CHAPTER-II

MENTAL HEALTH: A CONCEPTUAL FRAMEWORK

"Without health life is not life; it is only a state of languor and suffering- an image of death”

Buddha

2.1 MENTAL HEALTH

The concept of health is so familiar that many of us have never thought much about what it really means. If asked, most people would define health as “the absence of disease.” And in fact, if you look up ‘health’ in the Merriam-Webster dictionary, you will find a very similar definition as “the condition of being sound in body, mind, or spirit; especially freedom from physical disease or pain.” While this common definition of health certainly has merit, I think it’s too limiting and reductionistic. Imagine someone, Person A, who is the picture of physical health, he has boundless energy, perfect digestion, a sharp mind, no chronic, inflammatory conditions and rarely, if ever, get cold and flu. But in other areas of life, this person is a wreck, he has terrible relationships, he is selfish and does not contribute to the lives of others, he has no sense of humour, rarely has fun and is miserable most of the time. Now consider someone, Person B, who is in many ways the opposite of Person A, perhaps she has an autoimmune disease, she struggles with low energy, her digestion is weak, and she sometimes has difficulty sleeping. But unlike Person A, her life is incredibly rich and satisfying, she has deep, nourishing relationships with others, she does meaningful work that makes a difference in the world, she is full of joy and humour and she loves to have a good time. Which of these persons is truly healthy? Both? Neither? If you had to choose between these alternatives, which would you choose? Of course, there is another possibility; Person C. Person C is healthy physically as well as mentally, emotionally and socially. This is certainly what most of us aspire to, and it’s a perfectly natural and valid goal. The problem is that it’s not always attainable. A man named Moshe Feldenkrais, the creator of the Feldenkrais method, designed to improve human functioning by increasing self-awareness through movement, defined

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3Ibid.
4Ibid.
health as “the ability to live your dreams.” This definition does not refer to the absence of pain, discomfort, or disease. Instead, it points more toward a quality of life and way of being in the world. ³ ‘Mental Health’ is the key to wholesome adjustments; it denotes a sound state of mind; and it means facing and accepting the facts squarely.⁶ Mental health refers to a broad array of activities directly or indirectly related to the mental well-being component included in the WHO’s definition of health: “A state of complete physical, mental and social well-being, and not merely the absence of disease”. It is related to the promotion of well-being, the prevention of mental disorders, and the treatment and rehabilitation of people affected by mental disorders.⁷ The United States National Committee for Mental Hygiene defines mental health as the adjustment of individuals to themselves and the world at large with maximum effectiveness, satisfaction, cheerfulness and socially considerate behaviour and the ability to face and accept the realities of life.⁸ A sound mind in a sound body has been recognised as a social ideal over the centuries. Mental health is a balanced development of the individual’s personality and emotional attitudes which enables him to live harmoniously with rest of the society. Mental health is not an exclusive relation between persons. It is related with the community he lives in and the bigger society of which community is only a part. It is related with the social and educational institutions which build his life and establish him as a human being. It is the mental health that determines the individual’s earnings, life style, happiness, leisure, stability and security.⁹

2.2 HISTORY OF MENTAL HEALTH

Looking back at history we find that in the mid 19th century, William Sweetzer was the first to clearly define the term ‘Mental Health’, which can be seen as the precursor to contemporary approaches to work on promoting positive mental health.¹⁰

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³Ibid.
⁸Group 1 (MAPEH), Supra note 6.
⁹Dr. Nandita Adhikari, Law and Medicine 207 (2nd edn. 2009).
Isaac Ray, one of thirteen founders of the American Psychiatric Association, further defined ‘mental hygiene’ as an art to preserve the mind against incidents and influences which would inhibit or destroy its energy, quality or development.\textsuperscript{11}

Major reform movements were conducted by two people, Dix and Beers. These two outstanding persons spent all of their later lives to bring the detestable conditions that persons with mental illness were exposed to, to the attention of society. It was in the middle of the 19th century that find, Dorothea Dix and later around 1908, Clifford Beers fighting for better treatment of the insane. Dorothea Dix was the first to make the public aware of the abominable living conditions of the mentally ill when she did a one-person campaign across the country in the mid 1800’s.\textsuperscript{12} She was the first to document the conditions and made it possible to get the government involved. Yet so many continued to ‘fall through the cracks’ so as time when on, many nonprofits were organized to handle the ‘grass root’ problems of those not meeting the criteria of the government.\textsuperscript{13} The origin of the mental hygiene movement can be attributed to the work of Clifford Whittingham Beers in the USA. In 1908 he published a book, named as \textit{A mind that found itself}, based on his personal experience of admissions to three mental hospitals. The book had a great repercussion and in the same year a Mental Hygiene Society was established in Connecticut. The term ‘mental hygiene’ had been suggested to Beers by Adolf Meyer and enjoyed a quick popularity. In 1909 the National Commission of Mental Hygiene was created. From 1919 onwards, the internationalization of activities of this Commission led to the establishment of some national associations concerned with mental hygiene in France and South Africa in 1920, in Italy and Hungary in 1924. From these national associations, the International Committee on Mental Hygiene was created and later superseded by the World Federation of Mental Health.\textsuperscript{14}

\textsuperscript{13}Ibid.
\textsuperscript{14}Jose Bertolote, “The Roots of the Concept of Mental Health”, World Psychiatry (2008);7(2):113–116.
2.3 NORMALITY AND ABNORMALITY

Because there are no clear biological diagnoses, psychological disorders are instead diagnosed on the basis of clinical observations of the behaviors that the individual engages in. These observations find that emotional states and behaviors operate on a continuum, ranging from more ‘normal’ and ‘accepted’ to more ‘deviant’, ‘abnormal’ and ‘unaccepted’. The behaviour of each of us departs at times from what is considered normal. Under certain circumstances we may be inappropriately hostile, intensely anxious, or deeply depressed. Now and then we may withdraw from situations or be unable to maintain our relationships with people. The behaviors that are associated with disorder are in many cases the same behaviors we that engage in our ‘normal’ everyday life. Washing one’s hands is a normal healthy activity, but it can be overdone by those with an obsessive-compulsive disorder (OCD). But only when such behaviour becomes a person’s characteristic way of dealing with life situations do we call it abnormal. The term abnormal literally means away from normal. That is, the abnormal is defined in terms of the normal. In medical science, normal generally means the integrity of structure and function of an organ or other body part. A broken bone, an excess of certain sugars in the blood, an ulcer on the wall of the stomach are all abnormal. For physicians, the line between normal and abnormal is usually easy to draw. For psychologists and psychiatrists, the criteria that divide normal behaviour from abnormal are not so easily defined. Normal behaviour has also been defined as behaviour that accords with the customs of a culture; within this framework, behaviour that departs from these customs is called deviant. Using this criterion, the psychiatrist Harry Stack Sullivan believed normal behaviour to be behaviour that is adopted in a culture by the consensus of its members. By their approval, the group members give consensual validation to such behaviour. What is socially approved varies from culture to culture, however, and the same behaviour may be normal in one culture and abnormal in

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17 Supra note 15.
18 Supra note 16.
19 Id at 446.
another.\textsuperscript{21} For example, in some countries it is normal for men to kiss each other, whereas, in the United States the majority of men do not exchange kisses.\textsuperscript{22} In this view, normality is merely conforming behaviour, and conformity is never abnormal. Most theorists would argue that a more basic criterion of well being is needed, for conforming behaviour can be highly maladaptive, as when it results in rigidity and inability to cope with novel situations.\textsuperscript{23} Some personality and developmental theorists define normality as a goal, or ideal, that people strive to attain. This definition of normality has been called the \textit{ideal mental health criterion}. However, the criterion of ideal mental health differs from theorist to theorist: For Abraham Maslow and Carl Rogers it is self-actualisation; for Erich Fromm it is productivity and for Erik Erikson, integrity.\textsuperscript{24}

2.4 ADJUSTMENT

\textit{Mental health} is determined by the way a person feels about himself, towards others and how he is able to face and adjust to day-today living conditions.\textsuperscript{25} Adjustment is not an easy term to define, partly because it has many meanings, partly because the criterion for evaluating adjustment have not been clearly defined, and partly because adjustment and its contrary, maladjustment, have common boundaries which tends to blur the distinctions between them.\textsuperscript{26} Adjustment is a word of many meanings, and it sometimes means different things to different people. This is because it is complicated and because sometimes it is good and sometimes it is bad. When it is bad, we usually call it maladjustment. Good or bad, it has many relations to mental health.\textsuperscript{27} Adjustment is often used in preference to the concept of normality, especially by psychologists with a humanistic orientation who are dissatisfied with the concept of normality; Szasz is one of these. Many psychologists speak of maladjustment rather than of abnormality because decisions about who is maladjusted do not seem to require reference to a fixed moral or evaluative standard. Although adjustment does imply a referent outside the person—adjustment to something—the maladjusted person himself can choose the standard to which he should adjust (at

\textsuperscript{21}Supra note 16 at 446.
\textsuperscript{22}Supra note 20 at 542.
\textsuperscript{23}Supra note 16 at 446.
\textsuperscript{24}Supra note 20 at 542.
\textsuperscript{25}Supra note 6.
\textsuperscript{26}Alexander A. Schneiders, \textit{Personality Dynamics and Mental Health: Principles of Adjustment and Mental Hygiene} 32 (1965).
\textsuperscript{27}Ibid.
least sometimes). His adjustment can then be judged on a range of efficient to inefficient. In this type of arrangement, the therapist need not impose upon his client a particular ideal or a particular moral judgement, as he must if he is concerned with a fixed concept of normality. There are four main aspects with which people are concerned: physical, psychological, social and moral. Physically, the goal of adjustment is survival. If a person feels hungry, he eats; if he is attacked by disease-causing germs, his body marshal materials to fight the disease. At the psychological level, the most basic referent for adjustment is probably pleasure, or subjective happiness. In Freudian and non-Freudian theory, the ego is the agent of adjustment; it mediates between primitive impulses from the id and the moralistic demands of the superego. By means of defence mechanisms, the ego protects itself from anxiety generated by unsatisfied id impulses or from threats to its self-esteem generated by the superego. Learning theory also says that pleasure and the avoidance of pain are the basic goals of adjustment. Responses that bring rewards are repeated and those that bring punishment are extinguished. In some situations, however, specification of reward is not so simple: Hungry people sometimes give their food to others, and some Hindus have chosen to starve to death rather than eat the meat of sacred cows. Thus, although it is probably true that psychological adjustment brings pleasure, it is necessary to consider that, depending on the individual, the pleasure may stem from such different sources as satisfaction of hunger, social approval, or even ethical behaviour. People live with and depend on other people; they cannot survive and be happy without dealing with other people. In other words, physical and psychological adjustment presuppose social, the third aspect of adjustment. At the social level, the referent for survival is probably the species. Individuals do not lead isolated lives; in order to survive and maximize their pleasure, they must work together. People form social contracts; they agree to cooperate, and they establish certain rules and regulations to ensure that the social organization runs smoothly. But it sometimes happens that adjustment on one dimension—say, the social—results in maladjustment on another—say, the psychological. For example, stealing is considered necessary in order to be accepted by peer groups in certain subcultures, so a young person in such a subculture must balance his psychological adjustment (stealing for adjustment) against his adjustment to the society at large, which prohibits stealing. And different societies have different organisations and rules, so what constitutes adjustment in one society—or even in one sub-culture—is maladjustment in another. You can see, then,
that any talk of adjustment requires referents: adjustment to things—a fit between
certain goal, standard, or problem in a specified situation and behaviour that is
designed to cope with the goal, standard, or problem. The final dimension of
adjustment, the moral one, overrides the others in the sense that a person asks: “What
form of adjustment is right? What should I do to adjust?” Although there is no easy
answer to that question, some psychologists have tried to outline a rough hierarchy of
bases of moral adjustment. Lawrence Kohlberg, for one, has studied moral adjustment
in children and young adults and has found that as a person matures, his judgements
of what is moral pass through six stages. People in the first two stages view
adjustment in terms of personal pleasure and pain. At the second two stages the
referent for adjustment is the rules and regulations of the person’s social system. In
the final two stages, the rules of the social system are subordinated to higher ethical
principles, and people adjust to the principles. Kohlberg’s stages of moral
development can be interpreted as outlining a hierarchy of moral adjustment. The
question of adjustment, then, is far simple. Each person weighs and balances the
demands of physical, psychological, social, and moral adjustment.28 To illustrate these
points, let us consider two cases. Both youngsters (Peter and Helen) were about the
same age from much the same social and economic background. But Peter was a
happy, carefree young man, who got along well in school, was liked by others, had a
deep interest in sports and hobbies, was proud of his family, and had already decided
what he wanted to be when he finished high school and entered college. Helen was
just the opposite. She was a moody youngsters, hostile toward her parents, jealous of
other children in the family, uninterested in schoolwork or social activities, and
almost without friends. She had twice run away from home and was showing definite
signs of failure in school. Helen is emotionally disturbed and poorly adjusted. Peter,
of course, would be described as a well-adjusted adolescent who will probably sail
into adulthood with a minimum of conflict, frustration, or unhappiness.29

