

The definition of mental illnesses



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Psychiatry entails the study of the mental state, models that identify the causes of mind related disorders, grouping of schemes for the defects, information search pertaining to the disorders and treatments measures that are administered to address the disorders. Philosophy on the other hand attempts to explain the conceptual, social, metaphysical, ethical and epistemological procedures that pertain to psychiatry. It is on this tenet that the nature of mental illnesses becomes crucial to this study. The core philosophical study with relation to mental health does not deal solely with its occurrence but on the definition; whether an objective or scientific definition are subjects of study. For a successful identification of the proper definition, it is vital to evaluate discussions for purported mental disorders (Arpaly, 2005). The issue therefore arises when establishing the connection between treatment of mental illnesses and philosophical issues pertaining to the capacity of people with mental disorders to take responsibility of their actions and justification of insanity under the law. Philosophical literature has been dominated by four vital issues which include the definition of mental illnesses and their relationship with other physical illnesses, grouping of mental illnesses and the responsibility of mental illnesses with respect to symptomatic behavior.

Definition of mental illnesses

Mental illnesses are mental disturbances in terms of thoughts, encounters and emotional impairments and enhancing the capacity to evaluate interpersonal interactions which may cause self-destructive conduct. Mental disorders such as schizophrenia, major depression and schizoaffective disorder are usually chronic and can lead to crucial disorders. Symptomatic

mental illnesses attract diverse behaviors which are influenced by supernatural factors. According to Warner (2004), anthropological studies that have been carried out beyond western cultures have proposed that some behaviors which could be perceived as symptomatic mental illnesses do not account for mental illnesses in other cultures (Kleinmann, 1988).

Philosophy and ethics of mental health

Philosophers had initially spent relatively little time assessing irrationality. Philosophers have now developed interest in diverse areas in research and mental health activities (Bavidge, 2006). Those who engage in mental health research lack initial information due to inadequate background on philosophical tenets of mental illnesses. It therefore poses a stronger challenge to determine whether mental illnesses need to be included in the study of other physical diseases.

According to Szasz's argument, a disease is a bodily malfunction and literally, the mind does not fall as part of the body hence making it unwise to apply the concept to the mind. This has however attracted discussions on the fact that diseases actually entail bodily malfunctions. Critics have focused particular areas of mental disorders which are linked to moral decisions such as antisocial personality, homosexuality and pedophilia. Other mental illnesses have been categorized to be on the border between pathology and normality, for instance dysthymia, a mild chronic aspect of depression (Radden, 2009). Modern psychiatry is based on scientific objectives which seek to identify such causes as traumatic moments or genetic exposures. The understanding of human anatomy especially the

changes in the nervous system attempt to elucidate the occurrences. Some of the core issues facing the scientific framework involve various theories in support of this framework (Ghaemi, 2003; Perring, 2007). The reduction approach attempts to elucidate reduction in the social implications of mental disorders to explain mental health at various levels.

Delusions and mental illnesses

Delusions are aspects where people believe in something and create a perception of truth based on the existing evidence while in fact these beliefs are untrue. These false perceptions occur as a result of poor interpretations or unintentional actions. To determine if these beliefs are true or false, Professor Ramachandran, of University of California considers that despite a limb amputation, the brain continued to perceive the limb as present. The above case does not constitute a mental disorder per se but poses questions about the autonomy of mind. Schizophrenic behavior is one of the many examples where unique behavior and visions have a tendency to provoke uncontrollable actions in people (Graham, 2010).

Max Coltheart, A neurologist from Macquarie University proposes that it is a difficult task to identify delusion. Philosophers have argued that what one says is not actually what is meant and therefore a delusion does not have to be false. Their perception is impervious to evidence and the truth or the falsification of a statement does not matter. According to Colheart if a perception created in one's mind cannot be made to be false due to lack of enough evidence, then that can be referred to as a delusion. Mental illnesses

therefore become very difficult to identify with a particular disorder (Graham, 2010).

Differences between mental health and other physical disorders

Mental disorder and mental illness describe conditions involving chief unipolar depression, manic depression, compulsive disorder and schizophrenia. Physical illnesses on the other hand describe conditions for instance cancer, wounds, fractures, arthritis and influenza. Research has embraced considerable debate on the ways of establishing a distinction between the physical and mental illnesses. The recent discussion furthered to establish a distinction may be rare but is based on professional competencies which seek to establish a correlation between neurology and psychiatry. Most philosophers have agreed that mental illnesses have assumed psychological implications while physical disorders have assumed non-psychological implication. Increased susceptibility to illnesses has also been associated with stress which is an indication that psychological causes impact on the mental state of mind (Guze, 1992).

