

50 psychology ideas

you really need to know



Adrian Furnham

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Introduction

Psychology has its advocates and detractors. Some think of it essentially as the “queen of the social sciences” whose progress, insights and applications are keys to health, happiness and progress. Detractors see psychologists as deluded and even dangerous perpetrators either of commonsense or wrong ideas and practices.

The official birth of psychology was in the 1870s. Psychologists have been highly regarded international figures of influence. It could be argued that along with Darwin and Marx, Freud was the most influential thinker of the 19th century. Watson, Skinner, Milgram and others had a high impact on the way people do everything from raise and educate their children to how they select and manage people at work. And in the 21st century, a psychologist, for the second time, won the Nobel Prize for Economics.

Psychology is everywhere in today’s society. No crime fiction, documentary, chat show, or medical consultation is complete without the introduction of a psychological angle. The design of your car, your house, your choice of clothes, consumables and partners, the way we teach our children—all have been the topic of, and influenced by, psychological research. It also has an accepted role in management, sports and consumer marketing.

Psychology is both a pure and applied science. It aims to understand behavior and the basic mechanisms and processes that influence ideas, feelings and thoughts. It also tries to solve human problems. It is very multidisciplinary, having close connections with many other subjects including anatomy, medicine, psychiatry and sociology as well as economics, mathematics and zoology.

Newcomers to psychology are often surprised by the range of things that psychologists study—from dreaming to delusions of grandeur; computer phobia to the causes of cancer; memory to social mobility; attitude formation to alcoholism. Importantly and usefully, psychology teaches people a rich vocabulary through which they can describe and explain behavior: psychology teaches the student the language of behavioral description and explanation.

Some psychological theories are counterintuitive and some are quite commonsensical. I hope that in this book I have made sense of the former and clarified the latter.

01 Abnormal behavior

Abnormal psychology—also referred to as clinical psychology—is the study of abnormal behaviors. It looks at the origins, manifestations and treatments of disordered habits, thoughts or drives. These may be caused by environmental, cognitive, genetic or neurological factors.

Abnormal psychologists are concerned with the assessment, diagnosis and management of psychological problems. They are both scientists and practitioners who often specialize in the treatment of various disorders like anxiety disorders (anxiety, panic, phobias, post-traumatic stress disorders); mood disorders (depression, bipolar disorder, suicide); substance disorders (alcohol, stimulants, hallucinogens, etc.); or very complex problems like schizophrenia. Clinical psychology is a part, but by no means the central part, of psychology. It is certainly associated by lay people as the most interesting and important specialism in applied psychology.

Defining abnormality While it is relatively easy to spot people who are distressed or acting bizarre, it is much more difficult to define abnormality. “Abnormal” means departure from the norm. So very tall and very short people are abnormal, as are very backward and very gifted people. Thus, strictly speaking, Einstein and Michelangelo were abnormal, as were Bach and Shakespeare.

For clinical psychology, the issue is not so much whether the behavior is abnormal, as whether it is maladaptive, causing a person distress and social impairment. If a person’s behavior seems irrational or potentially harmful to themselves and others, we tend to think of that as abnormal. For the psychologist it is called psychopathology; for the lay person, madness or insanity.

We would all like the certainty and clarity of a precise distinction between normal and abnormal. Yet we know that history and culture shape what is considered abnormal. Psychiatric textbooks reflect this. Homosexuality was not that long ago considered a mental illness. Masturbation in the 19th century was thought of as abnormal.

“The years have layered onto this term (i.e. abnormal) too many value judgments and any number of synonyms are preferable: maladaptive, maladjusted, deviant, etc.”

A. Reber, 1985

Socio-economic status, gender and race are all related to abnormality. Women are more likely to have anorexia, bulimia or anxiety disorders than men, who, in turn, are more likely to be substance abusers. Poor people are more likely to be diagnosed schizophrenic than rich people. American children suffer a high incidence of disorders of undercontrol compared to overcontrol, but that is the opposite way around in the West Indies.

Early approaches to abnormality saw bizarre behavior as spirit possession. People believed in animism—the belief that we are similar to animals—and that madness was the result of uncontrolled regression. Ancient Greeks saw abnormality and general malaise as caused by bodily fluids or “humors.” As a result, early treatment of the insane was mostly involved in segregating them and then punishing them. Humane treatment didn’t really appear until the 19th century.

Generally agreed-upon criteria Today, psychological definitions of abnormality revolve around a handful of generally agreed-upon criteria. These have been classified as the 4Ds: distress, deviance, dysfunction, danger. Abnormality generally involves pain and suffering, one aspect of which is acute and chronic personal suffering. One criterion is poor adaptation—not being able to do the everyday things of life, such as hold down a job, maintain happy interpersonal relationships or plan for the future.

