CHAPTER - 2

THEORIES OF MENTAL HEALTH
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Meaning of Mental Health

Mental health or mental hygiene is usually viewed as opposite to mental illness or maladjustment. It has reference to the socially accepted standards of behaviour. Mental health is therefore understood as interpersonal behaviour which helps the individual to fulfill his social role requirements maintaining the social norms of behaviour. In the same terms mental illness or maladjustment is pathological interpersonal behaviour having transient adaptive functions. Mental health is not inherited from parents but it develops through his interaction with a social matrix. He has to make decisions constantly in tune with social expectancies. His interpersonal behaviour is determined by social setting and contextual circumstances. Pattern of maladjustment are therefore judged on the basis of specific patterns of interpersonal behaviour.

A number of causes create mental illness. For example, wrong child-rearing practices, family interaction, parental loss, lack of love, peer groups, race, socio-economic status, migration, social crises, war, unemployment, etc. are root causes of maladjustment. That the social factors play a crucial role in the etiology of mental illness and
health gains support from recurring evidence that different population groups differ in frequency and type of mental illness. Social scientists are intrigued by the challenge of discovering the ways in which different cultural groups produce different rates of healthy and unhealthy individuals.

Since mental illness is construed as intimately related to social values absorbed by the individual, it has become subject to strong and persistent reactions in the form of social behaviour. Public attitudes stigmatize the mentally ill adding social psychological dimensions to the problem. Attitudes of the family as well as other social groups influence the individual's development.

The effort of motivating mental health has a number of facets and draws upon many disciplines to fulfill treatment, research and educational needs. Status conflicts and cooperation among professional groups, value conflicts and differential methods of the treatment of mentally ill have significant implications for therapy and rehabilitation.

**Mental Health Movement**

Mental health or mental hygiene has attracted attention of the society for the following reasons:

1. The number of maladjusted individuals is increasing.

   One among three individuals has some sort of adjustment
problem. Many of these are severely impaired over a long time.

2. The damage done to the society by maladjustment is tremendous in human terms and social economic terms. Personal anguish, family disruption, loss in productivity, waste of human resources, etc. contribute to this damage.

3. Mental illness is evenly distributed through various sections of society and is inversely related to availability of treatment. This fact has important implications for the social and political structure of any society.

4. In India, the incidence and nature of mental symptoms are likely to be affected by increased urbanization and consequent conflicts, tensions and aloofness of some groups of individuals. Increasing automation, population growth, unemployment, loss of jobs, poverty, illiteracy, etc. are other causes contributing to maladjustment.

5. The increase in mental disorder and the shortage of coping resources are fit subjects for social psychological study. Theorists try to see if social order can be adapted to meet fundamental social needs of individuals. Social psychology seeks to discover the tolerance limits for population increase, social deprivation and interpersonal conflicts.
The Contribution of Social Psychology

Social psychology contributes of the field of mental hygiene in the following ways:

1. Social psychology stresses the importance of the social medium in which individual behaviour develops and seeks to evolve concepts and measures which will capture the relational and interactive quality of interpersonal behaviour.

2. Social psychology highlights the role played by values in defining well-being and disorder. It distinguishes among personal maladjustment, social deviation and productive non-conformity.

3. Social psychology offers a balanced conception of the field of de-emphasizing pathological ingredients and urging equal consideration of different aspects of positive mental hygiene.

4. Social psychology has received a bridging function between social environment and personality.

5. Social psychology has contributed to the understanding of individual's personality growth by adding new categories of analysis, particularly interpersonal ones. New types of nomenclature helps in breaking the constraints imposed on theory and practice by traditional medical models. In this connection the codification of family interaction has been particularly helpful.
6. Recognition of mental illness as cognate to deviant behaviour has permitted the social psychologist to draw upon findings from such areas as drug addiction and delinquency. Attention to cross-cultural variations in pattern of symptoms clarifies the relationship between social environment and mental illness.

7. Action research enhances social theory. Lewin emphasizes the link with practice which is a blessing for the development of theory. In action research, direct involvement with the system under study may be vital to both understanding and effecting change.

After this brief introduction of the subject, different psychologists' views on mental hygiene and mental illness are given hereafter. WHO's concern with mental health is also considered here.

WHO

The World Health Organization has defined health as a state of complete physical, mental and social well-being of a person and not only absence of disease or infirmity. Thus it does include the concept of mental health.

Mental health is the balanced development of the individual's personality and emotional attitudes which enable him to live harmoniously with his fellow men. Thus it is not simply a relation between an individual and an
individual, but it is the relation of the individuals towards the community, society and institutions which for a large part guides his life, determines the way of living, working, leisure and the way he learns up and spends his money, the way he sees happiness and stability and security.[21].

William A. Scott

Scott [1] (Wechsler, Solomon and Kramer, 1970, 13) reviewed mental illness under the following categories: (a) exposure to psychiatric treatment, (b) social maladjustment, (c) psychiatric diagnosis, (d) subjective unhappiness, (e) objective psychological symptoms, and (f) failure of positive adaptation.