What is the difference between these two young people? And why do we say
that one is well adjusted and the other is maladjusted? Is it the relation between them
and their environments? Is it the state of their own personal feelings? Is it the range or
depth of their interests and goals? We could say very simply that adjustment is

28 Supra note 20 at 543-544.
29 Supra note 26 at 33.
defined by how well you get along with yourself and with others— not a bad notion. But there are difficulties in this simple concept of adjustment. Strangely enough, the poor way in which Helen responded to circumstances and people must be regarded as adjustment. Hostilities, jealousies, moodiness, and so on were the way of coping with different situations. It is not the kind of behaviour that determines whether we are dealing with adjustment processes, but the way in which behaviour is used. Whether internal demands or environmental stresses are met by prayer, delinquency, neurotic symptoms, psychotic episodes, laughter, joy, or hostility, the concept of adjustment is applicable as long as the response serves to reduce or to mitigate the demands made on a person. When such responses are inefficient, detrimental to personal well-being, or pathological, they are designated as maladjustive.

Who, then, defines maladjustment? Physicians diagnose physical disorder; Courts rule on social abnormality according to the laws of the society; clergymen usually serve as authorities in the moral realm; and in most Western societies, psychiatrists and clinical psychologists decide about psychological maladjustment. Psychologist’s judgements are based on their training— both academic and practical— and on their experience. They interview a prospective patient and discuss his problem. The clinician uses his own conception his own conceptual categories of disorder as he processes the vast quantity of information he gets from the client. His categories are based on one of the models of normality, on his evaluation of the patient’s adjustment, or on some combination of normality and adjustment. In general, he will apply the label of abnormal or maladjusted to a person who is uncomfortable, who is unhappy with his inner life and interpersonal relations, who has difficulty performing the tasks expected of him, or whose actions appear bizarre.

2.5 COMMON PROBLEMS OF ADJUSTMENT

Problems of adjustment vary in degree. At the normal level are nervousness and worry, feelings of inferiority, and some lesser degrees of anxiety, and of

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30Ibid.
31Id at 33-34.
32Supra note 20 at 544.
33Ibid.
defensive behaviours. We all experience these types of failures, and hence in a statistical sense these common problems of adjustment are normal.\textsuperscript{34}

\subsection{2.5.1 Nervousness and Worry}

Nervousness by itself is not considered a serious problem. Many people suffer from nervousness at some point or another – some even from irrational nervousness. Being nervous is a part of being human, and recognizing that the world does have its dangers.\textsuperscript{35} Nervousness can overwhelm us and leave us feeling out of control. It feels as though we are driven to act like this, strengthens with every ‘attack’ and leads to constant searching for reasons and answers. Involving self-doubt, insecurity and fear, nervous problems can appear too powerful to deal with.\textsuperscript{36} When we look at the backgrounds of large numbers of people with nervous problems, they are often strikingly similar in many ways. Negative life experiences and subsequent feelings involving self worth and insecurity occur across the board with such regularity and are so similar that it is hard to see how they cannot possibly play a major role in these problems. Far from being an illness, something strange that has happened to us, or something that is wrong with us, we can see exactly how we become so nervous. It follows a logical psychological progression based on our life experiences and learning, and we can map out exactly what happens to cause it. Negative experiences, thoughts and feelings can become intertwined with deep-seated survival instincts to form a whole host of anxiety-related problems. The potential to develop these problems lies within us all, it’s a part of human nature, and it only takes a certain set of experiences to bring them out.\textsuperscript{37} Being nervous includes: feeling on-edge (jumpy and jittery), feeling apprehensive that something may happen, and being afraid to some degree. Nervousness marks the start of anxiety ‘kicking in.’ Heartbeat and breathing becomes faster and may have difficulty swallowing, begin to shake and tremble. Other symptoms include, blushing, stuttering and feeling generally uneasy. There is often an overwhelming need to flee or escape.\textsuperscript{38} Extreme nervousness does involve an element of anxious thinking but by far, the main part of these problems

\textsuperscript{34}B. Von Haller Gilmer, Psychology 427 (1970).
\textsuperscript{37}Ibid.
\textsuperscript{38}Ibid.
involves that second role of anxiety: our body being prepared for action.\textsuperscript{39} Whereas nervous habits may be overcome, with effort, by changing the responses or restraining the behaviour, the overcoming of chronic nervousness may require counselling or in more serious cases psychotherapy.\textsuperscript{40}

The mental counterpart of nervousness is called worry.\textsuperscript{41} Worry, feeling uneasy or troubled, seems to plague multitudes of people in our world today.\textsuperscript{42} Worry is like a rocking chair, it’s always in motion but it never gets you anywhere.\textsuperscript{43} Worry is the opposite of faith, and it steals our peace, physically wears us out, and can even make us sick.\textsuperscript{44} Some people are worriers, others are laid back. A little anxiety is a useful thing if it wasn’t for the motivation of a little anxiety, we would never catch a train, pass an exam or meet a deadline.\textsuperscript{45}

Worrying can be helpful when it spurs to take action and solve a problem. But if someone is preoccupied with “what ifs” and worst-case scenarios, worry becomes a problem. Unrelenting doubts and fears can be paralyzing. They can sap emotional energy, send anxiety levels soaring, and interfere with daily life. But chronic worrying is a mental habit that can be broken. People can train their brain to stay calm and look at life from a more positive perspective.\textsuperscript{46} Constant worrying takes a heavy toll. It keeps people up at night and makes them tense and edgy during the day.\textsuperscript{47} For most chronic worriers, the anxious thoughts are fueled by the beliefs—both negative and positive—they hold about worrying. On the negative side, people may believe that their constant worrying is harmful, that it’s going to drive them crazy or affect their physical health. Or they may worry that they are going to lose all control overworrying—that it will take over and never stop. On the positive side, people may believe that their worrying helps them to avoid bad things, prevents problems,
prepares them for the worst, or leads to solutions. Negative beliefs, or worrying about worrying, add to anxiety and keep worry going. But positive beliefs about worrying can be just as damaging.\textsuperscript{48}

Some of us arrange our worries in order of magnitude and if we have no real cause for concern, fall back upon a lesser feeling of just being uneasy. In amassing new worries it seems characteristics that we come round full circle. Worries tend to become exaggerated when they are kept bottled up inside. This is the reason that the good listener can be helpful at times. Seeking reliable information and doing something active about worry both tend to reduce it, as does turning to other types of behaviour. Some people are more prone to worry than others; some determine their worries, and some are other-directed; but at times we all worry. It seems to be built-in part of our makeup. George Lyon, the writer summed up worry as the interest paid by those who borrow trouble.\textsuperscript{49}

\textbf{2.5.2 Feeling of Inferiority}

Inferiority feelings begin in childhood and continue to crop up now and then throughout adulthood. They occur when someone does better than you, criticizes you, shows authority over you, hurts you, or otherwise gains advantage over you. Inferiority feelings are normal and even beneficial, because they lead to a compensating drive to become superior or improve yourself to avoid such feelings in the future.\textsuperscript{50}

Spoiling or pampering a child can also bring about an inferiority complex. Spoiled children are the centre of attention in the home. Their every need or whim is satisfied, and little is denied them. Under the circumstances, these children naturally develop the idea that they are the most important persons in any situation and that other people should always defer to them. The first experience at school, where these children are no longer the focus of attention, comes as a shock for which they are unprepared. Spoiled children have little social feeling and are impatient with others. They have never learned to wait for what they want, nor have they learned to overcome difficulties or adjust to other’s needs. When confronted with obstacles to

\textsuperscript{48}\textit{Ibid.}
\textsuperscript{49}\textit{Supra} note 34 at 428.
gratification, spoiled children come to believe that they must have some personal
deficiency that is thwarting them; hence, an inferiority complex develops. It is easy to
understand how neglected, unwanted and rejected children can develop an inferiority
complex. Their infancy and childhood are characterized by a lack of love and security
because their parents are indifferent or hostile. As a result, these children develop
feelings of worthlessness, or even anger, and view others with distrust.51

The inferiority complex, by contrast, does not motivate people; it paralyzes
them. People with an inferiority complex are convinced they are worthless or that they
will fail. They show their low self-esteem in all possible ways: with facial expression,
tone of voice, posture, choice of clothing and choice of activities. They avoid
challenge because they are sure they will fail.52

Attitudes of inferiority are found among children and adults alike and to such
a wide extent that we regard them as a normal aspect of living. Why are these feelings
so common? In some measure, it is because our culture is so success oriented. We
expect to win at games, to be outstanding in school, to get to the top in business and to
meet high professional standards. All of us in our attempts to measure up pick the
‘ideal’ as our standard. We tend to evaluate not by our abilities and accomplishments,
but by our handicaps and mistakes. And we know more about our own feelings than
anyone else does. We can provide some cover up for our feelings to the outside world
but find it difficult to pay a role to ourselves. Somewhere confronting us most of the
times is some indication of our inferiority. We feel sensitive to criticism, we react
poorly to competition and we may have a tendency to depreciate others. Even our
over response to flattery is an indication of these feelings. And we become more
conscious of our failures when we observe that maladjustment involves the whole
personality, that feelings of inferiority are a part of the picture. Feelings of depression
generally go along with severe inferiority. Whereas normal feelings of inferiority
relate to comparisons with the ideal, for the maladjusted person such comparisons
may turn to envy. He makes comparisons only about the things he is poor in, not
about those he is good in.53

51Aweken, “Inferiority Feelings: The Source of Human Striving”, available at:
19, 2014).
52Supra note 50.
53Supra note 34 at 428-429.
2.5.3 Degrees of Anxiety

Anxiety is hardwired into our brains. It is part of the body’s fight-or-flight response, which prepares us to act quickly in the face of danger. It is a normal response to uncertainty, trouble, or feeling unprepared. Mild anxiety is vague and unsettling, while severe anxiety can be extremely debilitating, having a serious impact on daily life. People often experience a general state of worry or fear before confronting something challenging such as a test, examination, recital, or interview. These feelings are easily justified and considered normal. Anxiety is considered a problem when symptoms interfere with a person’s ability to sleep or otherwise function. Generally speaking, anxiety occurs when a reaction is out of proportion with what might be normally expected in a situation.

