Psychopathology: A Journey Through the History of the Mind

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June 17, 2026

History of mental disorders

Prehistoric times

There is limited evidence by which to judge the existence or nature of mental disorder prior to written records. Evolutionary psychology suggests that some of the underlying genetic dispositions, psychological mechanisms and social demands were present, although some disorders may have developed from a mismatch between ancestral environments and modern conditions. Some related behavioral abnormalities have been found in non-human great apes.

There is evidence from Neolithic times of the practice of trepanation (cutting large holes into the skull), possibly as an attempt to cure ailments which may have included mental disorders.

Ancient civilizations

Egyptian and Mesopotamian

Limited notes in an ancient Egyptian document known as the Ebers papyrus appear to describe disordered states of concentration and attention, and emotional distress in the heart or mind. Some of these have been interpreted as indicating what would later be termed hysteria and melancholy. Somatic treatments typically included applying bodily fluids while reciting magical spells. Hallucinogens may have been used as part of healing rituals. Religious temples may have been used as therapeutic retreats, possibly for the induction of receptive states to facilitate sleep and the interpreting of dreams.

Indian

Ancient Hindu scriptures known as Ramayana and Mahabharata contain fictional descriptions of depression and anxiety states. Mental disorders were generally thought to reflect abstract metaphysical entities, supernatural agents, sorcery or witchcraft. A work known as the Charaka Samhita from circa 600 BC, part of the Hindu Ayurveda ("knowledge of life"), saw ill health as resulting from an imbalance among three kinds of bodily fluids or forces called (Dosha). Different personality types were also described, with different propensities to worries or difficulties. Suggested causes included inappropriate diet; disrespect towards the gods, teachers or others; mental shock due to excessive fear or joy; and faulty bodily activity. Treatments included the use of herbs and ointments, charms and prayers, moral or emotional persuasion, and shocking the person.

Chinese

Mental disorders were treated mainly under Traditional Chinese Medicine by herbs, acupuncture or "emotional therapy". The Inner Canon of the Yellow Emperor described symptoms, mechanisms and therapies for mental illness, emphasizing connections between bodily organs and emotions. Conditions were thought to comprise five stages or elements and imbalance between Yin and yang.

Hebrew and Israelite

The ancient nation of Israel was formed by people with origins in Mesopotamia and Egypt. The concept of a single God, as gradually articulated in Judaism, led to the view that mental disorder was not a problem like any other, caused by one of the gods, but rather caused by problems in the relationship between the individual and God. Passages of the Hebrew Bible/Old Testament have been interpreted as describing mood disorders in figures such as Job, King Saul and in the psalms of David.

Greek and Roman

Some ancient Greek scholars proposed that disease was caused by an imbalance in four humours of the body. Hippocrates (460-377 BC), influenced by humoral theory, proposed a triad of mental disorders termed melancholia, mania and phrenitis (an acute mental disorder accompanied by fever). He also spoke of other disorders such as phobia, and is credited with being the first physician to reject supernatural or divine explanations of illness. He believed that disease was the product of environmental factors, diet and living habits, not a punishment inflicted by the gods, and that the appropriate treatment depended on which bodily fluid, or humour, had caused the problem. However, he also objected to speculation about the etiology of madness (for example that it was seated in the heart and diaphragm or "phren") and favoured instead close behavioural observation. Plato (427-347 BC) argued that there were two types of mental illness: "divinely inspired" mental illness that gave the person prophetic powers, and a second type that was caused by a physical disease. Aristotle (384-322 BC), who studied under Plato, abandoned the divinely caused mental illness theory, and proposed instead that all mental illness was caused by physical problems.

In ancient Greece and Rome, madness was associated stereotypically with aimless wandering and violence. However, Socrates considered positive aspects including prophesying (a 'manic art'); mystical initiations and rituals; poetic inspiration; and the madness of lovers. Now often seen as the very epitome of rational thought and as the founder of philosophy, Socrates freely admitted to experiencing what are now called "command hallucinations" (then called his 'daemon'). Pythagoras also heard voices.

Through long contact with Greek culture, and their eventual conquest of Greece, the Romans absorbed many Greek (and other) ideas on medicine. The humoral theory fell out of favor in some

quarters. The Greek physician Asclepiades (c. 124 - 40 BC), who practiced in Rome, discarded it and advocated humane treatments, and had insane persons freed from confinement and treated them with natural therapy, such as diet and massages. Arateus (ca AD 30-90) argued that it is hard to pinpoint where a mental illness comes from. However, Galen (AD 129 -ca. 200), practicing in Greece and Rome, revived humoral theory. Galen, however, adopted a single symptom approach rather than broad diagnostic categories, for example studying separate states of sadness, excitement, confusion and memory loss.

Playwrights such as Homer, Sophocles and Euripides described madmen driven insane by the Gods, imbalanced humors or circumstances. As well as the triad (of which mania was often used as an overarching term for insanity) there were a variable and overlapping range of terms for such things as delusion, eccentricity, frenzy, and lunacy. Physician Celsus argued that insanity is really present when a continuous dementia begins due to the mind being at the mercy of imaginings. He suggested that people must heal their own souls through philosophy and personal strength. He described common practices of dietetics, bloodletting, drugs, talking therapy, incubation in temples, exorcism, incantations and amulets, as well as restraints and "tortures" to restore rationality, including starvation, being terrified suddenly, agitation of the spirit, and stoning and beating. Most, however, did not receive medical treatment but stayed with family or wandered the streets, vulnerable to assault and derision. Accounts of delusions from the time included people who thought themselves to be famous actors or speakers, animals, inanimate objects, or one of the gods. Some were arrested for political reasons, such as Jesus ben Ananias who was eventually released as a madman after showing no concern for his own fate during torture. It has been argued that Jesus of Nazareth was widely considered a dangerous madman, due partly to antisocial and disruptive outbursts including physical aggression, grandiose and nonsensical claims, and terse responses to official questioning - and may have been mocked as a king and crucified for that reason.

Middle Ages

Persia, Arabia and the Muslim Empire

Persian and Arabic scholars were heavily involved in translating, analysing and synthesising Greek texts and concepts. As the Muslim world expanded, these were integrated with religious thought. Over time, new ideas and concepts were developed. Arab texts contained full discussions of melancholia. Mania and various other disorders and phenomena including hallucinations and delusions were also described. Mental disorder was generally thought to be due to reason having gone astray or been lost entirely, and links were made to the brain in various ways, as well as to spiritual/mystical meaning. Al-Balkhi wrote about fear and anxiety, anger and aggression, sadness and depression, and obsessions. Al-Tabari wrote about the need for wise counselling, smartness and gaining trust. Al-Razi (Rhazes) suggested the benefits of hopeful comments and sudden

emotional shocks, and addressed psychological, moral and religious problems of the spirit. Al-Farabi (Alpharabius) wrote about the therapeutic effect of music on the soul. Al-Ghazali argued that spiritual diseases were dangerous and result from ignorance and deviation from God. Ibn-Sina (Avicenna) took a combined physiological and psychological approach, addressing conditions such as hallucinations, insomnia, vertigo, melancholia and mania. He speculated about physiological influences on the brain and mental disorders, as well as about psychological interventions. Al-Majusi (Haly Abbas) described diseases in terms of the brain, including sleeping sickness, loss of memory, hypochondria and love sickness. Abu al-Qasim al-Zahrawi (Abulcasis) may have addressed mental disorder related to injury in his pioneering work in neurosurgery, and Averroes described Parkinson's disease. Unhammad proposed nine categories of mental disorder.

