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A GLOBAL UNDERSTANDING OF MENTAL HEALTH

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Abstract: *The modern day concept of mental health in Western European culture has deep historical roots which continue to shape their understanding of mental health and mental disease. This article reviews the history of concepts of mental illness and the progression of ideas and historical events which have influenced modern mental health intervention. It examines the forces which lead to the three competing views of mental health: biological/physical; psychological; and societal. Recently the field of Global Mental Health has emerged. This movement places priority on improvement of the mental health and general level of functioning for all people with respect to cultural differences. Caution must be taken not to impose Western European values as counseling spreads globally.*

An Historical Background to Understanding Today's Global Mental Health Movement

The concept of Mental Health dates to at least the 5th century BCE.[1] The Greeks first described mental illness and by the 4th century BCE had developed a manual cataloging mental disorders.[2] Three major illnesses were identified: madness (psychotic behavior), melancholy (depression) and epilepsy. The first major schools of philosophy were the Stoics, the Skeptics and Epicureans, later came the Socratics and the Aristotelian schools of thought. These philosophies expressed some of the earliest ideas about mental illness and how to treat it. Even today these philosophies have an influence on the way we conceptualize mental illness. For example: the founders of cognitive therapy and rational-emotive therapy explicitly cited Stoic philosophy as the principal precursor and inspiration to their approach.[3]

In Greek and Roman times there were two theories about the origin of mental illnesses. The first theory that emerged was supernatural in origin. A psychotic individual was seen as having visions from the gods or perhaps the gods were speaking through them. Mental illness could be seen as either a blessing or condemnation by a god.

The gods could act for the benefit of mankind or do unspeakable harms. Religious leaders sometimes felt it necessary to rid the body of the god's possession through religious rites. Many cultures around the world have had similar beliefs. Some faiths even today conduct exorcisms in order to rid a person of demons and evil spirits.

A second view was that mental disorders were a consequence of some physiological abnormality. Hippocrates, the founder of the Hippocratic Oath, which is still taken by physicians in Western medicine today, wrote of seeing his colleague Democritus dissecting animals in an effort to locate the organs involved in mental illness.[4] Blood-letting, hot baths, purgatives, smelling incense and other

physical interventions were used to relieve the mental suffering of patients.

The competition between the spiritual and physical views of mental illness for dominance persisted through the height of the Roman Empire's reign. By the end of the 4th century A.D. mental illness had become nearly synonymous with sin. The search for physical roots of mental illness was forgotten by Europe for more than a millennium.

The Roman Catholic clergy felt mental illness was God's visitation of punishment for sin. This belief lead to a fear of the mentally ill as essentially evil beings intent on doing harm to others. It was thought that the mentally ill must be separated from the population, not so much for the good of the mentally ill as for the protection of the society. The conditions which we might label schizophrenia, mania, or obsessive compulsive disorder were thought to be the result of demonic possession. In the name of God exorcisms were brutally conducted as treatment to save the soul, if not the body.

Sufferers of melancholia (depression) were treated with colonics and herbal teas and medicines. Other unfortunate individuals were locked away in dungeons or tortured in an effort to drive out the "evil" spirits. Many were simply killed to "protect the community." Those in the dungeons received no medical care, little in the way of food and were left in rotting rags and their own soil. Many children born with some physical deformity were also deemed mentally ill and were locked away with criminals and those who suffered madness.

The first known specialist "hospitals" for madness developed in what is modern day Iraq. In 705 A.D. a hospital was built in Baghdad, another soon followed in Fes and a third in Cairo in 800 A.D. Several Medieval Islamic physicians wrote treatises on the diagnosis and treatment of mental illness.[5] Little of the literature of those scholars survives today. The first European hospitals for the mentally ill appeared in the 13th century and then these did not attempt a cure. Their purpose was to incarcerate, to protect the general public from the lunatics. Treatment in these hospitals was no different than in previous centuries in Europe. The mentally ill, the physically deformed, and criminals were frequently locked up together. They were tied or chained to beds, locked in small cages without blankets or even clothes.

