with which you have to do it, and the fact that you are breaking the law or committing some sin makes it very attractive. Obviously this suggests that, to make it less attractive, we only need to legalize it perhaps for some people or make it no longer a sin. She also mentions that the euphoria that the drug induced was attractive, that she did it to escape from very negative emotions, depression perhaps and anxiety, and that the high that she got while on heroin was a relief. It was a pleasant experience in contrast to her negative experiences.

Although Dot doesn't mention it, peer pressure is important. The fact that those that you know are taking the drug and later in the interview Dot will say that the way she broke the habit was to get away from her friends and away from the environment in which drug taking was accepted. Notice that Dot was not seduced into taking drugs. She was willing. She wanted to try heroin. But, note also that she admits to having seduced some of her friends into taking drugs, to having made it easier for them, to maybe even having suggested it to them.

Was she addicted immediately? Dot says no, although the first time that she shot up, she shot up a second time just a few hours later. But she probably wasn't physiologically addicted or even psychologically addicted immediately. However, addicts and deviants tend to disavow their deviance. They deny it. For example, the "peeping tom," the voyeur, will say, "I wasn't really peeping in that woman's window and watching her undress. It was her fault for undressing in front of the window. I just happened to be passing by." Or the man who molests a small child may say, "I didn't really mean to molest the child. I was drunk. I didn't know what I was doing." The person who is judged to be crazy may say, "I'm not crazy. You're the one that's crazy," or, "What do you mean? There really are people trying to poison me." Each of them denies that they are deviant, and similarly addicts very often deny that they are addicted. Dot admits to this, "They say, 'I can control it, I'm not really addicted', and you deny that you're addicted even though you may be."

The motive that Dot gives about taking heroin, to avoid depression, is critical because it tells us that, if you want to cure an addict, Dot for example, it is no good just taking away the heroin because what do we do about those basic feelings that made her take it? We have to find some substitute, some behavior, some activity, that will substitute for that need; that will gratify the need that the heroin was originally gratifying. We have to replace one goal by another goal. It is not enough just to remove one goal.

Can anyone get addicted? That is not clear from talking to Dot. She mentions that she had tried amphetamines, and they didn't suit her. They didn't fit her personality, and this suggests that Dot would not become an amphetamine addict, a speed freak. However, heroin fitted with her personality. It might be that some people would try heroin and find that it didn't suit their

personality, that they might prefer amphetamines or alcohol or cigarettes. It may not be that everybody can become addicted to any drug. There may be some drugs that are more suitable for some people, than for others.

If you remember my talk about the social model, I discussed the views of McAndrew and Edgerton. They said that, when under the influence of certain drugs, such as alcohol, we do not act out *any* behavior. We are in great control of our behavior, and that the behaviors that we show are shaped by the expectations of our society. I tried to ask Dot about that. Did she feel that her behavior was shaped by her friends and her peers? She said "No, probably not," but heroin, has certain effects on you that you cannot control. But notice that there is some evidence for shaping in her behavior. When she screamed, when she got upset and shouted, "Why am I doing this to me? Why am I taking heroin?" her friends didn't want to hear that. They threw her out, "Don't give us that!" So she would learn that certain behaviors are permitted by her friends when she is on heroin, and certain behaviors are not permitted. So, in fact, your peers, the subculture to which you belong, may indeed shape your behavior and affect the kinds of behaviors you show while under the drug. Let us return to the interview and see what else Dot has to say.

L: What was it that finally motivated you to get off heroin?

D: It's a combination of things, more than one thing. I realized that I was totally miserable. I wanted to go back to college, and I didn't like the way I was living.

L: What was wrong about the way you were living?

D: One week here, one week there, staying with one person here, staying with somebody else here, never knowing what I was doing, spending all my time getting high.

L: I thought that was supposed to be good?

D: What? Getting high or spending all your time in different places?

L: Getting high.

D: Getting high? It's good but it's not good. I mean, you think it's good at the time, but I realized it wasn't good.

L: Even at the time you realized that it wasn't good?

D: Sure.

L: What were you so miserable about?

D: Spending all my time trying to get high. Your personality changes when you become a junkie. You become selfish and nasty. Any friends that you once had you've lost. Even the friends you have who are junkies are not really friends. You'd beat your mother for a dime. You steal, It's just no way to live.

L: What kinds of things did you do as a result of being a junkie that you now look back on and say, “That was horrible”?

D: Well, I turned a lot of people on, and that’s something I remember and do not feel good about. I stole from people, stole from my family, and I beat a lot of people for their money.

L: You beat-up people?

D: No, beat.

L: What does that mean?

D: That means, they come to you and they say, “Would you get me some dope?” and you say, “Sure, I’ll get you some dope.” Then you never give them the dope or else you give them one-third.

L: Then the life you described as a junkie was not very pleasant?

D: No. Not at all. I can remember so many horrible things. I remember one day my uncle came over and, because he had been a junkie for so long, it was very hard for him to hit a vein and he would have to shoot-up in his temple or in his hand or in his thigh. One day he came over and he hit an artery instead of a vein and the blood spurted out and went all over the walls and there was blood dripping all over. We couldn’t stop it. It was just spurting all over. It was absolutely grotesque! I remember one Thanksgiving dinner, he came with one eye completely black because he had to get-off in his temple, and that’s just not a good way to live.

L: And that made you scared for yourself, at the time?

D: It didn’t make me scared so much, as just really kind of disgusted with myself. One of our friends OD’d one night, and everybody was mad at him because we thought that he’d taken more dope than he’d given us. He got higher, so that’s why he OD’d. So, after we shot-him up with a salt solution; we threw him down on the floor. He was lying there gurgling because he was laying with his head back. We were really aggravated at him, and so it must have been like 10 of us proceeded to kick him under the guise of trying to bring him around. When he woke up, he had bruises all over his body, and he didn’t understand where they came from. We just laughed while we were doing this. That’s pretty grotesque.

L: And at the time you realized that it was grotesque?

D: Sure.

L: And that was motivation

D: Back here though (indicates back of head), because, as I said, heroin takes this part of your head off, it wasn't really realizing it so much as having it in your subconscious somewhere. But knowing it's there.

L: You mention that, in looking back on it, you regret having introduced so many other people to heroin. Did that concern you at the time?

D: No.

L: You didn't feel guilty about it then?

D: No, because, as I said, these people wanted it because it was the hip and cool thing to do, and they probably would have gotten turned on by somebody else anyway. But still I regret that.

L: But eventually, for you, the whole life became so disgusting that you decided that you had to quit?

D: Yeh.

L: Was it easy to quit?

D: In some ways it was easy, and in other ways it wasn't easy, I was lucky. I had a place to go. I left town.

L: That made it easy?

D: Sure it makes it easy. The only way that a junkie can really get away from drugs is to totally dissociate himself with his former life. Now, if you're still in the same town, and it's a small town and you have to see these people every day, then it's going to be very, very difficult to get away from the drug. But if you can leave like I did and go 500 miles away, it's going to be a lot easier. I changed my life style completely. I went back to college. I went out with football players who drank a lot of beer which is something that I had never done before. But I realized that I had to change my life completely. I went and lived with a different family. I realized what I had to do.

L: What was difficult about it?

D: I still wanted the drug. My friends would call me. I remember it was New Years Eve and some people called me. I really wanted to get high. I could hear them on the phone that they were all high.

L: Did they ever exert pressure on you to go back and take up heroin again?

D: Well when I used to come back and visit? I would come back and visit. I had a very close friend, she was a prostitute by then, and I would come back and visit. I remember it was Easter, and I wanted to see her and it took me about 15 hours to track her down. I went to

where I knew she would be, and she was working out of this nightclub. She said the only way you're going to see me is if you come to work with me. So I went to work with her, and she went and did her thing and then we went back and it was so easy for me to fall right back into it.

L: She didn't even have to pressure you to do it?

D: Oh, no. She bought a bundle of dope, and she said, "Do you want to get high?" and I said, "Sure I want to get high!" I got greedy. I shot up once and then about an hour later I shot up again, and then I said, "Oh, boy." Everybody's nodding out, and I did it again. I OD'd. And that still wasn't the last time I ever did it! But it's very easy, you know, to fall back into that life.

L: And to break it after that, you had to go back.

D: Then I left, but it got to the point where, when I was in Buffalo where I had gone, I hooked up with some people who were junkies, and I started doing junk up there too. Then I got really scared, and I decided that I really had to stop what I was doing. So I went and got involved in something that would totally consume all my time and all my energy.

L: What was that?

D: *The* movement! The revolution.

L: Which movement?

D: Which movement?!! I got involved with a radical print shop, and that consumed all my energy. It gave me something to put my energy into.

L: And you didn't need anything to take the place of drugs.

D: I used *that* to take the place of drugs…

L: I see

D: …until that became more than the drug ever was.

L: How long have you been off drugs?

D: Well, it's very hard (pause) to remember that whole period. It's a big fog in my brain, but I'd say 1970. The last time that I used heroin, I think, was in 1971.

L: And if you meet some junkies now, that you know, do you have enough resistance to taking it or could you be seduced back into it again?

D: Well, I went to a wedding last summer, a very sad wedding and, after the wedding. this guy was going to go out and get some cocaine and turn everybody on to cocaine. He came back with heroin. I started shaking, and I left! *I got up and I walked out*! Everybody thought, "What's wrong with Dot?" Here she has to get up and walk out, and that's very uncool. But I can't even be around anything like that. It makes me very, very nervous! I'm not quite sure whether it makes me nervous because I want to do it, or because I don't want to do it, and I don't know the answer to that.

Why did Dot give up heroin? She mentions a lot of reasons. Her fear of needles that were aversive to her; her disorganized life, the fact that her friends were so unstable, the place that she was sleeping in any night was so unpredictable, and she didn't like that life-style. There were a lot of death threats in her life (a friend who overdosed, her uncle who hit an artery when shooting-up once), and so she was aware that there was a threat to her life, that she might suffer in these ways too, that she might die. And then, her behavior upset her. The fact that she turned some of her friends on to heroin, she made them drug addicts; or that, when her friend overdosed, she and her friends kicked him and punished him. After all he took more than his fair share of heroin. These behaviors upset her. It is clear that, finally, the negative features of taking heroin outweighed the positive features. But yet, does that really explain why she gave it up? A lot of heroin addicts, even when the negative features of their life are so strong, would still not give up heroin. They would be unable to. They would claim to be unable to. But Dot managed to.

What extra factor is necessary for her to be able to do this? How did she kick the habit when she decided to? It's interesting to note that she stopped taking the drug completely cold. She did not need any withdrawal, any period of time where she could reduce it. She just stopped. She left town. She left the culture that she was in. She left her friends, and she went to a different city, Buffalo. Changing the environment made it a lot easier for her to kick the habit.

It's interesting, in its context, to note the problem of heroin addiction in England where there are very few addicts, and heroin addicts are registered. They receive their heroin through a pharmacist, legally. They take their prescription, and they get heroin. How does this affect the drug addiction problem in England? It means that each heroin addict does not have to know other heroin addicts and does not need a pusher. The heroin addict, in England, is not in a subculture of addicts, ex-addicts and pushers. They are living among non-drug users, straight people, and so there is no peer pressure encouraging and supporting them in their drug habit. They go to the pharmacist, and they may never meet another drug addict at the pharmacist's. They get their heroin and they take it privately. The absence of this drug culture may keep the size of the drug addiction problem, in England, much smaller. It doesn't mean to say that we could use the English solution in America. England is very fortunate at the moment in not having that many drug addicts. It may be to late to apply such a policy in America. The drug subcultures already exist, and people already belong to them. There is no way of isolating a drug addict from fellow drug addicts.

Notice also that Dot is aware that something had to replace heroin in her life. It's not that you can give up heroin and leave those needs that were being satisfied by heroin, unfulfilled and unsatisfied. You have to find a replacement. Dot notes that she turned to social activism as a replacement. Not only did this give her some activity, something to do instead of taking drugs,

but it gave her a peer group or colleagues, friends and people who could support her. And not only just support her, but support her in a non-drug oriented life, rather than friends who shoot-up and would persuade her to shoot-up again. “Why don’t you try it? Why are you trying to be straight?” She had friends who would support her in a different kind of activity - political and social activism. This is very important, and luckily Dot found a replacement. Maybe she is fortunate in that. Many drug addicts cannot find their own replacement, and many agencies that treat drug addicts do not make any attempts to find a replacement - to find other ways of satisfying those needs that heroin satisfied. Next time we’ll turn to theories and research on drug-addiction and alcoholism, to see what evidence psychologists and sociologists have gathered to explain these kinds of behaviors.

LECTURE EIGHTEEN: ADDICTS AND ALCOHOLICS

Of all the lectures that I have prepared for this television lecture series, this one on alcoholism and addiction was the most difficult to prepare. I see myself as a scientist, and I like to base what I say on facts, not opinions. Although there is a lot of research done on addictions of various kinds, and although there is a lot of money spent on it - there's even a National Institute for the Study of Alcoholism and Drug Addiction - there are very few facts known about addiction. There are a lot of opinions, but these opinions are based on prejudice, bias or social and political stances, and they have no basis in fact. I found an interesting quote, from Craig MacAndrew, about alcoholism that illustrates this. MacAndrew wrote that:

While alcohol is a demonstrably toxic substance (a "poison"), it has also been termed the world's original miracle drug - both a brew of the devil and a gift of the gods, mankind's scourge and its liberator. Its ingestion by some persons has been variously termed a failure of will, a symptom (of sundry different things), a "runaway symptom" that has taken on disease significance, and a disease proper. It has been argued at one time or another that its ingestion prevents, constitutes, and causes psychosis. Its sale within the confines of this republic has been transformed within most reader's lifetimes from the status of a federal offense…..to a source of astronomical state and federal revenue. Even skid rows, while seen by most as a blight on the landscape of an opulent society, have been construed by some latter-day discussants as blessings in disguise.

If those Skid Row bums weren't bums on Skid Row, maybe they would be the revolutionaries and radicals of today and help to overturn our society. There are these various opinions, and none of them are based on facts at all.

Drug ingestion and addiction is an interesting topic because it is both a criminal offense (the possession of certain drugs, such as heroin or marihuana, is a criminal offense. It is not just that you pursue a criminal career in order to obtain money to buy these drugs, but that the possession of them is a criminal offense. If you possess particular drugs, you are a criminal. In addition, to be addicted to particular drugs is a psychiatric diagnosis. It is a personality disorder, and you are diagnosed as an addict with the mental illness of addiction. It is a psychiatric illness. What is intriguing, of course, is that not all drugs, possession of all drugs, or being addicted to them, constitutes crimes or mental illnesses - only some drugs. For example, in our society, it is now okay to possess alcohol. But if you are addicted to alcohol, that is a diagnosis, and you are mentally ill. Similarly, if you possess heroin, that is an offense. But with drugs like caffeine, nicotine or tranquilizers, to possess them is not an offense and to be addicted to them is not an offense. In fact, it is very difficult to find a rational basis for which drugs are legal and which drugs are not illegal, which addictions are mental illnesses and which addictions are not.

Again, I have a very nice quote from a psychiatrist that illustrates the irrationality of these views. This is from John Maurer who wrote:

Last year a senior came to me because he was concerned about his increasing use of the drug marihuana. When I asked him how it got started he said, "Well, last summer I was drinking a lot, but it was expensive, hard on my stomach, and gave me hangovers. Then I switched to pot which was a lot cheaper, didn't bother my stomach, and gave me no hangovers."

John Maurer sees this young student, Pete, and tries to treat him. He says, “Luckily it was not difficult to get him to stop using pot, since it is not an addicting drug, and he was using it as a tranquilizer. I merely substituted another tranquilizer.” Maurer gave him a prescribed tranquilizer, such as Valium. All that Maurer is saying is, “I can cure him of using marihuana as a tranquilizer by giving him Valium as a tranquilizer.” Why should Maurer want to get Pete off marihuana? Maurer explains “What makes marihuana so dangerous is the fact that it has few drawbacks - no drawbacks.” It has no more drawbacks than Valium, yet Maurer as a psychiatrist is concerned with getting Pete off marihuana onto Valium. Marihuana is a bad thing to take; Valium is perfectly okay. If you have ever worked in a mental health clinic where there are psychiatrists on the staff, you will know that most of the social workers, psychologists, and psychiatrists keep pills of Valium in their desk drawers. They pop them every few hours during the day to keep their anxiety level low. That is not illegal, and it is considered to be perfectly okay. But if they were to take a joint, smoke some marihuana, that would be bad, even though there are no drawbacks to it. So you have to conclude that there is no rationality behind some of the decisions that our society, and the professionals in our society, make about drugs.

In the lecture today, I would like to focus on just two drugs. I would like to focus primarily on heroin and alcohol. In fact, there are some similarities between people who are addicted to heroin and who are addicted to alcohol. First of all, with both heroin and alcohol, some people increase their intake of the particular drug until it is beginning to impair their functioning. They are taking so much alcohol or so much heroin that they can no longer function adequately in society. A second point is that there are some medical consequences for taking both drugs. The alcoholic, as he increases his intake of alcohol, will eventually suffer liver damage, may suffer vitamin deficiencies and, therefore, be more prone to death and various kinds of diseases. Similarly, heroin, if you take it, reduces your resistance to particular infectious diseases. It is only the junkie, with his reduced resistance to such diseases, that gets them. Certainly, both of them cause dependence, psychological dependence, and when you stop taking the drug you suffer what is called withdrawal symptoms. If you are an alcoholic and you stop taking alcohol, you suffer symptoms such as sweating, tremors, nausea, a rise in temperature, and sometimes convulsions and delirium, including delusions and hallucinations. If you are taking heroin and you stop taking heroin, you will suffer symptoms such as anxiety, restlessness, insomnia, perspiration, hot flushes, nausea, diarrhea, dehydration, and a high temperature. Both of them cause these physiological symptoms if you stop taking them.

We feel in our society that they differ, heroin and alcohol, in that only some people will become addicted to alcohol, but anybody can become addicted to heroin. Actually, there is not good evidence that that is true. For example, with respect to alcohol, it is true that many of us drink in our society, but not all of us become addicted to alcohol. If we look at animals, there are some strains of rats, for example, that are resistant to becoming alcohol addicts. There are other strains of rats that become easily addicted to alcohol. There are differences. When we do studies on humans we find that, for example, the physiological response of Orientals to alcohol is much stronger - the response of the body to a drink is much stronger and noticeable - than the response of non-Orientals. There are obviously differences in our resistance and our response to alcohol.

With heroin, we think it is different - that anybody can become a junkie if you take heroin and, in fact there is no good evidence that that is so. If you force people to take heroin, to be sure, most people will become (if not all people) physiologically dependent. But, what happens if you leave it to chance? If you let people voluntarily take heroin, then there is no good evidence that, if you take one shot of heroin, you will automatically go on to a second, third, fourth, and fifth, until you're hooked. As Thomas Szasz has pointed out, in countries such as Turkey and Iran, where they grow poppies to make Opium, very few of the peasants who grow the stuff, and who, perhaps, sample it from time-to-time, ever become addicted to it. In fact, in American, up to 1914, opium was freely available. You could go into a drug store or pharmacist and buy pure opium. Very few Americans became addicted to it. Left to themselves, people do not necessarily become addicted to heroin. If we study animals, such as rats, again we find there are some strains of rats that are resistant to heroin addiction and other strains of rats that become easily addicted. Therefore, it is not clear that heroin and alcohol differ that much in the ease with which they cause addiction.

When we consider the causes of addiction, let me read, from the Department of Health, Education and Welfare, a statement they made to Congress.

The causes of alcoholism (and it would be true of a drug addiction, too) are unknown, although the number of theories that have been advanced are as numerous as the professions and scientific disciplines concerned with the problem.

Now, what is important to remember here is not that there are differences in opinion, that is fine, but that there is absolutely no evidence to support the differences in opinion. When I talked about a behavior, such as schizophrenia, I mentioned there were genetic theories, but there is good evidence of the genetic basis. Some psychologist may ignore the influence of the family on producing a schizophrenic, but the evidence is good. But for all the theories of alcoholism and addiction, there is no good evidence whatsoever, even though there are strong opinions and biases.

Let us turn to one very strong and very predominant point of view about addictions these days - the medical model.

The Medical Model

The official view of addictions and, in particular, alcoholism is that it is a disease. This is the official government point of view. I would like to show you a couple of commercials produced by the government for television that illustrate this point of view.

> Welcome to the drunk tank. It's a strange treatment for alcoholism, strange because alcoholism is not a crime, it's a sickness. We don't lock up people for being diabetic or epileptic. Besides the drunk tank doesn't help. If it did, we wouldn't have 9 million alcoholic Americans. Help. Write: Alcohol, Box 2345, Rockville, Maryland.
>
> What if a terrible disease came to our land and 9 million of us got very sick and thousands died each year? What would we do? Nothing? Would we pretend the disease

was not a real disease – just a weakness? Alcoholism is a real disease. There are ways to treat it, but you have to Help. Write: Alcohol, Box 2345, Rockville, Maryland.