Under Islam, the mentally disordered were considered incapable yet deserving of humane treatment and protection. For example, Sura 4:5 of the Qur'an states "Do not give your property which God assigned you to manage to the insane: but feed and cloth the insane with this property and tell splendid words to him" Some thought mental disorder could be caused by possession by a djin (genie), which could be either good or demon-like. There were sometimes beatings to exorcise djin, or alternatively over-zealous attempts at cures. Islamic views often merged with local traditions. In Morocco the traditional Berber people were animists and the concept of sorcery was integral to the understanding of mental disorder; it was mixed with the Islamic concepts of djin and often treated by religious scholars combining the roles of holy man, sage, seer and sorcerer.

The first psychiatric hospital ward was founded in Baghdad in 705, and insane asylums were built in Fes in the early 8th century, Cairo in 800 and in Damascus and Aleppo in 1270. Insane patients were benevolently treated using baths, drugs, music and activities. In the centuries to come, The Muslim world would eventually serve as a critical way station of knowledge for Renaissance Europe, through the Latin translations of many scientific Islamic texts. Ibn-Sina's (Avicenna's) Canon of Medicine became the standard of medical science in Europe for centuries, together with works of Hippocrates and Galen.

Christian Europe

Conceptions of madness in the Middle Ages in Europe were a mixture of the divine, diabolical, magical and transcendental. Theories of the four humors (black bile, yellow bile, phlegm, and blood) were applied, sometimes separately (a matter of "physic") and sometimes combined with theories of evil spirits (a matter of "faith"). Arnaldus de Villanova (1235-1313) combined "evil spirit" and Galen-oriented "four humours" theories and promoted trepanning as a cure to let demons and excess humours escape. Other bodily remedies in general use included purges, bloodletting and whipping. Madness was often seen as a moral issue, either a punishment for sin or a test of faith and character. Christian theology endorsed various therapies, including fasting and prayer for those estranged from God and exorcism of those possessed by the devil. Thus, although mental

disorder was often thought to be due to sin, other more mundane causes were also explored, including intemperate diet and alcohol, overwork, and grief. The Franciscan monk Bartholomeus Anglicus (ca. 1203 - 1272) described a condition which resembles depression in his encyclopedia, De Proprietatibis Rerum, and he suggested that music would help. A semi-official tract called the Praerogativa regis distinguished between the "natural born idiot" and the "lunatic". The latter term was applied to those with periods of mental disorder; deriving from either Roman mythology describing people "moonstruck" by the goddess Luna or theories of an influence of the moon.

Episodes of mass dancing mania are reported from the Middle Ages, "which gave to the individuals affected all the appearance of insanity". This was one kind of mass delusion or mass hysteria/panic that has occurred around the world through the millennia.

The care of lunatics was primarily the responsibility of the family. In England, if the family were unable or unwilling, an assessment was made by crown representatives in consultation with a local jury and all interested parties, including the subject himself or herself. The process was confined to those with real estate or personal estate, but it encompassed poor as well as rich and took into account psychological and social issues. Most of those considered lunatics at the time probably had more support and involvement from the community than people diagnosed with mental disorders today. As in other eras, visions were generally interpreted as meaningful spiritual and visionary insights; some may have been causally related to mental disorders, but since hallucinations were culturally supported they may not have had the same connections as today.

Modern period

16th to 18th centuries

Some mentally disturbed people may have been victims of the witch-hunts that spread in waves in early modern Europe. However, those judged insane were increasingly admitted to local workhouses, poorhouses and jails (particularly the "pauper insane") or sometimes to the new private madhouses. Restraints and forcible confinement were used for those thought dangerously disturbed or potentially violent to themselves, others or property. The latter likely grew out of lodging arrangements for single individuals (who, in workhouses, were considered disruptive or ungovernable) then there were a few catering each for only a handful of people, then they gradually expanded (e.g. 16 in London in 1774, and 40 by 1819). By the mid-19th century there would be 100 to 500 inmates in each. The development of this network of madhouses has been linked to new capitalist social relations and a service economy, that meant families were no longer able or willing to look after disturbed relatives.

By the end of the 17th century and into the Enlightenment, madness was increasingly seen as an organic physical phenomenon, no longer involving the soul or moral responsibility. The mentally ill

were typically viewed as insensitive wild animals. Harsh treatment and restraint in chains was seen as therapeutic, helping suppress the animal passions. There was sometimes a focus on the management of the environment of madhouses, from diet to exercise regimes to number of visitors. Severe somatic treatments were used, similar to those in medieval times. Madhouse owners sometimes boasted of their ability with the whip. Treatment in the few public asylums was also barbaric, often secondary to prisons. The most notorious was Bedlam where at one time spectators could pay a penny to watch the inmates as a form of entertainment.

Concepts based in humoral theory gradually gave way to metaphors and terminology from mechanics and other developing physical sciences. Complex new schemes were developed for the classification of mental disorders, influenced by emerging systems for the biological classification of organisms and medical classification of diseases.

The term "crazy" (from Middle English meaning cracked) and insane (from Latin insanus meaning unhealthy) came to mean mental disorder in this period. The term "lunacy", long used to refer to periodic disturbance or epilepsy, came to be synonymous with insanity. "Madness", long in use in root form since at least the early centuries AD, and originally meaning crippled, hurt or foolish, came to mean loss of reason or self-restraint. "Psychosis", from Greek "principle of life/animation", had varied usage referring to a condition of the mind/soul. "Nervous", from an Indo-European root meaning to wind or twist, meant muscle or vigor, was adopted by physiologists to refer to the body's electrochemical signalling process (thus called the nervous system), and was then used to refer to nervous disorders and neurosis. "Obsession", from a Latin root meaning to sit on or sit against, originally meant to besiege or be possessed by an evil spirit, came to mean a fixed idea that could decompose the mind.

With the rise of madhouses and the professionalization and specialization of medicine, there was considerable incentive for medics to become involved. In the 18th century, they began to stake a claim to a monopoly over madhouses and treatments. Madhouses could be a lucrative business, and many made a fortune from them. There were some bourgeois ex-patient reformers who opposed the often brutual regimes, blaming both the madhouse owners and the medics, who in turn resisted the reforms.

Towards the end of the 18th century, a moral treatment movement developed, that implemented more humane, psychosocial and personalized approaches. Notable figures included the medic Vincenzo Chiarugi in Italy under Enlightenment leadership; the ex-patient superintendent Pussin and the psychologically inclined medic Phillipe Pinel in revolutionary France; the Quakers in England, led by businessman William Tuke; and later, in the United States, campaigner Dorothea Dix.

19th century

The 19th century, in the context of industrialization and population growth, saw a massive expansion of the number and size of insane asylums in every Western country, a process called "the great confinement" or the "asylum era". Laws were introduced to compel authorities to deal with those judged insane by family members and hospital superintendents. Although originally based on the concepts and structures of moral treatment, they became large impersonal institutions overburdened with large numbers of people with a complex mix of mental and social-economic problems. The success of moral treatment had cast doubt on the approach of medics, and many had opposed it, but by the mid-19th century many became advocates of it but argued that the mad also often had physical/organic problems, so that both approaches were necessary. This argument has been described as an important step in the profession's eventual success in securing a monopoly on the treatment of lunacy. However, it is well documented that very little therapeutic activity occurred in the new asylum system, that medics were little more than administrators who seldom attended to patients, and then mainly for other physical problems.

Although reports of numerous mental disorders and irrational, unintelligible, or uncontrolled behavior are common in the historical record back to ancient times, clear descriptions of some syndromes, such as the condition that would later be termed schizophrenia, have been identified as relatively rare prior to the 19th century, although interpretations of the evidence and its implications are inconsistent.

