The Bio-Psycho-Social Model of Psychiatric Illness and Positive Psychological Health: Stress and Human Control as an Example

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A mini-outline of lecture for Behavioral Science 11
September 28, ,1988

1. Issues in Defining Mental Illness and Health
   - 1.1 Thinking about thinking:
     - Where does "mental illness" come from?
       - Theoretical Orientation Inventory (Handout One).
   - 1.2 Importance of our views: Theories of Human Nature
     - Handout on Four Schools of Therapy
     - Biological (vs?) Behavioral:
       - Weiss "control" study with norepinehprine
       - Agras: anxiety disorders; eating disorders
       - Reite (556-Schizophrenia); anxiety and affective disorders (560)
       - Fride: prental stress alters cerebral lateralization of dopamine activity
       - Placebo and nalaxone
   - 1.3 Multiple Causation: Uni-determinism, reciprocal determinism and "omni-determinism" (culture plus). P. 2-3 of handouts
     - Reductionism; specialization
     - General principles (Artificial Intelligence/ cognitive science)
     - Mutiple modes of being: (article 49--compassion/ skill). (Caring context).
   - 1.4 Continuum views:
     - "normal culture" is psychopathological, a consensus trance (Tart);
     - there is no pathology (Szasz)--problems in living and defined by those in power.
     - NIMH study: (Mumford, pp.603-604): anxiety, disorders; alcoholism and drug abuse; schizoprhenic disorders; antisocial personality disorder
   - 1.5 Stress as example:
     - Stress and physical health: vulnerability to infectious diseases and/or coronary artery disease
     - Relevant Background/Pioneers (Stress from environment (stressor); stress as physiological response; stress as behavior. Stress causes stress which results in stress
       - --Walter Canon: fight or flight response--activation of sympathetic nervous system
       - --Hans Selye: General Adaptation Syndrome (alarm, resistance, exhaustion); eustress/distress
       - --Meyer Friedman: Type A Behavior Pattern
       - --Herbert Benson: hypometabolic state: relaxation response; activation of parasympathetic nervous system: reduced heart rate, o2;

1.6 Why Discuss Positive Health
WHO definition--more than absence of disease
Rosenhan study: Being sane in insane places

2. HUMAN CONTROL.

2.1 Thinking about thinking: How important? Can brain/mind control body? emotions? (chapter 3). Circadian Rhythms?
What is importance of control: Functional Analysis (handout, p. 7). Cross-cultural: Bali. Role of religion and psychology? Self-control, control by a benevolent other (Taylor); Handout, p. 3, terms

2.2 and mortality (Rodin and Langer nursing home study) Handout two.
overcontrol (Brady's monkeys);
too little control (Blume and Weiss: higher danger of ulcers and stomach lesions; Seligman's learned helplessness)
stress and productivity: U shaped curve; Yerkes/Dodson
Stress Hardiness: Maddi and Kabasa: committment, control, challenge
Perceived control (Glass and Singer)

2.3 Warning signs of stress: from Selye (also eustress/ distress); Holmes and Rahe

2.4 Self-observation: how do you know if you are feeling stressed: cognitive; somatic; visual.
Content Analysis Control Scale for psychiatric patients

2.5 is stressor in your control or outside your control
Issue of Denial (psychodynamic-- article 53)
benefits/problems

3. CLINICAL ISSUES IN HUMAN CONTROL AND SELF-CONTROL (handout p. 8, systems theory)

3.1. Motivation, decision making, freedom reflex, belief system, responsibility, adherence and compliance.
Example: Stress prevention:
hot meal (good breakfast); 7 to 8 hours sleep;
regular exercise; no smoking; no (low) caffeine
social support (people you can talk to about problems); give and receive affection;
able to speak openly about feelings when angry or worried;
take quiet time for myself during the day;
plan a fun activity at least once a week;

3.2 Adjust/ avoid/ accept

3.3 Other techniques:self-observation : ABC's
meditation (concentrative; opening up)
biofeeback (emg; eeg; temperature; gsr)
progressive relaxation; autogenic training

3.4 Instructions: slow, controlled, abdominal breathing; attentional focusing; thoughts and self instructions; imagery; assertive, altering strategies for control accepting, yielding strategies for control

FROM Shapiro, D.H. Psychological Health, (New York, Wiley, 1984) in Encyclopedia of Psychology (R. Corsini, Ed.)

