CONCEPTUAL SCHEMES OF ABNORMAL BEHAVIOUR: A STUDY ON THE LOGICAL FOUNDATIONS OF MEDICAL SCIENCES

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in
PSYCHOLOGY

TISSY MARIAM THOMAS

DEPARTMENT OF PSYCHOLOGY
UNIVERSITY OF CALICUT
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CERTIFICATE

Certified that this report on **CONCEPTUAL SCHEMES OF ABNORMAL BEHAVIOUR: A STUDY ON THE LOGICAL FOUNDATIONS OF MEDICAL SCIENCES,** is a record of bonafide study and research carried out by Ms. Tissy Mariam Thomas under my supervision and guidance. The report has not been submitted by her for any award of Degree or Diploma, in this or any other University.

University of Calicut
28.11.2008

Dr. T.SASIDHARAN,
Reader & Head,
Department of Psychology
University of Calicut

DECLARATION

I, Tissy Mariam Thomas**,** do hereby declare that this thesis entitled **"CONCEPTUAL SCHEMES OF ABNORMAL BEHAVIOUR: A STUDY ON THE LOGICAL FOUNDATIONS OF MEDICAL SCIENCES",** has not been submitted by me for any Degree, Diploma, Associateship, Fellowship, Title or Recognition in this or any other institutions. This work or any part of it has not been sent anywhere for publication or presentation purpose.

University of Calicut
28.11.2008

Tissy Mariam Thomas
Research Scholar,
Department of Psychology,
University of Calicut

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CHAPTER I

INTRODUCTION

"The transition from a paradigm in crisis to a new one from which a new tradition of normal science can emerge is far from a cumulative process… rather it is a reconstruction of the field from new fundamentals, a reconstruction that changes some of the fields most elementary, theoretical generalizations."

Thomas Kuhn (1970, cited from Roberts, 2001)

From time immemorial, ever since human being was born, concerns about health and illness, has prevailed. Human beings, as higher order species, even then and today conceptualized diseases one among the natural crises which interferes with their normal functioning. And when the human race is 'cultured' and 'civilized', their approach to deal with diseases took an organized form. Notions and reasons of diseases until then need to be grouped under common nomenclature. But disease has always been what society chooses it to mean – neither more nor less. As the Humpty Dumpty's paraphrase says, "when I use the word *disease*, it means just what I choose it to mean – neither more nor less" (Hudson, 1993). *" The experience and communication of distress requires a theoretical model which emphasizes the contextual nature of such experience." (*Alan Blair, 1995 cited from Roberts, 2001).

Hudson (1993) puts forward a number of important consideration for the contextual nature of defining health and illness (1) the definition of disease has varied with time and place in history; (2) the names assigned to diseases are ultimately abstractions, although it is useful at times to act as though they are real; and (3) what we mean by diagnostic terms, as with words in general, can be discerned more accurately by what we do with them than what we say about them.

Abnormality is a term applied to behaviour thinking process or feelings that are viewed by the individual and /or society as undesirable and requiring control or change, and

viewed as deficits which may or may not have a clear etiology but which should be compensated for by the individual and society.(DeWolfe,1996). DeWolfe (1996) notes that differing points of view about the theoretical orientation, tolerance for deviance, where to draw the line between the normal and abnormal and the use of labeling lead to differences in criteria used for definitions of abnormal behaviour.

From the point of view of abnormal and /or clinical psychology the term “abnormal” is diverging from the normal, not conforming with the general rule. It denote disturbed, disorganized, maladjustive behaviour: irrational, uncontrollable and disbalanced mental processes and/ or disintegrated personality structure (Wolman,1973). But when these term comes to medical sciences it refers to pathology or illness or disease. Here, the term “mental illness” is a disorder of organic or non-organic origin which is severe enough to require professional help. Wolman (1973) says that abnormal behviour is exchangeably used with mental illness and mental disorder.

This research explores four major medical systems – Allopathy/ Psychiatry, Ayurveda, Homeopathy, and Naturopathy to understand and describe the concept, causes & classification and diagnosis & treatment of abnormal behaviour .The researcher chose the term *abnormal behavior* rather than mental illness or mental disorder by taking a broader philosophical position than reducing the subject matter into biological. Moreover, being a student of Psychology, the researcher has incorporated psychological background of abnormal behaviour also. At the same time, the term mental illness or disorder is also accepted or used in many parts of the thesis. Out of the various names given to these four systems, the terms Allopathy/ Psychiatry, *Ayurveda*, Homeopathy, and Naturopathy are chosen for present work as these terms are more popular and frequently used in the discussion related.

1.1 A brief history of medical sciences

"Who controls the past, controls the future;

Who controls the present, controls the past"

George Orwell (1984, cited from Roberts, 2001)

Michael Foucault (2003) in his famous book *The Birth of the Clinic* says:

"For us, the human body defines by natural right, the space of origin and of distribution of disease… The body is a space whose lines, volumes, surfaces and routes are anatomically drawn and made solid and visible. But this body is only one way in which one spatializes disease. In all likelihood, neither the first, nor the most fundamental. There have been, and will be, ***other distributions of illness".*** In the present research the analysis of abnormal behaviour in the context of medical sciences is mainly done by placing the research questions on the broader perspective of health and illness proposed by medical sciences.

History of Western or Eastern medicine revolved around different ways of explaining health and illness before the 5th century B.C. till the date. The historical evolution is not static, idealized or planned rather spontaneous, timely and sometimes serendipitous. According to the historical surveys, it has started from Greece and Rome – magical procedures, drug treatments, Hippocratic medicine, Humoral theory by Galen – to name a few landmarks. After the collapse of the Roman Empire, Western medicine experienced a period of retrenchment and decline. Healing became an important act of Christian charity and Christians healed through the confession of sins, prayer, and the laying on of hands, exorcisms, and miracles, occasionally performed by saints or church fathers (Risse, 1993).

Islamic and Indian Medicine *(Ayurveda)* originated in distinct cultural traditions but has been in close contact for many centuries. These systems follow a holistic, eclectic, and pluralistic approach, evolving in response to complex influences that varied according to time and place. Islamic medicine is based largely on the Greek medical knowledge of later

antiquity and is more properly called Greco-Islamic or Galenic-Islamic medicine, reflecting the influence of Galen (Gallagher, 1993). This Mediterranean system was called *Yunai Tibbia* in Arabic, meaning Greek medicine, and is still practiced under that name in Pakistan, India, Sri Lanka and other South Asian countries (Leslie, 1977).

The term *Indian medicine* refers to *Ayurvedic* medicine. It has roots from *Vedas and Upanishads*, which contains medical doctrines, mostly of a magico relgious character and dates from as early as the second millennium B.C. Ayurvedic medicine has reached its highest point of development from the first to the sixth century A.D. This tradition lent itself to sophisticated reasoning, earnest speculation, and scholarly curiosity but also to involuted argumentation, abstract distinctions, and increasingly obscurantist generalizations (Gallagher, 1993).

Chinese medicine, at the same time, was very much prevalent in Korea, Japan and parts of Southeast Asia while Ayurveda had a marked influence in Tibet, Burma and Southeast Asia. Leslie (1977) notes that other healers were also coexisted with these practitioners, their arts falling into special categories: bone-setters, surgeons, midwives, snake-bite curers, shamans, and so on.

At the end of the Middle Ages, scientific research and forms of professional association in Europe began a development which led eventually to the worldwide traditions of cosmopolitan medicine. The scientific theories and social organization of cosmopolitan medicine evolved progressively over several centuries. They developed with the expansion of Europe, the rise of modern science, the Industrial Revolution and other movements. Research on anatomy and physiology during the Renaissance and Reformation generated new methods of scientific work and discovered facts that seemed to invalidate ancient medical authorities (Leslie, 1977). The rising prevalence of leprosy and plague made the concern of disease as a burden in Europe.

Paracelsus, in the sixteenth century, attempted to investigate nature directly and thereby discover the hidden correspondences between the cosmos and human beings. He argued that cures could be achieved only through the administration of chemically prepared remedies. Equally important were the innovation in surgical technique and management of gunshot wounds by the sixteenth century French surgeon Ambroise Pare (Risse, 1993).

The classical assumptions of humoralism that had explained human functioning in health and disease for nearly two millennia in the Western world were severely challenged in the seventeenth century (Risse, 1993). The changes that had happened in medicine as well as technology have been influenced by the philosophical discussion on body and mind during seventeenth century.

As mentioned above, the history of medicine since seventeenth century consists of heterogeneous theories, speculations and traditions. Any attempt to accommodate all the healing traditions would possibly fail to give an accurate and comprehensive picture about health and illness as historical, social and cultural factors influence this process. When it comes to the question of the history of mental illness, the picture is little more vague and complex as the conceptual definition of abnormal behaviour is subjected to lot of debates, confusions and issues which are handled by the disciplines of Philosophy, Psychology, Medical sciences, Sociology and Anthropology.

The next section focuses on the mainstream history of the concept of mental illness in the West in order to trace the background of the emergence of medical sciences (especially psychiatry) in dealing with it.

1.2 Concepts of mental illness in the West

Pressman (1993) traced the conceptual changes in approaching mental illness which was prevalent in the West. During early modern Europe to the seventeenth century, no single

approach to the problem of insanity dominated. Although categories of insanity in the Renaissance derived mainly from the classical system of mania, melancholy and dementia, which were based on the broad medical doctrine of bodily humors, the implications were diverse in practice. Physicians and lay people alike typically depicted mad persons as wild beasts, devoid of reason. Brutal handling of the insane was commonplace. Yet, the famous English hospital of St. Mary of Bethlehem, later known as "Bedlam", was founded in 1450 as an institution to those who had "fallen out of their wit and their health" (Pressman, 1993).

During seventeenth century, the body came to be viewed as something like a machine governed by physical principles. This view was expressed by the philosopher Rene Descartes. The Cartesian man had a dual nature: a physical body ruled by universal laws of matter and motion, and an immaterial soul or mind – a pure thinking entity – located in the pineal body of the brain. The body was conceived as a vast hydraulic network of hollow pipes, moving blood and nervous fluid in the circulatory and nervous systems under the influence of the mind (Risse, 1993).

The emergence of works by William Harvey, Thomas Willis, Thomas Wright and Robert Burton on neuroanatomy, circulatory systems and nervous system speeded up the studies on brain as the cause of insanity. But religious fanaticism was still in conflict with the naturalist model (Pressman, 1993).

The enlightenment

The eighteenth century period of the Enlightenment created an optimistic outlook concerning the role and benefits of medicine. Most contemporary thinkers believed that health was a natural state to be attained and preserved. Society had to be made aware of medical possibilities through the employment of professionals who could deal expertly with all health-related problems. Governments increasingly sought to develop social policies that included

the physical well-being of the public. New medical elite took charge and began to play a more prominent role in European society (Risse, 1993). Pressman (1993) says that because of the numerous ties forged between medicine and the problem of insanity, many consider the modern concept of mental illness to have been itself an Enlightenment product.

Efforts to classify diseases were intensified. Nosology, the systematic division of disease entities, prospered side by side with similar taxonomic efforts directed at plants and animals. The popular appeal of the new concepts of mental illness must also be attributed to developments in medical research and theory that stressed the importance of the nervous system to all pathology (Pressman, 1993).

Madness during the Enlightenment became a central cultural concern too. The legendary moment in 1795 when Philippe Pinel struck the chains from the inmates was marked in the institutional history of psychiatry (Pressman, 1993).

Nineteenth century

In the first half of the nineteenth century, the treatment of mental illness was marked by two trends: a wave of asylum building and the differentiation of a small band of medical professionals who claimed mental disorders as their special domain. These two developments were linked through a materialist model of mental physiology that had reformist connotation and the arrival of new categories of mental illness that advanced the value of psychiatric expertise.

In the second half of the nineteenth century, mental disorders gained a commanding social presence due to the perceived threat of the asylum population, the profession of nervous disorders, and their linkage to a range of polarized issues. This social interest was mirrored by the attention of diverse groups of learned scientists and physicians who competed for the privilege of claiming the field of mental disorders as their own. The latter half of the

nineteenth century was neurology's "golden age," in research, private practice and the urban teaching clinic. Each of these three neurological domains had significant repercussions in the medical conceptualization and treatment of madness (Pressman, 1993).

Twentieth century

The first half of the twentieth century is marked by two somewhat opposing currents in the conception of mental illness: the entrance of the Freudian model of psychodynamics and a rash of somatically oriented theories and treatments. Furthermore, when medical schools began to offer systematic instruction in the medical treatment of insanity, they united "nervous and mental disorders" in a single curriculum as dictated by the new nosology, thus bridging the historical gap between the asylum and private practice. The modern profession of psychiatry was born (Pressman, 1993).

In the 1920s and 1930s, virtually every branch of biomedical science sought to apply the tools of experimental medicine to the problem of psychiatry. The introduction of a wave of somatic treatments for mental illness in the middle 1930s transformed psychiatric practice. After World War II, professional organizations such as the *American Psychiatric Association* became active in the creation of standardized systems of nomenclature. The first *Diagnostic and Statistical Manual, Mental Disorders (DSM),* created in 1950, reflected the extension of the Kraeplin and Freudian systems, augmented by new theories of personality. In the decades following World War II, psychiatry as a medical profession experienced tremendous expansion. In the United States the advent of community mental health centers and third-party payments swelled the ranks of non-institutional practitioners. Another group of clinically trained psychologists, social workers and counselors have emerged and different forms of counseling and psychotherapy, though not necessarily Freudian psychoanalysis, became prevalent.

At the same time, dramatic developments occurred in somatically oriented treatment and research. Conceptualization of mental disorders has also been influenced by the social sciences, especially sociology and anthropology. Therefore, social class, social control, family interaction, social integration, life stress and the very act of psychiatric labeling and cultural factors would be having a role in determining patterns of mental disorder.

