DEVIANCE

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LECTURE 1: INTRODUCTION

In July 1959, Milton Rokeach, a psychologist, brought three men together in a room in Ypsilanti, Michigan. He suggested that the three men introduce themselves. A fifty-eight year old man spoke. “My name is Joseph Castle.” “Joseph is there anything else you want to tell us?” “Yes, I'm God.” The next man to talk was seventy years old. “My name is Clyde Benson, that's my name straight.” “Do you have any other names?” “Well, I have other names but that's my vital side, and I made God five and Jesus six.” “Does that mean you're God?” “I made God, yes, I made it seventy years ago.” Finally a thirty-eight year old man spoke. “Sir, it so happens that my birth certificate says that I am Doctor Domino Dominorum et Rex Rexorum. It also states on my birth certificate that I am the reincarnation of Jesus Christ of Nazareth.” Three men, each of whom thought that he was God.

An Introduction To Deviance

Hello, I'm David Lester, a psychologist., And for the next few weeks, you and I are going to examine deviant behavior. The behavior of men like Joseph, Leon, and Clyde, each of whom thought he was God. Of course, a long time ago, one man did think he was Jesus Christ. He was crucified, and he became the leader of a religion. But nobody believed Leon, Clyde and Joseph. They were locked up in a psychiatric hospital.

Mike was a young man who was interviewed by sociologist Stuart Palmer. Mike remembered these following incidents from his childhood. He had been constantly beaten as a child. When he was five, his uncle had become mad at him and thrown him across the room so that his head hit a stove. His two older brothers once beat him with sapling branches until he was covered with welts and bleeding, after which he was unconscious for two days. Once, for fun, his uncle put him under the hood of a car and started the engine. He remembered his brothers tying a snake around his neck so that he became panic-struck and terrified. His brothers once tried to teach him to swim; to do this, they threw him in a river so that he nearly drowned. Mike is of interest because when he was eighteen he went to a prostitute to have intercourse with her. Afterwards, he tried to rob her and when, she tried to stop him, he murdered her.

Nigel Hunt recently wrote his autobiography. Let me read you an excerpt from his autobiography.

> On my mother's birthday, in August, we went to Salzberg to celebrate with a drink somewhere. After that we went to have a look round the shops to get some souvenirs and a picture postcard for ourselves to imagine that you are in Austria. Then we went to St. Peter's Square for a drink, where my Dad went to christen it;

> he always says he must, and then to have a snack at the restaurant. There we had a real meal, Salzberger Knockel, which was very good, with roast.

When Nigel Hunt was born his parents were told that he had Downs Syndrome, that he was a Mongoloid child, that he would never be able to function very well, and that they had better put him in an institution. Nigel Hunt's parents kept him at home. They loved him; they worked with him, and finally, when he was eighteen, he wrote his autobiography. Nigel Hunt is deviant in two respects. First of all he was mentally retarded, but not only that, he is the only child with Downs Syndrome who has written his autobiography.

For the next few weeks, you and I are going to study deviant people. People like Joseph, Leon, and Clyde, who are mentally deviant. We call them crazy, in lay terms, or psychiatrically disturbed. We lock them up in hospitals. Or people like Mike who murdered a prostitute, a social deviant, a man who broke a rule of the society. And Nigel Hunt, an intellectual deviant, someone who is mentally retarded.

I have to warn you from the beginning that I have no truths to tell you, no kernel of truth which is generally true. Rather, I am going to confuse you. I am going to present you with six different ways of looking at abnormal behavior - six ways that conflict with one another. The proponents of each perspective argue that their perspective is the correct one and that the other five are wrong. Each of them argues that. What do I want you to do? I want you to remain curious about deviant behavior, to keep an open mind, to see the validity of each of those perspectives and to remain curious about the causes and the reasons behind deviant behavior.

Why Do We Study Deviant Behavior?

Why should we study deviant behavior? There are many reasons why we should study deviant behavior, the most critical of which is that, if we want to help those who are abnormal in some way, then we have to understand their behavior. For example, some twenty thousand people kill themselves in America each year. If we wanted to help those unhappy people, if we wanted to try and prevent them killing themselves, we have to understand the reasons why people kill themselves - the causes, the motives, behind their actions. Each year some ten thousand people in America murder somebody else. Again, if we want to prevent homicide, we have to understand what goes on in the mind of the murderer. What happened in their childhoods that make them murderers?

Let me give you an example of the magnitude of this problem. On a typical day in 1969, in California, there were 286,000 people going through the prison, parole and probationary system. There were 21,000 people in psychiatric hospitals and psychiatric clinics. There were 24,000 people who were retarded and being treated for it. That comes to some 330,000 people in a state of 20,000,000 people who were deviant in some respect. And think how many people are occupied taking care of these deviant individuals. Something like 200,000 people are looking after them. Half a million people concerned with deviance - either being deviant or looking after the deviant. It is critical,

if we are to reduce the magnitude of this problem, that we understand the causes of deviant behavior.

However, a second reason why we study deviant behavior, is that psychology is the study of human behavior - all behavior - normal and abnormal. Some psychologists think that, if we study the behavior of abnormal people, then we can learn something about the behavior of normal people. Let me give you an example. Sigmund Freud, in Vienna, Austria, toward the end of the 19th Century and the beginning of the 20th Century, mainly dealt with neurotic, middle and upper class, rich people in Vienna. He treated them for their psychiatric symptoms. You may have heard of some of his concepts, for example the Oedipal Conflict.

As a result of talking with his patients, he concluded that all of them, when they are about age three to five, went through a period when they became enamored of the opposite sex parent. The little boy wants to marry Mummy, the little girl wants to marry Daddy, and they see the same sex parent as a rival. "I wish Daddy would go away so I could spend all my time with Mummy." Freud said that all of his patients had gone through this stage. But Freud said something more. He said not only did his neurotic patients go through such a stage, but you went through such a phase, that I went through such a phase, that everybody, normal or abnormal, goes through such a period. The idea is that by studying these deviant individuals we learn something about normal people – including ourselves.

This approach is very common in psychology. The comparative psychologist, for example, studies animals, not only to learn about animals, but also to try and learn something about human behavior. The physiological psychologist studies people with brain damage - people who have some abnormality in their brain - not only to learn about them, but also to learn about you and me. The developmental psychologist studies children, not only to learn about children, but also to see what he can learn about us.

It is now time to turn to an important question. What is deviance? Can we define the concept of abnormality? .

Models Of Behavior

There are many ways of defining the concept of deviance or abnormality. One of the most common models is the Subjective Model.

SUBJECTIVE MODEL: EACH PERSON DECIDES FOR HIMSELF/HERSELF WHAT IS NORMAL

In the Subjective Model each of us decides who is abnormal. You decide who is abnormal from your perspective; I decide who is abnormal from my point of view. There's a very nice Quaker proverb that embodies this idea. It runs, "Everyone is queer save thee and me, and sometimes I think thee a bit queer too."

Now, obviously, this model does not have much use for the scientist. If we each define deviant and abnormal behavior in our own way, then there is no consensus. But it is very easy for this model to creep into our thinking. For example, consider suicidal behavior, a topic which I have studied for a large part of my life. Is it possible to commit suicide for rational reasons? Could a sane person commit suicide? Let me give you some examples. Percy Bridgman was a Nobel Prize winner. He had got his Nobel Prize in physics, and, at the age of 80, he learnt that he had a form of cancer and was due to die within a few months, probably suffering unbearable pain. He decided that he would kill himself. He would spare himself the pain and spare his family the suffering of living with him during those last few months. Or consider the kamikaze pilots who fought for Japan in the Second World War who would aim their plane at a ship, perhaps, and crash into the ship in an attempt to destroy it, and die along with the enemy. Or Romeo and Juliet who killed themselves because they thought that they could not be with the person that they loved. Are they rational? Are these rational reasons why people could commit suicide?

When I think about that problem, and when I think how other psychologists have thought about that problem, what they are really doing is saying, “Would I kill myself for that reason?” If you would kill yourself if you were 80 years-old with cancer, then you would consider Percy Bridgman to have been rational and sane. But, if you think that you would not kill yourself under those circumstances, you are very likely to judge him insane. And one can find psychologists and psychiatrists making this same kind of judgment.

A second way of defining normality is the Statistical Model.

STATISTICAL MODEL: THE AVERAGE OF ALL BEHAVIOR IS CONSIDERED NORMAL

In the Statistical Model of normality, we first find the average value of some quality in the population. For example the average eighteen year-old male is five foot nine. That means that, if you are very short, then you are deviant in that respect. For example Willie Shoemaker, a jockey, was deviant. Or if you are very tall like Wilt Chamberlain, a basketball player, you are deviant.

This notion of deviance is used in the study of intellectual deviance. Psychologists used to define an idiot as somebody who had a very low IQ, 0-19 IQ points; an imbecile was somebody who had an IQ from 20 to 49; a moron was somebody who had an IQ of 50 to 69. And at the other end of the scale we have the geniuses, people with IQs of 160 or above. In this respect, their measure of IQ, they are deviant, they depart from the norm. However, behavior is too complex to be appropriate for this model. For example, I could define 500 personality traits, ways of describing peoples' behavior (dependency, your need to achieve, your need for power, your self-esteem, etc.), and clearly you could be deviant on one or more of these traits but not deviant on all the others. How many do you have to be deviant on before I say, “You're abnormal.” So, because human behavior is so complex, we rarely use the Statistical Model.

Another very popular model of deviant behavior is the Cultural Model.

CULTURAL MODEL: BEHAVIOR IS CONSIDERED NORMAL IF THE MAJORITY DECIDES IT IS NORMAL

In the Cultural Model, it is as if a vote were taken. The society decides democratically what is deviant and what is not deviant. For example, in England in the 1960s, the British Parliament passed a law saying that homosexuality was no longer a crime - that homosexual behavior between consenting adults was legitimate behavior. A behavior which was a criminal act before 1960 became a non-criminal act after 1960. In America in 1974 the American Psychiatric Association voted to remove homosexuality as a mental illness. Before 1974, if you were a homosexual, you were considered mentally ill. Nowadays, if you are a. homosexual, you are not necessarily considered mentally ill. A democratic process. We vote upon it.

A very good example of this democratic process is in the study of masturbation. If you read the Bible, masturbation is not considered a very dangerous or sinful act. It is considered somewhat unclean, and one should cleanse oneself after masturbating, but nothing more than that. This view persisted until about 1700 when a Dutchman called Becker wrote a book with this title: *Onania or the heinous sin of self-pollution, and all of its frightful consequences in both sexes, considered with spiritual and physical advice for those who have already injured themselves by this abominable practice*. He said that masturbation lead to things such as fainting fits, cessation of growth, epilepsy, hysterical fits, tuberculosis and barrenness. What did Becker recommend? He recommended very mild treatment - things such as exercise, keeping clean, showering regularly, avoiding thoughts about your genital organs - nothing too severe. His book started a movement, and everybody began to see masturbation as a cause of all kinds of consequences. Tissot, in 1760, said that it caused blindness, insanity, rheumatism, tumors and constipation. But he still only recommended things like a good diet and regular baths. But along about 1800, masturbation stopped being a mental health problem, as it were, and it became a social problem. How could we stamp out this evil act in society? We have got to cleanse society so that nobody masturbates anymore! And the treatment became very punitive, like beating the children severely if you caught them masturbating; removal of the genital organs so that little girls had their clitorises removed and little boys had their penises cauterized and their spines cauterized; kids went to sleep bound in splints. These brutal, punitive behaviors persisted, in America, for example, through the 20th Century. Such treatments were still being recommended by textbooks in 1940!

About the middle of the eighteenth century people began to say, “Maybe it's not true. Maybe masturbations doesn't cause blindness and insanity.” This movement was aided by Freud who clearly stated that masturbation did not cause any physical consequences. But even Freud had a slight residual prejudice. He suspected that maybe masturbation did lead to some kind of mental disorders - perhaps not the severe ones, but mild ones such as neurosis and so on. Today, we no longer believe even that. Today, curiously, if your child doesn't masturbate, you’re likely to think that he has a problem. “Why doesn't my child behave like all other children?” So, a behavior that in 1600 was

considered normal, in 1700 was considered a mental health problem, in 1800 was considered a social problem that had to be wiped out, and today is considered a normal behavior. This presents a great problem for the psychologist who studies deviant behavior. You could be studying a particular deviant behavior, and some group or legislature or the American Psychiatric Association, has a vote that says that the behavior you're studying is no longer deviant. You've lost your job, your occupation. Scientists can't deal with such a shifting definition. We would like something more concrete, less arbitrary.

The fourth way of defining abnormal behavior can be called the ideal model, or the Perfectionist Model.

PERFECTIONIST MODEL: IDEAL BEHAVIOR IS CONSIDERED NORMAL AND DESIRABLE

In the ideal model, or the Perfectionist Model, we take medical diseases as our analogy. Somebody is medically healthy, is medically ideal, when they have no germs, no diseases, no illnesses and no blemishes. If you have a cut, a tumor or an infection, you are not normal, and something has to be done to bring you to a normal state. What does this mean if we look at behaviors? The various religions of the world have adopted this as their model. You adopt somebody, Jesus Christ if you are a Christian, Buddha if you are a Buddhist, and you set this person up as the ideal. We all try to aspire to the behavior of a Jesus Christ or a Buddha, or whomever, and that is the ideal towards which we aim. That is perfection; that is ideal; that is normality.

In psychology, Abraham Maslow has coined a concept called Eupsychia, or the self-actualized person, and this person is somebody who is completely, psychologically healthy. To be self-actualized you have to be not neurotic, not psychotic or psychopathic, not to have any psychiatric disorder. You have to fully use your talents; you have to be creative and spontaneous; you realize what you can become; you actualize your potential. Maslow would say that you and I couldn't be self-actualized. We're much too young. He studied 3,000 college students once and found perhaps one whom he thought could be self-actualized, but he wasn't very sure about it. To give examples of what he meant by self-actualization, and self-actualized people, Maslow cited people like Eleanor Roosevelt, Aldous Huxley, Albert Schweitzer, Spinoza, and William James, and said that these were self-actualized people, psychologically healthy people. He looked at his friends in New York where he was teaching at the time, people like himself, Abraham Maslow, and probably other social scientists such as Margaret Mead, and so on, and said these were self-actualized people. And this is the goal towards which we should aspire, this is psychological health; this is normality.

Clearly, with these four models of normality and abnormality, we are presented with some problems. For example, you could be normal according to one definition and abnormal according to another. Maslow was normal by the perfectionist, or ideal, model, but statistically speaking he was very abnormal. And as for what you or I might think of him, well we all have our different viewpoints. People use the definition, the meaning of

normality in different ways. And so when I use it, when you read of someone who uses the term you have to ask, “What model are they using?”

There might appear to you to be some value judgments involved in the concept of normality, so let us study this for a little bit.

Is All Deviance Bad?

From what I have been saying, it sounds as though it's not a good thing to be deviant or to be abnormal, and I would like to attack that thought. Consider schizophrenia. It is a disorder in motor behavior, in thinking, and in your emotions. It is a severe psychiatric disorder, and most schizophrenics are hospitalized in America. But could it be useful?

Some psychiatrists have noted that schizophrenics possess a few advantages. For example, they have fewer allergies, they're less sensitive to adrenalin and so have lower blood pressure, they suffer from arthritis less, they're less sensitive to pain, and they are much less likely to get infectious diseases such as pneumonia. Now consider early man, many thousands of years ago who was a hunter. Would these symptoms of schizophrenia have helped him? Let us consider a primitive man hunting an animal, trying to kill it so that he can feed his family. What happened if he had allergies? Somehow some pollen drifts through the air, goes into his nose, and he sneezes, and the prey that he was stalking runs off. Clearly to be resistant to allergies would help such a hunter. Or what about being less sensitive to pain? The primitive man hunting wild animals is very likely to get injured. Again, if he had schizophrenic symptoms, he would feel the pain less. Staying up all night tracking a wounded animal, he'd be less likely to come down with an infectious disease. So a primitive man would have certain advantages if he had a schizophrenic illness.

Of course, schizophrenia has some other symptoms that, to you and I, might seem deleterious. For example, schizophrenics hallucinate a lot. They see things and they hear things that aren't really there. How did primitive man cope with this? Well, primitive man often incorporated these hallucinations into rituals and the culture. For example, in some Indian tribes in America, to become a man you have to go out into the forest and fast, and you have to perceive some totem, some god, some animal; once you have perceived that animal, then you are a man, an adult. Clearly, if you can hallucinate, you are much more likely to perceive that object, and therefore to pass into manhood. What happens if somebody showed gross schizophrenic symptoms? Some societies made that individual into one of the most valued members of the society, perhaps the wise man of the village, the Shaman or the witch-doctor. A good analogy, perhaps, is sickle-cell anemia which for African Americans has some deleterious consequences, but has some advantages. If you inherit a single dose of sickle-cell anemia, you become resistant to malaria, which would be an advantage in some circumstances. But, if you inherit the trait from both parents, you may die of sickle-cell anemia. Similarly, a single dose of schizophrenia perhaps conferred upon man some advantages. However, a double dose, a severe amount of schizophrenia, might really incapacitate you so that you could no longer function in your

society.

A second thing to remember is that there are all kinds of deviance. There aren't just bad deviants, but there are good deviants. For the retarded on the one hand, there are the geniuses on the other hand. For the neurotics, there are the self-actualized people. For the suicides, there are the martyrs. Beside, you and I are deviant. You're deviant because you are one of the few people in America watching this TV lecture series. I'm deviant because I'm one of half-a-dozen or so people who stand before television cameras and give such lectures. But that doesn't make us bad.

A third thing to remember is that we all have deviant behaviors in various degrees. We all are a little bit creative, but we are not as creative as Leonardo da Vinci. We all get depressed sometimes, but not as depressed as the psychotic depressive. We all show various kinds of symptoms that in an extreme form are characteristic of abnormal people. For example, I remember once being at a party and going into a room where some friends of mine were talking, and thinking, “They're talking about me. They're laughing at me,” and experiencing what would be called a paranoid attack. I felt acute anxiety and panic. I had to leave the room where these men were talking and go and sit by myself, recover, and calm down. But that does not make me a paranoid schizophrenic. I can show the symptoms of abnormal behavior, without necessarily being severely disturbed. We all show these symptoms of abnormal behavior, but not as extensively, not to the same degree, as somebody who has to be put in an institution, or who is labeled by his relatives or his friends and neighbors as deviant, strange, or strange in some way.

A final point that you might think about is, do you want to be deviant, or would you prefer to be normal? Let me read you what a couple of psychologists and psychiatrists have said about this. Karl Menninger once said, “To be normal seems shockingly repellent to me. I see neither hope nor comfort in sinking to that low level.” And David Seabury said, “Only a fool would continue to be normal after he discovered what it would be like.” Much of our identity as we exist in this world is formed by showing how different we are from other people, how unique we are, how superior we are. Imagine how you would feel if you heard your husband or wife, or your boyfriend or girlfriend, saying about you, “Well, he is a pretty okay chap, about average in looks; he's okay as a lover, nothing special; he is not too bright, not too dull; he's okay. I could as well live with him as any other person.” How would you feel? Would you be pleased? Or would you be shocked and hurt? “How come I'm not special?” If I had to give you my opinion, I'd much prefer to be deviant. In a way that's why I volunteered to do this TV lecture series. There are very few of us standing before television cameras giving lectures. This makes me unique in some way and, feeling unique in some way, helps me feel good. So remember, deviance is not necessarily bad. Even though in this lecture series we will consider deviant people who are unhappy or depressed, who are outcasts of society in some way, who are “bad,” it need not necessarily be so.

LECTURE 2: THE ILLNESS MODEL

It is very common in our society to view abnormal or deviant behavior as indicative of some kind of illness much as we view cancer or the common cold as illnesses. Today we are going to examine this medical/illness model of abnormal behavior.

Today and for the next few weeks I'm going to introduce you to six different ways, of viewing abnormal and deviant behavior, and a good place to start is with the illness or medical model because this model provides us with most of the terms and concepts that we use in our discussion of abnormal behavior. The medical model is based on an analogy with medical illnesses. Let me give you an example. Let us say you have cancer. You would go to your doctor, and he would ask you particular questions to find out what are the symptoms of your problem. He might administer particular tests in order to be sure that you have what he thinks you have, that you have cancer. Once he is certain, he will diagnose you and label your illness. "You have cancer." He then might hospitalize you and institute a type of therapy. Maybe he will do surgery or administer drugs, and you will be a patient in the hospital. The aim of all this is to cure you.

These terms are used also when we describe abnormal or deviant behavior. Let us say that your parents were killed in a car crash a few weeks ago. You have been severely depressed since then, and you have come to see me, a psychologist, to ask for help with this problem. First of all I would talk to you. I need to find out what your symptoms are. What are you complaining of? Are you depressed? Are you guilty? How depressed are you? How guilty do you feel? I might then administer some tests. For example, I might think that there is a risk that you will kill yourself, and there are some tests that I can give to you to help me confirm my hypothesis. Are you, or are you not, a serious suicidal risk? After all of this I might decide upon a diagnosis. I might say, "I think you have a depressive disorder." I've given you a label. I might decide that the risk you will kill yourself is so great that I must hospitalize you in a psychiatric hospital where you will become a patient. Once you're in this hospital I will institute a course of therapy. I might decide that you need psychotherapy - talking to a psychologist or psychiatrist regularly about your problems; or perhaps chemotherapy - I might put you on an antidepressant. The aim of all this treatment, this therapy, is to cure you. You can see that the terms I would use about your depressive state are very similar to those I would use if you had cancer.