PSYCHOLOGICAL HEALTH

Scientists in general, and health care professionals in particular, generally operate from models in pursuing their work (Kuhn, 1970; Bandura, 1974). These models determine the scope and nature of what is investigated, and the ways in which results are interpreted (Meehl, 1960; Rosenthal, 1962; Tart, 1975; Walsh, 1980). All psychotherapeutic systems have a view of human nature, a concept of disease etiology, and a vision of psychological health (Shapiro, 1982). This vision of psychological health is the end point of "successful" therapy as defined by each particular orientation. In Gordon Allport's words, it is the "ought, or should toward which every counselor, therapist, and healer should seek" (Allport, 1955).

Until recently, psychology and psychiatry have been relatively silent on what constitutes positive psychological health. For example, the index to Freud's *Collected papers* contains 400 references to neurosis, but none to health; furthermore, all psychiatric categories of the *Diagnostic and statistical manual of mental disorders* (American Psychiatric Association, 1980) are pathological.

Reflecting a dissatisfaction with traditional pathology-based clinical and mental health classifications (Rosenhan, 1973; Mischel, 1968, Ullmann & Krasner, 1975), some researchers are developing and empirically investigating models of positive health. These investigations involve the pioneering efforts of Jahoda (1958), Maslow (1968), Allport (1955), Jourard (1968), and concepts such as "maturing" (Heath, 1977, 1982) and psychological health and the life cycle (Levinson, 1978; Vailliant, 1972, 1978, 1980). There has also been an increasing interest in non-Western approaches to psychological health. These investigations suggest that elimination of pathology may just give us the concept of the "average" or "normal" rather than a concept of true positive psychological health.

In the original constitution of the World Health Organization in 1946, a view of health evolved, which was stated in positive terms: "Health is a state of complete physical, mental, and social well-being and is not merely the absence of disease or infirmity."

IMPORTANCE OF STUDYING PSYCHOLOGICAL HEALTH (AND THE PROBLEMS)

One reason to pay more attention to positive psychological health concerns the self-fulfilling prophecy of models of human nature. If individuals are looking for pathology, they find pathology. This is illustrated in the study done by David Rosenhan in 1973. "Normal" individuals—pseudopatients—were admitted to 12 hospitals in five states with the entering complaint of hearing voices that said "empty, hollow, thud." Only the symptoms, name, and vocation were falsified, but nothing else (i.e., personal history, relation to parents and siblings, etc.). Once on the ward, the pseudopatients ceased simulating any psychiatric symptomatology. They took copious notes as a way of writing up the details of their observations. These notes were referred to in the charts as "bizarre writing behavior." Eleven of the 12 were diagnosed as schizophrenic, and one as manic depressive, and all, upon discharge, were considered to be "in remission." In other words, their behavior was interpreted pathologically, and the "in remission" discharge suggested that the "disease" was still within them.

Because of the criticism that the study was not done at a major medical institution, Rosenhan did a follow-up experiment, saying that a sane person was to enter a major university teaching hospital and he so informed the staff. Of the 192 regular patients admitted, 41 were alleged to be pseudopatients by one member of the staff; 23 were considered suspect by at least one psychiatrist; and 19 were suspected by one psychiatrist and one other staff person. Yet no pseudopatient entered the hospital. When the staff was looking for pseudopatients who presumably exhibited "healthy" behavior, it found within the regular patients "healthy behavior." Models are powerful determiners of the way in which we perceive and interpret our world and ourselves—the self-fulfilling prophecy.

An example can be seen in the way in which some Eastern psychologies have been interpreted by some Western psychologists. For example, mystical experiences have been interpreted as "neurotic regression to union with the beast," ecstatic states seen as narcissistic neurosis (Lewin, 1961), yoga and Zen dismissed as artificial catatonias (Alexander & Selesnich, 1966) and enlightenment diagnosed as regression to intrauterine stages (Alexander, 1959). Thus some of our traditional psychological models may have limited our ability to appreciate and understand well-being.

To extrapolate to positive health from psychopathology is an unsupportable generalization. As Jahoda (1958) and her study of mental health suggests, that mental health is the converse of mental illness has not been compellingly demonstrated.

But there are problems with the study of psychological health. Even though the study can produce models, there is a gray area between science and values. As Thomas Szasz (1970) has suggested society's definition of what is mentally ill may only disguise its own value judgments of what is a preferred way to live. Psychological health may be a cultural value. If psychological health is only a value, how does psychology keep from becoming merely sermonizing? The balance is a tenuous one as Donald Campbell noted: "On these issues (as to how people should live their lives—child rearing, sex, duty, guilt, sin, self-indulgence, etc.) psychology and psychiatry cannot yet claim to be truly scientific and thus have special reasons for modesty and caution in undermining traditional (religious) belief systems (Campbell, 1975, p. 1105).