A very common criterion is irrationality—bizarre, illogical beliefs about the physical or social world as well as, very often, the spiritual world. The behavior of abnormal people is often incomprehensible to others. They are often unpredictable; they can be very volatile, changing from one extreme to another and often quite unable to control their behavior. Their behavior is often very inappropriate.

Almost by definition their abnormality is characterized by unconventional, usually rare, undesirable behaviors. In addition, abnormality has a moral dimension. It is associated with breaking rules, violating moral standards and disregarding social norms. Illegal, immoral, undesirable behavior is abnormal.

One rather interesting criterion of abnormality is the discomfort that is generated in people around abnormal behavior. Observers often feel uncomfortable around clear evidence of abnormality.

“She always says she dislikes the abnormal, it is so obvious. She says the normal is so much more simply complicated and interesting.”

G. Stein, 1935

The problems of the concept The problems with any definition of abnormality are clear. Firstly, a healthy person in an unhealthy society is often labeled as abnormal. There are many examples where societies have been deeply intolerant of those who don't obey their narrow (unhealthy, maladaptive) standards of belief and behavior. Secondly, of course, expert observers can't agree on the categorization of normal vs. abnormal. Even when multiple criteria of abnormality are specified, there remains fundamental disagreement about whether a person is considered in some sense abnormal. Thirdly, there is the actor-observer difference: who is to make the judgment? Actors rarely think themselves abnormal: most of us are reasonably positive about ourselves and indeed have a great deal of information others do not have. Yet there are well-known traps and hazards in making a self-diagnosis. It is easier to be observers and label others abnormal, particularly those different from us or threatening to us.

Self-diagnosis A primary goal of counseling, training and therapy is helping people become more self-aware. Clearly some mentally ill, and supposedly normal people, have little insight into their problems. They seem deluded. Equally students of abnormal psychology say they recognize that they have certain mental illnesses when they read textbooks. This occurs because many of us have an exaggerated sense of the uniqueness of some private, nonshared, even “forbidden” or disapproved-of thoughts or behaviors. All of us hide certain aspects of ourselves and can suddenly see these alluded in textbooks that list all sorts of abnormal behaviors.

Normality vs. abnormality

Subjective This is perhaps the most primitive idea that uses ourselves, our behavior, our values as the criteria of normality. This is the stuff of idiom and adage (“once a thief, always a thief”; “there’s nowt so queer as folk”). So people like us are normal, those different are not. This approach also tends to think in simple categories or nonoverlapping types: normal-abnormal-very abnormal.

Normative This is the idea that there is an ideal, desirable state of how one should think and behave. This view of the perfect world is often developed by religious and political thinkers. Normality is perfection: the further from normality one is, the more abnormal. It’s a more “what ought to be” than “what is reasonably possible” state of affairs. Nothing is normal because nobody is perfect.

Clinical Social scientists and medical clinicians attempt to assess the effectiveness, organization and adaptiveness of a person’s functioning. Much depends on which dimension is being assessed. Clinicians also accept that the normal-abnormal distinctions are gray and somewhat subjective, though they strive for reliable diagnosis. Abnormality is usually associated with poor adaptations, pain or bizarre behaviors.

Cultural Culture dictates trends in everything from dress to demeanor, language to love. Culture prescribes and proscribes behaviors. Certain things are taboo, others are illegal. Again the further away or different from cultural norms a person appears to be, the more he or she is judged as abnormal. However, as cultural beliefs and practices change, so do definitions of normality. The case of homosexual behavior nicely illustrates this issue.

Statistical All statisticians know the concept of the bell curve or the normal distribution. It has particular properties and is best known in the world of intelligence. Thus a score of 100 is average and 66 percent of the population score between 85 and 115, and around 97 percent between 70 and 130. Thus if you score below 70 and over 130 you are unusual, though the word “abnormal” would not be applied. This model has drawbacks in the fact that behavior that occurs frequently does not necessarily make it healthy or desirable. Also, while it may work for abilities which are reasonably straightforward to measure, it works less easily with more subtle and multidimensional issues like personality or mental illness.

the condensed idea

What is “normal” behavior?

timeline

1600 First challenge to practice of witchcraft

1773 First mental asylum built at Williamsburg, USA

1890s Hypnosis, psychoanalysis starts

1940s Behavior therapies used

1952 First good diagnostic manual printed

02 Placebo effect

Doctors have been known to advise: “Take two tablets and call me in the morning. Although they know and acknowledge the idea that all (physical) treatments have active ingredients or procedures that produce physical changes in a patient, they know also of the power of psychological factors to cure all sorts of things. The concept of mind over matter in the world of health has been known for centuries.