Pressman (1993) said that psychiatry as a learned discipline contains no one school of thought that is sufficiently dominant to control the medical meaning of insanity. The two components of illness – why someone is disturbed and what should be done about it - still remained as a cultural reality. As psychiatry is emerged not in isolation but in relation to other areas of medicine, psychiatry's peculiar domain is precisely those problems that baffle regular medicine (Pressman, 1993).

Even though, Psychiatry, being a branch of Allopathy has emerged as the dominant system in treating mental illness, Homeopathy and Naturopathy were stood there as strong critics against this system. Both the systems have been emerged at the same time in the late eighteenth century which had theoretically shaken the roots of modern medicine. Leslie (1977) quotes Eliot Freidson who argues that social and political factors are more responsible for the domination of Modern medicine over other systems of medicine.

"If we consider the profession of medicine today, it is clear that its major characteristic is preeminence. Such preeminence is not merely that of prestige but also that of expert authority. This is to say, medicine's knowledge about illness and its treatment is considered to be authoritative and definitive. While there are interesting exceptions like chiropractic and homeopathy, there are no representatives of occupations in direct competition with medicine who hold official policy-making positions related to health affairs. Medicine's position today is akin to that of state religious yesterday – it has an officially approved monopoly of the right to define health and illness and to treat illness."

Leslie (1977) continues that the ways in which cosmopolitan medicine progressively subordinates other forms of practice are major variables for the comparative study of medical systems.

1.3 Philosophy of medicine

The researcher has organized the analysis of medical systems in the background of the existing debates and issues in philosophy. The Cartesian mind/body dualism, reductionism, analytical behaviorism and materialism are explored to provide philosophical support to the study. Searle (2004) says that a movement to do a more substantive, theoretical, constructive philosophy always surrounds the study of the philosophy of mind. Burwood, Gilbert & Lennon (2003) mention that modern philosophy of mind is almost exclusively concerned with the mind/body problem; how meaning, rationality and conscious experience are related to or arise from, a material world which, in itself, is devoid of such characteristics. Thus, the logical questions on health (physical/mental) and illness (physical/mental) cannot be addressed without these philosophical queries taken into consideration.

The Western philosophy of science is also brought into picture which has the basic questions such as, 'what is science about?' and 'what is a scientific theory?'. Bird (1998) provides the meaning of these questions by stating that "for a theory can be false yet still be scientific and a claim can be true without being scientific." E.D. Ark (1982) quotes William R. Overton, a judge who summed up the criteria of scientific theory.

(1) It is guided by natural law.

(2) It has to be explanatory by reference to natural law.

(3) It is testable against the empirical world.

(4) Its conclusions are tentative, i.e., are not necessarily the final word.

(5) It is falsifiable (E.D. Ark, 1982 cited from Bird, 1998).

The investigator believes that the above criteria can be used to explore the "scientificity" of medical systems and also to compare and contrast them in terms of their theoretical positions.

As *Ayurveda*, the Eastern medical system is rooted in *Samkhya* philosophy, the cardinal doctrines of *Samkhya Karika* are also brought together in the analysis. The *Nyaya* and *Vaisesika darsanas* have also provided philosophical strength to *Ayurvedic* concepts. These philosophies explain mind-body concepts not in a dualistic and dichotomous manner but mind, body and soul are co-existing in the conceptualization of health and illness. As one of the oldest schools of Indian philosophy, it talks about cosmology, metaphysics, ethics and epistemology which give a metaphysical realm of *Ayurvedic* concepts. The dualism, here, is between *Purusa*, the universal consciousness and *Prakrti*, the root cause or the creator (Weerasinghe, 1993). *Sat-Karya-Siddhanta* (the law of the identity of cause and effect), *Upadana* and *Nimitta* as causes, threefold pain – *Adhyatmika*, *Adhibhantika* and *Adhidaivika* and *Gunas* as primary constituents of *Prakrti* are emphasized. The prime importance given to *Manas*/ *Mahat* as cause to everything is also a supportive evidence in bringing out the Eastern metaphysical philosophy of *Ayurveda*.

1.4 Significance of the present research

Conceptualizing the health and illness dimensions has been an exercise done in academic medicine ages back. The philosophy of science/medicine is comparatively a new field which realized the relevance of conceptual or theoretical studies on health and illness in the context of medical sciences. The works on these entities are revealed in the history as numerous books, journals, researches, technological marks, and assessment procedures.

But even then, unresolved issues include the nature of the entities, the definition of normal/abnormal, the nosological principles for organizing psychiatric classification and the distinction between dichotomies in medical sciences. Controversies exist regarding the definition and logical status of diagnoses, basis of classification system and whether some conditions are pathological conditions (Blashfield & Livesley, 1999).

Bentall (2003) strongly argues that by examining the taxonomic assumptions that have underpinned modern theories of psychosis, the current psychiatric understanding of mental disorder/abnormal behavior is deeply flawed. This is the reason why there has been so little progress in the treatment of psychiatric disorders since the time of Kraepelin. Even though Psychiatry has witnessed diverse explanations, theories, realizations, and modifications about abnormality in the last century, Bentall (2003) puts forward that most researchers and clinicians have been stuck at the end of the blind alley into which he led us over a century ago.

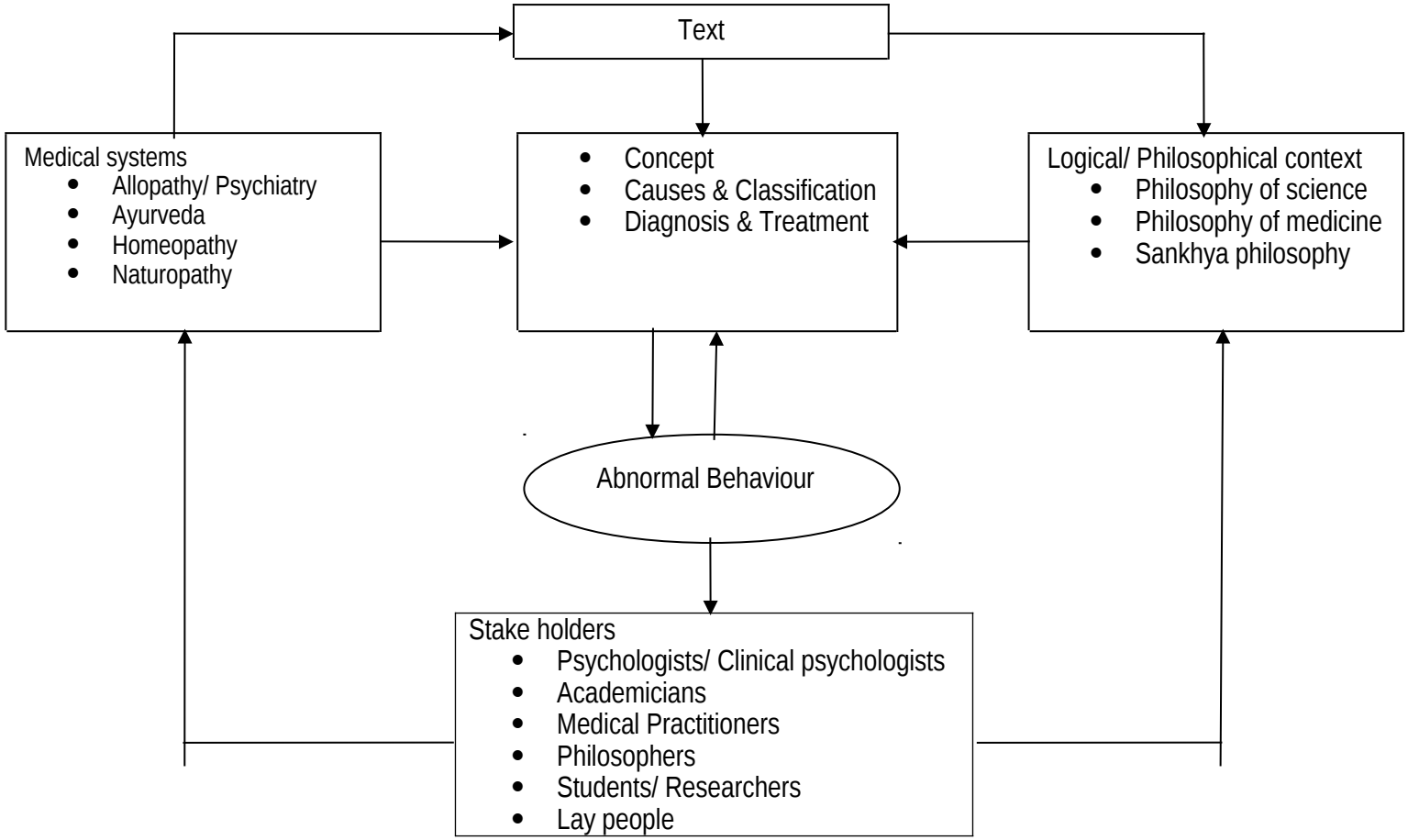
The way we think about abnormal behavior should be important to everybody and it should be accessible to non-specialists and lay people, given that most people have some acquaintance with these problems, which again says about the contextual relevance of the present study. Bentall (2003) also says that the brain, the mind and human emotions cannot be understood in isolation from their social context.

I take a similar position that of Bentall and place the significance of the study in the social constructivist paradigm. The procedure or primary importance given to biology instead of psychology by the medical systems has been a major concern all through the research and each chapter is organized on this fundamental philosophical issue. Bentall (2003) reports that many psychologists and psychiatrists sense that a new, radical way of thinking about psychiatric disorders is emerging, but few will have had the opportunity to try to gather together the many different strands of research that are contributing to this shift in thinking.

The research oscillates between the philosophical background of some of the basic questions on health and illness and their relevance in psychology as a discipline. The thesis also has the implication in finding out how psychological theories, for instance, psychoanalysis and behaviorism, can best be used to explain many of the normal and abnormal behaviors encountered both inside and outside the medical sciences. By raising many of the differences and similarities of the four medical sciences, the study tries to analyze and comment on our current conceptualization of abnormal behavior.

The present research attempts to draw together the different explanations given for abnormal behavior by medical systems and the ways of diagnosis and treatment. A conceptual map is developed for the present study and attached as Figure 1.1 which gives clarity to the research objectives.

Fig 1.1 Conceptual Map



Considering the brief history of the developments in the concepts of health and illness, the following objectives were formulated:

1.5 Major Research Concern

To study, describe and analyse the logical foundations of medical sciences i.e., Allopathy/ Psychiatry, *Ayurveda*, Homeopathy, and Naturopathy in terms of the concept, causes & classification, and diagnosis & treatment of abnormal behavior.

1.6 Objectives

The major research concern is studied along with the following objectives.

1. To describe the concept of health and illness (both physical and mental) in Allopathy/ Psychiatry, *Ayurveda*, Homeopathy, and Naturopathy.
2. To study the criteria used by medical sciences in the attribution of causes and classification of abnormal behaviour.
3. To understand the methods of diagnosis and treatment of abnormal behaviour in Allopathy/ Psychiatry, *Ayurveda* ,Homeopathy and Naturopathy
4. To bring out the philosophical discussions, debates and issues on the concept, causes and classification and diagnosis of treatment of abnormal behavior.
5. To compare the medical sciences on the conceptualizations of abnormal behavior to evolve fundamental questions and contradictions on health and illness.

The above-mentioned objectives were broad enough to be explored as the research theme incorporates four major medical sciences. The researcher limited her study by sampling a few original works or text books from Allopathy/ Psychiatry, *Ayurveda*, Homeopathy and Naturopathy. It is mentioned below to say that the findings given in the thesis are mainly based on them.

1.7 Referred Textbooks

Psychiatry

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2. Bentall, R.P. (2003). *Madness explained: psychosis and human nature.* Allan Lane: Penguin Books.
3. World Health Organization (1992). *ICD-10: International Statistical Classification of Diseases and Related Health Problems* (10th revised edn). Geneva: World Health Organization.

Ayurveda

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Homeopathy

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1.8 Structure of the report

The thesis is organized into six chapters which are structured in the following manner:

Chapter 1: Introduction

The introduction chapter comprises of a brief history of the medical systems, the relevance of the research, the planning of the chapters in the thesis, and the philosophical positions taken.

Chapter 2: Methodology

The rationale of using qualitative research method is emphasized and the approach used in the thesis too. The subject matter is analyzed based on the observations inferred from analysis of original textbooks in each medical system (textual analysis), consultation with subject experts and medical practitioners (individual interview) and paired (or triad) interview).

The methodological stand of the researcher and the epistemological tradions chosen are further explained in this chapter.

Chapter 3: Concept of Health and Illness

This chapter constitutes the basic logical argument of what is health and what is illness. By describing the conceptual understanding of each medical system, I conclude the chapter by dwelling on the mind/body dualism theories in philosophy.

Chapter 4: Causes and Classification of abnormal behaviour

Attribution of causes is the fundamental strength of any medical system. The elaborate classification system of diseases is dissected once again by asking whether the cause is physical or mental, ultimately. This chapter is further analyzed and continued in the next section too.

Chapter 5: Diagnosis and Treatment of abnormal behaviour

The theory of diagnosis and treatment, according to modern scientific logic, needs to be matched with the concept, causes and classification of diseases. This chapter, after describing the methods followed in four medical systems, brings out an interesting discussion on the role of inference, intuition and expertise of the doctor/physician in diagnosis/treatment which includes the objectivity-subjectivity elements in the process.

Chapter 6: Results & Discussion

Sixth and final chapter summarizes the major findings and the hypotheses generated from the research. Some of the queries and discussions brought in relation to the research objectives are also included here. The chapter ends with the future implications of the research.

Chapter II

METHODOLOGY

CHAPTER II

METHODOLOGY

"Though this be madness, yet there is method in't."

Shakespeare, Hamlet (Act II, Sc.II cited from Lilienfeld, 1995)

This chapter explains the methodological position of the present research. A qualitative descriptive research method is adopted for the study wherein the theoretical paradigm, perspective, research strategies, and methods of data collection and analysis are carefully planned. The term *Methodology* defines how one will go about studying any phenomenon. It comprises a preference for certain methods among the many available, a theory of scientific knowledge, a range of solutions and a systematic sequence of procedural steps to be followed (Silverman, 2006).The chapter ends with the way interpretation and evaluation of the research is executed.