This medical model of abnormal behavior is very popular in our society today, and it's worthwhile to consider "Why is it so popular?" First of all, the model has received widespread support from the government of the United States. Let me read you a couple of quotes from federal and state pamphlets about mental illness. Edith Stern, writing for the National Association for Mental Health said, "The most important thing for your patient's chances of recovery, and for your own peace of mind, is to realize that mental illnesses are illnesses like any other;" or the Tennessee Department of Mental Health writing, "If everyone would just realize that mental illness is no different from any other prolonged disease, and that a heart attack victim differs only from a mental victim

in the localization of the affliction, then the psychiatrist's/therapist's job would be greatly simplified.” Medical illness is an illness, and so are mental illnesses. They are identical.

Another reason why this model is so popular is that when we begin to study abnormal behavior we need a set of terms and concepts to use. The medical profession with its analysis and understanding of medical illnesses goes back many thousands of years. Physicians have existed since time immemorial. The profession has a long history, and graduate school training programs have been set up for a long time. Only a psychiatrist, a physician with an M.D. degree, can hospitalize somebody against their will, can prescribe medication for them, and can prescribe surgery for them. In contrast, psychology is a very young profession. The first graduate programs in psychology were set up only a century ago. Psychologists do not have a medical degree (they have a Doctor of Philosophy), cannot prescribe medication, and cannot hospitalize somebody. A psychologist is permitted to participate in the diagnosis of a patient and in the psychotherapy of a patient, but that is quite limited. Today, in America, mental health agencies have to have a psychiatrist in some supervisory or administrative capacity. It is this dominance of psychiatry over psychology that accounts today for the popularity of the medical model. But the important thing about the medical model of mental illness is that it is applied to behaviors for which we do not know a physiological cause, the so-called functional disorders.

Functional Disorders

It obviously makes a good deal of sense to apply the medical model to behaviors for which we know that there is an organic cause. For example, alcoholics (people who are addicted to alcohol) often neglect their diet. They do not consume the right amount of vitamins, and this vitamin deficiency often leads to Korsakoff's Syndrome. Korsakoff's Syndrome involves disorientation (Who am I? Where am I?), amnesia (the traditional blackout of the alcoholic), and confabulation (the alcoholic has a gap in his memory and invents some imaginary story to fill in that gap). We know that Korsakoff’s Syndrome is due to an organic cause - the vitamin deficiency that results from alcoholism - but the important thing to remember is that the medical model is applied to abnormal behaviors for which we do not know that there is a physiological cause.

This has implications. First of all, we assume that there is a physiological cause for this strange behavior, but we have not found it yet. If we were just to look harder, conduct a few more years of research, we would find out what the physiological cause is. So, if you believe in the medical model, you do research into the genetics of the behavior, the physiological causes and the biochemical correlates. What happens when you cannot find this physiological basis? You have to *assume* it is there. The disorder that we call minimal brain dysfunction is a very good example of this. A child who is diagnosed as having minimal brain dysfunction is sometimes hyperactive active in ways that the society does not like the child to be active in, and he may have some kind of learning difficulties. But when you look at the child he is emotionally stable, there is nothing wrong with his perception or his hearing, and you cannot find any physiological damage. But, if you believe in the medical model, it has to be there. The child obviously has a

brain dysfunction (the brain is not functioning correctly) but you cannot find it, so you call it minimal. It is so small (minimal) that you have not been able to locate it yet. But in calling this problem minimal brain dysfunction, you are assuming that it is physiologically caused.

Another implication is that, if you have somebody who is showing abnormal behavior, the best way to treat it is through medical means. Maybe you will put your hyperactive child on amphetamines, and it will quiet the child down; or you take your violent individual and you remove some part of the brain (you perform psychosurgery) and you make the individual no longer violent; or perhaps you put them on an antidepressant or a tranquilizer. It is important to acknowledge that these physiological methods of treatment can be very effective.

Varieties Of Mental Illness

In order to use the medical model we have to be able to label and diagnose diseases. So it is important for us to spend a few minutes today discussing the major categories of mental illness. The system of diagnosis that I'm going to talk about is that based upon the American Psychiatric Association classification system. There are several major categories of mental illness; there are transient situational disturbances, the personality disorders, the neuroses, and the psychoses.

Transient Situational Disturbances

Let me start with the transient situational disturbances. The transient situational disturbances are minor, temporary aberrations in behavior that result from some environmental stress. Perhaps you are a soldier in combat and, under the influence of this bombardment, you breakdown; perhaps you've been raped, or you're a small child and you've been put in a new foster home; or you have come down with some severe illness. Let me give you a good example of this. A psychologist called Bloch described a soldier in Vietnam whose platoon was caught in an ambush and overrun by the enemy; he was pinned down for about twelve hours before he could be rescued. At one point he had tried to run from his hiding place, looking very crazed, according to his companion, but his companion pulled him down and prevented him from getting killed. Helicopters arrived and took him back to the base. At the hospital he cowered in a corner, glancing furtively around, with a wild look. When he was untied he appeared to hold an imaginary rifle, and whenever he heard a noise he prepared to defend himself, to shoot this imaginary enemy with his imaginary gun. He refused to speak. They decided to tranquilize him and put him to sleep for about forty hours. When he woke up, he was very dazed and confused and had some problem remembering what had happened. But he was subdued, and in the course of the next few days he began to talk, to calm down, to eat, and to return to normal behavior. After three days in the hospital he was ready to return to duty and was sent back to his combat unit. This is a transient situational disturbance. A brief, minor disturbance in behavior that is clearly attributable to some stress in the environment.

Personality Disorders

The personality disorders are more deeply-ingrained, maladaptive and lifelong habits or patterns of behavior. It is a mixed bag of behavior patterns. We include here the sexually deviant - people who act relatively normal in most of their life, except perhaps for one aspect of their life. Perhaps they are attracted to children or some inanimate object like a boot; or perhaps they get their sexual gratification from an unusual mode - exhibiting themselves (exposing their genitals in public) or peeping at other people who are engaged in sexual activities. We include among the personality disorders those who are addicted either to alcohol or to other kinds of drugs such as heroin, cocaine, or morphine. We also include those who break the laws of society – the psychopaths or sociopaths - people who break the laws of society and do not show any shame, remorse, guilt or feelings that they have done anything wrong.

There are also more general maladaptive patterns of behavior that we give various labels to. Let me give you an example. Theodore Millen described a twenty-seven year old married woman who had three children. She complained of symptoms like fatigue, backache and stomach upsets, but there was no apparent physiological cause for these symptoms. She was refusing to have sexual intercourse with her husband, and she was asking him to seek a job in another community. She had become alienated from her neighbors, and she wanted the whole family to move away. However, this had happened many, many times in their life. Once they settled in a new community, she developed these physiological symptoms, began to dislike her neighbors and said to her husband, "I want to move." But at this point, he had got tired of her complaints. He was sick of her crying, her anger, and her refusal to have sexual intercourse with him. He told her to go for treatment. This woman realized that the problems were of her own making, that she played a great role in creating her unhappiness. But from time to time she would change her mind and then blame her husband, or blame the neighbors, and she drifted between an awareness that she was at fault versus blaming it upon others. This pattern of behavior had been noticed when she was a college student. She would find some roommates, move in with them and get on well them, and then become disillusioned with them, complain, and develop these symptoms. Millen gave her the label of passive/aggressive personality; that label - passive/aggressive - serves to describe her personality disorder, her lifelong way of relating to other people.

Neuroses

Another category consists of the neuroses. In the neuroses the crucial symptom is that of anxiety, and this anxiety can manifest itself in a variety of ways. It can be overt - free-floating anxiety - so that the person appears generally anxious, tense, perspires a lot, and has feelings of anxiety in the pit of their stomach. Some of the symptoms of neuroses are attempts to control this anxiety, to bring it under the control of the individual. If the individual focuses it upon one object (I am scared of cats, or crowds, or open spaces), we call them phobic. Perhaps they develop little rituals - "If I hold my pulse and count it, then nothing will happen to me, and I needn't be anxious," or "If I wash my hands fifty times a day then everything will be okay." These obsessions and compulsions serve the

function of structuring the person's life so that they do not feel this anxiety. Sometimes the anxiety is expressed as a somatic symptom. The person becomes blind without there being any physiological reason to be blind, or perhaps they become paralyzed in their legs or their arms without there being any physiological reason for the paralysis.

A final kind of symptom is called a dissociative symptom - the person develops amnesia. "Who am I? Where am I? What am I doing here?" In extreme cases, the person can split into two or more personalities, each of which may not be aware of the other - a Dr. Jekyll and Mr. Hyde existence.

Let me give an example of a case in which the anxiety is very noticeable. This was a young, 18 year-old girl described by George Kisker. She had attempted suicide, and so she came to the attention of the psychologist. She talked about her difficulties at home. She was intensely scared of her father. A few months after she had started talking to Kisker, she reported that he had often been arrested for being drunk, he had often beaten her, and once he had tried to molest her, getting as far as kissing her. She had very scary dreams involving her father and her mother. For example, she once dreamt that her father asked her to get a knife so that he could murder her mother. She insisted that her mother sleep with her at night and, before going to bed, she had a ritual of barricading the bedroom door, hanging a cloth over the door knob, and forcing the cloth into the keyhole with a knife blade so that she was safe. She was able to sleep only as long as her mother kept her arm over her in bed. As soon as her mother removed her arm the girl woke up. However, she also feared her mother. Sometimes she stayed awake for fear that her mother might kill her, and she also had fears that her mother might poison her. So here we have a girl whose anxiety is very evident, and she is focusing it primarily upon her parents.

Psychoses

The most severe kind of abnormal behavior or mental illness is called psychosis. In a way, the neurotic is aware of reality but denies it. In contrast, the psychotic is not aware of what reality is, so that he cannot deny it. This has been put in this way, "The neurotic builds castles in the air, whereas the psychotic lives in those castles." What are the symptoms of being psychotic? Some of the symptoms are disorientation - "Who am I? What am I? What day is 'it? Where am I right now?" - complete disorientation. The symptoms include delusions - "I am Jesus Christ," or "I am Napoleon" - or perhaps it is a delusion of persecution – "Somebody is trying to poison me. My wife is trying to poison me. The FBI is tapping my phone." The symptoms include hallucinations - perceiving things that are not there - and the majority of hallucinations for schizophrenics are auditory. They hear voices - people talk to them, voices that nobody else hears. There are also emotional disturbances - inappropriate emotions - they giggle inappropriately when something sad happens, or they cry when nothing that merits crying has happened. They show mood swings - one day they are very depressed, and a week later they might be very happy - without anything ever happening in their environment to cause these mood changes.

Another area of symptoms involves verbal communication. It is very difficult for you and I to follow the thought processes of the schizophrenic. Let me read you an example of a dialogue between a psychiatrist (P) and a schizophrenic (S).

P. What's your name?
S. It's called fast colors.
P. What is your father's name?
S. He put his head on the railroad tracks and see where he's at today. He's in heaven.
P. Do you have any children?
S. How are you today?
P. What day is it?
S. According to my brain it's two weeks from tomorrow.

What was this schizophrenic thinking about? Why did he say the things that he did? We failed to understand him.

Finally there are motor and non-verbal symptoms. In catatonia, the psychotic fails to move, lies in bed - not moving - in the same position for so long that he will develop bed sores unless he is moved. He will refuse to eat and will have to be force fed in order to keep him alive. The symptoms may involve manic agitation in which the person runs around and is very agitated. The motor symptoms can involve strange gestures. Schizophrenic children show what we call ballerina movements - all the time their hands weave intricate patterns. The schizophrenic may avoid eye contact - will look down at the floor and avoid looking you in the eye. They might sit there and rock back and forward, holding themselves, sitting in a in corner, movements that a normal person does not usually show.

The different kind of psychosis that you have will depend primarily upon your symptoms. If the delusions are the most prominent symptom, you will be called a paranoid schizophrenic. On the other hand if your emotions swing from mania to depression back up to mania, then you will be called a manic/depressive psychotic.

Before leaving this it is important to correct one common mistake. Nearly every magazine and every newspaper in the country confuses schizophrenia with multiple personality. None of the symptoms that I have mentioned for schizophrenia and psychosis involve splitting into two people. That is a multiple personality - a dissociative neurosis. The schizophrenic has not split into two people. He is just showing these different symptoms - hallucinations, delusions, inappropriate emotions and motor disorders - nothing like multiple personality.

Other Disorders

Before leaving the different diagnoses, there are a few more that we should mention. There are the behaviors called mentally retarded syndromes - people whose IQ, whose performance and whose thinking does not appear to be up to normal - and the degree of retardation can vary from very profound to mild. There are the organic brain

syndromes - abnormal behavior that is clearly caused by a physiological factor - a tumor in the brain, a car crash, a bullet entering the brain - and these can create very abnormal behaviors. I have an interesting case here of this. Theodore Millen described a man who was 69 years old, married, with three children, who had a car crash. His skull was fractured, and he had concussion and was unconscious for about 10 days. On awakening, he had no memory for the crash, and his memory, after he regained consciousness, was very poor. He was a farmer, and when he got back home after being released he became very irritable, and he started showing odd behaviors. He treated the chickens as if they were cows, and they stopped laying eggs. Not surprising if you think about it! He wrecked the farm machinery. He treated his cows as if they were chickens, and he changed their diets so that they began to starve. He stopped talking to his family except to berate them and to threaten them with violence. This is clearly abnormal behavior, but it is probably due to the car crash, the skull fracture and the brain damage that resulted.

A final major diagnostic category is that of the psychosomatic illnesses. In the psychosomatic illnesses, you express your psychological problem through a bodily symptom. If you express it through your stomach, you will develop ulcers - gastric, duodenal or intestinal ulcers. If you express the problem through your lungs, you will become an asthmatic. If you express it through your skin, you will develop dermatitis – rashes or hives. If you express the problem through your heart, you may develop high blood pressure or hypertension and, if you express it through your genitals, you may become frigid or impotent.

These are the major categories of mental illness that the American Psychiatric Association has described for us. Let me end by discussing some criticisms of this medical model of abnormal behavior.

Criticisms Of The Model

One of the basic criticisms of the medical model is that, of course, for most abnormal behaviors, we do not know of any medical or physiological cause. It is an assumption that we make, and it is an assumption that has not proved to be valid for most of these abnormal behaviors.

Secondly, one of the most crucial features of the medical model is that we must be able to diagnose people correctly - give them the right label - and a lot of research indicates that we are very poor at this. For example, David Rosenhan recruited some normal people and sent them off to a mental hospital to complain of a symptom. Their symptom was that they heard voices that said, "Thud," and "Empty." They were to see if they could get admitted. Rosenhan found that they all got admitted. The average stay was about 17 days before they were released as sane individuals, and none of the psychiatrists and none of the nurses at these hospitals realized that these people were playing at being psychiatric patients and were, in fact, not crazy. The interesting thing is that one-third of all the psychiatric patients in the hospital realized this. They would walk up to these pseudo-patients and say, "You're not really a psychiatric patient; you must be a student

doing a paper for a course or you're a journalist writing an article; you're not really crazy." The patients knew, but the professional staff did not know.

Aaron Beck, in Philadelphia, has done more formal studies on this and shown that, if he gets two psychiatrists to diagnose a patient, then they only agree on a diagnosis for about 54% of their patients. Think of what this means. Consider that you had cancer, let's say breast cancer, and you went into a hospital, and only 54% of the doctors agreed upon your diagnosis. They come to you and say, "54% of us think that you have breast cancer, 26% however think that you have tuberculosis, and 5% of us think you have pneumonia. So it's breast cancer! We are going to operate." What would you do? Well you would get yourself a better doctor very quickly. But when somebody comes to a psychiatric hospital, people cannot agree on their disorder. What does this mean? It means, for example, that when you read some research that has been done on schizophrenics, you should wonder, "Were they really schizophrenics?" Maybe other psychiatrists would have diagnosed them as neurotics or with personality disorders. Can you really trust that they were schizophrenics? This suggests a couple of things - either the medical model is faulty, incorrect, or that the diagnostic system that we use is faulty, and we need a better diagnostic system. Actually I'm not sure which one I believe. It is an open question at this moment.

A third criticism has been made by Thomas Szasz who says that to use the medical model absolves us of responsibility. It is a social tranquilizer. "You cannot punish me, I'm a schizophrenic" or "Don't do that to me, don't scold me, I'm an alcoholic." For Szasz it is a social tranquilizer, and Szasz would have people face their responsibilities.

In conclusion, it is worth noting that the model does give us a good set of labels and terms - terms like patient, symptom, and hospital – terms that are easy to use and that help us talk about abnormal behavior. Secondly, some diagnoses do make sense. Phobics do resemble each other in some respects, in their major symptom. But I have to admit to you that although I think the model is valuable, it does not really interest me much because, if somebody can show that your abnormal behavior is due to a physiological reason, then it ceases to be of interest to me as a psychologist. I pass you off to a neurologist or an internist, and he treats you. As long as your behavior has a physiological cause, I play no part in the treatment or the understanding of it.

LECTURE 3: THE PSYCHOANALYTIC MODEL

Today I am going to talk about the most important, the most powerful, the most influential theory of human behavior, Psychoanalytic Theory, proposed by Sigmund Freud a century ago. Freud's theories have many admirers and just as many critics. But those who believe it to be true and those who believe it to be absolute nonsense all agree that Freud's influence upon our understanding of human behavior has been greater than that of any other psychologist.

Before I can illustrate how Freud would explain abnormal behavior, I first have to explain the basic concepts of psychoanalytic theory, and a good place to start is with some of the basic assumptions made by Freud.

The Basic Assumptions Of Psychoanalytic Theory

There are three basic assumptions:

(1) That all behavior is determined (satisfies desires).
(2) That behavior is partly determined by unconscious desires.
(3) That all of our behaviors are determined by many, many desires and wishes.

Let us start with this first assumption - that all behavior is determined. Freud said that every behavior was determined. There is a reason why you are watching this TV show. There is a reason for choosing the career that you did. There was a reason why I moved from the stool just now, why I scratch my nose now. Everything has a cause. Now, there is an important distinction to be made here between causes and reasons. Let me explain. Say I had meant to say to you that Freud was the most important psychologist that has ever existed, and I said instead that he was the least important psychologist that ever existed. Why would I make such a slip of the tongue? Well, there can be various causes for this behavior. Perhaps I am anxious sitting in front of this television camera talking to you, and the anxiety confused my mind. Or maybe I knew that I was going to be so anxious that I took a couple of drinks before I came on camera, and actually I'm sitting here pretty tipsy, and I'm not too clear what I'm talking about. Or maybe I didn't get much sleep last night, and I am very tired, and that's causing my thoughts to get confused. Those kinds of explanations are causes.

Freud said that, rather than causes underlying behavior, there were wishes or motives. For example, say I really believed that Freud wasn't a very important psychologist. But I am being paid to sit here and tell you that he is important. I really would like to tell you, "Freud - forget him; he's not very important," and my wish intrudes upon my thinking and makes me say the incorrect thing. Why should I think that Freud is unimportant? Maybe I envy him; maybe I envy all famous people. I wish I was as famous as Freud was, and so I would like to belittle Freud.

But why should I want to belittle Freud? Why should I envy famous men? Well maybe I envied the first powerful, famous man that I ever met. Who was that? My father

whom I was never able to compete with or do better than - my father, the man who was, when I was a little child, all powerful and omnipotent. So the reason why I would like to belittle Freud is really that I would like to belittle my father. I would like to be better than him. Now, if you compare those two kinds of explanations - I make a slip of the tongue because I'm drunk or because I am anxious, versus I make a slip of the tongue because I really would like to tell you that Freud was not important - that is the difference between a cause and a reason. Freud said that there were reasons, wishes and desires behind our behavior.

What about the notion of free will? Don't we have free will? Is all of our behavior really determined? As a psychologist, the notion of free will is not much use to me. It doesn't help me explain behavior. Let's take an analogy. Say you went to a doctor, and he said to you, "I know you're feeling ill. You have pneumonia. But I don't believe in causes; I believe in free will. It's up to you to choose not to have pneumonia." What would you do? You'd get yourself a better doctor pretty fast. If you came to me and said, "I'm very scared of crowds. I panic when I am in a crowd," and I say to you, "I don't believe in determinism, I believe in free will. It's up to you to choose not be scared of crowds." Again, what would you do? You'd get yourself' a better psychologist than I am. As a psychologist, if I want to help people and if I want to understand behavior, I have to believe that behavior is determined.

Let's take the second assumption. Not only are there conscious wishes behind our behavior - I scratch my nose because it itches; my lips tickle so I scratch them - but there are also unconscious reasons behind my behavior that I'm not aware of. Maybe you might notice that I'm always touching my lips and you might wonder, "I wonder why he's always touching his lips." You may not be aware of it. I may not be aware of it. There might be unconscious motives underlying that behavior.

The third assumption made by Freud was that, behind any behavior - your choice of careers, your choice of a husband or wife, scratching your nose - there are lots of wishes that the behavior satisfies. Not just one. In examples that I give you in these lectures, I may only give one reason, I may simplify the situation. But remember - there are always many wishes lying behind any behavior.

The Elements Of Psychoanalytic Theory

Let us move to the basic elements in psychoanalytic theory. These are

(1) Wishes
(2) Anxiety.
(3) The defense mechanisms.

Let's start with wishes. In psychoanalytic theory we distinguish between systems of wishes. Most of these terms you probably have heard of. We talk about id wishes. Id wishes are primitive, child-like, non-specific, unorganized wishes and, if you want to get

a good feel for what an id wish is like, look at a small child of two or three and listen to what they say. My son says to me things like, "I would like to break you to pieces. I would like to throw a big truck at you and smash you." That's an angry wish - unfocused, diffuse. He simply wants to destroy me when he's angry at me. That is an id wish - primitive, childlike, and unorganized.