What is it? “Placebo” comes from the Latin word meaning “to please.” A placebo is simply defined as a preparation with no medicinal value and no pharmacological effects. An active placebo is one that mimics the side-effects of the drug under investigation but lacks its specific, assumed therapeutic effect.

**“The sound of the flute will cure epilepsy and sciatic gout.”
Theophrastus, 300 BC**

Some believe placebo effects are more effective for psychological rather than physical illnesses. One important recent study showed that nearly 60 percent of placebo-controlled patients did better than average waiting-list control patients, showing the power of the placebo.

History Modern research in the area is usually attributed to a paper written in the American Dental Association Journal over 50 years ago. Henry Beecher shocked the medical world by claiming that just placebo procedures like giving sugar pills or even sympathetically physically examining the patient would lead to an improvement in 30 percent of patients. Today that estimate has increased to between a half to three-quarters of patients, with all sorts of problems from asthma to Parkinson’s showing real lasting improvements from a range of treatments.

Curing everything?

Placebos administered in an orthodox medical context have been shown to induce relief from symptoms in an impressively wide array of illnesses, including allergies, angina pectoris, asthma, cancer, cerebral infarction, depression, diabetes, enuresis, epilepsy, insomnia, Ménière’s disease, migraine, multiple sclerosis, neurosis, ocular pathology, Parkinsonism, prostatic hyperplasia, schizophrenia, skin diseases, ulcers and warts.

Different placebos One question is: what type of placebo works best? The color and size of capsules and pills have been repeatedly subject to experimental manipulation, but with little reliable impact. It does not seem to make much difference. One scientist reported that for a placebo to be maximally effective it should be very large and either brown or purple or very small and either bright red or yellow.

More serious, “major” or invasive procedures do appear to have stronger placebo effects. Injections per se appear to have a greater impact than pills, and even placebo surgery (where people are cut open and sewn up with little or nothing done) has yielded high positive response rates.

The style of treatment administration and other qualities of the therapist appear to contribute substantially to the impact of the treatment itself. Those therapists who also exhibit greater interest in their patients, greater confidence in their treatments, and higher professional status, all appear to promote stronger placebo effects in their patients.

“Kinship is healing: we are physicians to each other.”
Oliver Sacks, 1973

How do they work? The fascination with placebo effects has led to many ideas and theories as to how they actually work. All sorts of concepts have been proposed, including operant conditioning, classic conditioning, guilt reduction, transference, suggestion, persuasion, role demands, faith, hope, labeling, selective symptom monitoring, misattribution, cognitive dissonance reduction, control theory, anxiety reduction, expectancy effects and endorphin release.

“It is the confession, not the priest that gives us absolution.”
Oscar Wilde, 1890

Randomized, double-blind, control trials The placebo effect is both a blessing and a curse. It's a blessing for all therapists irrespective of what treatment they prescribe. It's a curse for scientists who try to evaluate the real effect of interventions. The placebo controlled, randomized, double-blind study has become the gold standard of scientific research to assess therapy and “discount” any placebo effects.

The idea is that people are randomly sent to different groups, some of which are control groups having no treatment, alternative treatment or placebo treatment. Further, neither the doctor/scientist/therapist nor the client/patient knows which treatment they are receiving.

The first randomized, controlled trial took place soon after the Second World War. But it wasn't until 20 years ago that “blinded” studies were introduced. It was recognized that because psychological factors may affect the response to treatment, the patient should be kept “blind” to the nature of the treatment they got. Where both patient and clinician are unaware of the nature of the treatment (drug versus placebo, for instance), the trial is referred to as double-blind. Where the clinician is aware, but the patient is not, the trial is single-blind.

Problems Yet the placebo controlled, randomized, double-blind approach does have its difficulties. First, problems may arise because subjects randomized to different treatment groups may meet and discuss their treatment. Assignment to natural groups (e.g. comparison to two schools or two geographical regions) may be preferable to randomization. Next, blinding may not be feasible for some treatments. While neither doctor nor patient may be able to distinguish a real tablet from a sugar pill, placebo tablet, there are no clear equivalents to placebo drugs for some treatments. Third, participation in a study may affect the behavior of people taking part. Simply being monitored and assessed regularly may in itself have a beneficial effect.