The official view is that alcoholism is a disease. It is a disease like other physical diseases. A disease. Not only that, we use alcoholism (and drunkenness) as a way of excusing people. If you commit a crime and you were drunk, you say, "I wasn't to blame for my behavior. I was drunk." You will not be prosecuted if you are drunk, if it can be proved that you are an alcoholic. It is used as an excuse as if it is a disease that you have. It is intriguing to compare our views with those of the Romans. Back then, if you committed a crime under the influence of alcohol, you got double the penalty. It was considered to be an even worse thing to do, whereas, we would give you half the penalty, or no penalty, if you are under the influence of alcohol or if you are an alcoholic.

What evidence is there that alcoholism is a disease, that there is a physiological basis for it? Virtually none. For example, if we take the children of schizophrenic mothers, and put them in foster homes, what we find is that those children are very likely to become schizophrenic. They carry something in their genes that makes them schizophrenic. If we take the children of alcoholic parents and put them in foster homes, they are no more likely to become alcoholics than if they were born to their adopted parents. They do not carry anything with them in their genes that makes them alcoholics. If we do twin studies - identical twins raised in the same family - we do find some evidence that, if one is an alcoholic, the other will also become an alcoholic. However, the crucial study is to take identical twins born in one family, separate them at birth, and give them to different homes to be raised. That study has not been done yet. What we would expect to find is that they would not show an agreement (or concordance) in whether, if one becomes alcoholic, the other does also. I suspect that, if one becomes an alcoholic, the other one would not. It is not that they carry something with them in their genes.

There are a number of physiological theories of alcoholism. One is that a particular genetic abnormality causes vitamin deficiencies which causes cravings for alcohol. Most of the evidence for that comes from studies on animals, and animals aren't humans. We do not know that we can generalize that research, but the evidence is not even that good for the rats. Another one is that there are glandular deficiencies or abnormalities in alcoholics. Again, most of the research has been done on rats, and there isn't even good evidence that it is true for rats. So, again, although the medical model of alcoholism and addiction is the official government view, there is virtually no evidence to support it.

Thomas Szasz

Now to contrast with this view, I'd like to consider the views of a psychiatrist, Thomas Szasz. Szasz has argued that our knowledge about the effects of alcohol and drugs on people's behavior, that we obtain in our society is completely invalid, and it's invalid for one reason, and that is that the drugs that concern us, heroin, let's say, for example, is that it's illegal, and so what we are doing, we are studying the effects of a drug in a society which says it is illegal to possess it; it is a mental illness if you are addicted to it. Now why should the fact of it being illegal affect the knowledge that we gain? Well a simple thing is, of course, that if you have to buy your drugs on the street, they are often impure and so the effects of the drug on your body

are not the same as if you were getting pure heroin. You are getting it cut with various kinds of things; evidently anything from strychnine to flour and sugar. But more importantly the fact that it's illegal makes the heroin addict embark upon a criminal career; also the addict gets into a social group in which everybody in that group is addicted or taking heroin. Szasz argues that to study the effects of heroin in our society would be like studying the Jewish religion in Nazi Germany in the 1930's and the 1940's. I mean, think about it. If you studied the Jewish religion and Jews, in Germany, in those periods of time, where would you find the Jews? Well, you'd find them in concentration camps or walking about the streets branded as Jews. You would find them being very paranoid, very neurotic, and very disturbed. But is that because they're Jews or because the society persecuted them and punished them and killed them for being Jews? Szasz says just as you could not learn about Judaism from studying it in Nazi Germany, you cannot learn about heroin by studying it in our society. Szasz notes, as I've pointed out already, that the countries that grow opiates, Turkey, Iran, and so on, have very little addiction. It is not illegal in those countries. It's legal for them to grow it, to market it. It's a prime source of income for the country. And addiction is very rare.

Szasz points out that lots of our myths about the opiates are false. Like, we think they impair performance. Szasz has pointed out that, for example, opiates increase performance. The Chinese who took opiates a lot in the early part of this century worked better on the railroads, worked harder in the laundries, than people not on opiates. Freud was on cocaine most of his life. One of the surgeons who helped found Johns Hopkins University and the medical school, William Halstead, a surgeon, took morphine for all of his life.

Szasz argues that all drugs should be legal. Anything can be abused. You can abuse driving a car. You can abuse anything; you can abuse Dran-o, but that doesn't mean to say that we should ban Dran-o or we should ban cars. Szasz would say every drug should be made legal and that every one of us has the right to poison ourselves if we wish. It is not that heroin destroys, or that opiates destroy, or that alcohol destroys; we destroy ourselves. If we want to abuse heroin or alcohol, that is our right to, just as our society would permit us to abuse Dran-o if we wanted to. Szasz also points out the irrationality of our choices. Today methadone is a legal drug. It is used as a cure for heroin. Just as heroin, once upon a time, was seen as a cure for morphine addiction. In fact, methadone is as addictive, and in some ways is more toxic than heroin. Szasz calls it a government inspired racket that makes heroin illegal—the problem—and methadone legal and the cure. Just as my example earlier said pot was illegal—marihuana was illegal—but Valium, another tranquilizer, is legal. And so, I'm just going to give one final emphasis to Szasz's point. Heroin does not destroy people. People destroy themselves. And they will always find a way to destroy themselves.

Learning Model

Finally, let's move on to the learning model of addictions. Obviously drinking behavior and drug taking behavior is learned, in part. We have to ask first of all does the society *allow* the behavior and in what ways does the society *encourage* the behavior? There is much evidence to suggest that, in fact, addictions and alcoholism are learned. First of all, to take alcoholics, they often start drinking very early in life. There is a great period of time between the first drink that they take and when they eventually become addicted to the drug. Now there are exceptions to

this, but in general, there is a long time lag, so there is plenty of opportunity to learn the addiction. Secondly, the best predictors of whether someone is going to become an alcoholic or not is the attitudes that his family and his society have towards drinking, and the environmental support for drinking.

Let me give you some examples here. Among Jews, the rate of alcoholism is very low. Among people like the Irish, the rate of alcoholism is very high. And if we look at Jewish society, we find that the functions of drinking are made very clear to the Jewish society. The function of drinking is to draw people close together. There are lots of rules about drinking and they're clear rules and if you violate those rules, you will be punished. In fact, we find that alcoholism is very rare in these kinds of societies or in these kinds of families. Let me give you some examples. Where the children are exposed to alcohol early in life, within a strong family or religious group, whatever the beverage, it is served very diluted and in small quantities and, therefore, people very rarely get very drunk. Alcoholism is low in families where the parents present a constant example of moderate drinking, where there's no moral importance attached to drinking—it's neither considered a virtue nor a sin—in societies or families where drinking is not viewed as proof of adulthood or virility, where abstinence is not socially acceptable, where excessive drinking or intoxication is not socially acceptable, and finally where there is wide and usually complete agreement among members of the group—what might be called the ground rules of drinking. And those family and societal rules are the best predictors of whether a particular family or a particular culture will have a very high rate of alcoholism or not.

Now you might say, "Gee, to be an alcoholic or a drug addict is a great source of misery; people suffer." I mean look at the life of a Skid Row bum; is that really such a good life? If life is so unpleasant wouldn't they learn not to drink, not to be addicted? And, I guess, what you have to remember is that the Skid Row bum, for example, is not the typical alcoholic. According to the government, only about three percent of alcoholics are Skid Row bums. It is possible to be an alcoholic and to function reasonably well in society, to earn a living, to maintain your job, to, in fact, get promoted in your job, and still maintain an addiction to alcohol.

Now people do have a large degree of control over how much heroin and how much alcohol they take. Alcoholics that I have talked to claim that it's very easy for them if they have to, for example, be at a conference, present a paper, talk to their employers, to abstain from drinking. You might say, "Oh, gee, that's not so possible for heroin." But I've talked to ex-junkies, one ex-junkie in particular, who said that whenever her boyfriend was out of heroin and she had some, she would give up her supply and give it to him. Our society say, "Gee is that really possible? If you are a heroin addict can you just give away your stash to somebody else?" Some heroin addicts claim that they can. It is possible to exert some control over how much you take. So that although the learning model is persuasive—there is a good evidence for it—we have to bear in mind that there is no hard data to show that people do learn to be addicts or alcoholics. It's a supposition that we make. It's a possibility that maybe has some truth, but can we prove it? Can we prove that you learn to be an alcoholic or that you've learned to be an addict? No, we can't prove it.

There are a variety of other viewpoints about alcoholism. Just to mention a few, the psychoanalysts have a lot to say about alcoholism. The psychoanalyst, remember, would look for

unconscious motives, unconscious wishes that are, perhaps, satisfied by the intake of alcohol. Since alcohol is taken orally and since the alcoholic shows behaviors that sometimes indicate great dependence, or perhaps great problems in handling dependence; psychoanalysts have speculated that, perhaps, strong oral needs are present for the alcoholic. That maybe they suffered severe frustration during the first stages of development, the oral stage of development, and that these oral needs that, perhaps, were frustrated, perpetuate into later life and manifest themselves, in some people, by their ingestion of drugs. However, we have to ask, why alcohol? I mean, why not overeat and become overly fat, why not smoke cigarettes or bite your nails? There are various ways you can satisfy those oral needs. Why do some people choose alcohol; whereas others do not?

Karl Menninger has speculated that, perhaps, underlying alcoholism are self-destructive urges. Karl Menninger sees alcoholism as a kind of suicide and calls it chronic suicide, a way of killing yourself that takes many, many years but nevertheless is a reflection of your unconscious, perhaps, or maybe conscious, self-destructive urges. And that is the kind of way that psychoanalysts would approach alcoholism; what unconscious wishes are being satisfied by the ingestion of alcohol or drugs? A lot of psychologists have said, “Is there a particular kind of personality that takes alcohol or heroin and gets addicted to it? Like a psychosomatic disorder.” Do only particular kinds of people suffer addictions? Are prone to suffer from addiction? And again they look at things like personality traits such as dependency, or having a low tolerance for frustration, maybe having poor control over one’s impulses, and they suggest “maybe there is a particular kind of personality that gets addicted.” The trouble is they don’t agree on the particular traits that describe the addict, and there is no good evidence that there really is an addictive personality.

Maybe one final theory I could mention is that some, particularly sociologists and anthropologists, claim that the stresses of society, societies where there is a great deal of stress, encourage or facilitate people becoming addicted. For example, Ronald Horton did a study of primitive societies, and he found that societies which hunted for their food, and therefore were always less certain that they could find enough food to feed their family, had a much higher rate of alcoholism than societies which grew their own food, and therefore, had a greater degree of control as to whether their families would starve or survive during the following year. And he argues that the stronger the stresses and the anxiety in the society, the more likely that society was to turn to alcohol as a source of relieving that anxiety.

So where does that leave us? I guess, as I said at the beginning, I find myself being very confused. I really do not know which model best fits alcoholism and drug addiction. And it’s kind of interesting to reflect that alcohol has been found in almost every society in the world, has been around for thousands and thousands of years. Mankind has been ingesting alcohol and various kinds of drugs for thousands of years, and yet our knowledge of it, even today in the 1970’s, is so rudimentary that we have very little idea as to the causes of alcoholism and addiction.

LECTURE NINETEEN: GOOD DEVIANTS

So far in this lecture series I have talked about the retarded, criminals and the mentally ill, all undesirable forms of deviance to have. However, deviance can sometimes be desirable, and today we are going to focus upon the good deviant.

Geniuses and Astronauts

I want to describe for you the childhoods of some men who lived about 150 years ago, and I want you to listen to these descriptions and think, "Is this a healthy atmosphere or a healthy way in which to raise a child?" All of these children were born with average or superior intelligence. They all got a lot of attention from their parents, both affection and intellectual stimulation, and they were all cut off to a large extent from contact with their fellow children, peers, and play mates. They spent most of their time with adults. Let me give you a few examples. One young boy began hard intellectual work by the age of three. His father kept him apart from other boys in order to prevent the corrupting influence of those other boys and to isolate him from vulgar ways of thinking and feeling. Case two lived at home free from the liberties, temptations and follies of student life. Case three sought his father's advice when he chose a wife. In case four the father could not bear the thought of leaving his education to others, and so the father became his only teacher. Eventually the boy's health broke down. In case six his father kept him to a rigorous schedule of instruction, in everything from dancing and military drill to Greek, from an early age. Case eight: when he was a small boy his mother depended upon him as if he were a man, and both his parents tried to keep him from the corrupting influence of other boys. And so on, and so forth. The childhoods of these men were characterized by several features; a great deal of hard work – to such an extent that they often became physically ill; they were all isolated from their fellow children, from peers, and this resulted in them developing very poor relationships with other people; half of them never married; and these children were always thrown back on their own resources - they were always encouraged to think for themselves, to decide for themselves, and to be independent from their parents.

Now is this the way to raise children? A couple of psychologists, Robert and Carol Ammons, gave these descriptions of the childhoods of these men to a group of students who were training to be teachers, and said, "Do you think this is a good way to raise children?" Everyone of the student teachers said, "No!" It's a terrible way for these reasons; "These boys never learned to play. They didn't learn to be independent. They were always dependent upon adults. They couldn't socialize with other children. They had no opportunity to learn to adjust to society. They ended up with poor health. They never learned how to get along with females." The Ammons's asked these students, "How would you improve the life of these children?" The students said, "We've got to get them away from their parents. Put them in public schools. Encourage them to do non-intellectual activities. Make them associate with other children." The students all concluded that these boys would end up misfits, that they would have no real friends, that they would never get on with other people, and that it was a terrible way to raise children. Who were these men? The men that the Ammons' studied were twenty geniuses, twenty people who excelled in their profession. They included the poets Goethe, Chatterton, Pope; the politician Pitt in England; the philosophers Leibnitz, Pascal and Voltaire; and the historian McCaulay.

The Ammons's concluded that our society has an anti-intellectual bias and that we believe in a lot of myths. One of them is that in order to get on with adults, in order to become a leader, you had to be able to get along with other children when you were a child. Is there any evidence that that's true? We hold another myth, that you can never learn to solve problems – the everyday problems that all of us confront – unless you are confronted with them *ad nauseum* when you're a little child and that, if we protect someone from facing these problems, we are going to create an unhealthy individual. A third bias is that we don't consider intellectual activities "play." We consider play activites like building blocks and rough and tumble to be play but not thinking or problem solving.

Why did these twenty children turn into geniuses? There are a couple of features. First of all, their parents encouraged intellectual activity, and they rewarded intellectual activity. Second, the parents prevented incompatible behaviors from occurring. What kinds of incompatible behaviors did they prevent? What kinds of behaviors do we encourage in our children that prevent them from becoming potential geniuses? The things that we encourage our children to do are things like non-selective television viewing, reading for escape, playing escapist sports, doing chores in routine ways, reading comic books or babysitting, and as you get older, drinking, bumming around, engaging actively or passively in sports, and getting involved with sex - even to the point of promiscuity. In all these, we encourage an anti-intellectual bias in our society.

So far in this lecture series, I've considered the bad deviant, the immoral deviant, the unhappy deviant. We have to remember that for the retarded on the one hand, there are some good deviants, the geniuses, on the other hand. For the mentally ill on the one hand, there are the psychologically healthy on the other hand. If you recall, in an earlier lecture, I described Maslow's work on psychologically healthy individuals. The self-actualized person is somebody who has all the basic physiological needs satisfied, is emotionally stable, has a sense of belonging, is able to love and receive love, and is capable of realizing their potential – of becoming what they are capable of becoming.

In psychology today, psychologists very rarely study the good deviant. We are much more concerned with the bad deviant - with the criminals, the retarded, and the mentally ill, and the reason for this is that these individuals – the retarded, the criminals and the mentally ill – present problems for us. What do we do with a murderer? Should we punish them, or should we not? How can we treat them? If you consider prostitution a problem for society, we have to ask, "How can we understand prostitutes? How can we prevent this social problem?" Because they present a problem for us, a great deal of research is carried out trying to investigate the causes of their behaviors and to understand these bad deviants. But the good deviants are important too, although there is very little research on them. Today I would like to focus a little bit on two kinds of good deviants, geniuses and astronauts. First of all let us turn to the study of genius.

Geniuses

How do people become geniuses? What is the theory of genius? There are a couple of theories that have been used to explain genius. The first one is rather odd - it's that geniuses are crazy or insane, and this is a theory that has been held for about 2,000 years. Recently people

have looked back at someone like Socrates and said, “Look at Socrates! He had trances, he had hallucinations, and he sometimes had what appeared to be cataleptic fits. Obviously he was insane.” Those who believe this point of view have to explain, “How is it that to be crazy encouraged you to be a genius or facilitated you to be a genius?” They propose several explanations. First of all, the idea was that insanity might release the control of your mind from rational processes. It might enable you to be open, to be more novel in your thinking, and to have a greater variety of experiences. Therefore, insanity frees up your creative process. The second idea was that insanity made you feel inferior – that, if you were psychiatrically disturbed, you felt inferior, and your genius was a way of compensating for that. You excelled in something in order to make up for your feelings of inferiority. The third point of view is that being crazy enables you to have a richer fantasy life, and to be brilliant and creative involves having, perhaps, rich fantasies, of being able to see things in novel ways and to think and dream in creative ways. So again, being insane freed up your fantasy life and gave it greater variety and novelty and, therefore, helped you move to creative solutions.

It’s often been believed that geniuses are crazy - are psychiatrically disturbed. The evidence for this is not good, but again we might think, “Why might they be disturbed?” Several suggestions have been made. First of all, being a genius in our society is not easy. You are abnormal in some way. You are a deviant. To be deviant and to be intellectually superior to everybody else is a source of stress. Because you are different, you feel alienated, and you cannot talk to others as easily, perhaps. They react to you as if you are strange, and that extra stress makes you psychiatrically disturbed. The second hypothesis is that the genius is, perhaps, more sensitive, especially emotionally, to what goes on and, therefore, is subject to more emotional wear-and-tear as the genius confronts the problems of the world and the problems of society. The third explanation is a social hypothesis - that in fact the genius is labeled crazy because other people cannot accept his or her behavior. In fact, many geniuses have been called crazy because of their points-of-view and their ideas at the time, whereas a hundred years later we look back upon the geniuses and say, “My word. They were the healthy people. They were the sane people. It was other people who were crazy.” So that’s the first theory - that genius is, perhaps, a result of being insane.

The second idea is that geniuses are somehow qualitatively different from you or I, that somehow they differ in kind, from us. That is embodied in statements such as “the divine spark of genius” or “divine inspiration,” as if there is something extra that is added to the normal person to make them different. Maybe it comes from God or from fate. In contrast to this is a third hypothesis - that, in fact, they are no different qualitatively from you or I but just quantitatively. We all have an IQ score. To be a genius, all you have to have is a high IQ score, perhaps an IQ of 160 or above say. You don’t differ qualitatively but just quantitatively. You have more intellectual ability.

How do we study genius? There have been a couple of studies. The first was historical. We look back into history, we find some geniuses, and we try to find out, “What make them geniuses?” First of all, we have to identify them. Catherine Cox, a psychologist in the 1920’s, went back and tried to estimate the IQ of a number of famous men. Obviously, they never took intelligence tests, and she can’t really measure their IQ in an accurate way. What she tried to do was to find out when they acquired certain sills - when they learned to talk, when they learned to

play the piano, and when they learned to read. From the age at which they acquired these skills, she estimated their intelligence approximately. For example, the philosophers that she studied averaged an IQ of about 170, poets and novelist about 160, scientists about 155, musicians 145, and military leaders only 125 (they were not that high in IQ!).

Let me give you a couple of examples. John Stuart Mill, a philosopher, had an IQ estimated at 190. He began to study Greek at the age of 3; by the age of 7 he was reading Plato in the original Greek. He began Latin at the age of 8, and in one year was reading original works in Latin. At the age of six and half, he wrote a history of Rome. John Quincy Adams's IQ was estimated to be 165. At the age of eleven, he wrote a treatise on Roman antiquities. At the age of fourteen he translated Cicero's speeches from Latin to English. At the age of twelve he taught the French ambassador to the United States to speak English, and he astonished the ambassador with his knowledge of linguistics. At the age of fourteen he went to Russia with a gentleman, as the gentleman's secretary. At the age of fifteen he journeyed by himself from Paris to Russia via Sweden and Denmark for a six month trip, and he wrote on the treatment of strangers in Sweden, the policy of government in Denmark, commerce in Hamburg, and the wine cellars of Bremen. What were you doing at the age of fifteen? John Quincy Adams was clearly doing things that you and I never did at the age of fifteen.

Not every famous person had a high IQ. According to Catherine Cox, John Stuart Mill was estimated at 190, John Quincy Adams at 165. But Rembrandt had an estimated IQ of 110, the chemist Michael Faraday 105, and Andrew Jackson 110. When Catherine Cox studied the childhoods of these geniuses, she found that their physical health was about average, their mental health was about average; they were no more prone to a psychiatric disturbance than the average citizen living in the same time. As adults, they were no more psychologically disturbed, but she did find that certain kinds of geniuses tended to have more disturbance than other kinds of geniuses. For example, the poets, the musicians and the artists suffered from psychiatric disturbances much more that the revolutionaries or the statesmen.

