UNIT 1 HISTORICAL PERSPECTIVES OF MENTAL HEALTH

Structure

1.0 INTRODUCTION

Since psychological abnormality or mental illness has existed in the past and continues to exist in the present. This unit discusses about the existence and treatment of abnormal behaviour historically through various eras. With the help of history we can understand how each society has struggled to understand and treat psychological problems. Present, views and treatment has reflected some of the issues of difficulty in dealing with mental illness or abnormal behaviour in the past.

1.1 OBJECTIVES

With the help of this unit, you will be able:

- to understand the historical perspectives of mental illness;
- to know the evolution of current trends from ancient, middle age and 19th century views of mental illness;
- to know the method (criteria/descriptions) of identifying mental illnesses; and
- to understand the importance of promoting mental health.

1.2 HISTORICAL PERSPECTIVES OF MENTAL ILLNESS

1.2.1 Ancient Views

In the ancient times, any abnormal behaviour shown by an individual was viewed as a product of supernatural forces. It was believed that all such phenomena were a result of the actions of magical, sometimes sinister beings which controlled the world. In particular, ancients viewed the human body and mind as a battleground between external forces of good and evil. Abnormal behaviour was typically interpreted as a victory of evil spirits, and the cure for such behaviour was to force the demons to come out from the victim's body. This supernatural view of abnormality may have begun as far back as the Stone Age, a half-million years ago. Some skulls from that period recovered in Europe and South America show evidence of an operation called **trephination,** in which a stone instrument, or trephine, was used to cut away a circular section of the skull. Historians surmise that this operation was performed as a treatment for severe abnormal behaviour—either hallucinations, in which people saw or heard things not actually present, or melancholia, characterized by extreme sadness and immobility. The purpose of opening the skull was to release the evil spirits that were supposedly causing the problem.

However, this assumption is debatable as some scholars believe that trephination may instead have been used to remove bone splinters or blood clots caused by stone weapons during tribal warfare. Whether this method was used for treating abnormal behaviour or for removing clots, it is known that later societies clearly did attribute abnormal behaviour to possession by demons. Egyptian, Chinese, and Hebrew writings all account for psychological deviance this way. The treatment for abnormality in these early societies was often **exorcism.** The idea was to coax the evil spirits to leave or to make the person's body an uncomfortable place in which to live. A shaman, or priest, would recite prayers, plead with the evil spirits, insult them, perform magic, make loud noises, or have the person drink bitter portions. If these techniques failed, the shaman performed a more extreme form of exorcism, such as whipping or starving the person.

1.2.2 Greek and Roman Views

Over the centuries, the way in which abnormal behaviour was understood and explained changed. The naturalist approach to understanding abnormal behaviour dates back to the observations and records of Ancient Greek

physician Hippocrates. In the years from roughly 500 B.C. to A.D. 500, in the flourishing Greek and Roman civilizations, philosophers and physicians identified a number of mental disorders. The most prominent conditions identified by these philosophers and physicians were: *melancholia* which is a condition marked by unshakable sadness; *mania* which is a state of euphoria and frenzied activity; *dementia* which is a general intellectual decline; *hysteria* which is the presence of a physical ailment with no apparent physical cause; *delusions* which are idiosyncratic beliefs that are firmly held without adequate basis; and *hallucinations* that are the experience of imagined sights or sounds as if they were real. Although demonological interpretations of mental and physical illness were still widespread, philosophers and physicians began to offer alternative explanations during this period. Therefore there was clear cut commonality in the identified abnormal behaviour then and in the present era.

Hippocrates (460–377 B.C.), often called the father of modern medicine, taught propagated that illnesses had natural causes. He saw abnormal behaviour as a disease arising from internal physical problems. Specifically, he believed that some form of brain pathology was the cause and that resulted—like all other forms of disease, in his view—from an imbalance of four fluids, or **humors,** that flowed through the body: yellow bile, black bile, blood, and phlegm. An excess of yellow bile, for example, caused mania; an excess of black bile was the source of melancholia. To treat psychological dysfunction, Hippocrates sought to correct the underlying physical pathology. He believed, for instance, that the excess of black bile underlying melancholia could be reduced by a quiet life, a vegetable diet, temperance, exercise, celibacy, and even bleeding. Hippocrates' His focus on internal causes for abnormal behaviour was shared by the great Greek philosophers Plato (427–347 B.C.) and Aristotle (384–322 B.C.) and by other influential Greek and Roman physicians. Mental disturbance were noted and theories of abnormal behaviour developed. The reason behind such disturbances was supposed to be caused by biological factors.