“The best of healers is good cheer.”
Pindar, 500 BC

Fourth, participants agreeing to take part in a trial may not be typical of the general population of

patients with that particular problem. Entry criteria to a trial need to be strict to ensure comparability between groups and to give the best chance of showing a treatment benefit. Another problem is the reduced compliance with treatment because of the possibility of receiving placebo treatment. If patients are told that they might be taking a placebo, they might be more inclined to give up on the treatment if there are no immediate effects.

Sixth, using standard treatment in the trial may be artificial and have little relevance to the clinical practice. This may inhibit a more flexible patient-centered approach. The trial may therefore not be a true test of the therapy as used in clinical practice and the needs of the patient may conflict with the requirements of research. Next, individual variations in response are often ignored in an analysis that only considers average group responses. Patients who are made worse by the treatment may not be given enough attention in the reports, unless they suffered particularly obvious side-effects.

Eighth, ethical problems may arise in a variety of contexts, particularly where placebo treatments are involved or the patient or clinician has a marked preference for one treatment option over another. Ninth, the main outcome measure, based on clinical assessment and objective tests, may not reflect the patients' perspective of what constitutes an important and beneficial change. Patients may be more concerned with the quality of their lives, which may not be closely linked with changes in biochemical parameters or other disease indicators. Finally, the concern with eliminating the placebo effect when assessing a treatment in relation to a comparable placebo may mean that important psychological variables are neglected. Therapist characteristics and the attitude of the patient to treatment are seldom examined in a medical context, and yet may be important determinants to the patient's compliance with treatment and attitude toward illness.

“Medicine cures the man who is fated not to die.”
Proverb

the condensed idea

Susceptibility affects treatment outcomes

timeline

- 1500–1900** Therapeutic properties ascribed to all sorts of substances
- pre 20th century** All medicine until modern times is the history of the placebo
- 1950s** First research into the placebo
- 1960s** Placebo controlled trials used
- 1980s** 80 percent of doctors still admit to using placebos

03 Kicking the habit

“Every form of addiction is bad, no matter whether the narcotic be alcohol or morphine or idealism.” Carl Jung, 1960

Most people think of addictions primarily in terms of drugs. There is a long list of substances that people can and do become addicted to. These include alcohol, stimulants (like cocaine), opiates, hallucinogens, marijuana, tobacco and barbiturates.

Addiction involves the exposure to something and then the behavior seeking to repeat the experience very often. Over time the addiction becomes established. There is regular and increasing consumption with the takers knowing their habit is expensive, unhealthy and possibly illegal but seemingly being unable to give it up. It is a complex process that involves biological, psychological and social factors

“We drink to one another’s health, and spoil our own.”

Jerome K. Jerome, 1920

Some addiction researchers are interested in why some particular drugs or activities have such a propensity to become addictive. Others are fascinated by why some individuals seem more susceptible than others. Some scientists are concerned with the environmental and social conditions and features that make addictions more or less likely, while others look at attempts at recovery, and relapse from addiction.

Dependence vs. abuse With regard to drugs, the psychiatric literature distinguishes between substance dependence and abuse. Both have technical meaning. Dependence has very specific characteristics like tolerance (people take more and more for limited effect); withdrawal symptoms (on not taking the drug); obsessions with trying to get hold of the drug; a deterioration in all social, occupational and recreational activities; and continued use with full knowledge of all the damage that is being done.

Abuse means using the drug despite the need to fulfill various school, home and work obligations; use in dangerous situations (driving, at work); use despite illegal behavior; use despite persistent negative side-effects.

Smoking

The two most discussed addictions are cigarette smoking and alcohol consumption. In most Western countries around a quarter to a third of people still smoke, and smoking is thought to cause a third of all cancers. Smoking is now a “stigmatized habit” which has many causes. The factors that lead a person to start smoking (social pressure, role models) are often different from those that cause them to continue. Nicotine is a powerful stimulant: it increases heart rate and blood pressure; it decreases body temperature; it changes hormones released by the pituitary gland, and it releases adrenalin. The release of dopamine in the brain makes it reinforcingly addictive. More importantly, people continue because of the unpleasant withdrawal symptoms that occur—anxiety, headaches, irritability and insomnia. Quitting smoking has immediate and long-term effects.

Many individuals try to reduce and give up smoking. Governments use advertising bans, restrictive sales and consumption sites and price increases, with modest effects, as well as health and education campaigns. Individuals try everything from nicotine replacement patches and gum; psychotherapy and hypnosis; and finally just plain willpower. Because many factors—visual, olfactory, physiological and social—trigger the need for a cigarette, many smokers find it impossible to kick the habit.