Qualitative research is a field of inquiry in its own right. It crosscuts disciplines, fields and subject matters. Therefore, the present study which addresses Psychiatry, Ayurveda, Homeopathy and Naturopathy on the basis of their conception of abnormal behavior can best be designed only on qualitative research method. Each system has different theoretical base and this foundation can suitably analyzed with the help of qualitative research paradigm. Denzin and Lincoln (2005) also says, "Qualitative research embraces two tensions at the same time. On the one hand, it is drawn to a broad, interpretive, post experimental, postmodern, feminist, and critical sensibility. On the other hand, it is drawn to more narrowly defined positivist, post positivist, humanistic and naturalistic conceptions of human experience and its analysis. Further, these tensions can be combined in the same project, bringing both post modern and naturalistic or both critical and humanistic perspectives to bear."

Qualitative research has separated and distinguished histories in psychology, medical science, history, education, social work, organizational studies, anthropology and sociology. These separate and multiple uses and meanings of the methods of qualitative research make it difficult for scholars to agree on any essential definition of the field, for it is never just one thing. Denzin and Lincoln (2005) borrow Nelson et al.'s (1992) definition of QR in cultural studies here:

"Qualitative research is an interdisciplinary, transdisciplinary, and sometimes counterdisciplinary field. It crosscuts the humanities and the social and physical sciences. Qualitative research is many things at the same time. It is multiparadigmatic in focus. Its practitioners are sensitive to the value of the multimethod approach. They are committed to the naturalistic perspective and to the interpretive understanding of human experience. At the same time, the field is inherently political and shaped by multiple ethical and political positions".

The present research attempts to link theoretical perspectives of natural sciences with that of social sciences. Medical sciences which follow the scientific, positivist, naturalistic paradigm, are analyzed with the interpretive, constructionist paradigm of social sciences through qualitative research method.

2.1 Theoretical paradigm of the research

A complex, interconnected, family of terms, concepts, and assumptions surround the term *qualitative research*. These include the traditions associated with foundationalism, positivism, post foundationalism, post positivism, and the many qualitative research perspectives, and/or methods connected to cultural and interpretive studies.

A strong and clear theoretical perspective, which is a set of assumptions about the nature of reality and scientific knowledge, is necessary in designing qualitative research. As

Martin O'Brie (1993, cited from Silverman, 2006) says: "….. we can see social theory as a sort of kaleidoscope – by shifting theoretical perspective the world under investigation also changes shape."

In choosing the research design and analytical processes, it is essential to be able to identify which of the epistemological traditions the researcher has chosen to work within. It will give the researcher a more in-depth perspective of their influences on qualitative research the researcher seek to justify the research choice.

2.1.1 Epistemological positions

The term 'epistemology' comes from the Greek language, with *episteme* meaning knowledge and *logos* meaning theory. Epistemologies deal with questions about 'truth': what do we accept as truth? And how has this been constructed? Our claims to knowledge about the nature of being and reality (ontology) are also questioned: what do we know? And how can we know this? (Grbich, 2007).

What constitutes truth and (acceptable knowledge) has been a source of considerable argument over the last 200 years. There are four broad epistemological traditions impacting upon qualitative research within which claims for 'truth' have been made:

- Positivism/empiricism
- Critical emancipatory positions
- Constructivism/interpretivism
- Postmodern and poststructural positions

The researcher has adopted Constructivism/interpretivism and postmodernism as the knowledge tradition for the present research.

2.1.1.1 Constructivism / interpretivism

These positions assume that there is no objective knowledge independent of thinking. Reality is viewed as socially and societally embedded and existing within the mind. This reality is fluid and changing and knowledge is constructed jointly in interaction by the researcher and the researched through consensus. Knowledge is subjective, constructed and based on the shared signs and symbols which are recognized by members of a culture. Multiple realities are presumed, with different people experiencing these differently (Grbich, 2007).

The present research looks at these traditions in such a way that the concepts of medical sciences are believed to be constructed within wider social environments. The research focus is on the interpretation of medical sciences in terms of normality/abnormality dichotomy and how do they dealt in medical sciences, thereby. This paradigm gives freedom to the researcher in taking a stand where such interpretations are seen as limited by social, cultural and political frames. The subjectivity (the researcher's own view and how they have been constructed) and intersubjectivity (reconstruction of views through interaction with others via oral language and written texts) are also of interest for the researcher.

2.1.1.2 Postmodernism

As we moved toward the last decades of the twentieth century, literature began to mirror the changes in the economy, science, art and architecture by portraying reality as shifting and uncertain rather than set, and by incorporating multiple perspectives from a range of disciplines such as music, philosophy, psychology, sociology, and drama as well as including visual possibilities (Grbich, 2007).

Postmodernism views the world as complex and chaotic and reality as multiply constructed and transitional – unable to be explained solely by grand narratives or metanarratives (such as Marxism and Buddhism which make universal claims to truth). Postmodernism is very skeptical of such narratives, viewing them as containing power-laden

discourses developed specifically for the maintenance of dominant ideas or the power of individuals. The search for reality 'out there' is qualified by the understanding that society, laws, policies, language, discipline borders, data collection, and interpretation are all socially and culturally constructed. In recognition of this socially constructed nature of the world, disruption, challenge, and a multiplicity of forms are essential in order to pull these constructions epact and to expose them for what they are. Meaning rather than knowledge is sought because knowledge is limited by 'desire' (lack of knowledge or the imperative to being about change) and constrained by the discourses developed to protect powerful interests and to control the population's access to other explanations. Truth is multifaceted and subjectivity is paramount (Grbich, 2007).

The most apt characteristic of postmodernist perspective for this research is deconstruction. As social constructions and questionable discourses are increasingly seen to dominate knowledge, meanings become recognized as individual creations which require interpretation, negotiation and deconstruction. The age old questions on mind and body, health and illness and normality and abnormality dichotomies are attempted to explore once again through various medical models in this research. According to postmodern perspective, such an interactive communication becomes the context in which knowledge is clarified. Deconstruction of the power dimension of knowledge and accepting the relativity of knowledge as all are individual and situational constructions, provides a common platform for further negotiations and discussions.

Cultural understandings of health and illness models are highlighted where multiple realities are accepted. Different realities of medical sciences are believed to be subjected to formation, reformation, construction, deconstruction and reconstruction.

As Grbich (2007) says:

"No one view or group of views can be privileged over any others. All are "valid." Different contexts with different situations and different people allow different identities to be

constructed or foregrounded. There is an emphasis on multiple voices providing multiple perspectives but offering no finite answers."

The present research adapts such an approach wherein all views or ideas of health and illness are thought as being transitional, time limited, context bound and liable to change with the advent of new knowledge.

2.2 Research Strategies

In undertaking qualitative research, apart from deciding the research questions and identifying preferred epistemological traditions, research strategies need to be planned. The research strategies comprise:

- Research design
- Sampling
- Methods of data collection
- Designing field work strategies and material

2.2.1 Research design

A good research design is clearly defined, with coherence between research questions and methods, which will generate valid and reliable data and which can be achieved within the available resources. But social research always involves an element of the unknown and qualitative research offers the particular advantage of flexibility. In practice, the relationships between study design, theory and data collection are iterative, and each should inform and be informed by others. Research design is therefore not a discrete stage but a continuing process.

Grbich (2007) suggests that a good qualitative research design needs to identify and address a few issues. They are frames and framing, the position and power of the researcher, the position of the reader and research design approaches. A frame is provided by the specialist disciplines we are attached to, which gives a set of frames in terms of the theories, concepts and models which have gained explanatory dominance. I have adapted *intertextual frame* which are interpretive frames I am partial to or dominated by from the discipline of Psychology. Constructivist/Interpretive and postmodern approaches have been identified on which the research design would be built.

A postmodern position of the researcher is undertaken where the voice of the researched is of prime importance and the voice of the researcher will be one of many. The readers are encouraged to interact in a more dynamic way with the text by virtue of the gaps the researcher provide and they are also allowed to come to their own interpretations.

Grbich (2007) talks about four major traditions of inquiry: iterative, subjective, investigative, and enumerative. The present research undertook an ***iterative (hermeneutic), descriptive, evaluative, postmodern approach*** to explore the logic of the conceptual schemes of abnormal behavior on the basis of medical sciences. Iterative approaches involve

seeking meaning and developing interpretive explanations through processes of feedback. An iterative design is defined as one involving a series of actions of data collection which are repeated until the accumulated findings indicate that nothing new is likely to emerge and that the research question has been answered. As the present research is a theoretical one based on the analysis of medical texts, the data was subjected to analysis to determine 'what is going on' in order to build up a picture of the data emerging and to guide in the next set of data collection.

As the research question was intended to study and understand the concepts of normality and abnormality, *a descriptive, evaluative approach* is suitable. Description and then evaluation of the theories of medical sciences has been incorporated on the postmodern approach. A postmodern research design gives scope for the inclusion of the researcher's own bias and judgments in the interpretation.

The research design can also incorporate a comparative approach because multiple views on health and illness are being addressed which are derived from four various medical systems. A comparative dimension of reality will bring out the similarities, differences and contradictions between these different medical perspectives on abnormal behavior.

2.2.2 Sampling

A good research design always comprises of good sampling. Qualitative research samples are small for good reasons. There is a point of diminishing return where increasing the sample size no longer contributes to the evidence. The sample does not need to be large enough to support statements of prevalence or incidence, since these are not the concern of qualitative research. It is impossible to do justice to the richness of the data yielded if the sample is large scale. But their small scale only works if good purposive or theoretical sampling has taken place (Ritchie & Lewis, 2003).

Qualitative research studies use non-probability samples, the most robust approaches to which are criterion based or *purposive sampling and theoretical sampling*. The latter one is adopted for the present research.

Theoretical sampling

Theoretical sampling is a particular kind of purposive sampling in which the researcher samples incidents, people or units on the basis of their potential contribution to the development and testing of theoretical constructs. The process is iterative: the researcher picks an initial sample, analyzes the data, and then selects a further sample in order to refine his or her emerging categories and theories. This process is continued until the researcher reaches 'data saturation' or a point when new insights would be obtained from expanding the sample further (Ritchie & Lewis, 2003).

Theoretical sampling is undertaken for the present research because the research objectives are of theoretical purpose and theoretical relevance. Strauss and Corbin (1998, cited from Ritchie & Lewis, 2003) suggest that different sampling strategies be adopted at different stages of a research project. Initially, while categories are being identified and named, sampling is open and unstructured. As theory develops and categories are integrated along dimensional levels then sampling becomes more purposive and discriminate in order to maximize opportunities for comparative analysis.

Sample Frames and Sample

The sample frame used needs to be a comprehensive and inclusive basis from which to select the sample. There are broadly two key types of sample frames: existing lists or information sources, and sample frames that need to be specifically generated for a research study ((Ritchie & Lewis, 2003).

Existing information sources have been used for the present sampling purpose. The original texts or medical textbooks which are commonly used in the training of medical students are the sample frames for the present research. Those texts are decided to be sampled after the discussion with medical practitioners. The books adopted for sampling purpose are mentioned in the previous chapter.

The experts selected for individual interview and paired (or triad) interview are medical practitioners from the four medical systems, clinical psychologists, philosophers, academician, researchers, historians, pharmacists, medical students, psychology student etc. Selection of experts is mostly from different districts of Kerala and Bangalore.

2.2.3 Methods of data collection

The third aspect of research strategy is the choice of data collection methods. These decisions flow from the research questions, but they may also be influenced by the context, structure and timing of research.

The data collection methods followed in this research are:

1. Textual analysis
2. Individual interview

2.2.3.1 Textual analysis

Textual analysis is considered as naturally occurring data collection method as it will provide first hand information to the researcher about the subject matter. The original texts of four medical systems are analyzed to describe the research phenomenon in its context in which the research issue is located and how the system relates to it. As the discussions on normality/abnormality and health/illness is so bound up with social and cultural factors that generated data alone cannot be expected to give a truthful account. Therefore, the descriptive account of the models of health and illness are explored as preliminary and primary data.

2.2.3.2 Individual Interview

Individual interview is a generated data collection method which employed the role of researcher and participant interpretation. The experts from different medical systems and related fields are interviewed individually to convey their own meanings and interpretation through the explanations they provide, whether spontaneously or in answer to the researcher's probing. The interviews were of semi-structured in nature wherein the researcher has planned open-ended questions beforehand itself and then led the interview. They provide an understanding of deeply rooted issues in the research concern and opportunity for clarification and very detailed subject coverage.

2.2.3.4 Fieldwork Strategies and Materials

Despite the use of the term 'unstructured data collection', any qualitative research study requires some early consideration of the structure and content of data collection. The degree to which subject coverage and order can be specified in advance will vary, depending on the objectives of the research and the nature of data required.

The data collection is structured based on the research questions framed. It begins with textual analysis in order to get a mental picture about how different medical systems

theoretically place abnormal behavior. Textual analysis makes the researcher familiarize with the issues and debates about the subject matter, the nature of researches in the field, the kind of critical studies and perspective.

This stage is followed by the individual interview and paired (or triad) interview. The researcher identified the experts from different disciplines conveniently and interviewed them with the help of semi-structured interview schedule. *Field notes* were prepared which provided an opportunity to record what researchers see and hear outside the immediate context of the interview, their thoughts about the dynamic of the encounter, ideas for inclusion in later fieldwork and issues that may be relevant at the analytical stage.

The researcher does not stick rigidly to this order of data collection in the field, but employs a flexible approach which helps to explore issues earlier or later than envisaged.