(a) In Scott's view, the most frequent operational definition of mental illness is simply the fact of a person's being under psychiatric treatment, restricted to hospital treatment rather than outpatient service. Such a definition of mental illness is operational rather than conceptual, but its implicit meaning for the interpretation of research results is that anyone who is regarded by hospital authorities, relatives, neighbours, or himself as disturbed enough to require hospitalization or outpatient treatment is mentally ill and people who do not fit into such diagnoses are mentally healthy. However, the reliability of
psychiatric diagnosis is open to question, and any attempt to determine correlates of any type of mental maladjustment must take into account the error inherent in the measuring and interpreting process.

Adjustment is necessarily determined with reference to norms of the whole society or of some narrow section of the society. Thus adjustment is adherence to social norms. It would be possible to assess adjustment with reference to some externally defined set of requirements for a given social system.

(b) Though adjustment appears a more conceptually adequate criterion of mental health than does exposure to treatment, the necessity for considering different personal frames of reference and the demands of different social structures poses seemingly insurmountable obstacles to the establishment of mutually consistent operational definitions.

(c) The lack of standardisation of psychiatric diagnoses contributes to the incomparability of mental illness rates. So long as the criterion of assessment is largely dependent on the psychiatrist's subjective integration of a different set of facts for each subject, non-uniform results can be anticipated.

(d) A major indication of need for psychotherapy is the person's own feeling of unhappiness or inadequacy.
Conversely, the degree of mental hygiene may be assessed by manifestations of subjective unhappiness, self-confidence and morale. Many psychologists believe that the main criterion for effects of therapy is the patient's subjective sense of strength, confidence and well-being. Carl Rogers has maintained that a marked discrepancy between one's "perceived self" and "ideal self" constitutes evidence of psychiatric disturbance [2] (Rogers, 1951). Such objections to this criterion imply that it is possible to find persons who are mentally ill by other criteria, yet who nevertheless report themselves as happy or self-satisfied.

It is generally accepted almost by definition that mental illness entails both a disorganization of psychological processes and a deviation of behaviour from social norms [3] (Clausen, 1956). The deviation of behaviour may be assessed as maladjustment to one's social environment and the disorganization of psychological processes can be assessed by psychological inventories aimed at critical processes. The distinction between the psychological inventory approach and the subjective assessment procedure is not really a clear one. Subjective well-being may be regarded as one of the psychological processes which becomes disordered. The inventories
are sometimes called objective because they are not classed as devices for subjective report - they stop just short of requiring the subject to report his overall level of well-being.

A general characteristic of psychological inventories is that each item is assumed to involve a directional quality, such that one type of answer may be taken as indicative if psychological disorder, and the opposite answer as indicative of normal functioning; e.g. Do you often daydream? Yes-NO.

(f) A radically different approach of mental hygiene is indicated in the definitions proposed by some psychologists. Gruenberg suggests that, though failure to live up to the expectations of those around him may constitute mental illness, one should also consider the person's failure to live up to his own potentialities[4] (Gruenberg, 1953). Jahoda's beliefs to be discussed later in this chapter support this view.

Scott concludes that while many of these difficulties of defining mental disorder or illness would not be considered damaging from the point of view of certain of the definitions of mental illness, they run into conflict with others. They also suggest certain basic incompatibilities among the various approaches to conceptualization of mental illness.
Thomas S. Szasz

Szasz raises the fundamental question: Is there such a thing as mental illness?[5] Mental illness is literally not a 'thing' - or a physical object - and so it can 'exist' only in the same sort of way in which other theoretical concepts exist. During certain historical periods, explanations of mental illness were given as creation of deities, witches and micro-organisms and also as caused by innumerable diverse happening. Szasz maintains that this notion of mental illness has outlined whatever usefulness it might have had and that it now functions as a convenient myth.

The notion of mental illness is based on phenomena like delicious conditions of the brain such as intoxication, in which some persons manifest some peculiarities or disorders of thinking and behaviour. But these are in fact diseases of brain and not of mind. The assumption here is that some neurological defect will be found in the future in all disorders of thinking and behaviour. Many present day psychiatrists and physicians as well as other scientists hold this view. It means that people cannot have troubles, expressed in what are at present known as mental illness, because of differences in personal needs, opinions, social aspirations, values, etc. but all problems in living are
attributed to psycho-chemical processes which in due course
will be discovered by medical research.

Mental illness is thus basically regarded as no different
from all other physical diseases. The only difference in
this view between mental and physical diseases is that the
former, affecting the brain, manifests by means of mental
symptoms such as skin, lever, etc. manifests itself by means
of symptoms referable to those parts of the body. There are
two fundamental errors in this view according to Szasz.