The questions of definition, identification, and measurement of healthy people are quite difficult. The kinds of changes and modes of positive psychological health may stand out less and therefore be noticed by fewer people. The psychologically healthy do not wear name tags proclaiming their status; they are not thrust together in hospitals or outpatient clinics, and, therefore, may be more difficult to identify. Further, psychological health may occur along multiple dimensions, and, as suggested by developmental theorists, occur over time, making it harder to research, particularly in a piecemeal mode.

DIFFERENT VIEWS OF PSYCHOLOGICAL HEALTH

Theories of psychological health are often based upon the views of the individual that each tradition has.

View of the Individual

Each tradition's view of the individual is a *belief system* (implicit or explicit) describing human nature. Yet up to this point, no one knows what human nature is.

There are four broadly conceived beliefs about human nature, summarized in Table 1.

Theory 1 states that the person is evil, basically amoral. Christians talk about original sin; Freud talks about the amoral id. Theory 2 says that people are good. This view posits an innate nature that is good and positive. Theory 3 includes the blank slate or tabulae rasae view. In its most extreme form, argued by radical behaviorists, or the philosopher, John Locke, it suggests that people are neither good nor bad. It is existence preceding essence. Essence is created by how people act. Theory 4 states that people have self-actualizing innate natures that not only are personal as Theory 2 goes, but reflect a divine or cosmic or transpersonal spark intrinsic to everyone. Finally there are also combination theories

Table 1

Theory	View of Human Nature
1	Innately evil/amoral
2	Innately good, self-actualizing nature
3	Tabulae rasae: existence precedes essence
4	Innately good and in essence in harmony with the divine

The Goal of Teaching (Therapy, Discipline, etc.)

The goal of "teaching" refers to the vision of psychological health and the model of human nature from which it springs (Table 2).

Table 2

Theory	View of Human Nature		Vision of Health
1	Innately evil/amoral	→	Lessen the evil and/or seek salvation
2	Innately good, self-actualizing nature	→	Uncover the self
3	Tabulae rasae: existence precedes essence	→	Create self
4	Innately good and in essence in harmony with the divine	→	Uncover the essence of self

1. *The amoral theory of human nature.* Since people are basically evil, the vision can only be to make them "less so." In Freudian terms, the goal is to give individuals more control over the id impulses; in traditional Christianity, the goal is to have people seek salvation and God, realizing their basically evil nature.
2. *The good theory.* This theory suggests that a concept of health is having the individual uncover his or her own self-actualizing nature. "To move away from the facades, oughts, pleasing others, and to move toward self-direction—being more autonomous, increasingly trusting and valuing the process which is himself" (Rogers, 1961).
3. *The blank slate existence precedes essence theory.* The vision of this theory, in a relativistic world, is to choose one's self, to stand forth (existential) and to learn skills necessary for optimal cultural functioning (behavioral).
4. *Transpersonal approach.* The vision is an awakening, nirvana, kensho to one's true self, which is "no self" but rather part of the larger Self.

The first theory seeks to lessen the evil, the second and fourth theories seek to uncover the small self (Theory 2) and large Self (Theory 4), and the third theory seeks to create one's self.

VIEWS OF HUMAN NATURE

As an example of Theory 1, classical id psychology, represented by Freud, is a basically bleak picture of human nature. At a fundamental level, Freud believed that the individual is ruled by an amoral, pleasure-seeking id, is innately filled with anger and aggression, and is relatively helpless to effect change. As Freud noted, "Man is lived by unknown and uncontrolled forces" (Freud, 1923) that originate in the id. Further, he noted that the Christian commandment, "Love thy neighbor as thyself," is justified only by the fact that "nothing else runs so strongly counter to the original nature of man. The stranger is in general unworthy of my love; I must honestly confess that he has more claim to my hostility and even my hatred; men are not gentle creatures who want to be loved; they are on the contrary creatures among whose instinctual endowments is to be reckoned a powerful share of aggression . . ." (Freud, 1961/1924, p. 27).

Goal of Therapy

For those who begin with the Theory 1 view of human nature, the best they can do is come to some kind of resolution, that is, the "best possible" conditions for the ego. For psychoanalytically oriented therapists, the task of therapy is to uncover and understand initial traumatic events, "to make the unconscious conscious, to recover warded-off memories, and overcome infantile amnesia" (Greenson, 1968).