2.3 Nature of Analysis/Interpretation

Analyzing and interpreting the findings from a qualitative research is a challenging and exciting phase. It requires a mix of creativity and systematic searching, a blend of inspiration and diligent detection. There are many different tradition and approaches for analyzing qualitative data which vary with epistemological assumptions about the nature of the qualitative enquiry, the status of researcher's accounts and the main focus and aims of the analytic process (Ritchie & Lewis, 2004).

The present research has undertaken focuses Thematic Analysis as the method of analysis to understand the concept of abnormal behaviour on the logical foundations of medical sciences. Thematic analysis is a process where data are segregated, grouped, regrouped and relinked in order to consolidate meaning and explanation prior to display. This technique gives a further option depending on how much decontextualizing and segmenting the researcher regard as appropriate or desirable.

Several writers have distinguished between analytical approaches according to their primary aims and focus. The present research follows three different contexts of interpretation given by Kvale (1996, cited from Ritchie & Lewis, 2004).

a) Self understanding where the researcher attempts to formulate in condensed form what the participants themselves mean and understand;

b) Critical common sense understanding where the researcher uses general knowledge about the context of statements to place them in a wider arena; and

c) Theoretical understanding where the interpretation is placed in broader theoretical perspective.

Based on the above mentioned contexts, an analytic hierarchy is planned which comprises a series of 'viewing' platforms, each of which involves different analytical tasks, enabling the researcher to gain an overview and make sense of the data. Miles & Huberman (1994, cited from Ritchie & Lewis, 2004) describe qualitative analysis 'as a process of moving up a step on the abstraction ladder.' The analytic hierarchy is given in the Table 2.1.

Table 2..1 The analytic hierarchy: A depiction of the stages and processes involved in qualitative analysis

<table>
<tr><td>Seeking applications to wider theory/
Policy strategies</td><td rowspan="2">EXPLANATORY ACCOUNTS</td><td rowspan="2">Iterative process throughout analysis</td></tr>
<tr><td>Developing explanations (answering how and why questions)</td></tr>
<tr><td>Detecting patterns (associative analysis and identification of clustering)</td><td rowspan="5">DESCRIPTIVE ACCOUNTS</td><td>Assigning data to refined concepts to portray meaning</td></tr>
<tr><td>Establishing typologies</td><td>Refining and distilling more abstract concepts</td></tr>
<tr><td>Identifying elements and dimensions, refining categories, classifying data</td><td>Assigning data to themes/ concepts to portray meaning</td></tr>
<tr><td>Summarizing or synthesizing data</td><td rowspan="2">Assigning meaning</td></tr>
<tr><td>Sorting data by theme or concept in cross-sectional analysis)</td></tr>
<tr><td>Labeling or tagging data by concept or theme</td><td rowspan="2">DATA MANAGEMENT</td><td rowspan="2">Generating themes and concept</td></tr>
<tr><td>Identifying initial themes or concepts</td></tr>
<tr><td colspan="3">RAW DATA</td></tr>
</table>

The analysis and interpretation and then the formulation of the findings are planed mainly on the philosophical issues posed by the medical sciences in terms of abnormal behavior. The data collected so far would be analyzed on the philosophical issues of health-illness dualism and relate them on the background of psychology. Through this process, the emergent categories and theories would be identified and explanations would be developed. The concepts derived would be compared with a priori models and theories.

The final chapter talks about the nature of outputs from the research. It would comprise of major findings and hypotheses generated based on detailed descriptions

mentioned in the previous chapters. By answering ‘what is,’ ‘how’ and ‘why’ questions, the formulation of the findings encompass a wider social and cultural context of the theoretical construct of health and illness at hand.

Chapter III

CONCEPT OF HEALTH AND ILLNESS

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CONCEPT OF HEALTH AND ILLNESS

"If you talk to God, you are praying;
If God talks to you, you have schizophrenia.

If the dead talk to you, you are a spiritualist;
If God talks to you, you are a schizophrenic".

Thomas S. Szasz (1973)

No discipline could survive and flourish until and unless it is supported with strong and clear concepts and systematic theories for testing and evaluation. Concepts have evolved over thousands of years, and they are learnt, shared and tested by individuals in the course of putting them to practical use, in communicating with other people, making impressions of behavior, and even in organizing and modifying relevant conceptions. According to Stanford Encyclopedia of Philosophy, (2006) concepts, pretheoretically, are the constituents of thoughts. But the pre-theoretic notion only goes so far as an entry point into philosophical theories of concepts. This is partly because *concept* has become a term of art among philosophers and partly because of the diversity of projects and concerns that tend to get lumped under this one heading. According to Sloman (1978) **all concepts are theory-laden**. In using and analyzing them we are unwittingly making use of elaborate theories about language, mind and society. The concepts could not be used so successfully in intricate inter-personal processes if they were not based on substantially true theories. Disputes about concepts often reflect deeply opposing approaches to the study of the mind, language, and even to philosophy itself.

Sloman (1978) continues that most of the theoretical presuppositions of our ordinary concepts are **not concerned with laws or regularities, but with possibilities**. For example, the use of a concept like *careful* is based on our knowledge that people can act in certain

ways, not on any laws about how they always or usually act. Similarly, concepts on the mechanism of mind outline some possibilities rather than regularities.

SECTION I:

3.1 Philosophical study on concepts and conceptual analysis

Study on concept and conceptual analysis is one among the many intellectual exercises done by philosophers for the following objectives in mind:

- To discuss the similarities and differences among concepts and related concepts
- To address philosophical problems that arises out of confused reflections on things.
- To prevent muddled thinking and to make the subtle differences in the ways the concepts work explicit.
- To enhance the role of social and cultural factors in forming concepts.
- To offer a normative guidance to any discipline.
- Moreover, to place philosophy as a priori discipline in understanding any theoretical issues.

The researcher would like to fours on a few issues which would be considered as relevant to the present study. A brief introduction on the ontology and structure of concepts would be able to structure our discussion on the concept of normal and abnormal behaviour. The empiricism and nativism about concepts explains that how much of the conceptual system is innate.

3.1.1 The ontology of concepts

The ontological status of a concept identifies concepts with mental representations, with abilities, and with Fregean senses. (Stanford Encyclopedia of Philosophy, 2006). **Concepts as mental representations** view maintains that concepts are psychological entities, taking as it's starting point the representational theory of the mind (RTM). According to RTM, thinking occurs in an internal system of representation. Beliefs and desires and other propositional attitudes enter into mental processes as internal symbols. What makes these beliefs, as opposed to desires or other psychological states, is that the symbols have the characteristic causal-functional role of beliefs.

According to **the abilities view**, it's wrong to maintain that concepts are mental particulars—concepts are neither mental images nor word-like entities in a language of thought. Rather, concepts are abilities that are peculiar to cognitive agents (e.g., Brandom 1994, Dummett 1993, Millikan 2000).

The view that **concepts are Fregean senses** identifies concepts with *abstract* objects, as opposed to mental objects and mental states. Concepts are said to be the constituents of propositions. For proponents of this view, concepts mediate between thought and language, on the one hand, and referents, on the other.

3.1.2 The structure of concepts

The concepts are structured under different theoretical explanations. They are, Classical theory, Prototype theory, Theory theory, Conceptual atomism and Pluralism about structure. (Stanford Encyclopedia of Philosophy, 2006). The classical theory and the prototype theory are explained below.

3.1.2.1 The classical theory

In one way or another, all theories regarding the structure of concepts are developments of, or reactions to, the *classical theory of concepts*. According to the classical theory, a lexical concept *C* has definitional structure in that it is composed of simpler concepts that express necessary and sufficient conditions for falling under *C.* It offers unified treatments of concept acquisition, categorization, and reference determination. Concept acquisition can be understood as a process in which new complex concepts are created by assembling their definitional constituents. Categorization can be understood as a psychological process in which a complex concept is matched to a target item by checking to see if each and every one of its definitional constituents applies to the target. And reference determination, is a matter of whether the definitional constituents do apply to the target.

The criticisms of classical theory say that certain categories are taken to be more representative or typical and that typicality scores correlate with a wide variety of psychological data. Another criticism is that more typical items are categorized more efficiently. The problem isn't that the classical theory is inconsistent with results like these but that it does nothing to explain them. In philosophy, the classical theory has been subjected to a number of criticisms but perhaps the most fundamental is that attempts to specify definitions for concepts have a poor track record. The traditional definition of some concepts is incorrect or at least incomplete. It could be that the problem is that definitions are hard to come by. But another possibility—one that many philosophers are now taking seriously—is that our concepts lack definitional structure.

3.1.2. 2 The prototype theory

A non-classical alternative that emerged in the 1970s is the *prototype theory*. According to this theory, a lexical concept *C* doesn't have definitional structure but has probabilistic structure in that something falls under *C* just in case it satisfies a sufficient number of properties encoded by *C*'s constituents. The prototype theory has its philosophical roots in Wittgenstein's (1953/1958) famous remark that the things covered by a term often share a family resemblance, The prototype theory is especially at home in dealing with the typicality effects that were left unexplained by the classical theory. One standard strategy is to maintain that, on the prototype theory, categorization is to be understood as a similarity comparison process, where similarity is computed as a function of the number of constituents that two concepts hold in common.

The prototype theory does well in accounting for a variety of psychological phenomena and it helps to explain why definitions may be so hard to produce. But the prototype theory has its own problems and limitations. One is that its treatment of categorization works best for quick and unreflective judgments. Yet when it comes to more reflective judgments, people go beyond the outcome of a similarity comparison. Another criticism that has been raised against taking concepts to have prototype structure concerns compositionality. When a patently complex concept has a prototype structure, it often has emergent properties, ones that don't derive from the prototypes of its constituents. Further, many patently complex concepts don't even have a prototype structure (Fodor & Lepore 1994; Fodor, 1998 cited from Stanford Encyclopedia of Philosophy, 2006).

3.1.3 Empiricism and nativism about concepts

Empiricists maintain that there are few if any innate concepts and that most cognitive capacities are acquired on the basis of a few relatively simple general-purpose cognitive mechanisms. Nativists, on the other hand, maintain that there may be many innate concepts and that the mind has a great deal of innate differentiation into complex domain-specific subsystems.

In recent years, the debate over innate concepts has been reinvigorated as advances in cognitive science have provided philosophers with new tools for revisiting and refining the traditional dispute (Pinker 1994; Elman et al. 1996; Carruthers, Laurence, & Stich 2005 cited from Stanford Encyclopedia of Philosophy, 2000). Philosophers have greatly benefited from empirical studies in such diverse fields as developmental psychology, evolutionary psychology, cognitive anthropology, neuroscience, linguistics, and ethology. Part of the philosophical interest of this work is that, while the scientists themselves take sides on the empiricist-nativist dispute, their theories and data are often open to interpretation (Stanford Encyclopedia of Philosophy, 2006).

Is the question of disease biological or philosophical?

Because **mental illness** strikes at the very essence of human's nature, human beings always needed a science that could penetrate to where the natural sciences cannot probe into the universe of human's mind. A quick glance through the history of medicine and history of philosophy of medicine could bring out the cyclic nature of the origin of the concept of health and illness. Each medical science is evolved and developed based on the timely changes that happened in these concepts. The way each system diagnoses and treats diseases depends heavily on the way it defines and conceptualizes them. We could see that historically, attempts have been continued to find out the fundamental philosophical

concepts of health and illness. It addresses the historical, conceptual, ethical, metaphysical, social and epistemological issues that arise in each community.

What is an illness? Is it an absence of healthy conditions? Is it an entity? Is it an imbalance? Is it something that normally distributed in a bell- shaped curve? Is it a deviation from a norm of health? How do we approach the concept of illness?

The present research attempts to readdress some of these fundamental philosophical questions based on Allopathy, Ayurveda, Homeopathy and Naturopathy. This chapter analyses the "Concepts" put forward by these medical systems on health and illness. This chapter is structured in the following way:

A. The notions of health and illness theorized by Allopathy, Ayurveda, Homeopathy and Naturopathy would be described and presented.

B. Analysis of the concepts of health and illness in four medical systems in relation to the categories/ issues emerged.

Even though the researcher titled the study on the psychological dimension of abnormality-normality paradigm, the terms Health, Illness, Disease, Disorder, Dysfunction would be used concurrently as and when they are appropriate.

SECTION II :

3.2 The concepts of health and illness in medical sciences

In this section, the concepts or notions of health and illness followed by Allopathy / Psychiatry, Ayurveda, Homeopathy and Naturopathy are described. Each system is presented in terms of its concepts of Life, Health, Healthy personality, Disease/ Disorder, Illness and their conceptual issues.

3.2.1 Allopathy/ Psychiatry

The term Allopathy[1] is coined by Samuel Hahnemann, the proponent of Homeopathy which means *treatment by opposites*. This is also called as *the other suffering*. The mainstream medical field, Allopathy and its concepts are built on the Biomedical model. Psychiatry is a branch/ specialty in the Western medicine. Radden (2000) talks in his book Philosophy of Psychiatry that psychiatry is a branch of medicine and a healing practise with subject matter and presuppositions that are deeply and unavoidably philosophical. Bentall (2003) notes that despite important developments elsewhere, the world centre of psychiatry and most other medical specialties in the nineteenth century was Germany. It was a German, Johann Christian Reil, who first coined the term 'psychiatry' from the Greek 'psyche' (soul) and 'iatros' (doctor).

Mental disorder and mental health care engage philosophical ideas. Psychiatry still cleaves to its traditional self-conception as a biological science and medical subspecialty, and the philosophical presuppositions within psychiatry spotlights the need for philosophical approaches to this branch of medicine.