The next category of desires is superego wishes. There are two kinds of superego wishes. One kind is called our conscience. It's a set of wishes that we take over from society, from our mother and father and other noteworthy people. For example, say we masturbate, and our mother catches us and punishes us. "You shouldn't do that. That's naughty to do that." We eventually take over her wish, and we say, "I don't like to do that. I feel bad when I do it. I will not do that." We have taken over her wish, and it has become our wish. A second kind of superego wish is called the ego ideal. Maybe we admire our father, and he's very handy around the house. He builds things with tools. We model ourselves upon him. If we are small children, when our daddy gets out his hammer and nails, we get out our toy hammer and nails, and we build things. We may take over his gestures, his attitude, his style of dress. In all of these we introject his desires, and they become our superego desires.

The third category of wishes is an ego wishes. Ego wishes are mature, adult wishes. They are compromises with reality. For example, an id wish would be, "I would like to murder you," but a superego wish would be, "I was told it was wrong to murder people. I would feel guilty if I murdered you." So what do I do? I satisfy an ego wish. I shout at you, and I call you nasty names. It is a mature wish that is a compromise between the id wish and the superego wish.

It is important to remember that ids, egos, and superegos do not exist. There is no id somewhere in your brain and a superego somewhere else. These are just hypothetical constructs, convenient terms. The important thing to remember is that they refer to different kinds of wishes. They are just adjectives, labels.

Development involves gaining control over our wishes and our desires. How do we achieve this control? One way we achieve control is by forming derivative desires. When we were little babies, we liked to suck at Mommy's breast or maybe at the bottle. But eventually we were deprived of the breast or the bottle, and we have to put away these wishes and not satisfy them any more. But we can form derivative desires. We can suck on our pacifier, or on our thumb, or maybe we can suck candy, or smoke a cigarette or a pipe. We form derivative desires that satisfy that basic wish to put things in our mouths and suck on them.

In this way, we learn how to satisfy our wishes in more ways. For a little baby, whenever he's hungry, he gets a breast or a bottle in his mouth, and he gets the same kind of food. But as adults, we can satisfy that wish to suck things and chew things in various ways. We can eat different kinds of foods - solids, liquids, hot, cold, different textures, smooth foods and crunchy foods - various ways of satisfying that same basic wish.

Another way we get control over our wishes is that we learn to control the conditions under which the wish can be satisfied. If you are a baby and you are hungry all, you can do is scream, and scream, and hope that Mommy is going to come along and put a breast in your mouth or a bottle and feed you. But as adults we can satisfy the desire ourselves. We can go and cook some food or get something out of the refrigerator. We can even skip a meal if we want. We have control over the conditions under which desires can be satisfied.

What happens to those wishes that we have to give up? All of us sucked breasts or bottles when we were infants. What happened to that wish? We form derivative desires; we suck at cigarettes or candy; but what about that wish to suck at Mommy's breast? It is repressed. It moves from the conscious into the unconscious. As we grow up, we are no longer aware that we want to suck at Mommy's breast. How do we have any evidence that these unconscious wishes exist? You are probably sitting there saying, “You, David Lester, may have a wish to suck at your Mommy's breast that could be unconscious, but don't attribute that wish to me. I don't have it.” How can we prove that such a wish exists? It is very difficult to do this. A good example, perhaps, is the Oedipal Conflict.

When little children are about three to five, they form an attachment to the opposite sex parent. If they are little boys, they want to be with Mommy and marry Mommy, and they wish that Daddy were out of the way. If they are little girls, they want to be with Daddy and they wish Mommy were out of the way. Every little child, according to Freud, has those wishes. Now you probably don't remember that you had such a wish - that you were attracted to your opposite sex parent and perhaps wanted to marry them. But Mr. Rogers who runs a television program for children is very sensitive to the concerns and the wishes of children, and he has written a song to illustrate this wish in children - that they would like to marry their opposite sex parent.

> “One day” I said, "I'm really going to marry, really going to marry, really going to marry, "One day" I said, “I'm really going to marry you - my mother.”
> She smiled, didn't laugh, said, “I hope you will marry, I hope you will marry, I hope you will marry," She smiled, didn't laugh, said, "I hope you will marry, maybe someone like me."
> 'But you see," she said, “I'm already married, already married, already married, You see,” she said, "I'm already married, already married, I'm married to your daddy.” Etc.

Another example of this is depression. It is often found that people who are depressed are really angry at somebody else, but they are not conscious of that anger. The anger is repressed; it is unconscious. The anger is turned inward upon themselves, and they feel depressed, worthless, evil and wicked. If you can get them to express that anger, to realize that they are really angry at somebody in their environment, then the depression lifts. That unconscious anger becomes conscious, and the depression disappears.

Let's move on to the next concept, that of anxiety. Anxiety is very important in psychoanalytic theory, and we must discuss how it is aroused. Anxiety can be aroused in

two ways. First of all, when any wish that you have is not satisfied, then you become anxious. The longer you go without satisfying the particular wish, the more anxious you become. For example, if you are hungry, the longer you fail to satisfy your wish for food, the more anxious you will feel.

The second way in which you can feel anxiety is if you have an unconscious wish that may become conscious. For example, perhaps when you were a little child you had a baby brother or sister born. Most children are very angry at the arrival of the newborn, and they may try to express this. You may find them hitting the newborn baby or dropping them or trying to hurt them in some way. This is usually punished by the parent. "Don't you dare treat your baby brother like that. You’ve got to love your baby brother and baby sister." That anger is repressed; it becomes unconscious. The three or five year old child is no longer aware that he or she feels this anger. Instead, he or she says, "I love my baby brother and sister."

What happens when they are ten years old and get into a fight with their younger brother or sister? They are in a situation where they are rolling on the floor, fighting, and suddenly they have a chance to gratify that unconscious wish. They are in a position where they could beat up that kid that they resent. But, if they did that, they would become aware of that anger of which they have not been aware for many years. What they will feel is anxiety. That anxiety is a warning signal - it warns that an unconscious wish is about to become conscious. What the older brother may do then is break off the fight and go to do something else because he doesn't want to become conscious of that wish.

That sounds pretty simple. We get anxious if we don't satisfy wishes, and we fee anxiety if an unconscious wish might become conscious. But that leads to the dilemma of abnormal behavior. Let me explain. If you don't satisfy an unconscious wish you will feel anxiety, but if you satisfy your unconscious wish you will feel anxiety. Anxiety if you do satisfy it; anxiety if you don't. That's the dilemma. Is there a solution to this?

Defense Mechanisms

The solution lies in what Freud calls the defense mechanisms of which there are a variety. A defense mechanism involves substituting a socially acceptable wish for an unacceptable unconscious wish. Let me give you an example - displacement. Let us assume that you are angry at your father, but you are not allowed to hit your father or to swear at him. What you might do is kick the dog instead or you might go outdoors and chop down a tree. You displace your aggression from your father onto a dog or chopping a tree down. That is a defense mechanism. You get partial gratification for the anger towards your father by taking it out on some other object.

Sublimation is a long-term displacement. Let us say you are angry at your father, and you go out and chop down a tree. That gives some release for that anger. But what happens if you choose a career of being a lumberjack and you spend your whole life chopping down trees? In a way you have sublimated that hostility, and it has become a long-term displacement.

Another example of this is little children who love, when their diapers are being changed, to smear their crap all over the walls and play with it. Their mothers punish them for that. Freud suggested that one way we can sublimate that desire is to become a painter. We can spend our life smearing paint on canvases. What we are doing is satisfying that infantile wish that we had when we were two years old which was to play with our crap.

Another defense mechanism is reaction formation where you substitute one wish for the exact opposite wish. "I love you," becomes "I hate you." Or "I hate you," becomes "I love you." We switch wishes. Instead of satisfying an "I love you wish" and being affectionate towards you, I satisfy an "I hate you" wish and beat up on you. Love often turns to hate, depression turns to elation and elation turns to depression. It is very easy to switch from one extreme to the other.

In identification, the child substitutes a wish that somebody else has for his own wish. For example, say that a little girl would like Mommy to play with her. "Mommy, I wish you would come and play with me." But Mommy has got to do some cooking and goes out into the kitchen and cooks. The wish of that little girl gets unsatisfied, but what she may do is to take over Mommy's wish. She may get out her toy cooking stove, her toy plate, and her toy saucepans and she will pretend to be cooking. She takes over Mommy's wish, and it becomes a substitute for her own wish. That is a short-term identification. But we can also observe long-term identifications where we model ourselves on, perhaps, a parent, a teacher, or a professor we once knew, and we model their mannerisms, their gestures and their interests.

Another defense mechanism is regression where we substitute wishes that we had when we were much younger for wishes that we have now. When the five year old has a new baby brother born, he loses a lot of attention. He would like Mommy and Daddy to pay a lot of attention to him instead of this newborn baby that has arrived on the scene. Maybe he starts acting like a little baby himself. He sucks his thumb again. He wets the bed at night. He takes over the wishes and desires of somebody younger than himself, and he does it in order to get attention from his parents.

These are the defense mechanisms and, by employing, we minimize our anxiety. We do not eliminate anxiety completely, but we keep it minimal. We satisfy the wishes, especially our unconscious wishes, but not directly. We satisfy substitute wishes instead of the wish that we have repressed.

Stages Of Development

There is one final set of concepts that I have to discuss in order to explain psychoanalytic theory, and that is the stages of development. As children grow up, they move through several states of development, and you have probably heard of these: the oral stage, the anal stage and the phallic stage. Let me explain these. They are called psychosexual stages of development, and the use of the word "sex" there is poor. It has

misled people. They are simply stages of development that stress what kinds of sensations, what kinds of motor abilities the child is most concerned with, and what wishes the child has at any stage.

For example, in the first year of its life, the baby relates to the world to a large extent through its mouth. Things are put in its mouth to pacify it - a pacifier, a breast, a bottle. Eventually when the baby begins to recognize objects, you will see a baby look at his fists, and the first thing that it will do perhaps is put the fist in its mouth. Give a three month old baby or a six month old baby an object, and it will put it in its mouth. It explores the world through its mouth. The mouth is very important to the child. However there are other important things too at this stage. For example, the baby is learning to trust adults. What happens when the baby is cold, wet or hungry? It screams! It's been deserted! It relies on some person, often the mother, to come and take care of it, to rock it, to hold it, to feed it. If the mother never comes, if the mother leaves the baby to scream and be very frustrated, that baby may never learn to trust people because it could never trust that first person that it was in contact with - its mother.

These oral wishes, these dependency needs of the baby, have to be frustrated. For example, the baby cannot always be fed when it is hungry. Sometimes the baby has a bottle put into its mouth when it is not hungry. Perhaps things can happen unintentionally, for example when Mommy breast feeds the baby, she may forget to hold her breast away from the baby's nose, and his top lip may get pushed up over his nose so that he suffocates - each feeding experience may be suffocating for him.

In addition, eventually he has to be weaned. When the baby is weaned, he doesn't want to give up his mother's breast or a bottle. He would like to keep on sucking. But we say, "No. You've got to learn to feed yourself with a spoon and a fork and a knife." So, in the oral stage, there has to be some frustration, and that frustration means that the baby will get fixated upon those oral needs. The more frustration the baby experiences orally, the more those oral needs will persist into later life. They can persist in various ways. As an adult, the person may have to drink a lot or chew gum a lot. They may be orally fixated and do a lot of things with their mouth, even talk a lot. These are direct and symbolic ways of expressing those oral needs. These people may also perhaps be overly dependent.

As the child grows older, from ages one to three, other things become important – the manipulation of objects. One of these objects involves defecation and urination. The child has to be toilet trained! Those of you who have children know the problems you can go through - the frustrations the child has to endure - in being toilet-trained. These manipulatory wishes that are sometimes concerned with defecation and urination have to be frustrated. The child has to learn to do the behaviors that we want him to do. Again the more frustration, the more those needs will become fixated, and the more they will persist into his later life.

As the child moves on, gets to the age of three to five, he moves into what we call the phallic stage. He learns to run around, to interrelate interpersonally, and he learns that

there are two sexes. He learns that he has a Mommy and a Daddy. He goes through what Freud called the Oedipal Conflict. The child gets attracted to the opposite sex parent. He wishes the same sex parent were out of the way. The little girl wants to marry Daddy, to be with Daddy, to spend time with Daddy, to sleep with him and for Mommy to leave them alone. But, of course, in most families, the child gets frustrated. Mommy and Daddy stay together. The child does not displace the parent. How do they resolve this conflict, this desire to have the opposite sex parent? They resolve it by identification. As in the Mr. Rogers' song that you just heard: “If I can't marry Mommy, I'll become like Daddy because obviously Mommy loves Daddy, and I'll marry somebody who resembles Mommy." This is the resolution of the Oedipal Conflict.

After you go through the phallic stage, you then move through a quiet period of development from the point of view of the development of wishes and impulses. We call it the latency phase. As you move into puberty and adolescence, you move out of the latency phase into the genital phase of development, and you become aware of mature heterosexuality. You become interested in the opposite sex in a mature, adult way. Lots of you may be sitting there saying, "The way you have described children is not very accurate. Children don't really have those concerns. Three to five year old children are really not sexually attracted to the opposite sex parent,” and you yourself don't remember being sexually attracted in that way. Again, Mr. Rogers is a very sensitive person who is tuned in to the needs and the wishes of little children, and he has written a song that illustrates the curiosity, the interests, the motives of children at that point of development.

“Boys are fancy on the outside; girls are fancy on the inside…..” etc

LECTURE FOUR: THE PSYCHOANALYTIC MODEL (continued)

In my last lecture I laid out the basic concepts of Freud's psychoanalytic theory. Today I want to show you how we can use these concepts in order to explain abnormal and deviant behavior. I described many of the basic concepts of psychoanalytic theory, such as

a) Wishes - conscious and unconscious.
b) The causes of anxiety.
c) How we use defense mechanisms to reduce this anxiety.
d) The stages of development--what wishes are most important to a child at the different stages of development as he grows up

How can we use these concepts to explain abnormal behavior?

The Strength Of Wishes

The first way that we can use these concepts to explain abnormal behavior is to look at differences in the strength and intensity of different wishes. You have to remember that we all have id wishes and ego wishes and superego wishes. So we cannot explain abnormal behavior by saying that this person has a superego whereas this person does not. We all have superegos. However we can differ in the strength and the number of our superego wishes.

What would it mean to have a very strong superego? It would mean that you are very well behaved; that you followed the rules of your society; that you did what your parents wanted you to do; that you would feel guilt very easily when you transgressed against any of the rules of your parents or society. If you masturbated you would feel terrible afterwards. You would think that you were worthless, sinful, or wicked. If your superego was extremely strong, you would be accompanied all your life by this pervasive sense of guilt and worthlessness and think, "I am a terrible individual." You might end up severely depressed. You might even try to punish yourself for your worthlessness, perhaps, by committing suicide.

What would it mean to have a weak superego? That would mean that you had not taken over the wishes of society very strongly. You would not follow, therefore, the rules of the society or your parents. You would be misbehaved and unruly. Perhaps you would end up a delinquent or a criminal - what psychologists call a psychopath.

What would it mean to have a weak ego? Your ego wishes would be very weak, and very few. It would mean that, when faced with different kinds of stressful situations, you wouldn't be able to cope. You would break down under the stress. You would not have appropriate behaviors to execute.

So we can talk about differences in the strength of different kinds of wishes that we have and use these concepts to explain abnormal behavior.

Wishes In Conflict

A second way of explaining abnormal behavior is to focus upon conflicts between different wishes. Let me give you a few examples.

You probably have two ego wishes right now. You probably want to continue to live and you probably want to continue to hold onto your money. But what happens if you are out in the street and somebody comes up to you and says, "If you don't hand over your wallet, I'm going to kill you"? Your two wishes come into conflict. You can't both keep your life and your money. This conflict between two ego wishes is called realistic anxiety. This is not a cause of abnormal behavior. However, let's look at what might happen if an id wish and an ego wish came into conflict. Say unconsciously you harbor a great deal of resentment towards a parent, for example, your father. But it is unconscious, you are not aware of it. Consciously you are aware only of affection and liking for your father. What happens when you are with your father? You want to show the affection and the love that you feel, your ego wish, but unconsciously, you would like to aggress against him, to punch him in the mouth, to kill him. These two wishes are in conflict. What will happen? Well they will lead to what Freud called neurotic anxiety, and neurotic anxiety, as the name implies, lies behind neurosis.

Neurotic anxiety can take various forms. When we say that it is free-floating, this means that the anxiety is not attached to any particular object. As you go about your life, you feel this pervasive sense of anxiety. You may not know why you feel anxious, but it affects all of your behaviors. It makes you do everything in an anxious manner. However, some people focus this anxiety on a particular object, and we say that they have a phobia. They may become scared of crowds or scared of cats. A phobia is not just a mild fear. It is an acute anxiety. It is feelings of terror or panic, when faced with this object. Usually the object does not merit such anxiety. Cats may not always be pleasant, they may scratch you, but there is no reason to feel terror from a cat. When the anxiety that you feel, the fear that you feel for a particular object, is exaggerated, it suggests that that object, is the focus, of your neurotic anxiety.

Other symptoms are caused by attempts to control this anxiety, such as obsessive thoughts and compulsive rituals. Checking that you turned the gas off, that you turned the electricity off, when you go away for vacation; washing your hands fifty times a day to keep the germs off your hands - these are attempts to control the anxiety that you feel, to give it some kind of rational source because it is an anxiety that you do not know the source of because its source lies in an unconscious wish conflicting with a conscious wish.

A famous case of neurotic anxiety is the case of little Hans. Little Hans was a boy described by Freud about 100 years ago. Little Hans, when he was about five, became very scared of horses. He didn't like to go out into the street in case he saw horses, and he

was particularly afraid that they would bite him. Why was little Hans afraid of horses? Freud argued that what was happening with little Hans was that he was in the Oedipal Conflict. He was attracted to his mother, and he was scared that, if his father realized this, his father would punish him for being attracted to his mother. How did little Hans cope with this conflict? He maintained consciously the love that he felt for his father, but he repressed the anger and the fear, and he displaced these onto horses. Why should little Hans have chosen horses for displacement of the fear of his father? Freud suggested a couple of possibilities. First of all, Hans's father, like a lot of fathers with their little children, had often played "horsey" with him. Hans's father would get down on all fours, and little Hans would climb on his back, and they would pretend to be riding a horse. Secondly, Hans father had a very dark moustache that reminded little Hans of the bridle that horses wore. So, for these two reasons, Freud speculated that horses were sufficiently similar to his father that he could displace his fear of his father onto a fear of horses. Notice that little Hans was afraid that horses would bite him. That suggested a kind of regressive quality to his fears. The horse would attack him orally; the horse would not kill or destroy him but would bite him with his teeth. This was indicative of the kinds of wishes that the little boy had in the first year of life, so that the wishes have a regressive quality to them.

It is important to realize the implications of this. Freud said that all symptoms have a meaning. There was a reason why little Hans was scared of horses. It wasn't arbitrary; it wasn't by chance. There is an explanation for the choice of the particular object that you fear. Secondly, those symptoms, fearing the horse in little Hans's case, were attempts by little Hans to cope with his anxiety. We may say, "It isn't very adaptive to be very scared of horses, It's an unrealistic fear," but little Hans is doing the best that he can at his age to control, to minimize, his anxiety. Abnormal behavior, for Freud, is an attempt to cope.

What happens if a superego wish comes into conflict with an ego or an id wish? For example, say you have an unconscious or conscious desire to attack somebody, to kill them, to hurt them. But you've introjected wishes from society - "It is bad to hit people; it is definitely bad to kill them," and you'll feel guilty if you do that. Here two wishes are in conflict. You would like to hit somebody, but you would feel very guilty if you do. For Freud this led to moral anxiety or, as we call it today, guilt. The interesting thing is that, if you are not aware or conscious of the wishes that are in conflict, you will not know why you feel guilty. If the anger you feel towards the person is unconscious, you will feel guilty, but you won't know why you feel guilty.

Police departments are very accustomed to the circumstance that, when a murder takes place, certain people always come to confess. I'm sure the first time it happens, they say, "Oh, great! The murderer has come to confess to us. We have solved the crime," but then they realize that the person doesn't know how the crime was committed. The second time the person confesses, a few months later, to another murder, and again a third and a fourth time, then they say, "Here's Mrs. Smith coming to confess again!" Why do people do this? They have this sense of guilt, but they are not sure why they feel guilt.

There must be a reason why they feel this guilt, and so they try and make rational sense of it. "Perhaps it was me that committed that crime?"

David Rothstein, a psychiatrist, has studied people who make threats on the life of the President of the United States. Some of these people, if they are considered serious, are hospitalized. One young man was hospitalized after having made a threat on the President's life and, while he was in the hospital, President Kennedy was assassinated in Texas, and the patient was able to watch it on television. The patient reported to Rothstein that he felt as if he had committed that assassination. He wanted to confess to it. He "knew" that he had done it. He said to Rothstein, "It' s only the fact that I know I was locked up in this hospital during the events that I know that it couldn't have been me. But I believe that it was me."

So this is the second way in which we can explain abnormal behavior. It is when wishes come into conflict and create anxiety, and we try and resolve this anxiety.