Numerous different classification schemes and diagnostic terms were developed by different authorities, taking an increasingly anatomical-clinical descriptive approach. The term "psychiatry" was coined as the medical specialty became more academically established. Asylum superintendents, later to be psychiatrists, were generally called "alienists" because they were thought to deal with people alienated from society; they adopted largely isolated and managerial roles in the asylums while milder "neurotic" conditions were dealt with by neurologists and general physicians, although there was overlap for conditions such as neurasthenia.

In the United States it was proposed that black slaves who tried to escape were suffering from a mental disorder termed drapetomania. It was then argued in scientific journals that mental disorders were rare under conditions of slavery but became more common following emancipation, and later that mental illness in African Americans was due to evolutionary factors or various negative characteristics, and that they were not suitable for therapeutic intervention.

By the 1870s in North America, officials who ran Lunatic Asylums renamed them Insane Asylums. By the late century, the term "asylum" had lost its original meaning as a place of refuge, retreat or safety, and was associated with abuses that had been widely publicized in the media, including by ex-patient organization the Alleged Lunatics' Friend Society and ex-patients like Elizabeth Packard.

The relative proportion of the public officially diagnosed with mental disorders was increasing, however. This has been linked to various factors, including possibly humanitarian concern;

incentives for professional status/money; a lowered tolerance of communities for unusual behavior due to the existence of asylums to place them in (this affected the poor the most); and the strain placed on families by industrialization.

20th century

The turn of the 20th century saw the development of psychoanalysis, which came to the fore later. Kraepelin's classification gained popularity, including the separation of mood disorders from what would later be termed schizophrenia.

Asylum superintendents sought to improve the image and medical status of their profession. Asylum "inmates" were increasingly referred to as "patients" and asylums renamed as hospitals. Referring to people as having a "mental illness" dates from this period in the early 20th century.

In the United States, a "mental hygiene" movement, originally defined in the 19th century, gained momentum and aimed to "prevent the disease of insanity" through public health methods and clinics. The term mental health became more popular, however. Clinical psychology and social work developed as professions alongside psychiatry. Theories of eugenics led to compulsory sterilization movements in many countries around the world for several decades, often encompassing patients in public mental institutions. World War I saw a massive increase of conditions that came to be termed "shell shock".

In Nazi Germany, the institutionalized mentally ill were among the earliest targets of sterilization campaigns and covert "euthanasia" programs. It has been estimated that over 200,000 individuals with mental disorders of all kinds were put to death, although their mass murder has received relatively little historical attention. Despite not being formally ordered to take part, psychiatrists and psychiatric institutions were at the center of justifying, planning and carrying out the atrocities at every stage, and "constituted the connection" to the later annihilation of Jews and other "undesirables" such as homosexuals in the Holocaust.

In other areas of the world, funding was often cut for asylums, especially during periods of economic decline, and during wartime in particular many patients starved to death. Soldiers received increased psychiatric attention, and World War II saw the development in the US of a new psychiatric manual for categorizing mental disorders, which along with existing systems for collecting census and hospital statistics led to the first Diagnostic and Statistical Manual of Mental Disorders (DSM). The International Classification of Diseases (ICD) followed suit with a section on mental disorders.

Previously restricted to the treatment of severely disturbed people in asylums, psychiatrists cultivated clients with a broader range of problems, and between 1917 and 1970 the number practicing outside institutions swelled from 8 percent to 66 percent. The term stress, having

emerged out of endocrinology work in the 1930s, was popularized with an increasingly broad biopsychosocial meaning, and was increasingly linked to mental disorders."Outpatient commitment" laws were gradually expanded or introduced in some countries.

Lobotomies, Insulin shock therapy, Electro convulsive therapy, and the "neuroleptic" chlorpromazine came in to use mid-century.

An antipsychiatry movement came to the fore in the 1960s. Deinstitutionalization gradually occurred in the West, with isolated psychiatric hospitals being closed down in favor of community mental health services. However, inadequate services and continued social exclusion often led to many being homeless or in prison. A consumer/survivor movement gained momentum.

Other kinds of psychiatric medication gradually came into use, such as "psychic energizers" and lithium. Benzodiazepines gained widespread use in the 1970s for anxiety and depression, until dependency problems curtailed their popularity. Advances in neuroscience and genetics led to new research agendas. Cognitive behavioral therapy was developed. Through the 1990s, new SSRI antidepressants became some of the most widely prescribed drugs in the world.

The DSM and then ICD adopted new criteria-based classification, representing a return to a Kraepelin-like descriptive system. The number of "official" diagnoses saw a large expansion, although homosexuality was gradually downgraded and dropped in the face of human rights protests. Different regions sometimes developed alternatives such as the Chinese Classification of Mental Disorders or Latin American Guide for Psychiatric Diagnosis.

21st century

Starting from 2002 DSM-5 Research Agenda researchers were invited to contribute with their publication to the literature basis for the DSM-5, whose draft criteria are now available to the scientific community . In the meanwhile, serious limits of the current version of the DSM extremely high comorbidity, diagnostic heterogeneity of the categories, unclear boundaries have been interpreted as intrinsic anomalies of the criterial, neopositivistic approach leading the system to a state of scientific crisis. Accordingly, a radical rethinking of the concept of mental disorder and the need of a radical scientific revolution in psychiatric taxonomy was proposed.

Mental disorder

A mental disorder or mental illness is a psychological or behavioral pattern generally associated with subjective distress or disability that occurs in an individual, and which is not a part of normal development or culture. Such a disorder may consist of a combination of affective, behavioural, cognitive and perceptual components. The recognition and understanding of mental health

conditions have changed over time and across cultures, and there are still variations in the definition, assessment, and classification of mental disorders, although standard guideline criteria are widely accepted. A few mental disorders are diagnosed based on the harm to others, regardless of the subject's perception of distress. Over a third of people in most countries report meeting criteria for the major categories at some point in their lives. The causes are often explained in terms of a diathesis-stress model or biopsychosocial model. In biological psychiatry, mental disorders are conceptualized as disorders of brain circuits likely caused by developmental processes shaped by a complex interplay of genetics and experience.

Services are based in psychiatric hospitals or in the community. Diagnoses are made by psychiatrists or clinical psychologists using various methods, often relying on observation and questioning in interviews. Treatments are provided by various mental health professionals. Psychotherapy and psychiatric medication are two major treatment options, as are social interventions, peer support and self-help. In some cases there may be involuntary detention and involuntary treatment where legislation allows.

Stigma and discrimination add to the suffering associated with the disorders, and have led to various social movements attempting to increase acceptance.

Classifications

The definition and classification of mental disorders is a key issue for mental health and for users and providers of mental health services. Most international clinical documents use the term "mental disorder". There are currently two widely established systems that classify mental disorders--ICD-10 Chapter V: Mental and behavioural disorders, part of the International Classification of Diseases produced by the World Health Organization (WHO), and the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) produced by the American Psychiatric Association (APA).

Both list categories of disorder and provide standardized criteria for diagnosis. They have deliberately converged their codes in recent revisions so that the manuals are often broadly comparable, although significant differences remain. Other classification schemes may be used in non-western cultures (see, for example, the Chinese Classification of Mental Disorders), and other manuals may be used by those of alternative theoretical persuasions, for example the Psychodynamic Diagnostic Manual. In general, mental disorders are classified separately to neurological disorders, learning disabilities or mental retardation.

Unlike most of the above systems, some approaches to classification do not employ distinct categories of disorder or dichotomous cut-offs intended to separate the abnormal from the normal. There is significant scientific debate about the different kinds of categorization and the relative merits of categorical versus non-categorical (or hybrid) schemes, with the latter including spectrum,

continuum or dimensional systems.

Disorders

There are many different categories of mental disorder, and many different facets of human behavior and personality that can become disordered.

Anxiety or fear that interferes with normal functioning may be classified as an anxiety disorder. Commonly recognized categories include specific phobias, generalized anxiety disorder, social anxiety disorder, panic disorder, agoraphobia, obsessive-compulsive disorder and post-traumatic stress disorder.