3.2.1.1 The Biomedical Model

A model is defined as a conceptual system of explanatory constructs organized according to a series of assumptions with respect to a particular range of phenomena. The medical model is a multilevel, multifaceted system as it deals with the complex phenomenon of disease. Braunstein (1981) explains biomedical model as the traditional medical model of disease where etiology is attributed to a biologic agent that may originate either internally (e.g. genetic defect) or externally (e.g. infectious agent). The means by which the agent produces disease is referred to as pathogenesis, a process that is described in biochemical and

[1] The field of Allopathy is known in different names such as Western medicine, English medicine, Cosmopolitan medicine, Modem medicine, Orthodox medicine to name a few. For the present research these terms would be used concurrently, at the same time, Allopathy would be used frequently as it is commonly used.

physiological terms. Clinical diagnosis depends on an analysis of a patient's symptoms and signs plus the use of ancillary diagnostic methods such as laboratory tests and x-rays. Treatment of disease is designed to control or eliminate the causative agent and reverse the biochemical, physiological, and structural changes that have taken place. According to Engel (1978), this model is the dominant model of disease today with molecular biology its basic scientific discipline. Figure 3.1 represents the traditional biomedical model of disease.

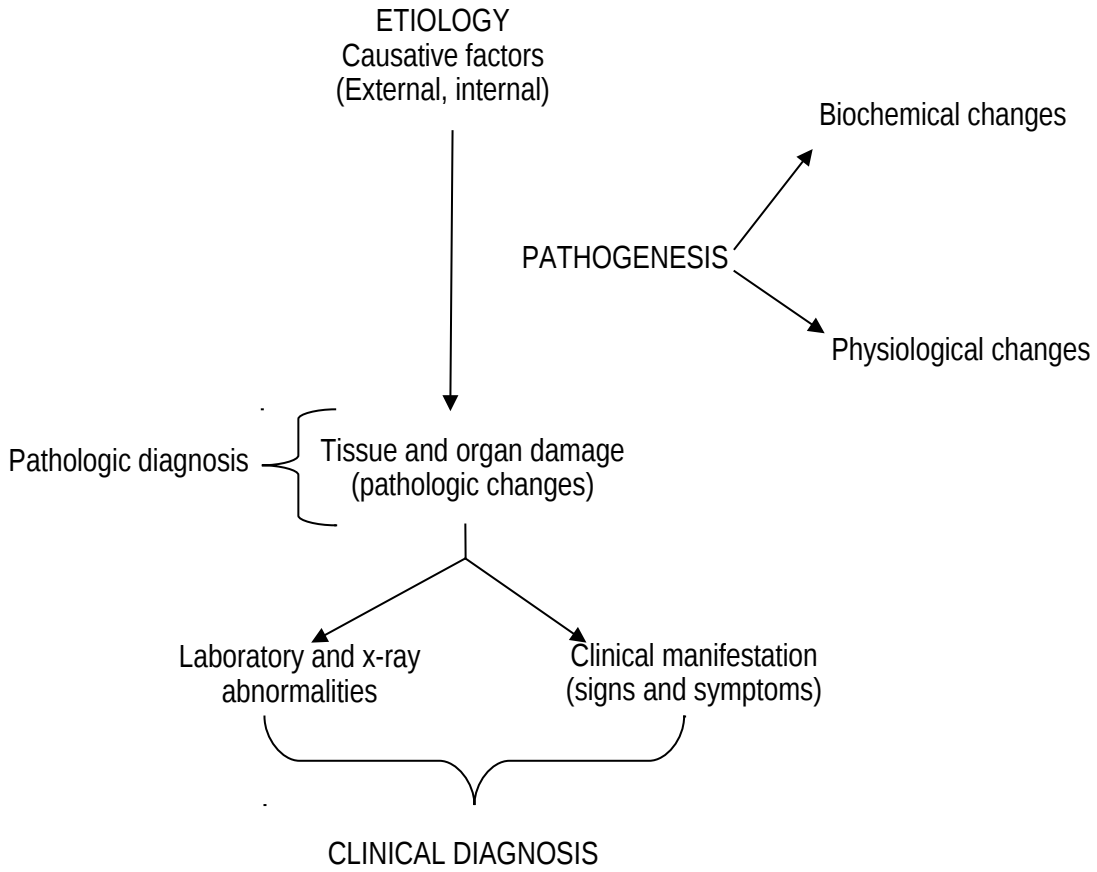

Fig. 3.1: The traditional biomedical model of disease (cited from Braunstein, 1981)

Despite the many important benefits that accrued from the disease-oriented approach, it became obvious in the 1960s that there were serious deficiencies. The medical model is failed to give adequate attention to several important aspects of health-care delivery. Medical personnel also neglected measures designed to promote and maintain health,

especially preventive care. Increased mortality rate due to acute infectious diseases and chronic degenerative diseases and inability of the system to meet the needs of many segments of the public called for the need of a new model of health and ill health.

3.2.1.2 Concepts of normality and abnormality in Psychiatry

In attempting to understand and explore the concepts of mental health and illness, the researcher studied and analyzed vast literature from classic works, previous studies and lectures and discussions. Based on the available literature, I could identify four main observations. First, lots of similarities in terms of the definitions and conceptualizations of abnormal behaviour put forward by various authors is observed. Secondly, an overlapping of Psychiatric and Clinical Psychological knowledge in understanding these concepts has been found. It could be also inferred that the developments occurred in both the disciplines have been shared, borrowed and benefited from each other. This trend is very evident in the nature of the concepts of mental health and illness. When it comes to defining the subject matter, although Psychiatry and Psychology is theoretically different, they contribute to each other. Third, some of the criteria are very frequently used in the process of conceptualization of mental illness. They are, Symptoms, Standard/ Norms set by the society, Values, Adjustment with the life stressors, Ideal or above average situation (statistically or theoretically) etc. They can be broadly divided under two approaches- *problem- oriented and well-being or growth oriented.* Fourth, Psychiatry's conception of illness is comparatively clearer than its concept of health, which means the pathological approach followed by General Medicine has influenced Psychiatry, too. Offer and Sabshin (1974) analyzed that as the psychiatrists are trained to recognize the abnormal, they have had difficulty in recognizing the normal. That is not to say, according to them, that the concept of normality is a clear and concise one. On the contrary, the concept is ambiguous, has a multiplicity of meanings and usages, and is burdened by being value-laden.

While explaining the arguments and counter arguments on the status of psychiatry in medicine, Shagass (1976) expressed his helplessness with the conception of mental illness. He states, "however, I cannot go along with the idea that the medical model is the prime villain responsible for abuses, and that its exorcism from the realm of behavioral disorders will bring about improved mental health care." He states that the usage of the medical model in the singular is incorrect, as there is more than one medical model. Siegler & Osmond (1974) in their book *Models of Madness, Models of Medicine*, describe at least three major medical models. They are (1) clinical medical model, which has at its core the reciprocal dyad of doctor and patient (2) public health model; its goal is the prevention of disease and the fostering of health for a particular population and (3) a scientific model, in which the doctor's role is that of the scientific investigator. The following table summarizes the major determining variables in defining the concepts of health and illness.

Table 3.1 Variables determining the concepts of health and illness

Normality / Health	**Abnormality / Illness**
Problem oriented	
Absence of gross symptoms	Objective symptoms – physical and mental
Statistical average	Not an average – deviant extremes
Adjustment	Maladjustment
Follows norms; value-laden	Against norms
Subjective definition	Objective psychiatric diagnosis and treatment
Well-being or Growth oriented	
Well-being, positive striving Utopia or Ideal Systematic process	

Before explaining the variables that determine the concepts of health and illness, let me introduce Psychiatry's dichotomy of Normality – Abnormality and Health Illness.

Normality/ Abnormality

Conceptualization of mental illness is often reframed in dichotomous criterion known as normality versus abnormality. Several guidelines are used by people to determine normality and abnormality. Braunstein (1981) defines these terms on the basis of the prevalence of a condition, desirability of a condition and moralistic basis. Something that

occurs commonly in a population is often considered to be normal, while something that occurs infrequently is called abnormal. This generalization appears to both physical and mental disorders. Desirability strictly follows cultural and societal norms. A person's behavior is usually considered to be within the range of normality as long as it does not interfere with his interaction and relationships with others. According to moralistic basis, some mental illnesses are considered to be moral, rather than medical issues, e.g., alcoholism.

Normality is not simply about that which is common, it is governed by norms, which are a 'means of producing the common standard, a rule for common judgment that makes law possible in modern societies'. Normality**,** as understood from the nineteenth century onwards, is a principle of valorization and a mechanism for social control. Each age and culture has its distinctive normality**.** The dichotomy normality**/** abnormality is very much contested with the acknowledgement of the diversity of medical and healing traditions. This has created a nebulous state of affairs in the study of behavioral abnormalities in human beings. The present study anticipates the various ways and different perspectives the medical sciences hold on the conceptual schemes of **abnormal behaviour.**

An organized review of the various definitions of mental illness, which is explicit or implicit in recent research, is necessary, thereby highlighting their commonalities and discrepancies on both a theoretical and an empirical level. The research criteria for mental illness are explained under the following categories. The tremendous number of researches done in the field of Psychiatry gives us an impression that the studies done or documented in the field of Western Medicine and/ or Psychiatry outweigh those conducted in Ayurveda, Homeopathy and Naturopathy in recent years.

a) Symptoms

Equating the absence of gross psychopathology with normal behavior is most

prevalently used in somatic medicine, and often somewhat awkwardly, is superimposed on psychiatry (Wurmser, 1978). This idea was prevailed in the early and middle portion of the nineteenth century. This view equates normality as health, which is basically the traditional medical psychiatric approach to health and illness. Most physicians view health as an almost universal phenomenon and as a result behavior is assumed to be within normal limits when no manifest psychopathology is present. Transposed upon a scale, normality would be the major portion of a continuum and abnormality would be the small remainder. Romano (1950, cited from Offer and Sabshin, 1974) illustrated this perspective in a simple form who states that a healthy person is one who is reasonably free of undue pain, discomfort and disability. In other words, health in this context refers to a reasonable rather than an optimal state of functioning. A clinical-descriptive or syndromal definition of disease is supposed to be held by Hippocrates and his disciples, says that to constitute a recognizable and typical clinical picture, a combination of signs and symptoms should be observed to occur together (Shepherd, 1974). A symptomatic explaining of abnormal behaviour could be traced from the biomedical model of Allopathy taken by Psychiatry.

b) Statistical average

This perspective is commonly employed in normative studies of behavior and is based on the mathematical principle of the bell-shaped curve. This approach conceives of the middle range as normal and both extremes as deviant. Norms have been established and pathology is defined according to strict statistical criteria.

c) Social, cultural & other demographic factors

This criterion is popularly known as **Deviance from Social Norms**. Deviance is based not on personal standards but on the standards of society. Deviance is behaviour that is undesirably different from social expectations; such behaviour is most likely to be

considered psychologically abnormal if it is unpredictable, bizarre or dangerous. (DeWolfe, 1996).

This approach has primarily focus on fields outside the person, including all forms of environmental contingencies and interpersonal situations with a particular focus on the family, larger social settings or the cultural setting. This model attributes the presence of mental illness to the general malfunctioning of society. Illnesses are seen as evolving processes, reactions to these environmental factors, such as poverty, overcrowding, stress, pollution, competitiveness, acquisitiveness, which so significantly determine the individual's personal success or failure and the degree to which he approximates to society's ideal of the 'mentally healthy' individual. The social model widens the area of psychiatric involvement quite considerably. Now it is no longer the individual himself but the individual plus his social situation that should become the proper objects of the psychiatry's professional concern (Shepherd, 1974).

The concept of mental illness as a contrived categorization for social control and political oppression has gained popularity in the current anti-psychiatric movement for discrediting the medical model. In this view, psychiatrists are considered as the politically sanctioned "gate-keepers" of the established social system or as conspirators. Legal concepts of abnormality and mental illness can also come under this criteria wherein the nature of the pathology and its relation with regard to criminal responsibility, competency and commitment are the major concerns.

Koos (1954) demonstrated that members of the same social and cultural background tend to share similar concepts about illness. Another study by the National Opinion Research Center (King, 1962 cited from Braunstein, 1981) showed that people with different occupations, income, and education responded differently to questions about their expectations and knowledge of illness. Baumann (1961, cited from Braunstein, 1981)

surveyed people of different backgrounds to determine their definitions of health. She used three criteria of health in the study: 1) the presence of a general feeling of well being (feeling-state orientation), 2) the absence of symptoms of illness (symptom orientation), and 3) the ability to perform the activities that one wishes (performance orientation). She found that a concept of health that stresses the symptom orientation was more common among educated people and those in the upper socioeconomic classes, while a concept emphasizing the feeling-state orientation was found more often among people without much education and those in the lower socioeconomic class. Baumann noted that there was a tendency for people to become symptom-oriented once they accepted a role of a patient, because after one receives a diagnosis by medical personnel, he begins to focus on symptoms to which he previously may have been different. In the aged population, the criterion of performance is more important than the criteria of feeling-state and symptoms.

Redlich (1966) points out "any molar proposition about biological health and illness will depend on the **precise context** in which it occurs as well as on the general cultural setting" (cited from Braunstein, 1981). Grinker and associates (1962) suggests that health is dependent on factors such as coping, defenses, internal compensation, age, cultural and social attitudes and the like, and that health may be maintained when strains affecting one part of the mind and body are compensated for by another part. Feinstein (1980) also stresses the vital role played by psychosocial factors in the health of an individual. He says, "good health is not an attribute of a person or group of people which happens by chance or which exists unrelated to other aspects of living. It is an integral part of life affected by education, social class, diet, income, and many other factors." Some of the other factors are environment (living and work), lifestyle, interpersonal relations, personal habits, access to health care and occupation (cited from Braunstein, 1981). Scott (1958) says that when conformity to societal expectations is equated with mental health, the possibility that the social system, or even an

entire society, may be 'sick', and conformity to its norms would constitute mental illness, stands apart.

d) Values

Researchers take the position that mental health criteria must be based on an explicit set of values. Philosophical discussions on this issue focus much on the moralistic base of mental illness. Davis (1938, cited from Thornton, 2004)) strongly puts forward the idea that mental hygiene has inevitably been influenced by the Protestant ethic inherent in Western culture. The main features of this Protestant ethic, as seen by him, are its democratic, worldly, ascetic, individualistic, rationalistic and utilitarian orientation. To the extent that it is based on some other set of "absolute" norms for behavior, it is probably biased toward some other cultural configuration.