The study I talked about, at the beginning of this lecture, of the childhoods of geniuses gave us some insight into what kinds of families produced geniuses, but obviously this kind of historical study is not of that great a use. The data are very unreliable, and the children were not described in detail as they grew up. We have to take into account the cultural setting in which the children were raised which is very different from our cultural setting. We have to ask, "Are these geniuses a representative sample of all geniuses?" A much better kind of study is to study geniuses in contemporary society. The problem with this is that, if we study geniuses today, we can't identify them. Who is going to be a genius? Here we have a little baby who looks pretty bright, but we don't know that this baby is going to turn out to be a genius. What we can do is study gifted children who may become geniuses. They may not, but at least they're gifted as children. Let me give you an example of a child whose IQ was estimated by a modern intelligence test at 180 IQ. He began to talk at 10 months old; at 14 months he could pick out letters on a typewriter by himself; at 12 months he could say the alphabet forward; and at the age of 16 months he got bored with saying the alphabet forward, and so he taught himself to say it backwards. He learned to read for himself during his third year and could read fluently before he went to school. Now obviously such a boy would not develop his intellectual skills if his parents hadn't encouraged him. But what is important to note about that boy is that he did much of it

himself, and he did it for fun. I think those of you who have children and who have watched Sesame Street on the public television stations can get the idea that that program for children, tries to make intellectual activities fun - that it's okay to build blocks and to get into fights and to run around and scream and shout, but it's also fun to count up from 1 to 10, to try and spell words, and that intellectual pursuits can be fun.

The major study of gifted children, conducted by Lewis Terman, began in 1921. He studied a group of 1,500 children whose IQ was estimated at about 140 IQ points or greater. He found that they were taller and heavier from birth onwards, than non-gifted children. They learned to walk earlier and to talk earlier. They reached puberty earlier, they had fewer headaches, they had fewer hearing defects, and they were less nervous. In fact, in all respects, they were much healthier than the average child. There was only one way in which they were less healthy and that is their vision was poorer – they tended to wear eye glasses more than non-gifted children. But in almost all other respects they were superior. They were very high in motivation, in will power, self-confidence, cheerfulness and, in other traits such as popularity, leadership, sympathy and generosity, they were about average. It's not as if they excelled in motivation and intellectual ability while other traits suffered. It's not that they were unpopular - they were about average in popularity.

Terman followed up these children about twenty years later. How were they at the age of 20, 30 and 40? He found that, for any kind of abnormal behavior that he studied, whether it was delinquency, mental illness, alcoholism or divorce and marital adjustment, they either were about average, that is, they were just the same as their non-gifted peers (children who were not as bright but of the same age) or else they were even lower. They had lower rates of alcoholism and lower rates of mental illness. Physically they were still superior. They were still taller, heavier and fitter. They had a lower death rate from suicide and homicide. On the whole, they were still healthier and were still superior. We tend to believe in our culture that to be deviant in one respect means that you are likely to be deviant in other respects, that, in fact, if you're intellectually deviant, you'll be psychiatrically deviant. In none of the research that's ever been done has there been any evidence that this is so. In fact, as I have said, it's the other way around. It is less likely that the gifted individual is going to be psychiatrically disturbed. It is much more likely that they are going to be healthier.

Let us move on to a different kind of good deviant – the astronaut.

Astronauts

Astronauts are, clearly, very highly selected individuals. In order to choose someone who is going to go to the moon in a rocket ship and perform strenuous tasks there, you have to select such an individual carefully. Most of the astronauts who have been selected by the United States Government have been highly screened, chosen from a highly selective population, and then most of that highly selective population has been ruled out as unfit. Just a few have been chosen. Most of the early candidates were already pilots, and most were test-pilots for the Air Force or the Navy. In subsequent years a few private test-pilots have been allowed to be candidates, but the early ones were nearly all already in the military service and, of these test-pilots, only a few were selected to be potential astronauts.

Michael Collins wrote a book, called *Carrying the Fire* which describes the candidates who went through the selection process with him as hyperthyroid, super-achieving, first-born sons of super-achievers. What does this mean? First, they tended to be first-born and first-born sons in the family - rarely second, third or fourth-born sons. Second, they had an extremely high need to achieve. Not only that, they had fathers who had equally high needs to achieve which perhaps had influenced their son's needs. By hyperthyroid, he means very aggressive, energetic, active people; not passive, behaviorally retarded, quiet individuals, but go-getters. People who set goals and who set out to meet them.

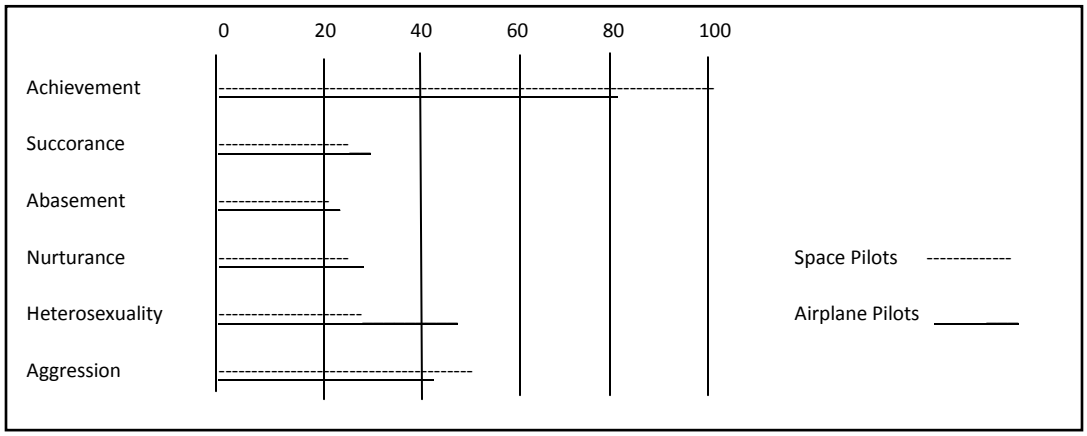
There have been a couple of studies reported that have tried to describe the criteria that were use to select these astronauts. Carlos Perry took a pool of fifteen potential astronaut-candidates from which five were chosen as good material, and five were chosen as absolutely the worst material out of the fifteen. Let me just describe a few things that he found. First, of the fifteen applicants twelve of the fifteen were first-born sons. They were all about twenty-six to thirty-five, they were all married, they all loved flying and they all had shown themselves capable of handling stress. They had flown combat missions in Korea. They had crashed planes and survived the crashes, and acted cool under such stresses.

The five who were ruled out were ruled out for these reasons. Two were judged to have their motivations for traveling to the moon to be neurotically over-determined. They were driven. Why did they want to go to the moon so much? One was the least motivated and the least physically fit. One was considered to be psychosexually immature, he was not as emotionally developed as the others, and he had troubles with his wife. One, the least intelligent, had a professional setback in his career and had never really gotten over it. He always regretted that event and grieved over it.

The five who were selected all showed that they could handle their aggression openly and without discomfort. They got angry, but they didn't block it. They could express it openly and in a constructive way. The five who were selected as being the best applicants handled the personal interview extremely well. The personal interview was very stressful. The psychologists and psychiatrists pried into the people's personal lives. They wanted to know everything about them, and this is a stressful experience. How defensive do you get? "You have no right to know that about me. You have no right to ask me that question." These candidates could handle such an interview with ease and comfort. They related well to other s. They were sympathetic to others. They were empathic. All of them had suffered very stressful life experiences but had survived them and had grown as a result of these experiences rather than become less healthy.

In a second more extensive study, Don Flinn, a psychologist, studied thirty-two potential candidates to be astronauts, and he found that twenty-eight of the thirty-two were first-born males. Three of them were only children - an only male-child in the family. So again, we have this predominance of first-born male children. Their average IQ was about 132, and the range was 122 to 138, Flinn argued that four traits are necessary to be an astronaut: you have to be extremely emotionally stable; you have to have a lot of motivation; you have to have good self-concept (you have to like yourself, to be at ease with yourself), and you have to be able to get

along well with other people. He gave them a couple of psychological tests, and let's look at a chart that describes some of the personality traits of these astronaut-candidates.



The chart that you're looking at compares the astronaut candidates with other test-pilots. If you look at achievement (an average score in achievement would be about 50) you'll notice that the test-pilots and the astronaut-candidates had very high needs to achieve, but the astronaut-candidates had an extremely high need to achieve. They were in the top 1% of the population on this trait. On need to receive succorance (the need to receive help from others, to depend upon others) you'll notice that both of them were extremely low on this need. But again, the astronaut candidates were even lower than the test-pilots. In the need for abasement (to feel inferior, to belittle yourself, to feel guilty) both groups scored very low, and the astronaut-candidates scored extremely low. On the need to be nurtured (to look after other, to take care of others), both groups scored low, and the astronaut candidates scored lower than the pilots. On the need for heterosexuality, the test-pilots were about average. The astronaut-candidates had a relatively low need for heterosexual relationships and activity which seems reasonable in so far as they would be so motivated in their work. They want so much to be test-pilots and to be astronauts that this deflects, perhaps, from their interpersonal and, therefore, their sexual behavior. Finally, on the need to aggress and a variety of other needs, the astronauts and the test-pilots didn't really differ that much from each other or from the average population. They scored at about the 50th percentile.

On another psychological test, The Gordon Personal Profile, the test-pilots were found to be very responsible and very emotionally stable. In comparison to the test-pilots, the astronauts were found to be extremely responsible, very stable, and perhaps a little less sociable. Again, that might be a result of their intense involvement in their work and in their mission - their mission of being a pilot and wanting to be an astronaut. For the need to achieve, the astronaut candidates were almost in the top 1% of the population, and in emotional stability they were in the top 10% of the population. Statistically speaking, the astronauts were very deviant. One sometimes wonders whether Christopher Columbus would have been selected if he had to go through a psychological screening in order to sail to the New World. The screening was very rigorous.

There are a couple of points to think about in conclusion. One is that these traits were ideal for astronauts, but they may not have fitted them for other tasks. Those traits that were

considered good for the astronauts may not make a good president, may not make a good politician, and may not make a good psychologist. Secondly, even these astronauts have had difficulty readjusting to society after they completed their mission. There have been a number of depressions among former astronauts, some psychological breakdowns, and a great deal of difficulty in fitting into ordinary society. So the traits that make for a good astronaut may not make for a good citizen.

LECTURE TWENTY: A CASE STUDY: TRACY

In the medical model of deviant behavior, we look for some organic basis for the behavior. Is there some genetic abnormality in the person? Maybe there is some hormonal irregularity, or maybe some damage happened to the person as a child or as an adult. Maybe they were deprived of oxygen during birth, or the mother got German measles when she was pregnant. Perhaps, as a baby, there was some damage to the head from a car crash or being dropped from a great height. Occasionally, we can find behaviors in which there is a clear organic etiological basis for the behavior.

Down's syndrome, which used to be called Mongolism, is a kind of mental retardation for which we know there is a clear organic basis. In the most common form of Down's syndrome, there is an extra chromosome, a 47th chromosome instead of the 46 that normal people have. This particular kind of Down's syndrome does not run in families, and the cause takes place when the ovum is formed as the mother releases the ovum each menstrual period, or it can be transmitted by the father in his sperm. It is very common. About 9,000 children are born each year with Down's syndrome - about one in 700 of all births.

Although we know there is a clear organic basis for the behavior, there is no way of treating it through medical means. The best we can do with children who have Down's syndrome is to apply the principles of the learning model to shape their behavior, to educate them, to try to train them in the basic skills, to try to teach them to talk, to take care of themselves and to be clean. Recently we interviewed the parents of a child who has Down's syndrome. Let us now turn to Tracy and listen to what her parents have to say.

L: How many children do you have?[1]

M: We just have the one, Tracy.

L: How old is Tracy?

M: Tracy is two and a half now.

L: Tracy has had Down's syndrome. When do you first find out that a child has Down's syndrome?

M: We found out, I guess, maybe three hours after she was born.

L: They can tell that quickly? How did you feel when you found out about it?

M: Like I had been hit with a sledgehammer. It was a big shock. It was just a numbing. I really didn't think too much except for the numbness that set in.

[1] L is me, M the mother and F the father.

L: How did you feel?

F: Well, I was quite shocked. I knew it before Jackie did because when I went in to see the baby I recognized it instantly. I knew it quite a bit of time before she did and then, when the doctor called us into the office and explained, I wasn't too surprised when he was telling us about it.

L: Was the doctor and the other staff of the hospital supportive?

M: Not at all, as far as I was concerned. The doctor just told us the child has Down's syndrome, and that was it. Go home. That was the end of it. I didn't even know what Down's syndrome was. If he said it was mental retardation, that I could grasp, but Down's syndrome? I had really no idea it was a chromosome problem or the other things that went with being a Down's syndrome child. I knew nothing. The nurses were very nice. They knew what was going on, but there was no follow through. Nothing.

L: They left it up to you.

F: Entirely.

L: Were you able to get some advice, information?

M: Finally we went to the state, the Bureau of Retardation. We went to the state, and we asked them. We have a child with Down's syndrome. What do we do? We had no idea. We didn't know whether we had to have special medications, nothing. When we were first told, I really didn't have these questions on my mind then. It was such a thing to happen.

F: We did go talk to the doctor, too. He was very cold, and he said put her away. Just like that. We couldn't see that.

L: He advised you to put the child in an institution?

M: Yes, right. We knew there had to be different answers than that. We couldn't accept that, so we kept going to different doctors and seeing what we could find. But it seems the doctors didn't know too much about the Down's syndrome or anything else. They really couldn't tell me anything. But finally, the Bureau of Retardation did tell us some facts. What Down's syndrome was, and what to expect.

L: In the two and a half years since then, have you found a source of support and advice?

F: Very much so. The schools have been very cooperative. They have given us quite a good outlook on it - what can be done with the child. How far she can advance. As long as you realize her potential is limited, very limited, and accept it, that's the main thing, I think. First to accept it and then work from there.

M: I think we were very lucky in finding a school in Camden which follows through. You take your child there from two weeks on. They work with the parents, counseling the parents

intensively from six to eight weeks while the child is being worked with on muscular problems, and fine motor skills when they get older. But the parents are really given a lot of support and explained this is what it is, and how you can help yourselves. Not just take the child home. This is it. This is your problem.

L: Do you take her there now, to the school?

M: Yes, she goes three days a week, and she likes it.

L: What kinds of things do they do, let's say, for a two and a half year old?

M: Right now they break it up into segments. For twenty minutes she will be doing fine motor skills - beads and buttons and, a lot of fine motor skills. The other half hour they do self-help skills - shoes, taking your socks off, putting a sweater on, eating correctly sitting at a table. How to eat, things that they would get at home, but they get in school also. And they do finger-painting, bathroom skills, lots of very good things.

L: Is there a program for you, or do you just have to leave your child there?

M: Not any more. They figure, if you can function fine after the 8 weeks, then you are on your own.

L: But you have to go all the way to Camden for this?

M: Yes.

When a wife is pregnant, often the mother and the father fear that the child may be born deformed or retarded. Not only may there be a material struggle - can you support the family financially - there is going to be a lot of emotional wear and tear dealing with such a child. And also, to have a retarded or deformed child affects your own self-concept. You feel that there is something wrong with you, and often the parents of such a child will try to have another child quickly that is normal to prove that they are normal, that they are capable of having normal child, and this restores their self-concept.

It is impressive how little physicians, pediatricians, obstetricians and gynecologists do to prepare parents for this possibility. Listening to Tracy's parents, we find that, in fact, the staff was not supportive after the birth of the child that had Down's syndrome The parents were given very little information about children with Down's syndrome, and all they were advised to do was to put the child in an institution. But that is not an easy decision to make. The parents who do that will often feel grief, and they will mourn the loss of the child. They will feel guilt at having put the child in an institution, and so, even if a child is institutionalized, the parents will need advice and support for how to deal with this.

Tracy's parents decided to keep her at home. Tracy's parent were strong, they were healthy individuals, and they sought out their own resources. They contacted the Bureau of Child Services, and they found where there were classes. What is impressive is that they were not just

classes for Tracy, but classes for the parents too, to help the parents adjust, to give them peer support from the parents of other Down's syndrome children, and to learn what to expect from her. Let us now return to the interview with Tracy's parents and find out what kind of child she is. How retarded is she? What kind of behavior does she show? Is she an easy baby?

L: Do you know how retarded Tracy is?

F: Not really. I think they don't have a complete evaluation until after five years.

M: They suggest that, at four and a half years, that we have a complete evaluation on her.

L: She's two and a half. How far behind do you think she is now?

M: I think she is functioning at a one and a half year level.

L: Is there much variation in the functioning level of children with Down's syndrome?

M: Very much. I found that a couple in her class are at their chronological age. They are doing very, very well.

L: How far down do they go, do you know?

M: Yes. To severely retarded - where they are just lying down. They never walk. They don't feed themselves.

L: I see! A lot of people say that Down's syndrome children are very easy children. They're happy, cheerful.

F: They are very happy, cheerful people, but they are also very stubborn, very stubborn.

L: Tracy is two and a half, what kind of things can she do?

M: She is almost potty trained. She tells me when she wants to go. She feeds herself; she dresses herself some; she sometimes puts her top on; she'll comb her hair; she'll wash her face. She really does an awful lot of things that a two and a half year old would do at this time.

F: She eats very well by herself, too. She handles a spoon or fork very well.

M: She is very well behaved in restaurants which is more than a lot of two and a half year olds are.

L: What's her vocabulary like?

M: She has maybe a vocabulary of six words, six or seven, not much more.

L: I am sure she understands much more than that?

M: Oh yes. She understands a lot. She won't try to say a lot - maybe the first two letters of a word, but she will try, which is the main thing.

L: Do you have any idea how she will progress as she gets older?

F: Not really. How do you know how far your children are going to progress. It's kind of hard to tell right now. We take it from day to day and, when she does something new, it's very nice. We don't have any long-range plans as far as, when you have children, you usually pick out the college, you pick out their profession. Tracy will be with us a long time, and we'll just enjoy her.

L: Do you know what the life expectancy of Down's syndrome children are? Is it longer than ours?

F: Quite a few of the children have a chronic heart condition, and some have weak chests but, thank goodness, Tracy doesn't have either. She seems to be a very healthy child.

L: So she should have a long life?

F: We think so, yes.

M: The life expectancy for these children is just normal. If they don't have the heart problem.

F: or the chest problem.

M: They are very susceptible to colds and any kind of infection that is going around, but, with antibiotics, that's almost mastered now. She will probably live just a normal life span.

L: What kinds of things can children with Down's syndrome do as adults?

F: It varies. There is such a wide range of what they are capable of doing. Some of them will proceed a lot faster and a lot further than others. Some will be limited as an adult. Some graduate from high school, and others perhaps grade 5 or grade 6.

L: But a number for graduate from high school?

F: Yes, definitely. I've heard of a few cases where they even went to college.

M: You're talking then about a different kind of Down's syndrome.

F: It's very rare, though, for them to go to or beyond high school.

L: What do you mean a different kind Down's syndrome?

M: Well there's three types of Down's children. There's the translocation. There's a twenty-first chromosome, which is Tracy. And then there is the mosaic kind of Down's syndrome, which

does not always affect the brain, so they have normal intelligence. They have the features and everything else - the lax mouth - but their brain is not affected. They lead very normal lives, and, of course, they can get through college. But Tracy is a twenty-first chromosome child, so she is affected in all areas.

L: You mentioned the physical features. What are the physical features?

M: All the children have a number of them. They don't all have all of them. There are something like 23 different kinds of physical features that they may have. It's the flattening of the bridge of the nose, the almond-shaped eyes, the ears very low on the head, the thickness of the neck, the extra folds of skin, the very lax muscles. This is why they have problems coordinating. It's the laxness of muscles.

F: Weak neck muscles.

M: Yes. All the muscles are very floppy. You have to really work to get them toned out. And, of course, the retardation in varying degrees. The fingers are webbed, the toes webbed. Some of the children have extra joints in their fingers. They are all double-jointed; they can bend backwards and forwards. And the flatness of the head; the back of the head is usually very flat.

L: Tracy doesn't seem to have many of those.

F: No, not to any excessive degree. She does have a little flatness, and the nose is very snub.

M: You wouldn't be able to say she is not a Down's syndrome child. You can tell just by looking at her that she is a Down's syndrome child. Some people, of course, notice this. So, at least in this respect, we are lucky. We knew what she had when she was born. We knew where to go because we knew what we had to handle. The children with different kinds of retardation, if they are not Down's children, maybe wouldn't find out until the next two or three years.

Obviously Tracy's mother knows a lot about Down's syndrome. There are three kinds of children who have Down's syndrome - three different genetic causes. In trisomy, the child has a forty-seventh chromosome instead of the 46 that you or I have. This variant of Down's syndrome is caused in the sperm or the ovum of the mother being formed with this extra chromosome. It is a genetic defect that exists in the sperm or ovum of the parents. It is not inherited in the same way that blue eyes or hair color is inherited. It doesn't run in families. Normally, this kind of Down's syndrome is more common the older the parent, so that the older the mother or the father is at the time of the conception of the child, the more likely this particular kind of Down's syndrome child it is going to be.