Firstly, what central nervous system symptoms would
 correspond to a skin eruption or a fracture? It would not
be some emotion or complex behaviour. It would rather be
blindness or paralysis of some part of the body. A disease
of the brain, analogous to a disease of the skin or bone is
a neurological defect and not a problem in living. For
example, a defect in a person’s visual field may be
explained by correlating it with certain tensions in the
nervous system. On the other hand, a person’s belief,
whether religious or political, or in the idea that his
internal organs are rotting and that his body is, in fact,
dead, cannot be explained by a defect or a disease of the
nervous system. Explanation of this type of occurrence must
be sought along different lines.
Secondly, complex psycho-social behaviour maladjustment is an error pertaining to no mistakes in observation or reasoning, as such, but rather to the way in which we organize and express our knowledge. In the present case, the error lies in making a symmetrical dualism between mental and physical symptoms, a dualism which is merely a habit of speech and to which no known observations can be found to correspond. In medical practice, when we speak of physical disturbances, we mean either signs like fever or symptoms such as pain. We speak of mental symptoms, on the other hand, when we talk about a patient's communications about himself, and the world around him. He might state that he is the president of India or that he is being persecuted by naxalites. These would be considered mental symptoms only if the observer believed that the patient was not the president of India or that he was not being persecuted by the naxalites. It means the mentally ill is making a statement which involves rendering a judgement. The notion of mental symptom is therefore inextricably tied to the social and ethical context in which it is made in much the same way as the notion of physical symptom is tied to an anatomical and genetic context (Szasz, 1961).

In this way Szasz tries to show that mental illness has outlived whatever usefulness it might have had and that it now functions merely as a convenient myth.
In Adam’s view, there is no such thing as significantly meaningful sense, and the concept of mental illness is only a verbal analogy. He thinks that it is appropriate to speak of neurological disorders on true organic illness of the nervous system, comparable to organic illnesses, involving the circulatory or digestive system, it is questionable to apply the term ‘illness’ to arbitrarily defined patterns of behaviour, particularly when there may be no evidence of any physiologically meaningful malfunctioning. During the nineteenth century "moral therapy" was practised to eradicate mental illness, but it was essentially a programme of planned psychological retraining within a positive, sympathetic social milieu.

Moral therapy had its inception were the end of the eighteenth century under the leadership of Pinel, Tuke, Chiarugi and others.[6]. The world ‘moral’ was used at that time in a sense comparable to the contemporary usage of the words ‘psychological’ or ‘interpersonal’. Despite ample evidence of its effectiveness, moral therapy was abandoned in American and British mental institutions after 1860 and later almost forgotten. It was due to the fact that moral therapy was a form of treatment for mental illness, but as physical medicine developed during the late nineteenth century, it was thought that the types of procedures found
effective with physical illnesses could be carried over unaltered into the treatment of mental illness. Later on the impersonal approach was adopted in the late nineteenth century and is reflected in the conceptual language of psychology today. These concepts centre around words borrowed from non-psychological fields, such as medicine, physics, mechanical engineering, biology and electronics.

Adams questions as to what the label 'mental illness' is applied. It is applied, as he asserts, to arbitrarily designated types of maladaptive interpersonal behaviour, often accompanied by reports of subjective discomfort, unsatisfying human relationships and social rejection [7]. Adams maintains that mental illness is a phenomenon that involves interpersonal behaviour, not a health or medical problem. Programmes to correct or prevent mental illness must therefore rest upon a systematic understanding of interpersonal conduct. The empirical studies of mental illness have three distinguishing features: (a) the basic observations involve interpersonal actions, (b) the observers are concerned not with superficial stylistic features, but with the content of the impersonal acts themselves, (c) the investigators aim for comprehensiveness, classifying every act systematically in relation to every other. The results of these studies of mental illness indicate that all interpersonal behaviour, both adaptive and
non-adaptive can be meaningfully categorized within one systematic frame of reference. They suggest a circumplex structure around the two orthogonal axis of Dominance-Submission and Affection-Hostility. One pole of the Dominance-Submission axis is defined by acts of self-confident, assertive leadership and achievement in the face of obstacles. At the opposite pole are acts of passivity, submissiveness and acquiescence. The Affection-Hostility dimension reflects variations in the degree of positive or negative effect manifested towards others. The positive extreme describes warm, friendly, kind, affiliative acts, while the negative extreme describes critical, angry, disaffiliative acts.

The same fundamental patterns have been repeatedly observed by many contemporary and historical writers, even though their words may be different. The similarities and convergences would not have been so consistently noted unless there were certain universal features in all human conduct. Adams questions as to how do these universal features relate to mental health and mental illness. Within the two-dimensional circular structure outlined above an elaborate system has been developed for classifying the interpersonal behaviour of both psychiatric patients and normal persons [8] (Henry, 1957). The main differences between mental illness and mental hygiene are to be found in the characteristics frequency, intensity, and nature of
interpersonal behaviour. For example, Schizophrenics manifest intense degrees of passivity and hostility by unconventional, bizarre, negativistic and distrustful behaviour. In contrast, hysterics prefer bland, pleasant, friendly and conventional types of interaction. Both these contrasting behaviours are considered mental illnesses. The most effective therapy for these illnesses is that which succeeds best in altering the characteristics nature, frequency, and intensity of maladaptive acts in the direction of greater moderation, versatility, appropriateness and effectiveness.

