There have been major advances during the last 60 years regarding both, the diagnosis and treatment of mental disorders. Contemporary psychiatry is comparable to cardiology in consideration of life expectancy as well as the quality of life of patients treated. The application of the "disease model" exhibits significant advances concerning crucial clinical and research issues such as: (i) Taxonomy of mental disorders. (ii) Exploring the potential underlying mechanisms. (iii) Applying modern therapeutic models (pharmacological and psychotherapeutic). However, the "disease model" has some fundamental shortcomings, (i) it victimizes and pathologizes, (ii) it focuses on weaknesses and malfunction, while tending to ignore talents of the individual, (iii) It rushes to the request for assistance as dictated by disease/disorder, without investing in promoting healthy life.

In this framework it appears imperative that the principles of "positive psychology" not be applied in a contradictory, but in a complementary way.

In contrast "positive psychology" is focused on strength as well as weakness, and is interested in building the best things in life while repairing the worst. It is also concerned with making the lives of normal people fulfilling and with nurturing high talents as with hailing pathology.

The following models are currently applied in promoting mental health: (i) the clinical model, based on the criterion of the behavior "Above Normal", (ii) the maturity model, (iii) the model of positive psychology, (iv) the models of social/emotional intelligence, (v) the model of subjective well-being, (vi) the adaptation model (Resilience).

The models based on the perspective of "positive psychology" put forward questions regarding the elucidation of innate diagnostic and treatment issues whereas simultaneously reinforcing the need for localization and regulation of weaknesses and difficulties. However, these models have no constructive coherence. Furthermore they do not manifest unified hypotheses regarding the promotion of mental health, constituting a system of health rules with limited practical application.

It is a common, eternal, and cross-cultural experience that clinical psychiatry and research are associated with prejudice. Both the "disease model" and "positive psychology" are considered with prejudice; hence a vicious circle is formed.

An obvious question is raised: what is the nature of prejudices and how are they elicited and/or maintained?

Although the term prejudice includes a wide spectrum of beliefs and behaviors, a common denominator that reflects the essence of the theme is an incorrect conception of the dipole between cause and effect. Given the need of the organism to comprehend its environment with consistency and dealing with it effectively, this leads the organism to calibrate the relationships between cause and effect. In other words, whereas the individual seeks the best possible relationship with our tyrants of our life, i.e., pleasure and displeasure are subjected to errors, which correspond to type I and type II statistical errors. Type I statistical error is equivalent to prejudice.

Prejudices exhibit cross-cultural universality being resistant to education. This rather general position appears to be adopted from the scientific community and the same position might be applied irrespective of whether the prejudice is attributed to the individual, is carried cross-culturally, or yet is determined genetically.

Contemporary advances in neuroscience and the related fields supported by the clinical practice provide evidence with explanatory power regarding underlying mechanisms that serve and express the prejudice. Empirical research provides evidence indicating that the nature of prejudice is of dissociative texture being associated with childhood injuries.

Psychophysiological studies lend support to the notion that contradictory reasoning, "ex-consequentia reasoning", forms the sensitive substratum that predisposes for the becoming and maintenance of post-traumatic stress disorder and further anxiety disorders.

Paradoxical causation concerns the coincidence such as intuition pre-apprehension and telepathy are characterized as magical ideation, which is regarded as the core of positive symptom of schizophrenic delusion.
For the production and preservation of prejudices, the learning’s theories suggest the implication of Social Learning, the Cognitive Dissonance, the Attribution Theory as well as the Gestalt Theory.

Congruent evidence indicates that the left prefrontal cortex (Broadman area 45) responds based on beliefs, but not reasoned analysis; in contrast the right prefrontal cortex is activated during uncertain information based on reasoned analysis inhibiting/preventing the left prefrontal cortex from deducing immature conclusion. In this sense it is indicative that the impairment of the prefrontal cortex, with its connections being thought to underlie the prejudice, manifests significant correlation with the clinical and non-clinical obsessive-compulsive symptomatology.

It was not so long ago when inflammations were attributed to "sins" and/or "wicked ghosts" but their successful treatment was established with the implementation of evidence-based methodology, finally a modification of the way of thinking. Mutatis mutandis we are obliged to approach and manage the dilemma involved in the prejudice: Astronomer vs Astrologer, Chemist vs Alchemist, Doctor vs Charlatan.

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References

• Bloom CM, Venard J, Harden M, Seetharaman S. Non-contingent positive and negative reinforcement schedules of superstitious behaviors. Behav Processes 2007, 75:8–13
• Goel V, Vartanian O. Negative emotions can attenuate the influence of beliefs on logical reasoning. Cogn Emot 2011, 25:121–131
• Παπαδημητρίου ΓΝ, Λιάππας ΙΑ, Λύκουρας Ε. Σύγχρονη Ψυχιατρική. ΒΗΤΑ Ιατρικές Εκδόσεις, Αθήνα, 2013
• Subbotsky E. The permanence of mental objects: Testing magical thinking on perceived and imaginary realities. Development Psychol 2005, 41:301–318