At the most basic level, anxiety is an emotion. Simply stated, an emotion is a subjective state of being. It is often associated with changes in feelings, behaviors, thoughts, and physiology. Anxiety, like all emotional states, can be experienced in varying degrees of intensity. For instance, we might say we are happy. A more intense expression of this same emotion might be an experience of joy. But unlike the emotion “happiness”, which has several different words to convey these differing levels of intensity (e.g., intensity ranging from happiness to joy), anxiety is a single word that represents a broad range of emotional intensity. At the low end of the intensity range, anxiety is normal and adaptive. At the high end of the intensity range, anxiety can become pathological and maladaptive. While everyone experiences anxiety, not everyone experiences the emotion of anxiety with the same intensity, frequency, or duration as someone who has an anxiety disorder. There are an infinite number of human experiences that cause normal anxiety. Life offers us the experience of many anxiety-provoking “firsts” -- a first date, the first day of school, or the first time away from home. As we journey through life, there are many important life events, both good and bad, that cause varying amounts of anxiety. These events can include things such as, taking a school exam, getting married, becoming a parent,

getting divorced, changing jobs, coping with illness and many others. The discomfort anxiety brings in all of these situations is considered normal and even beneficial. Anxiety about an upcoming test may cause you to work harder in preparing for the exam. The anxiety you feel when walking through a dark and deserted parking lot to your car will cause you to be alert and cautious of your surroundings, or better yet, get an escort to your vehicle. While it’s pretty clear to see that anxiety is normal and even beneficial, for many people it becomes a problem. The main difference between normal anxiety and problem anxiety is in the source and the intensity of the experience. Normal anxiety is intermittent and is expected based on certain events or situations. Problem anxiety, on the other hand, tends to be chronic, irrational and interferes with many life functions. Avoidance behaviour, incessant worry and concentration and memory problems may all stem from problem anxiety. These symptoms may be so intense that they cause family, work and social difficulties. The components of problem anxiety include the physical responses to the anxiety such as palpitations and stomach upset, distorted thoughts that become a source of excessive worry and behavioural changes affecting the usual way one lives life and interacts with others. Left unchecked, problem anxiety may lead to an anxiety disorder.\(^{57}\)

2.5.4 Defensive Behaviour

Behaviour can be described as going in one of these directions: First, we may attack our problems in ways that lead to solutions. Most normal people do solve most of their problems in ways that lead to effective adjustments. Second, there are some situations that involve “no-solution” problems...Third are those problems that lie somewhat between effective solution and no solution. These are the problems to which we make partial or substitute adjustments. These are the behaviours we call defensive.\(^{58}\) In the face of confusion, disappointment, conflict and frustration, we fall back from time to time on defense mechanisms. Because we all engage in some forms of defensive behaviour, we regard these responses as normal. They hold us together at times when we need help. However, if used excessively they can become a crutch that


\(^{58}\)Supra note 34 at 429.
prevents us from searching to our problems. The behaviours which can be described as defensive are:

- **Dissociation**
  Dissociation is when a person loses track of time and/or person, and instead finds another representation of their self in order to continue in the moment. A person who dissociates often loses track of time or themselves and their usual thought processes and memories. People who have a history of any kind of childhood abuse often suffer from some form of dissociation. In extreme cases, dissociation can lead to a person believing they have multiple selves (multiple personality disorder). People who use dissociation often have a disconnected view of themselves in their world. Time and their own self-image may not flow continuously, as it does for most people. In this manner, a person who dissociates can “disconnect” from the real world for a time, and live in a different world that is not cluttered with thoughts, feelings or memories that are unbearable.

- **Projection**
  This involves individuals attributing their own thoughts, feeling and motives to another person. Thoughts most commonly projected onto another are ones that would cause guilt such as aggressive and sexual fantasies or thoughts. For instance, you might hate someone, but your superego tells you that such hatred is unacceptable. You can ‘solve’ the problem by believing that they hate you.

- **Displacement**
  Displacement is the redirection of an impulse (usually aggression) onto a powerless substitute target. The target can be a person or an object that can serve as a symbolic substitute. Someone who feels uncomfortable with their sexual desire for a real person may substitute a fetish. Someone who is frustrated by his or her superiors may go home and kick the dog, beat up a family member, or engage in cross-burnings.

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59Ibid.


62 Ibid.
• **Denial**
  Denial involves blocking external events from awareness. If some situation is just too much to handle, the person just refuses to experience it. This is a primitive and dangerous defense - no one disregards reality and gets away with it for long. It can operate by itself or, more commonly, in combination with other, more subtle mechanisms that support it. For example, smokers may refuse to admit to themselves that smoking is bad for their health.\(^6^3\)

• **Regression**
  This is a movement back in psychological time when one is faced with stress. When we are troubled or frightened, our behaviors often become more childish or primitive. A child may begin to suck their thumb again or wet the bed when they need to spend some time in the hospital. Teenagers may giggle uncontrollably when introduced into a social situation involving the opposite sex.\(^6^4\)

• **Acting Out**
  Acting Out is performing an extreme behavior in order to express thoughts or feelings the person feels incapable of otherwise expressing. Instead of saying, “I am angry with you,” a person who acts out may instead throw a book at the person or punch a hole through a wall. When a person acts out, it can act as a pressure release, and often helps the individual feel calmer and peaceful once again. For instance, a child’s temper tantrum is a form of acting out when he or she doesn’t get his or her way with a parent. Self-injury may also be a form of acting-out, expressing in physical pain what one cannot stand to feel emotionally.\(^6^5\)

• **Intellectualization**
  Intellectualization is the overemphasis on thinking when confronted with an unacceptable impulse, situation or behavior without employing any emotions whatsoever to help mediate and place the thoughts into an emotional, human context. Rather than deal with the painful associated emotions, a person might employ intellectualization to distance themselves from the impulse, event or behavior. For instance, a person who has just been given a terminal medical

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\(^6^3\)Ibid.  
\(^6^4\)Ibid.  
diagnosis, instead of expressing their sadness and grief, focuses instead on the
details of all possible fruitless medical procedures.  

- **Rationalization**
  Rationalization is putting something into a different light or offering a
different explanation for one’s perceptions or behaviors in the face of a
changing reality.  

- **Sublimation**
  Sublimation is simply the channelling of unacceptable impulses, thoughts and
emotions into more acceptable ones. This is similar to displacement, but takes
place when we manage to displace our emotions into a constructive rather than
destructive activity. This might for example be artistic. Many great artists and
musicians have had unhappy lives and have used the medium of art of music
to express themselves. Sport is another example of putting our emotions (e.g.
aggression) into something constructive. Sublimation can also be done with
humour or fantasy. Humour, when used as a defense mechanism, is the
channelling of unacceptable impulses or thoughts into a light-hearted story or
joke. Humour reduces the intensity of a situation, and places a cushion of
laughter between the person and the impulses. Fantasy, when used as a
defense mechanism, is the channelling of unacceptable or unattainable desires
into imagination. For example, imagining one’s ultimate career goals can be
helpful when one experiences temporary setbacks in academic achievement.
Both can help a person look at a situation in a different way, or focus on
aspects of the situation not previously explored.  

- **Compensation**
  Compensation is a process of psychologically counterbalancing perceived
weaknesses by emphasizing strength in other arenas. By emphasizing and
focusing on one’s strengths, a person is recognizing they cannot be strong at
all things and in all areas in their lives. For instance, when a person says, “I
may not know how to cook, but I can sure do the dishes”, they’re trying to

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66Ibid.  
67Ibid.  
68Supra note 60, available at:  
69Ibid.  
70Ibid.
compensate for their lack of cooking skills by emphasizing their cleaning skills instead. When done appropriately and not in an attempt to over-compensate, compensation is defense mechanism that helps reinforce a person’s self-esteem and self-image.\footnote{Ibid.}

- **Repression and Suppression**

  Repression is another well-known defense mechanism. Repression acts to keep information out of conscious awareness. However, these memories don’t just disappear; they continue to influence our behavior. For example, a person who has repressed memories of abuse suffered as a child may later have difficulty forming relationships.\footnote{Kendra Cherry, “Defense Mechanisms”, available at: http://psychology.about.com/od/theoriesofpersonality/ss/defensemech_4.htm (Visited on Nov. 28, 2014).} Sometimes we do this consciously by forcing the unwanted information out of our awareness, which is known as suppression. In most cases, however, this removal of anxiety-provoking memories from our awareness is believed to occur unconsciously.\footnote{Ibid.}

- **Reaction Formation**

  Reaction formation reduces anxiety by taking up the opposite feeling, impulse or behaviour. An example of reaction formation would be treating someone you strongly dislike in an excessively friendly manner in order to hide your true feelings. Why do people behave this way? According to Freud, they are using reaction formation as a defense mechanism to hide their true feelings by behaving in the exact opposite manner.\footnote{Supra note 72.}

2.5.5 **Behaviour in Unusual Situations**

  In emergencies, such as being caught on the highway in a severe snowstorm, people tend to be cooperative in seeking shelter and food; they place safety before comfort, and many of them view emergency situations with a measure of thrill once they feel reasonably safe.\footnote{Supra note 34 at 432.}

2.5.6 **Adjustments to Danger**

  There have been many formal studies of the reactions of military personnel to combat in the air, on land, and both on and under the sea. Two generalizations have

\footnotesize{\textsuperscript{71}Ibid.} \hfill \footnotesize{\textsuperscript{72}Kendra Cherry, “Defense Mechanisms”, available at: http://psychology.about.com/od/theoriesofpersonality/ss/defensemech_4.htm (Visited on Nov. 28, 2014).} \hfill \footnotesize{\textsuperscript{73}Ibid.} \hfill \footnotesize{\textsuperscript{74}Supra note 72.} \hfill \footnotesize{\textsuperscript{75}Supra note 34 at 432.}
come from these investigations. First, even the bravest of men get scared. Second, a preparation for danger is essential for both physical and mental health.\textsuperscript{76}

Psychologists have found that soldiers who are informed of a dangerous mission before it takes place will commit themselves to higher risks. If they learn of impeding action several days before H-hour, there will be fear but no emotional shock. The risks can be calculated, and the psychological preparation that follows lessens the fear.\textsuperscript{77}

\subsection*{2.5.7 Reaction to Disaster}

There is a big difference between the military man facing combat and the civilian facing catastrophe. Whereas the former has been prepared for trauma, knows what to do, and has confidence in “a system,” the latter is totally lost. For the civilian, the experience is often sudden and unexpected. Not all survivors react to disaster in the same way. Some are relatively cool (an estimated 15 percent) and approximately the same number show severe excitement and panic. The 70 percent in the majority conform pretty closely to a disaster syndrome. However, most individuals, regardless of the immediate reaction, tend to recover rapidly once the crisis is past. A few may be permanently damaged psychologically.\textsuperscript{78}

\subsection*{2.6 CRITERIA OF MENTAL HEALTH}

There is no clear-cut distinction between ‘mental health’ and ‘mental illness’. Those of us who are normal have periods of depression; we lose our tempers and walk blindly into problems leaving no avenue of escape. In a similar way, people who have been professionally classified as mentally ill are at times free of abnormal symptoms.\textsuperscript{79}

Mental or emotional health refers to our positive characteristics and overall psychological well-being. Mentally healthy people are known to deal with stress effectively by being able to bounce back from adversity. They are basically content

\begin{flushright}
\textsuperscript{76}Id. at 433. \\
\textsuperscript{77}Ibid. \\
\textsuperscript{78}Id. at 435. \\
\textsuperscript{79}Supra note 34 at 426.
\end{flushright}
people whose activities and relationships are meaningful. Some characteristics of mentally and emotionally healthy people are outlined as follows.\textsuperscript{80}