1.2.3 Middle Ages

In the middle ages, the explanations towards any kind of abnormal behaviour shown by individuals were guided by supernatural beliefs only. The enlightened views of Greek and Roman physicians and scholars did not prevent ordinary people from continuing to believe in demons. And with the decline of Rome, demonology enjoyed a strong resurgence, as a growing distrust of science spread throughout Europe. From A.D. 500 to 1350, the period known as the Middle Ages, the power of the clergy increased greatly throughout Europe. In those days the church rejected scientific forms of investigation, and it controlled all education. Religious beliefs, which were highly superstitious and demonological and it dominated almost all aspects of life. Once again, the abnormal behaviour was as usual interpreted as a conflict between good and evil, God and the devil. Deviant behaviour, particularly psychological dysfunction, was seen as evidence of Satan's influence. Although some scientists and physicians still insisted on medical explanations and treatments, their views carried little weight in this atmosphere. The Middle Ages were a time of great stress and anxiety, of war, urban uprisings, and plagues. People blamed the devil for these troubles and feared being possessed by them. The incidence of abnormal behaviour apparently increased dramatically during this period. In addition, there were outbreaks of mass 'madness,' in which large numbers of people apparently shared delusions and hallucinations.

Studies reflect that amongst them, in one such disorder, **tarantism** (also known historically as St. Vitus's dance), groups of people would suddenly start to jump, dance, and go into convulsions. Some dressed oddly; others tore off their clothing. All were convinced that they had been bitten and possessed by a wolf spider, called a tarantula, and they sought to cure their disorder by performing a dance called a tarantella. In another form of mass 'madness,' **lycanthropy**, people thought they were possessed by wolves or other animals. They acted wolf-like and imagined that fur was growing all over their bodies. Stories of lycanthropes, more popularly known as were wolves, have been passed down to us and continue to fire the imagination of writers, moviemakers, and their audiences. Not surprisingly, some of the earlier demonological treatments for psychological abnormality re-emerged during the Middle Ages. Like the ancient times, it was again thought that the best possible way to cure such abnormal behaviour was to get the person's body rid from the devil that possessed it. Exorcisms were revived, and clergymen, who generally were in charge of treatment during this period, would plead, chant, or pray to the devil or evil spirit. If these techniques did not work, they had others to try, some indistinguishable from torture like activities.

Anyhow, with the advent of development and changes, these methods began to lose favor. Towns throughout Europe grew into cities, and municipal authorities gained more power and took over nonreligious activities. Among their other responsibilities, they began to run hospitals and direct the care of people suffering from mental disorders. During these same years, many people with psychological disturbances received treatment in medical hospitals.

1.2.4 The Nineteenth Century

Thus, gradually abnormal behaviour was seen as an illness and in the 18th and 19th century, hospitalization of those who were mentally disturbed became common. The conditions of these hospitals and asylums were usually degrading and cruel. Late in the eighteenth century Philippe Pinel and William Tuke were pioneers in bringing about reform in these institutes. Their approach came to be known as moral therapy. They stressed on the need for peaceful environments for these institutes, need to provide useful work to the patients and the need to provide dignified treatment. In the 19th century Dorothy Dix and others were responsible for development of more number of humane hospitals and institutions. However, the reformers could not find the expected results because many of the patients were kept in hospitals primarily for custodial care. The conditions deteriorated in the hospitals and institutions because of lack of personnel to cater to the large number of patients.

1.2.5 The Early Twentieth Century

The view of mental illness in 19th Century was declining by the late 1800s, when two opposing perspectives emerged and began to vie for the attention of clinicians: the **somatogenic perspective,** the view that abnormal psychological functioning has physical causes, and the **psychogenic perspective,** the view that the chief causes of abnormal functioning are psychological. These perspectives came into full bloom during the twentieth century.