Theodore R. Sarbin

Sarbin quotes Ellis for the definition of mental illness. Ellis's view point is as follows:

This is what we really mean when we say that an individual is 'mentally ill' - that he has symptoms of mental malfunctioning or illness. More operationally stated, he thinks emotions, and acts irrationally and he can usually uncondemningly acknowledge and change his acts. If this, without any moralistic overtones, is the definition of 'mental illness', then it can distinctly help the afflicted individual to accept himself while he is ill.[9]

Sarbin proposes that the general conclusions drawn by Ellis must be rejected on logical grounds. Since Ellis does not
establish the ontological argument for "mental illness", Sarbin feels that his conclusions are illicit. Most of Ellis's arguments aimed at retaining the mental illness label flow from concealed, tacit and disguised implications contained within the label itself. Most of Ellis's arguments, in the view of Sarbin, topple of their own structural defects related to the uncritical acceptance of "illness of the mind" as the proper concept for describing the behaviour of people who violate propriety norms. The basic reference for illness and for words like sickness and diseases is a stable one, extending over centuries. Sarbin questions, "How did the concept of illness come to include gross behaviour, that is misconduct, rather than complaints and somatic symptoms which were the defining criteria of pre-Renaissance diagnosis?" [10]. The concept of behaviour disorder as 'illness' did not come about suddenly or accidentally. Rather, the label illness was first used as a metaphor and later changed into a myth. This view of considering mental illness was supported by Galen and others during the 16th century. The natural causes of mental illness were thought to be (1) melancholy (Galenic humoral pathology), (2) weak imagination, and (3) drowsiness. The modern practitioners of Galenic psychiatry and psychology operates on the principle that the 'illness' is in the mind. But for these psychiatrists, the mind is too abstract and undifferentiated concept.
Since the mind is invisible and immaterial, it cannot have the same properties as the body. Three developments contributed to the concept of mind on the repository of special states and as an organ that suffered "illness": (1) dispositional terms were readily available, (2) the introduction of new terms of faith and religion that located religious experience 'inside' the person, and (3) the development of a scientific lexicon.

Thus mental states were postulated to fill gaps in early knowledge. However, when the adjective, 'mental' is prefixed, a new set of implications follow. The interpreter asks, "what about this person or his behaviour calls for such as special designation, viz. mentally ill?" Sarbin argues that the process whereby a person is converted into a mental patient carries with it the potential for self-devaluation. The stigmatization may work in the nature of a self-fulfilling prophesy.[11]. Sarbin then rejected the mental-illness concept, because he felt that it achieved only a mythic status and that its continued employment stands in the way of developing policies and programmes for meeting many social problems. He further says that it is futile to try to support the proposition that some people be labeled "mentally ill". The label is vacuous, he says, save as an epithet of peroration. Its scientific utility is suspect because of its reliance on an outworn mentalistic concept.
David P. Ausubel

Szasz and Mowrer both believed that mental illness is a myth as has already been discussed earlier in this chapter. It was so for four reasons:

1. Only symptoms resulting from physical leinous quality as legitimate manifestations of disease. But under no circumstances can mental symptoms be considered illness.

2. A basic dichotomy is found between mental symptoms which are subjective in nature, dependent on subjective judgement and the personal involvement of the observer, and the physical symptoms, which are objective in nature. Only the symptoms of the latter type can be considered illness and hence amenable to medical treatment.

3. Mental symptoms are merely expressions of problems of living and they cannot be regarded as manifestations of a pathological condition. The concept of mental illness is misleading because it seeks to explain psychological disturbance in terms of metaphorical and non-existent disease entity, instead of considering them due to inherent difficulties in solving them with elusive problems of choice and responsibility.

4. Personality disorders therefore should be considered products of moral conflict, confusion and aberration. Mowrer goes to the extent of considering them to be
primarily unacknowledged sin, and so these symptoms are responsible for and deserve their suffering.

Ausubel examined these four propositions and reached the following conclusions:

1. Though brain pathology is probably not the major cause of personality disorder, it does account for some psychological symptoms by impairing the neural substrate of personality. Moreover, a symptom need not reflect a physical lesion to qualify as a genuine manifestation of disease.

2. Szasz's dichotomy of differentiating mental and physical symptoms is untenable, as Ausubel puts it, because the assessment of all symptoms is dependent to some extent on subjective judgement, emotional factors, cultural ethical norms and personal involvement of the observer. [12]. Moreover, the use of medical procedures in treating behaviour disorders can be defended on the ground that it inadvertent impairment of the neural substrate of personality can have distortive effect on behaviour, directed manipulation of the same substrate may have therapeutic effects.

3. Ausubel thinking that there is no inherent contradiction in considering mental symptoms both as expressions of problems in living and as manifestation
of illness. The latter results when for any reason the individual is unable to cope up with his problems and so reacts with seriously distorted behaviour or maladjustment. Three behavioural symptoms - (i) manifestation of impaired functioning, (ii) adaptive compensation, and (iii) defensive over reaction are also found in physical diseases.

4. The view that personality disorder is less a manifestation of illness than of sin, i.e. of culpable inadequacy in meeting problems of ethical choice and responsibility, and that people with behaviour disorders are morally accountable for their symptoms is neither logically nor empirically tenable. In most examples, immoral behaviour and mental illness are clearly distinguishable conditions. Guilt is only a secondary etiological factor in anxiety and depression, and in other personality disorders is neither a prominent nor a conspicuously absent phenomenon. The issue of culpability of symptoms is largely irrelevant in handling the behaviour disorders and in any case does not detract from the reality of the illness.