Other affective (emotion/mood) processes can also become disordered. Mood disorder involving unusually intense and sustained sadness, melancholia or despair is known as Major depression or Clinical depression (milder but still prolonged depression can be diagnosed as dysthymia). Bipolar disorder (also known as manic depression) involves abnormally "high" or pressured mood states, known as mania or hypomania, alternating with normal or depressed mood. Whether unipolar and bipolar mood phenomena represent distinct categories of disorder, or whether they usually mix and merge together along a dimension or spectrum of mood, is under debate in the scientific literature.

Patterns of belief, language use and perception can become disordered (e.g. delusions, thought disorder, hallucinations). Psychotic disorders in this domain include schizophrenia, and delusional disorder. Schizoaffective disorder is a category used for individuals showing aspects of both schizophrenia and affective disorders. Schizotypy is a category used for individuals showing some of the characteristics associated with schizophrenia but without meeting cut-off criteria.

Personality--the fundamental characteristics of a person that influence his or her thoughts and behaviors across situations and time--may be considered disordered if judged to be abnormally rigid and maladaptive. Categorical schemes list a number of different such personality disorders, including those sometimes classed as eccentric (e.g. paranoid, schizoid and schizotypal personality disorders), to those sometimes classed as dramatic or emotional (antisocial, borderline, histrionic or narcissistic personality disorders) or those seen as fear-related (avoidant, dependent, or obsessive-compulsive personality disorders). If an inability to sufficiently adjust to life circumstances begins within three months of a particular event or situation, and ends within six months after the stressor stops or is eliminated, it may instead be classed as an adjustment disorder. There is an emerging consensus that so-called "personality disorders", like personality traits in general, actually incorporate a mixture of acute dysfunctional behaviors that resolve in short periods, and maladaptive temperamental traits that are more stable. Furthermore, there are also non-categorical schemes that rate all individuals via a profile of different dimensions of personality rather than using a cut-off from normal personality variation, for example through

schemes based on the Big Five personality traits.

Eating disorders involve disproportionate concern in matters of food and weight. Categories of disorder in this area include anorexia nervosa, bulimia nervosa, exercise bulimia or binge eating disorder.

Sleep disorders such as insomnia involve disruption to normal sleep patterns, or a feeling of tiredness despite sleep appearing normal.

Sexual and gender identity disorders may be diagnosed, including dyspareunia, gender identity disorder and ego-dystonic homosexuality. Various kinds of paraphilia are considered mental disorders (sexual arousal to objects, situations, or individuals that are considered abnormal or harmful to the person or others).

People who are abnormally unable to resist certain urges or impulses that could be harmful to themselves or others, may be classed as having an impulse control disorder, including various kinds of tic disorders such as Tourette's syndrome, and disorders such as kleptomania (stealing) or pyromania (fire-setting). Various behavioral addictions, such as gambling addiction, may be classed as a disorder. Obsessive-compulsive disorder can sometimes involve an inability to resist certain acts but is classed separately as being primarily an anxiety disorder.

The use of drugs (legal or illegal), when it persists despite significant problems related to the use, may be defined as a mental disorder termed substance dependence or substance abuse (a broader category than drug abuse). The DSM does not currently use the common term drug addiction and the ICD simply talks about "harmful use". Disordered substance use may be due to a pattern of compulsive and repetitive use of the drug that results in tolerance to its effects and withdrawal symptoms when use is reduced or stopped.

People who suffer severe disturbances of their self-identity, memory and general awareness of themselves and their surroundings may be classed as having a dissociative identity disorder, such as depersonalization disorder or Dissociative Identity Disorder itself (which has also been called multiple personality disorder, or "split personality"). Other memory or cognitive disorders include amnesia or various kinds of old age dementia.

A range of developmental disorders that initially occur in childhood may be diagnosed, for example autism spectrum disorders, oppositional defiant disorder and conduct disorder, and attention deficit hyperactivity disorder (ADHD), which may continue into adulthood.

Conduct disorder, if continuing into adulthood, may be diagnosed as antisocial personality disorder (dissocial personality disorder in the ICD). Popularist labels such as psychopath (or sociopath) do not appear in the DSM or ICD but are linked by some to these diagnoses.

Disorders appearing to originate in the body, but thought to be mental, are known as somatoform disorders, including somatization disorder and conversion disorder. There are also disorders of the perception of the body, including body dysmorphic disorder. Neurasthenia is an old diagnosis involving somatic complaints as well as fatigue and low spirits/depression, which is officially recognized by the ICD-10 but no longer by the DSM-IV.

Factitious disorders, such as Munchausen syndrome, are diagnosed where symptoms are thought to be experienced (deliberately produced) and/or reported (feigned) for personal gain.

There are attempts to introduce a category of relational disorder, where the diagnosis is of a relationship rather than on any one individual in that relationship. The relationship may be between children and their parents, between couples, or others. There already exists, under the category of psychosis, a diagnosis of shared psychotic disorder where two or more individuals share a particular delusion because of their close relationship with each other.

Various new types of mental disorder diagnosis are occasionally proposed. Among those controversially considered by the official committees of the diagnostic manuals include self-defeating personality disorder, sadistic personality disorder, passive-aggressive personality disorder and premenstrual dysphoric disorder.

Two recent unique isolated proposals are solastalgia by Glenn Albrecht and hubris syndrome by David Owen. The application of the concept of mental illness to the phenomena described by these authors has in turn been critiqued by Seamus Mac Suibhne.

Causes

Mental disorders can arise from a combination of sources. In many cases there is no single accepted or consistent cause currently established. A common belief even to this day is that disorders result from genetic vulnerabilities exposed by environmental stressors. (see Diathesis-stress model). However, it is clear enough from a simple statistical analysis across the whole spectrum of mental health disorders at least in western cultures that there is a strong relationship between the various forms of severe and complex mental disorder in adulthood and the abuse (physical, sexual or emotional) or neglect of children during the developmental years.

An eclectic or pluralistic mix of models may be used to explain particular disorders, and the primary paradigm of contemporary mainstream Western psychiatry is said to be the biopsychosocial (BPS) model, incorporating biological, psychological and social factors, although this may not always be applied in practice. Biopsychiatry has tended to follow a biomedical model, focusing on "organic" or "hardware" pathology of the brain. Psychoanalytic theories have continued to evolve alongside congitive-behavioural and systemic-family approaches. Evolutionary psychology may be used as an overall explanatory theory, and attachment theory is another kind of evolutionary-psychological

approach sometimes applied in the context of mental disorders. A distinction is sometimes made between a "medical model" or a "social model" of disorder and disability.

Studies have indicated that genes often play an important role in the development of mental disorders, although the reliable identification of connections between specific genes and specific categories of disorder has proven more difficult. Environmental events surrounding pregnancy and birth have also been implicated. Traumatic brain injury may increase the risk of developing certain mental disorders. There have been some tentative inconsistent links found to certain viral infections, to substance misuse, and to general physical health.

Abnormal functioning of neurotransmitter systems has been implicated, including serotonin, norepinephrine, dopamine and glutamate systems. Differences have also been found in the size or activity of certain brain regions in some cases. Psychological mechanisms have also been implicated, such as cognitive (e.g. reason), emotional processes, personality, temperament and coping style.

Social influences have been found to be important, including abuse, bullying and other negative or stressful life experiences. The specific risks and pathways to particular disorders are less clear, however. Aspects of the wider community have also been implicated, including employment problems, socioeconomic inequality, lack of social cohesion, problems linked to migration, and features of particular societies and cultures.