Other philosophers have defended the distinction between physical and mental illnesses using non-traditional means. Murphy (2006) clarifies that the distinction is imperative to establish a clear psychiatric science. This can be facilitated through identifying all the challenges experienced in psychological procedures which are inclusive of mental defects being judged as neural dysfunctions which have been against human intuition. This is geared towards accommodating psychiatric model of explanation within the broader cognitive neuroscience. Murphy's view shares some aspects with

Gauze in the belief that psychiatry and medical neurology and psychology ought to disappear to avoid the contradiction. The traditional distinction between mental and physical disorders has therefore not gained much popularity. Some proposers of theories have advocated for refiguring of the differences to be between brain related and non-brain related defects. Other theorists have assumed a holistic approach with skeptical views that even this difference is a significant way to separate the two categories.

Mixed theories

According to Jerome Wakefield (1992), although the medical model has been challenged on numerous grounds, minor modifications can be put into place to make the models acceptable. The desire to maintain a modality of natural function and the idea of dysfunction are central in the perception of mental disorders. Wakefield argues that disease is a dysfunctional and poorly valued condition and according to his personal belief, it is more of a dysfunctional scientific fact. Although some conditions may be determined negatively, the probability of counting as a disorder is low since it also disapproves its existence in relation to dysfunctional causes. It can be claimed for example that children who practice masturbation have a masturbation disorder but according to Wakefield such a disorder does not exist. According to the scientific view on evolutionary philosophy, such behaviors are common and are dependent on once values. Another claim by Wakefield is that not all the dysfunctions amount to disorders for their valuation is unchallenged. If it is possible for evolutionary theory to proof that homosexuality emerges from a dysfunction, then it would not be categorized as a disorder and it may be decided that it causes no harm to the society. The society has undergone

major transitions whereby a change of behavior or participating in unique activities provides an opportunity for us to appreciate our personal abilities.

Sigmund Freud case study

Conceptions have been held pertaining to the origin of psychoanalysis with the belief that early patients who visited Sigmund Freud suffered from emotional challenges which were identified to have psychological origin. During private practice, Freud was consulted for medical advice by patients who were suffering from physical symptoms. It is believed that the patients had sought the advice of the doctor due to the belief that they were sick and needed medical treatment. The symptoms exhibited by the patients were headaches, vomiting, gastric pains, neuralgia and other physical malfunctions (Slaveney, 1990). Freud concluded after making a diagnosis that there were emotional causes of diseases which were associated with traumatic moments in the patient's life. Freud had provided inappropriate diagnosis during this period which was greatly affected inadequate medical knowledge and poor diagnostic techniques. The modern techniques of administering treatment had not been discovered and diseases and ailments which are considered minor in the administration of treatment were considered complicated and demanded the intervention of highly qualified medical doctors. The use of x-rays and scanning machines were techniques which were unheard of to majority of the physicians providing neurological and psychiatry diagnosis. The medical data banks that are currently witnessed were not available or were in the early stages of build up.

Both medical physicians and medical historians nowadays underestimate the nature of diagnostic inadequacy that their predecessors had experienced in their daily prescription of treatment. Physicians do not have the tendency to display their shortcomings and misdiagnoses even in situations where patients have died in their hands. There is greater probability that they do not understand the nature of the mistakes they make while executing their duties. Orthodox commentaries have been given to the effect that medicine has invisibly assumed the name of successful medical care. Medical personnel have assumed the role of writing about themselves while putting emphasis on their own medical breakthrough. This is usually done at the expense of deceptions, mistakes and self-deceptions which have vanished from the medical history completely (Slavney, 1990).

Philosophy of hysteria

One major factor pertaining to healthcare history tend to be deterred by the way in which disease-syndromes have emerged in to existence after being brought by doctors due to their failure to provide diagnostic uncertainty. An example of this can be observed in the syndrome of convenience which is provided by neurasthenia which derived its origin from the American doctor Beard and later played a crucial role in psychoanalysis. This has lead to the understanding of hysteria as just a syndrome. This perception has been copied by several philosophers and neurology experts from the time of Charcot. The concept of hysteria will soon become a historical ideology and the claims of its previous existence would not be available. According to Charcot, hysteria is composed of a tissue of many threads which is associated with many diseases accompanying it but do not have anything to

do with it (Steyerthal and Hallen, 1908). The idea of agnostic hysteria has attained vital recognition within philosophy of psychiatry especially within United States but the challenge has prevailed in terms of addressing the problem. In Britain together with other regions of continental Europe, hysteria has been determined as a syndrome portrayed by philosophers and neurologists in their literature (Steyerthal and Hallen, 1908). This concept has attained much popularity with physicians where it has reflected a meaning that is different from the initial perception. Instead it now identifies with any deviation from normal behavior which cannot be pathologically explained and which is perceived to be as a result of emotional distress, prolonged anxiety or other psychological disorders.