Thornton (2004) brings out Bill Fulford's (1999) argument that debate about the nature of mental illness and disorder centrally concerns whether values are "in" and "out" of their analysis. If the diagnostic judgment of mental illness is an evaluation – an expression of our values – rather than simply a description of the facts, then mental illness cannot be an objective matter; it cannot be a feature of the fabric of the world, independent of our own perspective. Such an argument matches with Szasz's influential attack on the status of psychiatry (Thornton, 2004). It is because judgments of mental illness are evaluative that they lack the objectivity of judgments of physical disease. Szasz goes on to argue that because diagnosis of mental illness is evaluative, psychiatry – the discipline that charts mental illness – cannot be a science.

Gert & Culver (2004) say that DSM's definition of mental disorder is criticized by two quite distinct and opposing views. The first kind of definition of Christopher Boorse provides an objective account of mental disorder solely in value-free scientific terms. The second kind

of definition by Tristam H. Engelherdt and Peter Sedwick define mental disorder solely in society-based value terms. According to Kendell, "*the most fundamental issue and also the most contentious one, is whether disease and illness are normative concepts based on value judgments, or whether they are value-free scientific terms; in other words, whether they are biomedical terms or sociopolitical ones.*" Thus Kendell, in a paradigm of the fallacy of assumed equivalence, accepts the view that biomedical terms are value-free scientific terms and that normative concepts based on value judgments are sociopolitical terms (cited from Gert & Culver, 2004).

Jerome Wakefield, against these two extreme accounts, says: "*I argue that disorder lies on the boundary between a given natural world and the constructed social world; a disorder exists when the failure of a person's internal mechanism to perform their functions as designed by nature impinges harmfully on the person's wellbeing as defined by social values and meaning*" (Wakefield, 1992 cited from Gert & Culver, 2004). Wakefield defines a disorder as "a harmful dysfunction wherein harmful is a value term based on social norms, and dysfunction is a scientific term referring to the failure of a mental mechanism to perform a natural function for which it was designed by evolution."

This criteria holds the view that the concept of abnormal behaviour is value laden which calls for the treatment mehtods also to take care of this dimension.

e) Adjustment

Adjustment is necessarily determined with reference to (a) Norms of the total society or of some more restricted community within the society (b) A law or other visible sign of social norms and (c) Externally defined set of requirements for a given social system. This criterion brings considerable divergence of opinion among various segments of the public regarding what constitutes good and poor adjustment. One must specify adjustment to what and

adjustment to whose standards. The necessity for considering different personal frames of reference and the demands of different social structures poses seemingly insurmountable obstacles to the establishment of mutually consistent operational definitions (Scott, 1958).

Engel (1962, cited from Cavenar & Walker, 1983) who stresses psychosomatic medicine, focuses on both the psychological and physical, and notes the importance of the interaction between the two spheres. He views health and illness as successful or unsuccessful adaptations by individuals to their environment.

f) Subjectivity

According to the subjective (view of the majority) model, abnormality is determined by whether or not it is regarded as such by the majority of persons in a specific social setting or culture. In this model, the definition of mental illness is subjective, depending on the person's own feelings of unhappiness, suffering, inadequacy or need for help. Rogers has maintained that a marked discrepancy between one's "perceived self" and "ideal self" constitutes evidence of psychiatric disturbance. Scott (1958) pointed out that a person's own feeling of unhappiness or inadequacy is considered as a criterion of mental illness by research studies. But defining mental illness based on the patient's subjective sense of strength, confidence and well-being is not much appreciated by some researchers. It might be presumed that under some circumstances psychological defense mechanisms could operate to prevent the person's reporting or becoming aware of his own underlying unhappiness and disturbance. Jahoda (1953) has rejected happiness as a criterion for mental health by saying that "*there are certain circumstances in which to be happy would make it necessary first to be completely sick.*"

Braunstein (1981) says about the above position by naming it as **patient's perspective** in conceptualizing mental illness. He found that the patient's concepts of ill health often differ from those held by medical personnel. These affect people's perceptions of symptoms, the diagnostic labels they attach to them, the manner in which they respond to sickness and their communication with physicians. Lay concepts of ill health are based to a large extent on socially and culturally determined attitudes and beliefs. The ideas that most lay people have of disease and illness are composed of elements of scientific, magico-religious, and folk concepts.

This view also talks about two other typical standards or criteria of abnormality: **Discomfort and Disability.** They are often evaluated by one's personal standards. One is

feeling discomfort because of problems one knows best oneself, or one is inefficient compared to what expects of oneself make him abnormal. These two criteria have similarity to the general indicators of a physical disease (DeWolfe,1996).

g) Objective psychiatric diagnosis and treatment

Other-defining models are operational approaches used by behavioral researchers or social agencies as a means of creating working definitions. For example, psychopathology may be defined on the basis of exposure to psychiatric treatment, psychiatric interviews or objective psychological tests. This definition of mental illness is operational rather than conceptual, which means that anyone who is regarded by someone (hospital authorities, relatives, neighbors, or him/herself) as disturbed enough to require hospitalization or outpatient treatment is mentally ill, and people who do not fit into such diagnoses are mentally healthy. According to Scott's observation, nearly all the ecological studies and most of the studies correlating mental illness with demographic characteristics use this criterion as the most frequently used operational definition of mental illness. The reliability of psychiatric diagnosis is open to question and we can expect large errors inherent in the measuring process. One study of the association between diagnosis at Boston Psychopathic Hospital and previous diagnoses of the patients at other hospitals showed only 51% above-chance agreement between the two (Epidemiology of mental disorder, 1950 cited by Scott, 1958).

The next three criterion of the definition of Normality/ Abnormality focus on the **Well-being or growth oriented approach**. They are Utopia or Ideal, A systematic process & a positive striving. This trend could be considered as one of the remarkable changes that had happened in the approach of the Western Medicine during the later part of the twentieth century. The number of people opting for Complementary & Alternative Medicine (mostly of Eastern origin) and its significant popularity in the United States and England during 1970s and 1980s challenged the mainstream medicine to rethink and reformulate its theoretical

principles. The questions on - What is Health? Is it only the absence of gross symptoms? Is it beyond Normality? Is there something called above average health? - were understood as very pertinent and a shift needs to be done from the Biomedical model to something broader than that. Thus, within the constraints of the Biomedical model, the holistic and metaphysical aspects of the Eastern medical systems have been incorporated as an immediate solution. The WHO' s definition of Health as well-being in 1974 could also be interpreted as an urgency of the medicine to be holistic and growth oriented. This inclination finally turned to create a new model replacing the old one, which is known as Biopsychosocial model. The important characteristics, inadequacies and historical importance will be discussed later in the thesis.

h) Utopia or Ideal

Offer & Sabshin (1974) say that this perspective conceives normality as harmonious and optimal blending of the diverse elements of the mental apparatus that culminates in optimal functioning. This approach is characteristic of a significant segment of psychoanalysts who quotes Freud's statement of normality, *"a normal ego is like normality in general, an ideal fiction."*

World Health Organization brought out the official definition of health in 1948, as "health is a state of complete physical, mental, social well-being and not merely the absence of disease or infirmity." (Shepherd, 1974). Some of the critics of this definition felt it was too idealistic and impractical that to use it as a basis for the delivery of health care would involve medicine in areas that were not within its proper sphere of interest. Other critics said that the implied goal of the WHO definition of health to have a major segment of the population function optimally from a physical, psychological and social standpoint – is unrealistic and unattainable. The criticisms on biomedical model which is not broad enough to accommodate the ideal definitions of health was much stronger within Psychiatry itself and Orthodox Medicine in general.

i) A systematic process

According to Offer & Sabshin (1974), this perspective stresses that normal behavior is the end result of interacting systems that change overtime. Normality as transactional systems perspective stresses changes of processes rather than a cross-sectional definition of normality. The idea of Normality and abnormalities as results of systematic process changed the pathological or symptomatic view of looking at them.

j) Positive striving

Writers with mental hygiene orientation suggest that, though failure to live up to the expectations of those around him may constitute mental illness, one should also consider the person's failure to live up to his own potentialities (Gruenberg, 1953 cited from Scott, 1961). Frank (1953) speaks of the "positive" aspect of the mental health and Henry (1953) discusses successful adaptation of the person in the "normal stressful situation." (cited from Scott, 1958). Jahoda (1955) proposes three basic features of mental health: (a) the person displays active adjustment (b) the person manifests unity of personality and (c) the person perceives the world and himself correctly, independent, of his personal needs. Clausen (1956) has maintained that researchers must ultimately face the task of relating mental health defined in positive terms to the individual's ability to resist mental illness under stress. This approach suggests that mental health and illness may be a multidimensional phenomenon. Moreover, this approach is criticized as an application of the Protestant ethic to the mental health movement which might introduce culture and class biases to one's conclusions (cited from Scott, 1958).

Analysing the various definitions on health and illness, Scott (1961) says that the implication of poor congruence between one measure and other need to be explored. The research definitions of mental illness implicitly or explicitly contradict each other, which have

implications both for the person and for the social system. The conflicting nature of definition brings a lot of dispute into the discussion of conceptualizing mental illness. As the incompatibilities among the various approaches are not yet analyzed, further theoretical and empirical exploration on valid indicators of mental health and illness should be constituted with a multidimensional perspective. Reviewing Scott's (1961) findings makes one question**, what are the criteria which determine Psychiatry's concept and treatment of mental illness or to what extent they are inter-related.** Lack of research studies in addressing the contextual nature of the basic question also challenges today's conceptualization and practice of mental illness in Psychiatry.

3.2.1.3 DSM Definition of Mental Disorder

Diagnostic and Statistical Manual of Mental Disorder (DSM) is studied to understand the definition of mental disorder. DSM is such an officially accepted account of mental disorders that for psychiatrists to be reimbursed by an insurance company or the government for treating a patient, they must classify the patient's mental disorder by listing the number assigned to that disorder by DSM. Gert and Culver (2004) report that the definition in DSM-III-R made some important philosophical changes to the definition in DSM-III, but it made absolutely clear that deviation from a social norm by itself is never a sufficient condition for having a mental disorder. The preliminary remarks mentioned in DSM-IV make clear that **mental disorders are viewed as somewhat imprecise subclass of disorders or diseases**, which differ from physical disorders primarily in their dominant symptoms.

"..... although this manual provides a classification of mental disorders, it must be admitted that no definition adequately specifies precise boundaries for the concept of "mental disorder." The concept of mental disorder, like many other concepts in medicine and science, lacks a consistent operational definition that cover all situations.... Despite these caveats, the definition of mental disorder that was included in DSM-III and DSM-III-R is presented here

because it is as useful as any other available definitions and has helped to guide decisions regarding what conditions on the boundary between normality and pathology should be included in DSM-IV.

In DSM-IV, each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occur in a person and that is associated with present distress (a painful symptom) or disability (impairment in one or more important areas of functioning) or with a significantly increased risk of suffering, death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original cause, it must currently be considered as manifestation of a behavioral, psychological, or biological dysfunction of the person. Neither deviant behavior (example, political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the patient as described above."

(Gert & Culver, 2004)

3.2.1.4 Medical-behavioral model / biopsychosocial model

This model is developed with a realization in the medical field about the importance of behavioral (psychological, social and cultural) factors in the determination of both health and illness. Health is defined as an optimal degree of function in all these areas, while ill health is defined as dysfunction in one or more of these spheres. Disease is a biologic process in which psychological and social factors are important in terms of both etiology and treatment. Thus, this model retains the fundamental biologic viewpoint of the traditional medical model of disease, but broadens it to include a role for psychosocial factors that are relevant to health.

This model emphasizes prevention of illness. Traditional medical model proved to be less effective in dealing with many disorders for which there is no known cause or specific therapy. Biopsychosocial model views that as the biological cause of many of the major disorders is either unknown or untreatable, medical personnel have to rely on the modification of predisposing psychosocial factors in order to control them. In 1979, Surgeon General's report on Health Promotion and Disease Prevention states:

"Of the ten leading causes of death in the United States, at least seven could be substantially reduced if persons at risk improved just five habits: diet, smoking, lack of exercise, alcohol abuse and use of antihypertensive medication"

(cited from Braunstein, 1981).

The description of the conceptualization of health and illness in Allopathy gives us an idea that the concepts are of arbitrary or hypothetical in nature. Even if several criteria have been used to explain the term mental illness by Psychiatry, the concepts do not clearly give a prototypal view of mental illness. Several studies also commented on the inadequacy of biomedical model in offering a proper definition of the concept 'abnormal behaviour'. An alternative 'biopsychosocial model' is put forward which also retain the biological model as its fundamental base.

3.2.2 Ayurveda

Ëyurveda, (Ayu = all aspects of life from birth to death; Veda = knowledge or learning), the Indian medicine has a long history since Vedic period which is believed to be Upa Veda or a subsidiary teaching of *Atharva Veda*. *Ëyurveda* is comprehensive in its approach of philosophical aspects of mind and body, ideal human personality, pursuits of life as well as theories on diseases. The present day Ayurvedic concepts and treatments have been indebted to *Caraka Samhita*, *Susruta Samhita* and *Astanga Hrudaya* which are

considered to be the classic texts in *Ëyurveda*. Being known as *Upanga of Atharva Veda, Ëyurveda* as a knowledge system has strong roots in the metaphysical speculation of philosophy of *darsanas*[2]. Dasgupta (1975) had remarked *that "..... medicine was the most important to of all the physical sciences which were cultivated in ancient India, was directly and intimately connected with Samkhya and Vaisesika physics, and was probably the origin of the logical speculations subsequently codified in the Nyayasutra."* The fundamental principles of *Ëyurveda* are mostly derived from *Samkhyayoga* system and the applied principles are largely based on *Vaisesika* and *Nyaya* schools (Gupta, 1977).