To sum up, it is both unnecessary and potentially dangerous as per Ausubal to discard the concept of mental illness on the grounds that only in this way can clinical psychology
escape from the professional domination of medicine. In such disciplines as dentistry, pediatrics, optometry and osteopathy, they have managed to acquire an independent professional status without rejecting the concept of disease. Ausubal regards it unnecessary and dangerous to substitute the doctrine of sin for illness in order to counteract prevailing a moral and non-judgmental trends in psychotherapy. The hypothesis of latent guilt does not properly explain most types of personality disorders, and the concept of mental illness does not preclude judgements of moral accountability were warranted. Definition of behaviour disorder in terms of sin or difficulties associated with ethical responsibility would unnecessarily bring in theological and philosophical disputes about values for specific criteria of disease.

**Erving Geoffman**

Geoffman has discussed [13] the medical model at length in various books and articles authored by him giving notes on the vicissitudes of the tinkering trades as he calls them. He deplores the way in which patients are admitted to mental hospitals when physicians immediately apply the medical service model, irrespective of the patients social circumstances and the particular character of his disorder. The patient is treated as someone whose problem can be approached by applying a single technical psychiatric view. That one patient differs from another in sex, age, race
grouping, marital status, religion or social class is merely an item to be taken into consideration and corrected so that general psychiatric theory can be applied and universal themes detected behind the superficialities of outward differences in social life. A uniform professional courtesy is shown to patients is matched with a uniform applicability of psychiatric doctrine.

In some cases of mental disorders which appear to fulfill all the requirements of the service model, there may be injuries to the client's mental functioning without anyone intending it and without his being personally to blame. But the psychiatrist treats all disorders in the uniform manner. After some time, he or his associates sense that something is wrong. Through routine referrals it comes to the attention of the psychiatrist that the disorder may be due to some other reasons. He gathers information, makes observations, provides a diagnosis, a prescription and also suggests a course of treatment. The patient may recover or die or reduces merely to vegetative life. In the more benign cases, where the patient can benefit markedly from treatment, he reevaluates his past experience so as to recognize that the psychiatric service was performed in his own interests and the right treatment was given to him. Everything ends happily ever after or at least tidily. In many mental hospitals one can find framed care records that
provide an outline of early social signs and symptoms and documentation of the lay failure to assess these correctly, and descriptions of the behaviour of the patient while he was sick and also drawings of the autopsy findings confirming the correctness of the diagnosis and appropriateness of the treatment. Thus social misconduct and visible organic pathology are brought together in perfect confirmation of the applicability of the medical model. Of course, some mental cases may be properly dealt with within the framework of the medical model, but there are very evident sources of difficulty in the case of a number of mental patients, psychosis. Many of these difficulties are described at length in the literature of psychiatry. Some such cases are reviewed by Geoffman in his books and articles.

Geoffman says that one issue in the applicability of the service model arises from the fact that part of the official mandate of the public mental hospital is to protect the community from the danger and nuisance of certain kinds of misconduct. He further states that if the mentally ill persons are viewed as persons that others have had a special kind of trouble with, then the custodial role of the hospital like the prison is understandable and many would feel justifiable. The point however is that a service to the patient is not necessarily a service to the inmate. He
feels that instead of a server and the served, we find a governor and the governed, an officer and those subject to him.

The second point that Geoffman raises is that the patient is admitted to a mental hospital largely involuntarily. Instead of the medical attention required by the patient, there is an effort to employ the guardian principle and assimilate action taken by next of kin to action taken by the patient himself.

It seems that the patient is not the only one who declines to view his trouble as simply a type of sickness to be treated and then forgotten. Once he has a record of having been admitted to a mental hospital, a social stigma is attached to him permanently. Even the hospital itself tacitly acknowledges that mental disorder is shameful. This is evident from the fact that many hospitals provide a code mail address so that patients can send and receive mail without having their status advertised on the envelope. Geoffman concludes that under the guise of the medical service model, the practice of maintenance medicine is sometimes to be found.

D.I. Levinson and E.B. Gallagher

These two mental hygienists who have identical views on mental hygiene have written many articles and some books
together to project a socio-psychological conception of the mentally ill person.

These authors have tried to define who a hospitalized patient is. Many mental hygienists have defined him as having a serious mental illness and so he enters the mental hospital voluntarily or sometimes through legal commitment. Thus he is a client receiving the professional services of a physician.

Some people regard him as an inert material being moulded or an empty vessel being filled with new knowledge or new virtues. They regard the maladjusted adolescent as neglected during his childhood whose therapeutic need is for generous doses of tender, loving care, or as a confused misinformed youth in need of good advise and counsel.