Causes of mental disorders

The causes of mental disorders are complex, and interact and vary according to the particular disorder and individual. Genetics, early development, drugs, a loss of a family member, disease or injury, neurocognitive and psychological mechanisms, and life experiences, society and culture, can all contribute to the development or progression of different mental disorders.

General theories

There are a number of theories or models seeking to explain the causes (etiology) of mental disorders. They may be based on different foundations, including their basic classification of mental disorders.

The most common view is that disorders tend to result from genetic vulnerabilities and environmental stressors combining to cause patterns of dysfunction or trigger disorders (Diathesis-stress model). A practical mixture of models may often be used to explain particular issues and disorders, although there may be difficulty defining boundaries for indistinct psychiatric syndromes.

The primary model of contemporary mainstream Western psychiatry is the biopsychosocial model

(BPS), which merges together biological, psychological and social factors. It may be commonly neglected or misapplied in practice due to being too broad or relativistic, however, and biopsychiatry has tended to follow a biomedical model focused on organic or "hardware" pathology of the brain.

Psychoanalytic theories, focused on unresolved internal and relational conflicts, have been posited as overall explanations of mental disorder, although today most psychoanalytic groups are said to adhere to the biopsychosocial model and to accept an eclectic mix of subtypes of psychoanalysis.

Evolutionary psychology (or more specifically evolutionary psychopathology or psychiatry) has also been proposed as an overall theory, positing that many mental disorders involve the dysfunctional operation of mental modules adapted to ancestral physical or social environments but not necessarily to modern ones. Attachment theory is another kind of evolutionary-psychological approach sometimes applied in the context for mental disorders, which focuses on the role of early caregiver-child relationships, responses to danger, and the search for a satisfying reproductive relationship in adulthood.

An overall distinction is also commonly made between a "medical model" (also known as a biomedical or disease model), and a "social model" (also known as an empowerment or recovery model) of mental disorder and disability, with the former focusing on hypothesized disease processes and symptoms, and the latter focusing on hypothesized social constructionism and social contexts.

Genes

Family-linkage and twin studies have indicated that genetic factors often play an important role in the development of mental disorders. The reliable identification of specific genetic susceptibility to particular disorders, through linkage or association studies, has proven difficult. This has been reported to be likely due to the complexity of interactions between genes, environmental events, and early development or to the need for new research strategies. The heritability of behavioral traits associated with mental disorder may be greater in permissive than in restrictive environments, and susceptibility genes probably work through both "within-the-skin" (physiological) pathways and "outside-the-skin" (behavioral and social) pathways. Investigations increasingly focus on links between genes and endophenotypes--more specific traits (including neurophysiological, biochemical, endocrinological, neuroanatomical, cognitive, or neuropsychological)--rather than disease categories. With regard to a prominent mental disorder, Schizophrenia, genetics have been shown to have an increasingly complicated role in the disease. For a long time consensus among scientists was that certain alleles were responsible for schizophrenia, but recent research has shown that this is not necessarily the case. In a study done in 2008 by Walsh et al., the genetics of schizophrenics were compared to those of non-affected

individuals. The group did micro-arrays of each individuals' genome looking for structural variants greater than 100kbp. Individuals with schizophrenia were three times as likely to harbor structural variants that duplicated or deleted one or more genes. This was even more prevalent in children as schizophrenics under age 18 were four times as likely to harbor these mutations. More importantly 53 previously unreported microduplications/deletions were discovered and virtually every rare structural mutation was different .

Pregnancy and birth

Environmental events surrounding pregnancy and birth have been linked to an increased development of mental illness in the offspring. This includes maternal exposure to serious psychological stress or trauma, conditions of famine, obstetric birth complications, infections, and gestational exposure to alcohol or cocaine. Such factors have been hypothesized to affect specific areas of neurodevelopment within the general developmental context and to restrict neuroplasticity.

People with developmental disabilities, such as mental retardation, are more likely to experience mental illness than those in the general community.

Disease, injury and infection

Higher rates of mood, psychotic, and substance abuse disorders have been found following traumatic brain injury (TBI). Findings on the relationship between TBI severity and prevalence of subsequent psychiatric disorders have been inconsistent, and occurrence has been linked to prior mental health problems as well as direct neurophysiological effects, in a complex interaction with personality and attitude and social influences.

A number of psychiatric disorders have often been tentatively linked with microbial pathogens, particularly viruses; however while there have been some suggestions of links from animal studies, and some inconsistent evidence for infectious and immune mechanisms (including prenatally) in some human disorders, infectious disease models in psychiatry are reported to have not yet shown significant promise except in isolated cases. There have been some inconsistent findings of links between infection by the parasite Toxoplasma gondii and human mental disorders such as schizophrenia, with the direction of causality unclear. A number of diseases of the white matter can cause symptoms of mental disorder.

Poorer general health has been found among individuals with severe mental illnesses, thought to be due to direct and indirect factors including diet, bacterial infections, substance use, exercise levels, effects of medications, socioeconomic disadvantages, lowered help-seeking or treatment adherence, or poorer healthcare provision. Some chronic general medical conditions have been

linked to some aspects of mental disorder, such as AIDS-related psychosis.

The current research on Lyme's disease caused by a deer tick, and related toxins, is expanding the link between bacterial infections and mental illness.

Individual characteristics

Mental characteristics of individuals, as assessed by both neurological and psychological studies, have been linked to the development and maintenance of mental disorders. This includes cognitive or neurocognitive factors, such as the way a person perceives, thinks or feels about certain things; or an individual's overall personality, temperament or coping style or the extent of protective factors or "positive illusions" such as optimism, personal control and a sense of meaning.

Abnormal levels of dopamine activity have been implicated in a number of disorders (e.g., reduced in ADHD, increased in schizophrenia), thought to be part of the complex encoding of the importance of events in the external world. Dysfunction in serotonin and other monoamine neurotransmitters such as norepinephrine and dopamine has also been centrally implicated in mental disorders, including major depression as well as obsessive compulsive disorder, phobias, posttraumatic stress disorder, and generalized anxiety disorder, although the limitations of a simple "monoamine hypothesis" have been highlighted and studies of depleted levels of monoamine neurotransmitters have tended to indicate no simple or directly causal relation with mood or major depression, although features of these pathways may form trait vulnerabilities to depression. Dysfunction of the central gamma-aminobutyric (GABA) system following stress has also been associated with anxiety spectrum disorders and there is now a body of clinical and preclinical literature also indicating an overlapping role in mood disorder.

Findings have indicated abnormal functioning of brainstem structures in disorders such as schizophrenia, related to impairments in maintaining sustained attention. Some abnormalities in the average size or shape of some regions of the brain have been found in some disorders, reflecting genes and/or experience. Studies of schizophrenia have tended to find enlarged ventricles and sometimes reduced volume of the cerebrum and hippocampus, while studies of (psychotic) bipolar disorder have sometimes found increased amygdala volume. Findings differ over whether volumetric abnormalities are risk factors or are only found alongside the course of mental health problems, possibly reflecting neurocognitive or emotional stress processes and/or medication use or substance use. Some studies have also found reduced hippocampal volumes in major depression, possibly worsening with time depressed.

Life events, emotional stress and relationships

It is reported that there is good evidence on the importance of psychosocial influences on

psychopathology in general, although less known about the specific risk and protective mechanisms. Maltreatment in childhood and in adulthood, including sexual abuse, physical abuse, emotional abuse, domestic violence and bullying, has been linked to the development of mental disorders, through a complex interaction of societal, family, psychological and biological factors. Negative or stressful life events more generally have been implicated in the development of a range of disorders, including mood and anxiety disorders. The main risks appear to be from a cumulative combination of such experiences over time, although exposure to a single major trauma can sometimes lead to psychopathology, including PTSD. Resilience to such experiences varies, and a person may be resistant to some forms of experience but susceptible to others. Features associated with variations in resilience include genetic vulnerability, temperamental characteristics, cognitive set, coping patterns, and other experiences.