3.2.2.1 Concept of Health and Illness

Roga *Vijñ*nam is a specialty in *Ëyurveda* through which the definite knowledge of disease is obtained. *Samprñ*pti or Pathology in *Ëyurveda* implies correct knowledge of the exact nature of disease as to its seat, its mode of advent or birth in the body, its principal cause and the different forms in which it manifests itself, along with a thorough understanding of the various factors working to produce a complex disease, presenting a combination of disorders at one and at the same time.

The term '*vyñ*dhi' appears at many places in Vedic literature. The different Vyñdhis, with their respective separate names have been mentioned there. The *roga paryñyah* or the synonyms of the term 'disease' used in Ayurveda are *amaya, gada, papma, jvara, vyadhi, vikara, duhkha, yaksma,atanka* and *abadha.* Each of these terms indicates a certain aspect of the disease. The disease is called *roga* because it gives rise to pain, it is *papma* because it is born from sinful acts, *jvara* because it torments, *vyñdhi* for it brings in different kinds of

[2] *Darsana* which is a noun form of the root '*drs*', refers among others to the 'act of looking at', 'seeing', 'observing', 'knowing', 'understanding', 'perceiving', 'sight', 'vision', 'the eye', 'inspection', 'examination' and 'mirror' etc. Sot it refers to the act of perception, which is both sensory and direct or unaided or aided and as well as intuitive. It deals with the knowledge obtained either by direct perception and or by intuition (Gupta, 1977).

abnormalities, *duhkha* as it causes various kinds of unhappiness, *amaya* because it is caused by *ama* (undigested, improperly processed metabolites), *yaksma* as it is a group of diseases (symptom complex, syndrome), ¡tanka for it makes life miserable, *gada* because it is produced by multiple causes and, *abadha*, for, it produces constant discomfort (to the body, mind and / or sense organs). In addition to these even the term *doÀa* is also used as a synonym to indicate the disease (Gupta,1977).

These synonyms cover the different aspects of vy¡dhi ie, physical, psychological and metaphysical considerations. In *Sabdasathoma Mahanidhi, vy¡dhi* is shown to be related to mind. Even if various writers have defined the term, all of them have used it in the sense of a state, in which both mind and body are inflicted. (Gupta,1977). *Caraka* regards that *Manas* and ár¢ra along with the *Indriyas* are the *adhisth¡na* of *vedana*. It is therefore, evident that Ayurvedists concepts of disease is both mental as well as physical.

Broadly speaking, both *Ëyurveda* and *darsanas* primarily speak about "Duhkhaniv¤tti" which means alleviation of pain. *Susruta* counts the triad of pain **(disease**) i.e., intrinsic, extrinsic and superhuman pains while describing '*vy¡dhi*'. This is derived from the *Samkhya* philosophy whish says that *duhkha* or misery is three-fold (cited from Gupta,1977):

- Misery caused by the daiva or the karma (*Ëdhidaivika*)
- Misery resulting from men, animals and inanimate objects (*Ëdhibhautika*), and
- Misery caused by intrinsic influences, bodily or mental (*Ëdhyatmika*). (Weerasinghe,1993).

The purpose of *Ëyurveda* has been described as to protect the health of a healthy person and to eliminate the ailments of a diseased man. But the purpose of the attainment of proper health is not the ultimate object of *Ëyurveda*. Health is a means, but is not the end. *Caraka* regards that "health is the supreme foundation to fulfill the scripturally posited four 'ends' (purushartha) of life, namely, *dharma, artha, kama, and moksa*." *Vagbhata* in the beginning of *Astanga Hrdaya* says, " Health is the prime need to realize the ideals of religion, acquirement of monetary gains, gratification of desires and final emancipation (*Dharma- Artha- Kama- Moksha*) and to achieve all these, great respect should be paid to the teachings and learning of *Ëyurveda*"(Gupta, 1977). As the *rogas* (diseases) are the destroyer of health – a great obstacle to humanity; it is, therefore, essential that health should be maintained to achieve these four *arthas* of life. *Moksa* – the ultimate pursuit of life in *Ayurveda* has been regarded '*mokse nivrttir nissesa*' (Gupta,1977). Health is a state of dynamic equilibrium of the bodily elements. The *Ëyurvedic* theory emphasizes the equilibrium of the three humors (*tridoÀa*) – *V¡yu* (wind), *Pitta* (bile) and *Kapha* (phlegm) as health (Kakar, 1982). Illness occurs when any one of these three humors becomes excessively "agitated" and increases disproportionately in relation to others. *Dosa dhatu sammurc¡nam* ie, the morbid interaction between the vitiated dosas and tissues is health. Each of the *doÀas* possessing its specific quantity (*pram¡´a*), qualities (guna) and functions (guna) is known as *s¡mya* (equilibrium) whereas increase (*v¤ddhi*) and decrease (*k¿aya*) in its quantity, one or more of its qualities and functions are known as its *vai¿amya* (disequilibria). The imbalance of humors occurs (and this is the general theory of the causation of disease in *Ëyurveda*) due to the excessive use, deficient use or misuse of (1) the objects of the sense, (2) action (consisting of the action of body, mind and speech) and time, i.e., the different seasons (Kakar, 1982).

The restoration of the balance of bodily elements and thus of health rests on the consumption of environmental matter in the right form, proportion, combination and at the right time. After ascertaining the nature of any imbalance in the body, the doctor identifies a substance (or a combination of substances) in nature – drug or diet – which, when transformed within the body, will correct the humoral disequilibrium. Therefore, *Ëyurveda integrates seasons, plants, natural substances and constituents of the body in a complex yet aesthetically theory of health as equilibrium of somatic and environmental elements.*

Ëyurveda is steadfast in insisting the *medicine should always be centered on the person rather than on the disease*. It believes that the living goals of maintaining good health and deliverance from disease in ill health can be reached only if the doctor has a thorough understanding of the patient as a person. The person in his wholeness is called the "asylum" (*Ë¿raya*) of disease and constitutes the main subject of medical science. In the words of an oft-quoted verse, Mind, soul and body – these three are like a tripod; the world is sustained by their combination: they constitute the substratum for everything. This (combination) is the person (*puru¿a*), this is sentient and this is the subject matter of this *Veda*: it is for this that this *Veda* (*Ëyurveda*) is brought to light (Kakar, 1982).

3.2.2.2 Concept of mind in *Ëyurveda*

The concept of mind in *Ëyurveda*, unlike the notions held by Psychiatry and modern psychology, is regarded not as a unitary concept. *Ëyurveda* is the science of life and life according to *Ëyurveda* is the state of union of four components namely the body (*sar¢ra*), the sensory and motor faculties (*indriy¡s*), mind (*manas*) and the soul (*¡tma*).

According to *Ëyurveda*, mind known as *Satva* or *Chetas* is supersensual and is responsible for all the activities of the sense organs. *Manas* is the fifth principle of the *Samkhya* system. It is the central organ of the senses. The *Manas* acts as a center of union between perceptive and motor activity. (Weerasinghe,1993) *Manas* possesses the character of the *Indriyas* of Cognition and the character of the Indriya of Action, because its operation is in both directions (Sinha, 1979). Without the direction of *Manas*, none of the organs can function in relation to their objects. Though *Manas* is very subtle, it is (supposed to be) made up of parts; consequently it can come in contact with the different senses at the same time.

The term *Manas* occurs in different parts of the *Îgveda* with several different shades of meaning.

- *Manas*, the inner organ is considered as a seat of various mental activities.
- *Manas*, as thought or will.
- The quickness with which *Mans* functions is implied in many expressions of the *Îgveda*. We may refer, for example a few passages such as, *mano-java*, the quickness of mind (R.V.x. 71, 7). *mano-ju*, quick as mind (R.V. I.119,I.etc) and so on.
- The cosmic sense of *Manas* too is found in the *Îgveda*. *Manas* (cosmic mind) is that state when the ideal universe becomes the object, emerging into the view and forming a clearly defined picture.
- *Manas* is the central organ of the sensory functioning (*buddhi-indiriy¡ni*) is also explicit in two late *Upani¿ads*, the *Kausitaki Upanishad* and the *Maitri Upanishad* (cited from Weerasinghe,1993)

Kakar (1982) explains the functions of *Manas* as: activation, direction and coordination of the sensory and motor organs (*Indriyabhigraha*); self-regulation (*Svyasya nigraha*); Reasoning (*Uha*); and Deliberation, judgment, and discrimination (*Vic¡ra*). **Mental illness** primarily refers to the impairmet of these functions.

3.2.2.3 Concept of trigunas

There are three types of mental dispositions based on the dominance of *Trigunas*, viz., *Satva*, *Rajas* and *Tamas*.[3]

As mentioned in Samkhya philosophy, each Guna is described to possess two characteristics.

- *Sattva*- light and bright,
- *Rajas*- exciting and mobile
- *Tamas*- heavy and enveloping

Like a lamp, their function is to gain an end. (Weerasinghe,1993). In every individual, all three *Gunas* will be present, but the proportions vary from individual to individual. The diversity (of *Manas*) is owing to the difference of the transformations of the *Gunas*; as is the case with the (diverse) conditions (of a man) (Sinha, 1979). The *Guna* that is dominant will decide the characteristic features of that particular individual. Dominance of *Satva Guna* determines the *Shuddha* or *Satvika Satva*, it is considered to be pure without any taint and represents the beneficial aspect of the intelligence. Dominance of *Rajas* and *Tamas* form the *Rajasa* and *Tamasa Satvas* respectively. These are considered as tainted as *Rajasa Satva*, represents the violent aspect and *Tamasa Satva* represents the deluded aspect, hence the later two are considered as the pathological factors of the mind. Thus it infers that enhancement of *Satvaguna* in an individual makes him mentally healthy and adjusted (Kakar, 1982).

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[3] *Isvarakrsna* describes them as follows:

sattvam laghu prakasakam
istam upastabhakam calam ca rajah
guru varanaka eva tamah
pradipavac carthato vrttih.

(S.K. 13 cited from Weerasinghe,1993)

According to *Samkhya* philosophy, the mutual activities of the *Gunas* are five-fold (S.K.12):

- To suppress each other (*anyonya-abhibhava*)
- To cooperate with (= to support) each other (*anyonya- aasraya*)
- To produce each other (*anyonya- janana*)
- To consort each other (*anyonya- mithuna*)
- To exist mutually (*anyonya- v¤tti*) (Weerasinghe,1993).

Apart from these *Trigunas* various other factors also determine the *Satva* (mental disposition) of an individual. *Caraka* called these factors as *Satva Visheshakara Bhavas*, these are psychic temperaments of the parents, behaviour of mother, what she hears and reads during pregnancy, deeds of previous life and practices resulting into habits (*abhy¡sa*). He advises certain practices to bring about or built up an ideal temperament (Kakar, 1982).

3.2.2.4 The metaphysical realm of Ayurvedic concepts

Like physical and mental disorders, *Ëyurveda* considers the cycle of birth and death as spiritual disorders and *Ëyurveda* directs every man to overcome this cycle of birth and death by attaining liberation (*moksa*). Due to the common aim of elimination of pain and attaining the true salvation, both are put on the same plane, resulting thereby that it becomes impossible to a scholar of *Ëyurveda* to be indifferent to the treasure of *dar¿anas* – the Indian Philosophy (Gupta, 1977).

Ëyurveda and *dar¿anas* share the doctrine of similarity between *Loka* (Universe) and *Purusa* (living entity). This constitutional similarity between man and Universe brings the cosmological metaphysics of Indian philosophy in order to understand the physical,

psychological, and spiritual levels of the human individual. It is, therefore, the theory of '*purusoyam lokasammatah*' was established in *Caraka Samhita*. The question was raised by *Agnivesa* 'what actually is the utility of this doctrine in *Ayurveda*,' the Lord *Atreya* had replied that no one who contemplates the whole world as being in himself and himself in the world with equanimity, there is born a true understanding leading to final emancipation.

3.2.2.5 Panca-mahabh£tas and Trigunas

According to the *pancamahabh£tha* theory, everything in the universe, animate or inanimate, is made of five forms of matter – *prithvi* (earth), *agni* (fire), *v¡yu* (wind), *jala* (water) and *akasa* (space). Under favourable conditions, matter becomes organized in the form of living creatures. These living creatures constantly absorb the five elements (nutrition) contained in environmental matter, which is transformed by the fires in the body into fine portion (*pras¡da*) and refuse (*kitta or mala*).

Fundamental concepts of structural, functional and pharmacological branches of Ayurveda are based on the metaphysical doctrine of *Panca-mahabh£tas* and the psychic concepts in *Ë yurveda* are based on the well established *darsanic* doctrine of *trigunas.* Besides this, the *Panca-mahabh£tas* are the consequent evolutes of the *trigunatmaka prakrti* which in different predominance are responsible for the promotion of three *Dosas – vata, pitta*, and *kapha*, six *Rasas* (pharmacological basis of *Ayurveda*), *Dhatus* (different tissues of the body), etc. However, Ayurveda regards that *trigunas* (*Sattva*, *rajas* and *tamas*) are the basic matter for the constitution of *Panca-mahabh£tas* and each *mahabh£ta* has got its own specific *trigunatmaka* constitution. Therefore, *Panca-mahabh£tas* cannot be explained without understanding its upper cosmological link, i.e. *trigunas*, which are directly related to

ground (*prakriti*), etc. (Gupta, 1977).

3.2.3 Homoeopathy

Samuel Hahnemann (1755-1843), a German physician, consistently criticised allopathy medicine's orthodoxic practices of venesection, polypharmacy, overdrugging and barbaric treatment of the insane (Organon N. 56-60). Hahnemann first coined the word "homeopathy" ("homoios" in Greek means *similar*, "pathos" means suffering) to refer to the pathological principle, the law of similar, as its basis. Actually, the law of similars was previously described by Hippocrates and some medieval alchemists like Albertus Magnus (1193-1280), Agrippa von Nettsheim (1486-1535) and Theophrastus Paracelsus (1493-1541) and was utilized by many cultures, including the Mayans, Greeks, Native American Indians and Asian Indians, but it was Hahnemann who codified the law of similars into a systematic medical science and brought consistency within medicine (Ullman, 1995). Dr. Robert E. Dudgeon (1820-1904), a nineteenth century English homeopath quotes a long list of authors before Hahnemann, thus brings a clear acknowledgement of the medical simile prior to Hahnemann (Morrell, 2004).