2.6.1 Mental Efficiency

Efficiency can be used to evaluate mental health. It is certainly significant that emotionally disturbed, neurotic, or inadequate personalities are characteristically lacking in this quality.\textsuperscript{81} Certainly health of any kind is basic to efficiency, and Jones, for example, considers efficiency to be one of the three main aspects of mental and normality, the other two being happiness and adaptation to reality. However the concept of efficiency has its own meaning, referring to the use of capacities to the best possible effect under the circumstances that exist at the time. Mental efficiency refers to the effective use of our capacities for observation, imagination learning, thinking and choosing, as well as the continuous development of mental functions to a higher level of efficiency. It requires, for example, using principles and methods of learning in a way that promotes the rapid acquisition of knowledge or skills. It excludes excessive fantasy thinking or distorted perception.\textsuperscript{82}

The highest form of mental efficiency, then, requires mental health. Deep-seated prejudices, hostilities, projections, or anxieties make it impossible to organise and control thinking in a way that is necessary to mental efficiency. Factors like these are the enemies of logic and truth. They stand in the way of effective studying and learning or of planning intelligently for the future. It can be seen that mental health stands in the same relation to mental efficiency to mental efficiency that physical health does to physical efficiency. Just as the sick child cannot play or study well, so the emotionally disturbed person cannot observe, think, or learn effectively.\textsuperscript{83}

2.6.2 Control and Integration of Thought and Conduct

Effective control is always one of the surest sign of healthy personality, and this applies particularly to mental process. An unbridled imagination, such as we see in excessive fantasy-thinking, is detrimental to mental health because it impairs the

\textsuperscript{81}Supra note 26 at 49.
\textsuperscript{82}Id. at 47.
\textsuperscript{83}Ibid.
relation between mind and reality. Without such control, obsessions, fixed ideas, phobias, delusions and other symptoms are likely to develop.\textsuperscript{84}

Integrity is also a basic characteristic of good mental health and involves the concept of matching words and deeds...Others may not agree with your beliefs or behaviors, but good mental health requires being true to yourself by following your words with consistent activities.\textsuperscript{85}

2.6.3 Integration of Motives and Control of Conflict and Frustration

The integration of thought and conduct is paralleled in the mentally healthy person by the ability to integrate personal motivations and to maintain control of conflicts and frustrations. When motives are not integrated, serious conflict can result...amusement often conflicts with personal responsibilities or integrity.\textsuperscript{86}

These divergent tendencies must be integrated with each other if conflicts and frustrations are to be controlled. It can be seen that control of conflict is an extension of the criterion of integration; however, it must be emphasized that it is necessary for the maintenance of mental stability.\textsuperscript{87}

2.6.4 Positive, Healthy Feelings and Emotions

The integration necessary to mental health can be strongly supported by positive feelings, and by the same rule negative feelings can act to disrupt or even to destroy mental stability. Deep feelings of insecurity, inadequacy, guilt, inferiority, hostility and hatred, jealousy, and envy and signs of emotional disruption, can lead to mental ill health. Contrary to such feelings are those of acceptance, love, belonging, security, and personal worth, each one of which contributes to mental stability and serves as a signpost of mental health. Of these feelings, security is probably the most dominant because of its pervasive effect on the relation between the person and reality demands. Emotional health, therefore, is an integral part of mental health, and

\textsuperscript{84}Id. at 49.
\textsuperscript{86}Supra note 26 at 49.
\textsuperscript{87}Id. at 49-50.
emotional adequacy, which may be defined in terms of the control, depth, and range of emotional life, is itself a criterion by which mental health can be evaluated.88

2.6.5 Tranquility or Peace of Mind

Many of the criteria of adjustment and mental health are oriented to peace of mind, which is often mentioned in discussions of mental health. Where there is emotional harmony, positive feeling, control of thought and conduct, integration of motives there will be tranquility. We cannot have the one without the other. This suggests that mental health, like adjustment, require the absence of disabling symptoms. The development of symptomatic responses, like day dreaming, delusions, or hallucinations, is directly opposed to mental stability.89

2.6.6 Healthy Attitudes

Attitudes are very similar to feelings in their relation to mental health. Invariably, in are encounter with maladjusted or disturbed personalities, we are forcibly reminded how important it is to maintain a healthy outlook regarding life, people, work, or reality. Mental health is impossible in a context of hatred and prejudices, pessimism and cynicism, or despair and hopelessness. Attitudes such as these are to mental health are certain bacteria and toxins to physical health.90

2.6.7 Having a Positive Self-Concept

Mentally healthy people have positive self-concept. For, example, Ramon is a person with a positive-concept. He is an officer of a student organization. He takes pride and full responsibility of the many projects he has directed. Nevertheless, he accepts the facts that some of his project may turn out well as planned. Ramon tries to improve his effort rather than put himself down by failures or difficulties. Ramon has a goal of becoming president of the organization, so he works hard to achieve his goal.91

Having positive self-concept makes way of an object judgment. He has the ability to look at all kinds of facts squarely and accurately, neither overlooking some

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88Id. at 50.
89Ibid.
90Ibid.
91Supra note 6.
nor exaggerating others. This ability is also called rationality, good sense and even common sense.\textsuperscript{92}

\textbf{2.6.8 Taking Responsibilities for Yourself}

Mentally healthy people take responsibility for themselves. They do not blame others for what happens to them, nor do they see themselves as victims in their world. Instead, they make decisions on how to handle their own problems or ask others for help when needed. An individual should have the self-realizing drive. This is the habit of working hard to one’s full capacity. People vary greatly in their physical, intellectual and social potentials, but it is possible to see how far an individual puts to work his own particular potential to achieve pleasing results.\textsuperscript{93}

\textbf{2.6.9 Having Satisfying Relationships}

Mentally healthy people accept others as they are and respect individual differences. They can give and accept love and support. They are sensitive to the needs of others and are concerned about another person’s thoughts and feelings. Mentally healthy people communicate clearly and honestly in order to build honest relationships.\textsuperscript{94}

\textbf{2.6.10 Adapting to Changes}

People often feel uncomfortable when they experience changes in their lives. This feeling is natural because any kind of change can be stressful. However, mentally healthy people tend to adapt change in their lives. They understand that learning to adapt can be a difficult process. Sometimes, they may lack confidence in their ability to adapt to changes, and they may have periods of self-doubt. However, mentally healthy people accept that change is a natural way of daily living. They adapt to new situations by changing what can be changed and accepting what cannot be changed.\textsuperscript{95} It is often difficult to tell how well adjusted a person is, but there are some significant signs. Some specific indications are as follows:

- A well adjusted person knows how to deal with others, which makes him a good companion and co-worker;

\textsuperscript{92}Ibid.
\textsuperscript{93}Ibid.
\textsuperscript{94}Ibid.
\textsuperscript{95}Ibid.
He is able to accept himself and the conditions of his life fairly persistent satisfaction;

Confronts his problems that come each day with evasive or compensatory reactions;

He aborts or masters the inevitable conflicts, frustrations, disappointments and temporary defeats without undue emotional turmoil;

He contributes a spirit of cooperation and good will to the necessary activities of his group; and

He has wide interests, attacks his work with zest and gets satisfaction out of doing it.  

2.6.11 Flexibility

We all know people who hold very rigid opinions. No amount of discussion can change their views. Such people often set themselves up for added stress by the rigid expectations that they hold. Working on making our expectations more flexible can improve our mental health. Emotional flexibility may be just as important as cognitive flexibility. Mental healthy people experience a range of emotions and allow themselves to express these feelings. Some people shut off certain feelings, finding them to be unacceptable. This emotional rigidity may result in other mental health problems.  

2.6.12 Tenacity

Tenacity means that an individual is able to focus on a selected task without allowing distractions or procrastination to interrupt or delay. With tenacity, the satisfaction of accomplishment becomes a frequent experience.  

2.7 MENTAL ILLNESS

While there is debate over how to define ‘mental illness’, it is generally accepted that mental illnesses are real and involve disturbances of thought, experience and emotion, serious enough to cause functional impairment in people, making it more difficult for them to sustain interpersonal relationships and carry on their jobs,
and sometimes leading to self-destructive behavior and even suicide. The most serious mental illnesses, such as schizophrenia, bipolar disorder, major depression and schizoaffective disorder are often chronic and can cause serious disability.99

What we now call mental illness was not always treated as a medical problem. Descriptions of the behaviors now labeled as symptomatic of mental illness or disorder were sometimes framed in quite different terms, such as possession by supernatural forces. Anthropological work in non-Western cultures suggests that there are many cases of behavior that Western psychiatry would classify as symptomatic of mental disorder, which are not seen within their own cultures as signs of mental illness. One may even raise the question whether all other cultures even have a concept of mental illness that corresponds even approximately to the Western concept, although, this question is closely tied to that of adequately translating from other languages, and in societies without equivalent medical technology to the west, it will be hard to settle what counts as a concept of disease.100

The mainstream view in the West is that the changes in our description and treatment of mental illness are a result of our increasing knowledge and greater conceptual sophistication. On this view, we have conquered our former ignorance and now know that mental illness exists, even though there is a great deal of further research to be done on the causes and treatment of mental illness. Evidence from anthropological studies makes it clear that some mental illnesses are expressed differently in different cultures and it is also clear that non-Western cultures often have a different way of thinking about mental illness. For example, some cultures may see trance-like states as a form of possession. This has led some to argue that Western psychiatry also needs to change its approach to mental illness. However, the anthropological research is not set in the same conceptual terms as philosophy, and so it is unclear to what extent it implies that mental illness is primarily a Western concept.101

A more extreme view, most closely associated with the psychiatrist, Thomas Szasz, is that, there is no such thing as mental illness because the very notion is based on a fundamental set of mistakes. While it is not always easy to delineate the different

100Ibid.
101Ibid.
arguments in Szasz’s voluminous work, Reznek, for instance, separates out at least six different arguments within his work. Szasz has compared psychiatry to alchemy or astrology, contending that the continued belief in mental illness by psychiatrists is the result of dogmatism and a pseudoscientific approach using ad hoc defenses of their main claims. He has also argued that the concept of mental illness is based on a confusion. The belief in mental illness rests on a serious, albeit simple, error: it rests on mistaking or confusing what is real with what is imitation; literal meaning with metaphorical meaning; medicine with morals. More specifically, Szasz has argued that by definition, “disease means bodily disease”; and given that the mind is not literally part of the body, disease is a concept that should not be applied to the mind. Although Szasz’s position has not gained widespread credence, his writings have generated debate over questions such as whether disease must, by definition, refer to bodily disease.  

More recent critics of psychiatry have been more focused on particular purported mental illnesses. The most heated controversies about the existence of particular mental illnesses are often over ones that seem to involve culturally-specific or moral judgments, such as homosexuality, pedophilia, antisocial personality disorder and premenstrual dysphoric disorder. Other controversies exist over disorders that are milder in character and are on the borderline between normality and pathology, such as dysthymia, a low level chronic form of depression. 