Ego Psychology

Ego psychology is used by different individuals, at different times, to describe a wide variety of approaches. These range along a continuum from neoanalytic viewpoints of the conflict-free sphere of the ego (e.g., Hartman, Kris, and Lowenstein, 1964) to those believing in an innate, self-actualizing, intrapsychic ego (e.g., Rogers, 1951; Maslow, 1970; Angyal, 1965; Goldstein, 1939; etc.). In between there are, of course, Jung and his concept of the individuated self (1960) and R. White (1961) and the concept of competence, and so on. To delineate the differences in this article most clearly, the term "ego psychology" refers to Carl Rogers' client-centered therapy, which reflects the "humanistic psychology" viewpoint of an intrapsychic self-actualizing nature (a Theory 2 viewpoint).

View of the Individual

Rogers believes that the individual is not a warring battleground between forces of the id, ego, and superego. Rather, he believes that the individual's basic need is to constantly strive toward positive growth, and if given a choice between progressive and regressive behavior, the person will choose the former. As Rogers noted, "The organism has one basic tendency in striving—to actualize, maintain, and enhance the experience of the organism" (Rogers, 1951).

Theory 2, represented by Rogers (1951), believes there is an innate self-actualizing quality within each individual. Therefore, the goal of therapy is merely to provide a warm, supportive, trusting environment to allow the person to see and accept that innate self.

Behavioral Approach

This approach is used as an example of a Theory 3 viewpoint. Within a behavioral approach, there are many different groupings, among them the radical behaviorists, the cognitive behaviorists, and the social learning theorists, and within each of these groupings there are additional subgroupings. Behavior therapy consists of activities implying a contractual agreement between therapist and patient to modify a designated problem behavior with particular application to neurosis and affective disorders. (Wolpe, 1969; Lazarus, 1971).

Behaviorists hypothesize that there is neither the uncontrollable passionate unconscious of the id psychologists nor the self-actualizing intrapsychic nature poisted by the ego psychologists. John B. Watson, reacting against the introspectionist school of psychology, said that "behavior can be investigated without appeal to consciousness . . . for the behaviorist recognizes no dividing line between man and brute" (Watson, 1913). The individual, according to social learning theory, is not motivated by the intrapsychic forces of ego and id, but by the environmental stimuli and contingencies.

Behaviorists suggest that to be free, people need to have knowledge of the internal and external factors that control them. This means (1) having more accurate knowledge of the consequences of alternative behaviors, (2) learning more skills necessary for achieving objectives, and (3) diminishing anxieties that restrict participation in the alternatives chosen.

Table 3 Comparison and Contrast of Four Schools of Psychotherapy

Subject	Psychodynamic (Id Psychology: Freud)	Client-Centered Therapy (Ego Psychology: Rogers)	Social Learning Theory (Behavioral Psychology)	Zen Buddhism
View of human nature	Aggressive; hostile, life out of control; ruled by unconscious	Innately good; intrapsychic self, which is self-actualizing	Person is tabulae rasae at birth; with no "essence"	A human being has pure, innate, good, unconscious "self" that is like Buddha nature and is within all
Goal of psychotherapy	To make the unconscious conscious; overcome childhood amnesia; recover warded-off memories	To let the person experience that self inwardly and knowingly	The target behavior: if deficit, teach it; if excess, decrease it; make it appropriate	To make the unconscious conscious; to hear the bird in the breast sing
Etiology of disease	Repression of sexual and hostile childhood wishes by superego and ego	Trying to meet external shoulds and oughts; inability to assimilate experiences into one's self concept	Environmental variables; learning deficiency	Belief there is a "self"; greed; ego; attachments

Freedom also involves having precise awareness of the internal and external environments, and arranging these environments in such a way as to maximize individual choices.

Table 3 summarizes these three different viewpoints—id psychology, ego psychology, and behavior therapy—across the three dimensions. These viewpoints represent Theories 1, 2, and 3 respectively.

NONTRADITIONAL APPROACHES: THEORY 4—ZEN

These three approaches are contrasted in Table 3 with the religious/philosophical Eastern view of Zen Buddhism, representative of a Theory 4 viewpoint. Because of the "nontraditional" nature of viewing a religion in a consideration of psychological health, a brief comment is appropriate. Insofar as religious systems represent an attempt at healing both the mental and physical distress of the individual, and insofar as "spiritual beliefs" create mental and physical well-being (Ellis, 1962; Benson, 1978; Franks, 1963), they may be perceived as a type of psychotherapy.