Relationship issues have been consistently linked to the development of mental disorders, with continuing debate on the relative importance of the home environment or work/school and peer group. Issues with parenting skills or parental depression or other problems may be a risk factor. Parental divorce appears to increase risk, perhaps only if there is family discord or disorganization, although a warm supportive relationship with one parent may compensate. Details of infant feeding, weaning, toilet training etc. do not appear to be importantly linked to psychopathology. Early social privation, or lack of ongoing, harmonious, secure, committed relationships, have been implicated in the development of mental disorders.

Some approaches, such as certain theories of co-counseling, may see all non-neurological mental disorders as the result of the self-regulating mechanisms of the mind (which accompany the physical expression of emotions) not being allowed to operate.

Neighborhoods, society and culture

Problems in communities or cultures, including poverty, unemployment or underemployment, lack of social cohesion, and migration, have been implicated in the development of mental disorders. Stresses and strains related to socioeconomic position (socioeconomic status (SES) or social class) have been linked to the occurrence of major mental disorders, with a lower or more insecure educational, occupational, economic or social position generally linked to more mental disorders. There have been mixed findings on the nature of the links and on the extent to which pre-existing personal characteristics influence the links. Both personal resources and community factors have been implicated, as well as interactions between individual-level and regional-level income levels. The causal role of different socioeconomic factors may vary by country. Socioeconomic deprivation in neighborhoods can cause worse mental health, even after accounting for genetic factors. In addition, minority ethnic groups, including first or second-generation immigrants, have been found to be at greater risk for developing mental disorders, which has been attributed to various kinds of life insecurities and disadvantages, including racism. The direction of causality is sometimes

unclear, and alternative hypotheses such as the Drift Hypothesis sometimes need to be discounted.

Mental disorders have also been linked to the overarching social, economic and cultural system. A value system that promotes individualism, weakens social ties, and creates ambivalence towards children, is being spread or imposed via globalization, yet could adversely affect children's mental health.

Gender-specific influences

Diagnosis

Many mental health professionals, particularly psychiatrists, seek to diagnose individuals by ascertaining their particular mental disorder. Some professionals, for example some clinical psychologists, may avoid diagnosis in favor of other assessment methods such as formulation of a client's difficulties and circumstances. The majority of mental health problems are actually assessed and treated by family physicians during consultations, who may refer on for more specialist diagnosis in acute or chronic cases. Routine diagnostic practice in mental health services typically involves an interview (which may be referred to as a mental status examination), where judgments are made of the interviewee's appearance and behavior, self-reported symptoms, mental health history, and current life circumstances. The views of relatives or other third parties may be taken into account. A physical examination to check for ill health or the effects of medications or other drugs may be conducted. Psychological testing is sometimes used via paper-and-pen or computerized questionnaires, which may include algorithms based on ticking off standardized diagnostic criteria, and in rare specialist cases neuroimaging tests may be requested, but these methods are more commonly found in research studies than routine clinical practice.

Time and budgetary constraints often limit practicing psychiatrists from conducting more thorough diagnostic evaluations. It has been found that most clinicians evaluate patients using an unstructured, open-ended approach, with limited training in evidence-based assessment methods, and that inaccurate diagnosis may be common in routine practice. Mental illness involving hallucinations or delusions (especially schizophrenia) are prone to misdiagnosis in developing countries due to the presence of psychotic symptoms instigated by nutritional deficiencies. Comorbidity is very common in psychiatric diagnoses, i.e. the same person given a diagnosis in more than one category of disorder.

Management

Treatment and support for mental disorders is provided in psychiatric hospitals, clinics or any of a diverse range of community mental health services. In many countries services are increasingly

based on a recovery model that is meant to support each individual's independence, choice and personal journey to regain a meaningful life, although individuals may be treated against their will in a minority of cases. There are a range of different types of treatment and what is most suitable depends on the disorder and on the individual. Many things have been found to help at least some people, and a placebo effect may play a role in any intervention or medication.

Psychotherapy

A major option for many mental disorders is psychotherapy. There are several main types. Cognitive behavioral therapy (CBT) is widely used and is based on modifying the patterns of thought and behavior associated with a particular disorder. Psychoanalysis, addressing underlying psychic conflicts and defenses, has been a dominant school of psychotherapy and is still in use. Systemic therapy or family therapy is sometimes used, addressing a network of significant others as well as an individual.

Some psychotherapies are based on a humanistic approach. There are a number of specific therapies used for particular disorders, which may be offshoots or hybrids of the above types. Mental health professionals often employ an eclectic or integrative approach. Much may depend on the therapeutic relationship, and there may be problems with trust, confidentiality and engagement.

Medication

A major option for many mental disorders is psychiatric medication and there are several main groups. Antidepressants are used for the treatment of clinical depression as well as often for anxiety and other disorders. Anxiolytics are used for anxiety disorders and related problems such as insomnia. Mood stabilizers are used primarily in bipolar disorder. Antipsychotics are mainly used for psychotic disorders, notably for positive symptoms in schizophrenia. Stimulants are commonly used, notably for ADHD.

Despite the different conventional names of the drug groups, there may be considerable overlap in the disorders for which they are actually indicated, and there may also be off-label use of medications. There can be problems with adverse effects of medication and adherence to them, and there is also criticism of pharmaceutical marketing and professional conflicts of interest.

Other

Electroconvulsive therapy (ECT) is sometimes used in severe cases when other interventions for severe intractable depression have failed. Psychosurgery is considered experimental but is advocated by certain neurologists in certain rare cases.

Counseling (professional) and co-counseling (between peers) may be used. Psychoeducation programs may provide people with the information to understand and manage their problems. Creative therapies are sometimes used, including music therapy, art therapy or drama therapy. Lifestyle adjustments and supportive measures are often used, including peer support, self-help groups for mental health and supported housing or supported employment (including social firms). Some advocate dietary supplements.

Prognosis

Prognosis depends on the disorder, the individual and numerous related factors. Some disorders are transient, while others may last a lifetime. Some disorders may be very limited in their functional effects, while others may involve substantial disability and support needs. The degree of ability or disability may vary across different life domains. Continued disability has been linked to institutionalization, discrimination and social exclusion as well as to the inherent properties of disorders.

Even those disorders often considered the most serious and intractable have varied courses. Long-term international studies of schizophrenia have found that over a half of individuals recover in terms of symptoms, and around a fifth to a third in terms of symptoms and functioning, with some requiring no medication. At the same time, many have serious difficulties and support needs for many years, although "late" recovery is still possible. The World Health Organization concluded that the long-term studies' findings converged with others in "relieving patients, carers and clinicians of the chronicity paradigm which dominated thinking throughout much of the 20th century."

Around half of people initially diagnosed with bipolar disorder achieve syndromal recovery (no longer meeting criteria for the diagnosis) within six weeks, and nearly all achieve it within two years, with nearly half regaining their prior occupational and residential status in that period. However, nearly half go on to experience a new episode of mania or major depression within the next two years. Functioning has been found to vary, being poor during periods of major depression or mania but otherwise fair to good, and possibly superior during periods of hypomania in Bipolar II.

Suicide, which is often attributed to some underlying mental disorder, is a leading cause of death among teenagers and adults under 35. There are an estimated 10 to 20 million non-fatal attempted suicides every year worldwide.

Despite often being characterized in purely negative terms, some mental states labeled as disorders can also involve above-average creativity, non-conformity, goal-striving, meticulousness, or empathy. In addition, the public perception of the level of disability associated with mental

disorders can change.