To reiterate, however, the dominant view is that mental illness exists and there is a variety of ways to understand it. Modern psychiatry has primarily embraced a scientific approach, looking for causes such as traumatic experiences or genetic vulnerabilities, establishing the typical course of different illnesses, gaining an understanding of the changes in the brain and nervous system that underlie the illnesses, and investigating which treatments are effective at alleviating symptoms and ending the illness. One of the central issues within this scientific framework is how different kinds of theory relate to each other. Reductionist approaches try to reduce social explanations of mental illness to explanations at “lower” levels such as the

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102 Ibid.
103 Ibid.
biological, while pluralist approaches encourage the co-existence of explanations of mental illness at a variety of levels.\textsuperscript{104}

As alternatives to reductionist approaches there is also the first-person phenomenology and narrative understanding of mental illness. These focus on the personal experience of living and struggling with mental illness, and give careful descriptions of the associated symptoms. Some see a careful phenomenology as essential to scientific psychiatry, while others argue that phenomenology is not essential to psychiatric explanation. The work in this phenomenological tradition is especially important in pressing the question of what it is to understand or explain mental illness, and how a phenomenological approach can relate to scientific approaches.\textsuperscript{105}

\subsection*{2.8 DIFFERENCE BETWEEN MENTAL ILLNESS AND PHYSICAL ILLNESS}

The terms ‘mental illness’ and ‘mental disorder’ normally refer to conditions such as major unipolar depression, schizophrenia, manic depression, and obsessive compulsive disorder. “Physical illness” and “physical disorder” refer to conditions such as influenza, cancer, broken bones, wounds and arthritis. There has been considerable discussion of how to draw a distinction between the two. Given the current debate, the prospects of finding a principled way of drawing the distinction that matches our current practices may be slim. The main practical reason for trying to draw distinctions between physical and mental illnesses comes from demarcating boundaries between professional competencies, and in particular, from distinguishing the domain of neurology from that of psychiatry. However, this boundary is not sharply drawn and has moved over time. It is likely that as neuroscience progresses, the domains of neurology and psychiatry will start to merge.\textsuperscript{106}

Most agree that the distinction between mental and physical illness cannot be drawn purely in terms of the causes of the condition, with mental illnesses having psychological causes and physical illnesses having non-psychological causes. While we have not identified the causes of most mental disorders, it is clear that many non-psychological factors play a role; for example, there is strong evidence that a person’s

\textsuperscript{104}\textit{Ibid.}
\textsuperscript{105}\textit{Ibid.}
\textsuperscript{106}\textit{Ibid.}
genetic make-up influences his or her chances of developing a mood or psychotic disorder. Conversely, psychological factors such as stress are reliably associated with increased susceptibility to physical illness, which strongly suggests that those psychological factors are, directly or indirectly, part of the cause of the illness.¹⁰⁷

Nor can we draw any simple distinction between mental and physical illnesses in terms of the condition’s symptoms. First, it is often unclear whether to categorize symptoms as mental or physical. For example, intuitions are mixed as to whether pain is a physical or mental symptom. It is also unclear whether we would want to classify insomnia and fatigue as physical or mental symptoms. However we classify fatigue, it is a symptom of illnesses normally characterized as physical, such as influenza and those characterized as mental, such as depression.¹⁰⁸

Furthermore, distinguishing between physical and mental illness in terms of symptoms may give counterintuitive results. A person who suffers a stroke can have emotional liability, and a person who has experienced a brain injury may become disinhibited; both may suffer memory loss. Yet stroke and brain injury would generally be classified as physical rather than mental disorders.¹⁰⁹

In the light of these problems, some recommend doing away with any principled distinction between physical and mental disorder. First, certain researchers with a strong reductionist inclination argue that mental disorders are ultimately brain disorders; mental disorders are best explored through neuroscience. Second, some researchers with a strong belief in a bio-psychosocial approach, according to which all disorders have biological, psychological, and social dimensions, argue that, while we should maintain a distinction between the psychological and the biological ways of understanding people’s illnesses, no particular illness is purely mental or purely physical.¹¹⁰

Others defend retaining the distinction between physical and mental disorders, but to non-traditional ends. Murphy, for instance, argues that it is important to have a distinction between physical and mental disorder so that it is possible to have a distinctive science of psychiatry. He argues for an expansive definition that includes

³⁰⁷Ibid.
³⁰⁸Ibid.
³⁰⁹Ibid.
³¹⁰Ibid.
problems in all psychological mechanisms. While this would entail that forms of blindness due to neural dysfunction count as mental disorders, which goes against our normal usage, his goal is not to completely capture our intuitions, but rather to have an adequate set of definitions to accommodate a theory of psychiatric explanation within the field of cognitive neuroscience. As with Guze, on Murphy’s view, the distinction between psychiatry on the one hand and clinical neurology and neuropsychology on the other should disappear.  

Thus we see that there are few defenders of the traditional distinction between mental and physical illnesses. Some theorists advocate refiguring the distinction so that it becomes that between brain-based and non-brain-based disorders. Others who take a more holistic view are skeptical that even this distinction is a useful way to separate illnesses into two groups.

2.9 SYMPTOMS OF MENTAL DISORDER

The symptoms of mental illness include recent social withdrawal and loss of interest in others, an unusual drop in functioning, especially at school or work, such as quitting sports, failing in school, or difficulty performing familiar tasks, problems with concentration, memory, or logical thought and speech that are hard to explain, heightened sensitivity to sights, sounds, smells or touch; avoidance of over-stimulating situations, loss of initiative or desire to participate in any activity; apathy, a vague feeling of being disconnected from oneself or one’s surroundings; a sense of unreality, unusual or exaggerated beliefs about personal powers to understand meanings or influence events; illogical or ‘magical’ thinking typical of childhood in an adult, fear or suspiciousness of others or a strong nervous feeling, uncharacteristic, peculiar behaviour, dramatic sleep and appetite changes or deterioration in personal hygiene, or rapid or dramatic shifts in feelings or ‘mood swings.’ One or two of these symptoms can’t predict a mental illness.

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111 Ibid.
112 Ibid.
114 Ibid.
2.10 TYPES OF MENTAL DISORDERS

Hippocrates, the ancient Greek physician and his colleagues are generally credited with having developed the first classification system for mental disorders. His ideas, relating to *humoral theory* have long since been discredited by modern medical science although some ideas, such as the importance of diet and physical activity are still relevant. Many years later, in the early 1900s, after numerous versions of classification systems, Psychiatrist Emil Kraepelin advanced a new system. This was the first comprehensive classification system including descriptive categories that grouped disorders into presumed common aetiology based on symptom similarities. He grouped a number of existing diagnoses that seemed to have a deteriorating course. This system provided a standardised and functional approach for training and a common language for communication between clinicians. During the 19th and 20th centuries attempts were made to collect statistical data across mental hospitals in a number of countries in an attempt to develop broad classificatory categories. The need to develop a clearer system for classification was highlighted by an international study in the 1970s that brought to light the extent of diagnostic unreliability. In this work video-taped interviews allowed comparison of diagnoses between psychiatrists in New York and London. Psychiatrists in New York diagnosed schizophrenia twice as often, and mania and depression correspondingly less often, as psychiatrists working in London. This led to the WHO ten countries study to investigate this issue further, the application of and further development of standardised diagnostic tools such as the Present State Examination (PSE), and the elaboration of diagnostic systems via expanded rule sets. At present there exist two established classification systems for mental disorders: The International Classification of Diseases (ICD-10) published by the World Health Organization (WHO) and the classification system of the American Psychiatric Association (APA), the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). India adopted the ICD-10 in 2000 which is the latest version of the ICD and the Central

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Bureau of Health Intelligence took up the initiative of directing all states for implementing ICD-10.\textsuperscript{117}

### 2.10.1 The International Classification of Diseases (ICD)

The International Classification of Diseases (ICD) is the international standard diagnostic classification for storage and retrieval of diagnostic information for clinical, epidemiological and quality purposes. The ICD-10 also provides the basis for the compilation of national mortality and morbidity statistics by WHO member states. The ICD system also uses a multi-axial system similar to DSM. Chapter five of the ICD-10 relates to Mental and Behavioural Disorders. The potential for confusion as a result of two widely used classification systems has been acknowledged. There has been much international effort to align the DSM and ICD systems to the point where there is now much consistency between the systems.\textsuperscript{118}

The International Classification of Diseases (ICD) now exists in its tenth revision. Chapter V is relevant for mental and behavioural disorders. The ICD-10 classification for mental disorders consists of 10 main groups:\textsuperscript{119}

- F00-F09: Organic, including symptomatic, mental disorders.
- F10-F19: Mental and behavioural disorders due to psychoactive substance use.
- F20-F29: Schizophrenia, schizotypal and delusional disorders.
- F30-F39: Mood (affective) disorders.
- F50-F59: Behavioural syndromes associated with physiological disturbances and physical factors.
- F60-F69: Disorders of adult personality and behaviour.
- F70-F79: Mental retardation.
- F80-F89: Disorders of psychological development.
- F90-F98: Behavioural and emotional disorders with onset usually occurring in childhood and adolescence.
- F99: Unspecified mental disorder.\textsuperscript{120}

\textsuperscript{118}Ibid.
For the chapter of mental disorders, every main group has the identification letter “F”. For each group exist more specific subcategories.\textsuperscript{121}

\section*{2.10.1.1 F00-F09 Organic, Including Symptomatic, Mental Disorders}

Psychoses resulting from acute or chronic brain disorders will become increasingly common as medical technology extends the average life span of human beings. The brain deterioration that may accompany growing old can distort memory, judgment, comprehension and emotional control.\textsuperscript{122} Patients in their seventies account for as much as 30 percent of all those admitted to mental hospitals each year. These patients not only have cerebral arteriosclerosis (hardening of the brain arteries) and other forms of senile brain disorder, they also display unmistakable evidence of psychotic disruption of their lives. Controls that these patients were once able to exert over their behaviour, emotions and thoughts seem to deteriorate and become ineffective. However, there is no necessary connection between the amount of damage to the central nervous system and the severity of psychosis. Brain damage does not produce psychosis so much as it triggers the psychosis process in some persons. For these persons, past, present, and future are jumbled together, conscious and unconscious thoughts merge and mingle, and the senses do not function properly. These events create a psychological crisis great enough to tip the balance of rational adjustment.\textsuperscript{123} Deterioration of the brain and central nervous system in an aging organism is only one of a number of possible causes of organic psychosis. Psychosis can be associative with infection or trauma or with family metabolism, nutrition or growth. Of these, a significant contributor will continue to be accidental trauma to the brain. More than 50,000 persons killed each year in automobile accidents, and a great many more are injured. When brain tissue is cut, torn, crushed, or penetrated in an accident, enough damage may be done to produce a crisis in the person’s life. If the damage is not too severe, it is the patient’s psychological response to faulty psychological functioning that determines whether he will become psychotic or manage to begin the long road back to a near-normal existence. The psychological

\textsuperscript{120} Supra note 115.
\textsuperscript{122} Supra note 20 at 553.
\textsuperscript{123} Ibid.
state of an individual before he has undergone brain damage is a prime detriment of how he will respond to this new event.124

2.10.1.2 F10-F19 Mental and Behavioural Disorders due to Psychoactive Substance Use

There are many substances like alcohol, tobacco, caffeine etc which are in common use, or opioids, cannabis or hallucinogens as well as prescription-medications like sedatives, all of which alter mind and its functions. These substances may be abused as a habit, or many persons may become dependent on them. These substances can induce psychiatric disorders by themselves; or, the dependence on them may produce withdrawal symptoms if the drugs are stopped or withdrawn abruptly without medical assistance. It is to be recognized that often the use or abuse of many of these psychoactive substances can occur in the background of underlined primary psychiatric disorders. De addiction by itself may not ameliorate all problems, unless the basic psychiatric disorder is also diagnosed and appropriately treated. The substance related disorders are classified sometimes as Substance-use Disorders and Substance-induced Disorders; dependence and abuse are problems classified under the former, and intoxication and withdrawal diagnosed under the latter. Worldwide, drug and alcohol used disorders are considered by the WHO as the sixth leading cause of disease- burden in adults, whereas tobacco use and smoking are the leading preventable causes of death.125