The qualities of a healthy person as suggested by the Eastern tradition include determination and effort, flexibility and adaptability, a sense of meaning, an affirmation of life, dying to a finite ego, loss of self-importance, development of compassion and selfless service, increased depth of intimate relationships, development of control of one's mind and body, and ethical qualities such as the four illimitables or measureless states—compassion, sympathetic joy, all-embracing kindness, and equanimity.

SUMMARY

Not all of the innumerable views of psychological health fit into the four-theory model described. Other important theories include Jung's concept of the individuated self, Rank's use of creativity, and Maslow's self-actualizing people. Marie Jahoda (1958) has pointed out that most definitions of positive and mental health call attention to one or more of the following six aspects: (1) the attitude shown by a person to self; (2) the style and degree of self-actualization; (3) the degree of personal integration achieved by the individual; (4) the degree of autonomy achieved by the person; (5) the degree of the person's conception of reality; (6) the degree of environmental mastery achieved by the person.

Greater knowledge of positive health can add considerably to clinical practice, and potentially to society at large.

BEHAVIORAL MEDICINE
COMMUNITY PSYCHOLOGY
HEALTH PSYCHOLOGY
HEALTHY PERSONALITY
MENTAL ILLNESS: EARLY HISTORY

PRIMARY PREVENTION OF PSYCHOPATHOLOGY PSYCHOANALYSIS

D. H. SHAPIRO

FROM: Shapiro, D.H. In R. Walsh and D. Shapiro Beyond Health and Normality (New YOrk: Van Nostrand, 1983)

Table 18-9. Comparison and Contrast: Four Schools of Psychotherapy.

SUBJECT	PSYCHODYNAMIC (ID PSYCHOLOGY: FREUD)	CLIENT-CENTERED THERAPY (EGO PSYCHOLOGY: ROGERS)	SOCIAL LEARNING THEORY (BEHAVIORAL PSYCHOLOGY)	ZEN BUDDHISM
Motivation	Motivation based primarily on id energy and impulses; a tension reduction model	A hierarchy of motivation ranging from security needs to self-actualizing needs (from Maslow)	Social and environmental contingencies; models; reinforcement	A harmony with oneself and the world around; learning to hear the sound of one's heart
Awareness	Know thy unconscious past; self-awareness is defined as insight into childhood; the crucial element in therapeutic cure	Know thy self-actualizing ego; insight is fresh understanding and experience of the self; this is the crucial element in making self-concept and self-experiences congruent	Know thy controlling variables; self-observation is method of defining problem; and a potential intervention strategy (reactive effect)	Know the bird's song; nonreactive observation is a means and end in itself; self-evaluation and self-reinforcement are extraneous
Origin of self-awareness	Not discussed fully; only mention is id cathecting ego, in *On Narcissism* (1914)	Both from evaluation of others and from within oneself	Socially conditioned by verbal community	Socially conditioned by language, culture; logic
Techniques to increase self-awareness	Verbal, intellectual, rational only; interpretation by therapist	Verbal, experiential, rational; reflection rather than interpretation; no interpretation	Verbal, intellectual, rational; use by client of charts, wrist counters, self-quantification; antecedents, consequences	Some verbal; mainly nonverbal; doing, not talking; non-intellectual; nonrational

Focus	Past; childhood memories	Present feelings	Present perceptions and controlling environment	Now
Detached observation; self-objectification as goal of self-awareness	Freud: patient must assume a crystal ball attitude toward himself; not to be afraid of revealing his true memories	Rogers: client, by therapist reflection, can come to see himself objectively; his feelings stripped of complications of emotion and evaluation	Desensitization is an attempt to get client to see himself in fear-arousing situation, be objective to self, and not become tense	Self-observation without self-evaluation is the goal of life
Techniques	Techniques are used to overcome patient resistance	Ostensibly, none are used; other than "authenticity" of therapist	High use of techniques	Ostensibly no techniques needed, but many are used; Koan meditation etc.
Role/qualities of the therapist	High for therapist; his role is critical; analysis of transference/countertransference; Greenson[65] says that for an analyst to have empathy, "he must renounce for a time part of his own identity; and for this he must have a loose or flexible self-image"	Therapist role important; no analysis of relationship; dynamics, however; Rogers says the therapist must be able to see the client without reacting emotionally or judgmentally; to be strong enough to be a separate person; and at the same time to see clearly and accurately what the client is saying	Therapist role important only as a teacher or coach; not much attention to qualities of the therapist; Lazarus[23] states, though, that the therapist should be compassionate and empathetic	Zen says that the highest ego is no-ego; empty, like a mirror; this gives flexibility; strength; accurate reflection; the teacher models "right action," but ultimately teaches no teaching