A second less common kind is called translocation, and here the parent has a 47^{th} gene in some of the cells, and it is fused to some one of the other genes in the cells. This particular kind of Down's syndrome can run in families, and the children born to such parents either have Down's syndrome or else they are carriers of it so that their children might well have the syndrome. A third kind, much less common than the first kind, trisome, is called mosaic. Here, the genetic abnormality occurs in the fetus as the fetus is developing, as the cells in the fetus split

and split. As the fetus grows, the split goes awry. Some cells are formed with the 47^{th} chromosomes, and the child will develop some Down's syndrome characteristics. In the mosaic kind, the more abnormal cells there are, the greater will be the features of Down's syndrome.

In fact, there is a close correlation between the number of abnormal cells in the child and, for example, the intelligence quotient that the child will later develop. The risk of this most common kind, having a 47^{th} chromosome, varies with age, as I stated. If you are 15 to 19 years old when you get pregnant, there is a one in 2,300 chance that your child will have Down's syndrome but, if you are 45 to 49 when you get pregnant, there is a one in 46 chance that your child will have Down's syndrome, a much greater chance the older you are.

Female children who are born with Down's syndrome are often fertile, and their offspring can be quite normal. In a study of 14 children born to females who had Down's syndrome, five were normal, five of them had Down's syndrome. Two of them were retarded for other causes and two of them were born dead, but a small proportion were born normal.

How do children with Down's syndrome develop? What can we expect from them? At the age of six weeks, a rough estimate of their intelligence or their developmental quotient is about 85 points - the average of the population would be 100. At six months, the average is about 70 IQ points, at one year 40 IQ points, and at two years, 35 IQ points. So the older the child gets, the more backward they become relative to normal children of the same age. This decline can be prevented to some extent, but not eliminated completely, for example, if you do not treat Down's syndrome children, if you just put them in an institution and ignore them. When they are adults, their mental age will vary from about two years of age to five years of age mental age. If you treat them, if you try to educate them and shape their behavior, you can increase their mental age from about five years to nine years. They are still retarded but considerably above what their mental age would be if they were untreated.

You remember that, in the first lecture, I read you from the autobiography of a Down's syndrome child who, at the age of 18, sat down at her typewriter and typed out an autobiography. Tracy's mother says that Tracy is now two and a half years old, but she only has a mental age of about one and a half. Down's syndrome children are often born with a lot of physical defects and ill health and, in a recent study in Australia in the 1950's, the average age life's expectancy of a child with Down's syndrome was only 18 years of age. There was no Down's syndrome adult above the age of 50. Tracy was born relatively healthy, and she should have a normal life expectancy.

Tracy's mother describes Tracy as being cheerful but stubborn, and this stubbornness is of a particular kind. It is much better seen as perseverance. Down's syndrome children have great difficulty switching from one task to another, of shifting their attention, which is the opposite of the problem found with other kinds of retarded children with learning disabilities. For them, it's often difficult to keep their attention on a task. But the Down's syndrome child can be preoccupied with a task for a long time, can build the blocks again and again and again, and not get bored. They are often described as the "Prince Charmings" of retarded children. They are described as being cheerful, affectionate and amusing and as easy children. Their parents often describe them as like little pets, cute little animals, or dolls.

Not all Down's syndrome children are like that. Frank Menellesino studied 95 children with Down's syndrome and found that about 17 were hyperactive, four were psychotic, 8 had adjustment reactions, five from being separated from their parents and three from being with their parents, and 3 were diagnosed as neurotic. So, about 37% of the Down's syndrome children were described as being psychiatrically disturbed. Of course, a lot will depend upon the parents. To be retarded does not mean that you will not be psychiatrically disturbed as well. A lot depends upon how well the parents treat the children, how sensibly they treat the child. Obviously, Tracy is lucky. Her parents seem psychologically healthy and wise people, and there is no reason to expect that Tracy will be psychologically maladjusted or psychiatrically disturbed. She will probably be a normal child and a normal adult. In Tracy, the retardation is most noticeable at this point in her speech and, to some extent, in her physical characteristics - the different eyes that she has compared to normal children are obvious and indicate to anybody who meets her that she has Down's syndrome. Her parents also referred to her weak muscle tone, and to the fact that her muscles are very relaxed. It is difficult for her to be motorically coordinated.

Let us return to the final part of the interview with the parents of Tracy, in which we learn something about the discrimination that Tracy will face as an adult and the stigma that will be attached to her.

L: How do people react to Tracy?

F: Well, strangely enough, most people don't even realize that she is a Down's syndrome child. The few that do are usually professional people.

L: Is there a societal reaction,?

M: I think that, right now, she is two and a half. I think the people react to the child in her, more than that she is a Down's syndrome child. She is still a child, and they react to the child part. I think that this is not always going to be like this. When she gets older, then you are going to see a very marked difference. I think that when society can be a little more tolerant of mental retardation, it will be much better. But I think there will be quite a lot of soul--searching when she gets older.

L: For whom?

M: For us as parents - when she is discriminated against, and we have to watch this. I don't think by the time Tracy is older that attitudes will have changed that much. It's changing but very slowly, and not fast enough as far as I'm concerned.

L: In what way might she be discriminated against?

M: For work. A lot of these children or adults can do much more than what is being done with them now in sheltered workshops or work in community centers. They're doing tasks, they are earning money, little money, but they can do much more. I think they shouldn't be given just

menial jobs, I think they should be given something worthwhile. Retarded adults right now are bringing in 6 billion annually, and this is just in menial jobs. I think they can do much, much more. And they are doing much more in Europe with the retarded people.

L: Many of the places where the retarded work are special workshops, factories and offices for the retarded. Is it easy to integrate them into the other working force?

M: No. I think this is probably the reason that things are going so slow. Of course, employers are a little apprehensive in employing the retarded if they don't have any background with retarded people. And there again, retardation is confused with mental illnesses, and this is one of the big things that's going to take a long time for people to really get straight. I think we could have more education of the public to show them what a mentally retarded person is like. They have so much to give to society. The very basic things are the things they enjoy most, and this is what we so-called normal people never have time for - the very basic things.

Tracy's mother is greatly concerned over the stigma that will be attached to Tracy and the discrimination that she will face. At the moment, Tracy is physically cute; Mongoloid children look cute. People like them. But what about when she is 15 or 20 or 30? Will she still look as cute? In a way, it is bad that your face carries the stigma, that it is clear what label must be applied to you. And yet, in a way, at least the facts about you are known from your appearance, and it gives people a chance to adjust. We discriminate a lot against those who have stigma - the retarded, the mentally sick, the social deviants; and I shall return to this issue of stigma in later lectures.

But you might think how often you have seen a retarded child or a retarded adult in the community. We tend to keep them out of sight and out of mind. We don't like to be reminded of their existence. In the next lecture, I will return to the topic of mental retardation and discuss some of the causes and some of the facts that we know about the topic.

LECTURE TWENTY-ONE: MENTAL RETARDATION

Every year in America some four million children are born, and of these four million, about 120,000 will sometime during their lives be labeled as mentally retarded. Of those 120,00 children, some 15,000 will have to be put in institutions. They will just not be able to take care of themselves, and their parents won't want to take care of them. The State, the Government, has to take over their care. Not all of these mentally retarded children are similar. There are very many kinds of retarded children, and the first issue that we must address is how can we classify these different kinds of retarded children?

Classification

One of the simplest ways of classifying retarded children is in terms of how they appear to us - what they look like physically, in terms of their gross physical characteristics. The majority of retarded children do not have any gross characteristics that we can observe and say, "This child is retarded." We call them common, garden-variety types of retarded children, and these account for about 75% of all children who are labeled retarded. Of the rest, there are various kinds of deformities and malformations that we can observe and that indicate to us that they are retarded or that something is wrong. For example, there are microcephalic children who have very small brains. Sometimes the brow slopes back very sharply from the eyebrows above, and they don't seem to have any front to the brain. There can be various causes for microcephalia, such as damage to the parents as a result of excessive X-rays and other radiation or if the mother gets some infection while she's pregnant.

A second kind of easily observable defect is if the brain is enlarged. Sometimes we call these hydrocephalic children, and what they have is they have an excessive fluid in the brain which causes the skull to deform. The excess fluid can cause pressure on the child's brain and brain damage, and increases the degree of retardation. A third kind is cretinism. A child who is labeled a cretin will have stumpy hands and feet, a swollen abdomen, curved legs, and a curved spine, and eventually the nose becomes flat, the eyes widely spaced, the ears large and flabby, the lips thick and broad, and the skin dry and rough. Cretinism is due to a lack of iodine which can be due to the diet that the child eats (which does not contain enough iodine), something in the water supply (or lacking in the water supply), or it can be an inherited defect in the thyroid gland that interferes with the metabolism of iodine in the child. There are various other kinds of malformations that we can recognize in children.

A second way of classifying them, however, is by the cause of the retardation. What is the exact cause? There can be various kinds of causes of retardation in children. An obvious cause is genetic factors. You probably have heard of Tay-Sachs disease which affects mainly Eastern European Jews and involves a defect in the metabolism of fat in the diet of these people. It results in mental retardation, and we know that there is a genetic cause. There may be various toxic agents that can cause retardation. For example, while the child is being carried in the womb the mother's blood may be incompatible with the child's blood, and cause some chemical reaction that interferes with the development of the child. Kernicterus, a result of this, involves jaundice, and a hearing defect, and the child may well be retarded as it develops.

Infectious agents can also cause retardation. For example, if the mother gets German measles during the first three months of pregnancy, the child may well be born with defects and end up mentally retarded. Or if, after the child is born, the child gets encephalitis; this can cause brain damage and eventually retardation.

A fourth cause for retardation can be some trauma, some damage that occurs through an external agent. For example, when the child is born, he may suffer from oxygen deprivation for a while, and that deprivation of oxygen during the birth process can lead to brain damage. Or, perhaps, after he is born, he may be dropped on his head, be in a car crash, or receive some blow to the head. These trauma can cause brain damage and, again, retardation can result. These are all organic (physiological) causes of retardation, but we can also find psychological causes of retardation.

Perhaps the most common psychological cause is deprivation of stimulation - of visual, auditory, intellectual stimulation - which can lead to retardation. Let me give you an example of this. Two psychologists, Burton White and Peter Castle, went into a home where orphaned children were kept, and where these orphaned children received minimal care. They were left in their cribs. About once every four hours they would be picked up for about ten to fifteen minutes, and fed by a nurse or an aide. Once every morning they would be weighed, and they would be washed, but apart from that they received very little other stimulation from adults. They were left in their cribs for the rest of the day. White and Castle decided to give these children a little bit of extra stimulation. For each of the children, from six days old to thirty-six days old, they picked up each child for twenty minutes. When they picked up the child they blindfolded the child since they didn't want to give the children any visual stimulation, but just tactile stimulation. They would blindfold the baby, pick it up for twenty minutes, and sit in a rocking chair and rock back and forth with the child in their arms. Did those twenty minutes have an effect on the children? Yes, indeed. It didn't affect their weight or their health, but when they were tested at the age of one month and at two months old, the children that had received the twenty minutes of rocking were more visually attentive. If you dangled a little object in front of them, their eyes opened wider, they focused on it more clearly and they shifted their gaze whenever the object shifted much more that the children who hadn't been picked up.

What is impressive about this study is that just picking up a child for twenty minutes a day and rocking it, even though it is blindfolded, affected the child's visual curiosity. Think what a normal child has in a normal home. It doesn't have just twenty minutes of rocking a day. It has twelve, eighteen hours of attention from adults and, if twenty minutes of rocking can affect a child's intellectual development and its curiosity, think what effect a rich childhood would have on the intellectual development of a baby. It is clear then that, if we deprive a baby of this kind of stimulation, it is not going to be as curious, but rather it is going to function as if it were retarded. Clearly, the psychosocial sources of retardation are very important.

A third way of classifying retarded children is to give them a test of mental age, an intelligence test perhaps, and we then label them according to the score they get with a particular diagnosis of how severely retarded they are. For example, if they receive an IQ score of below 20 points they are called profoundly retarded, and we used to call these individuals in the olden days idiots. If they receive an IQ score of about 20 to 35 points, they are called severely retarded.

If their IQ score is from 35 to 50 IQ points, they are called moderately retarded, and we used to call these individuals imbeciles. Those with an IQ score of about 50 to 70 are called mildly retarded, and we used to call these individuals morons. Finally, those with an IQ score of 70 to 85 are called borderline retarded.

Remember that the average IQ of everybody in America in 100 points. The lower the IQ score, the more severe or profound the retardation is. This means that they are more likely to have the gross physical abnormalities that we can recognize and the more likely there is to be brain damage. Their death rate is very high. The more profoundly retarded child is much less healthy than the borderline retarded child. The more profound the retardation, the more likely custodial care is going to be necessary for the child, and the emphasis with the profoundly retarded child is on simple, basic skills such as, "Can we teach them to talk? Can we teach them to feed themselves? Can we teach them to keep themselves clean?" - very simple, basic skills.

Let's move on. What is it like if you go into an institution for the retarded? What sights meet you when you enter such an institution? Let me read from a description. This is from Craig MacAndrew and Robert Edgerton describing what it's like in an institution for the retarded.

Words, however well chosen, cannot begin, adequately, to convey the combined sights, sounds and smells which initially confront and affront the outsider on his first visit. For example, on Ward Y, the simultaneous presence of its eighty-two patients invokes an immediate impression of overcrowding. Most of the patients are marked by obvious malformations so that their abnormal status appears evident at a glance: heads that are too large or small, asymmetrical faces, distorted eyes and noses and mouths, ears that are torn or cauliflowered, bodies that present every conceivable sign of malrotation and malfunction. Most are barefooted. Many are without shirts. Most are at least momentarily naked. The mass begins to differentiate itself after you've been there a few minutes. You may see a blond teenager flitting about rapidly flapping his arms in a birdlike manner, emitting birdlike peeping sounds all the while. A large Buddha-like man sits motionless in a corner staring straight ahead and so on and so forth. Different kinds of people doing different kinds of odd behaviors. In the background strange and wondrous sounds originate from all sides. Few words can be distinguished although many utterances resemble English speech, but you hear, rather, screams, howls, and grunts. Cries predominate and reverberate in a cacophony of only sometimes human noise. At the same time, the institution is playing loud and rhythmic music out of loud speakers, and so this acts as a background the whole time. And finally there are the odors. Although many of the patients are not toilet-trained, there is no strong smell of crap, neither is there a distinct smell of sweat. Yet there is a peculiar smell of something indefinable, perhaps a combination of institutional food, kitchen smells, soap, disinfectant, feces, urine, and the close confinement of many human bodies. All in all, it's a rather grim experience; an affront to your senses and your sensibilities."

What are the ways of conceptualizing mental retardation? First of all, I'd like to turn to the social model.

The Social Model

Obviously a large number of retarded children have gross physical, genetic, organic things wrong with them - children who have Down's Syndrome (who used to be called mongoloid children) for example; children who are microcephalic or hydrocephalic - but a larger number of children that we find in institutions for the retarded do not fit these kinds of descriptions. They appear physically normal; they do not appear to function much below the average person in a society. Some psychologists have asked the question, "Why are these children labeled mentally retarded?" The social model, remember, asks this question. Not, "What do you do that causes you to be labeled mentally retarded?" but, "What do you do that causes other people to say you are mentally retarded? What makes us judge other people mentally retarded?"

Dorothy and Benjamin Braginsky did some studies on children in an institution for the retarded in two state-run institutions. There were about 1,000 children in each institution. The average age of the people they studied was about 20 years. The average IQ score was about 60, with a range of 20 to 83. First of all, they decided to see how manipulative these retarded individuals were in the institutions. Were they able to be cunning, devious, and manipulative? The test that they used was a test we call Machiavellianism. How much do these children use the kinds of cunning and strategies that Machiavelli described several hundred years ago? They gave them a test that measured this, and lo and behold, the retarded individuals came out as much more manipulative and Machiavellian than the professional staff in the institution and the aides. Let me give you an example. On the item "The best way to handle people is to tell them what they want to hear" 89% of the retarded children agreed with that compared to only 12% of the professionals and 22% of the aides. On the item: "Anyone who completely trusts anyone else is asking for trouble" almost 50% of the retarded individuals agreed it, but only 16% of the professional staff. These retarded residents appear to be extremely manipulative. They agreed with items that indicate manipulativeness. Dorothy and Benjamin Braginsky said that:

Staff members when they deal with the retardates do not have to engage in manipulative behavior. They don't have to try and manipulate the retardates to accomplish their goals, because they have the power; but the retardates, on the other hand, must resort to manipulation in order to control the responses of the staff to them.

The Branginsky's next gave the retarded residents a question about "What do you think about the institution?" On this questionnaire there were some absurdly positive items, such as: "There is absolutely nothing wrong with this institution, it's just great." For some of the retarded residents they said, "We want you to sign your names," and to others, they said, "You don't have to sign your names, you can complete it anonymously." What did they find? When the retarded residents signed their names, they tended to agree with these absurdly positive statements much more often than if they didn't have to sign their names. The Braginsky's concluded that the retarded residents who signed their names were trying to please the staff. They were trying to butter them up by saying, 'Oh, this institution is so great.' The Braginsky's noted that you and I might say that, so there is nothing strange about it. But, remember, these are retarded children and adults. They don't know how to function; they can't even take care of themselves. They are in an institution because other people have to take care of them, and yet they know that they know they have to lie if they are signing their name to a questionnaire. Perhaps we underestimate how well they can function.

In a third study, the Braginsky's told the children, "We devised a special program for some of the residents here," and they described it to make it seem like the most horrible program you could possibly imagine. They wanted to give the impression to the retarded children and adolescents that there was no way you would want to be in this program. And then, they tested their intelligence, both before they told them about the program and afterwards, to see how they would score. If the Braginsky's told the children that the bright kids were going to be selected, the retarded children played dumb. In fact, their mental age on the tests dropped from 10.5 years to 8.9 years. If they were told that the dumb kids were going to be selected, their mental age on the two tests rose from 9.4 to 11.7 mental years. So, these children, when they take an intelligence test, can fake it. If they feel that it's to their advantage to fake good, their mental age may increase by as much as two years. If they think it's to their advantage to fake bad, they will drop their mental age by a year and an half. Now, again, let's think about this. These are children who are in an institution supposedly because they are retarded, and yet they can fake their mental age. What is their real mental age? Maybe they can score as high as 12 years old. Could they score as high as 13, 14, 15, 16? If they can, why are they in the institution?

The Braginsky;s also asked these children, "What kinds of attitudes do you have about life in general?" Let me give you some examples. Most of the children that they interviewed wanted a laissez-faire, comfortable and non-demanding life. Eighty-three percent believed that the retarded children should make their life in the training school as simple as possible. They thought they would get on much better if the aides and the professional staff didn't bother them as much. Most of the time agreed that the best way to fit in the institution was to have a good time while you were there. Eighty percent of them thought that retarded children and adolescents were not as stupid as most people think they are. Most of them believed that people outside of the institution were as retarded as they were. Most of them wanted to have some say in how the institution was run. And most of them thought that retarded children were lonely, and they themselves were lonely in the institution. And to give you an example of the flavor of some of the children who were in this institution, let me read you from an interview that the Braginsky's carried out with one 16-year old girl who had an IQ score of about 60.

B: Do you consider yourself retarded?

G: No, but I heard a lot of people saying we are retarded, but us bright girls are not really retarded; maybe they are talking about the small ones in the hospital wing, but us bright girls are not retarded. I don't know how come they call us retarded.

B: How does it make you feel when they call you retarded?

G: Well, I just get up and walk away, and say the same thing to them, "You're retarded."

B: What's this place for?

G: Well, it's a place for kids who run away or something like that. Some kids get into trouble by boys. (This girl had been raped and made pregnant by a foster brother and had been institutionalized as a result.)

B: If you could, would you leave this place tomorrow?

G: And go where, I wouldn't know where to go. I would have to know where I would go.

B: Are there kids here who try to make people think that they are stupid, when they're really bright?

G: Yeah, I've seen some like that.

B: Are there any girls here as bright as some of the staff, the attendants?

G: There are girls here in this building that are as bright as some of the attendants, yeah, some are pretty bright: some are brighter than the attendants.

B: Why are they here?

G: Some are here because they've been bad, and some are here because they have mean mothers who don't take care of them and hit them and everything like that.

Does this girl sound retarded? She doesn't think she's retarded. Why does she think she's in an institution? She did something wrong, she misbehaved. In fact, however, she wasn't wanted by her foster family, and she was abused by them.