The addictive personality The original idea was that people had some particular profile or flaw or vulnerability that made them prone to specific or all addictions. However, the concept has not been successful. Some psychiatrists see addiction as a consequence of mental illness like depression or antisocial personality disorder. The idea is that risk-takers or the mentally ill are vulnerable to becoming reliant on drug taking as a crutch. They are more likely to experiment and ignore or downplay any potentially adverse consequences.

Therapists also point out how addicts and drug-dependent people use drugs to compensate or cope. Drugs are used to numb feelings, reduce painful emotional states or reduce internal conflict. It may help loneliness or make up for a lack of gratifying relationships with others. Drug takers feel they can only say and do things when under the influence of the drugs and therefore, in time, they become dependent on the specific drugs for effective social functioning.

“Drunkenness is simply voluntary insanity.”

Seneca, 60 BC

Genetic vulnerability Addictions run in families. Thus the children of alcoholics are four times more likely themselves to be alcoholic than children of nonalcoholics. Twin studies have clearly indicated that substance abuse has genetic determinants. It is likely that complex genetic factors lead to an individual’s particular biological response to drugs, probably specifically around neurotransmitter systems. So people may be self-medicating with drugs that “correct for” a biochemical imbalance in the brain that they have inherited.

Opponent-process theory This theory states that systems react and adapt to stimuli by opposing the initial effects. A desire, then craving, for something which did not exist before any experience of the drug, increases with exposure to it. A number of phenomena are associated with all addiction and

dependence. The first is affective pleasure—a physical and emotional hedonic state that follows use. ~~could be relaxation, or stress release, or just feelings of sudden energy.~~ Then there is affective—tolerance, which means that one needs more and more of the substance to have the same effect. The third, is affective withdrawal, which is what occurs if the drug is not taken.

So the drug causes a process which sets off an opposite reaction which grows in strength with repeated exposure. This is affective contrast. With more use, the dominant reaction is negative. So one needs the drug to achieve a neutral state and little pleasure is derived from taking the drug.

“Cocaine isn’t habit-forming. I should know—I’ve been using it for years.”
Tallulah Bankhead, 1960

Positive-reinforcement theory Drugs can make one feel good, even euphoric. In the 1960s psychologists allowed monkeys to “self-administer” morphine and they showed all signs of addiction. Psychologists have become increasingly interested in the drug reward pathways in the brain, particularly the brain regions and neurotransmitters that may be involved in “natural rewards” like food and sex versus artificial stimulants like drugs and electrical brain stimulation. We know that drugs like cocaine and amphetamines increase synaptic dopamine in the brain region called the nucleus accumbens. So lots of drugs give us real highs that we want to repeat.

Learning theories Drug-taking and the pleasures associated with it become associated with very specific situations, sights and sounds. Thus people associate the drugs from alcohol to amphetamines with very specific cues or reminders. Put people in particular settings and they will experience drug cravings—so pubs for alcoholics or the smell of smoke for nicotine addicts, induce cravings. Cues that deliver impending drug delivery can induce strong desires which “have to be” fulfilled. In many senses this is the old-fashioned behaviorism and conditioning theory.

Psychiatric criteria for substance dependence

A maladaptive pattern of substance use, leading to impairment or distress, as manifested by many of the following, occurring at any time in the same 12-month period.

1. Tolerance, meaning either a need for markedly increased amounts of the substance to achieve intoxication or desired effect and/or markedly diminished effect with continued use of the same amount of the substance.
2. Withdrawal showing as withdrawal syndrome for the specific substance or where the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms.
3. The substance is often taken in larger amounts or over a longer period than was intended.
4. A persistent desire or unsuccessful efforts to cut down or control substance use.
5. Much of the time is spent in activities necessary to obtain the substance, or recover from its effects.
6. Important social, family, occupation or leisure activities are given up or reduced because of substance use.
7. Substance use is continued despite clear knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

the condensed idea

The mind causes and cures addiction

timeline

1875 San Francisco bans opium

1919–33 Prohibition in USA

1935 Founding of Alcoholics Anonymous

1960s Counterculture advocates psycho-active drugs

2000s Widespread bans on smoking in public places

04 Lost touch

Most people are terrified by the prospect of meeting a schizophrenic. They are thought of as deranged, dangerous and demented as well as unhinged, unpredictable and uncontrollable. Films and books have probably done more to perpetuate myths about this condition than to explain it. Schizophrenia is a psychotic illness characterized by a disorder of thoughts and perceptions, behavior and moods.