2.10.1.3 F20-F29 Schizophrenia, Schizotypal and Delusional Disorders

Schizophrenia, insanity, madness are synonymous terms that describe an individual who has chosen to allow themselves to form the habit of engaging in sinful behaviours that annoy, bother, offend, threaten others and create their own false reality of self-delusion for the purpose of escaping some personal life problem which they achieve through the control of others for personal gain through lies, manipulation and sympathy through outward displays of self-created suffering, hardship and victimhood. Historically, Schizophrenia is known as ‘dementia praecox’, insanity or madness and is always associated with delusion and paranoia. When, in 1911, Bleuler

124 Ibid.
renamed dementia praecox ‘schizophrenia’, he identified the disease not by its characteristic histopathology, as was customary with diseases of the nervous system, but by its incurability. That this is an utterly destructive way of describing a disease, a disease that, moreover, has no objective bodily manifestations and has never been known to be fatal, should be obvious. Saying someone is ‘Mad’ has its origin in the root word for ‘out of control anger’: madness. When people would launch into out of control acts of violence, they were said to be mad. Literally, that’s where the idea of Madness came from.\textsuperscript{126} Schizophrenia, insanity, madness are synonymous terms that describe an individual who has chosen to allow themselves to form the habit of engaging in sinful behaviours that annoy, bother, offend, threaten others and create their own false reality of self-delusion for the purpose of escaping some personal life problem which they achieve through the control of others for personal gain through lies, manipulation, and sympathy through outward displays of self-created suffering, hardship and victimhood.\textsuperscript{127}

2.10.1.4 F30-F39 Mood (Affective) Disorders

In the affective disorders, which are sometime called affective psychoses, we see extreme disturbances in mood. Unlike the neurotic mood disturbances, affective disorders often occur without any known precipitating factors. Excessive depression or elation or a combination of both dominate behaviour to such a degree that such persons cannot cope with reality. For example, affective disorder known as involutional malancolia is characterized by worry, anxiety, guilt feelings, agitation and insomnina; it may also involve elements of paranoia. The onset of this disorder is often in middle or old age, and it appears to be related to an awareness that the end of life is approaching. Its incidence is twice as high among women as among men, and there is speculation that it is linked with menopause. Lay people may be more familiar with the category of manic-depressive disorders. These may consist exclusively of manic episodes or of depressed episodes, with intervening periods of normality. Often, however, the manic-depressive goes through change cycles, alternating between mania and depression.\textsuperscript{128}

\textsuperscript{127}Ibid.
\textsuperscript{128}Ibid. Supra note 16 at 446.
The manic patient displays symptoms of increasing agitation, excitement and deteriorating judgment in relationships with others. The usual history of an expanding manic reaction describes a lightening of mood, a rising level of activity, a subjective sense of accelerated thought processes and increased alertness and perception. As the mania strengthens, speech and activity speed up, eating and sleeping become annoying interferences, and the victim becomes more agitated and easily irritated by attempts to slow him down. In the final stages of a full-blown manic reaction, the patient may be close to delirium—confused, disoriented, incoherent and difficult to control. His world is very much like a movie that has been speeded up until the figures and events are no than a blur of frantic, purposeless movement.¹²⁹

Depression, like mania, is an exaggeration of the mood that all of us experience for brief periods of time. The person sinking into a deepening depression becomes preoccupied with feelings of failure, sinfulness, worthlessness, and despair. He cannot be reasoned with or told to cheer up, for his woe is an internal event that does not correspond to reality as others see it. Overcome with his hopelessness, the depressive cuts off communication with the outside world, abandons active attempts to help himself and usually begins to contemplate ending it all by suicide. The depressive may not hallucinate, but he may descend to such a stuporous level of mental physical inactivity that he may become bedridden and require force-feeding.¹³⁰

2.10.1.5 F40-F48 Neurotic, stress-related and somatoform disorders

Neurotic disorders are psychological disorders characterized by anxiety or distress over certain circumstances.¹³¹ Everyone fears some things and takes steps to avoid them. A neurotic fears from the things inside himself (urges, thoughts and feelings) whose expression may be punished. The steps the neurotic takes to avoid his fears merely hide rather than abolish them. He is continually anxious that the fearful things he has may reappear. As long as the anxiety is bearable, the neurotic may have no noticeable trouble with life and society. But if the anxiety increases, he must take increasingly severe steps to cope with it. As a result, the neurotic focuses on his own internal problems, and his social behaviour suffers. His friends recognise that he is uptight, but they are unable to see inside him to the source of his fears. As the

¹²⁹ Supra note 20 at 551.
¹³⁰ Id at 551-552.
neurotic social behaviour becomes less and less satisfactory, he also begins to worry about that, thereby adding to his anxieties. He takes additional steps to cope with both his anxiety and the problems in his social behaviour. If these steps fail, the neurotic may suffer a breakdown; if they succeed, he continues to live in a society, but his social existence is often limited and crippled.132

Many observations and studies of children have demonstrated that the basic patterns of neurotic behaviour often develop in childhood. In this connection, at least three principle sources of neuroses have been identified.133

The first is early traumatic experiences (startling or threatening experiences that have a lasting effect on a person’s mental life), like that of the five year old girl who was required to kiss her dead grandmother in her coffin. The little girl was so frightened by this event that she subsequently developed a dissociative reaction. That is, facets of her personality seemed to be unrelated to, or unaware of, other facets. For example, she would occasionally appear as a shy, subdued, inhibited wife and mother. But at the other times, she would act the part of a siren, drinking, dancing, flirting with strange men. When living through one of these personalities, she seemed to have no awareness of the other personalities within her.134

Chronic neurotic family patterns can also provide the bases for neurotic behaviour in adulthood. For example, the behaviour of parents may lead a child to constantly rejected in danger of desertion. As an adult such a person is likely to be insecure, extremely vulnerable to stress and conflict, overly dependent on others. Children sometimes adopt the neurotic behaviour patterns of parents or older siblings, taking them as models of how to respond in stressful situations. Undesirable child rearing practices such as the use of physical punishment may also instill a neurotic core in children. When discipline is physical, it is often directed against aggressive behaviour. Studies show, however, that although physical punishment may stop aggression in the home, outside the home a child follows the model of his or her parents in aggressing against others. On the other hand, when parents use psychological discipline by withdrawing their love or showing visible suffering, they

132 Supra note 20 at 546-547.
133 Supra note 16 at 456.
134 Ibid.
generate anxiety or guilt in their children; if the child’s feelings become too intense, they may lead to neurotic behaviour pattern.\textsuperscript{135}

Many mental health disorders can lead to other chronic diseases and death.\textsuperscript{136} Excessive or prolonged stress can lead to illness and physical and emotional exhaustion. Taken to extremes, stress can be a killer.\textsuperscript{137} Stress-related disorders result from abnormal responses to acute or prolonged anxiety, and can include obsessive-compulsive disorder and post-traumatic stress disorder.\textsuperscript{138}

Somatization disorder causes individuals to display psychological stress as physical symptoms. Somatic symptoms are physical symptoms that a patient feels, but that cannot be medically validated through testing and other diagnostic procedures. Psychological treatment is the best course of action for people suffering from this, though many people with the condition resist psychiatric intervention because they believe their symptoms to be truly physical in nature.\textsuperscript{139}

2.10.1.6 F50-F59 Behavioural Syndromes Associated with Physiological Disturbances and Physical Factors

Behavioural syndromes associated with physiological disturbances and physical factors includes—

(a) Eating Disorder: The most common eating disorders are anorexia nervosa and bulimia nervosa. These affect about 2\% of adult females and some men. Both are serious mental health problems and anyone experiencing them needs a great deal of help and understanding.\textsuperscript{140} People with anorexia nervosa don't eat enough, usually because they feel that their problems are caused by what they look like. They think that they appear fat even though they may look slim or even painfully thin to others. Their morale becomes low and their health can be seriously affected. Because they are not eating enough they may develop a number of physical problems including poor

\textsuperscript{135}Ibid.
\textsuperscript{138}Supra note 136.
\textsuperscript{139}Supra note 131.
circulation, brittle bones and hair loss, as well as kidney disease.\textsuperscript{141} People with bulimia nervosa can’t stick to a healthy eating pattern. They tend to binge, that is, eat a lot at once. This makes them feel guilty and out of control so they then panic and punish themselves by starving, making themselves sick, taking laxatives or over-exercising. This can lead to a number of physical problems including tooth decay, constipation and intestinal damage, as well as heart and kidney disease. Telltale signs of bulimia nervosa include making excuses to avoid eating in company or rushing to the lavatory after a meal.\textsuperscript{142}

(b) Sleep Disorder: Sleep is not just 'time out' from our busy routine. Most of us need to sleep well to help our bodies recover from the day and to allow healing to take place. But with increasingly busy lives it’s estimated that we now sleep around 90 minutes less each night than we did in the 1920s. If you add to this the large numbers who are known to have problems sleeping, it’s obvious that many people are now functioning in a permanently sleep-deprived state. Lack of sleep can make us feel physically unwell as well as stressed and anxious, and scientists also believe that it contributes to heart disease, premature ageing and road accident deaths.\textsuperscript{143}

There are more than 80 different sleep problems listed in the medical textbooks, ranging from the inability to get to sleep (insomnia) to the inability to stay awake (narcolepsy). Many sleep problems are temporary, and you may find the self-help measures below help get you back to more normal sleeping pattern. But sleep problems can also be a symptom of other conditions, such as a problem with thyroid gland or depression, so it’s worth seeing GP (general practitioner) if sleeping problems continue.\textsuperscript{144}

Insomnia is the most common sleep disorder, affecting an estimated 20% of people. Typical symptoms are: problems falling asleep, problems staying asleep (so that you wake up several times each night), waking up too early, or daytime sleepiness, anxiety, impaired concentration and memory and irritability.\textsuperscript{145}

\begin{footnotesize}
\textsuperscript{141}\textit{Ibid.} \\
\textsuperscript{142}\textit{Ibid.} \\
\textsuperscript{144}\textit{Ibid.} \\
\textsuperscript{145}\textit{Ibid.}
\end{footnotesize}
Short-term insomnia, lasting for a few nights or a few weeks, generally affects people who are temporarily experiencing one or more of the following:

- stress
- change in environmental noise levels
- extreme change in temperature
- a different routine, perhaps due to jet lag
- side effects from medicines

Chronic insomnia, lasting for a month or longer, often results from a combination of factors that sometimes include underlying physical or mental health problems. It can also be due to behavioural factors such as too much caffeine or alcohol or a long-term disruption to your routine such as shift work.

(c) Sexual disorders: Most sexual disorders are simply behaviour choices or natural physiological consequences to common life circumstance.

Sexual dysfunction covers the various ways in which an individual is unable to participate in a sexual relationship as he or she would wish. Sexual response is a psychosomatic process and both psychological and somatic processes are usually involved in the causation of sexual dysfunction.