According to Slater, (1982) hysteria has been identified as one of the areas that experiences difficulties when seeking a pathological explanation to the physical symptoms. Suggestions have been made to the effect that since it does not define a particular disease, then its diagnosis is rather vague. The argument postulated here is that if patients who show signs of physical symptoms are to be dubbed hysterical, then the ideology may become so broad to the point of losing its meaning. Hysteria, therefore fails to retain the identity it possessed initially and portrays a negative assertion pertaining to the symptoms displayed. The term hysterical has been used the same way as non-organic or psychogenic. On the other hand the noun hysteria is inconsistently used to refer to positive disease identification creating a conclusion that patients are 'suffering from hysteria'. Philosophers tend to challenge this ideology on the opinion that a patient is suffering from

undefined symptoms which lack a thoughtful explanation by neurologists and psychiatrists, the adoption of the term would cease completely.

Previously, one factor that was portraying destructive effects of hysteria was the fact that it made physician to believe that they have successfully diagnosed the symptoms which is contrary to the actual situation. This mysterious mentality has convinced the doctors making them miss the real fact and obscure organic diseases. The determination of hysteria has been portrayed as an escapist technique to obscure confrontation with lack of knowledge. This is dangerous where organic pathology is in existence but has not attained recognition. According to philosophers, patients know that they are ill but forwarding themselves to ignorant and doctors who are unwilling to change continue to torment their emotional stability. Patients perceive illnesses from the nature of pain they experience which makes them know that they are ill but the tests carried out prove to be negative (Slater, 1982).

Eliot Slater case studies of hysteria

The core diagnosis of hysteria has therefore been described by philosophers to be the disorder of doctor-patient interaction, the evidences being lack of communication, misunderstanding and unwillingness to tell the truth or accept ignorance. Elliot Slater (1982), formulated his own skeptical attitude towards hysteria after conducting several researches. One of the researches involved the study of eighty-five patients who had been diagnosed with hysteria in the Britain's National Hospital for Nervous Diseases in London between 1951 and 1955. The study found out that there were gross

misdiagnoses earlier and patients had died while others had become completely or partially disabled. The experienced incidences of death or disability were due to misconstrued opinion that it was hysteria according to the diagnosis that was given by psychiatrists and neurologists who included Eliot Slater. Some of the deaths occurred as a result of suicide while other died of undiagnosed cases at the National Hospital.

Another case formulated is one diagnosed by Slater as hysteria but the man was diagnosed with disseminated sclerosis from another hospital. In another occurrence, a woman complained of vision problems and headaches was diagnosed from drug abuse and hysteria and was transferred to Maudsley hospital. Here the patient was diagnosed with conversion hysteria but later died of brain growth after two years.

Conclusion

From the history of hysteria, a null hypothesis has been formulated which has not been disapproved. Lack of conclusive evidence pertaining to the medical status of patients suffering from hysteria has not been identified. One aspect that hysterical patients have attained is that all are patients and need proper medical care to address their situation. The malady of the womb which began as a myth has persisted despite the fact that it is known to be a myth. The ideology has attracted credence and its diagnosis has been disguised for ignorance and has been stated as erroneous despite the danger posed (Slater, 1982). In United States, the disappearance of the theory from the main psychiatry has been witnessed in the diagnosis. According to Slavney (1990), the term enjoys economic value within the

facets of medical history in America. Despite the criticisms from medical experts and crusaders of gender rights, the popularity of the term hysteria continues to persist within the health sector. Philosophers have expressed different opinions pertaining to physical diseases as compared with mind disorders. These opinions have been through the collectively conducted research involving philosophers, psychiatrists and physicians. The view on whether mental illnesses ought to be grouped together with other physical diseases is therefore not an idea that can be pursued by doctors alone but also by researchers from other fields to provide diverse opinions and wider knowledge base pertaining to the disorders.