Epidemiology

Mental disorders are common. World wide more than one in three people in most countries report sufficient criteria for at least one at some point in their life. In the United States 46% qualifies for a mental illness at some point. An ongoing survey indicates that anxiety disorders are the most common in all but one country, followed by mood disorders in all but two countries, while substance disorders and impulse-control disorders were consistently less prevalent. Rates varied by region.

A review of anxiety disorder surveys in different countries found average lifetime prevalence estimates of 16.6%, with women having higher rates on average. A review of mood disorder surveys in different countries found lifetime rates of 6.7% for major depressive disorder (higher in some studies, and in women) and 0.8% for Bipolar I disorder.

In the United States the frequency of disorder is: anxiety disorder (28.8%), mood disorder (20.8%), impulse-control disorder (24.8%) or substance use disorder (14.6%).

A 2004 cross-Europe study found that approximately one in four people reported meeting criteria at some point in their life for at least one of the DSM-IV disorders assessed, which included mood disorders (13.9%), anxiety disorders (13.6%) or alcohol disorder (5.2%). Approximately one in ten met criteria within a 12-month period. Women and younger people of either gender showed more cases of disorder. A 2005 review of surveys in 16 European countries found that 27% of adult Europeans are affected by at least one mental disorder in a 12 month period.

An international review of studies on the prevalence of schizophrenia found an average (median) figure of 0.4% for lifetime prevalence; it was consistently lower in poorer countries.

Studies of the prevalence of personality disorders (PDs) have been fewer and smaller-scale, but one broad Norwegian survey found a five-year prevalence of almost 1 in 7 (13.4%). Rates for specific disorders ranged from 0.8% to 2.8%, differing across countries, and by gender, educational level and other factors. A US survey that incidentally screened for personality disorder found a rate of 14.79%.

Approximately 7% of a preschool pediatric sample were given a psychiatric diagnosis in one clinical study, and approximately 10% of 1- and 2-year-olds receiving developmental screening have been assessed as having significant emotional/behavioral problems based on parent and pediatrician reports.

While rates of psychological disorders are the same for men and women, women have twice the

rate of depression than men. Each year 73 million women are afflicted with major depression, and suicide is ranked 7th as the cause of death for women between the ages of 20-59. Depressive disorders account for close to 41.9% of the disability from neuropsychiatric disorders among women compared to 29.3% among men.

Society and culture

Different societies or cultures and even different individuals in a culture can disagree as to what constitutes optimal versus pathological biological and psychological functioning. Research has demonstrated that cultures vary in the relative importance placed on, for example, happiness, autonomy, or social relationships for pleasure. Likewise, the fact that a behavior pattern is valued, accepted, encouraged, or even statistically normative in a culture does not necessarily mean that it is conducive to optimal psychological functioning.

People in all cultures find some behaviors bizarre or even incomprehensible. But just what they feel is bizarre or incomprehensible is ambiguous and subjective. These differences in determination can become highly contentious.

The process by which conditions and difficulties come to be defined and treated as medical conditions and problems, and thus come under the authority of doctors and other health professionals, is known as medicalization or pathologization.

In the scientific and academic literature on the definition or classification of mental disorder, one extreme argues that it is entirely a matter of value judgements (including of what is normal) while another proposes that it is or could be entirely objective and scientific (including by reference to statistical norms). Common hybrid views argue that the concept of mental disorder is objective but a "fuzzy prototype" that can never be precisely defined, or alternatively that it inevitably involves a mix of scientific facts and subjective value judgments.

Professions and fields

A number of professions have developed that specialize in the treatment of mental disorders, including the medical speciality of psychiatry (including psychiatric nursing), a subset of psychology known as clinical psychology, social work, as well as mental health counselors, marriage and family therapists, psychotherapists, counselors and public health professionals. Those with personal experience of using mental health services are also increasingly involved in researching and delivering mental health services and working as mental health professionals. The different clinical and scientific perspectives draw on diverse fields of research and theory, and different disciplines may favor differing models, explanations and goals.

Movements

The consumer/survivor movement (also known as user/survivor movement) is made up of individuals (and organizations representing them) who are clients of mental health services or who consider themselves "survivors" of mental health services. The movement campaigns for improved mental health services and for more involvement and empowerment within mental health services, policies and wider society. Patient advocacy organizations have expanded with increasing deinstitutionalization in developed countries, working to challenge the stereotypes, stigma and exclusion associated with psychiatric conditions. An antipsychiatry movement fundamentally challenges mainstream psychiatric theory and practice, including asserting that psychiatric diagnoses of mental illnesses are neither real nor useful.

Intangible experiences

Religious, spiritual, or transpersonal experiences and beliefs are typically not defined as disordered, especially if widely shared, despite meeting many criteria of delusional or psychotic disorders. Even when a belief or experience can be shown to produce distress or disability--the ordinary standard for judging mental disorders--the presence of a strong cultural basis for that belief, experience, or interpretation of experience, generally disqualifies it from counting as evidence of mental disorder.

Western bias

Current diagnostic guidelines have been criticized as having a fundamentally Euro-American outlook. They have been widely implemented, but opponents argue that even when diagnostic criteria are accepted across different cultures, it does not mean that the underlying constructs have any validity within those cultures; even reliable application can prove only consistency, not legitimacy.

Advocating a more culturally sensitive approach, critics such as Carl Bell and Marcello Maviglia contend that the cultural and ethnic diversity of individuals is often discounted by researchers and service providers.

Cross-cultural psychiatrist Arthur Kleinman contends that the Western bias is ironically illustrated in the introduction of cultural factors to the DSM-IV: that disorders or concepts from non-Western or non-mainstream cultures are described as "culture-bound", whereas standard psychiatric diagnoses are given no cultural qualification whatsoever, reveals to Kleinman an underlying assumption that Western cultural phenomena are universal. Kleinman's negative view towards the culture-bound syndrome is largely shared by other cross-cultural critics, common responses included both disappointment over the large number of documented non-Western mental disorders

still left out and frustration that even those included were often misinterpreted or misrepresented.

Many mainstream psychiatrists are dissatisfied with the new culture-bound diagnoses, although for different reasons. Robert Spitzer, a lead architect of the DSM-III, has hypothesized that adding cultural formulations was an attempt to appease cultural critics and stated that the formulations lack any scientific motivation or support. Spitzer also posits that the new culture-bound diagnoses are rarely used, maintaining that the standard diagnoses apply regardless of the culture involved. In general, mainstream psychiatric opinion remains that if a diagnostic category is valid, cross-cultural factors are either irrelevant or are significant only to specific symptom presentations.

Relationships and morality

Clinical conceptions of mental illness also overlap with personal and cultural values in the domain of morality, so much so that it is sometimes argued that separating the two is impossible without fundamentally redefining the essence of being a particular person in a society. In clinical psychiatry, persistent distress and disability indicate an internal disorder requiring treatment; but in another context, that same distress and disability can be seen as an indicator of emotional struggle and the need to address social and structural problems. This dichotomy has led some academics and clinicians to advocate a postmodernist conceptualization of mental distress and well-being.

Such approaches, along with cross-cultural and "heretical" psychologies centered on alternative cultural and ethnic and race-based identities and experiences, stand in contrast to the mainstream psychiatric community's active avoidance of any involvement with either morality or culture. In many countries there are attempts to challenge perceived prejudice against minority groups, including alleged institutional racism within psychiatric services.

Laws and policies

Three quarters of countries around the world have mental health legislation. Compulsory admission to mental health facilities (also known as involuntary commitment or sectioning), is a controversial topic. From some points of view it can impinge on personal liberty and the right to choose, and carry the risk of abuse for political, social and other reasons; from other points of view, it can potentially prevent harm to self and others, and assist some people in attaining their right to healthcare when unable to decide in their own interests.