The renaissance period witnessed the beginning of a new view of mental illness, one in which physical and social causes were sought as the origin of mental illness. In 1621, an Oxford University mathematician, astrologer, and scholar Robert Burton published an English language book, *The Anatomy of Melancholy…* [6] He made a scholarly case for the need to study the human mind. His call for the study of the human mind went unanswered until the English physician William Battie wrote his *Treatise on Madness* in 1758. He advocated humane treatment of the mentally ill and the search for the causes and cures for such conditions. When the English King George III recovered from his mental disorder a new era dawned.[7] Mental illness was then seen as an illness which could be cured or at the very least controlled. By the 1790's Philippe Pinel,[8] M. D., of France and William Tuke, an English Quaker and tea merchant, independently advocated for the removal of chains from the mentally ill.[9,10] The York Retreat (Tuke's facility) in England became a model for the Americas and Europe for the treatment of the mentally ill. A focus on moral development, healthy living and humane conditions was viewed essential for the patient's recovery to mental health. Despite these emerging views the conditions and treatments offered to the mentally ill showed no improvement outside of a few enlightened institutions.

In 1808 Johann Christian Reil took the Greek words *psyche* "soul" or "breath" and *iatros or* "healer" and combined them to create "psychiatry" as a new division of medicine.[11,12] During the next hundred years the understanding of mental disorders and their categorization grew dramatically, as did the housing of those who were ill. Much of this change must be attributed to the rise of the scientific method which began its ascendency in the 17th century over the previously dominate religious fervor. This shift in thinking allowed for the re-emergence of the

search for physiological basis for mental illness.

During the latter part of the 1800's mood disorders, levels of depression, monomania (obsessive-compulsive behaviors) and neurosis were identified and treatments were sought. Mesmer began mesmerism in the 1850's (hypnosis therapy), Freud followed with his version of psychotherapy and the Vienna School. He believed that the brain function was somehow altered by childhood experiences and that by discovering those experiences which have been subjugated to the subconscious or unconscious mind one could effect a cure within the individual. He also said that his technique would become obsolete someday because medicine would be able to explain the physiological malfunctions which caused various forms of mental disorders.

While Freud and his Vienna Circle colleagues were exploring the art of psychoanalysis and creating an understanding of human behavior that included the ego, alter ego, unconscious and subconscious mind another movement was also developing independently of medicine and psychiatry.

Due to industrialization across Europe, England and the United States, living conditions deteriorated for the masses of people who migrated to the industrial centers for work or to escape the European armed conflicts and famine. These are the conditions which the famous author Charles Dickens portrayed in his novels. A social conscience movement emerged in which poverty, living conditions, and the social class system were challenged. The social conscience movement postulated that many of the mental health issues of the day were the result of poverty and the lack of education and opportunity. This new movement was a social justice or social welfare model which eventually created the modern concept of social work. This social welfare movement was gaining strength in the United Kingdom and the United States.

Dorothea Dix was a prominent American leader in this movement. In 1843 her "Memorial to the Legislature of Massachusetts"[13,14] described the conditions in which the mentally ill were kept and their brutal and inhumane treatment. She lobbied for the humane treatment of the mentally ill for many years. By the 1860's the New York State Legislature established separate asylums for the mentally ill.[15] Despite these new facilities and improved living arrangements treatment was minimal and often still brutal. Ice cold water submersions, the use of strait jackets and the experimentation with drugs were used without the modern constraints of patient's rights or the ethical standards of practice understood today.

By the early 1900's the United States of America housed approximately 150,000 mental ill and physically deformed people. German speaking countries had more than 400 public and private mental facilities and psychiatry was a recognized medical specialty. Treatments included psychoanalysis and the traditional treatments of ice cold baths, electric shock, experimental drugs, colonics, and other purgatives.

Clifford Beers described what it was like to be a patient in an American asylum in 1908 in his book *A Mind That Found Itself.*[16] This marked the beginning of the "mental hygiene" movement with its emphasis on childhood prevention. It also signaled a rejection of the medical model of the common treatments of the time and a refocusing on mental health, not illness. The movement examined the social environment and its impact on maladaptive behavior. Now there were clearly three competing views regarding the original

and thus the treatment of mental illness: biological/physiological; psychological; and sociological.

By this period the academic discipline of psychology was well established in many universities. There were studies of how the mind, as opposed to the physical brain, worked. The American philosopher James and others began to postulate theories of learning and memory. Others examined group or mass psychology and what we would term propaganda for the manipulation of the masses. Intelligence testing for educational purposes advanced. Employment and career counseling emerged.