The Braginsky's argued that most children were there because they were unloved and unwanted by their parents. If you have a child, it can be a trouble to you, a set of hassles, but most parents put up with that. If a child is not overly bright or intelligent, it may create more hassles and problems for the parents, but most parents put up with those problems. What happens if they don't want to? Then we try and help those parents out. We say, "Let us put these children in state institutions. We'll call them retarded or maybe mentally ill, and we'll institutionalize them. We'll put them in foster homes, orphanages, mental institutions, children's shelters or training schools for the retarded. In fact many are not really retarded when we put them there. But we've got to do something with them because nobody in the community will take care of them. So we institutionalize them, and then we call them retarded. Once they are there, they act retarded. Why do they act retarded? Well, partly to please the staff. If they act too bright, they'll lose some privileges, or maybe they don't want to go home again - they didn't like the home environment - and so they play dumb in order to stay in the institution, in order not to rock the boat, for a nice, quiet, simple life. And, perhaps, the final reason why they act retarded is that it's awfully dull to be in that institution. There's no stimulation, virtually no fun and no intellectual stimulation, and in an environment like that you begin to act more and more dumb. You begin to become more retarded. The Braginsky's argued that, for a lot of retarded children, to call them retarded is not a psychological label. It's a social or a political label. It's a label we give them in order to excuse us taking them from the parents and putting them in the institution.

In contrast to this, let us turn to the medical model.

The Medical Model

In the medical model, we look for a physiological cause of retardation. When I discussed the classification of retardation; I mentioned various kinds of causes - genetic causes, toxic agents, and the result of infectious diseases - and one of the most common forms of mental retardation that has a clear organic, physiological basis is Down's Syndrome. Down's syndrome is the name we now give to children we used to call Mongoloid children. In 1959, a French geneticist, Jerome Lejeune, found that there was a definite chromosomal abnormality in children who had Down's syndrome. Most people in America, have 46 chromosomes, and the majority of children with Down's syndrome have 47 chromosomes, and so we know that there is a clear genetic basis to Down's syndrome children. It is important to remember that Down's Syndrome is not inherited in the usual sense, like your eye color. Often blue eyes will run in a family. Similarly handedness and baldness are inherited - they run in families. Down's Syndrome does not run in families in the same way. It is not that they have parents or relatives who have Down's Syndrome. It is a genetic defect that occurs when the egg is fertilized by the sperm. Something goes wrong in that fertilization, and the chromosomal pattern becomes abnormal that results in Down's Syndrome. About 1 in 700 children born in America have Down's Syndrome, and it is increasingly common the older the mother is when she gets pregnant. There must be something about the uterine environment or the ova as they are released in the older woman that makes it more likely that this genetic defect will occur. There are about 9,000 children born every year with Down's Syndrome and about 10 percent of those, 900 a year, have to be institutionalized.

The Down's Syndrome child has obvious physical defects. (Often, if there is an organic cause to retardation there are physical defects that accompany it.) The Down's Syndrome child has almond-shaped eyes which accounted for the name original label Mongoloid. They tend more often to have webbed necks and flattened noses. Many Down's Syndrome children are described as being cheerful and affectionate and easy children to handle. They are not always all that easy. There are some studies to indicate that a large number of them can be emotionally disturbed and hyperactive, but on the whole most of them are cute and parents do try to keep them at home. They are relatively easy to raise, a little stubborn perhaps. But they can be kept at home, and they don't have to be institutionalized.

These forms of retardation clearly have an organic basis and they fit into the medical model. But what about the children who are not in an institution because they are unloved and unwanted, and also are not clearly retarded because of a physiological or genetic defect or brain damage? What about those?

That is where the great debate lies. Do they fit the medical model? Or do they fit the social model? Is there perhaps in those children some obscure, minimal brain damage that we cannot detect. Perhaps most of those retarded children do have some neurological damage, but we just have not found it. Is it that they fit the medical model, or is it perhaps that they are emotionally disturbed? A child who is emotionally disturbed might become retarded because their emotional disturbance will prevent them learning the skills that your or I learnt as children. Because of their emotional disturbance, they just do not learn to talk as early, and so on. Insofar as they are emotionally disturbed, perhaps again, they fit the medical model of mental illness. Or, perhaps, when we give them an IQ test, the test is biased in favor of white upper-middle-class

values. As a result, the children do poorly on the intelligence test, and are, therefore, classified as retarded. The test is unfair to them. It is culturally biased. In that respect, perhaps, they fit the social model. They are being labeled as retarded because they are being given an unfair test.

Or, perhaps, they fit the social model, or the psychological model, insofar as they did not receive enough stimulation as children. Their mother and their father neglected them. They were left in their crib all day or in their playpen. Nobody attended to them, nobody talked to them, and nobody picked them up and hugged them. They were neglected and, because they didn't receive any intellectual stimulation, they ended up retarded. On the one hand, we can look at a child who is a cretin and has a thyroid deficiency or a Down's Syndrome child and say, "Clearly the medical model applies here." We can go into an institution, and we can talk to a girl or a boy in an institution and say, "This child is not retarded. They're just unloved and unwanted, and they've been shuttled off to this institution because on one else wants to take care of them." These cases are easy to evaluate and classify. But the group of retarded children who neither fit one model nor the other model are very difficult problems for us to understand. We do not know which model they fit - whether it is that our tests are unfair; that they did not receive enough stimulation or that there is some brain damage in them that we haven't yet located. I think the answer to this problem has to be decided for each child and, even when we study each child, it is often very difficult for us to decide between the different models.

LECTURE TWENTY-TWO: STIGMA

A stigma is a mark that sets you apart from others, like a physical handicap. Let me read you what one girl confined to a wheel chair reported: Oh, there's one person I know who constantly kicks my wheel chair as if to say, "I don't care that you're in a wheelchair, I don't even know it's there." Today we are going to examine the phenomenon of discrimination and stigma associated with being labeled deviant.

The Stigma of being Labeled Deviant

Stigma refers to the results of being labeled deviant. It originally meant a mark or sign that you put on a slave or prisoner to indicate that they were different from other people. But today we use it to mean something like a loss of your reputation or a stain on your good name. There are two components to the notion of stigma. First of all, there are the reactions of others toward you as a result of your stigma. If someone knows you have been in a mental hospital, how do they react towards you? Do they react differently than if they did not know you had been in a mental hospital? The second component of stigma is the effect of that label on you yourself. How do you feel about having been in a mental hospital or having been a convict or a criminal? Perhaps you feel worthless, a failure or evil as a result of it, somehow set apart from other people. These two components feed into each other and, if you feel low in self-esteem because of your experience, if you act in such a way that other people recognize your low self-esteem, then you react to that. The stigmatized individuals say to themselves, "This person acts as though it's something to be ashamed of. Maybe it is something to be ashamed of." The reaction of other people toward you effects your own opinion of yourself. If their mouth drops open when you tell them something about yourself such as, "I was in a mental hospital once," if they look upon you with shock and disgust, then it makes you feel worthless. "Maybe, because they think I'm worthless, I really am worthless." If they think it was a shameful experience, maybe it really was. So these two components, your feelings about yourself and the reactions of other people toward you, aggravate each other, help build each other up, and increase the effects of each other.

Some people who are stigmatized have visible signs about them that indicate their status and that facilitate the stigma, for example, the handicapped, the blind, and people who have limbs missing. If you meet someone who has such a visible, stigma how would you react? Do you ignore it? Do you focus upon it? When you ignore it, do you ignore it in a way that indicates that you are ignoring it? Fred Davis interviewed a number of people who had visible stigma and got their reactions to the reactions of other people towards them. For example, there are people who focus upon the handicapped, and let me read you an example from a woman. "I was visiting my girlfriend's house, and I was sitting in the lobby, waiting for her, when this woman comes out of her apartment and starts asking me questions. She walked right up. I didn't know her from Adam. I never saw her before in my life. She said, "Oh, gee what did you have? How long have you been that way? Gee, that's terrible." I answered her questions but I got very annoyed and I wanted to say, "Lady, mind your own business." This lady responded to the visible stigma, but the girl felt she shouldn't be doing this. You should ignore it. For a lot of people the reaction is pity, or fear, or repugnance and it shows through sometimes in a subtle way. Let me give you a report of another girl who was blind.

> One night I was going to visit a friend, and two people from my office put me in a taxi. I could tell at first that the taxi driver didn't know I was blind because, for a while there, he was quite a conversationalist. Then he asked me what the sticks were for, and I told him it was a cane. Then he got very different, and he didn't talk about the same things he did at first. Before this he joked and said, "Oh, you're a very quiet person. I don't like quiet people, they think too much." He probably wouldn't have said that if he had known I was blind because he would have been afraid of hurting my feelings. He didn't say anything like that afterwards.

Some people are unkind in their response. One attractive girl told Davis that she frequently gets this kind of reaction from new acquaintances, "How strange that someone so pretty should be in a wheel chair." Or a professional worker for a government agency met a fashionable female client who said to him, "How nice that you have something to do."

We must remember that, sometimes, those people who have visible handicaps are overly sensitive to their stigma. They act sometimes to make it more visible; they show off the stigma. People with eye defects quite often will not cover up the eye, but will leave it in the open so that you cannot avoid noticing it. It is a bit like wearing hot pants then objecting when people notice that you're wearing hot pants. Some people with stigma do act in such a way as to flaunt their stigma, to arouse a reaction in other people. So we must wonder whether those who have visible handicaps have really accepted the fact that they handicaps? Can they live with it? To what extent are they projecting their feelings about it onto other people? Among the deviants we have discussed in these lectures, some do show physical defects, especially the retarded. If you think back to the interview with the parents of Tracy, the child who had Down's Syndrome, the question of stigma and discrimination was very important. Let us listen again to part of that interview.

F: Strangely enough, most people don't even realize that she is a Down's Syndrome child. The few that do are usually professional people.

D: Is there a societal reaction too?

M: I think that right now she is two and a half, and I think that people react to the child in her more than, you know, that she is a Down's Syndrome child. She is still a child, and they react to the child part. I think this is not always going to be like this. So, when she gets older you are going to see a very marked difference and I think then is when, if society can be a little more tolerant of mental retardation, I think it will be much better. I think there will be quite a lot of soul-searching when she gets older.

D: For whom?

M: For us parents, when she is discriminated against, and we have to watch this, because I don't think that, by the time that Tracy is older, the attitude will have changed that much. It's changing but very slowly, not fast enough, as far as I'm concerned.

D: In what way might she be discriminated against?

M: Well, for work. A lot of these children or adults can do much more than what is being done with them now in sheltered workshops or work in community centers. They're doing tasks, they are earning money, a little money, but they can do much more, and I

think they shouldn't be given just menial jobs, I think they should be given something worthwhile. Retarded adults, right now, are bringing in six billion dollars annually, and this is just in menial jobs, and I think they can do much much more. And they are doing much more, in Europe, with retarded people.

D: Many of the places where the retarded work are special workshops, factories, offices for the retarded. Is it easy to integrate them into the other working force?

M: No, I think this is probably the reason that things are going so slowly, of course. Employers are a little apprehensive in employing the retarded if they don't have any background with retarded people. And there again, retarded people are still confused with mental illnesses, and this is one of the things it is going to take a long time for people to really get straight. I think we could have more education of the public, and show them what a mentally retarded person is like; that they have so much to give to society - you know, the very basic things are the things they enjoy most, and this is what so called normal people never have time for, the very basic things.

To some extent the visibility of the mentally retarded causes us to want to hide them from the rest of society - put them in institutions, put them in their own factory so we won't have to work with them. On the other hand, the visibility of the stigma sometimes has advantages. It warns people that there is something different about you, and it gives them time to prepare their reaction. There is just as great a problem if the stigma is not visible. For example, if you are an ex-convict, an ex-mental patient or an ex-prostitute, you know that you have this experience in your past and that it might cause a reaction in other people, but they don't know it, and you fear that they will find out. You hide the facts of you past, you fear the discovery, you try to pass for normal, and this feeling that you know something about yourself that you do not want other people to know makes you feel alienated from society. For example, say you spent the last two years of your life in a cell, you can't talk about it. Other people can say, "Last year we went on a vacation," but you can't say, "A funny thing happened to me last year - there was this other prisoner in the cell that I live in, etc." You can't talk about it. You know interesting things happened when you were in a ward in mental hospital, but you can't talk about them. That whole block of your life has to be hidden from other people. This puts distance between you and them. In the interview with the ex-junkie that you saw in this lecture series, the woman mentioned her name in the last segment of the interview, and she was very worried about this. Will people recognize who she really is from her name? Will they find out? Will her friends, therefore, now react and say, "My God, she is an ex-junkie!" She lives, to some extent, with a great deal of anxiety about being found out.

How do people with stigma deal with this? One way is to associate with people who share the same stigma, who have the same experiences. If you've been in an institution, such as a jail or a mental hospital for fifty years, quite often you don't want to get out into the community. I remember a psychologist at a state hospital in Massachusetts telling me about one young man they were very pleased with. They cured him, they rehabilitated him, they found him a job in the community, they found him an apartment, and they said, "Out you go." One day, the psychologist was driving to the hospital on a Saturday to do some research, and he found the man hitching. He picked him up and said, "Where are you going?" The man said, "I'm going back to the mental hospital." The psychologist said, "But why? Why aren't you in the community?" The man said, "Well, all my friends are in the mental hospital, I don't know any

people in this new town I live in. I'm very lonely and isolated there, and so every weekend I hitch back to the hospital, my friends on the ward find me a bed for the night, and I stay over for the weekend." That's where his friends were. He felt easier with people who knew that he was an ex-mental patient and who shared the same stigma as he did.

Another solution is to work with deviants. Szasz has noted that quite often, when a deviant gets rehabilitated, they tend to join an institution trying to rehabilitate other delinquents: To do this reinforces your non-deviance. If you are an alcoholic and, after you are cured, you work with Alcoholics Anonymous, your working with Alcoholics Anonymous as a helper reinforces the fact that now you are a non-deviant while the people you are helping are deviants. You are an ex-alcoholic - they are still alcoholics. Second, there is a lot of job discrimination. Quite often you can't get a job in another institution or another business, and so only the institution that helped rehabilitate you will hire you. Third, working in the institution that you once went through as a patient or as a client helps support and care for you now, care that you wouldn't get if you moved out into the society at large. Synanon, for example, a group that deals with drug addicts, often hires and uses most of its ex--clients to work with new clients going through Synanon. Again, this gives them support when they need it and reinforces their non-deviant behavior.

Stigma has a good deal of effect on other people around you. People who are associated with you feel stigmatized by association with you. This is especially true for parents who have children who are labeled deviant in some way. Quite often the parents of hyperactive children, autistic children or children with learning disabilities form associations - an association for parents of children "with such and such a disorder." These parents often believe in physiological causes for the behavior. They believe that schizophrenia in children is caused through organic factors or that hyperactivity is caused through organic factors. This may be correct. There may well be physiological reasons for such behaviors, but the parents also have an effect on such behaviors, and perhaps in many cases cause the behaviors. But the parents like to deny their responsibility, and they form an association to get group support for the fact that, "We didn't cause our child to become hyperactive. It was something in their brain that we had no control over." I remember a physician acquaintance of mine who had two hyperactive children, and kept switching doctors and the schools that he sent them to until he found both a doctor and a school that said the causes are organic, that is, you do not have to blame yourself for your child's behavior. Quite often parents who have a deformed or defective child will immediately try to have another child in the hope that it will be normal and will show that they are normal parents. To have had a deformed child reflects up on you as a parent. "What is wrong with me that I cannot have a perfect child?" They are motivated to have another child in order to prove that they are capable of having normal children, that is, that they are normal as parents. This is found in a wide variety of behaviors. When people commit suicide, the relatives and friends often do everything they can to deny their responsibility; the role that they might have played in precipitating the suicidal actions of the person. Denial of your responsibility is a very common phenomenon.

Let us move on to another question. Do we really stigmatize deviants? Perhaps you doubt that we really do stigmatize deviants. Perhaps you say to yourself, "I wouldn't discriminate against an ex-mental patient." Let me give you some evidence that indicates that we really do

discriminate against such people. Richard Kalish, a psychologist in California, gave a questionnaire to some undergraduate students who he was teaching a social-distance scale which asked questions such as:

Would you willingly accept as a member of your family, by marriage, this kind of person?

Would you willingly go out on a date with such a person?

Would you willingly admit such a person to your street, to live within a few doors of you?

Would you willingly accept as a visitor to the United States this kind of person?

Consider how you would feel about a Nazi on those questions, or a communist? Or if you are black, how would you feel about a white person? And if you're white, how would you feel about a black person? And for all of you, think about these categories: an addict, a convict, an alcoholic, an attempted suicide, a gambler, a person in constant pain, a person recently released from a mental hospital or a person dying from an incurable disease. We think that our society has a good deal of religious, racial and ethnic prejudice, but the prejudice we feel toward deviants is much greater. Let me give you a couple of examples. Would you willingly accept as a friend? Some 69% of those interviewed by Kalish would accept a black person, (he asked white students these questions) 85% would accept a Mexican-American as a friend, but when it came down to addict only 12%. Even for an ex-mental patient, only 46%; for someone in pain, only 35%. What about willingly accepting as a visitor to the United States. You don't even have to meet this visitor, but just allow him to visit the United States. 88% would admit a black person as a visitor, 96% a Mexican-American, but an addict only 46%; a mental patient 69%; and someone in pain; 77%. Think about that: 23% of those people interviewed would not allow someone in pain to visit the United States. Why? It iss incredible the degree of prejudice that we do feel toward these deviants - people who are ex-mental patients, ex-addicts, gamblers, or even people in pain.

Charles Whatley carried out a similar study by interviewing 2,000 people who lived in Louisiana to get at their attitude towards the ex-mental patients. He found that there was a good deal of prejudice. He found that the prejudice was greater in older people and those who had had less education. There was more prejudice among blacks than among whites. The poorer and the unskilled felt more prejudice towards mental patients, and those who were separated, widowed or divorced felt more prejudice towards mental patients than those who were married or single, He didn't find any more prejudice in men as compared to women. He didn't find any association with religion or whether you had friends or relatives who had been mentally ill, or whether you had ever visited a mental hospital. This is rather incredible. To have had a friend or relative who is mentally ill or to have visited a mental hospital did not change your prejudice towards those who are mentally ill. You still felt equally prejudiced even after visiting a hospital. What is important is that psychiatric patients share this prejudice. Robert Swanson and Stephen Spitzer gave a questionnaire to psychiatric patients before they were hospitalized, during their hospitalization and after their hospitalization. He also gave it to their friends and relatives. He gave the questionnaire to them in the first seven days, just before they were hospitalized, then once during their time in the institution, and then within one month after release from the hospital. What he found was that psychiatric patients felt most stigma and felt most worthless

during the time that they were in the hospital. They felt least stigma and least worthless after they had been hospitalized. In contrast, their friends and relatives felt equally prejudiced against them during all stages, before, during and after the hospitalization. They also found that, among the patients, the stigma, the prejudice felt towards patients by other psychiatric patients was greater in males than in females, was greater in those who were older and those who were less educated. Their diagnosis was not associated with how much prejudice they felt.

Derrick Phillips explored two components of this prejudice we feel towards ex-mental patients. He felt that there were two sources. First, the actual behavior. Somebody who has been or who is a mental patient often acts differently. Second, the actual fact of receiving treatment. How do we respond to that? He made up character sketches of different kinds of patients showing different kinds of behaviors and described their behaviors. For example, he described a paranoid schizophrenic, an anxious depressed person, a phobic person and a normal person, and he varied the kind of treatment that they had received - whether they had been to see a psychiatrist, been in a mental hospital, been to see a physician or clergyman or priest, or whether they had received no treatment. Then he got women who lived in New England where he did his study to answer a social-distance scale.

Would you let your children marry this person?

Would you rent a room in your house to this person?

Would you let this person join your club?

Would you let this person be your neighbor?

What he found was that the women whom he interviewed had more prejudice toward the paranoid schizophrenic and the simple schizophrenic, less prejudice to towards those who were neurotic, those with phobias and anxiety depression, and obviously least prejudice towards those who were normal. What he also found was that the more treatment that they had received, the more prejudiced the people felt. For example, if you had been in a mental hospital, whatever your diagnosis, then you would be subject to more prejudice than if you had not been in a mental hospital. There was a little less prejudice, but still a great deal, if you had been to see a psychiatrist and still some if you had been to see a clergyman or priest. If you had received no help, if you had rejected all community resources, then there was the least prejudice. Regardless of how disturbed you are, the actual act of seeking treatment in a mental hospital or from a psychiatrist, or even from a clergyman or priest made other people in the community feel more prejudice toward you and want to put more social distance between them and you. If the respondents had had relatives who had had emotional, psychological problems, then they did not feel as prejudiced toward people who had received treatment, but it did not effect their prejudice toward people with different kinds of diagnosis.

Let us turn to the final issue here - is there a relationship between stigma and your status.