2.10.1.7 F60-F69 Disorders of Adult Personality and Behaviour

(a) Enduring Personality Changes, not Attributable to Brain Damage and Disease:

Disorders of adult personality and behaviour that have developed in persons with no previous personality disorder following exposure to catastrophic or excessive prolonged stress, or following a severe psychiatric illness. These diagnoses should be made only when there is evidence of a definite and enduring change in a person’s pattern of perceiving, relating to, or thinking about the environment and himself or herself. The personality change should be significant and be associated with inflexible

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146 Ibid.
147 Ibid.
and maladaptive behaviour not present before the pathogenic experience. The change should not be a direct manifestation of another mental disorder or a residual symptom of any antecedent mental disorder.\textsuperscript{150}

Excludes: personality and behavioural disorder due to brain disease, damage and dysfunction.\textsuperscript{151}

(b) Enduring Personality Change after Catastrophic Experience:

Enduring personality change, present for at least two years, following exposure to catastrophic stress. The stress must be so extreme that it is not necessary to consider personal vulnerability in order to explain its profound effect on the personality. The disorder is characterized by a hostile or distrustful attitude toward the world, social withdrawal, feelings of emptiness or hopelessness, a chronic feeling of ‘being on edge’ as if constantly threatened, and estrangement. Post-traumatic stress disorder may precede this type of personality change.\textsuperscript{152}

2.10.1.8 F70-F79 Mental retardation

Mental retardation (MR) is a condition diagnosed before age 18, usually in infancy or prior to birth, that includes below-average general intellectual function and a lack of the skills necessary for daily living. When onset occurs at age 18 or after, it is called dementia, which can coexist with an MR diagnosis.\textsuperscript{153} It includes intellectual deficits and difficulty functioning in daily life in areas such as communication, self-care, home living, social/interpersonal skills, self-direction, academics, work, leisure, health, and safety.\textsuperscript{154}

Levels of Mental Retardation: Mental Retardation is divided into four levels based on IQ and degree of social adjustment.

(a) Mild Mental Retardation: At this level, a person takes longer to learn to talk, but can communicate well once he or she knows how fully independent in self-care has problems with reading and writing is socially immature is unable to deal with responsibilities of marriage or parenting may benefit from specialized education plans

\textsuperscript{150} Ibid.
\textsuperscript{151} Ibid.
\textsuperscript{152} Ibid.
has an IQ range of 50 to 69 may have associated conditions, including autism, epilepsy, or physical disability.\(^{155}\)

(b) Moderate Mental Retardation: At this level, a person is slow in understanding and using language has only a limited ability to communicate can learn basic reading, writing, counting skills a slow learner unable to live alone can get around on own can take part in simple social activities has an IQ range of 35 to 49.\(^{156}\)

(c) Severe Mental Retardation: At this level, a person has noticeable motor impairment, has severe damage to and/or abnormal development of central nervous system and has an IQ range of 20 to 34.\(^{157}\)

(d) Profound Mental Retardation: At this level, a person is unable to understand or comply with requests or instructions, is immobile, must wear adult diapers, uses very basic non verbal communication, cannot care for own needs, requires constant help and supervision and has an IQ of less than 20.\(^{158}\)

(e) Other Mental Retardation: Children in this category are often blind, deaf, mute, and physically disabled. These factors prevent physicians from conducting screening tests.\(^{159}\)

(f) Unspecified Mental Retardation: Signs of Mental Retardation exist, but there is not enough information to assign the child to a level.\(^{160}\)

2.10.1.9 F80-F89 Disorders of Psychological Development

Developmental disorders, also referred to as childhood disorders, are those that are typically diagnosed during infancy, childhood, or adolescence. These psychological disorders include: Intellectual Disability or Intellectual Developmental Disorder, formerly referred to as mental retardation, Learning disabilities, Communication disorders, Autism, Attention-deficit hyperactivity disorder, Conduct disorder and Oppositional defiant disorder.\(^{161}\)
2.10.1.10 F90-F98 Behavioural and Emotional Disorders with Onset Usually Occurring in Childhood and Adolescence

This category includes—

(a) Hyperkinetic disorders: A group of disorders characterized by an early onset (usually in the first five years of life), lack of persistence in activities that require cognitive involvement, and a tendency to move from one activity to another without completing any one, together with disorganized, ill-regulated, and excessive activity. Several other abnormalities may be associated. Hyperkinetic children are often reckless and impulsive, prone to accidents, and find themselves in disciplinary trouble because of unthinking breaches of rules rather than deliberate defiance. Their relationships with adults are often socially disinhibited, with a lack of normal caution and reserve. They are unpopular with other children and may become isolated. Impairment of cognitive functions is common, and specific delays in motor and language development are disproportionately frequent. Secondary complications include dissocial behaviour and low self-esteem. 162

(b) Conduct disorder: Conduct disorder is a serious behavioral and emotional disorder that can occur in children and teens. A child with this disorder may display a pattern of disruptive and violent behavior and have problems following rules. It is not uncommon for children and teens to have behavior-related problems at some time during their development. However, the behavior is considered to be a conduct disorder when it is long-lasting and when it violates the rights of others, goes against accepted norms of behavior and disrupts the child's or family's everyday life. 163

Such behaviour should amount to major violations of age-appropriate social expectations; it should therefore be more severe than ordinary childish mischief or adolescent rebelliousness and should imply an enduring pattern of behaviour (six

months or longer). Features of conduct disorder can also be symptomatic of other psychiatric conditions, in which case the underlying diagnosis should be preferred.\footnote{WHO, “Chapter V: Mental and behavioural disorders (F00-F99), available at: http://apps.who.int/classifications/apps/icd/icd10online2003/fr-icd.htm?g90.htm (Visited on Jan. 2, 2015).}

(c) Emotional disorders with onset specific to childhood: Mainly exaggerations of normal developmental trends rather than phenomena that are qualitatively abnormal in themselves. Developmental appropriateness is used as the key diagnostic feature in defining the difference between these emotional disorders, with onset specific to childhood, and the neurotic disorders.\footnote{Ibid.}

(d) Tic disorders: A tic is an involuntary, rapid, recurrent, non rhythmic motor movement (usually involving circumscribed muscle groups) or vocal production that is of sudden onset and that serves no apparent purpose. Tics tend to be experienced as irresistible but usually they can be suppressed for varying periods of time, are exacerbated by stress, and disappear during sleep. Common simple motor tics include only eye-blinking, neck-jerking, shoulder- shrugging, and facial grimacing. Common simple vocal tics include throat-clearing, barking, sniffing, and hissing. Common complex tics include hitting oneself, jumping, and hopping. Common complex vocal tics include the repetition of particular words, and sometimes the use of socially unacceptable (often obscene) words (coprolalia), and the repetition of one's own sounds or words (palilalia).\footnote{Ibid.}

### 2.10.2 DSM-V

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) is the 2013 update to the American Psychiatric Association's (APA) classification and diagnostic tool.\footnote{Ibid.} The classification system of the American Psychiatric Association (APA), the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), consists following diagnostic criteria.

**Diagnostic Criteria of DSM-V are:**

- Neurodevelopmental Disorders
- Schizophrenia Spectrum and Other Psychotic Disorders

\footnote{Ibid.}
• Bipolar and Related Disorders
• Depressive Disorders
• Anxiety Disorders
• Obsessive-Compulsive and Related Disorders
• Trauma- and Stressor-Related Disorders
• Dissociative Disorders
• Somatic Symptom and Related Disorders
• Feeding and Eating Disorders
• Elimination Disorders
• Sleep-Wake Disorders
• Sexual Dysfunctions
• Gender Dysphoria
• Disruptive, Impulse-Control, and Conduct Disorders
• Substance-Related and Addictive Disorders
• Neurocognitive Disorders
• Personality Disorders
• Paraphilic Disorders
• Other Mental Disorders
• Medication-Induced Movement Disorders and Other Adverse Effects of Medication
• Other Conditions That May Be a Focus of Clinical Attention

2.11 DETERMINANTS OF MENTAL HEALTH

There is no single cause for mental illness, and no one is to blame when someone is experiencing a mental illness. There are many factors that contribute to a person becoming mentally ill. Some of these are internal or intrapersonal, and others are external, that is, they come from person’s environment or culture. According to WHO, mental or psychological well-being is influenced not only by individual characteristics or attributes, but also by the socioeconomic

170 Supra note 26 at 89.
circumstances in which persons find themselves and the broader environment in which they live.\textsuperscript{171}

2.11.1 Individual Attributes and Behaviours

These relate to a person’s innate as well as learned ability to deal with thoughts and feelings and to manage him/herself in daily life (‘emotional intelligence’), as well as the capacity to deal with the social world around by partaking in social activities, taking responsibilities or respecting the views of others (‘social intelligence’). An individual’s mental health state can also be influenced by genetic and biological factors; that is, determinants that persons are born or endowed with, including chromosomal abnormalities (e.g. Down’s syndrome) and intellectual disability caused by prenatal exposure to alcohol or oxygen deprivation at birth.\textsuperscript{172}

2.11.1.1 Genetic and Biological Factors

Each individual’s own genetic make-up can contribute to being at risk of developing a mental illness and traumas to the brain (via a form of head-injury) can also sometimes lead to changes in personality and in some cases ‘trigger’ symptoms of an illness. Misuse of substances such as alcohol or drugs and deficiencies of certain vitamins and minerals in an individual’s diet can also play a part.\textsuperscript{173}

2.11.1.2 Heredity

Many mental illnesses run in families, suggesting that people who have a family member with a mental illness are more susceptible (have a greater likelihood of being affected) to developing a mental illness. Susceptibility is passed on in families through genes. Experts believe many mental illnesses are linked to abnormalities in many genes, not just one. That is why a person inherits a susceptibility to a mental illness and doesn’t necessarily develop the illness. Mental illness itself occurs from the interaction of multiple genes and other factors such as


\textsuperscript{172} Ibid.

stress, abuse, or a traumatic event, which can influence, or trigger, an illness in a person who has an inherited susceptibility to it.\textsuperscript{174}

\subsection*{2.11.1.3 Physical Constitution}

As a psychiatrist, Kretschmer tried to find a relationship between psychological disorders and body types in his typology, then generalized his observations also for healthy people. In his typology, he defines the pyknic types who can be recognized by their short, stubby, wellfed, round physique, and fine features. Of an international sample of 1,361 manic-depressed patients, almost two-thirds were of pyknic type, which led Kretschmer to generalize that healthy people of this constitution are also of cyclothymic type.\textsuperscript{175}

The other type is the slender, skinny, thin, narrow-shouldered leptosomic or – in the case of extremely weak physique – asthenic type, the overwhelming majority of whom can be characterized by a schizothymic temperament. In Kretschmer’s study, over half of the more than five thousand (5,233) patients diagnosed as schizophrenic were of this constitution type. The oversensitive type appearing on one extreme can be introverted, refined, idealist, irritable, reacting from time to time with fierce outbursts. The other extreme is characterized by the insensitive type, which can be very diverse from cold, distant, inhibited, and blank to being a misfit and eccentric. The schizothymic mid layer includes distantly systematic and less energetic individuals. In his research, Kretschmer observed a third body type, the athletic, who have strong muscular body shape, with little fat and can be characterized as having a stable temperament adapting to the environment, called viscous. Nearly thirty percent of the one and a half thousand epileptic patients studied were of this physique.\textsuperscript{176}

Kretschmer also described two opposing pathologic temperaments: cycloid and schizoid. Cycloid individuals are those who show marked and repetitive swings in mood, whereas schizoid individuals tend to be aloof, timid and introverted. In more exaggerated form these two abnormal personality extremes correspond to two of the most common psychoses, manic depressive psychosis and schizophrenia,

\begin{thebibliography}{9}
\footnotesize
\item \textsuperscript{175}EnikoGyongyosine Kiss, Laszlo Nagy, “Personality typology in traditional and modern temperament theories”, \textit{available at:} http://old.psziholgia.pte.hu/files/tiny_mce/File/Kiss%20Eniko/Personality%20typology.pdf (Visited on Dec. 26, 2014).
\item \textsuperscript{176}\textit{Ibid.}
\end{thebibliography}
respectively. Kretschmer observed that cycloid individuals, and those with manic depressive psychosis, typically are of pyknic body build, whereas those of schizoid temperament, or with schizophrenia, are more often leptosomes. Studies reported by Kretschmer and others involving large groups of hospitalized psychotic patients tend to corroborate this relationship.\textsuperscript{177}