Incidence Schizophrenia affects 1 in 100 people and is the most serious of mental disorders. Roughly a third of people require long-term institutionalization; a third show remission and could be considered cured; while a third have periods of symptoms followed by “normality.” They are different because of the symptoms that they do have (positive) and don’t have (negative) compared with normal people. They tend to have various manifestations of thought disorders (disorganized, irrational thinking), delusions and hallucinations. They tend to lack energy, initiative and social contacts. They are emotionally very flat, have few pleasures and are withdrawn.

**“Schizophrenia cannot be understood without understanding despair.”
R.D. Laing, 1955**

Schizophrenia often has major social and occupational consequences. “Episodes” can last for long periods of time and reoccur. It is for many, but not all, a debilitating and long-lasting problem.

History and misconceptions There are many common misconceptions about schizophrenics. The first is that they are dangerous, uncontrollable and unpredictable, while the reality is that most are rather shy, withdrawn and concerned with their problems. The second is that they have a split Jekyll and Hyde personality, whereas what is split is the emotional (affective) and cognitive (thought) aspect. Third, many people believe they do not, and cannot, recover and that once a schizophrenic always a schizophrenic.

It was not until the turn of the 20th century that Emil Kraepelin, a German psychiatrist, tried to draw up the first psychiatric classification system. One disorder he called dementia praecox, which meant predictive deterioration, and he described various behavioral cues that we today would call schizophrenia. He influenced many in the field in his belief that the cause and therefore “cure” would be biomedical. Another German, Adolph Meyer, argued at the beginning of the 20th century that there was no physiological basis to the disease and that it originated from early learning problems and underdeveloped interpersonal processes.

Classification The classification of schizophrenia remains complex because of the diversity of symptoms. These include delusions; hallucinations; disorganized speech (incoherence, loose association, use of nonsense words); disorganized behavior (dress, body posture, personal hygiene); negative, flat emotions; poor insight into their problems; and depression.

Because of complications with the diagnosis, various subtypes have been named. Thus there is paranoid and catatonic schizophrenia. Catatonics (from the Greek “to stretch or draw tight”) often adopt odd, stationary poses for long periods of time. Paranoid schizophrenics have delusions of

control, grandeur and persecution and are consistently suspicious of all around them. Disorganized schizophrenics manifest bizarre thoughts and language, with sudden inappropriate emotional outbursts. Some psychiatrists mention simple or undifferentiated schizophrenia. Others have distinguished between acute (sudden, severe onset) and chronic (prolonged, gradual onset). Another distinction is between Type I (mostly positive symptoms) and Type II (mostly negative symptoms).

There is still no complete agreement about the subtypes or the precise “deficits” in functioning, though these usually come under four headings: cognitive or thinking; perceptual or seeing; motor or moving; emotional or feeling. Researchers are continuing to seek out the source or cause of areas of “vulnerability” that cause some people to develop schizophrenia. So there are increasingly sophisticated genetic studies as well as those looking particularly at complications of pregnancy and traumatic childhood experiences, brain functioning and family and cultural influences.

Researchers as well as medical and lay people tend to believe in, or follow, different approaches that describe the cause and cure of schizophrenia. Essentially these split into biological models, stressing genetic, biochemical or brain structure causes; and the socio-psychological, focusing on problems of communication and punishment in early life. Certainly developments in behavioral genetics and brain science have led to more interest in the biological approach to cause and cure.

“Schizophrenia: a successful attempt not to adapt to pseudo-social realities.”

R.D. Laing, 1958

The medical model In this model schizophrenic persons are in most cases called “patients,” reside in “hospitals,” and are “diagnosed,” given a “prognosis” and then “treated.” The medical model regards mental malfunction such as that found in the schizophrenic patient primarily as a consequence of physical and chemical changes, primarily in the brain. Twin and adoption studies have convinced most researchers that a genetic factor is involved. Other researchers have concentrated on brain biochemistry. Some hypothesize the existence in schizophrenics of brain abnormalities, possibly caused by a virus. Treatment consists primarily of medical and sometimes surgical procedures, but mainly the use of neuroleptic (antipsychotic) drugs.

The moral-behavioral model Schizophrenics according to this model are seen as suffering for their “sinful” or problematic behavior in the past. Much schizophrenic behavior contravenes moral or legal principles, and this is the key to both understanding and curing the disorder. Treatment is by far the most important aspect of the moral-behavioral model, which is rarely held in developed countries these days. Whether behavior is seen as sinful, irresponsible, simply maladjusted or socially deviant, the crucial thing is to change it so as to make it socially acceptable. The methods used range from simple moral exhortations to complex behavioral techniques, such as token economies—a form of behavior modification, verbal control of behavior, and social-skills training.