Stigma and Status

How we respond to people who are labeled deviant depends a lot upon their status. Let me give you an example of what I mean by this. Richard Schwartz and Jerome Skulnick invented a personnel file for an unskilled worker. They made it up for a 32 year-old male who was single, who had a variety of short-term jobs, and who had some mechanical skills. They made up four folders. The man was described the same in each folder, but the folders differed in this respect. In one, he had been tried and convicted for assault, in the second folder he had been tried and acquitted of the crime of assault, in the third folder he had been tried and acquitted for the crime of assault and the judge had put a letter in the file saying, "Remember this man was acquitted, and therefore must be presumed innocent," and the forth kind of folder contained no reference to any trail or any prosecution for any trial for assault. Different employers were handed one of the folders saying, "Could you use this man?" How many of them said they could use the man? If the man had been tried and convicted for assault, only 4% of the employers said that they could use the man. If there was no reference to any trial for assault, some 36% of the employers said that they could use the man. If he had been tried and acquitted for assault, only 12% of the employers said that they would use him and, even if there was a letter from the judge saying the man was innocent, only 24% of the employers would say that they could use him. Here we have a situation which, if the man had had no criminal history, 36% of the employers could have used him, but to be tried and acquitted reduced the number of employers that said they would be willing to use him, even if there was a letter from the judge saying that this man must be presumed innocent. Therefore, the actual fact of having been tried and acquitted still meant that there was stigma attached to you.

Now if we look at a different kind of status, a higher status individual, we find a very different phenomenon. For example, a study has been done of physicians who have been sued for malpractice. In this study, 59 physicians who had had suits filed against them for malpractice were interviewed about the effects of the suit on their practice. Did it affect their practice? Of these 59 physicians, four of them lost the suit in court. A few of them had settled out of court, and in a number of cases the plaintiff had dropped the suit. In 19 cases the doctor had won the suit. So, it is very clear that it is difficult to win a malpractice suit against a doctor. Of the 59 physicians, 52 of them said the effects of this legal action had no effect on their practice. Five said that their practices improved after the suit. Their practices improved! How could this happen? One of the doctors interviewed gave this reason "I guess all the doctors in town felt sorry for me, because new patients started coming in from doctors who had not sent me patients previously." For these doctors, after being sued and sometimes losing and sometimes winning, the case had no effect on their practice and sometimes their practice had improved. Obviously these doctors differed from the unemployed man. They differed in belonging to a community. The local association of physicians who supported them in this helped them make-up for the potential loss in their practice. None of them lost their hospital privileges and none of them lost their insurance, although their rates for malpractice insurance did increase. None of them had problems with their licensing commission. Obviously doctors are in short supply. Their higher status protected them, and obviously their colleagues supported them. In these ways the effects of a criminal action on a doctor differ greatly from the effects of a criminal action on an unskilled worker.

What is the solution for stigma? What could we do? How could we prevent people from feeling such stigma? There are a couple of things we can focus on. One is we can focus on

society. One of the ways that, in the past, we have tried to deal with stigma is to change the label, to call probation departments “Manpower Resources Units,” so that the stigma attached to a particular label is eliminated. But I think that we should take a different approach, that what we have to do is re-educated people in our society, introduce them to different kinds of deviants, and show them that they’re not so different from you or I, that they’re very similar, in fact. We need to do a re-education process, and not to segregate the deviant from the rest of the community. Secondly, we need to work with the deviant to help the deviant overcome the feelings of low self-esteem, the feelings of worthlessness, and the feelings that they are failures that they feel as a result of being deviant. I think in these two ways we can, perhaps, help overcome the effects of stigma on the deviant individual.

LECTURE TWENTY-THREE: TREATMENT OF DEVIANTS: PART 1

So far in this course I have discussed different kinds of deviants and some different ways in which we can conceptualize them. But can we help deviants, rehabilitate them, cure them, or make them fit into society? Today I want to begin a discussion of the methods our society uses to cure deviants.

Why do people seek to change their behavior? There are a couple of reasons that we can give. First, of all, you may be unhappy with your own behavior. You may look at yourself and say, "I don't like the person I see. I wish I didn't behave in this way, think in this way, act in this way." The second reason is that other people may not like your behavior. They may tell you, "We don't like the way you behave. We don't like the way you do this or you think this or you say that. Go change your behavior." These two kinds of reasons are very important - for their differences.

In the first situation, where you want to change your behavior, the psychotherapist that you go and see is working on your behalf. You say to him, "I want to change." He says, "I will help you change. Let us work together on this." But when you seek to change your behavior because others insist that you do so, for whom is the therapist really working? Is he working for you or is he working for society? If he's working for society, maybe you won't trust him. Maybe you don't see him as on your side. He is on the side of those other people who want you to change. An example that comes to mind when I think of this distinction is of a parent I talked to once who didn't like the fact that his three-year old daughter sucked a pacifier. Whenever she got upset, she would go upstairs to her room, put the pacifier in her mouth, and suck it for a while. Eventually she would calm herself down, put it in her crib, and come back downstairs. I said, "Why don't you like that?" He said, "Well, she shouldn't do it. What should she do instead?" He thought about it for a while, and then he came to an insight. He was sucking on a cigar that he hadn't lit yet, and he said, "I guess she should smoke a cigar like I do." He came to the realization that, although he wanted to change her behavior, she didn't want to change her behavior. From her point of view, it wasn't a maladaptive behavior. He was at fault, perhaps, for wanting to change her behavior.

Thomas Gordon, who has written a book called *Parent Effectiveness Training*, says that each parent should always ask himself or herself, "If my child is doing this, whose problem is it? Is it the child's problem or is it my problem?" When a student comes to me and says, "I want to go into therapy because my roommates say I ought to," I always say, "Do you want to? If your roommates don't like your behavior, maybe they're the ones that should go into therapy and learn how to adjust to your behavior." Ideally, the only way you should go into therapy is if you yourself want to change your behavior. This is especially important in institutions like mental hospitals and jails because the counseling staff in such institutions are being paid for by the state. They are agents of society, and they are not on the side of the patient. As a consequence, the patient should never trust them, and attempts to change behavior and psychotherapy will not be effective. I think self-motivation is crucial for people seeking to change their behavior. Changing your behavior because other people insist that you do is not a good idea at all.

Who do you go to if you want to change your behavior? You can go to a variety of people, including psychiatrists, psychologists, social workers, ministers, priests, even friends, relatives, professors, and school teachers. How do you choose to whom to go? What guidelines can you use? I think there are a couple of guidelines.

First of all, the person who acts as your therapist should be objective and not involved. It is very difficult for someone who is involved with you, a husband or a wife, a child or a parent, or a friend, to be really objective toward you because you satisfy some of their needs. They want you to behave in a particular way. It's important to choose people you don't know, a stranger or an uninvolved person. Second, what's important to know is the training of the person, their experience and their reputation. For example, in America today, anybody can call themselves a sex counselor and counsel you on sexual problems. It doesn't require a license. You can hang up a shingle outside your door and say, counseling done here. Anybody can do it with no experience. But there are certain professions such as psychiatrists, psychologists, and social workers, for which licensing is required. You have to pass certain exams, and you have to prove that you are competent. It is important choose people who are competent. You can perhaps find out from other people what are they like as therapists. Are they good or are they bad? Will their style fit my style? You should ask whether the therapist is likely to screw you both metaphorically and literally because some therapist will. So, first of all, choose someone who is competent.

What can you expect when you go into therapy? What's going to happen? The techniques of therapy we use today are very different from those we used in the past. I'd like just for contrast to compare the two methods and describe the two methods that we used in the past for almost the last 2,000 years.

One major kind advocated brutality, saying in fact people who were disturbed were possessed by the devil or spirits. They were witches, and they had to be punished. So people advocated things like flogging, starvation, burning and torturing people. Let me read you an example. Esquiro wrote in 1838 of mental patients:

> I have seen them naked or covered with rags and protected only by straw from the cold damp pavement upon which they were lying. I have seen them coarsely fed, deprived of fresh air or water to quench their thirst. I have seen them in squalid stinking little hovels without air or light, chained in caves where wild beasts would not have been confined. Whips, chains, and dungeons are the only means of persuasion employed by keepers who are as barbarous as they are ignorant.

That was one way in which psychiatric patients or those who were disturbed were treated.

Along with this, people advocated a more humane way of treating them, things like praying for them, having them pray, using rituals, exercises, diets, bars, rest, music, a kind of Hippocratic technique.

In the last fifty years, techniques of treating those who are disturbed have changed drastically. But some people still see psychiatric and psychological treatment as barbarous and

brutal. For example, you may have read *One Flew Over the Cuckoo's Nest*, a novel by Ken Kesey, in which the procedures used on the mental patients in that book are described as brutal, almost as punishment by the staff at the hospital for unmanageable and uncontrollable patients. Today some psychiatrists and psychologists talk as if we are still being brutal to psychiatric patients. I think it's important to remember that people are fallible, and that is true too of psychologists, nurses, and social workers. But because in one hospital patients may be abused or treated brutally, or because one therapist may abuse his patient does not mean that that is what all therapists do or what all psychiatric hospitals are like. I think we have to remember that the theory behind the treatment and the treatment process can still be valid and useful and sound even if it is abused sometimes by some people.

Let us turn to the methods of treatment that we use today.

Methods of Treatment

Physiological Treatment

First of all, I'd like to talk about physiological methods of treatment, those which fit into the medical model. Remember in the medical model we believe that there is some organic cause-some brain damage, some genetic damage, or some hormonal damage. The idea is that it would be nice if we could find some medical way of treating the patient.

The first major kind is surgery. Some epileptics, for example, have their fits clearly caused by areas in the brain that are damaged. One way of treating the epileptic is to open the brain up and to remove that damaged part of the brain. It helps to control the fits and to change the behavior. That is rational. However, surgery for psychiatric disturbances is not always so rational.

A Portuguese surgeon in the 1930's, Moniz, came to America, and he saw a couple of chimpanzees who had the front part of their brain removed. He noticed they were very docile. The psychologists could do what they wanted with them, and the chimpanzees didn't object. Moniz said, "I've got a lot of violent patients back home in Portugal. What would happen if I cut out the front part of their brain? Would they calm down and would they be less violent?" So he went back to Portugal and worked on techniques of operating to do this. He started by trying to remove the front part of the brain, and the operation eventually became refined so that they just severed the connection between the front and middle sections of the brain, by going through the eye socket commonly. It is called a pre-frontal leucotomy. Pre-frontal leucotomy reduces the intensity of people's emotions. Instead of being euphoric and depressed, the emotions become much less intense. The person becomes emotionally bleached.

It has problems of course. It doesn't have to mean that the person can get out of the hospital and it doesn't improve their day today functioning. It simply means that their emotions are less strong. Second, it's irreversible. Once you've severed that connection, you can never reconnect it. As a result, the operation has fallen out of favor. The rationale was based on a couple of chimpanzees, it did not make that much sense, and the irreversibility of the effects makes it a last-ditch procedure.

Today, for some other behaviors such as violent behavior, some surgeons still advocate removing parts of the brain - the thalamus, the amygdala, and the hypothalamus. This still raises grave ethical questions. Can the person consent to have the operation? If a prisoner is locked up in a prison cell, is he free to consent when you say, “If we do this operation on you, you will no longer be violent and we might release you.” Because he’s in prison he doesn’t really have the freedom to consent. Or a psychiatric patient who’s locked up in a hospital, can he freely consent? A second ethical problem is, does it work? Even though they consented to it, maybe it won’t help them. Maybe it won’t help them get out of the jail or the hospital.

A different kind of surgical procedure is electric convulsive shock. The person is administered a relaxant so their muscles are relaxed, and then an electric current of about 200 to 1,000 milliamps is passed for a few seconds through the brain. In fact it has beneficial effects. It alleviates some people’s depression at least in the short term. There is no good rationale for doing it, and recently it’s been found that it can cause serious memory disturbances. I recently read a report by an economist who said that, after she had electric convulsive shock therapy, she was no longer able to remember any of the economics she had learned. She had to retire from government service. Again, there is no good a rationale for it, and it can have deleterious consequences.

Perhaps the best method that today fits into the medical model is using medications, and these are widely used. For example, tranquilizers are used to lower anxiety and hyperactivity, and they don’t actually impair your cognitive activity, your skill in thinking or your alertness. Antidepressants can help reduce your depression and reduce your euphoria. Drug-like sedatives do control anxieties, but they also dampen your motor activity and your thinking activity and can be addictive. Many of the stimulants which energize you can also be addictive. But the tranquilizers and the antidepressants are very effective. They are easy to administer, and they are cheap. You go in, pick up your prescription, and take them at home. Medication requires few staff. The treatment can be very precise: take two daily, take one and a half daily, take three daily. They can also be used to supplement or to compliment psychotherapy. It is difficult to do psychotherapy with a very depressed patient. If one can alleviate the depression through drugs, then psychotherapy may be more effective. Finally the effects are sometimes reversible when you stop giving the person drugs. There may be very long-term effects to being on a tranquilizer for fifteen or twenty years, but people haven’t been on tranquilizers for that long and so we are not sure about the long-term effects. At the present time, it looks as if the effects are reversible. We can take you off the drug and your behavior returns to as it was before. What is more interesting to me as a psychologist, however, is psychotherapy, and let us turn to that next.

Psychotherapy

In psychotherapy, you visit a trained therapist who talks to you. Let us start by discussing face-to-face therapy with one therapist and one patient. You sit in the therapist’s office and you talk to one therapist. There are many types of psychotherapy systems - Freudian, Rogerian, Gestalt, and existential.

The basic model from which they all derive is Freud's psychoanalysis. The basic assumptions of psychoanalysis are that all behavior is motivated, that many of your motives are unconscious, and that the sources of your unconscious motives lie in your childhood. They're the result of things that happened to you as a child, and they formed the basis for your present unconscious motives. The aim of psychoanalysis can be stated as making that which is unconscious, conscious. This seems like a very simple goal. In fact the goal can be phrased in other ways - to strengthen the ego at the expense of the id or the super ego and so on. But basically the goal is to make what is unconscious, conscious.

Why do we choose that goal? Let me give you an example. I remember once having a colleague that I worked with at a college where I taught, with whom I got into many rows with over trivial matters. We had to share a typewriter, and we would leave the typewriter in each other's office and scream at each other. "Why didn't you bring the typewriter back?" We would stop talking to each other for weeks on end. I used to ask myself, "Why do I have such rows with this person. What are the underlying motives?" I tried to analyze myself unsuccessfully. "Is there something sexual going on?" I could never decide that there was. Is it that she reminds me of my mother, and I'm fighting with her because I used to fight with my mother? That didn't make sense. So I didn't know what was going on and, as a result of not knowing, I had great difficulty in controlling it. My only way of controlling it was to take myself out of the situation or not to interact with her. Since I wasn't aware of what motives were behind the behavior, I couldn't control it.

To contrast with this let me give you another example of my behavior. When I sit in a group of people, I tend to move my chair back from the group and tip it against the wall. Why do I do this? Once, my employer at the time had me watch somebody else acting the way I do in my group. When I looked at this person doing what I did - tipping the chair back and moving back from the group, I saw what it did. It drew everybody's attention to myself. I was upstaging the leader of the group at that point. If that really is my motive, I now have control over the behavior. The next time I tip my chair back against the wall I can say, "I'm going to draw visual attention to myself. My legs will swing, and I may fall over backwards. Do I want to do what?" Maybe I don't want to do it. Or if I do, maybe I'd prefer to do it verbally rather than visually. I might prefer to participate in the discussion and let my point of draw attention to myself. I can ask, "Do I do it in every group? When I do it in groups, at what times do I do it? Do I do it when I'm anxious?" As I begin to understand the motives behind the behavior, I began to get control over the behavior. Understanding leads to control, hopefully.

Another thing that is important is your childhood. Since the source of our motives lies in our childhood, it is important to go back into your childhood and re-experience those motives developing. Say the problems you have with your wife or your husband are really derivative of the problems you had as a child with your mother or father. You can change your behavior with respect to your wife or husband, but you really won't get basic change until you go back and rethink your interactions with your mother and father. What Freud said is that you need to go back and re-experience those problems as you did when you were a child. You have to work them through, and you have to work them through not just intellectually, but emotionally.

For example, most of us can accept intellectually the Oedipal conflict. I must have been sexually attracted to my opposite sex parent. I can accept that intellectually. But can you feel it emotionally? You'll never resolve that conflict or deal with it until you experience it emotionally, not just intellectually. Once you feel that it happened you will experience the anxiety that you felt as a little child. Now you are experiencing it as an adult, and you are experiencing it in the presence of a guide, an objective, neutral, caring, but uninvolved psychoanalyst. The psychoanalyst will not judge you, scold you, or punish you for what you are thinking or for that anxiety. He will help you work it through. You will learn that the feared consequences ("If I say this to my mummy, then she will do such and such") do not happen. You learn that you can handle the wish and that you can handle the emotion behind it. You re-categorize your behavior. As a five-year old you thought it was shameful; as a thirty-year old you can say, "That behavior is pretty okay." It sounds pretty simple. In fact, in psychoanalysis you have to put in from three to five hours week, from anywhere from three to ten years. Today you would have to pay about $50.00 an hour, soit could cost you about $130,000 to complete psychoanalysis. It's time consuming, it's expensive, and it's not as easy as it sounds, there is a lot of effort involved.

What techniques are used in psychoanalysis? The major technique is that of free association. You have to get into the habit of saying to your analyst the first thing that comes into your mind, and that is by no means easy. How many times have you had something that you were thinking of or wanted to say and you forgot it? You block it from your own awareness, let alone having somebody sitting there and you have to say what you thought assuming you can remember it. You say, "Do I dare say that? What will he think of me if I say that? Maybe he'll judge me. Maybe he'll scold me. It's too shameful to say that." It takes time to unblock and to be able to free associate properly. Although some people can talk a mile a minute and can apparently free associate, their words are a smoke screen to hide what they're really thinking. Sometimes myself, I have a tune running through my head, and I often ask myself, "Am I avoiding thinking of something? I may be free associating or thinking that I'm letting my mind relax, but am I?"

To what should you free associate? Anything that comes up. You all know that psychoanalysis love dreams, and dreams are a good place to start because when you're sleeping your defenses are reduced. You think of things that you wouldn't think about in your day-to-day state. But you can start anywhere - from the clothes that you wear, why you were late, what happened between you and your wife last night, to what's going on between you and your therapist (that is, the transference). It's a very slow and laborious process. Freud once tried letting the client talk about himself under hypnosis, but he found that that was too fast. Because it took place too quickly, it wasn't complete. There was less effect on the person's behavior and less self-insight. So he decided, "Let's take it really slowly. Let's spend years at it, and it then will have more impact.

The second important technique is that of interpretation. The psychoanalyst will suggest ideas to you. He will be somewhat directive, and he'll try to facilitate your thinking. It's best if you come to that insight by yourself. The therapist might say, "That fight you had last night with your wife, did it being anything to mind? Can you see the connection?" Or he might be a little bit more directive and say, "What about that other time when you did such and such, do you see any

parallel?" He's prodding you to some insight, to connect up two pieces of behavior and to find the reason for it. Psychoanalysts very rarely lay an interpretation right on you, "Listen, what I think is wrong with you is this and this and that." That's too harsh, and the timing is too quick. The timing is critical because quite often your analyst can tell you something, and you'll reject it and that means two things. It could be wrong. What he thought about you is not correct. But maybe he told it to you too soon, your anxiety is too high, and you can't face it. It is difficult to really understand what psychoanalysis is about until you experience it. Even reading a first-hand account of it is not quite the same as going to your analyst and experiencing the difficulties, the effort, the confusion, and the time that it takes.

But what I tried to give you is some of the basic principles involved. What is useful at this point would be to compare and to contrast it with a couple of other kinds of psychotherapy. Let's start with Gestalt Therapy.

Gestalt Therapy

Gestalt Therapy was devised by Fritz Perls. Perls saw psychological health as the harmonious integration of all the aspects of your personality. He feels that they don't fit together because you avoid experiencing particular emotions. In that case, your interaction with other people will not be normal, and you disown parts of your personality, "That's not me. I disown that part of me." Perls said that in order to become aware of these different parts of yourself is curative in itself. The organism, your mind, and your body, is wise. If you just let yourself be aware of things, you will resolve all the conflicts and the discrepancies. He focuses upon the here and now. I don't care what happened to you in the past. What are you doing right now? He doesn't really care that much about motives. He would never ask you why are you doing something. What he will say is what or how. He might say, "What are you doing with your finger right now?" "I notice that I'm picking at it." But not why are you doing it? He might listen to your voice and say, "What is the tone of your voice right now?"

Fritz Perls felt that neurotics go into psychotherapy to help improve their neuroses, to become better neurotics. He said you have to frustrate them. You have to unblock them and make them become aware of themselves. He makes them face their blocks and their inhibitions. He saw free association as taking you away from the thought. You're associating away from the basic thought to something else. He said, "Stay with it." If you tell Perls you're depressed or you're anxious, he would say, "Stay with it, face it, and then your mind will resolve it." He focuses on integrating the person, not analyzing him, and he tries to integrate the feelings, the intellect, and the body awareness, all aspects of you.

For a second therapy to contrast, let's turn to client-centered therapy.

Client Centered Therapy

Carl Rogers, who devised this kind of therapy, said that help comes not through knowledge or self-knowledge, but by the therapist accepting, empathizing with the patient, and being honest and genuine with the patient. Rogers listens to what you say, tries to feel what you're feeling, tries to encourage you to explore yourself, and he does that by reflecting what he

thinks you're saying. He might say, "You sound as if you're very unhappy," or, "Tell me more, or are you really telling me such and such." The client moves, and Rogers follows. He doesn't interpret, and he doesn't give advice. If you ask him, "What should I do," he says, "I feel that you're confused and you want me to take over your life." He will not tell you what to do.