There are basically two ways in which we can maintain a sense of control in our lives. One is an active, assertive way in which we try to change or alter events. Since, however, we cannot control all events, the other way in which we can maintain a sense of control is by yielding, accepting and adapting to what is. One of our tasks is to make sure that when we use an active sense of control, we aren't trying to control things that are really out of our control; and similarly, when we use a letting go or yielding mode, we are actually being too passive in a situation where we could exert some more active forms of control.

ACTIVE, ASSERTIVE TYPES OF CONTROL

1. Notice what you can control, and make decisions, act on it, even in the midst of uncertainty.

2. Almost all decisions are made without enough information. Don't be afraid, as discussed in In Search of Excellence, to "ready, fire, aim." It may cause less anxiety or arousing feelings to make a mistake than continued indecisiveness.

3. Don't let life just happen to you--don't let things pile up; if there's tension or difficult situations in your life, take active steps to deal with them. Control those things you can control and act on them.

4. Turn stress into an active motivator--use the energy and physiological motivation in a clear-sighted, positive direction toward your goals.

5. Have an image of excellence, adventure, determination and excitement toward what you are pursuing.

6. Develop images of conflict resolution, where your have chosen among competing alternatives; have been in negotiating situations and have resolved the conflict in a win-win situation.

YIELDING, LETING GO, ACCEPTING TYPES OF CONTROL

1. Develop images trusting yourself at a very deep and fundamental level and believing in yourself.

2. Develop an image of self-love for who you are, just as you are, without trying to accomplish or do anything.

3. Develop an image of self-acceptance for who you are just as you are.

4. Be gentle and respectful of your body and your mind, being aware of and sensitive to its cues.

5. Let life happen to you: take time for softness and relaxation.

6. Not everything in life is under your personal control. Notice if you consistently go after the impossible, demanding perfection and unrealistic expectations of yourself, and if you do, insure that you take soft time for yourself, make yourself a daily priority with stress breaks, not always a focus on the external demand.

TABLE TWO: A FOUR-QUADRANT MODEL OF SELF-CONTROL

QUADRANT ONE	QUADRANT TWO
ACTIVE CONTROL POSITIVE ASSERTIVE	LETTING-GO CONTROL POSITIVE YIELDING ACCEPTING
QUADRANT THREE	**QUADRANT FOUR**
OVER-ACTIVE OVER-CONTROLLING	OVERLY PASSIVE DEPENDENT, DIFFUSE

The Bio-Psycho-Social Model of Psychiatric Illness and Positive Psychological Health: Stress and Human Control as an Example

Deane H. Shapiro, Jr., Ph.D.

A mini-outline of lecture for Behavioral Science 11
September 28, ,1988

chap 3: Edlin and Galanty
49--Werjman--religion/dying
52 Reite--biological
53--pardes, psychodynmaic
54-mumford sociocultural
55-Stoyva, Behavioral, biofeedback

1. Title: why health; why "psychitaric illness| grounded in one construct--control, and one clinical area--stress.

2. Please pay attention. not easy. TMI, chernobol; your reactions; listen; watch yourself in process. Active focus mode, receiving mode analogy, feeling.

OPENING: My goals:

1) open your belief systems up; maybe even change them. Not easy: belief systems, preconceived ideas we aren't even aware of; think about thinking; see different sides of issues; figure out what attracts you to one side in the absence of convincing data JOKE OF BALD HEADED WOMAN.

2) increase your feeling in touch with the healing part of yourself and that motivation (Multiple motivations to become dr.)

3) control/ SELF-MODELING what we practice_ : my belief system through which I filter much of the world.; rorschach mind: see large picture; behaviorist; studied Asian thought. JOKE: IF YOU can remain calm and in control when all about you are stressed....; three types of people: MAKE THINGS HAPPEN; watch ~~things happen; wonder what happened.~~

4) science and values; how they do~don't related

5) me: bheaviorist/zen, bali: I could have tranced all night;

1. Issues in Defining Mental Illness and Health

????How often do you think about control

where do you get your views of health from?

phsycial health; psychological health; values?

1.1 Thinking about thinking:

Where does "mental illness" come from? Vissuhdimaggie nurturing person those that weaken us; both within? Theoretical Orientation Inventory (Handout One).