“It is hypothesized that a person caught in a double bind may develop schizophrenic symptoms.”

G. Bateson, 1956

The psychoanalytic model The psychoanalytic model differs from the others in that it is interpretative, treating the patient as an agent capable of meaningful action. Rather than seeing people with schizophrenia as “acted on” by various forces (both biological and environmental) that cause

them to behave in certain ways, the psychoanalytic conception is concerned with patients' intentions, motives and reasons. This model suggests that unusual or traumatic early experiences or the failure to negotiate some critical stage of emotional development are the primary causes of schizophrenia. The behavior of the person with schizophrenia is to be interpreted symbolically; it is the therapist's task to decode it. Long-term, one-to-one therapy with a trained psychoanalyst is the primary treatment offered by this model.

The social model In this model, mental illness is seen partly as a symptom of a "sick" society (other being a high divorce rate, work pressures, juvenile delinquency, increased drug addiction). The pressures of the modern world fall more heavily on the poor and disadvantaged, and thus they seem to suffer more of what is described as "illness." There is no individual treatment in the social model. Instead what is required is large-scale social change to reduce the stresses on individuals and thus the incidence of mental illness.

The conspiratorial model The conspiratorial theory is perhaps the most radical conceptual model of schizophrenia in that it denies the existence of mental illness (as a physical disorder) and stands in direct opposition to the medical model. Mental illness is not "something someone has," but "something someone does or is." Psychiatric diagnoses are, according to this model, simply stigmatizing labels applied to persons whose behavior offends or annoys others, and are used to control eccentric, radical or politically harmful activity.

Conceptual dispute

The diagnostic term "schizophrenia" is a major cause of dispute and debate among psychiatrists, patient groups and the lay public. The most common objection is that it is an unhelpful umbrella term that covers a range of different disorders with different symptoms and different causes. Diagnosis is therefore unreliable. Some advocate the idea of *schizotypy*, which refers to a continuum of personality characteristics and experiences related to psychoses, particularly schizophrenia. This is different from the categorical view that you either have or do not have the problem.

the condensed idea

The concept of schizophrenia has evolved

timeline

- 1893** Kraepelin describes schizophrenia
- 1908** Bleuler first uses the term "schizophrenia"
- 1933** T.S. Eliot talks of "split personality"
- 1946** MIND: mental health charity founded

05 Not neurotic, just different

“Our whole life is taken up with anxiety for personal security, with preparations for living, so that we really never live at all.” Leo Tolstoy, 1900

There have long been those who challenge the power, practices and pretensions of psychiatrists. Critics, dissidents and reformers have at different times and in different countries made stinging attacks on conventional academic and biological psychiatry.

Politics and psychiatry Inevitably as psychiatry became more established and institutionalized as a medical practice, it had its detractors who liked neither psychiatrists' power nor their labels. There are the various accounts from artists and writers as well as patient groups who strongly opposed particular treatments (drugs, electroshock and surgery) for various “mental” diseases. There were famous cases from Nazi Germany and Soviet Russia that illustrated how psychiatry was used as an oppressive political force. Psychiatrists seem in some situations to operate as part of the repressive arm of the state.

Antipsychiatry critics questioned three things: the medicalization of madness; the existence of mental illness; and the power of psychiatrists to diagnose and treat certain individuals with compulsion. Antipsychiatry was more than anticustodial: it was often antistate, almost anarchic. It saw many state institutions, particularly mental hospitals, as distorting and repressing the human spirit and potential in various groups.

It was not until the 1960s that the term “antipsychiatry” came into use. There were a number of different strands to the various groups that formed together under this umbrella term. And paradoxically perhaps, the greatest critics were psychiatrists themselves.

**“Neurosis is always a substitute for legitimate suffering.”
Carl Jung, 1951**

History of the movement There were three main origins of the movement. The first started in the early 1950s and was a result of the war between Freudian-inspired psychoanalytic psychiatrists and the new biological-physical psychiatrists. The former, who were losing power and who favored protracted, dynamic, talking cures, were challenged by the latter, who saw that approach as not only costly and ineffective but profoundly unscientific. The biological psychological treatments were surgical and pharmacological and they had some important early successes. The old guard challenged the new guard.

The second attack began in the 1960s with figures like David Cooper, R.D. Laing and Thomas Szasz in different countries getting highly vocal about the use of psychiatry to control those deviating from societal norms. Thus people who were seen to be sexually, politically or morally deviant or different were subject to psychiatric processing and control. Szasz's famous book *The Myth of Mental Illness* explains this position well.