Exaggerated Defense Mechanism

A third way that we can try and explain abnormal behavior is to view abnormal behavior as an exaggeration of our defense mechanisms. If you get drunk, sometimes you may lose your memory for what happened the night before. "What did I say? What did I do? I hope I didn't do anything that was embarrassing." You just have amnesia for it. Or if you have been in a car crash, you may have no memory of the events of the crash. "What happened? How did I get into that crash?" You will not know. You can forget things through causes that we can specify. But some people forget things without there being any reason or any cause for it. No trauma, no blow to the head, no alcohol, no drug intake - they just have complete amnesia for those events. They may come to in a strange city and say, "Who am I? What's my name? What am I doing here?" They will have no awareness of what is happening and why they are where they are.

The causes lie in psychological reasons, unconscious wishes that are satisfied by this amnesic behavior, a behavior such as multiple persona1ity, in which a person dissociates into two personalities neither of which are aware of the other. There is often no physiological cause for such a behavior. The cause lies in the wishes, unconscious perhaps, of the patient that such behavior satisfies. Mild forms of this would be things like sleep-walking when you are not consciously behaving. You are not consciously saying, "I'm going to go for a walk and get a glass of water from the kitchen", but you may come to in the kitchen, or somebody sees you in the kitchen almost asleep getting yourself a glass of water. Thus, repression, a defense mechanism, in an exaggerated form, can be seen as a description of an abnormal behavior.

What about regression? A lot of patients seem to regress, to show behaviors that are appropriate of somebody at a much earlier stage of development. Ronald Laing described a patient that he met in a hospital where he worked, called Mary. Soon after she was admitted to the hospital Mary began to regress. At night, she would tear off her clothes and lie on the floor. When she would urinate or defecate, she would smear it over

the floors and the walls of the hospital. For a time she refused to eat solid food, and she had to be fed milk from a bottle by Laing and his colleagues. Mary, an adult woman, was regressing and behaving like a two-year-old infant. She showed behaviors in an extreme form that are characteristic of a two-year-old, not of a thirty-year-old.

At one point Mary regressed even further. She stopped eating completely. She stopped urinating. She stopped defecating. She just lay in a stupor. She had regressed almost to a fetal state. This particular story has a happy ending because Laing and his colleagues indulged her. They fed her from a bottle, they let her act out her wishes, they let her behave like a two-year-old. Eventually she began to grow up again. She began to wear clothes again, she began to play like a little child, dance and move like a little child, play with balls, dress dolls, play with doll's houses. Then she began to draw. First of all she would draw on paper like a child or on the walls of the room. She moved to canvases and, after several years, she was still in the hospital but functioning as a reasonably creative artist. So her schizophrenia, her psychosis, seemed to consist of regression to the behavior of a two-year-old, and then development and growth began again.

What would the person be like if they used the defense mechanism of projection in an exaggerated form? In projection we take a wish that we have, usually unconscious, and we project it onto somebody else in the environment. We assume that they have that wish. I love you, but say that I'm unconscious of that wish. If I project it onto you, I conclude that you love me, and I am not aware that the basis for that thought is that really I love you. My wish remains unconscious, and I project it onto you. Freud argued that paranoid schizophrenia, in which the psychotic believes that other people are out to persecute him, are trying to kill him, wish harm for him, is a disorder based on projection.

Freud postulated that what the paranoid individual has is an unconscious homosexual wish. Let us assume that this happens to me. I meet a man, and unconsciously I am sexually attracted to that man. I love him, but this wish is unconscious. If I became conscious of it and I thought, "I am a homosexual," I may not be able to accept that. I would perhaps have a complete breakdown. I cannot cope with the conscious awareness of that thought. First of all, according to Freud, I switch that desire by reaction formation to, "I hate him." "I love him" gets switched into "I hate him." Then I project "I hate him" onto the other person. "I hate him" becomes "He hates me." So I have translated my unconscious sexual attraction for this other man into a thought that, "He hates me; he's out to get me." My unconscious wish that I am attracted to him remains ungratified, and so it will cause anxiety. Having projected the wish explains my anxiety. "The reason why I feel this anxiety is because I should fear him; he's trying to kill me; he's trying to poison me."

Lots of people when they hear these kinds of explanations say, "That's pretty far-fetched." But in fact psychological evidence supports Freud's idea about paranoid schizophrenia. Paranoid schizophrenics, people who really have suspicions that other people are out to persecute and to kill them, tend to show a lot of overt homosexual behavior at different points in their life and tend to show evidence that they have strong,

unconscious homosexual wishes. So, very surprisingly, research data confirms this speculative mechanism that Freud proposed for paranoid schizophrenia.

That is the third way of explaining abnormal behavior – seeing abnormal behavior as an exaggeration of particular defense mechanisms.

Problems In Development

The fourth way of viewing abnormal behavior is to see it as some disorder in the orderly development of the child from infant to adult. Let me give you some illustrations. The first stage that the child goes through is the oral stage of development, when oral needs and dependency needs are very crucial. I mentioned that if the child is frustrated during this stage, then he will fixate upon those wishes. They will become important to him, and they will drive his later behavior. What would this mean for an adult? Direct oral needs involve things like mouthing things, eating things, sucking things. So a person who has strong oral needs that persist from infancy into adulthood may become obese, may drink a lot to excess and become an alcoholic, may smoke a lot and have to manipulate cigarettes, cigars and pipes with his mouth and die of lung cancer. But there are other indirect, symbolic satisfactions of oral needs - being extremely dependent, being very talkative, being gullible and highly suggestible. Notice that we say of the suggestible person, “He will swallow anything.” We incorporate the idea that there is an oral quality to being highly suggestible and manipulated by other people.

Not only that, but the oral stage of development involves the child learning to trust other people, especially his mother. What happens if that is never achieved? What happens if the mother frustrates the child does not satisfy those dependency needs? Then the child may never learn to trust other people. They may end up schizophrenic. Let me describe a case. David Viscott described a case of a woman who was born was the sixth of seven children. Her mother was a music teacher. She was very worried that something would happen to her sixth child - she had a premonition. So she decided that she would keep the child near her at all times. She gave a lot of music lessons each day, and she kept the child in a crib near the piano, in the music studio.

She hardly ever picked up the child - she didn't have the time to pick her up and rock her and attend to her needs. She fed her between lessons very briefly, and for the rest of the time the child was left by herself. The other children, the first five children, resented this newborn baby who was allowed to stay in the music studio with Mommy. When Mommy wasn't around or wasn't watching, they would come up and punch, pinch and beat this little girl. She suffered a lot of pain.

Because the mother was giving music lessons, she didn't want this child running around, and so the child was kept in the crib in the music studio day and night for the first two years of her life. She wasn't allowed up and around. If she was allowed up - at the age of eighteen months she could easily have been allowed to run around the house - maybe some harm would come to her? So this little baby was raised for two years in severe frustration. Her dependency needs, her oral needs, were not met. What happened

to the child? At the age of two she was already severely emotionally disturbed. By the time she was ten, she was diagnosed as schizophrenic and hospitalized from time to time in a psychiatric hospital. The more you are frustrated during this oral stage of development, the more those needs will persist, the more you will not learn basic trust in other human beings, and this can lead to a variety of symptoms.

The second stage of development is the anal stage. From about the age of one to three, you become interested in manipulating objects, and you get into a power struggle with your mother and your father over when you will defecate, when you will go to the toilet, and under what circumstances. What will happen if you are frustrated at that stage of development? Again, the more you are frustrated at that stage, the stronger those wishes will be and the more they will persist into later life. What does this mean? It means as an adult, you may well have problems with those functions - defecation and urination. You may well have constipation or diarrhea. You may have obsessive compulsive rituals that are associated with cleanliness - washing your hands fifty times a day in order to keep them clean because Mommy, when you were a little baby, punished you if you got crap on your hands. She washed you, saying, "Ugh! Dirty, disgusting!" You may become stubborn or negativistic. When anybody tells you to do something, you say, "No! I'm not going to do it," just as you might have done when you were two years old and Mommy said, "Now go and sit on the potty and perform for me." These anal traits, these behaviors that are associated with autonomy, will affect your later behavior and cause you to behave abnormally.

In the third stage, the phallic stage of development, a major conflict is the Oedipal Conflict. You fall in love with the opposite sex parent. How do you resolve that? You decide, "I couldn't marry Mommy, but I'm going to grow up like Daddy and marry somebody like Mommy." But what happens if Mommy is seductive towards you? What happens if Mommy raises the possibility that maybe you could have her? Maybe your Daddy dies or goes away. Then perhaps, heterosexual relationships will always be very anxious for you, and you may foreswear them altogether. "I will remain celibate" or "I won't have sex with the opposite sex. I will avoid women." You may become a homosexual as a result. So frustrations or inadequate resolution of the Oedipal Conflict can lead to abnormalities in your sexual behavior in later life.

Summary

These then are the four ways in which we can view abnormal behavior. We can see it as problems in the strength of wishes, conflicts between wishes, extreme manifestations of defense mechanism and problems in psychosexual development.

Let me say a few words in conclusion about the psychoanalytic model of abnormal behavior. First of all, the model is individual-centered. The model focuses upon you. All the causes of your behavior are there inside of you, the result of your wishes, conscious and unconscious. I don't have to worry about your relatives or society. I can study you.

Secondly, it is an historical approach. The causes of your behavior lie in your childhood. It is how you were treated as a little boy or little girl, when you were an infant, when you were one, two, three, four, five years old. The important things I have to find out about you are what happened to you when you were a little baby. Can you remember them? Can I get you to re-experience them? You may say, "How can early events be that important?" But try and put yourself in the position of the little baby who, the first time that he is breastfed, gets his top lip pushed over his nose and almost suffocates. It is the only feeding experience in his life - the first one and the only one. He suffers! He can't breathe! If you were to eat a meal in which the food had some poison, and you were to be ill tonight, that is just one meal in 30,000. It is not that important to you. For the small baby anything that happens is crucially important to that baby. Therefore, it is important to understand those historical events.

A third thing is that the differences between normal and abnormal behavior are really quantitative, not qualitative. We all have abnormal behaviors. We all project. We all regress at some times, and we all show reaction formation. We all were frustrated as children at some point. We're no different from the abnormally-behaving person. That person just shows more extreme behaviors.

A fourth point about Freudian theory is that it views abnormal behavior as adaptive. Anything that the person does, even though we may say that the person is behaving abnormally, they do because they are trying their best to cope. Even though we may say, "It's not very adaptive to be scared of cats or horses," the alternative might be a complete breakdown. As long as that person can focus the anxiety into one symptom, perhaps they can cope the best they can. So this perspective sees deviant people as doing their best to cope in a very difficult world.

Obviously the theory can be abused. It is a very sloppy theory, and one can always postulate any unconscious wish one likes in somebody. How can you prove or disprove it? But the fact that it can be abused does not detract from the fact that it is very useful and has validity in many cases.

Two final points. First, it is a powerful theory. It is the most powerful theory that we know. It explains a broader range of behaviors than any other psychological theory. Finally, all the other psychological perspectives that I am going to talk about are reactions against psychoanalytic theory and, therefore, heavily influenced by it. The humanistic model of man rejects the Freudian view of man as driven by unconscious, child-like impulses. The social perspective rejects the individual centeredness of Freudian theory and says "Let's look at society instead." The moral theory rejects Freud's focus on neurotic anxiety, and says we should look at moral anxiety instead. But each of them accepts Freudian theory in order to reject one part of it.

LECTURE FIVE: THE SOCIAL MODEL

Today I am going to suggest to you that mental illness is a role that you play, as if you were an actor upon a stage, and that the reaction of your audience, that is, society, is critical in labeling whether you are mentally ill.

Last time I discussed the psychoanalytic model of mental illness, in which the causes of mental illness were seen as residing inside you. It is some unconscious wish that you have, or two wishes that you have that come into conflict, that are responsible for you appearing to be deviant or being mentally ill.

Today, I want to contrast it with a very different perspective on mental illness, the idea that mental illness and deviance is a judgment made by society upon you - that I label you as deviant, and it is my act of labeling that is critical. Now, for social deviance, this is pretty obvious. We label prostitutes as being deviant; we say that that behavior is wrong, abnormal. "You are a deviant." You should bear in mind that, in this case, the prostitute herself does not necessarily agree with you. She may say, "I'm not deviant. There's nothing wrong with me." It is a judgment that we make about her. That kind of approach is easy to observe for social deviants, the criminals, those who break the laws of the society. But the social model of deviant behavior says that this applies to all kinds of deviants, including the mentally ill. I decide that you are crazy; I label you crazy.

This model makes us ask very different kinds of questions. We ask questions such as: Who gets labeled? Under what circumstances do they get labeled? Why does society react to some people in such a way that they label their behaviors as crazy? What are the effects of the environment - the institution, the home, the mental hospital - upon people's abnormal behavior? In talking about the social model, I am going to focus on the ideas of Thomas Scheff.

Key Assumptions

Thomas Scheff makes two key assumptions about mental illness. First of all, chronic mental illness is a social role that you play. Secondly, the reaction of society is the most important determinant of whether you enter into that role. Let us talk about rule breaking, a very important concept for Scheff.

Rule Breaking

Mental illness is a label that we give those who break rules - certain rules. Let's look at the different rules of society. We have many rules. We know that when you say, "Hello," to somebody, you shake hands with the right hand; that it is wrong to wipe your nose on your hand and then wipe your hand on your trousers; that "thou shall not covet thy neighbors wife;" and "thou shall not kill." These rules are pretty well codified for each society. If you break the rules, then you are judged deviant in some way. If you don't shake hands with you right hand, you might be called ignorant or ill-mannered. If you wipe your nose on your hand or your trousers, again you might be described as

ignorant or uneducated. If you covet your neighbor's wife you might be described as sinful in our society, and if you steal from somebody else, then you are a criminal.

An important thing to remember is that not every society agrees with us. In some societies it is perfectly okay to "covet thy neighbor's life" and go to bed with her. In some subcultures of society it may be permitted to steal. It is only in certain societies that an act might be judged sinful or criminal.

Now, there are a large number of rules that we have to follow that are not codified, that are not found in any statute book, any bible, or any system of philosophy - a few unwritten rules of society that "go without saying" and, if we break them, various things might be said about us. In the past we might be called a witch, or we might be said to be possessed by devils. Today we say the person is mentally ill. What kind of rules are these? For example, consider the behavior of loafing around. We do not permit people to loaf around. In order to loaf around you have to do certain things. For example, you may have to light a cigarette, pick up a book, (it doesn't matter if you hold it upside down) and pretend to read. Then you are left by yourself; you're allowed to be by yourself. You may put on a uniform, a swimsuit, and go and lie on a beach, and everybody permits you to loaf. You may get on a bus and take a five hundred mile trip, and people leave you to yourself. You could dress up in old clothes, pick up an old bottle, and go lie in a gutter in the skid row section of town, and everybody will walk around you and let you lie in the gutter. But you have to adopt a particular uniform and activity - whether it's smoking a cigarette, wearing a swimsuit, lying in the gutter with a bottle - for people to permit it. If you loaf incorrectly, you will be judged strange, weird, perhaps mentally ill.

If I lapsed into silence right now in the middle of this lecture, what would you think? You would say, "That's weird behavior." If you are a school teacher, and little Johnny in your class just sits there and gazes off into the distance, you'd say, "There's something wrong with that child. I'd better send him to the school psychologist." In these situations - loafing here, loafing in the classroom – it is inappropriate. But it's not a rule that's written down anywhere. The person is breaking an unwritten rule. For example, say I was to lie down on this desk to give this lecture. In fact it's pretty comfortable for me. From my point of view it would be much better to lie here, but what would you say? You'd say, "Hey Ethel. Come look at this weird professor on the television. He's lying down on the desk. I always knew those psychologists were crazy." There's no rule that says that I can't lie on this desk to give a lecture, but you would judge me to be strange, weird, crazy, psycho1ogical1y disturbed, if I did lie on the desk.

Say, for example, you were walking by a room, and you looked in and saw somebody talking. You'd say, "I wonder why that person's talking. Let me inquire into this." You might look into the room and see somebody else that you didn't see at first, and you'd say, "Oh, he's talking to somebody else; that's okay." You might look and say, "Look that's a telephone receiver. He's talking on the phone; that's okay." You might see the person holding a crucifix and say, "They're obviously praying; that's okay." But if you couldn't find any of these things - a crucifix, a telephone, or another person - you would say, "They're talking to themselves!" That is not allowed in our society. People by

themselves are not allowed to talk to themselves and, if you see a person doing this, you are likely to say, “They're senile. We'd better put them in an old persons' home;" or, "They're cracking up. I think they'd better go into a psychiatric hospital." The behavior itself, talking in a room by yourself, is not in itself abnormal. It's a judgment that you and I make as we pass that room and look at that person.

Let me read you from the acts of the apostles, in Chapter Nine:

> And Saul fell to the earth and heard a voice saying unto him, "Saul, Saul, why persecutest thou Me?" And he said, "Who art thou Lord?" And the Lord said, "I am Jesus whom thou persecutest." And the men which journeyed with him stood speechless, hearing a voice but seeing no man.

Hearing voices, and talking to them, but you don't see them? That's strange behavior. In that context, we don't judge Saul to be disturbed or senile. However, if he did it today, in our society, although there is no written rule that he cannot behave in that way, we would say that that man needs watching and maybe he should be hospitalized.

What is the incidence of people who break these unwritten rules? In fact, the incidence is very high. But most residual rule breaking remains unorganized, unreported. For example, in a study of mid-town blocks in Manhattan, some psychiatrists found that 80% of all the people they studied and interviewed had at least one psychiatric symptom. In fact, almost a quarter of the people that they looked at were severely impaired in their functioning in normal life. But only 1% of these were actually labeled psychiatrically disturbed and were receiving treatment. So, although a lot of people break these rules, not all of us get labeled as mentally ill or psychiatrically disturbed. Scheff calls the incidence of this residual rule breaking, breaking these rules that are not written down, the unorganized phase of residual rule breaking but, for some of us, it becomes labeled as mental illness, and that is due to the reaction of the society.

A very good example here is that of combat in wars. A number of men at the front, who are fighting, break down. They panic, they get into acute terror states, very disturbed states, and they are removed from the front, from the battlefield. It's found that, if you label them as psychiatrically ill and allow them to talk to a psychiatrist, that it takes them a long time to get well. They become chronic psychiatric patients. By labeling them as mentally ill, they begin to act like chronic, mentally ill people. However, if you ignore the fact that it might be a psychiatric symptom and just say, “You need a little rest and relaxation," and you give them some rest and relaxation, then they are able to go back to the front, often within two or three days. They don't become chronic psychiatric patients and receive discharges from the service. The way that the staff labels the soldier who breaks down under stress is critical in determining whether he accepts the role of being mentally ill or not.

Another example. Some 22% of young male children bang their heads on their crib walls, on the bedroom walls, but only a very small proportion of those become chronic head-bangers so that it becomes a severe problem. Why? Because, for most of the

boys, the parents do not label it as a deviant behavior, as an abnormal behavior. They label it as; "It's something he'll grow out of." Therefore, for those boys it does not become a role that they get into playing. What does all this mean? Especially what does it mean for psychiatric symptoms?

Psychiatric Symptoms

Scheff would say that psychiatric symptoms are not necessarily faked, that in fact the patients to a large extent may not have conscious control over those symptoms, but once we do have some stress and we do act a little bit differently because of the stress, we may play that role for all that it's worth.

How do we learn these symptoms? How do we learn how mentally sick people behave? In fact, society teaches us. When we're little children, we may do something and our mother says, "Don't do that. That's crazy. Only crazy people do that." Maybe we read about them; we read about crazy people in books and novels, in children's fiction and comic books. Maybe we watch television, and we see a schizophrenic murderer portrayed, and we say, "That's how they behave." The mouth hangs open, the eyes are kind of glassy, the people mumble, they act strangely, they rock back and forth, they laugh at inappropriate times. We learn how they play the role, and we imitate them, mimic them.

How often have you read in the press something like, "A fifteen year old girl, with a history of mental illness, is being questioned in connection with a kidnap/slaying of a three year old boy." Nearly every day you can read something like that. Have you ever read in the newspaper, "Mrs. Ralph Jones, an ex-mental patient, was elected president of the Fairview Home and Garden Society, at their meeting last Thursday." You never read that. The press stresses the abnormal behavior of those who are mentally ill. They stress the strange things that they do, the crimes that they commit, the odd behaviors that they show. You never read about the normal behaviors that the mentally ill show.

Another way that you learn the roles is that those you are in contact with teach you the roles. Let me read you a dialogue between a patient who's just been admitted to a mental hospital and her fellow patients. New patient says, "I don't belong here. I don't like all these crazy people. When can I talk to the doctor? I've been here four days and I haven't seen the doctor. I'm not crazy. Another patient says, "She says she's not crazy," and everybody laughs. Another patient says, "Honey, what I'd like to know is, if you're not crazy, how'd you get your ass in this hospital'?" "Well, it's complicated. I can explain, my husband and I..." "That's what they all say." And all the patients laugh. Those patients are forcing that woman to behave in a particular way; they are not going to accept her as long as she denies that she is crazy. She's got to admit that she's crazy, and then they will accept her. How about your psychiatrists?

Let me read from a psychiatrist's case notes. "The patient denied any heterosexual experiences; nor could I trick her into admitting that she had ever been pregnant, or into any kind of sexual indulging. She even denied masturbation as well." It's clear that, if you

meet that psychiatrist, what he wants you to tell him is, "I was sexually promiscuous, I masturbate a lot, I've been pregnant three times." His attitude informs you what he expects to hear from you.

In these various ways you learn the role of being mentally sick. You learn how psychiatric patients behave, and you are trained in the role. To get out of the hospital, you may have to accept the role. "Yes, Doctor I was paranoid and depressed, but now I am cured." Then, perhaps, they will let you out. Having been labeled, being a psychiatric patient can enable you to satisfy lots of your desires. You may like it in the mental hospital. They may have bowling alleys, and swimming pools, and dances every weekend. It might be a great life for you. You may get a lot of secondary gain, out of being a mental patient, or being a phobic, or whatever. People pay attention to you.