Why Discuss Positive Health

WHO definition--more than absence of disease

Rosenhan study: Being sane in insane places

Slides 2-23

1.2 Importance of our views: Theories of Human Nature
Handout on Four Schools of Therapy
Biological (vs?) Behavioral: MONTE STORY.
Biological: view of health? correlation is not causation. Other speakers with biological glasses. Not wrong, but incomplete
DSM LLL--not unnecessary, but hides positive; and scizpoprhenia is not across all situations. Not like a broken leg. Mumford, 54, rater diagnosis problems; 55, Stoyva, doesn't mention them.
Weiss "control" study with norepinehprine
Simson, PG, Weiss, JM, Ambrose, MJ, and Webster, A, Infusion of a monoamine osidase inhibitor into the locus coeruleus can prevent stress-induced behavioral depression. Biological Psychiatry 21, 724-734.

Stress-induced behavioral depression is defined by Weiss as behavioral changes brought about by uncontrollable shock; this is correlated with reductions of monoamines (particularly NE) in the locus coeruleus region of the brain.

Since the MAO inhibitor pargyline blocks the catabolism of NE, this study had the following 2x2 factorial design:

	Stress	No stress
pargyline	1	2
saline	3	4

Cell 3 (stress, saline) had least activity and least NE. All other cells showed non-significant differences. Thus, the usual behavioral depression following stress was not observed (cell 1). Although NE levels in LC were not depleted in cell one, NE in other brain regions showed no change.

Agras: anxeity disorders; eating disorders
ARTICLE THREE: Agras, SW (1987) Presidental Address: So where do we go from here? <u>Behavior Therapy</u>, 18, 203-217.
BT is now in mainstream of psychotherapy research but has "lost its initial unity and theoretical cohesion." Need a search for active versus inert ingredients (versus all therapies are same). Sees little utility in theoretical melding. Longer follow up; more randomized clinical trials. BT and psychopharmacology. Ex: obesity: four groups, six months(p.209 Fenfluramine in physicians office--lost 6.4kg ; Fenfluramine plus support group--lost 14.kg; Fenfluramine plus behavior therapy--14.5 kg; BT alone--10.9kg. One year follow-up, BT group had regained least weight, drug alone had fared the worst. With anxiety, Psychopharmacology studies tended to focus on the panic attach, BT studies focused on the phobic limitation. Combined:

imimprmine plus BT. Need for research and model building to go together if BT is to progress.

Reite (556-Schizophrenia); anxiety and affective disorders (560)

Fride: prental stress alters cerebral lateralization of dopamine activity

Placebo and nalaxone

1.3 Multiple Causation: Uni-determinism, reciprocal determinism and "omni-determinism" (culture plus). P. 2-3 of handouts

Reductionism; specialization

General principles (Artificial Intelligence/ cognitive science)

ARTICLE ONE: Waldrop, MM, (1988). Toward a unified theory of cognition. Science241, July 1, 27-29.

Allen Newell of Carnegie Mellon seeking unified theory of cognition: "It is one mind that minds them all." Based on work with AI (artifical intelligence. Issues in expertise/generalist. The former has difficulty with new problem for which rules didn't apply. Generalist needs domaine-specific grounding. Seen as two ends of the same continuum. Discussion of subgoaling; learning via encoding how the impasse was overcome. Therefore problem solving becomes cumulative.

Mutiple modes of being: (article 49--compassion/ skill). (Caring context).

1.4 Continuum views:

normal culture is psychopathology, a consensus trance (Tart);

there is no pathology (Szasz)--problems in living and defined by those in power.

NIMH study: (Mumford, pp.603-604): anxiety, disorders 8.3%, #1 for women; 2 ford men (masked by alcolhol, drugs?; alcoholism and drug abuse (6.4%); affective disorders 6%); schizoprhenic disorders (1%); antisocial personality disorder (.9) (20% of US population, only 1/5 seek treatment

where do we get values from. Einstein quote; r eligion article, 49; EINSTEIN:

It is true that convictions can best be supported with experience and clear thinking. On this point one must agree unreservedly with the extreme rationalist... (but) the scientific method can teach us nothing else beynd how facts are related to, and conditioned by, each other. The aspiration toward such objective knowledge belongs to the highest of which man is capable...

Yet it is equally clear that knowlege of what is does not open the door directly to what should be. One can have the clearest and most comnplete knowledge of what is, and yet not be able to deduct from that what should be the goal of our hu;man aspirations. (6, pp. 21-22).