The third force were American and European sociologists, notably Erving Goffman and Michel Foucault, who saw the devious power of psychiatry and its effects on labeling, stigmatizing and

hospitalizing people.

The high point of this movement occurred at the time of the 1960s countercultural, challenging spirit of the age. Popular films (like *One Flew Over the Cuckoo's Nest*) and radical magazines appeared that challenged the biological psychiatrists, state services and practices.

Being sane in an insane place

One of the most famous antipsychiatry studies was done in the early 1970s. Eight “normal,” mentally healthy researchers tried to gain admission, through diagnosis, to a number of American mental hospitals. The only symptom they reported was hearing voices. Seven were diagnosed as schizophrenic and admitted. Once in the hospital they behaved normally and were ignored when they politely asked for information. They later reported that their diagnostic label of schizophrenia meant they had low status and power in the hospital.

Then they “came clean” and admitted they had no symptoms and felt fine. But it took nearly three weeks before they were discharged, often with the diagnosis “schizophrenia in remission.” So normal, healthy people could easily be diagnosable as “abnormal.” But could the reverse happen? The same researchers told psychiatric hospital staff that fake or pseudopatients pretending to be schizophrenics may try to gain access to their hospital. They then found that 19 genuine patients were suspected as frauds by two or more members of staff, including a psychiatrist.

The conclusion was that it is not possible to distinguish the sane from the insane in mental hospitals. Though this famous study has received considerable criticism on ethical and experimental grounds, it added great impetus to the antipsychiatry movement.

The antipsychiatry movement was always a loose coalition between social action groups and they tended to focus on very specific problems like schizophrenia or the sexual disorders. They talked of authenticity and liberation, of empowerment and personal management rather than pharmaceutical intervention. Many began to attack the pharmaceutical industry and the established institutions like the Victorian mental hospitals.

Fundamental beliefs The movement did share some fundamental beliefs and concerns. The first was that families, institutions and the state are as much a cause of illness as a person's biological functioning or genetic make-up. Second, they opposed the medical model of illness and treatment. They believed that those who were living by different codes of conduct were erroneously and dangerously labeled delusional. Third, they believed that certain religious and ethnic groups were oppressed because they were in some sense abnormal. They were pathologized and therefore made to believe they needed treatment.

The movement was very concerned with the power of diagnostic labels. They saw those labels as giving a bogus impression of accuracy and immutability. Diagnostic labels and manuals are rejected because people meet multiple criteria (or none) and there is little agreement between experts.

Attacks on therapy The movement also focused its opposition on very specific therapies, particularly

drugs such as those designed to treat primarily childhood problems (ADHD) and depression. They attacked them because of their costs and side-effects and also because patients were not told the truth about them. Antipsychiatry activists have focused on all aspects of pharmaceutical company behavior, arguing that they fake their data and massively overcharge for their drugs. This in turn has led the industry to be carefully monitored and policed by legislative actions.

Other targets have been electro-convulsive therapy (ECT) as well as very specific procedures like brain surgery (prefrontal lobotomies). Despite certain evidence of success, critics argue they are “forced upon” naïve patients and cause massive permanent side-effects.

The power of psychiatrists to section or involuntarily hospitalize patients is also attacked by the movement. Many critics see professional psychiatrists as an arm of the state, and on a par with policemen, judges and juries.

Antipsychiatry advocates called for a more humane psychiatry. They still challenge psychiatric language and the illusion of a biomedical, scientific psychiatry that searches for biological and genetic explanations. Thus, for instance, they are saying that poverty, not neurotransmitter dysfunction, is the major cause of depression.

The original movements were ideologically based, heavily politicized, antireductionists. They attempted to exorcize and rehabilitate psychiatry. They opposed “the system.” In many ways they succeeded: many treatments have been stopped; many mental hospitals closed. Psychiatric labels have changed and are used with much more care.

The antipsychiatry movement has transformed into the patient-based consumer movement. The focus is not so much on trying to dismantle organized psychiatry but rather on patients’ rights and power.

The new psychiatry

Many psychiatrists have attempted to answer the antipsychiatry critics by adopting specific principles or guidelines. Thus they may try to institute the following.

Firstly, admit that the goal of treatment is to get better rather than just increase insight or self-understanding. Secondly, treatment should be evidence-based and only proven treatments used. Thirdly, recognize that patients have the right to see their files, know their diagnosis, be told about what treatments are available and their associated risks. Patients and psychiatrists should have realistic expectations of what treatment and therapy can and cannot do. All patients with psychiatric illnesses deserve care, compassion and respect.

the condensed idea

Psychiatry has its critics

timeline

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