Let me recapitulate. For Thomas Scheff, you receive the label of being mentally ill when you break one of the residual rules in our society, a rule that is not written down. Some people come to accept that label. They say, "Yes, you are right. I am disturbed. I do need treatment." Then, having accepted the label, they are trained into how to behave. This raises some question about what people who are in psychiatric hospitals are like. What kinds of people are they? What do they do there?

Two psychologists, Benjamin and Dorothy Braginsky, did some studies in a psychiatric hospital in America. Let me describe a couple of their studies. In the first study that they did, they studied a group of patients who were about fifty years old, who had been in the hospital for about ten years. They were all men. They were given a ten-minute interview with a psychiatrist, and different patients were told different things. Some patients were told, "You're being interviewed to see whether you should be locked up on the closed ward." Other patients were told, "You're being interviewed to see whether you should be discharged from this hospital as cured." The people were interviewed for ten minutes, and they were asked about their symptoms, "How do you feel physically?” and. "How do you feel mentally?" The interviews were taped, and some psychiatrists who didn't know the instructions that the patients had been given rated the interviews for how disturbed the patients seemed to be.

Those who had been told that they were being examined to see if they should be locked up on the closed wards reported very few symptoms. They didn't report things like delusions or hallucinations. They reported mild distress, but nothing very severe. On the other hand, those patients who were being threatened with release mentioned a great number of symptoms - hallucinations, delusions - severe symptoms. The Braginsky's concluded that these patients did not want to get out of the hospital, but neither did they want to get onto the closed ward. They constructed their responses to the psychiatrists to assure that they would be kept in the hospital, but kept on the open ward, with grounds privileges, so that they could go to the cafeteria or the bowling alley or the swimming pool. These patients do not want to get out of the hospital, but they don't want to be locked up, under restraint. What does his mean about mental illness?

Think about a medical illness. A tumor is a tumor. Assuming that you have a tumor, two doctors can look at it and say, "That's a tumor." But what about a delusion? You think that people are persecuting you. Well, if you're interviewed by one psychiatrist under one condition, you might say, "I don't have delusions." If you are interviewed under different conditions, you might say, “Yes, I have delusions." Does the patient really have delusions? How can I decide whether you are faking or not? Psychiatric symptoms have this evanescent quality - now you see them, now you don't.

Why are patients in the hospital? The implication of that first study is that they like to be there. The Braginsky’s took a hundred patients, and they asked, “Where can you go in this hospital?" and "What do you know about this hospital?" Let me read you some of the information that they found out. 82% of the patients knew where the bowling alley was in their hospital. 80% knew where the gym was. 80% know where the swimming pool was. 70% knew the location of the dances every weekend and where the theatre was where the movies were shown. How about the name of their psychologist in their building? Only 26% knew the name of their psychologist. Only 26% knew the name of a social worker, and only 22% knew where the social worker's office was. These patients aren't in the hospital to see the social worker and the psychologist. A good proportion of them are in there for the bowling alley, the swimming pool, the cafeteria, and the dances.

The Braginsky's explored a little further. What do patients do in the hospital? How do they spend their time? There are three main activities that you can do. You can socialize a lot. You can spend a lot of time visiting patients in other wards, talking in the cafeteria with them, meeting them in the bowling alley, and that kind of thing. These patients are called socializers. You can also get a job in the hospital, and get paid a small reimbursement for working. You become a secretary or a janitor or do some simple work around the hospital. Those are the workers. Or you can stay on the ward all day. If you go into a psychiatric hospital, you will see many patients just sitting there in their chairs, watching television, not talking to anybody, hour after hour after hour. The Braginsky's found that about 65% of all patients could be classified into one of these three categories.

They also found that these three classes of patients have very different ideas about mental illness. For example, those who socialize a lot, who go around and are very social and meet other patients in the hospital, stress how similar they are to normal people. They see their role in the hospital as temporary, they see psychotherapy as very useful, and they think that they should be kept comfortable in the hospital. What about those who spent the whole day on the ward? They feel that they are very different from normal people; they see their condition as permanent. “Nothing will ever change. I am a psychiatric patient for the rest of my life." They believe the patients should be restricted, they want to be left alone, and they expect to suffer. They need to be punished for their behavior. The workers fall in-between. They stress how different they are from normal people, but they believe they should have control over what they do in the hospital.

What determines whether you get released from the hospital? The Braginsky's found that how severely disturbed you were had no relationship to whether you got

released or not. Those who socialized more got released sooner. Those who worked more in the hospital got discharged less quickly. So, it wasn't how disturbed you were; it wasn't what diagnosis you had; it was your life-style in the hospital, which is under your control, that got you released quickly.

In a third study, the Braginsky's asked the psychiatrists in the hospital, "How many of your patients can you remember?" The psychiatrists varied. One psychiatrist, the worst, could only recall 12% of his patients - one in eight. The best psychiatrist remembered 75%, but the average was around 60%. What determined whether a psychiatrist recalled the name of his patient? "Let me see. I have James Gerwin, John Smith….." What determines that? It was the patient initiating contact with the psychiatrist. It was patients who went up to their psychiatrist to say, "Hi," or, "How am I getting along? When can I get grounds privileges?" "Can I talk to you about my problem?" It was the patients initiating the contact that made them visible to the psychiatrist. .

Which patients got discharged from this hospital? In fact, within six months after the Braginsky's interviewed the psychiatrists, only 8% of the non-visible patients, the patients the psychiatrist didn't recall, got released. But nearly half of those patients that the psychiatrists recalled got released. Think about that. If you initiate contact with your psychiatrist in the hospital, you are very likely to get released. But if you hide from your psychiatrist, you are very unlikely to get released. So, if you're in this hospital, you know very easily how to construct your life. If you want to get out of that hospital, make yourself visible. Socialize a lot, go up to your psychiatrist and say "Hi there. I'd like to talk to you about my problems," "Tell me about this," "Can I see you about that?" and you'll get out pretty soon. If you would like to stay there, then that is very easy to arrange. You work a lot, and you hide from your psychiatrist. You can spend the rest of your life in this hospital if you want.

Why should people want to spend their life in a hospital? That seems rather strange. You or I don't think about spending the rest of our life, or even a period of our life, in a psychiatric hospital. The Braginsky's said that hospital life is very attractive. You get meals regularly, on time; you don't even have to cook them yourself. You're kept warm; there are clothes for you to wear. There are activities. The ward life is very stable, organized and orderly. There are very few decisions for you to make. There are leisure activities on demand; whenever you want to go to the snack bar or to the bowling alley, you can.

Of course, there are a few disadvantages too. There is a lack of freedom. You can't drive into town at will. You have to get special permission. In rare circumstances, you might have to be locked up on a closed ward. But most of the patients have a good deal of freedom and, in fact, the Braginsky's argued that the patients had so much freedom that they were too busy exploiting their freedom to notice that they were restricted.

Another disadvantage is that there is a stigma attached to being a psychiatric patient. When you get out people say, “You were in a psychiatric hospital?" Will they hire you? How will your friends and relatives react to you? But that's only a problem once you get out. As long as you are in the hospital, everybody is crazy, and there's no stigma attached to being a psychiatric patient.

The Braginsky's noted that, in fact, a lot of patients choose psychiatric hospitals to get a time-out. Their lives are unpleasant on the outside. They want to get away from that stress, and they choose to act like a chronic psychiatric patient. Maybe they simulate the symptoms; maybe they exaggerate the symptoms that they have; and they go to the hospital for a time-out. The Braginsky's ask: Why do we spend all this money on psychiatrists and psychiatric hospitals? If people want time-outs, let's give them time-outs. Let's construct places like retreats or monasteries. Maybe we can have some on the coast and some in the mountains and, if anybody wants to have a time-out from their stressful life, they can go and stay in one of these for a few weeks, free. The Braginsky said: We don't want any mental health professionals. We don't need any psychologists or psychiatrists at these places. What we need is a good recreational staff, people who can organize fun and games and activities for the patients.

What happens if a patient wanted to stay there permanently? The Braginsky's said: That's fine. They would have to join the staff; they would have to become a cook or a janitor, or maybe organize the recreation activities for the other patients. There is nothing wrong in that. Of course, the critics of the Braginsky's said: But that means that thousands of people would go to these resorts, these spas. They would be supported at the public expense. But is that true? Would you go if you had the choice? Would I go if I had the choice? Probably not. Most of us like our life too much. It is fun and exciting leading a real life. Most of us enjoy our work. Most of us enjoy the friends and relatives we have and the leisure activities we do on weekends. We like our children and our parents and our friends next door. Most of us would not go into such a retreat. Only those people who are severely distressed in society would go.

What are the lives of these people like? Are they really like the lives that you and I lead? No. The Braginsky's interviewed some psychiatric patients to find out what kinds of lives they led when they were not psychiatric patients. Let me read you what the Braginsky's said:

> Many of these people lived alone. Typically these stayed in skid row hotels and went on relief. Some, though adult, moved back with parents - who were very frequently aged and infirm - barely able to take care of themselves, substituting mostly on state welfare and social security. Those who lived with relatives generally found themselves becoming Cinderellas in other people's chimney corners.

These people have no viable alternatives. That doesn't describe you and I.

So that, in fact, our mental hospitals and even our jails are, perhaps, filled with people who are not criminals, who are not necessarily psychiatrically ill, but who are choosing to enter these institutions in preference to living in the real world. It's commonly found, for example, that at Christmas and Thanksgiving, when most of us join with our families to experience warmth and a sense of belonging, those who are lonely and isolated in our communities act crazy or break shop windows so as to get admitted to a jail or a psychiatric hospital. There they get a bed for the night, they get the company of their fellow criminals or patients, and they get a meal. Are these people really deviant? Or are they choosing to play the role of the deviant?

LECTURE SIX: THE SOCIAL MODEL (continued)

In the last lecture, I began a discussion of the social model of deviant behavior. Today, I would like to suggest to you that our behaviors when under the influence of alcohol and drugs, such as marihuana, is under our control. We behave only in the ways that our society approves of.

Alcohol And Learned Behavior

What is the conventional wisdom about the effects of alcohol on our behavior? Most of us assume or “know” that alcohol affects our senses and makes our perception less sharp, less accurate. Maybe we miss seeing things that are actually there? Popular mythology has it that we also see things that aren't there - pink elephants perhaps. Sometimes we feel creepy, crawly things on our skin that aren't there. Definitely alcohol affects our senses. It. also affects our motor abilities. We're not able to drive as accurately when under the influence of alcohol, to respond as quickly to the stressful situations that we encounter as we drive. Conventional wisdom has it that drink and driving do not mix, and that is accurate.

However, we also assume that alcohol uninhibits our behavior - that somehow it depresses the functioning of the thinking part of our brain, our cortex, and it releases lower impulses so that they manifest themselves. In particular, alcohol uninhibits our sexual behavior and our aggressive behavior. We act out in ways when we are drunk that we would not normally do. Craig MacAndrew and Robert Edgerton have suggested a very different view about the effects of alcohol. What I would like to do now is discuss this point of view.

Craig MacAndrew and Robert Edgerton assume that we learn how to behave under the influence of alcohol. What evidence do they have for saying such a thing? MacAndrew and Edgerton are anthropologists, and they have collected a lot of reports on how different people in different lands around the world behave when drunk. Let me read you a couple of examples. The Abipone Indians of Paraguay were described in 1822 as a cheerful and courteous, kind and gentle people. What happens when they get drunk?

> Disputes are frequent among them concerning pre-eminence in valor, which often produce confused clamors, fighting, wounds and slaughter. It often happens that a contention between two implicates everybody and incites them all, so that they snatch up their arms and take the part of this person and that person, and rush to attack and slay one another.

These Indians when drunk, become violently aggressive to the point of killing each other. This fits in with our view of what alcohol does to people.

But let’s look at the Aritamia Indians of Columbia. They're a very self-conscious and inhibited group of people. They have a lot of inhibitions; they are always very polite

to each other, but underneath there is seething anger. Sometimes they long to die so that they can avenge all the hurts and the grievances that they suffered during their lives. What happens when these people get drunk? After the first euphoria accompanied by small talk and a few jokes, there may be some singing.

> Somebody may go and bring a drum and play it for a while, but soon all conversation stops and gloominess sets in. There is never any physical aggressiveness; there's just not much merry socializing, or romantic serenading, or obscene talk. They get quiet and gloomy.

Now here is a group of people who are waiting to release their aggression and, when they get drunk, they get gloomy. Among the Abipone Indians, alcohol leads to aggression, and yet for the Aritamia Indians it leads to gloominess. How can we explain this?

Another thing that MacAndrew and Edgerton noticed is that, within any group, the effects of alcohol depend upon the circumstances. For example, when the Urubu Indians in Brazil get drunk they often get violent - they seize up their machetes and they attack and slay one another. But how do the Urubu end wars that they fight with neighbors? Everybody sits down and gets drunk together, and they end the war in mutual friendliness. Among themselves, they will attack each other when drunk, but with strangers they act polite and cheerful. In some villages in Raira in Okinawa, when the men drink together, they get very violent and obscene, but, if there are any women in the group, they are restrained and polite.

This set MacAndrew and Edgerton thinking. If alcohol uninhibits us, why does it only uninhibit us under some circumstances? Robert Edgerton had a very interesting experience when he was studying the Kamba, a tribe in Kenya in 1962. Let me read his report.

> I heard a commotion and I saw people running past me. One young man stopped and he urged me to flee because this dangerous drunk was corning down the path attacking all whom he met. As I was about to take his advice and leave, the drunk burst wildly into the clearing where I was sitting. I stood up, ready to run. But much to my surprise, the man calmed down and as he walked slowly past me he greeted me in polite, deferential terms. Then he turned and dashed away. I later learned that .in the course of his drunken rage, he had beaten two men, pushed and hurt a small boy, and eviscerated a goat with a large knife.

What is this man doing? He is acting out his aggressive impulses amongst his friends, the people in his society, but woe betide you if you attack an American anthropologist. That means trouble. So he meets the American anthropologist (even though he's drunk), he stops greets him politely, and then moves on. Clearly he can turn off his drunken, uninhibited behavior at will.

MacAndrew and Edgerton suggested that, in learning to drink alcohol, we have to learn the rules of our society. What does our society permit us to do when we are drunk?

For example, in our society, what happens at the office party? We all know that maybe it's okay to get tipsy and make-out with one of the secretaries. We also know that, if we make-out with the boss's wife, we're going to be fired the next day. So we're usually very careful and very polite to the boss's wife, but we're not so polite to the secretary. We can turn our behavior on and off at will. For example in the United States of America, the general culture permits people when drunk to become much more violent that they are when sober, and this violent behavior is excused. "He was drunk, he was tipsy." We excuse the violent behavior. In Britain such behavior is not tolerated. If you become violent when you are drunk, you're thrown in jail and punished. So in Britain people do not get violent because alcohol is not considered an excuse. Again and again, we come across data that suggests that our behavior under the influence of alcohol can be turned on or turned off at will. A very good example of this is the American Indian.

Alcohol And The American Indian

The conventional view about the American Indian is that the American Indian cannot hold his liquor. One can read description after description of the uninhibited behavior that is found in Indians once they get drunk. Peter Jones, a Chippewa Indian, wrote in 1861,

> I have seen such scenes of degradation as would sicken the soul of a good man, such as husbands beating their wives and dragging them about by the hair of their head, children screaming with fright, the older ones running off with the guns, and the tomahawks, and the spears, and knives in order to prevent the commission of murder by their enraged parents.

This is the conventional view of what happens to Indians under the influence of alcohol.

MacAndrew and Edgerton traced back in historical documents what happened when Indians in the Northeast of America were first given alcohol. One of the earliest reports comes from 1534 when a Frenchman, Jacques Cartier, gave alcohol to Indians for the first time at a place called Gaspe Harbour. What happened? He saw no violence. The chief of the group became very affectionate and so did his fellow Indians. They hugged and kissed the French traders and soldiers and were very congenial and friendly. When Henry Hudson gave some Delaware and Mohawk Indians some alcohol, they got drunk, but they didn't get violent or abusive. They got cheerful, happy and sleepy and slept it off. They woke up the next morning saying, "That was very nice can you give us some more of it?" But by the 1700s, the Jesuits in the Northeast of America and Canada were describing violent and aggressive behavior in Indians again.

MacAndrew and Edgerton thought about it. They asked, "Who were these Indians able to watch? Who did they model themselves upon?" Of course they modeled themselves upon the French and English soldiers who, when they got drunk, then became violent and abusive and aggressive and did things that they didn't do when they were sober. MacAndrew and Edgerton suggested that the Indians watched the French and British soldiers and said, "It looks as if, when you are under the influence of alcohol, it's

okay to beat up on your wife and your children and your friends, and then afterwards you can say, 'I'm so sorry. You will have to excuse me. I was drunk.'" MacAndrew and Edgerton claimed that the Indians modeled themselves upon the French and British soldiers that they observed.

One thing that is very interesting to note about this is that, when the Indians did get drunk and violent and abusive, they were only violent and abusive towards one another. They were very rarely violent and abusive towards the French or the British soldiers or towards the Jesuit missionaries or the traders because they knew full well that, if they beat up on their wife and even killed her, nothing would happen to them. They would not be punished. But, if they killed a British soldier or a Jesuit priest, they would be executed for it. One can find reports of wild and drunken behavior by Indians, but the British soldiers and the Jesuits and the fur traders could just walk up and disarm them, take away their tomahawks.

Let me give you an example from the journals of Alexander Henry, a fur trader in the l800's. In one instance, Maymiutch, an Indian, wanted more alcohol and was making trouble. So Henry took his gun away. About midnight, Maymiutch began chopping at the garden gate with an axe demanding some alcohol. They took his axe from him and threatened him with a beating. A few hours later Maymiutch attacked and wounded two fellow Indians. He attacked and wounded his fellow Indians but not Henry and his traders who took away his knives and guns because he knew that, if he attacked Henry, then he would be punished for it.

What will happen to the American Indian in the future? What has happened to him already? MacAndrew and Edgerton argued that he will learn that this violent and aggressive behavior is not approved. Eventually his own culture, his fellow Indians, will say that they don't like that behavior any more. It's time to change your behavior. MacAndrew and Edgerton noted that, among the Indians in Tahiti, they have followed the same kind of cycle. When they were first introduced to alcohol, it made them cheerful, happy and contented. Then they modeled themselves on the traders and the soldiers that they saw passing through their ports and became violent and aggressive and sexually uninhibited under the influence of alcohol. Now, as a result of cultural pressure from their peers, their behavior under the influence of alcohol is very similar to the behavior of you and I in America.

What is happening then to people under the influence of alcohol? MacAndrew and Edgerton argued that people need time-outs. If you live in any society, there are a lot of frustrations and rules that you have to follow: "Don't do this. Don't do that. Don't make a pass at this person. Don't sock this person on the jaw." We have to abide by these rules, and that's kind of frustrating. Some of us can get exempt from that for good. Maybe you become king, and we always let our kings and queens break the rules. Maybe you are judged to be psychiatrically disturbed and, once you are a psychiatric patient, then it is okay to hit someone on the jaw. They will just say, "What do you expect of a psychiatric patient?" But most of us do not have that opportunity. We don't want to become criminals or psychiatric patients, and most of us can't become kings or queens.

Alcohol provides a time-out for us - the Saturday night when we can forget all the rules of the society, and we can go and beat up on people and make passes at them and nobody will worry too much. They will say, "He's drunk, and on Sunday he is a much more respectable citizen." This is expressed very nicely by an Australian Aborigine who noted that the Australian Aborigines have a ceremony where, once a year they all get together, and everybody swaps wives and sleeps with other people. One Australian Aborigine said of this ceremony, "It is better that everybody comes with their women and all meet together at this ceremony and play with each other, and then nobody will start having sweethearts the rest of the time." You forget the rules of the society that you are supposed to remain faithful to your wife just for that one occasion, and then you toe the line for the rest of the year.

Alcohol provides a time out so that we can act out some of our impulses. This means that they are under our control - we uninhibit only some of our behaviors that we know our friends and relatives will accept and that they will not punish us for.

Why is alcohol used? Alcohol is a very convenient substance. First of all it produces these sensory and these motor changes so we say that, "If it affects my senses and my motor movements, obviously it affects my impulse control." That sounds rational. It makes sense, even though it's not true.

Secondly alcohol is easy to make, and nearly every society in the world has discovered alcohol and brewed it. A third thing is that its effects are not long lasting. You get drunk tonight, and tomorrow you may have a hang-over, but you're sobered up. You don't go on for a week or a month out of control. It's only for a very limited period.

The fourth and final advantage of alcohol is that it is easy to monitor its effects. We can take our first drink and say, "I'm feeling a little tipsy. I think I need another one." You can take another one and say, “I'm just in the right state - not too much, not too little." We can monitor our progress under the alcohol.

Not only that, other people can monitor our progress. As they see us staggering around, they can say, "That person's drunk. That person is going to make a pass at me. I don't want them to make a pass at me. I'll avoid them." It enables other people to say, "This person is going to act out. They may sock me on the jaw or they may make a pass at me. Do I want to participate?" If they do, they can and, if they don't, they don't have to. Alcohol is a very convenient substance to use as a basis for these time-outs.