1.2.5.1 The Somatogenic Perspective

The somatogenic perspective was based on Hippocrates' view that abnormal behaviour resulted from brain disease and an imbalance of humors. One of the factors that were responsible for this new beginning was the work of an

eminent German researcher, Emil Kraepelin (1856–1926). In 1883 Kraepelin published an influential textbook which argued that physical factors, such as fatigue, are responsible for mental dysfunction. He identified various syndromes, or clusters of symptoms; listed their physical causes; and discussed their expected course. Kraepelin also measured the effects of various drugs on abnormal behaviour. New biological discoveries also triggered the rise of the somatogenic perspective. By the 1950s, a number of effective medications were finally discovered, by this time, the somatogenic perspective truly begin to pay off for patients.

1.2.5.2 The Psychogenic Perspective

The late nineteenth century also saw a parallel emergence of the somatogenic approach, called the psychogenic perspective. The psychogenic perspective viewed that the chief causes of abnormal functioning are often psychological. This view, too, had a long history. The Roman statesman and orator Cicero (106–43 B.C.) opined that psychological disturbances could cause bodily ailments, and the Greek physician Galen believed that many mental disorders are caused by fear, disappointment in love, and other psychological events. However, the psychogenic perspective did not gain much importance until studies of hypnotism demonstrated its potential. It was used to help treat psychological disorders as far back as 1778, when an Austrian physician named Friedrich Anton Mesmer (1734–1815) established a clinic in Paris. His patients suffered from hysterical disorders, mysterious bodily ailments that had no apparent physical basis. A surprising number of patients seemed to be helped by this treatment, called *mesmerism*. The treatment was so controversial; however, that eventually Mesmer was exiled from Paris.

Among those who studied the effects of hypnotism on hysterical disorders was Josef Breuer (1842–1925) of Vienna. This physician discovered that his patients sometimes awoke free of hysterical symptoms after speaking candidly under hypnosis about past upsetting events. During the 1890s Breuer was joined in his work by another Viennese physician, Sigmund Freud (1856–1939). Freud's work eventually led him to develop the theory of **psychoanalysis,** which holds that many forms of abnormal and normal psychological functioning are psychogenic. In particular, he believed that unconscious psychological processes are at the root of such functioning.

Self Assessment Questions 1

Fill in the blanks:

1) In a disorder, called ..... (also known historically as St. Vitus's dance), groups of people would suddenly start to jump, dance, and go into convulsions.

2) ..... and ..... were pioneers in bringing about reform in the hospitals and asylums.

3) The somatogenic perspective views .....and the psychogenic perspective views .....

4) In the middle ages, the explanations towards any kind of abnormal behaviour shown by individuals were guided by ..... only.

1.3 HISTORICAL PERSPECTIVE OF MENTAL HEALTH

With changes in views towards abnormal behaviours and mental disturbances, attempts towards contributing sound mental health started getting importance. One of the initial attempts to define mental health took place in 1941 in the United States. John Clausen and his coworkers were commissioned to assess mental health for the draft board, as part of the Selective Training Act for enlistment of young men into the United States army. To assess the mental health of recruits, the board focused on the absence of psychosomatic symptoms. This approach of defining mental health was followed till the 1970's; wherein, the absence of psychopathology was considered as synonymous with normal. After the end of the world war, certain changes in the procedure for assessment of mental health were seen. At the end of world war, the normal adaptive behaviour of those who served in the army was studied and the observations were published in scientific literature. Important studies focused on the adaptation of non patients from the army into civilian life. It was Marie Johoda who brought a major change in the conceptualization of mental health in 1958. In her model, she proposed that the criteria for assessing mental health should focus on positive aspects of mental health, rather than on absence of symptoms of mental illness. According to her, an individual can be considered to be mentally healthy only if he/she is in touch with his/her identity and feelings, they should be oriented towards the future and overtime they should be fruitfully invested in life, their psyche should be integrated and provide them resistance to stress, they should possess autonomy and recognize what suits their needs, they should perceive reality without distortion and yet possess empathy and they should be master of their environment. They should able to work, love and play and be efficient in problem-solving.

More recently, Carol Ryff and her colleagues repeated Jahoda's analysis by surveying and integrating what different theorists/clinicians said about the psychological components of being and doing well—striving and thriving, as it were. They identified six points of convergence across discussions of psychological well-being, which agree substantially with those specified decades earlier by Jahoda:

- Autonomy
- Environmental mastery
- Personal growth
- Positive relations with others
- Purpose in life
- Self-acceptance

Moreover, Ryff and her colleagues created reliable and valid self-report surveys of these components of psychological well-being. Using these measures, they explored the links between psychological well-being and physical health, by finding positive associations and implicating the left prefrontal cortex to aid in the organization of goal-directed activity.