A basic dimension along which these considerations vary is in the degree to which the patient is seen as an active agent in the therapeutic educative process. At one end is the view that he is an object of manipulation on whom the doctor throw specific treatment technologies just as a repairman fixes a machine. At the other end is the view as a patient as a participant being influenced and guided but still having an active, self-generated responsible part. In this view, there is a collaboration between the patient and the mental hygienists. The patient is both an agent and an
object of change [14]. Between these two extreme views, there are many intermediate steps and qualitative variations. Levinson and Gallagher's approach starts from a version of role theory in which "role" is used as a connecting concept between "personality" and "social structure". The concept of role leads concurrently in two directions - (a) a role is conceived in a socio-cultural sense as something external to the individual patient - a set of expectations, norms, and social influences inducing the patient to think feel and act in some particular ways; (b) the role has interpersonal aspect, ultimately it is the patient himself who evolves his role-definition, and he does so on the basis not only of external pressures but also of inner wishes, preferences and a genuine socio-psychological conceptions. The two psychologists then put up a poser, "what is the way to recovery?" This is the most obvious role-issue confrontation for the patient. It is the most emphasised issue by professional staff but it is certainly not the only one and is often not the most salient one. The answer to this question leads us to five problematic issues in addition to the above discussed one.

(1) To develop a conception of self which gives meaning to the fact that one is, in an unavoidable public sense, a mentally ill person,

(2) To develop himself in the therapeutic environment and come to terms with community expectations and values
regarding his own position.

(3) To adapt to the administrative decisions made by psychologists about his case.

(4) To develop viable relationships with other patients in the hospital.

(5) To reconcile the anithesis between security and freedom as it appears in each new stage of hospitalization.

The patient may be strongly influenced by the presence or absence of significant persons and groups outside the hospital. When the person in the hospital has meaningful contact with persons in the normal community during his hospitalization they may play a significant role in his therapeutic career.

When we consider these external demands and opportunities we must also consider interpersonal determinants within the patient himself. Many elements of his role-definition are formed in the therapeutic situation. The interpersonal determinants of role-definition have their sources in various levels and aspects of personality. A role-definition involves modes of thought, feeling and behaviour within a particular social context. The patient's role-conception and his behavioural strivings within this situation are influenced by relatively enduring features of his personality, which have origins earlier in his development including childhood as well as later growth.
periods, and gain expression in various sectors of his adult life.

Levinson and Galleyber conclude that the patient's role definition is to be seen as a personal achievement, which he fashions for himself in response to both external and intrapsychic influences.

**Norman M. Bradburn**

Bradburn has developed a model to interpret psychological well-being [15] or mental hygiene in our words. He first makes a mention of some observations as follows:

1. Some people seem to have an easy time, while others have much greater difficulty in accomplishing those things they want to do in life.
2. Almost everybody has periods in his life when he has difficulties with some or many parts of his life.
3. These variations in intensity and duration of difficulties do not appear to be randomly distributed through society, but are found to differing degrees in various groups of society.

Bradburn then develops his theory of psychological well-being to interpret these observations. He based this model on the empirical work done by him and Caplovitz as a pilot study [16]. The framework of this study takes as its fundamental dependent variable awowed happiness or the
feeling of psychological well-being. A person's position on the dimension of psychological well-being is seen as a resultant of the individual's position on two independent dimensions - one of positive feeling and the other of negative feeling. In Bradburn's model, an individual will be high in psychological well-being, the degree to which there is an excess of positive over negative effect, and will be low in well-being, the degree to which negative feeling dominates over positive feeling. This model is very similar to older pleasure-pain or utility models which consider an individual's happiness or well-being in terms of the degree to which pleasure predominates over pain in his life experiences. The advantage of Bradburn's model is that it is based on empirical pilot study in which a cross-section of the population of four small towns was asked whether they had experienced any of several feeling states during the earlier week. The analysis of the study indicated that individuals varied along two dimensions - one indicative of positive effect and the other of negative effect. It was clear that these two dimensions were independent of each other. It was not possible to predict an individual's score on the negative dimension from any knowledge of his score on the positive dimension and vice-versa. On the contrary, both dimensions were related in the expected direction to overall self-ratings of happiness or subjective well-being. The best predictor of the overall
self-rating was the discrepancy between the two scores. The greater the excess of positive over negative feeling, the higher was the overall rating of psychological well-being. This does not show any departure from the pleasure-pain models.

This model suggests on one hand that there are a series of forces whose presence is related to the presence of positive effect, but whose absence merely results in a lowering or absence of positive feeling rather than any change in negative feeling. On the other hand, there are also a series of different circumstances which contribute to the presence or absence of negative feeling, but which have no influence on a person's positive feeling. In order to understand an individual's position along the dimension of well-being, we must look at those sets of forces contributing to positive effect as well as those contributing to negative effect.

The question that now arises is: If we consider these two dimensions of positive and negative effects as independent of each other, and related to different things, can we specify what the factors are that do influence them? Although all results and cause and effect relationships are not worked out in this pilot study, negative effect appears to be related primarily to the variables that have been dealt with by the traditional "mental illness" approaches.
Variations in negative effect are associated with difficulty in role-adjustment such as marital problems, work dissatisfaction, interpersonal tensions and the more standard indicators of anxiety and worry. None of these factors seem to be related to the positive feeling. The positive effect appears to be related to a series of factors having to do with the degree to which one is involved in the environment around him, social contacts and active interest in the world. These factors include such variables as the degree of social participation reflected in variations in organizational membership, number of friends, frequency of interaction with friends and relatives, degree of sociability and companionship with one's spouse, and exposures to life situations that introduce a degree of variability into one's life experiences.