Marihuana And Learned Behavior

Howard Becker is a sociologist who's made a very similar point about the effects of drugs such as marihuana, the so-called recreational drugs. Becker has argued that the effect of these drugs varies from person to person. Not only that, they have a wide variety of effects. They affect our heart rate, our thinking state, our sense of time - a tremendous number of physiological and psychological affects. But we only pick out some of these as

being suggestive of a high. Not only that, we have to learn, we have to be educated by our friends, about which of these effects we have to look for and about the whole ritual involved in, for example, smoking marihuana - from holding the cigarette, to the kinds of behaviors that are permitted. Let me illustrate this. Very often people don't get a high the first time they smoke marihuana, and the conventional wisdom of this is that they're not smoking it right. Let me read you a quote from a marihuana user.

> The trouble with people like that is they're just not smoking it right. That's all there is to it. Either they are not holding it down long enough, or they are getting too much air and not enough smoke, or the other way around, or something like that. A lot of people just don't smoke it right, so naturally nothing is going to happen.

You have to learn how to smoke marihuana. “I was smoking like I did an ordinary cigarette and he said, No! Don't hold it like that. He said, Suck it, you know, draw it and hold it in your lungs till, you know, for a period of time. I said, is there any limit of time to hold it and he said, No, just till you feel that you want to let it out, and then just let it out. So I did that three or four times." Here this person is learning how to smoke marihuana and, until he learns how to smoke, he probably will not experience the high.

Even after you've learned how to smoke it properly, you still may not get the high. Why? Because you do not know what effects to look for. You may experience particular sensations, but is it the effect of the marihuana? Maybe it's the effect of your anxiety in waiting for the effect. It's a bit like, "Mommy, how will I know when I am in love?" You don't know until it happens to you. You have to learn. "That's what love was.” Again, let me read a quote from a marihuana user.

> They were just laughing the hell out of me because I was eating so much. I just scoffed so much food, and they were just laughing at me, you know? Sometimes I'd be looking at them, wondering why they're laughing you know, not knowing what I was doing. "Didn't they tell you?" Yeah. Yeah. I come back, Hey man! What's happening? Like, you know, like I'd ask what's happening? And all of a sudden I felt weird, you know? Man, you're on, you know, you're on pot. I said, 'No am I? Like I don't know what's happening.

This gentleman has to learn that, in fact, it's very common to feel hungry once you've got your high on marihuana, and the fact that you feel hungry can be taken as a sign that you're high and that the drug has been successful. Or somebody else: “I heard little remarks that were made by other people. Somebody said, My legs are rubbery, and I can't remember all the remarks that were made because I was very attentively listening for all the cues for what I was supposed to feel like." You have to learn what you're supposed to feel like, which cues you pick out. You don't worry about the heartbeat perhaps; you worry about the hunger. That means you're high. You worry about that your legs are rubbery. "That means I'm high.”

Having done that, having learnt what you're supposed to get out of marihuana, you've then got to learn to like it. You may be experiencing these things and say, "Yuck! That's fun? That's not fun for me. “I felt I was insane, you know. Everything people done to me just wigged me. I couldn't hold a conversation, and my mind would be wandering and I was always thinking, oh, I don't know, weird things like hearing music different. I got the feeling that I can't talk to anyone, I'll goof completely." That particular individual is not enjoying this state; he feels anxious about it; he feels crazy; and that person, left to himself, would probably never smoke marihuana again. You have to be educated. Here's the expert talking about how to handle the naive smoker.

> Well they get pretty high sometimes. The average person isn't ready for that and it's a little frightening for them sometimes. You have to, like, reassure them. Explain to them that they're not really flipping out or anything, that they are going to be all right. You have to just talk them out of being afraid. Keep talking to them, reassuring them, telling them it's all right, and come on with your own story, you know. The same thing happened to me. You'll get to like that after a while. And you keep corning on like that and pretty soon you talk them out of being scared.

So the three things you have to learn are: the ritual, how to do this behavior; you have to learn which symptoms to recognize; and you have to learn to like them. Left to ourselves, we probably would never do that. It's the effect of your peers, those with whom you're smoking, who teach you these things. Not only that, there are a lot of rituals associated with marihuana smoking. You share the joint, you pass it around; it's an altruistic behavior. Violence is often not permitted in the cultures that smoke marihuana, so you don't get violent. And each little clique may formulate its own rules as to how you behave and, again, you have to learn those rules.

For both alcohol and marihuana then, the social model argues that we adopt a role under the influence of these drugs, that we learn that role, and that, once we learn it, we play it to the hilt. In fact, you can often read descriptions of people who, when they are with other people who are drinking or smoking marihuana will say, "I only pretend to get drunk or to be high so that I can make the best of the social situation, like picking up somebody, and I try and stay sober.” MacAndrew and Edgerton and Becker would argue that they are behaving no differently from the person under the influence of the drug. That person is just as capable of moderating and controlling his or her own behavior

Let me move on to another topic that I've alluded to from time to time, and that is the stigma associated with being labeled deviant.

The Stigma Of Being Labeled Mentally Ill

The problem of becoming a deviant or showing abnormal behavior is that there is a stigma attached to it. The stigma that is attached to being called deviant or abnormal is what sociologists call a master status. We have various kinds of statuses: husband, professor, wife, mother, child, teacher, doctor, man, woman, young, old. But the label

mentally ill, deviant, or abnormal takes precedence over those. The fact that somebody is a doctor is irrelevant. The fact that he is mentally ill that takes precedence - it's a master status - and that status has important consequences for that person.

It has important consequences for those who come into contact with them as well. Would you hire somebody who was an ex-psychiatric patient, who was mentally ill or had been mentally ill? “I really shouldn't discriminate against them,” we say, but would you? Most of us do! What about the friends and relatives? What do they tell their neighbors? "George had to go away for a little while, he needed a rest." Will they say, "He flipped out, and he's been in the local psychiatric hospital for the last three months." No! They're ashamed of it. Not only that, the status has implications for yourself. You feel worthless. "How is it I couldn't cope? Why aren' t I strong enough to be able to cope with the stresses of society. Other people can!" You may say, "The prejudice against those who are psychiatrically ill is not that great," but let me give you some data.

A psychologist, Richard Kalish, interviewed some undergraduates and he gave them a social distance scale, with questions like, "Would you date this person? Would you allow them to live on the same street as you? Would you let them visit the United States?" He gave them a variety of groups to judge: ethnic groups, blacks, Mexican/Americans, Canadians; religious groups, Jews; and deviant groups; ex-mental patients, drug addicts. How did people respond? Let's look.

96% of those asked would let Mexican Americans visit the United States as visitors from abroad. Only 64% would let ex-mental patients visit the United States. Only 34% would let ex-drug addicts visit the United States. What about having the person live on the same street? Only 54% would let a mental patient live on the same street, and only 10%, a drug addict. The prejudice expressed towards the deviant people – the addicts, the alcoholics, the ex-mental patients - was far greater than that expressed towards any ethnic or religious group.

This prejudice is not always found. For example in the town of Geel in Belgium, the townspeople have been taking in psychiatric patients into their homes for the last 700 years. It has been the tradition to look after patients in the home. It has been, as it were, the occupation of the town. The Hutterian Brethren of the plains in Canada and in the Midwest do not hospitalize the retarded or the disturbed in their community. They keep them in the community. If they’re dangerous, they arrange someone to look after them, but they allow the people the freedom of living in the community, of participating in the community life the best they can, and still maintaining relationships with their friends and relatives.

Comments

Let me comment on some of the aspects of the social model that I have talked about. First of all, the social model has a great deal of validity. Society often does make judgments about people, and this suggest lots of areas for study. Why do we label each other mentally sick or deviant? What is the effect of this labeling? Let us study the stigma

involved. What is the effect of putting somebody in the hospital. Does that make them act crazier - more deviant - or less deviant?

But the problem with the social model is that it doesn't explain why a psychiatric patient has this symptom rather than that symptom. Why does one person have delusions and another person have hallucinations? Why does this person have a phobia and this person have blindness when there is no physiological reason to be blind? The social model does not permit us to make this distinction as to why you choose one symptom rather than another. It has to leave it to something like chance. "We don't know why you got this symptom, but maybe you learnt it from somebody." Although the social model has validity, it does not explain the full range of deviant behaviors.

Another problem with it is that deviant behavior is not always a societal judgment. Some people are anxious; some people are depressed. It is a self-judgment that they make. I worked in a suicide prevention center, and when someone called me and said, "I am depressed, I feel like killing myself. Can you help me?" it wasn't I who made a judgment about them. It was they who told me, "I am unhappy, I am feeling abnormal, and I seek your help." For those kinds of people, a social model does not really have much usefulness .

LECTURE SEVEN: THE RELIGIOUS MODEL

Some of you may have sinned recently. In fact, some of you out there may be sinning at this very moment. You should be careful! The religious model of mental illness claims that, if you sin, and fail to confess and do penance, you will become mentally ill.

We psychologists like to think of ourselves as objective, scientific, and to avoid ethical and moral issues. We don't always succeed in that. If you believe in the psychoanalytic model of mental illness, then it's very easy to believe, for example, that homosexuality is an inferior choice - not a good behavior. In fact, until 1974, it was considered a mental illness and, although the American Psychiatric Association voted last year that it was no longer a mental illness, the vote was not unanimous.

Hobart Mowrer has taken a very different point of view. He has said that the question of ethics is critical in judgments about mental illness and deviant behavior. In fact, he has asserted that abnormal behavior is a result of sin. To explain this model to you, a good place to start is to consider the notion of guilt and anxiety.

Guilt And Anxiety

Let me recapitulate something I said in the psychoanalytic model of mental illness. In psychoanalytic theory, you have some wishes that you have taken over from society, parental prohibitions. Society says, "Do not do this; do not do that," and sometimes those wishes that you have taken over, and that now are your wishes, come into conflict with other wishes. Your mother told you that it was dirty or wrong to masturbate, but you want to. When those wishes come into conflict, you feel guilt. That is psychoanalytic theory. Mowrer's religious model is slightly different. He says that it is not the conflict between wishes that causes guilt, but it is actual acts that you commit, actual sins. It is not the wish to commit that act, but the actual commission of that act. If you commit that act, if you go against societal values, if you sin, then you will feel guilt. What happens to this guilt?

The problem as Mowrer sees it is that some of us repress our guilt. We stifle our conscience. We block it out of awareness. What is the result of this? If we're no longer conscious of our conscience, if we've repressed our guilt, then we have to withdraw from society because, whenever we interact with somebody else, whenever we come into contact with societal values, we will be forced to recognize that we are sinning, that we are going against societal values. Our only choice is to withdraw, to become alienated from society, and that already is a psychiatric symptom.

A second result is that, once you stifle your conscience, once you repress your guilt, you are much more likely to sin again because you don't feel as guilty the next time. Let me put this in another way. In the psychoanalytic theory of neurosis, we repress our instinctual wishes, our id-like wishes, and our conscience is overly strong. But, for Mowrer, it's our conscience that we repress which means that our id wishes are given

fuller rein. We act out our id wishes more often. Remember, those wishes are primitive, unorganized, aggressive, and sexual in nature.

A second important concept in Mowrer's Model is that of socialization.

Socialization

The way that psychoanalytic model views socialization is that one problem with people is that they are over-socialized. The neurotic has too strong a superego. He has introjected societal values too much. He feels guilty too often, when he shouldn't really feel guilty. At the other extreme, we have the psychopath - the person who has not introjected societal values and, therefore, has too weak a superego. Mowrer's position is very different. For him, both the psychopath and the neurotic are under-socialized, and it is only the normal individual who has the right amount of conscience, or has introjected societal values to the fullest extent. Let me explain this with this chart (see page 55). On this chart we have the Freudian position noted - the normal individual has the right amount of socialization, the psychopath is too little socialized, the neurotic is too greatly socialized. For Mowrer, the position is reversed, the neurotic and the normal individual switch positions. It is the normal individual who has the correct amount of socialization, and both the neurotic and the psychopath are undersocialized.

This has important implications for both therapy and treatment and even for the way we raise the children in our society. Mowrer knows that today there is a lot of emphasis on permissive child-rearing, encouraging children to do what they want to do, to do their own thing, to follow their own persuasions. Mowrer says this is very dangerous. This will raise children who aren't socialized enough - whose superego is too weak, whose conscience is not strong enough - and so they are going to end up neurotic. Mowrer is opposed to permissive child-rearing techniques.

A second implication is that certain forms of treatment will increase our symptoms of mental illness. When a psychoanalyst treats you, he tries to get you to become conscious of your unconscious id impulses, those primitive, aggressive, sexual, child-like wishes that you have repressed since you became an adult. The psychoanalyst's aim is to weaken your superego. But, for Mowrer, that would make you more likely to sin and, therefore, more likely to become mentally ill. Mowrer argues that psychoanalytic treatment is increasing the incidence of mental illness in our society. So far I've talked about neurosis, but Mowrer applies his theory also to psychosis.

Psychosis

For Mowrer, the paranoid individual, that is, an individual who has feelings of persecution - "Other people don't like me," "Other people are out to get me," "People are trying to persecute me," "They're listening in to my phone," - is projecting his guilt rather than acknowledging it. He is projecting it onto and blaming others. According to Mowrer, what he should really do is blame himself. Another good example of the application of

Mowrer's theory to psychosis is a paper once written by a schizophrenic who had been in a psychiatric hospital for many, many years, and this is what that schizophrenic wrote.

> I propose that the motive force of schizophrenic reactions is fear. In the case of schizophrenia, the chronic fear is more properly called terror, or concealed panic, and secondly the fear is conscious and thirdly the fear is concealed from other people. In schizophrenia, detection by others of a guilty deed is what is feared, the detection pointing to the past, and it is defended against. My hypothesis might be called the Dick Tracy theory in honor of the familiar, fictional, human bloodhound of crime. The repression of sociality accounts for the well-know indifference of schizophrenics. To repress your sociality means to repress those values that you share with society. Schizophrenia is the cultivation of a lie. The real truth is that the schizophrenic is responsibly guilty for some crucial misdeeds. The ultimate goal is to avoid punishment.

The schizophrenic ends up with this: "As Freud found Shakespeare's Hamlet to be representative of neurosis, I take Shakespeare's Lady Macbeth to typify schizophrenic psychoses. The motto of the schizophrenic might well be "Out damned spot!" and that of the therapist working with schizophrenics, "Find the crime!"

When Mowrer showed this essay by a schizophrenic to other psychologists, they split in their reactions. Some said, "That's a very interesting and original theory of schizophrenia," and others said, "That essay is symptomatic of the disease of schizophrenia." That last statement is an indication of how other psychologists view Mowrer's theory. There are very few who accept it.

Let us think through the implications of this theory. How would we treat people? What kind of therapy would you do if you believed in the religious model of mental illness? According to Mowrer, the first thing you have to do is confess. You have to acknowledge your sins both to yourself and to others. You have to make a public confession. Secondly, you have to do expiation - you have to do some penance, you have to pay a penalty, and you have to recommit yourself to societal values. Mowrer is fully aware that he is using this religious metaphor, that he is using religious terms, but Mowrer does not believe that his model fits our current concepts of Christianity and religion.

He noted that in the early days of Christianity, confession was public. You didn't confess your sins to your priest in private. You made a public confession of your sins and, not only that, the penance was not easy - not some small payment you made or a few words that you said or prayed. It was a severe punishment that you paid for your sins. Mowrer noted that, to popularize itself, Christianity had to drop the idea of public confession. It was too embarrassing for people. Confession became private, and penance was made much more easy. Mowrer says that modern Christianity is wrong. It is going in the wrong direction. Mowrer’s view is that the only current Christians who fit his model and are doing the right thing according to his model are the Anabaptists, that Christian sect that was founded in Switzerland in 1523 led by Conrad Grebel and today is, in

America, represented by the Amish, the Hutterians, and the Mennonite sects. They still make confession more important, and they make penance difficult. For Mowrer, therefore, they are likely to reduce mental illness in their societies.

There are several other forms of therapy that are congruent with Mowrer's model. In group psychotherapy, rather than going as an individual and talking to your psychotherapist on a one-to-one basis, so that only he hears what you have to say, in group psychotherapy you meet with a group of other patients, maybe with one therapist, or sometimes two or three, and then when you make your statements, when you confess your faults, when you talk about what you have done wrong, your confession is much more public. Insofar as it is more public, its effects will be more curative, according to Mowrer.

We should bear in mind that most group psychotherapists do not believe that that is why their group psychotherapy cures people. But Mowrer would say, regardless of what they say, in fact, it is the public confession that accounts for the success of group psychotherapy.

Let us consider a group like Alcoholics Anonymous. Alcoholics Anonymous is a self-help group. It is set-up by ex-alcoholics to help other alcoholics. On the whole psychiatrists and psychologists do not have much to do with Alcoholics Anonymous. Alcoholics Anonymous stresses several features. It stresses the spiritual awakening. It is convenient if you believe in God and if you commit yourself to God. You don't necessarily have to believe in God to belong to Alcoholics Anonymous, but it helps. There is a religious aspect to the philosophy of Alcoholics Anonymous. You have to confess your sins and your faults. For example, in Alcoholics Anonymous, you don't ever call yourself an ex-alcoholic. I was something, but I am no more. You say, "I am an alcoholic." It is a label, a stigma that you carry with you for the rest of your life. You're never an ex-alcoholic; you're always an alcoholic. Secondly, your confession is public. In Alcoholics Anonymous meetings, it is common for one person to stand up and tell his story to everybody else - a kind of public confession. And there is a penance involved - a recommitting yourself and helping others. Let me read you some examples of this. The Alcoholics Anonymous philosophy consists of 12 steps, and some of their steps illustrate Mowrer's ideas very nicely.

Step one: We admitted we were powerless over alcohol, that our lives had become unmanageable. Step four: We made a searching and fearless moral inventory of ourselves. Step five: We admitted to God, to ourselves, and to another human being the exact nature of our wrong. A confession! Step eight: We made a list of all persons we had harmed and became willing to make amends to them. That is the penance. I will make up for all those wrongs that I have ever committed. Step nine: We made direct amends to such people wherever possible, except when to do so would injure them or others. Step ten: We continue to take personal inventory, and when we are wrong we promptly admit it. Confession, expiation, penance. Now obviously Alcoholics Anonymous involves other supportive factors. There is the group support for others; there is a kind of psychotherapy

carried out. My point is to say that it is consistent, congruent with Mowrer's model of mental illness.

Another self-help group which is consistent with Mowrer’s theory is known by the name Synanon. In 1958, a gentleman called Chuck Dederich, an ex-alcoholic, set up a group in California in Santa Monica, to treat ex-drug addicts. A Synanon is formed as follows. They buy a house in the community, and the addicts move in. They live in the house. On the whole a Synanon is self-supporting - the drug addicts do the work around the house, they quite often will have an industry, they make goods which they sell to the public, in order to make money.

Each evening in such a house, you meet in a group encounter meeting. It's called a Synanon or sometimes it is called a stew. In the stew, the aim is to trigger feelings, to prompt a cathartic release of your feelings, to attack one another, to face the truth, and to confess. All those who've been in such meetings say that they are very grueling and very difficult to endure. Let me read some examples from Jane Howard who wrote a book and described her visits to a stew. "A kid who stank was ordered to leave the stew immediately in the company of a Synanon staff member and, 'Go take a bath. A bubble bath if you like, but hurry, you stink, you smell, go out and take a shower. We don't want you in here.' A young man who hung around with men five or ten years his senior, 'My role models,' he called them, was told to make friends his own age, 'You're eighteen and you did two years in some kiddie joint and you come on like Al Capone,' they told him, 'but you're not a tough-guy at all; you're a sweet, sensitive kid who ought to hang-out with kids your own age. That's where it's at; it's a tremendous fix; you really need to get kicked in the ass by your chronological peers. Cut out that Marlon Brando stuff.' Somebody accused a carpenter named Al of being a phony. 'I guess I am,' he said. 'I guess I project a tough-guy image when I'm really a teddy-bear. I guess I needed that image in the jungle where I was, but I don't need it here. I'm learning how much I don't know, how ignorant I am. Heck, I've never even been in a nightclub in my whole life, or up in an airplane.’ Those examples will illustrate my point. You confess, and you admit you're false. "I'm ignorant. I come on phony." If you don't, you will be told it. If you have body odor, “Get out and take a shower." There's no pulling the punches in a stew. Again, in Synanons there are a wide variety of curative factors besides this public confession, but Mowrer would say, that the public confession helps.

There is a well-known form of therapy that has become popular these days called Reality Therapy which has been devised by William. Glasser. He says that the basic thing wrong with psychiatric patients is that they are irresponsible, and they do not accept that they are irresponsible. His job as a psychiatrist is to teach those patients to be responsible. Reality Therapy is very congruent with Mowrer's views.

One of the interesting things about Mowrer is that he acknowledges something that most psychologists would not. Most of that we believe, our theories, actually stem from our personal experience, our own lives. Most of us would deny that. Mowrer has made this very explicit in his case by writing his autobiography and showing how his model fits his own life.

Let me give you examples from his life. When Mowrer was at high school, he began to suffer from periods of anxiety and depression. He managed to finish his high school studies, and he went on and became an undergraduate, but these feelings of anxiety, unreality and depression pursued him and from time to me became very bad. He finally finished his B.A., and he entered graduate school at Johns-Hopkins University. There his symptoms of anxiety, depersonalization and depression became so bad that he finally sought psychiatric treatment, and he went into psychoanalysis. During this time he got married, he got his Ph. D., and he became a psychologist. He became a very successful psychologist. He published some fantastically creative and original work. His fame grew and his fame spread, but his depression and his anxiety and his feelings of depersonalization continued.