All human-rights oriented mental health laws require proof of the presence of a mental disorder as defined by internationally accepted standards, but the type and severity of disorder that counts can vary in different jurisdictions. The two most often utilized grounds for involuntary admission are said to be serious likelihood of immediate or imminent danger to self or others, and the need for treatment. Applications for someone to be involuntarily admitted may usually come from a mental

health practitioner, a family member, a close relative, or a guardian. Human-rights-oriented laws usually stipulate that independent medical practitioners or other accredited mental health practitioners must examine the patient separately and that there should be regular, time-bound review by an independent review body. An individual must be shown to lack the capacity to give or withhold informed consent (i.e. to understand treatment information and its implications). Legal challenges in some areas have resulted in supreme court decisions that a person does not have to agree with a psychiatrist's characterization of their issues as an "illness", nor with a psychiatrist's conviction in medication, but only recognize the issues and the information about treatment options.

Proxy consent (also known as substituted decision-making) may be given to a personal representative, a family member or a legally appointed guardian, or patients may have been able to enact an advance directive as to how they wish to be treated. The right to supported decision-making may also be included in legislation. Involuntary treatment laws are increasingly extended to those living in the community, for example outpatient commitment laws (known by different names) are used in New Zealand, Australia, the United Kingdom and most of the United States.

The World Health Organization reports that in many instances national mental health legislation takes away the rights of persons with mental disorders rather than protecting rights, and is often outdated. In 1991, the United Nations adopted the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, which established minimum human rights standards of practice in the mental health field. In 2006, the UN formally agreed the Convention on the Rights of Persons with Disabilities to protect and enhance the rights and opportunities of disabled people, including those with psychosocial disabilities.

The term insanity, sometimes used colloquially as a synonym for mental illness, is often used technically as a legal term. The insanity defense may be used in a legal trial (known as the mental disorder defence in some countries).

Perception and discrimination

Stigma

The social stigma associated with mental disorders is a widespread problem. Some people believe those with serious mental illnesses cannot recover, or are to blame for problems. The US Surgeon General stated in 1999 that: "Powerful and pervasive, stigma prevents people from acknowledging their own mental health problems, much less disclosing them to others." Employment discrimination is reported to play a significant part in the high rate of unemployment among those with a diagnosis of mental illness.

Efforts are being undertaken worldwide to eliminate the stigma of mental illness, although their

methods and outcomes have sometimes been criticized.

A 2008 study by Baylor University researchers found that clergy in the US often deny or dismiss the existence of a mental illness. Of 293 Christian church members, more than 32 percent were told by their church pastor that they or their loved one did not really have a mental illness, and that the cause of their problem was solely spiritual in nature, such as a personal sin, lack of faith or demonic involvement. The researchers also found that women were more likely than men to get this response. All participants in both studies were previously diagnosed by a licensed mental health provider as having a serious mental illness. However, there is also research suggesting that people are often helped by extended families and supportive religious leaders who listen with kindness and respect, which can often contrast with usual practice in psychiatric diagnosis and medication.

Media and general public

Media coverage of mental illness comprises predominantly negative depictions, for example, of incompetence, violence or criminality, with far less coverage of positive issues such as accomplishments or human rights issues. Such negative depictions, including in children's cartoons, are thought to contribute to stigma and negative attitudes in the public and in those with mental health problems themselves, although more sensitive or serious cinematic portrayals have increased in prevalence.

In the United States, the Carter Center has created fellowships for journalists in South Africa, the U.S., and Romania, to enable reporters to research and write stories on mental health topics. Former US First Lady Rosalynn Carter began the fellowships not only to train reporters in how to sensitively and accurately discuss mental health and mental illness, but also to increase the number of stories on these topics in the news media. There is a World Mental Health Day, which the US and Canada subsume under a Mental Illness Awareness Week.

The general public have been found to hold a strong stereotype of dangerousness and desire for social distance from individuals described as mentally ill. A US national survey found that a higher percentage of people rate individuals described as displaying the characteristics of a mental disorder as "likely to do something violent to others", compared to the percentage of people who are rating individuals described as being "troubled".

Violence

Despite public or media opinion, national studies have indicated that severe mental illness does not independently predict future violent behavior, on average, and is not a leading cause of violence in society. There is a statistical association with various factors that do relate to violence

(in anyone), such as substance abuse and various personal, social and economic factors.

In fact, findings consistently indicate that it is many times more likely that people diagnosed with a serious mental illness living in the community will be the victims rather than the perpetrators of violence. In a study of individuals diagnosed with "severe mental illness" living in a US inner-city area, a quarter were found to have been victims of at least one violent crime over the course of a year, a proportion eleven times higher than the inner-city average, and higher in every category of crime including violent assaults and theft. People with a diagnosis may find it more difficult to secure prosecutions, however, due in part to prejudice and being seen as less credible.

However, there are some specific diagnoses, such as childhood conduct disorder or adult antisocial personality disorder or psychopathy, which are defined by or inherently associated with conduct problems and violence. There are conflicting findings about the extent to which certain specific symptoms, notably some kinds of psychosis (hallucinations or delusions) that can occur in disorders such as schizophrenia, delusional disorder or mood disorder, are linked to an increased risk of serious violence on average. The mediating factors of violent acts, however, are most consistently found to be mainly socio-demographic and socio-economic factors such as being young, male, of lower socioeconomic status and, in particular, substance abuse (including alcoholism) to which some people may be particularly vulnerable.

High-profile cases have led to fears that serious crimes, such as homicide, have increased due to deinstitutionalization, but the evidence does not support this conclusion. Violence that does occur in relation to mental disorder (against the mentally ill or by the mentally ill) typically occurs in the context of complex social interactions, often in a family setting rather than between strangers. It is also an issue in health care settings and the wider community.

In animals

Psychopathology in non-human primates has been studied since the mid-20th century. Over 20 behavioral patterns in captive chimpanzees have been documented as (statistically) abnormal for their frequency, severity or oddness--some of which have also been observed in the wild. Captive great apes show gross behavioral abnormalities such as stereotypy of movements, self-mutilation, disturbed emotional reactions (mainly fear or aggression) towards companions, lack of species-typical communications, and generalized learned helplessness. In some cases such behaviors are hypothesized to be equivalent to symptoms associated with psychiatric disorders in humans such as depression, anxiety disorders, eating disorders and post-traumatic stress disorder. Concepts of antisocial, borderline and schizoid personality disorders have also been applied to non-human great apes.

The risk of anthropomorphism is often raised with regard to such comparisons, and assessment of

non-human animals cannot incorporate evidence from linguistic communication. However, available evidence may range from nonverbal behaviors--including physiological responses and homologous facial displays and acoustic utterances--to neurochemical studies. It is pointed out that human psychiatric classification is often based on statistical description and judgement of behaviors (especially when speech or language is impaired) and that the use of verbal self-report is itself problematic and unreliable.

Psychopathology has generally been traced, at least in captivity, to adverse rearing conditions such as early separation of infants from mothers; early sensory deprivation; and extended periods of social isolation. Studies have also indicated individual variation in temperament, such as sociability or impulsiveness. Particular causes of problems in captivity have included integration of strangers into existing groups and a lack of individual space, in which context some pathological behaviors have also been seen as coping mechanisms. Remedial interventions have included careful individually tailored re-socialization programs, behavior therapy, environment enrichment, and on rare occasions psychiatric drugs. Socialization has been found to work 90% of the time in disturbed chimpanzees, although restoration of functional sexuality and care-giving is often not achieved.

Laboratory researchers sometimes try to develop animal models of human mental disorders, including by inducing or treating symptoms in animals through genetic, neurological, chemical or behavioral manipulation, but this has been criticized on empirical grounds and opposed on animal rights grounds.

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