The best way of describing the therapy is to read a little section of what he says:

> For the therapist, therapy is a new venture in relating. He feels, here is this other person, my client, I'm a little afraid of the depths in myself. As he begins to speak I feel a respect for him, I feel my kinship to him, I sense how frightening his world is for him, how tightly he tries to hold it in place. I would like to sense his feelings and I would like him to know that I understand his feelings. I would like him to know that I stand with him in his tight, constricted little world and that I can look upon it unafraid. Perhaps I can make it a safer world for him.

Rogers is a non-directive. He does not give advice and does not guide. He simply tries to understand what is going on to show that he accepts the patient and cares for and values the patient - that nothing the patient could say or do will make Rogers reject him. This process of sharing, of empathizing, of communicating one's caring for the patient helps the patient, cures the patient, leads the patient to self-insight perhaps or to happiness, or at least a feeling that he no longer needs psychotherapy.

LECTURE TWENTY FOUR: TREATMENT OF DEVIANTS: PART II

In our discussion of how society treats our deviants last time, I talked about two main methods: the medical methods (surgery and electro-convulsive shock therapy) and psychotherapy (where one therapist talks with one patient). Today, I'd like to discuss some more kinds of ways we try and change people's behavior that contrasts with these previous two methods - behavior therapy. When I discussed the learning perspective on deviant behavior, I mentioned ways in which the learning model can be used to try and devise methods of changing people's behaviors. Let me refresh your memory with a couple of examples. If you look at this first chart, I describe how we can cure people, for example, of alcoholism by pairing drinks with nausea.

US → UR
apomorphine nausea

CS → CR
drink nausea

We inject the clients with a drug called apomorphine, and they eventually feel nauseous and vomit. If we give them a drink, and we then make them throw up; eventually they begin to feel nauseous and to throw up just at the taste of a drink and at the sight of a drink. By means of a simple process of classical conditioning, we have made alcohol an aversive stimulant. They feel nauseous at the thought of alcohol. If you remember, the person has to be motivated in this. The person has to want to change his or her behavior in order for this to work. Another example, which is diagramed in the next chart, is that of curing the child of bed wetting.

US → **UR**
bell wakes child up
so he can urinate

CS → **CR**
bladder wake up
muscles stretched

If we ring an alarm clock, ring a bell, this wakes most people up - the unconditioned response. What we do is pair this with the bladder muscles being stretched when the child has a lot of urine in his bladder. When the child wets the bed, the urine completes an electrical circuit which rings the bell which wakes the child up. The bladder gets full, the child wets the bed, the bell rings, and the child wakes up. Eventually after many pairings of these stimuli, the child wakes up when the bladder muscles are stretched. We now have attached the response of waking up to the conditioned stimulus of the bladder muscles being stretched. Again for this process to work it helps if the child is motivated to change his or her behavior, and it may require many pairings of the stimulus of the bell and the child wetting the bed before the treatment is complete. But the success rate is considered to be very high. It's claimed in some studies to be as high as 80 percent of all children cured of wetting the bed by this technique.

We can also shape a behavior via an operant conditioning by rewarding people for the behaviors that they show spontaneously and that we want them to show. For example, when a psychiatric patient puts on lipstick or has her hair done, makes herself look nice or converses with another patient, we can reward them with cigarettes or with tokens or, if they are young children, with M&M's. This is the process of operant conditioning - rewarding people when they emit a behavior that we want them to emit. In fact, operant conditioning is no different to what we do with any child. We encourage a child when they say please when they ask for something at the dinner table. When they say thank you, we reward them perhaps with a hug, a kiss or a smile or by giving them what they want. So we apply the same principles that we use in normal everyday child rearing to disturbed children and disturbed adults.

Behavior therapists are very creative and innovative, and they have devised very many ways of changing people's behaviors using these simple techniques. I'd like to give a couple of examples for phobias. The first is called *systematic desensitization*. Let us say we have someone who fears cats. What we do first of all is teach them how to relax - train them in something like yoga or hypnosis, or just relaxation. We train them to breathe rhythmically and to be able to relax every muscle of their body. We also make a hierarchy of all the things that they fear. Perhaps the thing that they fear most is having some large, smelly tomcat on their lap. That would panic them. All the way down to the least stimulus which would be looking at a photograph in which there is a little kitten in the corner of the photograph. We get maybe 50 stimuli that range from minimal anxiety-arousing to maximum anxiety-arousing. We take our client, relax him and show him the least feared stimulus. All the time he is looking at it, we give him relaxation instructions until he can look at the picture of that little kitty without feeling anxious. When that is complete, we show him the next most feared stimulus. Maybe it's a picture of a slightly larger cat. And son on, until eventually he can have large smelly tomcat put right on his lap without feeling anxiety. How long does this take? It doesn't happen in one session. It may take 20 to 30 sessions to dull the anxiety to each of the stimuli in the hierarchy, from the least feared to the maximally feared.

To contrast with this, some behavior therapists have invented a procedure called *flooding*. In flooding, we take the client, sit him down, and take a really scary stimulus. Maybe we get an actual live cat, we present him with it, and he feels acutely anxious. We make him stay with that anxiety until the patient implodes, which means there is a spontaneous reduction in anxiety. What we're really trying to do is extinguish the anxiety by making him suffer the anxiety and learn that nothing happens. No feared consequences happen. The ceiling doesn't fall in, he doesn't faint, he doesn't die, he lives with the smelly tomcat.

These two procedures are in great contrast - systematic desensitization and flooding. Some psychologists claim that flooding is unethical because it subjects the patients to a large degree of stress. They suffer a high level of anxiety and trauma. On the other hand, desensitization is not as anxiety producing because the patients are exposed to the anxiety-producing stimulus gradually and are relaxed all the time; but it takes much longer. On the one hand, we have ethics; on the other hand, we have the time involved, and perhaps, the expense. This gives you one example of a couple of techniques that behavior therapists have used to change people's behavior, in this case, phobias.

Psychotherapists also change behavior. They advise. They suggest to their clients, “Why don’t you try this. Why don’t you experiment?” They sometimes reinforce particular behaviors. They say, “Hmm. Tell me that again or can you think of another time you felt like that. Focus on this kind of thought rather than that kind of thought.” They try and change behaviors. Behavior therapists do talk to their clients. They take their history, and they empathize with them. They don’t just present them with pictures and give relaxation instructions. They relate to the client like human beings. So there is a degree of overlap between the behavior therapist on the one hand and the psychotherapist on the other hand, but they do split on what you should do - whether you should just change a behavior - eliminate the symptom - or whether you should try to lead the patient to some self-insight, to some understanding of why they are doing what they are doing.

Let us move on to the dimensions on which we can classify the different kinds of psychotherapy.

Dimensions of Psychotherapy

There are many systems or schools of psychotherapy. One recent book was called *Thirty-Six Systems of Psychotherapy*. Can we get any sense of how these different kinds of psychotherapy differ? One dimension along which they differ is that of being directive versus nondirective, or active versus passive. Let me give you a couple of examples. Client-centered therapy devised by Carl Rogers is a very non-directive therapy. Let me read a part of a transcript of a therapy session between a non-directive therapist and a client.

The client says, “I have all the symptoms of fright.” The therapist says, “Fright - that is a very scary thing. Is that what you mean?” The client says, “Ah-huh.” The therapist says, “Do you want to say anything more about what you mean by that? That it really does give you the symptoms of fright?” The client, “Ah, I don’t know whether I quite know. I mean, well it really means that I’m cut loose and it seems that I’m very, I don’t know, in a vulnerable position. But I brought this up and somehow it almost came out without, without saying, it seems to be, it seems to be something that I let out.” The therapist says, “Hardly a part of you,” and the client says, “Well I felt surprised.”

All the therapist is doing here is saying ah-huh or you say you feel fright, that must be very scary. Or when the client says, “It’s something that I let out,” the therapist says, “It’s not really a part of you.” The therapist is reflecting back what the patient is saying and encouraging the patient to say more. “Tell me more about that fright.” He’s being slightly directive but not greatly; he’s not saying, “I think what you should do is this.”

In contrast, let me take Fritz Perls with Gestalt therapy. Client: “I guess I’m supposed to say something. I don’t have any interesting dreams. Mine are sort of ordinary.” Therapist: “Are you aware that you’re being defensive? I didn’t ask you only to bring in dreams.” “You asked for them last night, and I was afraid that that would disqualify me, but I could manufacture a few.” “Now you have a very interesting posture, “says the therapist. “The left leg supports the right leg, the right leg supports the right hand, and the right hand supports the left hand.” “Yeah it gives me something to hang on to. With a lot of people out there, you kind-of get on some stage

fright. There are so many of them." Fritz Perls here is being very confrontive. "You're being defensive." He's not reflecting back exploring that feeling. He's challenging. He's saying look at your body posture. He's drawing the patient's attention to something. He's being more directive than Carl Rogers is.

Let me give you an example from William Glasser, a reality therapist who says, with his patient, "Initially I took the initiative. I asked him to tell me his plan. Asking him for his plan tells him that he should have a plan or at least start thinking of one. Putting him in a position where, instead of unburdening his troubles, he should begin some constructive thinking about what he's doing right now and about his future." He reacted typically by saying, "What plan do you have in Mind?" I say, "Well, here you are in college you must have a plan or a goal, some place you are heading for, some idea of how to get there?" My open question does not tie him to a concrete plan, but I was telling him that he should bear his aspirations to me. Again Glasser is being very directive. He's saying, what is your plan. Tell me your plan. You don't have one? Well, damn it, you should have one. That is, perhaps, extreme activity and directiveness on the part of the therapist.

The second dimension is that of whether the therapist focuses upon your thoughts or your emotions. Someone like Albert Ellis, who has a system called Rational-Emotive Therapy, focuses upon the thoughts. For Ellis it's your irrational thoughts that lead to irrational behavior. For example, say someone rejects you, a boyfriend or girlfriend. A rational belief is that it's unfortunate, and a rational consequence would be I feel sorrow as a result. An irrational belief upon being rejected would be - I am worthless. No one will ever love me. The consequence of that would be depression, anxiety or suicidal tendencies. Ellis says we've got to make people think rationally, and then their behaviors will be rational.

To contrast with that, Fritz Perls with his Gestalt therapy focuses upon emotions much more. Let me give you an example. His patient says, "Yes, I feel afraid and I'm shaking and my face is hot and it's hard for me to breathe. When I started talking I began to tense up." Fritz Perls says, "Close your eyes and tense up. Take responsibility for tensing up. See how you tense up. Which muscles tighten?" "It's in the top part of my body and in the chest and in my arms, in my hands, and it restricts my voice." "Stay with your hands, they're trembling. Let them tremble. What else do you feel?" "I feel numb." "Say this again." "I don't feel anything, I'm numb." "Now close your eyes and get into the numbness. How do you feel?" "I feel gray. Grayish cold. I still feel closed in, just all gray." What Fritz Perls is saying is experience that emotion. Get into it. Feel it. His assumption is that, having let yourself feel it, it will begin to resolve itself. But notice the difference between Ellis who would focus on your thoughts, what you are thinking, and how rational or irrational they are, and Perls would ask what are you feeling, get into that, experience it.

A third distinction is those therapists who focus upon the past as opposed to those who focus on the present. Now, as you must have realized, psychoanalysis focuses upon your childhood. The crucial things that happened to you happened in your childhood - how your parents treated you, the rejections, the love, the nurturance that you got. As opposed to people like Fritz Perls in Gestalt therapy, who says, "I don't care what happened in the past, what's going on right now with you, right now," or William Glasser who says, "To worry about what

happened to the child is to look for excuses. You've got to confront reality right now, current reality." Yet, in a way, this dichotomy is artificial because everything we do in the present is determined by things that happened in the past. One can look at the present by looking at the past. For example even in psychoanalysis the way you react to your psychoanalyst is going to be similar to the way you reacted to perhaps your father or your mother. It's called transference. You transfer the behaviors that you showed towards your father to your psychoanalyst now. One can learn about the patient, therefore, by studying the reactions to the analyst or to the reactions to the father. So perhaps the dichotomy is artificial, but it is real. Some therapies are historical and some are not historical. They focus on here and now.

A fourth dimension is that of strategies for behaving versus self-understanding - counseling versus psychotherapy. In psychoanalysis, the aim is to make conscious what is unconscious, to bring the thoughts or the motives in the recesses of your mind into consciousness, to find out why you do things. The aim is for self-insight. In reality therapy or crisis intervention, we don't care about self-insight. We just want to give you strategies for behaving. You are doing this; what are some alternatives that you could do instead? Self-insight is not crucial; can I find you an alternative behavior that you could try? If you think about what would be ideal, perhaps most clients could do with both. They could both use the insight, that will give them some basis for their behavior, plus some new strategies, that are tied to the basic principles along which they operate or should operate. So perhaps self-insight should go along with new strategies. Maybe the ideal therapist gives you counseling sometimes and psychotherapy at other times.

The final dimension is one I've already discussed earlier in this lecture - that of symptom versus cause. The psychotherapist focuses upon the cause of the behavior, the basis for your behavior, whereas the behavior therapist focuses upon the symptom. Do you wet the bed? Okay, I'll cure it. I don't care why you wet the bed. I don't care what your mother did to you, or your father or your brothers and sisters. I'll just cure the symptom. The psychotherapist would say that it's no good curing the symptom. We've got to find the unconscious motives, the reasons behind the behavior. That's what we have to deal with. This is a major split perhaps between the two kinds of therapy - psychotherapy and behavior therapy.

What I'd like to do now is to contrast all the kinds of therapies I've talked about so far with a couple of more types, and I'll start with group psychotherapy.

Group Therapy

In group psychotherapy, you meet with a group of about five to ten other patients. You meet, perhaps, twice a week for about an hour and a half each time, with usually one therapist. What cures people when they go into group psychotherapy? Irving Yalom has thought through what it is that helps people by being in a group with a therapist. First of all, you acquire a lot of information. You learn all about mental health and maybe psychodynamics, and you get advice and guidance, and you get this both from the psychotherapist and from the other patients. They advise you too. Sometimes this information giving is implicit, sometimes it's explicit. For example, in Morita therapy, which is a very common form of therapy in Japan, or in Recovery Incorporated, a self-help group for neurotics, they actually give lectures on mental health. This is

important information that you should know. Of course you do get some of this occasionally in face-to-face therapy too, so this is not unique to group psychotherapy.

Secondly, group psychotherapy involves the installation of hope, and the hope keeps the patient in therapy. The hope and the faith that everything will turn out well helps to cure the patient. You get this quite often in the group from people who are further along in their cure, who have survived crises. You can look at them and say, “My God! They survived. Maybe I can survive too.”

Thirdly, you learn that you’re not unique, You’re not the only person who suffers. You’re not alone in your misery or in your fears or in your fantasies. All the other people in the group too have similar fears and similar fantasies. It’s almost as if sometimes patients feel, “I feel I’ve rejoined the human race. I’m just like other people, I’m not alone in my suffering. “

A fourth factor is that you begin to be altruistic. You help each other. Each patient helps the other patients, and this relieves your morbid self-absorption. Instead of, “I can only think about my problems,” you have to think about other people’s problems. You help them, and that makes you feel good and begins you on the process to recovery.

There’s a whole lot of social learning in the group. First of all, you recapture your family group. Your therapist is your father, all the other patients are your brothers and sisters, and you have a new family experience. Except this are better than your parents and your brothers and sisters, because you’re older and, because the therapist is there, everything goes much better. You don’t suffer the same trauma that you did in your family. In social learning, you learn social skills, and you learn to generalize your behavior to other people in the group, which applies, therefore, much better to life outside of the group which consists of a lot of other people too. Face-to-face psychotherapy is artificial. You only relate to one therapist. How do you generalize your behavior in face-to-face therapy when you have to go to work the next day and confront 30 other employers or employees? Group psychotherapy generalizes much more easily.

Another thing is that there’s a chance at imitating. You can imitate the treatment vicariously. You can watch the therapist work on this patient, and benefit from it vicariously. “Look what he’s saying to that person. Maybe I can learn something from that?” You can watch other patients try other behaviors - get angry, cry, scream - and you can say, “Maybe I could try that too. They did it, and nothing bad happened. Maybe I can try screaming or crying—which I’ve never dared do before.”

There’s a lot of inter-personal learning in a group. The group is a kind of social microcosm of the real world, and you can become aware of your strengths and your limitations and how you distort your perception of other people’s behavior and what are your maladaptive behaviors. Perhaps there’s also catharsis when you’re allowed to release your emotions in a group. Other people respond appropriately, and you feel so much better for ventilating your emotions, for screaming at people, for crying, or for talking about your emotions. In a way, the more emotional your experience, perhaps the more impact it has on your behavior.

Finally, there is cohesiveness in the group. In a group of patients, you learn to accept one another, to share your experiences, and you get a sense of belonging to the group. You eventually begin to mean a great deal to one another, you become friends, and this group cohesiveness leads to you accepting yourself more as a person, to raising your self-esteem. You feel a whole lot better about yourself, and aware in particular that you can express negative emotions without disrupting your life or your world completely – that it is possible to express negative emotions without destroying relationships.

A different kind of counseling that I'd like to talk about to contrast with these other forms is that of telephone counseling.

Telephone Counseling

Telephone counseling is particularly appropriate for my background in which I worked at a Suicide Prevention Center where the major mode of treating clients is by the telephone. There are certain unique features to telephone counseling. First of all, it is often done by para-professionals, i.e., non-professionals people who have had about 15 to 45 hours of training, who live in the community, and who don't have as much training as a psychologist or a social worker who went through perhaps eight years of college and one year of clinical work.

The second factor is that, if you call such a center, you can remain anonymous. You don't have to go through a receptionist, make an appointment, be known be visible, or give your name and social security number. You can call up and you can say, "I'm not going to give you my name. I don't want to give you my name, or my name is David and that is all I'm going to tell you." What this means is that you're less anxious about the interaction. You can initiate the contacts more easily because you don't have to feel so anxious, and, if you get anxious, you can hang up. If you are sitting with a therapist in his office, to leave him you'd have to get up, say, I'm leaving," go to the door, open it, walk out, and what will he do? Maybe he'll shout, "Sit down," or maybe he'll run to the door and close it and say, "No, I'm not letting you go." It is very easy just to hang up. Click.

Secondly, the counselors are also anonymous. You don't know who the counselor is, and so you can fantasize more. Maybe, if you need a particular kind of counselor, you can pretend that he or she is that kind of counselor. For example, if you think you need an authoritarian counselor, you can see your counselor as more authoritarian. I've often tried to encourage clients to do what **they** wanted to do, but they still see me as telling them what to do because they need to see me as telling them what to do. The problem with this is that it leads to less contact with reality. You are fantasizing more about a person, and so you're not really learning skills that are appropriate in your day-to-day interaction with other people. The fantasizing about your counselor can be good in one way and bad in the other way.

A fourth factor about counseling by telephone is that it's short-term and crisis-oriented. The idea is to define the problem and, to do that, we try to be non-directive. Tell me about your problem. Can I get into what you're feeling, into your world? Can I then assess what resources you have? Then I have to become very directive and give you a solution, suggest an alternative strategy. In that respect I move from being very non-directive to being much more directive.

I don't care about the causes of you behavior, the history or the motives behind it. Quite often when we train telephone counselors we say, don't open the patient up, don't get into psychodynamics, just focus on current behaviors and current strategies. So telephone counseling is short-termed - five minutes to two hours - as opposed to psychoanalysis which is 500 to 2,000 hours. If you call a lot on the telephone service, if you make it into a more of a long-term relationship, you'd probably be defined as a problem caller, and the center will discuss and say, "This person is calling too often." At my center, we had one woman who spent 35 hours on the telephone talking to our counselors. Or one teenager who would call five times a day - something like 1,500 calls a year. We defined this dependence upon the center as a problem. The aim is not to get into long-term psychotherapy, but to keep it brief and short. Why don't you try this, why don't you try that? Call us back and let us know what happened." But we do not want to get into a long-term relationship with you, we're not going to discuss your motives and the causes of your behavior and what happened to you as a child.

When you talk to somebody on the telephone with a short-term crisis orientation, you often find that, after about 30 minutes, we've talked about this already. We seem to be going in a circle. We talk about this topic, we go through it, we come back to the beginning and then we start off again. In addition, if we do try to talk to patients for a long time, we find that we're getting into conversation rather than dealing with their problems. We're getting into a conversational mode with them, and a conversational mode is not therapeutic. People have had conversations with their friends and their relatives and their neighbors, and it didn't help them. It's got to be a non-conversational interaction with the client for the client to improve.