M. Brewster Smith

Smith believed in values and so he has reviewed mental health or hygiene from the point of view of values in psychology [17]. Like many others, Smith also was embarrassed by the use of the words "mental illness". He said that the various lists of criteria that have been proposed for positive mental health reshuffle overtracking conceptions of desirable functioning without attaining agreement or giving promise that agreement can be reached. In particular, he compared Jahoda's and Allport's
conceptions if positive mental health in terms of multiple criteria as follows:

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<tr>
<th>Jahoda (1958)</th>
<th>Allport (1960)</th>
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<td>Attitudes towards the self</td>
<td>Self-objectification</td>
</tr>
<tr>
<td>Growth and self-actualization</td>
<td>Ego-extension</td>
</tr>
<tr>
<td>Integration</td>
<td>Unifying philosophy of life</td>
</tr>
<tr>
<td>Autonomy</td>
<td>Realistic coping skills,</td>
</tr>
<tr>
<td></td>
<td>abilities and perceptions</td>
</tr>
<tr>
<td>Perception of reality</td>
<td>Warm and deep relation of</td>
</tr>
<tr>
<td></td>
<td>self with others</td>
</tr>
<tr>
<td>Environmental mastery</td>
<td>Compassionate regard for all</td>
</tr>
<tr>
<td></td>
<td>living creatures</td>
</tr>
</tbody>
</table>

Smith stated that these criteria are well-known and it is no use adding to them. He however, recognized mental health as an evaluative term, that personal and social values as standards of the preferable are crucially involved in any discourse about mental health. He favoured the intrusion of values in psychology although lamented by some psychologists. He suggested that "mental health should not be regarded as a theoretical concept at all, but as a chapter heading under which fall a variety of evaluative concerns". He poses a question: Why should the mental health movement be impelled to extend itself to concern with the "mental hygiene" of promoting positive mental health in the absence of firm knowledge or clear guidance? He then answers it thus: The demand for a psychologically informed
phrasing of objectives, for conceptions of positive mental health, comes most compellingly from those concerned with the rearing and education of children. A counselor may leave objectives to his client to set his goals himself; but the case can hardly be extended to the child as ward of teacher and parent, who in turn look to the psychologist for guidance. One of the ways of minimizing responsibility for educational goal-setting in terms of mental health is to accept as ultimate the values prevailing in the particular culture, to define the function of education as cultural transmission and leave matters of value choice to parents and school authorities. However, the parents and school authorities too are confused and involved in the fray.

If values are social products, they rest on a personal commitment. Everybody, scientists or humanist or man in the street has the right to posit values. However, the most question is: What value dimensions are to get on our lists of mental health involves a conception of the good life, which nobody can impose on anyone else though it is fair enough for each of us to try to persuade others to accept what values we consider best.

Smith then gives an illustration of narrow and broad conception of mental health and the values involved as follows:
## Mental Health of Child[18]

<table>
<thead>
<tr>
<th>Scope</th>
<th>Present behaviour</th>
<th>Present disposition</th>
<th>Adult prognosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal Conception</td>
<td>Freedom from incapacitating symptoms</td>
<td>Good resistance to stress</td>
<td>Absence of mental disorder in adulthood</td>
</tr>
<tr>
<td>Extended Conception</td>
<td>Momentary well-being</td>
<td>Capacities for competent, happy</td>
<td>Capacities for happy, zestful, etc.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>child life, etc.</td>
</tr>
</tbody>
</table>

Smith further states that regarding mental health as a theoretical concept, we have no particular reason to expect resistance to mental disorder to correlate with various aspects of positive functioning. So long as we grope futilely toward a concept of mental health, the advantages of specificity and researchability appear on the side of the minimal conception. Viewing these versions as different locations of chapter boundary lines, however, one can be as specific as possible about the positively valued criteria. The extended version includes the valued dimensions of behaviour and personality that are most responsive to our intervention. Mental health promotion in this sense may not be as impractical as some of us have come to assume.

During the 1950s, many psychologists gave lists of the criteria for positive mental health. Jahoda’s criteria will be discussed a little later. Many others gave lists of
their criteria of mental health. Chief among them were Allport in 1955 Maslow and Mittelman in 1951, Rogers in 1959, etc. In 1961, Smith showed the futility of adding to Duch lists, since the main criteria can be given any other labels. He however recommended that dimensions of mental health should be selected on the basis of their -
(a) representing positive human values,
(b) capacity to be specified and measured,
(c) articulation with personality theory, and
(d) relevance to the social context for which they are being defined.

Therefore, the later writers like Offer and Sabshin in 1966 and Hudson in 1975 did not give new lists, but on the other hand focussed on normality or sanity. Later on "coping" as the criterion of positive mental health has been accepted in the profession.