→ to readings

Power: chessler, sex roles; who makes categories of deviancy; homoxexuals; russian jews, refuseniks and others religiously persecuted,

deviancy; who defines. Reite, 52: if we consider psychiatry as a medical specialty whose proper focus involves all aspects of human behavior, including that considered "deviant" by varying cultural and societal nromals, it is porper to consder criminality.

1.4 Stress as example:

Stress and physical health: vulnerability to infectious diseases and/or coronary artery disease

Relevant Background/Pioneers (Stress as in environment; stress as physiological response; stress as behavior.

--Walter Canon: fight or flight response--activation of sympathetic nervous system heart rate, respiration rise; blood sugar level rises; pupils dilate.

--Hans Selye: General Adaptation Syndrome (alarm, resistance, exhaustion); eustress/distress

--Meyer Friedman: Type A Behavior Pattern

--Herbert Benson: hypometabolic state: relaxation response; activation of parasympathetic nervous system: reduced heart rate, decreased oxygen consumption

2. HUMAN CONTROL.

2.1 Thinking about thinking:

???How do you control yourself. pipilongstockings.

How do you control others?

What are your beliefs about self-efficacy Can brain/mind control body? emotions? (chapter 3). Circadian Rhythms? Is control important.

Menninger: no separate psychiatric illnesses. only degress of psychological disorganization and threts to disintegration of mental funcitoning. the disorganization might be produced externally--grief, or internally, conflicts between awqrrring components of the mind. The disorganization and the attempts to master it produced the psychiatric symptoms. "Greater ilness was simply a minfiestation of greater dyscontrol; lesser illness a manifestation of lesser dyscontrol.. Only quantitative difference bwetween mental dyscontrol associated with irritability or mild anxiety and that which produced schizoprhenia.330-331

Freud: not as much in control as we'd like to believe.

pt. of article 53: I had to be perfect. I could not let things slip out.

our content analysis of psychiatraic outpatients.

What is importance of control: Functional Analysis (handout, p. 7). Cross-cultural: Bali. Role of religion and psychology? Self-control, control by a benevolent other (Taylor); Handout, p. 3, terms JUNG: patients all needed religion. MODERN MAN IN SEARCH OF A

SOUL. AMONG ALL MY PATIENTS IN THESECOND HALF OF LIFE--over 35--there has not beenone whose problem in the last resort was not that of finding a religious outlookon life. It is safe to say that everyone of them fell ill because he had lost that whichthe living religions of every age have given totheir followers,and none of them has been relally healed who did not regain his religlious outlook. modern man in searh of a soul, p. 244

2.2 and mortality (Rodin and Langer nursing home study) HANDOUT TWO.

overcontrol (Brady's monkeys);

too little control (Blume and Weiss: higher danger of ulcers and stomach lesions; Seligman's learned helplessness)

stress and productivity: U shaped curve; Yerkes/Dodson

Stress Hardiness: Maddi and Kabasa: committment, control, challenge

Perceived control (Glass and Singer)

ILLUSION OF CONTORL. alcoholism

2.3 Warning signs of stress: from Selye (also eustress/ distress); Holmes and Rahe (less than 150, 30%; 150-300, 50/50; over 300, 90% chance

2.4 Self-observation: how do you know if you are feeling TAKE OUT PENCIL ANDPAPER stressed: cognitive; somatic; visual.

Content Analysis Control Scale for psychiatric patients

2.5 is stressor in your control or outside your control

Issue of Denial (psychodynamic-- article 53)

benefits/problems

four quadrants. JOKE; MAN ON MT., ANYNE THERE.

3. CLINICAL ISSUES IN HUMAN CONTROL AND SELF-CONTROL (handout p. 8, systems theory)

3.1. Motivation,

decision making: FEAR OF GOAL: LADDER JOKE; ZEN WOBBLE.

freedom reflex,

belief system,

responsibility, NEJM: TUBERCULOSIS ONCE THOUGHT TO BE DISEASE OF EXCESSIVE FEELING

adherence and compliance.

Example: Stress prevention:

hot meal (good breakfast); 7 to 8 hours sleep;
regular exercise; no smoking; no (low) caffeine
social support (people you can talk to about problems); give and receive affection;
able to speak openly about feelings when angry or worried;
take quiet time for myself during the day;
plan a fun activity at least once a week;

3.2 Adjust/ avoid/ accept; JOKE PEANUTS; PUSH QUICKLY,