The temperance movement convinced Americans that alcohol and alcoholism were "social diseases" which prohibition could cure. Alcohol and drug addictions were labeled as morale weakness from which the government needed to protect the greater society. Physicians saw addictions as a psychologically based disease with physiological aspects. The social welfare movement viewed excessive drinking as a symptom the decay of the social environment and endemic poverty. Alcoholics Anonymous was founded by a physician on tenets of religious faith, social fairness, and psychological insight.

Throughout the first half of the century the debate regarding mental health raged between the medical, biological proponents, the psychological/psychiatry approach and the social work belief that mental illness was at least in part a response to the inequities of society.

After World War II a host of new approaches to mental health emerged. In the last half century there has been an astonishing growth in mental health services available in the United States, Canada, and the United Kingdom. With this growth came the introduction of new therapy models and theories. Today the variety of psychotherapies is staggering. There are Albert Ellis' Rational Emotive Behavior Therapy (REBT), Aaron Beck's cognitive therapy (CBT), Human Social Functioning, Gestalt, Positive psychotherapy, Narrative Therapy, Coherence Therapy, Feminist and Brief Therapies. There is of course Client-Centered Counseling (Rogerian), Somatic Psychology, Expressive Therapy including art and play therapies and EMDR. There is career counseling, couples counseling, divorce counseling, addictions counseling and a host of other variations. And then there are specialties in the medical field of psychiatry.

Notably Carl Rodgers began the "counseling movement." He was a trained psychoanalyst who felt the patient–doctor relationship was an incorrect model for treatment of most mental conditions. He preferred the legal model of client and counselor in which the client determined the direction of therapy and what issues were to be discussed. He stressed the relationship between the therapist and client as the key to assisting the client in attaining a healthier way to function in life. His goal in therapy was to help clients become "fully functioning individuals" within the social context in which they found themselves. This model shifted the control of treatment from the doctor to the patient. Behaviour modification, first seen in the 1920's, became popular in the 1960's and 1970's. It emphasized the biological concept of stimulus and response and learning theory. Notable contributors were Joseph Wolpe of South Africa, Shipiro and Eysenck in the United Kingdom, and J.B. Watson and B.F. Skinner in the United States.[17] Another significant therapeutic approach grew out of the Second World War. Existential Psychology concerned itself with the individual's ability to create and preserve meaning and purpose in life, despite terrible experiences and circumstances.[18] This approach placed its emphasis on the social circumstances in which the individual was situated and how that individual responded. Vocational Counseling, begun in the early 1900's, never had much support or recognition as a profession. Following World War II and the Korean Conflict the United States government funded vocational education and built upon John Holland's theories. The government had two basic objectives. One was to employ as many of the veterans as possible, and the second was to out-pace the Soviets in science and technology. Although each new theory or

approach was different in structure and theoretical foundation each originated from social needs and was not based on medical model assumptions.

By 1950 the psychological model was also re-emerging with its own new approach to mental health. In that year the *Diagnostic and Statistical Manual* (DSM) was first published. This was an attempt to label disorders for research purposes and to collect data using a code system which categorized mental disorders. It was not dissimilar in conception to Karl Ludwig Kahlbaum's disease classification[19] on which Emil Kraepelin built early in the last century.[20] These ideas culminated in medicine's development of the *International Classification of Diseases (ICD).*[21]

There were many opponents to the original *DSM* as it seemed to some to adopt a medical model: perhaps most notable was William Glasser, M.D., who still remains an opponent of the system and its subsequent editions. One repeated complaint is the *DSM* model portrays social adjustment and many normal behaviours as mental disorders. In May of 2013 the 5th Edition of the *DSM* was released with nearly 1000 pages with several new diagnoses.

The discoveries that lithium carbonate stabilized manic-depression (now known as bi-polar disorder) in 1948 and chlorpromazine was effective in treating schizophrenia in 1952 helped in the establishment of Biological Psychiatry.[22,23] By the end of the decade the psychoanalytic school of thought had been marginalized. Psychology and counseling techniques had become dominant in dealing with the "simpler" forms of mental illness (neuroses).

Social Workers, the natural outgrowth of the social welfare models of service of the first part of the century, also became common. Career counseling services were established in every US secondary school, university and college. Although initially the funding was federally based, most institutions found it advantageous to continue services even after federal funding ended. In the secondary schools these counselors helped "track" students into vocational education or preparation for entrance into colleges and universities. In colleges and universities counselors focused on placement in jobs post-graduation.