There are various other problems that can arise in telephone counseling. It's very easy when the client is at home, sitting in their favorite chair, to get overly confident, to not feel as anxious as when they first called you. Here they are sitting in their own chair, in their own living room, holding the telephone with you talking into their ear. It's a very intimate experience, even though there is a great distance. So, quite often when you call, as soon as you start talking, your anxiety level goes down. You say to yourself, "I don't have a problem after all. I feel so much better. I can end this contact." So you hang up, but then you realize perhaps that you haven't dealt with the problem because you didn't face your true anxiety and then maybe you'll have to call back again. In face-to-face therapy, there is anxiety. There is tension. You're sitting there being confronted by a therapist who looks you in the eye and has implicit demands for you, and so perhaps you're forced to accept reality, to accept your problems, to accept the anxiety associated with them, and to try and work them through. This you don't do with telephone therapy.

LECTURE TWENTY-FIVE: EPILOGUE

Although the title for this lecture that you've just seen said "Epilogue," we are not really on the epilogue now. If you remember, last time I was talking about the treatment of the deviant, but I didn't quite finish. What I'd like to do today, first of all, is to finish talking about treatment. Last time I talked about group psychotherapy - how sometimes people get together - a group of patients with one therapist - and they try to work through their problems and to gain some self-insight in a group psychotherapy setting. I'd like to contrast that with what is becoming very popular today, the so called "encounter group."

Encounter Groups

In an encounter group, a group of people, who are usually strangers, meet together for a week or a weekend or two sessions a week, and the aim is to explore their interpersonal functioning, their personal anxieties, and so on. There is a common theme or pattern to these group meetings. Let me read from a book by Jane Howard called *Please Touch*.

An encounter group is a gathering, for a few hours or a few days, of 12 or 18 personable, responsible, certifiably normal and temporarily smelly people. Their destination is intimacy, trust, and awareness of why they behave as they do in groups. Their vehicle is candor. Exhorted to get in touch with their feelings, and to live in the here and now, they sprawl on the floor of a smoky room littered with Styrofoam coffee cups and half empty Kleenex boxes and overflowing ashtrays. As they grow tired, they rest their heads on rolled up sweaters, or corners of mattresses, or on each other's laps. In many instances they've never met before, but like the proverbial strangers on a train, quickly talk of their deepest emotions. Sometimes they use gadgets, and exercises, and props, sometimes they don't. Some of them shout, seethe, sulk, attack and eventually embrace each other. All of them survive long spells of silence. In fact they become connoisseurs' of different qualities of silence: awkward, peaceful, Quaker, pregnant, painful, and comfortable.

These meetings are quick, they are intense, and there is immediate intimacy. I have a brief excerpt from an encounter group led by Carl Rogers, in which he encourages some people to explore their feelings that they feel towards one another.

- CR: This is one of the valuable aspects of an encounter group that people *can* risk themselves in a variety of ways.

- M: I don't know what's been going on between you and I ever since that day at the table, you know, and I really don't know how you feel about that. When I look at you I notice that you smile at me, you look the other way all the time, but I do the same thing. And I guess I've been anxious about that. So, when you came, I was really happy you came, and Bill held your hand and I thought that was kind of nice. But I just don't know how you feel about me, I guess, I'm kind of interested in that not really kind, I *really* am, you know?

- W: I feel we really haven't had any contact, or just so very light and superficial since we've been here. And…there goes my niceness - wanting to be nice and say something - but like I don't have a whole lot of feelings in any direction.

- CR: But you evidently felt something happened at that meal.

- M: Yeh, I really did, you know, uh…

- W: Let me make sure.

- CR: Does that have any reality for you?

- W: Yah, but let me make sure I've got the right…

- M: Meal.

- W: …meal.

- B: Worse yet the right person!

- W: When I was gonna…

- CR: Why don't you give her a few clues?

- W: When I was gonna sit down and I said…and then someone was sitting alone…and I said I was going to take my feminine prerogative to change my mind. Well, at that time, like I was sort of torn because, you know, I've been using meals very consciously, I noticed it from the first night and the party after, not to spend…like if it's going to be lunch-time and I'd been with my group for four hours, and I know in an hour I'm going to be with them for another four hours, it's like I've got to get away for that hour - I can't sit with them all at a table because it's not the whole group so it's not like "the continuation of" anyway, I've been doing that. Like, you know, I've seen you and you were a new person that I sort of wanted to sit with and also…too, because I think my real feeling…and I can't, you know, I'm blocking now within, myself who the other person was I want to even sit with, but not really feeling I wanted to sit with that person, like I was doing what I thought either, you know, that niceness again or that need rather than just how I felt, and okay another person might feel bad but just "do that".

- M: I tried to make you feel bad. I made a conscious effort to do that.

- W: Yah, but I didn't take it…

- CR: You felt sort of rejected or deserted or something.

- M: Yah! Well, you know. I don't know whether - - yeh I did and, you know, like…and I really tried to put you in a bind and the reason I wanted to do that is 'cause I wanted to touch you, in some way. And I thought if I could get you angry or something it would be just a good deed…well toward me…I find that I can do.

- W: And I didn't get angry.

- M: No.

- CR: You're too nice to get angry.

- W: Well, I wouldn't say that! Maybe I don't know how. You know, like I didn't take it personally; as me, you know, so in that way you were trying to make me feel bad and I didn't feel bad. I was able to get out of it in an intellectual, witty kind of way.

- M: Yeh.

- W: Because I didn't take it personally.

- B: I was at the table with you at the time and I kind of thought that you were just a little bit angry or a little bit uh…

It's worth saying a couple of things about that. First of all, you notice how little Carl Rogers (CR) said. He let the people talk. The only times he intervened was to encourage them to explore something a little more. If you remember what I said last time about client-centered therapy, it is very non-directive. Carl Roger is not that active. He encourages you to explore what is going on in you. He tries to understand. Secondly, it's important to remember that all those people that you saw in that film clip were not part of the group. The group is just about 8 people sitting around facing each other. The other people were a large audience who are watching the group. That laughter came from most of the audience of about 50-100 people. There is also a film camera crew there, so it wasn't a very intimate encounter group. It was an encounter group of 8 people in the midst of a huge audience.

Another thing worth noting was what they talked about. They talked about how the man and the woman interacted at the meal last night. They're not talking about their childhood or what went on in the past, but what happened relatively recently - last night at a meal and how they interacted with each other. They tried to explore what their motives were. He says, "I tried to make you feel bad. I was doing this." Then she says, "and I was doing this back." They are exploring their interpersonal functioning. From time to time they might get feedback from other people in the group who might say, "You came on this way, and this is how I interpreted your behavior." Hopefully, the aim is that they will learn from this experience about how they interact with others; what kinds of things they do; how other people perceive them; and maybe then, having learned this, they can control their behavior much better when they're with other people again.

How do these encounter groups differ from group psychotherapy? First of all, in encounter groups those people are strangers before they meet. The best encounter group is one in which the people do not know each other before the group and do not know each other after the group. Since you never have to meet that person again, you can say things and you can try out behaviors that you would never do if you knew that the next day you would have to go and meet that person again. Maybe, next day, you are their boss and that person works for you or you both work together in the same firm. Then you would be much less likely to be open and to be honest. The fact of being strangers constitutes a prime mover of openness and honesty in the group.

Secondly, the movement is quick. The group only meets for a brief time - a few days - so you have to hurry. A lot of exercises are devised in order to speed up the intimacy so that you can get to know each other much more quickly. Perhaps one of you is blindfolded, and the other takes you for a walk so that you have to learn to trust the person who is guiding you. Or you each write down your secrets anonymously on a piece of paper and redistribute them and then somebody else reads out somebody else's secrets and people discuss them. Do I have similar secrets? The intimacy is so quick. I've been in one group in which, after 30 minutes, a number of the members were telling the person who was the center of the group's attention, "Come on you can trust me," "You can trust us," "Tell us everything about yourself." In fact, you cannot really trust people after 30 minutes. That takes weeks, months or years. But in an encounter group you have gone home after a few days, and so you have to trust very quickly, and that is why it is important to be strangers.

In group psychotherapy, on the other hand, the patients have personal problems; they are very anxious; they're very depressed; they are not going to let their defenses down in 30 minutes; they may take weeks or months to let their defenses down and to begin to reveal things about themselves; and they need that therapist sitting there helping them, guiding them, making it easy for them. Therefore, a psychotherapy group is a much more long-term process as compared to the encounter group.

A third thing to comment upon is that Fritz Perls says, as often as not, neurotics go into treatment to improve their neurosis, to become better neurotics, and, in a way, encounter groups are very good for this. You get into an encounter group with strangers, and you can act out, you can do things and behave in ways that you would never do with your friends or acquaintances. You can satisfy all kinds of impulses - aggressive impulses, sexual impulses, whatever you want to do - because in a few hours or a few days you are going away, never to see those people again. You go back to your other self. Thus, in a way an encounter group can reinforce your maladaptive behavior. You don't learn to integrate all the different parts of your personality. You behave one way in the encounter group and another way when you go back home to your friends and relatives. You learn to dissociate a part of yourself. You can even become an encounter group junkie. You can go to your encounter group every month to lose yourself, to act out those impulses you'd never otherwise do.

A fourth thing to remember is that there is no follow up. It's short-term. The person who leads it doesn't call you up a week later or a month later and ask, "How do you feel now about what happened? Have you managed to utilize any of the insights that you had in your behavior? What's going on with you?" In contrast, in group psychotherapy, it is a long-term process, and

the psychotherapist is greatly concerned with you and wants to check that what you learn in the group can generalize to the rest of your life and that you have improved in all aspects of your functioning.

Finally, you can learn a lot from encounter groups; you get feedback from other people, you can try new behaviors on for size. “How do I feel if I act aggressive - I like it. Maybe I can be more aggressive in the rest of my life.” You can get some self-insight, and you can even grow, even if the growth is unsupervised.

Before I leave the treatment of deviants, perhaps, there are two final thoughts about people who are motivated to seek to change their behavior - to go into psychotherapy. People often give two reasons for *not* going into psychotherapy. One of them is that it is selfish. Here you are, talking about yourself with this psychotherapist; it seems self-indulgent; you shouldn’t do it. Let me read you a quote from a book by Jules Masserman of a patient who thought this:

I believe a great many people think it’s admitting defeat to go to an analyst; that a person with a strong character should be able to solve his own problems. I still had a childish notion that it was wrong to think so much about myself. It was self-centered. It was egotistical. You are supposed to think about other people. And, in fact, I’d always found the greatest relief from my own unhappiness is turning my thought outward, in doing grand and glorious things for someone else, usually outside my own family. But, presently, I realized that my personality was the only instrument by which I could really reach other people, and everything important in this world: in work, in friendship, and in love, and that something was wrong with the instrument. It made me want to take a good look inward to see what was the matter.

The second reason that people give is that it’s weak to go into psychotherapy and weak to seek help. If you’re strong and mature you should be able to work it out by yourself. Again, a quote from another patient, in the book by Jules Masserman:

> Let me say, right now, that you solve your own problems in psychoanalysis *if* they get solved at all. The difference is that you are guided by the analyst, and his guidance consists principally in not letting you kid yourself about anything or skip anything that you’d rather skip, and this isn’t as simple as it sounds. As to admitting defeat will, perhaps it is, if admitting defeat is to know when you need to consult an expert.

Well, that concludes this lecture series. I’ve told you most of what I want to tell you about the ways of looking at abnormal behavior, different kinds of deviant people, and the ways we treat abnormal people. I’ve finished my lectures. I have no more cue cards to look at.

What I thought I’d do for this epilogue is talk off the top of my head for a few minutes about what I think about all the material that I’ve talked about. What do I think about these models of abnormal behavior that I’ve discussed? Do I have a preference? I’ve tried to be as unbiased as I can as I’ve talked to you. Let’s just go over the models a little.

The first one I talked about was the Medical Model - that there is some organic cause for abnormal behavior. In the strong form of this model, in any abnormal behavior there must be

some form of brain damage or some hormonal damage. This is uninteresting to me. I wouldn't be a psychologist if I thought it was interesting. I'd have become a psychiatrist. This is my own personal bias. As soon as I find that a behavior has a genetic cause, I say, "That's interesting for the psychiatrist. It's not much of interest for me as a psychologist." Yet, I have to admit, although it's uninteresting, it's very satisfying. It's very satisfying to look at a child who has Down's Syndrome and say, "I know what is wrong. I *know* what's the cause. It's this gene that it I can see under a microscope. I *know* the answer." As a psychologist, looking at behaviors for which I don't know that there's an organic cause, I never know what's the matter. This child is acting in this way - what's the cause? Who knows what the cause is? Maybe it's genetic. Maybe it's what the father did to the child at some point. There's this dissatisfaction. I never know the answer as a psychologist. There are too many variables, and sometimes, I envy the psychiatrist who knows for sure what is going on. It's this gene; it's this hormone; it's this gland; it's this tumor you have in your skull. I feel it's uninteresting, but very satisfying, but I'm a psychologist.

The next model I talked about was the Psychoanalytic Model. The ideas of Freud (that we have unconscious motives, how they form and how we derive new desires), I have to admit, that is my favorite! Maybe it's because I like playing games. I like looking at people and saying, "I wonder what they're really doing?" What kinds of explanations can I invent? Can I make up hypotheses for why they behave the way they do? Why did I just touch my cheek then? Can I think through my own motives? Can I play psychoanalytic games? Intellectually, I find that very satisfying. I also find it to be the most complete theory of all those that I've talked about. It seems to have something to say about any and all behaviors, from why I scratch my check, pick my nose, give this lecture series, choose a wife, and why I became a psychologist. For any question you want to ask about me, psychoanalytic theory has some answer. It's broad and encompassing. It's also a very nice language to use. The terms; ego, id and superego, unconscious and conscious, the stages of development - they give us a new language, a language that we didn't have before, that we can use to describe different kinds of behavior. I find it a fascinating game to play.

The Social Model (that our abnormal behavior is a result, to some extent, of how people label us) again, I'm a psychologist and not a sociologist. So I don't like that model. It somehow misses the point. Often the social model talks about the general deviant, the general mentally ill, but there are all kinds of mentally ill people. There are schizophrenics and neurotics, and the social model ignores these distinctions. Its proponents ignore the fact that this person has delusions and this person has hallucinations. It oversimplifies the picture. Another problem is that it implies that these people are not really abnormal. It's because society labels them abnormal. I think that is true for some people. But for example, I've talked to people who have tried to kill themselves, and I don't label them as attempted suicides. They tried to kill themselves. When you talk to somebody who's hallucinating or somebody who thinks he's Howard Hughes when he's not really Howard Hughes, it's not you who is deciding that he's not Howard Hughes. It's not a matter that you label him. This person is a murderer; this person is hallucinating. The behavior exists, and it's not a matter of my judgment. Quite often someone will come to me and say, "Help me! I am feeling this. I am scared of cats." I don't label them that way. They label themselves. The social model ignores this aspect of it. It tries to persuade us that people are normal, and we choose to label them deviant because of our prejudice perhaps.

Maybe if I was a sociologist, I'd buy that model more, but, as a psychologist, it doesn't really interest me. I'm interested in what's going on inside you.

The Learning Model? I have great difficulty with the learning model. How we learn particular behaviors is rather interesting (classical conditioning and operating conditioning). How a behavior is shaped. It's very specific. I can map it out and say, "This is the unconditioned stimulus, this is the conditioned stimulus," and so on. I can put it on a chart. But people are very complex. When it comes to how did I learn the behaviors that I learnt, why do I make the gestures that I learnt? Nobody can go back and reconstruct, "There was this unconditioned stimulus and this unconditioned response." My behavior is much too complex. The theory seems very specific and tidy, but it can never really be applied in principle. My favorite theory, psychoanalytic theory, says that we are affected by our experiences - our experiences with our parents, at the breast of our mother, with our father as we grow up, and so on. They shape our behavior. They may not specify what are the stimuli and what are the responses, but the theory assumes that we learn. So learning theory seems intriguing; may be useful for rats, and may be useful for devising a new form of behavior therapy, but it is not really basic or deep, in analyzing people's behavior. It is too superficial.

Next we considered the religious model. Abnormal behavior is the result of sin and, in order to cure yourself, you have to confess and repent. Well, that sounded very nice and novel, but in that lecture I pointed out how it was very similar to psychoanalytic theory. Mowrer is talking about guilt, he's talking about superegos and egos. He's using the same terms, and, although his implications are different, the theory is simply a derivation of psychoanalytic theory. So I go back to my favorite again. Psychoanalytic theory is really the best (and basic) theory.

Finally I talked about the Humanistic Model, that, maybe the abnormally behaving person, the deviant, has something that we don't have. He's creative, he's innovative, he's sane and we're the crazy ones. He may be locked up in a mental hospital and a minority, but he's got something that we don't have. That's very tempting to think about, and it's intriguing. The people who propose the model tend to take a political stance about it, but is it really true? For <u>all</u> deviants? Is it true that the murderer or the suicide or the schizophrenic is really having a more creative experience than we are? He's having a different experience. That's for sure! He may be having an intense experience, but he's also probably having a painful experience. In the recent play by Peter Schafer, called "Equus," the basic issue is; is it worth having the intensity of experience, the passion and the pain that it causes you? If you read some firsthand reports from schizophrenics, they didn't want to be left in their state. They might say afterwards, "It was an interesting experience. I learned a lot from it," but they are glad that they're out of it. In *The Autobiography of a Schizophrenic Girl*, by Marguerite Sechahaye, at one point, Renee, the girl in it, is trying to kill herself, and she is struggling against being put in a straightjacket. But afterwards, when she writes her autobiography, she says, "I wanted the staff to stop me. I really did not want to kill myself. I felt that I couldn't control myself and I needed to be put in restraints, and therefore, I wanted it done." She did not want to be left in that experience. Therefore, although I find the humanistic point of view intriguing; I don't buy it for most patients. It may be true of a few. It may be true of the geniuses or one or two people, but most people who are deviants are suffering. It would be nice if they weren't, but they are - the social

deviants suffer, the mental deviants suffer, and even the intellectual deviants suffer a great deal, and, in fact, they want their suffering removed.

So, in the end, what does it come down to? My favorite model? Well, the Psychoanalytic Model. I don't know that it does me much good in my personal life. I'm often sitting around thinking, "I wonder what was the real reason I did that? I wonder if I can understand my motives. What were my unconscious motives?" I don't think I've ever decided what my unconscious motive was. Whenever I think of a reason why I did something, I think, "I could be fooling myself, couldn't I?" So, in a way, I have a tendency to become an obsessive, psychoanalytically-oriented psychologist about myself, always wondering about my motives and not really ending up with any conclusions and ending up confused. But I like to play those games with other people, and with particular behaviors that I can research and study, like suicide and homicide and sexual deviation. Can I apply those theories to explain the behavior? In the end, I'm beginning to be more and more persuaded by psychoanalytic theory, which is interesting because, when I first read it, ten years ago, I dismissed it. I said, "I've never read such nonsense in my life," but gradually, over the course of the last ten years, I'm becoming more and more convinced that it has more and more of value to say.

Maybe another thing tell you about is what kinds of behaviors do I study? As somebody who studies abnormal behavior, I, on the whole, prefer not to study behaviors that have a diagnosis like neurosis, schizophrenia or psychosis because, as I pointed out in the lecture on the medical model, it's not that easy to arrive at a diagnosis. Can we agree on what's a schizophrenic? Psychologists find it difficult to agree. The behaviors that make up schizophrenia are very complex. There are a lot of criteria, and very few patients meet all of them, and so we have to make decisions. Well, is this person a schizophrenic or isn't he? We are applying labels that really have little meaning, and there's no consensus among psychologists. I study behaviors like suicide and homicide and homosexuality, behaviors which are very clear and which are easy to define. Is this person a murderer or is he not a murderer? It's an easy distinction to make compared to, "Is he a schizophrenic or is he not" The problem that I find is that these groups are so heterogeneous. There are all kinds of suicides ranging from the man who commits suicide when he finds he has cancer to some housewife who puts her head in the gas oven because her husband has rejected her. There are all kinds of suicides, and they have very little in common. The behavior is shown by so many people that it has always been very difficult for me to find what all suicides or all murderers have in common. So, on the one hand, I can clearly define the behavior, but I never find out that much of interest about it.

Maybe one final point before we end this lecture series. A number of people often come up to me and say, "What's the point of all these lectures? What are you trying to tell us? Tell us the truth!" So I am often forced to think, "What is the point of all these lectures? What am I trying to do for you?" I'd like to reiterate something I said at the beginning. My first aim is to introduce you to psychology, to make it seem like an interesting subject. This is what psychologists do and to dispel some of the myths you might have. To illustrate and explain some of the theories that we have when we talk about behavior. But the major aim I have is to make you curious - to whet your appetite. I have no truths to tell you. There are few facts in psychology or in the study of human behavior. There are a lot of hypotheses and a lot of ideas but no facts. We can never say anything for sure. I want you, next time you open your newspaper

or a magazine and you read a fact that's about human behavior, to say, "I don't believe that fact! You know, I listened to David Lester on the television last year, and I know that psychologists, sociologists and psychiatrists can never be that sure about behavior. I can think of two or three other reasons or explanations for that. I refuse to believe what those people are telling me." I want to make you distrust psychologists. I want to make you think for yourself, to try and see if you can come up with hypotheses that you generate from within yourself about human behavior, and never to accept a fact given to you by a psychologist as the ultimate truth!