Another contemporary positive psychologist who developed Jahoda's earlier work is Corey Keyes. Keyes stated that the two dimensions- (mental health) and (mental illness) are two separate and distinguishable components. Keyes

explained the concept of complete mental health is as psychological well-being along with the absence of signs and symptoms of psychological disorder. While a condition of complete mental illness is defined by signs and symptoms of psychological disorder along with the absence of psychological well-being.

Other important longitudinal studies showed that mental health characteristics were predictable and that mental health can be empirically studied. Eventually, the importance of defining mental health has been increasingly recognized and attempts have been made to continue to describe and define mental health. An international body known as American Psychiatric Association has been actively involved in this field. It is also involved in categorising Psychological disorders on basis of its symptoms, causes and effects. It regulates a Diagnostic Statistical Manual (DSM) which provides a list of such disorders. The DSM 1V TR is the classification system of mental disorders published by American Psychiatric Association which uses the Global Assessment of Functioning, on one of its axes, to measure "above average" mental health.

1.3.1 DSM IV TR

This system involves assessing five areas of an individual's functioning so that the treatment can be planned accordingly and the course of the disorder can be predicted. The DSM comprises of five axes:

Axis I: Clinical disorders and other conditions that may be a focus of clinical attention

This axis is used for listing the various forms of abnormality, that is, the clinical syndromes or disorders with the exception of the personality disorders and mental retardation, such as schizophrenia, the different types of anxiety disorders, such as social phobia, specific phobia, generalised anxiety disorder, obsessive compulsive disorder, etc. If an individual has more than one Axis I disorder, all should be reported with the primary reason for the visit being listed first.

Axis II: Personality disorders and mental retardation

All the personality disorders like paranoid personality disorder, narcissistic personality disorder, etc., and mental retardation are reported on Axis II. Maladaptive personality features or excessive use of defense mechanisms can also be mentioned here. This axis ensures that the unhealthy personality characteristics and mental retardation will be taken into account while attending to the primary complaint.

Axis III: General medical conditions

This axis is for reporting the general medical conditions that are important in understanding an individual's mental disorder. General medical conditions may be related to the mental disorders in several ways. In some cases they may play a role in the development of an Axis I disorder, for example, hypothyroidism may lead to depressive symptoms in some or an individual may develop an adjustment disorder as a reaction to the diagnosis of brain tumour. In certain cases medical conditions may influence the treatment of the Axis I disorder, for instance, a person's heart disease may influence the clinician's choice of medicines for this patient's depression.

Axis IV: Psychosocial and environmental problems

The psychosocial and environmental problems that influence the diagnosis, treatment and prognosis (future course) of mental disorders listed on Axis I and/or II are reported on this axis. This includes a negative life event, interpersonal stresses, lack of social support, etc. These problems may influence the development or treatment of mental disorders or may develop as a result of the Axis I/II condition.

Axis V: Global assessment of functioning

This axis is for reporting the clinician‘s judgement of the individual‘s overall functioning, which is useful in treatment planning or predicting its outcome. The Global Assessment of Functioning (GAF) scale is used to rate the individual‘s psychological, social and occupational functioning. For example, score of 100 means superior functioning with no symptoms, while a score of 50 indicates serious symptoms.

1.3.1.1 Global Assessment of Functioning (GAF scale) – the scale range and its interpretation may be mentioned as follows:

91 – 100 - Superior functioning in a wide range of activities, life’s problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.

81 – 90 - Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members).

71 – 80 - If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in school work).

61 – 70 - Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social occupational, or school functioning (e.g., occasional truancy or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.

51 – 60 - Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers).

41 – 50 - Severe symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational or school functioning (e.g., no friends, unable to keep a job).

31 – 40 - Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).

21 – 30 - Behaviour is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability

to function in almost all areas (e.g., stays in bed all day, no job, home, or friends).

11 – 20 - Some danger of hurting self or others (e.g., suicidal attempts without clear expectation of death; frequently violent; manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears feces) OR gross impairment in communication (e.g., largely incoherent or mute).

1 – 10 - Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.

0 - Inadequate information.

Self Assessment Questions II

State whether the following statements are 'True' or 'False':

1) Axis I is used for listing the various forms of abnormality, that is, the clinical syndromes or disorders with the exception of the personality disorders and mental retardation ..... .