Biological Psychiatry and Neuropsychology grew quickly in reputation and the number of providers after Otto Loewi's discovery of acetylcholine's neuromodulating properties.[24] This was the first of many neurotransmitters to be identified. Neuroimaging was developed and utilized in the 1980's. These discoveries have further advanced the pharmacological approach of Biological Psychiatry which dominates psychiatric interventions in mental health today.

Perhaps the most frequently employed model of initial data collection regarding a client's care is based on the "bio-psycho-social" model which recognizes the interaction of the environment with the human organism and heredity. Although there are differences in the emphasis placed on the three basic components of the model by different theories and practitioners, the model recognizes the intersection and interaction of the three components. In medicine greater emphasis is placed on the biological component. In psychology the emphasis is on the psychological development of the individual, whilst counselors, social workers, marriage counselors, career counselors and addiction specialists stress the social and family aspects of life influences.

Even within these three approaches there is another distinction between those psychotherapies that employ a medical orientation and those that employ an humanistic one. The medical orientation considers the patient as unwell and in need of "curing" or at least controlling the progression of the disease. The *DSM* and *ICD* are the guide books for this orientation and have become the Global standards. The humanistic view stands in stark contrast to the medical orientation. It seeks to depathologize the human condition and to understand emotional turmoil in the context of the environmental stressors faced by the client. Reactions to these stressors are seen as normal responses to difficult situations. Some responses are unsuccessful or less successful than others in coping with life circumstances. These counseling approaches strive to assist the client in developing more successful coping strategies which will be available to the client for future use as needed.

Therapeutic Efficacy

The proliferation of therapies has resulted in competing claims regarding the greater efficacy. Controversy surrounds which form of psychotherapy is most effective and which interventions are optimal for certain diagnoses. "Furthermore, it is controversial whether the form of therapy or the presence of factors common to many psychotherapies best separates effective therapy from ineffective therapy."[25] It has been argued that the quality of the relationship is of greater importance than the therapeutic theory. This position would be supported by Client-Centered therapists.

Psychotherapy outcomes research as early as 1952 found that two thirds of patients improved significantly or recovered fully within two years with or without treatment.[26] The Helsinki Psychotherapy Study which is examining long-term effects of therapy will continue until 2014. The three and five year follow-up reviews revealed that brief therapies bring more immediate results, but long-term therapy yields greater results.[27]

In 2001, Bruce Wampold published *The Great Psychotherapy Debate*[28] which reported; 1. psychotherapy is effective,
2. the type of treatment was not a factor,
3. neither the theoretical bases of the techniques used nor the strict adherence to the techniques were not factors.
4. the therapist's belief in the efficacy of the technique is a factor,
5. the personality of the therapist is a factor, and
6. the alliance (rapport, trust, collaboration in treatment) between the client and the therapist is a key factor in effecting a positive therapeutic outcome.

The conclusion drawn by Wampold was therapy can effect an improvement in the client due more to personality, client-counselor relationship, and a belief in the effectiveness of the therapy than on the type of therapy or the counselor's skill in utilizing the techniques of the theory.

The Global Mental Health Movement

The World Health Organization, seeking to find a definition which serves common ground across cultures, defines mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."[29] The agreement that mental health must be understood from a cultural perspective with the goal of improving one's ability to succeed within one's own culture has gained wide acceptance. Recently a global mental health field has emerged and has placed a "priority on improving mental health and achieving equity in mental health for all people worldwide."[30] This movement recognizes the biomedical aspects of mental illness whilst endeavoring to hold the humanistic aspects of counseling as foremost in importance to mental health.