2.11.1.4 Physical Health and Disease

Diseases, injuries and other physical problems often contribute to poor mental health and sometimes mental illness. Some physical causes (such as birth trauma, brain injury or drug abuse) can directly affect brain chemistry and contribute to mental illness. More commonly, poor physical health can affect self-esteem and people’s ability to meet their goals, which leads to unhappiness or even depression.\textsuperscript{178}

2.11.1.5 Nutritional Factors

A poor diet can also contribute to mental health problems. While it is unlikely that diet alone can cause a mental illness it could trigger the onset of illness if there are other factors contributing to the problem as a whole.\textsuperscript{179}

2.11.1.6 Hormones

Hormones are substances produced by the endocrine glands that have a tremendous effect on bodily processes. The glands in the endocrine system influence growth and development, mood, sexual function, reproduction and metabolism.\textsuperscript{180} In some cases, hormonal imbalances affect mental health.\textsuperscript{181}


2.11.1.7 Drugs

Substance abuse has been linked to increasing the risk or causing the onset of mental illnesses. Long-term abuse of drugs or alcohol is a common trait amongst people who suffer from mental illnesses.\textsuperscript{182}

2.11.1.8 Personality Development and Maturation

To many people, terms like development, growth, maturation and learning all mean the same thing.\textsuperscript{183} Maturation is the physical, intellectual, or emotional process of development. Maturation is often not quantifiable.\textsuperscript{184} According to Erikson’s theory, successful completion of each stage of development is necessary to move on to the next stage of life development. Unfortunately, if a stage of development is never completed, that individual may not complete a healthy life-long development. For example, in early stages of life, a child learns competence sometime between the ages of six and twelve. If this child’s competence is hindered for some reason, he may have difficulty graduating to the next developmental stage, which is identity versus role confusion. This adolescent could grow into adulthood feeling inferior and lacking competence, which is often crucial for successful, healthy living.\textsuperscript{185}

2.11.2 Social and Economic Circumstances

The capacity for an individual to develop and flourish is deeply influenced by their immediate social surroundings – including their opportunity to engage positively with family members, friends or colleagues, and earn a living for themselves and their families – and also by the socio-economic circumstances in which they find themselves. Restricted or lost opportunities to gain an education and income are especially pertinent socio-economic factors.\textsuperscript{186}

\textsuperscript{184}Ibid.
\textsuperscript{186}Supra note 171.
Negative experiences within our family or social circle can have a huge impact on our ability to cope and our tendency to become mentally ill.\textsuperscript{187} Separation or divorce or the loss of a parent or sibling is extremely painful. Finding ways to cope and adjust to the changes wrought by these events is critical for everyone, but particularly for youth.\textsuperscript{188} Children that experience stress from poverty and abuse and neglect are vulnerable to developing depression, anxiety and antisocial behaviors that may continue into adulthood.\textsuperscript{189}

Even factors like how well represented an ethnic group is in a neighborhood can be a risk or protective factor for developing a mental illness. For example, some research indicates that ethnic minorities may be more at risk for developing mental disorders if there are fewer members of the ethnic group to which the individual belongs in their neighborhood.\textsuperscript{190}

2.11.3 Environmental Factors

The wider socio-cultural and geopolitical environment in which people live can also affect an individual’s, household’s or community’s mental health status, including levels of access to basic commodities and services (water, essential health services, the rule of law), exposure to predominating cultural beliefs, attitudes or practices, as well as by social and economic policies formed at the national level; for example, the on-going global financial crisis is expected to have significant mental health consequences, including increased rates of suicide and harmful alcohol use. Discrimination, social or gender inequality and conflict are examples of adverse structural determinants of mental well-being.\textsuperscript{191} Despite some claims to the contrary, environmental influences have been found to operate within the normal range, and not just in relation to extreme environments (although, for obvious reasons, the effects of the latter are greater). Environmental effects have been shown not only for influences in infancy, but also for influences in middle childhood and even in adult life.\textsuperscript{192}

\textsuperscript{188}\textit{Supra} note 178.
\textsuperscript{191}\textit{Supra} note 171.
\textsuperscript{192}Michael Rutter, “How the Environment Affects Mental Health”, \textit{Br J Psychiatry} Jan 2005, 186 (1) 4-6.
2.12 MENTAL ILLNESS AND SOCIETY

Mental disease and its stigma is observed in most of the culture. People of different age, gender or socio-economic status may suffer from mental illness. At least twenty percent of people pass through mental disorders in some way or the other during their lifetime. Stigma towards mentally ill people is very risky. This affects on their ability to perform duties, their revival, treatment procedure and support they receive, and their recognition in the group of people. Stigma is considered as a sign of shame, dishonour or disapproval, of being rejected by others. Stigma is painful and humiliating. In our social structure stigma surrounds with mentally ill persons which is worsening patient’s life.\(^{193}\)

Labeling someone with a condition and stereotyping people with that condition, creating a division - a superior group and a devalued group, resulting in loss of status in the community, discriminating against someone on the basis of their label. Some illnesses remain on the social fringe ignored, mocked, disrespected and discredited. People diagnosed with a mental illness are typically categorized as an object of contempt.\(^{194}\) Even among educated laymen, attitudes toward those with mental disorders were derogatory (though to a lesser degree).\(^{195}\) In rural areas of India, many villagers still believe mental illness is caused by evil spirits angry that the sick person had killed a cow during a past life. The so-called therapy conducted by which doctors or family members, can include chaining up the mentally ill, chanting spells, poking them with pins and beating them to force the spirits out.\(^{196}\)

No doubt public fear of mental disorders has been intensified by the sharp restriction in several states (including New York, Massachusetts, and California) in the past five years, large number of patients who are considered non dangerous have been discharged. One of the ongoing concerns of Psychiatrists, Psychologists, and others involved in mental health movement is with the rights of the individual and the point at which those rights may endanger public safety. At what point, for example,


\(^{194}\)Ibid.

\(^{195}\)Supra note 16 at 477.

does a person’s eccentric or bizarre behaviour become a threat to the community? Can we commit a person to an institution, possibly for years, merely because a few people consider his behaviour socially undesirable? And what are his legal rights? 197

2.13 MENTAL HEALTH IN INDIA

Mental illness has been defined under various Indian statutes. Mental illness under the Mental Healthcare Act, 2017 means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by sub-normality of intelligence. The Indian Lunacy Act defined “Lunatic”, as an idiot or person of unsound mind. The Hindu Marriage Act defines the expression ‘mental disorder’ as mental illness, arrested or incomplete development of mind, psychopathic disorder or any other disorder or disability of mind and includes schizophrenia. Mental illness is defined under Persons with Disabilities Act, as any mental disorder other than mental retardation. ‘Mentally ill Person’ defined under the Mental Health Act, Section 2(l), as a person who is in need of treatment by reason of any mental disorder other than mental retardation. The expression ‘psychopathic disorder’ under The Hindu Marriage Act means persistent disorder or disability of mind, whether or not including sub-normality of intelligence which results in an abnormally aggressive or seriously irresponsible conduct on the part of the other party, and whether or not it requires or is susceptible to medical treatment.

The morbidity rate of mental disorders is surprisingly high in India. At least 5% of the population lives with a mental illness, which translates to over 50 million

197 Ibid.
198 Section 2(s), The Mental Healthcare Act, 2017.
199 Section 3(5), The Indian Lunacy Act, 1912.
200 Section 13(1), Explanation (a), The Hindu Marriage Act, 1955.
203 Section 13(1), Explanation (b), The Hindu Marriage Act, 1955.
people.\textsuperscript{205} Prevalence of mental disorders in the State of Punjab is 13.4%.\textsuperscript{206} Six percent of Kerala’s population has mental disorders and 1 in 5 have emotional and behavioural problems, ranging from mild to severe. This also doesn’t begin to account for the extent of counselling that is required. According to the government’s estimates about 1 in 5 people in the country need counselling, either psychological or psychiatric...there are 4,000 psychiatrists, 1,000 psychologists and 3,000 social workers for the whole of the country and only 1,022 college seats for mental health professionals are set aside in India.\textsuperscript{207}

In India, there has being very recent change that few people have started acknowledging the relevance of general mental health.\textsuperscript{208} Mental health care in India over the last 25 years has been an intense period of growth and innovation. India enters the new millennium with many changes in the social, political, and economic fields with an urgent need for reorganization of policies and programmes. The mental health scene in India, in recent times, reflects the complexity of developing mental health policy in a developing country. The National Health Policy, 2002, clearly spells out the place of mental health in the overall planning of health care. These developments have occurred against the over 25 yr of efforts to integrate mental health care with primary health care (from 1975), replacement of the Indian Lunacy Act, 1912, by the Mental Health Act, 1987, replacement of Mental Health Act, 1987 by Mental Healthcare Act, 2017, the enactment of the Persons with Disabilities Act, 1995 focusing on the equal opportunities, protection of rights and full participation of disabled persons and replacement of the Persons with Disabilities Act, 1995, with the Rights of Persons with Disabilities Act, 2016. The growth of voluntary action for mental health care in the areas of suicide prevention, disaster mental health care, setting up of community mental health care facilities, movement of family members (care givers) of mentally ill individuals, drug dependence, public interest litigation to address the human rights of the mentally ill; research in depression, schizophrenia and

\textsuperscript{207} Supra note 205.
\textsuperscript{208} Supra note 204 at 16.
child psychiatric problems are other major developments. The rapid growth of private psychiatry with associated spread of services to peripheral cities and small towns and challenges of regulation is another significant development of the last 10 years. Against the positive developments, the main challenges are the extremely limited number of mental health professionals (about 10,000 professionals of all categories for one billion population) and the very limited mental health service infrastructure (about 30,000 psychiatric beds for over a billion population); limited investment in health by the government (estimated public sector expenditure on health is only 17% of total health expenditure) and problems of poverty (about 30% of population live below poverty line) and low literacy with associated stigma and discrimination for persons with mental disorders.

In brief, Mental health refers to a broad array of activities directly or indirectly related to the mental well-being component included in the WHO’s definition of health: “A state of complete physical, mental and social well-being, and not merely the absence of disease”. It is related to the promotion of well-being, the prevention of mental disorders, and the treatment and rehabilitation of people affected by mental disorders. Mental disease and its stigma is observed in most of the culture. In our social structure stigma surrounds with mentally ill persons which is worsening patient’s life. In rural areas of India, many villagers still believe mental illness is caused by evil spirits angry that the sick person had killed a cow during a past life. So-called therapy conducted by which doctors or family members, can include chaining up the mentally ill, chanting spells, poking them with pins and beating them to force the spirits out. Today, the mental disorders stand among the leading causes of the diseases and disability in the world. Therefore, it has become necessary to generate the awareness of mental health especially in countries like India where too many misconceptions are existing. These people need treatment which should consist of care and love, but most often they are ill-treated by the larger society.

210 Supra note 7.
211 Supra note 193.
212 Ibid.
214 Supra note 204.
are considered as unproductive and useless, often thrown out of their houses. Most countries of the world today run Asylums and other healthcare facilities for these people where they are treated but in these facilities as well, they are ill-treated and often not provided with the basic necessities. It thus becomes important for us to know the rights that are available to mentally challenged people in India. All these issues have been attempted to be addressed in the ensuing chapters of this research.

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