In 1945 he made a decision. He decided to give up psychoanalytic treatment and to confess his faults to his wife. He sat down one evening, and he told his wife who he was. He told her of his instability as an adolescent. He told her of some "ugly perversion" as he calls it, that he engaged in as an adolescent, although he doesn't tell us what that perversion was. But he confessed it to his wife. He told her of his extra-marital affairs, how he'd been unfaithful to her since he'd been married to her. He confessed. What happened? Let me quote. "That hour of truth with my wife did more to heal and release me from neurotic bondage than all the professional help I had previously received. That act of self-disclosure to my wife, in 1945, did more to stabilize me emotionally than all the professional treatment I had previously received during a fifteen year period." For the next eight years Mowrer remained symptom free. His anxiety went, his depression lifted, he no longer felt feelings of depersonalization.

In 1953, the psychologists in America decided to honor Mowrer. They recognized his truly creative and original work, and they elected him president of the American Psychological Association. When going to the annual meeting to make his presidential speech, he broke down. The feelings came back with extreme intensity - the anxiety, the depression, the "Who am I?" feeling - and he had to be hospitalized in a state psychiatric hospital. When the convention took place, Mowrer was in the hospital. The psychologists said, "What's happened to Mowrer? He's been hospitalized. What shall we do?" What they decided to do was to accept him as president, to keep him as president and to tell him that he would not give his speech that year, but that they would let him give his speech the following year. He stayed in the hospital about four months. When he came out, he continued his work, and the next year he went to the convention, and he gave his presidential speech. How does Mowrer view that incident?

He says that the private confession to his wife was not sufficient. His confession had not been public enough. In a way, having the breakdown at the time that he did made his confession public. He confessed to every psychologist in America who belonged to the association, “I have sinned, and as a result I am mentally sick.” His confession became public. What about his penance? He says, “I was in that hospital for four months. I might have been thrown out of the association. They might have refused to let me give my speech. And those four months in the hospital were grim. That was my penance.”

Having made that public confession, and having done penance, Mowrer has remained free of symptoms ever since. To persuade you of the fact that you should confess publicly, he has published his autobiography so that you and I can buy his book and read about his life. He continually publicly confesses his faults; he goes around to different groups and talks, and tells them about his sins, his perversions, his infidelity; and as a result, he would argue, he remains symptom free.

Comments

Let me make some comments in closing about this model. Mowrer's model is seen as very controversial. It has aroused hostility in other psychologists, and it has been rejected by more psychologists than perhaps any other model in contemporary times. Let me read you a couple of quotes from other psychologists. Perry Landon, a psychologist, wrote in 1964, that, "The theory of the origin and treatment of neurosis put forth by Mowrer may deserve more serious attention than any such theory since Sigmund Freud's Psychoanalysis, for in the two generations that lie between them, no other mental health theorist has been subjected to such voluble and vituperative criticism." As David Ausubel, another critic, has said, "To accept Mowrer's view would, in my opinion, turn the psychiatric clock back 2500 years. It would be like going back to Greek science, which we no longer accept." It's very controversial.

Yet if you think very carefully about the theory, it is not that different from psychoanalytic theory. The same concepts are used. The idea of a superego, of a conscience, of the defense mechanisms, of repression and projection, the diagnostic labels of neurosis and psychopath - the same terms are there, but they are shuffled around in a very different way so that their implications become very different. Whereas, for Freud, the major problem is in the repression of our id wishes, those unconscious, child-like impulses that we have, for Mowrer, it is the repression of our guilt that causes us more problems. For Freud, whereas we project our id wishes, "I hate you," but I cannot accept that consciously and so project it onto you and think that you hate me, for Mowrer, it's a superego wish, guilt, that we project. The crucial concept of guilt is the same in both. Freud may have called it moral anxiety, whereas, Mowrer calls it guilt but, when we read Freud's term "moral anxiety," we translate it into "guilt." We translate the term of superego into conscience. So that although Mowrer's theory is very provocative and has received a lot of criticism, it is in some respects very similar to psychoanalytic theory.

Why then does Mowrer use the terms of sin and confession and penance? He needn't. To use those terms alienates a lot of other psychologists. He has put it in this way, "As long as one adheres to the theory that psychoneurosis implies no moral responsibility, no error, no misdeed on the part of the afflicted person, one’s vocabulary can, of course, remain beautifully objective and scientific. But as soon as there's so much as a hint of personal accountability in the situation, such language is at the least very wide of the mark, and conceivably, quite misleading. Therefore, if moral judgment does enter the picture, one may as well beard the lion and use the strongest term of all, sin. So Mowrer would hold you responsible for your actions.

This view is found in other psychologists and psychiatrists. Thomas Szasz, a well-known psychiatrist, has argued that people are responsible for their actions. To say that your behavior is the result of your schizophrenia or your alcoholism is not an excuse. He calls those diagnostic labels, and our humane treatment of such people by excusing their behavior, a social tranquilizer. A social tranquilizer not very conducive to curing those people. I've pointed out that William Glasser also believes that irresponsibility is part of mental illness.

One final point is of interest. When Freud proposed psychoanalytic theory a hundred years ago, society was very restricted, inhibited. The Victorians draped the legs of their pianos so that they would not be offended by the sight of the leg of the piano. They were inhibited in their sexual behavior with their wives and their intimates. Freud proposed a theory that said, "Uninhibit. Get rid of our inhibitions, become conscious of those unconscious impulses." Today, we're in a much more permissive society. Expression of all kinds of impulses is allowed. Mowrer at this time has proposed a theory which says, "We too uninhibited. It is important to inhibit, to repress some of those impulses" These two powerful theories, psychoanalytic theory and Mowrer's religious mode, can be seen as reflections of the historical time in which they were first proposed.

LECTURE EIGHT: THE LEARNING MODEL

For the last seventy years, psychologists have been studying the behavior of animals in the laboratory and how they learn particular responses. For the last twenty years, psychologists have been trying to apply this body of knowledge to normal and abnormal behavior by humans so that today the learning model of deviant and abnormal behavior is one of the fastest growing models. In order to explain this model to you there are two major processes that I have to describe, and the first of these is classical conditioning.

Classical Conditioning

In classical conditioning, we start with some unconditioned stimulus which elicits an unconditioned response - this is known as a reflex. We always automatically produce a response to this stimulus. In classical conditioning, we try to attach this response to a new stimulus. Let me illustrate this with an example. A British psychiatrist, Rachman, has tried to show that he can teach male undergraduates who are normal to be fetishists. For the normal male undergraduate, the sight of an erotic nude female is an unconditioned stimulus and automatically produces sexual arousal, which we can call the unconditioned response. This happens automatically. What Rachman did was present the picture of a boot to these students, follow it by a picture of an erotic nude female, and thus elicit sexual arousal in the young men.

CS boot US nude female UR sexual arousal

He kept repeating this sequence, the boot and the erotic nude female, and getting the male students sexually aroused. After multiple pairings of these two stimuli, presentation of the boot alone produced sexual arousal. We now have a student who formerly was sexually aroused by the sight of an erotic nude female, but who now is sexually aroused by the sight of a boot. We have produced what is called a fetishist. Rachman has demonstrated that such an abnormal behavior can be learnt simply by the process of classical conditioning.

Another famous example was that (some hundred years ago) by John B. Watson, the founder of behaviorism, who showed how you could produce a phobia in a small child. Again let me illustrate

CS white rabbit US loud noise UR crying

Watson noticed that, if you make a loud noise to a small child behind him so that he can't see you, it produces reactions of fear in him. This boy, Albert, cried and got very fearful. Watson first presented a white rabbit to the child. He followed it by making a loud noise behind little Albert, and little Albert got scared and cried. Watson kept presenting this sequence - the white rabbit, the loud noise, and making little Albert cry. Eventually just the presentation of a white rabbit by itself produced the same response. Little Albert cried at the sight of the white rabbit. This response of fear and crying was produced by a new

stimulus, a white rabbit, whereas previously it was produced by noise. Little Albert showed some interesting behaviors because he generalized his fear of white rabbits. He began to cry when any furry animal was brought in, and in fact one of the doctors in the hospital had a white beard and, when little Albert saw the doctor with the white beard, he got scared and he cried.

A third example was presented by Eysenck. Eysenck had a man come to him with a problem of impotence. The man reported that, whenever he tried to have intercourse with his wife at home, he was impotent - he wasn't able to; but, whenever he went into a hotel or a motel with her, he was perfectly able to have intercourse with her. Eysenck talked to him, found out some of the experiences he had had, and constructed this situation. It appears that the man had once had an affair with the wife of his boss. During that affair, he'd been caughtby his boss in bed with the woman, and his boss had beaten him up. Beating produces in most of us reactions of fear, pain and anxiety. What Eysenck found was that the young man had noticed the wallpaper during the beating - he had noticed the pattern - and so, in one trial, the wallpaper became associated with fear and pain.

CS	wallpaper	US	beating	UR	fear and pain

Eysenck found that the man had the same kind of wallpaper on the wall in the bedroom of his own house so that, whenever he tried to have intercourse with his wife at home, he could see the wallpaper in the room, and it elicited these feelings of fear and anxiety as a result of this classical conditioning experience earlier in his life. Eysenck's cure was very simple. Re-wallpaper your bedroom! The man re-wallpapered his bedroom, and his impotence vanished.

I should perhaps make the point that this is a very rare case of impotence. Most cases of impotence do not have such a simple causation or etiology; but this particular example illustrates the principles of classical conditioning.

Now there are two sources of problems that can stem from classical conditioning. First of all we can learn some abnormal behavior. You may learn to be a fetishist by that chance association of some object like the sight of an erotic nude female; or by chance you may get fear conditioned to wallpaper and end up impotent. You learn a maladaptive response. But a second source of problems that can arise through classical conditioning is to fail to learn the correct response. And again, let me illustrate this with a chart.

CS	misbehavior	US	beating	UR	fear and pain

For most of us when we are beaten, the unconditioned stimulus, we become scared of our father perhaps, and we feel pain. We cry; we suffer discomfort. Let us say we commit some antisocial act. We steal from our parents, or we steal from a shop. What happens is that, after having stolen and being caught, we are beaten by our parent, and we experience fear and pain. Maybe the first time we steal and are punished by our parents, we wouldn't necessarily learn to feel fear and anxiety from the act of stealing. But maybe

we'll steal again and get beaten, and again, and again, and finally the act of stealing itself, the actual responses involved, perhaps even the thought that you're going to steal, elicits fear and anxiety. What do we call this? We call it a conscience. Whereas formerly just beating created fear and anxiety, now antisocial acts for which we were punished cause fear and anxiety. The psychopath, the criminal, the delinquent, has failed to learn this. Somehow these antisocial acts - stealing, beating up on other people, lying - are acts he did not learn to fear. It may be partly that his parents didn't punish him. He was not beaten. He was not made to suffer. It could be that even though they punished him, somehow the punishment did not take effect. For some reason he was a poor learner. Hans Eysenck argued that, in fact, psychopaths and delinquents and criminals have a deficit in their learning ability. They fail to learn through classical conditioning those important responses that we learn.

Classical conditioning not only can be used, in the eyes of the learning theorist, to create abnormal behavior. It can easily be used to do away with abnormal behavior. Again let me give you an example. Behavior therapists have devised a method of treating alcoholism. If you inject somebody with apomorphine, a drug, it leads to nausea and vomiting.

CS alcohol US apomorphine UR vomiting and nausea

To use this to cure an alcoholic, what you do is give the alcoholic a drink. You follow it by creating the nausea, make the alcoholic throw-up. You keep pairing these stimuli - you keep forcing alcohol on him and you keep forcing him to throw-up. Eventually, taking the drink, thinking about taking a drink, makes him feel nauseated and makes him throw-up.

You may have read of this treatment or seen it in a film called The Clockwork Orange, based on a novel by Anthony Burgess. Here they try to treat the protagonist, the hero in the film - to cure his violence by associating violence with nausea and vomiting so that, whenever he thinks of committing a violent act, he throws up. Anthony Burgess's novel is not very realistic. The protagonist in the novel, and in the film, did not want to give up this behavior of violence. Classical conditioning as a therapy does not work unless the person is motivated because it is very easy to consciously set your mind against the learning. Having learnt a new response (if it is possible), you can easily unlearn the behavior. Let us say we have an alcoholic who's been conditioned to throw-up at a drink. All he has to do, once he leaves the hospital, is to take a drink and throw-up. He takes another drink. Maybe he'll throw up. If he keeps taking drinks, eventually he will cease to throw up because the apomorphine drug is no longer reinforcing this behavior. He can easily extinguish his behavior.

For classical conditioning, aversive therapy, to work, the person has to be thoroughly motivated. Let me read you an example of how this treatment works. Raymond, a British psychologist, has reported a case of curing a fetishist who, as part of his behavior, attacked women’s pocketbooks and baby carriages. He liked to attack them,

ride his motorcycle into them, scratch them, destroy them, and these objects played a large part in his sexual fantasies. The man had been arrested many times. He was married, and he wanted to cure himself of this compulsive, irresistible behavior. When he was admitted to the hospital, the treatment was given every two hours, day and night! No food was allowed, and at night they used amphetamines to keep him awake. During this time, they showed him pictures of pocketbooks and baby carriages. They presented actual baby carriages in his room and made him throw-up every time he saw one. Every two hours! Day and night. No food allowed. You can imagine what state he would be in after several days of this. At the end of the first week of treatment, he was temporarily allowed home. He returned home to his wife for a week. When he came back, he was extremely happy because he reported that, for the first time, he had had sexual intercourse with his wife without the use of fantasies about pocketbooks and baby carriages.

They resumed the treatment. After five days of more treatment, he said the mere sight of the objects made him sick. He was now confined to his bed, and the prams and the handbags were continually with him. On the evening of the ninth day, he rang his bell and was found to be sobbing uncontrollably. He kept repeating, "Take them away" He appeared to be impervious to anything that was said to him. They finally removed the object with ceremony, and he was given a glass of milk and a sedative. After that he gave up some pictures of pocketbooks and baby carriages that he had carried around with him for years. By use of classical conditioning they had cured him of this behavior. The behavior now made him sick. It is important to remember that the man was motivated. He wanted to stop the behavior. Not only that, he had a supportive wife, a wife who encouraged him in this treatment and who actually provided him with an alternative sexual outlet, that of mature heterosexuality. So, bearing in mind these points, classical conditioning can be used to facilitate a cure, to unlearn a response that you have learnt.

The second major process that is central to the learning model is that of operant conditioning.

Operant Conditioning

In operant conditioning, it does not have to be some stimulus that automatically produces a response. All we have to do is wait for a particular response to occur and then react to it in some way. Commonly we say we reward the response, or we reinforce the response. Again let me illustrate this with a chart.

S R Reward/reinforcement

The person makes a response in the presence of a stimulus, and we follow this response with a reward or what we call a reinforcement. Let me give you an example. Let us say you have a small child, and at night you put him in bed, and he's alone. How might he feel? He might feel scared, anxious; he wishes Mummy would come up, and so he calls out. What happens if you don't come up - if you leave him in the dark, by himself, alone, so that he's scared? Maybe he rocks to and fro, and by chance one night he bangs his head. That provides some stimulation for him and maybe he bangs it again, and

downstairs you hear this and say, "What is that noise up in the bedroom? Is our baby banging his head?" You go up and you look. You reward his behavior by attending to him. You end his loneliness.

baby in bed   bangs head   attention/end of loneliness

You respond to him. "What are you doing?" The child learns that, when in bed alone at night, if he bangs his head, then you will come up, and he will no longer be alone. He will get attention.

You may say, "what happens if I go up, and I beat him? I say, don't you dare do that, and I hit him." Psychologists find that this is still a reward. The child may prefer, given a choice, for you to come up and hug him and kiss him and spend some time with him, but even if you come up and beat him, at least you are spending some time with him, he's getting attention, he's no longer alone. A lot of children will suffer the pain of a beating just to get the attention and the end of the loneliness.

Some 22% of all male children are found to bang their heads at some point in their childhood; but most parents somehow avoid reinforcing or rewarding this behavior, and only a very small percentage of young boys eventually turn into chronic head-bangers. Those boys have parents who, somehow, unwittingly, reinforced this behavior.

We can look at rewards and reinforcers as being of two kinds. The positive reinforcer is a stimulus that is pleasant, like hugging the child, paying attention, and the beginning of such a stimulus is a reward for the child. But there also are reinforcers that end something unpleasant. If a child has been lonely and scared and somebody comes up so that negative state ends, then that is also reinforcing, and we call that a negative reinforcer. It's important to note that psychologists don't think much of punishment because punishment is not a reinforcer. It doesn't reinforce any response that occurred before the punishment. It just makes the child suffer. Punishment is useful in classical conditioning, but not in this process of operant conditioning. To operantly condition a child, we want to give them reinforcers, give them pleasant things or end negative states. Socialization, growing up, can be seen as a process of shaping a child's behavior and, by accident, we can shape the wrong behavior. We reinforce, reward, an inappropriate, maladaptive behavior.

That is one source of maladaptive, abnormal behavior. We reinforce the incorrect response. We reinforce head-banging. We can also get maladaptive behavior by failing to teach the child a correct response, a socially appropriate response, calling out and saying, "I feel lonely, could you come up, could you come up and just be with me a while? Then I'll go to sleep."

Suppose unwittingly we reinforce head-banging. Operant conditioning can be used to cure people, to change behaviors. All we have to do is omit the reward or reinforcer. A very common example of this is parents who have children who, when they put them to bed at night, cry. If you left them to themselves, they might cry for hours, and

so usually parents let the child cry for a few minutes and then go up. Maybe they say, "Shut up!" or they soothe the child and come down. The child cries, and maybe you go back up. Some parents have children who cry for hours at night. How can they cure this? All they have to do is omit the reward, which in this case is going up and giving the child attention.

Obviously, the first night that you leave your child alone, they might cry for hours, three or four hours, before he eventually cries himself to sleep. But the parents should not go up. The second day, the child will also cry again, but it is likely that he will cry for a lesser period of time, and on the third day even less time. Eventually, on successive days, he will cry less and less until eventually the child will go to sleep when he is put to bed and not cry.

It is found that if you start this process and then, just once, go up and attend to the child, then you're back to square one. The child will start crying for hours again when you first put him to bed. You're changing your child's behavior of crying a lot at night by omitting the reward, omitting the positive reinforcement of giving the child attention. Many parents would say, "I can't do that. It makes me suffer too much myself." That is your choice. It is possible to change behaviors, if you want to, by omitting the reward.

This kind of system is used a lot in various kinds of institutions these days. Let us consider a psychiatric hospital. Nowadays, some wards in some hospitals are set up on what we call a token economy system. First of all, we make patients pay for certain privileges. We make them pay for their meals. We make them pay if they want to lie on their bed in the afternoon. We make them pay if they want to play ping-pong or pool. How do they get the money to pay? We give them tokens for doing certain things. For example, if the patient gets up and dresses himself and takes a shower, we reward him with a token. If the patient makes her own bed in the morning, we reward her for that. If we see patients talking to each other, social conversation, which is very rare among psychiatric patients, we give them tokens. We reward them with tokens whenever they emit a behavior that we consider would be useful to them, which resembles that of normal people. What can they do with these tokens? They can buy privileges, meals, cigarettes, candy, a nap in the afternoon if they want it. By appropriately giving them rewards, we shape their behavior, and also we ignore any maladaptive behavior.

If they show delusions or hallucinations, they regress, or they show odd motor movements, we just ignore it. We don't punish them; we don't reward them; we ignore it. We only reward the behaviors we want to make more common in them. In this way we can change their behavior and make the patients act more like those of us who are functioning outside of the mental hospital.

It is interesting at this point to mention why the model is so popular. The model is popular these days because it's very economical. One mental health professional can work with many, many patients. All the professional has to do is give rewards and positive reinforcers at appropriate moments. In fact, we can even use people like attendants, custodians, nurses or, if we're working in a jail, we can use the jailers, to run

token economies - to reward the prisoners or the patients at appropriate times. Whereas individual psychotherapy has a very high ratio of the staff needed to treat patients for a given number of patients, a learning model approach enables us to service a large number of patients with a very few mental health professionals, and we can even use relatively untrained people. This accounts in part for the popularity of the model. Today when everything costs more and more and inflation is rampant, token economy systems, re-teaching people using these simple techniques of operant conditioning and classical conditioning, is very economical.

Comments

There are some important comments that I would like to make about this model. First of all, in the learning model there is no difference between normal, adaptive behavior and maladaptive behavior. They're all learnt by the same principles of learning. All behaviors, whatever they are, are learnt through classical conditioning or through operant conditioning. Wherein then lies the difference between these two behaviors, normal and abnormal, adaptive and maladaptive?

The thing to remember is that the difference lies in the label that either you yourself or society gives to them. In this respect the learning model is congruent with the social model. It is you who label your behavior as abnormal. In my example of the fetishist who attacked the pocketbooks and baby carriages belonging to women, he said, "Help me! I don't want to have this behavior." He labeled it as inappropriate. At other times we might label it. "We don't like you behaving this way." "You, Mr. psychiatric patient, we don't like you lying in bed all day and looking sloppy and not earning a living. We label you disturbed and we want you to change your behavior."

If learning is involved, one question that has been asked is, “Why are abnormal behaviors so similar?" Why are there so many phobics? Why are there so many sexual deviants? If maladaptive behavior is due to chance circumstances, why aren’t there thousands of different kinds of abnormal behaviors? Here the learning model is very congruent with the social model. The idea is that we show a particular behavior, and then society gives it a label and begins to shape the behavior. Say you're a young boy and you act in a somewhat effeminate way. You don't play rough games. You prefer to sit at home and read. You play with dolls. Somebody eventually may label you. They may say, "You are a sissy. I wonder if that boy is going to end up homosexual." You are given the label, and that label begins to shape you behavior. "Maybe I am a sissy. They call me a homosexual. Maybe I am." You begin to channel your behavior into one of the diagnostic categories because that was the label given to you.[1] I've pointed out before in these lectures that the doctors that you talk to shape your behavior. "Have you ever had this symptom?" And you say, "Ah! That's a symptom I'm supposed to have had." Other patients that you might meet will shape your behavior. "I have these kinds of dreams. I have these kinds of problems. Do you have them?" You say to yourself, "Ah, that's the kind of behavior I should have."