Ironically, some psychologists gave such lists once again as shown below here:

(1) Adler in 1982 gave this list -
   (a) performing major social roles,
   (b) self-concept
   (c) interactions with others,
   (d) managing effect or emotions,
   (e) being involved in productive activities,
   (f) handling stressful events,
   (g) accessing available resources, and
   (h) cognitive functioning
In 1984, Lewis and Lewis proposed the following is:

(a) building satisfying relationship with others,
(b) developing effective cognitive problem solving skills,
(c) managing personal stress,
(d) gaining access to available resources for help when needed,
(e) becoming involved in productive activities,
(f) taking responsibility for one's own behaviour, and
(g) maintaining a self-concept that is positive and also realistic.

The use of the word "coping" which is now-a-days used profusely means one's ability to achieve appropriate purposes effectively and efficiently within the specific context in which one is functioning [19]. Therefore, coping involves answers to the following questions:

(1) Is coping situation-specific, but involves the application of strategies that one learned in prior situations?

(2) Does coping involve using one's assets and resources? Is it largely a matter of "what you do with what you have got?"

(3) Can coping be helped or prevented by environmental factors, so that failure to cope need not necessarily reflect inadequate mental health?
Marie Jahoda

Jahoda [19] has developed from her experience and study, various criteria for positive mental health. She surveyed the relevant literature and pointed out the following six approaches to the concept of mental health:

(1) The indicators of positive mental health should be sought in the attitudes of an individual toward his own self.

(2) The individual's style and degree of growth, development, or self-actualization as expressions of mental health.

(3) Various proposals emphasize a central synthesizing psychological function, incorporating some of the suggested criteria defined in (1) and (2) above. She called this function integration.

(4) Some consider autonomy as the individual's degree of independence from social influences and as most revealing of the state of his mental health.

(5) A number of proposals suggest that mental health is manifested in the adequacy of an individual's perception of reality.

(6) There are suggestions that environmental mastery be regarded as a criterion for mental health.
Although some of these concepts may be overlapping to some extent, all ideas on positive mental health in the literature can be classified into these six categories. Marie Jahoda then examines all these criteria one after another.

**Attitude Towards the Self**

The mentally healthy attitude toward one's own self can be described by such terms as self-acceptance, self-confidence, or self-reliance, each with a little different connotation. Self-acceptance implies that the person has learned to live with himself, accepting both his strengths and weaknesses. Self-confidence, self-esteem and self-respect have a more positive slant. Self-reliance connotes self-confidence and independence from others and initiative from within. A number of different dimensions and components appear to run through the various proposals. Those aspects of the self-concept that stand out prominently are (1) accessibility to consciousness, (2) correctness, (3) feeling about the self, (4) the sense of identity.

**Growth, Development and Self-actualization**

Many authors see the criteria of mental health in an ongoing process variously called self-actualization, self-realization, growth or becoming. This notion that an organism strives to realize its own potentialities is very
old. Various authors who regard it as a criterion of positive mental health seem to emphasize one or more of the following aspects: (1) self-concept, (2) motivational processes, (3) investment in living including achievements of the self-actualizing person which demonstrates a high degree of differentiation of his basic equipment.

Integration

In the proposals suggesting qualities of self-concept or self-actualization, there is a hidden criterion called integration of personality.

Integration relates to all processes and attributes in an individual. Psychological treatment of a maladjusted individual is predicted for its fruitfulness in the search for a unifying principle in terms of which most inconsistent manifestations of behaviour can be understood to hang together. Integration emphasizes one of the following aspects: (1) a balance of psychic forces in the individual, (2) a unifying outlook on life, emphasizing cognitive aspects of integration, and (3) resistance to stress.

Autonomy

Many psychologists regard an individual's relation to the world as mentally healthy, if it shows autonomy, self-determination or independence. This criterion deals with one
or both of the two aspects - (1) the nature of decision-making process, emphasizing the regulation of behaviour from within in accordance with internalized standards of behaviour, and (2) the outcome of the decision making process in terms of independent actions.

Perceptions of Reality
The perception of reality when occurs is construed as mental health when what the individual sees corresponds to what is actually there. Perception here means social perception involving other human beings. This can be further divided into two other criteria of mental health: (i) perception free from need-distortion, and (ii) empathy or social sensitivity.

Environmental Mastery
No other area of human functioning has more frequently been selected as a criterion for mental health than the individual's reality orientation and his efforts at mastering his environment. Two central themes pervade the relevant literature - (i) achievement in some significant areas of living, and (ii) appropriate functioning with emphasis on the process rather than the product. Environmental mastery can be treated on these aspects: (1) the ability to love, (2) adequacy in love, work and play, (3) adequacy in inter-personal relations, (4) efficiency in
meeting situational requirements, (5) capacity for adaptation and adjustment, and (6) efficiency in problem-solving.

The Stand of the Present Writer

For this doctoral research, the present writer has adopted Marie Jahoda's analysis or survey of various criteria of mental health as found in adjustment literature and has prepared her inventory on that basis. She has found Jahoda's survey the most comprehensive of all writers in the literature.
References


11. ibid, p.57.


18. op. cit.