Psychiatry and psychology have agreed upon some definitions of mental disorders that appear worldwide. Depression, paranoia, suicide ideation, eating disorders, schizophrenia, addictions and mania are some disorders upon which there is a general consensus. The *ICD* and the *DSM* are global

attempts at gaining universal acceptance of definitions of specific disorders by listing a series of behaviours and thoughts which a patient/client reports or that are directly observed by the therapist which serve as a basis for diagnosis. Both the *DSM* and the *ICD* have tried to objectify diagnoses by stating specific behavioural criteria on which to base a diagnosis. One need not demonstrate all of the listed criteria but a specified number must be met to receive a proper diagnosis. In both of these diagnostic systems the presence of illness is determined on a polar basis: either one has the disorder or one does not. If one meets enough of the criteria then the individual is ill. In parts of Canada a system with a Likert type scale in which the degree of functioning is estimated is being used. The higher the number on the scale the greater the particular behaviors or thoughts and feelings are present. This recognizes that mentally healthy people may not always function well and it allows for a fluid diagnosis as conditions change. It incorporates mental health into the mental illness model on a continuum from healthy to unhealthy. The Chinese have developed their own system for diagnosis of mental disorders based on their traditional understanding of medicine.

Although there is some agreement on what constitutes mental illness, there is wide divergence in what is considered mental health. Health is not simply the absence of illness and there is no one universally agreed upon definition of mental health. Mental health has been described as the capacity to enjoy life in the absence of a mental disorder.[31,32] It may also be defined as the ability to cope appropriately and effectively with life's stressors within one's cultural environment. The idea that coping behaviors are culturally contextual means that nothing more than a very general definition of mental health will serve all peoples in various nations and subcultures.[33] Cultural differences make a globally acceptable definition impossible at this time.

A notable criticism of therapy suggests that to some degree it is idealized as only a helping relationship. But because of the cultural context and its dominant value system therapy is fundamentally a political practice supporting societal norms and practices while undermining or disqualifying viewpoints which deviate from the acceptable variation from the norm. While this may be unintended, the counselor-client relationship always participates in the society's understanding of relationship power and political dynamics.[34] Thus the Global Mental Health Movement presents a danger. The theories and systems from which the movement stems originate from Western European culture with its long history and evolution. If care is not taken the underlying European values may be imposed in a new colonialization of less developed nations.

The understanding of cultural importance cannot be overstated. Even in countries which share a common language and heritage there cultural differences exist and words do not always have the same meaning. Different experiences and cultural histories, which are at times subtle and often unrecognized, influence how people think about and react to the same stimuli. When two cultures do not share a common language the difference in understanding can be even more complex. How one organizes thoughts is both culturally and linguistically determined and then in turn how one thinks aids in the social construction of culture. This interaction is dynamic and continuous causing an evolution of the cultural experience. The culture in which one grew to

adulthood is not the same culture in which one's children and grandchildren will mature.
Language is symbolic shorthand for objects, thoughts, ideas, and concepts of human experience. Some languages are more abstract than others thus permitting greater opportunities for misunderstandings. Anyone who speaks multiple languages recognizes that some words and phrases have no identical meaning in another language, thus requiring an approximation in translation.
Despite these considerations and difficulties there is merit in attempts to create an international agreement in general terms as to what constitutes good mental health and how it can be achieved. There is room for both a biological, medical understanding of the brain physiology and chemistry which underlies some mental illness, and there must also be an acceptance of the social and environmental circumstances into which humans are born. It seems that there needs to be a new system created which does not impose concepts of mental health which initiated in ancient and medieval, Western European cultures universally. Therein lays the danger of diagnostic systems such as the *DSM* and the *ICD* and a Global Counseling Movement rooted in Western European culture.

Summary and Conclusion

Mental disorders were recognized by ancient cultures for at least 2500 years and many of the original conceptualizations of the ancient Greeks have been incorporated into today's theories about mental health and illness. The attempts to codify and catalogue mental illness began in Greece about 500 years BCE and continue to this day in the forms of the *ICD* and the *DSM*. The early belief in the dualistic nature of the etiology of mental illness, i.e. physiological basis versus the experiential basis, continues today with just as much controversy.
There is a cultural component to the definition of mental illness as well as mental health which is inescapable and underlies therapies of all types. This makes gaining agreement on what constitutes mental health on a world wide scale nearly impossible. However, the World Health Organization has proposed a broad statement of healthy behavior which can focus efforts on improving the quality of emotional well-being. There is a global mental health movement growing which is focused on just such a goal. Caution must be taken not to impose values which are deeply imbedded within the theories and techniques originating in the Western European cultures and the dualistic understanding of human beings.
Within the two positions of biological/medical model and the humanistic model of mental health care a great many theories have evolved. Wampold's and others research have demonstrated the efficacy of therapy regardless of type but associated with the counselor-client relationship. Therapy works even if we do not always know why.

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