[1] These lectures were given in the period when homosexuality was still a diagnosis in the DSM.

One other important factor is the effect of the institution, if we consider the institutionalized deviant. What is the effect of just being locked up? Maybe that makes everybody's behavior become very similar. Some psychologists have compared the behaviors of people that we lock up in institutions with those of animals who are locked up in zoos. When you take a wild animal and lock it up in a cage, what effect does that have on its behavior? Is that similar to what happens to a psychiatric patient put in a psychiatric hospital? Let me give you an example. The actual trauma of being captive, of being put in a closed ward, or if you're an animal being put in a cage, has certain effects on you. It makes you anxious. You become feverishly active. You pace up and down. You show certain symptoms, and these are the symptoms that are caused by the effect of being institutionalized.

Also, when you're put in a ward, if you're a psychiatric patient, and when you're put in a cage, if you're an animal, you nestle. That's the word we use. A certain chair becomes your chair, and you protect it against all other patients. For an animal a particular corner of its cage becomes the safe corner, the corner where it sleeps. You develop stereotype rituals. Animals, if you look at them in a zoo, pace back and forth in stereotyped patterns. If you go to an institution for the psychiatrically disturbed, you will see patients pacing up and down, in stereotyped patterns. Also, you get social competition in an institution. Who's the top dog in this ward? A social hierarchy, a pecking order, gets set-up, and this establishes particular behaviors. "This is my chair, no other patients can sit in that chair or else I'll beat them up." Patients avoid other patients, withdraw from other patients, because they are low in status, whereas these patients are high in status.

Finally, we might note that being put in an institution, just the same as when we put an animal in a zoo, creates for the patient an impoverished intellectual environment. People deteriorate intellectually. After years in a zoo for an animal, of after years in an institution for a human, they appear retarded because, there has been so little stimulation.

One final point to make is that the learning model is often criticized because the symptoms are treated rather than the underlying cause. You have a behavior that you want to get rid of? We can re-educate you, re-train you so that you'll no longer have that behavior. We cure the symptom. Someone like a psychoanalyst would say, "You eliminate the symptom but, if you haven't dealt with the underlying cause of that behavior, then the person will show another symptom very quickly. Whereas formerly they did this maladaptive response, now they will make this other maladaptive response." The debate continues still today.

LECTURE NINE: THE HUMANISTIC MODEL

So far, the ways in which we have looked at abnormal behavior have made it seem bad and undesirable - something we must be cured of. Is it possible to view abnormal behavior, such as mental illness, as creative states, times of growth, voyages of discovery? Today we are going to explore this possibility.

The five models of abnormal behavior that we have examined so far have been relatively specific, focused, organized ways of looking at abnormal behavior. A number of psychologists and psychiatrists reject these structured approaches. They stress concepts such as growth - the fact that people grow and develop values - "What is right? What is good? What should we aim for?" - concepts such as creativity and originality, existence, the meaning of life ("Why are we here?") and psychological health.

What does it mean to be psychologically healthy? Those who propose these concepts are often grouped together and called the humanistic psychologists, and the model is called the humanistic perspective, but it is a very different perspective from those that I have talked about so far. It has no complex theory, no system of postulates, no assumptions. Each scholar who takes this viewpoint develops his own theory and his own concepts, and so it is rather difficult to introduce you to this perspective. What I'm going to do today is introduce you to three scholars, each of whom can be seen as humanistic in their orientation and each of whom illustrates the way in which this perspective applies to abnormal behavior: Abraham Maslow, Ronald Laing and Carl Rogers. Let us begin with Abraham Maslow.

Abraham Maslow

Abraham Maslow is known as the founding father of the humanistic school of psychology. He began writing in the 1940's, and he made two basic points. First of all, he noted that psychologists as a whole study people who are unhealthy - people who have brain damage of some kind or people who are psychotics or neurotics and are being seen in treatment. Maslow has said, "What can we learn about normal people from the study of these unhealthy people?" He said that, if we study crippled people, we will develop a crippled psychology. Maslow suggested that we should study healthy people - those who are psychologically healthy or, in his terminology, self-actualized.

Self actualization is a very rare behavior, and it is a very difficult behavior to define. To try and illustrate what it means, Maslow has mentioned famous people whom he thinks are self-actualized - people like Aldous Huxley, Schweitzer, Einstein, Eleanor Roosevelt. He also tried to specify what the self-actualized person is like. For example, he has said that they are realistically oriented - they are in touch with reality. They do not delude themselves. They accept themselves and other people in the world for what they are. They're not trying to be somebody else other than they are. I am what I am! They are spontaneous. They are problem-centered rather than self-centered. They have an air of detachment and a need for privacy. They are autonomous and independent. Most of them have had profound mystical or spiritual experiences, although not necessarily religious in

character. Maslow has called these "peak experiences.” They identify with mankind. Their intimate relationships tend to be profound and deeply emotional rather than superficial. Their sense of humor is philosophical rather than hostile. They have a great fund of creativeness. They do not conform to the culture, and they transcend the environment rather than just coping with it. Maslow has argued that, if we were to study people like these, we would develop a very different view of human behavior and of abnormal behavior - a very different one than we would get if we studied those who are mentally disturbed - the psychotics and the neurotics of the world. So that is his first point.

The second point is that most psychology seems to focus on behaviors in which we are goaded or pushed into acting - things like hunger, sex and thirst, where something is driving us to behave in some way. Or perhaps we are running from fear and pain - a kind of push-pull psychology. Some deficiency exists and we try to remedy that deficiency.

Maslow said, isn't there more to life than that? Aren't there things we do for fun, out of curiosity? Aren't there times when we welcome our impulses - when we seek variety and novelty - when we play - when we solve puzzles? There, we're not being pushed or pulled or goaded into acting. We're acting spontaneously, out of fun. He calls these growth motives (as distinct from the deficiency motives), and he has said that psychologists focus on deficiency states not growth states. Take something like sex. Psychologists have studied sex in the laboratory in animals and in humans for many decades now. But what about love? Psychologists don't study love. It's a behavior that they don't seem to be able to cope with, to grapple with intellectually. They study a deficiency behavior, sex, rather than a growth behavior such as love.

These concepts are all very well, but how would we apply them to a discussion of abnormal behavior? Maslow once did a study of healthy women. He defined health simply, for his study, as being dominant - highly dominant instead of submissive - and having high self-esteem. He compared a group of women who were dominant and had high self-esteem, and he looked at their sexual behavior in particular. What he found was that these highly dominant women with high self-esteem committed every sexually “deviant” act that you could thin, but he did not see them as neurotic or driven or goaded. Let me read you how he described these women. “Very frequently in a marriage between high dominance people, it is found that there has been experience, if only a single experiment, with practically every form of sexual behavior known to the psychopathologist as well as the sexologist. These acts have no pathological tinge, nor are they pathogenic in any way. It would appear that no single sexual act can itself be called abnormal or perverted. It is only abnormal or perverted individuals who can commit abnormal or perverted acts. These healthy women performed acts that we sometimes call deviant. But they were healthy women, and the acts were performed in a healthy way, for fun, for growth, for experience, not out of deficiency needs.”

This is how Maslow, would apply his concepts, but Maslow has not developed his theory to the extent that some other people have, and for these I would like to move on and discuss the views of Ronald Laing.

R. D. Laing

Ronald Laing's important concept is that of experience. The crucial thing for us in our existence is how we experience ourselves, how we experience the world, and how we experience other people. Laing has said that life involves an alienation of ourselves from our experience. Let me give you a few examples. Think back to your childhood. How much do you remember? For myself, I remember very little before the age of twelve, and virtually nothing before the age of five. I have become alienated from my experience. I have forgotten it. It is no longer a part of my conscious awareness. Think about your dream life. How many times have you awakened and said, "I had this fascinating dream" and, by the time you've eaten your breakfast, you've forgotten it. Your experience has been taken away, repressed, pushed into unconsciousness. Think about the psychoanalytic defense mechanisms. We have an unconscious wish that we cannot, dare not, become conscious of, and we go through all sorts of maneuvers to try and avoid becoming conscious of it - we repress it, we sublimate it, we show reaction formation, we project it. Every defense mechanism, says Laing, involves an alienation of ourselves from our conscious experience.

Other people encourage us in this. Think of a time when you were depressed last. You were sitting there, feeling low and gloomy, and other people came by and said, "Come on, cheer up! Don't be gloomy. Let’s go do something." You are not permitted to feel depressed. It is an experience that you must reject, repress, forget. Think about the times you've been in love. Perhaps you were very young, or perhaps you're married and you've fallen in love with somebody else outside of your marriage. What do people say? "That's not love that you’re feeling. Your experience is not real. It's infatuation, or puppy love, or lust." They help us deny the validity of our experience.

What are the consequences of denying this experience? Laing has put it very dramatically. "If we are stripped of experience, we are stripped of our deeds. And if our deeds are, so to speak, taken out of our hands, like toys from the hands of children, we are bereft of our humanity.” Our experience is central to us, and we must not run from it.

Laing has also noted how we take into account how other people experience us. We are not only concerned with our experience but with what we think other people are thinking. Here is an example that he has given.

John and Mary have a love affair and, just as they are ending it, Mary finds she is pregnant. Both families are informed. Mary does not want to marry John. John does not want to marry Mary. But John thinks Mary wants him to marry her. Mary doesn't want to hurt John's feelings by telling him that she doesn't want to marry him. She thinks he wants to marry her, and that he thinks she wants to marry him. Their actions are all determined by "How are they thinking of me; how are they experiencing me?" They do

not act out of their own experience which is “I don't love this person. I don't want to get married." In this situation the parents come into it. What do the parents think? What do the neighbors think? The boy’s father is worried about what the girl's mother will think of him. The girl’s mother is worried about what everyone will think of her. The boy is concerned with what the family thinks he has done to his father. And so on and so forth. It goes on until we are completely alienated from our experience.

Laing has argued that health lies in getting back in touch with our experience. He has suggested that the experience of the disturbed person, even the psychotic, even the schizophrenic, is an experience that we should value, and that we should encourage the schizophrenic in this experience. We should view it almost as a voyage of discovery. Our role with the schizophrenic, the neurotic or whoever, is to help guide him on this voyage, like a pilot guiding a ship. He has said that most psychologists, psychoanalysts and psychiatrists say, "Don't feel that experience. We're going to brainwash you of that experience. We are going to give you an electroconvulsive shock, psychotherapy, tranquilizers, antidepressants, put you to sleep for a week, anything to deprive you of that experience.” Laing would take you through that experience. One schizophrenic once put it like this: "Living with schizophrenia can be living in hell. But seen from another angle it can really be living. For it seems to thrive on art and education. And it seems to lead to a deeper understanding of people and living for people.” A schizophrenic says that it wasn't fun; it was hell. But it's a valuable experience to go through, perhaps. Let me give you another example. What would happen if you heard two schizophrenics talking?

JONES (laughs loudly, then pauses): I'm McDougal myself. (This actually is not his name.)
SMITH: What do you do for a living, little fellow? Work on a ranch or something?
JONES: No, I' a civilian seaman. Supposed to be high muck amuck society.
SMITH: A singing recording machine, huh? I guess a recording machine sings sometimes. If they're adjusted right. Mm-hm. I though that was it. My towel, mn-hm. We'll be going back to sea in about-eight or nine months though. Soon as we get our destroyed parts repaired. (Pause)
JONES: I've got lovesickness, secret love.

And the conversation goes on in which they do not seem to be talking to each other. We listen to it, and we say, "I don't understand that conversation. They are crazy.” But what we have done is made our ignorance into their symptom. Laing would say, "Think about it and get to know those people. Decipher what they are saying. Get into their experience and then perhaps you won't be ignorant anymore. But don't invalidate their experience by saying, I don't understand it. They must be crazy.”

What does this mean in reality? One researcher, Wilson van Dusen, has demonstrated what it might mean. He was interested in what schizophrenics experience - their hallucinations - and he wanted to find out about their hallucinations by talking to them. He got a group of patients in a mental hospital and told them that he was interested in finding out about their experience - not labeling it and not judging it. He didn't hold

out any hope that, if he got to know their experiences, he could help them. He said, "I want to know what you are thinking," and so he talked to them.

Most of them, at first, were very embarrassed about their hallucinations. They know that they hear voices that nobody else hears. When they first heard these voices, they were very frightened. The voices often came on very suddenly. They said, "What is that? What am I hearing? Do other people hear it?" They don't like to talk about their hallucinations.

Van Dusen had to work a long time with them to gain their trust and their confidence. What did he find out? He found out that they often refer to these voices as if they were other beings. They called them names like "The Eavesdroppers," "Other Beings," as if they're from another world. Van Dusen distinguished two kinds of voices. The first kind he called lower order voices, and they sounded like drunken bums. These voices plotted, threatened, insulted, made obscene statements to the patients. Let me give you some examples. One man heard voices teasing him for three years over a ten-cent debt that he once had but had paid off. One patient heard voices plotting his death over a period of weeks. Some patients reported that they were shouted at constantly by dozens of voices. Now stop and think. If you heard voices plotting your death over a period of weeks, how would you feel? You're sitting in a room and you hear voices discussing how to kill you. Can you get into that experience and see how the schizophrenic might react as a result of that? It is frightening, it is fearful, and you know that other people do not hear those voices, and yet how do you explain it?

Van Dusen also distinguished what he called, higher order voices - a different kind of hallucination. Let me give you an example of this. One man who heard voices plotting to murder him also had a light come to him at night, like a sun. When he approached the friendly sun, he found himself in a corridor with doors behind which raged the powers of hell. He was about to open one of the doors and let the powers of hell out, when he was approached by a Christ-like figure who counseled him to leave the doors closed and to follow him. This higher-order hallucination was a comforting one, a supportive one, and a guide. But the fact is that most of the hallucinations that the schizophrenic hears are the lower order ones - the insults, the threats, the voices shouting at you constantly. Van Dusen hasn't helped the patients. We have no idea how to cure them now or what to do with them, but he has tried to get into their experience. "What are they feeling? What are they experiencing? For only then can I understand them."

A good example of what this might mean has been provided by a psychiatrist, Marguerite Sechahaye, who worked with a schizophrenic girl called Renee, who wrote her autobiography after she recovered. Renee at one point moved in with Sechahaye, and Sechahaye treated Renee in her own home. Let me give you an example of how the interaction went on. One day Renee began to refuse to eat - especially she refused to eat some apples that had been bought for her. But when she went out, she went into a farmer's orchard, and she stole some apples from the tree. Those she would eat. But she was caught by the farmer and, as he chased her out of the field, she ran back to her room, and this is how she describes her experience.

> The horror that gripped me on hearing these words is impossible to describe. Shame, rage, the deceit, and above all an intolerable burden of blame struggled in my heart. Prostrated on the floor, in the darkest corner of my room, I wept and cried out in anguish. The most appalling misfortune seemed to have befallen me. Completely abandoned, stripped, I was persuaded that a will, an irresistible authority, wished me dead. The one favor, my only remaining sanction, had just been brutally wrenched away and my awful guilt put in its place.

What does Sechahaye do? What Sechahaye tries to do is to get into contact with Renee's experience and to try and help her by getting into this experience. Renee calls her therapist Mama, and her therapist allows her to call her Mama. Renee is twenty-two years old at this point, but she calls Sechahaye Mama.

> Mama tried affectionately to calm me, but without success.' Why," she said, "don't you take my apples, the ones that I bring you?" I can't do that Mama," I answered. And while in my heart I was outraged that Mama, too, wanted to force me to eat, my eyes fell to her bosom. And when she insisted, "But why don't you want the apples that I buy you?" I knew what I was yearning for. And I was able to say, "Because the apples that you buy are food for grown-ups. And I want real apples, Mama's apples, like those," and I pointed to her breasts.

What does Sechahaye do? She doesn't say, "That's nasty. You can't think that! I'm going to feed you with a knife and fork."

> She got up at once to cut a magnificent apple. And she cut a piece off and gave it to me saying, "Now Mama is going to feed her little Renee. It is time to drink the good milk from Mama's apples." And she put the piece in my mouth and, with my eyes closed, she held my head against her breast. And I ate, or rather I drank, my milk. And it was as though suddenly, by magic, all the agony, the tempest which had shaken me a moment ago had given place to a blissful calm. I thought of nothing. I discerned nothing.

What did Sechahaye do? She breast-fed her symbolically by holding her close to her breast and feeding her apples. The important thing to remember here is that this perspective encourages her to get into that experience - not to say that the experience is illogical, nonsense, ignorant, crazy, but to say that it has meaning. It is very difficult to understand that meaning. It is very difficult to talk to the schizophrenic in the language that the schizophrenic uses. But it is crucial to do so if we are going to help that schizophrenic.

Other kinds of treatments are seen as brainwashing, denying the schizophrenic of his experience, indoctrinating them to think as we do. The hope is, if we don't do that, if we let them experience their voyage of discovery, they will recover and return to the symbols that we use and to the society as we know it. Let me move on to Carl Rogers.

Carl Rogers

Carl Rogers is unique in that he has proposed a slightly more well-formulated and organized theory. His basic assumption is that the little child is born with an innate tendency to self-actualize itself - to grow, to be curious, to develop its potential to be what it can be. As it grows up, it gradually forms a self-concept. The little baby begins to realize that there is a me and that the me is different from you. There is me, an inside world, and you, an outside world. At this point, he becomes dependent upon what you think of him. “How do you view me? Do you like me?" How can the parents respond at this point?

Most parents respond by setting up conditions of worth, or what Rogers has called Conditional Positive Regard. I like you IF. "I don't like little boys who do that." "I don't like you when you say that." "My son will get good grades." "My daughter will be pretty." These are conditions of worth and, if you don't meet these conditions, then you will not be loved. As you grow up under these conditions, you set up standards for yourself. “To be nice, to be liked, I have to be this." "I have to be that.” But we can't always be this or that. Often a discrepancy forms between our experiences and our conditions of worth. "Daddy only liked us when we got straight A's," and therefore we only like ourselves when we get straight A's. What happens one day when we fail a course - maybe we get a B?

There is a discrepancy between the experience, the B, and our conditions of worth. To be loved, I have to get A's. Rogers says that this incongruence creates anxiety, and that abnormal behavior is a result of ways in which you try to defend against this anxiety. Perhaps we deny the information, "Oh, I didn't really deserve a B; I was sleepy." We excuse it away; we rationalize. The defense mechanisms are ways of avoiding, of reducing this discrepancy between our experience on the one hand and our conditions of worth on the other.

If the anxiety is acute, if it comes on suddenly, and if it comes on in huge amounts, we may become psychotic. Rogers says the best example of the person in this situation is the person who has delusions of grandeur. "I am Jesus Christ." "I am Napoleon." "I am the President of the United States." This person has faced so big a discrepancy that he has rejected himself completely. I am not me; I am not David Lester; I am the president; I am someone else because the discrepancy, the incongruency is too great to cope with.

What is a solution? The solution, the way to prevent this happening, is to give unconditional positive regard. "I love you, little baby, no matter what you do. I always love you. I may not like that habit. I may not like certain things you do , but I always love you. Unconditionally!”

I remember a student I once knew who had an elder brother who went to what is considered to be one of the best boys’ schools in the country. She, as a girl, could not go. She went to perhaps what is the best girls’ school, and she felt that she was a failure. Her

conditions of worth said that she had to go to the best school in the country, and she couldn't because she was a girl. When another leading male school went, co-ed she decided to apply. I tried to point out to her that the conditions of worth had been set by her parents and that she would never be able to satisfy them. She would never get to the school that her brother went to – she would never be her brother – that it was no good transferring to this boys' school – that it really wouldn't help. But I didn't manage to communicate this. She transferred, and sure enough it didn't help. A year-and-a-half later she seriously attempted suicide, and she had to be hospitalized by her parents in a psychiatric hospital. She was still trying to meet those conditions of worth and failing, and it produced more and more unhappy, maladaptive behavior.

Comment

Let me make some comments about this model. The first point to make is that it stresses that people are good and wise. People, left to themselves, will self-actualize, will grow. It almost becomes a political stance. People such as Freud and his psychoanalytic model stress our unconscious, primitive impulses and see us as bad or evil. The humanistic perspective says, "No! People are good."

Why do people not end up good? It is because society, primarily our parents, ruins us. Because of the way they treat us, they lead us to be unhappy, depressed; they make us aggressive. With the right kinds of parents and with the right kind of society, we would grow and be healthy. So the humanistic psychologist often becomes politically involved, antagonistic to society, resistant to society's impositions on us. There is no evidence that people are born good just as there is no evidence that people are born bad. It's a point of view.

Secondly, the model defines growth and health absolutely. Maslow knows what healthiness is. It forgets the important point that what is healthy in one culture may not be health in another culture. I often wonder what would happen if Maslow went to Japan, or maybe to a Zen monastery. Would they consider him to be healthy? Each culture defines health in its own way, but the humanistic perspective sees health as something clear, indisputable.

Finally, it is worth noting that the humanistic perspective is provocative. It provides a very contrasting point of view. It shakes us in our opinions and keeps us on our toes. Maybe I am viewing abnormal behavior incorrectly? Maybe I shouldn't devalue the schizophrenic? Perhaps a schizophrenic is sometimes saner than I am. I must always be alert to that possibility.