2) It was John Clausen who brought a major change in the conceptualization of mental health in 1958 ..... .

3) DSM (IV) TR involves assessing seven areas of an individual's functioning so that the treatment can be planned accordingly and the course of the disorder can be predicted ..... .

4) Keyes stated that the two dimensions- (mental health) and (mental illness) are two separate and distinguishable components ....

1.3.2 A Growing Emphasis on Preventing Disorders and Promoting Mental Health

After the consideration of mental health, an emphasis was given towards preventing individuals from disorders and promoting individuals' mental health and well being. The process of prevention programmes began after the 1960's. Primary prevention programmes attempted to enhance the resilience or the ability to cope with stressful environment. Later on with the emergence and growth in the field of positive psychology the prevention programs focussed on promoting and preventing strategies. Positive psychology is the study and enhancement of positive feelings such as optimism and happiness. It recognizes and encourages positive traits like perseverance and wisdom. It focuses on strengthening positive abilities such as interpersonal skill and other talents. Finally, it promotes group-directed virtues (community support system), and promotes altruistic deeds and tolerance.

In the clinical arena, positive psychology suggests that practitioners can help people best by promoting positive development and psychological wellness. While researchers study and learn more about positive psychology in the laboratory, a growing number of clinicians are already beginning to apply its principles in their work. Studies show that the positive psychologists are teaching people coping skills that may help protect them from stress and adversity and encouraging them to become more involved in personally

meaningful activities and relationships. Thus, it can be observed that there is increased focus on promoting mental health proactively, preventing mental disorders by addressing the risks factors.

1.4 LET US SUM UP

The above discussion shows a swift in thought of individuals towards the abnormal behaviour. Historically, abnormal behaviour has been viewed as a product of supernatural forces. Over the centuries, the way in which abnormal behaviour was understood and explained also changed. The naturalist approach to understanding abnormal behaviour dates back to the observations and records of Ancient Greece physician Hippocrates. Mental disturbance were noted and theories of abnormal behaviour developed. These disturbances were believed to be caused by biological factors. In the middle ages, supernatural explanations again surfaced and dominated concepts about abnormal behaviour. However, gradually abnormal behaviour was seen as an illness and in the 18th and 19th century, hospitalization of those who were mentally disturbed became common. But the patients were treated in an unkind manner. Late in the eighteenth century Philippe Pinel and William Tuke started the moral therapy to change the condition. Unfortunately, the moral treatment movement disintegrated by the late nineteenth century, and mental hospitals again became warehouses where the inmates received minimal care.

In the 19th century two opposing perspectives emerged - somatogenic perspective, the view that abnormal psychological functioning is caused primarily by physical factors and psychogenic perspective, the view that the chief causes of abnormal functioning are psychological. An important factor in the rise of the latter was the use of hypnotism to treat patients with hysterical disorders. Sigmund Freud's psychogenic approach, psychoanalysis, eventually gained wide acceptance and influenced future generations of clinicians.

Initially mental health was equalized with the absence of psychopathology. Later, after the world war the view of mental health changed gradually, and in 1958, Marie Johoda gave the criteria for assessing mental health. Her model emphasized on looking at the positive aspects of mental health rather than simply the absence of symptoms of mental illness. Vaillant suggested that mental health should be broadly defined; and that it should be based on fundamental premise of cultural sensitivity and it should be empirically and longitudinally validated.

The process of development of prevention programmes began after the 1960's. Primary prevention programmes attempted to enhance the resilience or the ability to cope with stressful environments.

1.5 UNIT END QUESTIONS

1) Write about the ancient views of mental illness.

2) Describe the biological explanation of mental illness given by Hippocrates.

3) Write about somatogenic and psychogenic perspectives.

4) What are the criteria that were given by Marie Jahoda to assess mental health?

5) How do the current concepts of mental illness differ from ancient views?

6) Write about the importance of promoting mental health.

1.6 ANSWERS TO SELF ASSESSMENT QUESTIONS

Self Assessment Questions 1

1) tarantism

2) Philippe Pinel and William Tuke

3) The somatogenic perspective views that abnormal psychological functioning has physical causes, and the psychogenic perspective views that the chief causes of abnormal functioning are psychological.

4) Supernatural beliefs

Self Assessment Questions 2

1) True

2) False

3) False

4) True

1.7 REFERENCES

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