As said before, Homeopathy arose as a staunch critic to the mainstream medicine, Allopathy. We could see lots of oppositions pointed against the practices of Allopathy in any of the writings of Homeopathy. An extract is added below.

"The celebrated Bouvard, physician to Louis XIII, ordered his royal patient forty-seven bleedings, two hundred and fifteen emetics and purgatives, and three hundred and twelve clysters during the period of one year! . . . . more than six million leeches were used, and more than two hundred thousand pounds of blood were spilled in the hospitals of Paris in one year. The mortality was appalling" (Close, 1924 cited from Morrell, 2004).

There were clear and largely justified criticisms of Heroic medicine. *"Of all therapies ever conceived, there is none more allopathic, senseless, and futile than Broussais's debilitating blood letting and starvation diet . . . . No sensible man could ever find any medical benefit in such treatment"* (Organon, v. 74).

3.2.3.1 Concept of disease

The concept of disease in homeopathy would seem to be quite different from that used in allopathic medicine. Disturbed and disagreed very much on that day's medical orthodoxy, Hahnemann revisited the concepts of disease, drugs and treatment in a philosophical way. According to him, the illness is not to be defined, named, or explained or its cause to be sought, but it is just to be described in ordinary language i.e., the *symptoms*. The symptoms are regarded as the *language of nature* perhaps an expression of an invisible cause or agent (Morrell, 2004). A disease consists of nothing "besides the totality of the symptoms" (Aph.18). It therefore follows that "medicines could never cure disease if they did not possess the power of altering man's state of health," and "their curative power must be owing solely to this power they possess of altering man's state of health". (Aph. 25) "The curative power of medicines, therefore, depends on their symptoms, similar to the disease but superior to it is strength, so that each individual case of disease is most surely, radically, rapidly and permanently annihilated and removed only by a medicine capable of producing (in the human system) in the most similar and complete manner the totality of its symptoms, which at the same time are stronger than the disease". (Aph. 27).

"The disease is not to be named but perceived; not to be classified but to be viewed, that the very nature of it may be discovered" (Kent, 1926 cited from Morrell, 2004).

Any 'disease' is simply a *deviation from normal health and well-being*, characterized by various symptoms in every part of the psychophysical totality. Disease per se, Hahnemann

says, is "nothing more than an alteration in the state of health of healthy individual." Caused by the dynamic action of external, inimical forces *upon the life principle of the living organism* making it known only by perceptible signs and symptoms, the totality of which represents and for all practical purposes constitutes the disease (Close, 1984). "*The totality of the symptoms must be the principle, indeed the only thing the physician has to take note of in every case of disease and to remove by means of his art, in order that it shall be cured and transformed into health"* (Morrell, 2004). The illness is purely and simply the totality of the symptoms of the patient: nothing more and nothing less. The disease is thus a rather abstract notion on homeopathy, an invisible cause (or miasm according to Hahnemann) that underlies all the visible symptoms. As in Plato and Plotinus, the disease is the "noumenon" (invisible) or hidden cause of the "phenomenon" or outer visible effects (the illness symptoms) (Morrell, 2004).

At the more subtle level, the disease actually *"depends only on a peculiar morbid derangement of one vital force in sensation and functions"* (Aph. 29). Therefore, a true homeopathic cure of the vital force deranged by the natural disease (Aph. 29), not through the removal or suppression of symptoms (Morrell, 2004).

To homeopaths, the illness is the whole person in his/her psychological reality. It is not confined to one area of the body such as a headache or skin rash, and has no conventional barriers e.g. mind or body, one organ etc. The illness and diagnosis thus overlap greatly in homeopathic medicine, and in fact blend into one another.

"Ultimately all disease symptoms (mental and physical) arise from an invisible source within the organism. External environmental factors, including bacteria and viruses, merely excite into activity disease processes already present, they are not the ultimate causes of symptoms" (Morrell, 2004).

3.2.3.2 Concept of vital force

"In the state of health the spirit-like vital force (dynamics) animating the material human organism reigns in supreme sovereignity. It maintains the sensation and activities of all parts of the living organism in harmony that obliges wonderment . . . . without the vital force the material organism is unable to feel, or act or maintain itself . . . Without the vital force the body dies and then, delivered exclusively to the forces of the outer material world, it decomposes, reverting to its chemical constituents" (Hahnemann, Organon, 1810, v. 9-10). The vital force is the concept Hahnemann uses to describe the natural healing power of the organism. He also sees it as the invisible cause of health and the harmonious functioning of the diverse pacts of the body. He likens it to the soul or spirit. Vithoulkas (1980) refers to the vital force as the 'defence mechanism' (Morrell, 2004).

Vital force equivalent to mind?

Morrel (1984) says that the vital force is the innate intelligence of the organism that is constantly striving to maintain an internal homeostasis in the face of continuous environmental change. Homeopathy strives to nurture and strengthen this vital force and to remove all agents that impede its action within the organism. Homeopathy stresses the vital force as the source of all life, ill-health and as the target for treatment. To many homeopaths the concept of the vital force has become virtually synonymous with spirit and mind. According to Close (1924), *"mind is a substance, since it acts to think or produce thoughts and things. Mind, therefore, has intelligence . . . . life and mind are one and identical . . . . mind is the primary cause of motion. Life is energy, and all energy is living energy"* (cited from Morrel,1984).

Close (1924) continues, *"Hahnemann . . . . refused to speculate about the essential nature of things. To him, spirit and matter, force and motion, mind and body, health and disease, in all their mutations and modifications, co-exist as facts of observations . . . . He was not a materialist who denied . . . . the existence of spiritual or mental phenomena are the result of some peculiar organisation of matter". "Homeopathic medical science views the*

facts . . . . from a vitalistic . . . . standpoint . . . . which regards all things and forces . . . . including life and mind, as substantial entities, having a real, objective existence". This principle holds the view that vital power of an organism could be equated with mind. The mind is considered as the supreme concept and cause which plays a major role in the healing process (cited from Morrel, 1984).

Disorder is always in relation to vital force

Organon. 10 reads like this:

"The material organism, without the vital force, is capable of no sensation, as function, no self-preservation; it derives all sensation and performs all the functions of life solely by means of the immaterial being (the vital force) which animates the material organism in health and in disease".

Organon. 11 states that morbid symptoms appear first in vital force.

"When a person falls ill it is only this spiritual, self-acting (automatic) vital force, everywhere present in his organism, that is primarily deranged by the dynamic influence upon it of a morbific agent mimical to life; it is only the vital force, deranged to such an abnormal state, that can furnish the organism with its disagreeable sensations and incline it to the irregular processes which we call disease; for, as a power invisible in itself, and only cognizable by the effects on the organism, its morbid derangement only makes itself known by the manifestation of disease in the sensations and functions of those parts of the organisms exposed to the senses of the observer and physician; that is, by morbid symptoms, and in no other way can it make itself known".

Thus Hahnemann says that it is a disorder of the activities of the internal man, a lack of harmony or lack of balance, which gives forth the signs and symptoms by which we recognize disease. These sensations constitute the language of disorder. This immaterial

vital principle, this simple substance, everywhere pervades the organism, and in disease this disorder everywhere pervades the organism, it pervades every cell and every portion of the human economy.

3.2.3.3 Diseases and the results of diseases

Most of the conditions of the human economy that are called diseases in the books are not diseases, but the results of disease (Kent, 1993). Homoeopaths view organic change as the result of disease. To call a group of symptoms a disease of one part, and another group of a symptoms a disease of another part is a great heresy and leads to errors in prescribing that can never be corrected. Morbid disturbances can be perceived solely by means of the expression of disease in the sensations and actions. In the case of a chronic disease like cancer, when someone tries to find remedy for cancer, they consider only the symptoms of cancer; that is, the symptoms that represents the results of disease and not the symptoms that represent the disease itself. There is a vast difference between the two - cancer is the result of disorder, which disorder must be turned in order and must be healed (Kent, 1993).

In defining disease it is necessary first to discriminate between disease per se, as a morbid vital process and the material results or products in which the morbid process ultimates. With the latter, homoeopathy primarily has nothing to do. It is concerned only with disease per se, in its primary, functional or dynamical aspects. It becomes necessary, therefore, in homeopathic prescribing to carefully separate the primary, functional symptoms, which represent the morbid process itself, from the secondary symptoms which represent the pathological end products of the disease (Close, 1984).

"The tangible thing which the examining physician finds in the body are not the disease, but merely its effects. It is as impossible, and therefore as futile, to try to find a

disease in the hidden interior of the organism as it would be to try to find a thought by an exploration of the interior of the brain, the electricity in the interior of a dynamic, or the song in the throat of a bird. Such things are known only by their phenomena. Metaphysically considered, they may be said to subsit in the dynamic realm as substantial entities, or forces, but as such they are perceptible only to the "inner vision", through the eye of the mind. They are "spiritually (that is, mentally) discerned". The metaphysical conception serves as an aid in the interpretation of the phenomena".

Thus, from the above explanations I summarize that *Health* is that balanced condition of the living organism in which the integral, harmonious performance of the vital functions tends to the preservation of the organism and the normal development of the individual. *Disease* is an abnormal vital process, a changed condition of life, which is inimical to the true development of the individual and tends to organic dissolution. *Vital phenomena* in health and disease are caused by the reaction of the vital substantial power or principle of the organism to various external stimuli. So long as a healthy man lives normally in a favourable environment he uncover, feels, thinks, acts and reacts in an orderly manner. If he violates the laws of life, or becomes the victim of an unfavourable environment, disorder takes the place of order, dis-ease destroys ease, he suffers and his body deteriorates. In fact, homeopathy might well be defined as the *science of Vital Dynamics.*

3.2.4 Naturopathy

I was once asked, "What is Nature Cure"? To the best of my limited capacity I replied, ending with the words. "It is really only ordinary common sense". "But you're wrong", was the rejoinder. "It's not ordinary common – sense – it's extraordinary common- sense!"

(cited from Moyle, 1950)

Naturopathy or Nature cure is a method of curing disease without the use of drugs or surgical interference. Nature cure is the art of assisting Nature to overcome disease and to maintain health. It is the dissatisfaction with allopathic methods that has caused the resurgence of Naturopathy. (Moyle, 1950). The whole 'natural' search for an eternal cure of man's illnesses started from the realization of the pioneers of naturopathy that the world's disease problem is still waiting to be solved at medical hands. At the same time, Western allopathy appears to be growing more and more insoluble every day. Because medical science having always looked to externals for the cause of disease, instead of factors at work within the body of the individual concerned, has based its whole theory and practice upon a conception as to what disease is, and how it should be dealt with, which is entirely false and misleading.

Nature cure has had a remarkably rapid development since its inception in Germany many years ago, and its great home today is America. There, through the great work of such leaders of Naturopathy as Dr. Jackson, Dr. Trall, Dr. Kellogy, Dr. Lindlahr and Dr. Tilden, it has settled itself largely in public favor, despite the hostility of orthodox medical circles. They were all orthodox medical practitioners to begin with, but seeing the futility and uselessness of the methods they were called upon to employ daily in their work of healing the sick, they instinctively turned to methods more humane and natural in their character and effect (Benjamin, 1946).

Orthopathy had its genes in 1802 in the US with the studies of Dr. Issac Jennings. Many allopathic doctors of the day threw down their bleeding lancets and join the orthopaths once they realized the truth. This medical paradigm fuelled the medical reform movement of the 1800's. What they did not accept was the germ theory, of disease, the useless and excessive use of drugs, and needless and useless surgery. They viewed sanitation as necessary, drugs as temporary expedients, and surgery was for emergencies and trauma.

They became known as the Natural Hygienists. Natural Hygiene remains a part of American history and America today.

Naturopaths had profound criticisms against allopathic and homeopathic medical systems. The Eclectic Medical Institute, Cincinnati, Ohio was a medical school founded in 1830 as protest against the allopathic and homeopathic schools of medicine of that time where Dr. John H. Tilden (author of 'Toxemia explained') received his medical education.

3.2.4.1 Laws of life

The orthopaths had 16 physiological laws of life to guide them in their understanding of the human organism.

1. Life's great law**:** Every living cell of the organized body is endowed with an instinct of self-preservation, sustained by an inherent force in the organism called "vital force" or "life force." The success of each living organism – whether it be simple or complex – directly proportional to the amount of its life source and inversely proportional to the degree of its activity.

2. The law of order**:** The living organism is completely self-constructing, self-maintaining, self-directing, self-repairing, self-defending, and self-healing.

3. The law of action**:** Whenever action occurs in the living organism, as the result of extraneous influences, the action must be ascribed to the living thing which has the power of action and not to the lifeless, the leading characteristic of which is inertia.

4. The law of power**:** The power employed, and consequently expended, in any vital or medicinal action is vital power, that is, power from within – and not from without.

5. The law of distribution**:** The power of the body, whether that power is great or little, is distributed in a manner proportionate to the importance and needs of the various organs and tissues of the body. There are five basic areas where the body expends energy (power). Mental activity (the brain), movement and muscle action, cellular metabolism, digestion and assimilation, and elimination. Of these, elimination is one most often short-changed or slighted.

6. The law of conservation and law of autolysis**:** Whenever nutritive abstinence is affected, the living organism's reserves are autolyzed in the inverse order of their usefulness, while toxic substances are being eliminated. This was a principle used for hygienic fasting under close medical supervision.

7. The law of limitation**:** Whenever and wherever the expenditure of vital power has advanced so far that a fatal exhaustion is imminent, a check is put upon the unnecessary expenditure of power; and the organism rebels against the further use of even an accustomed stimulant. Excessive physical exertion is one example. Alcoholics becoming ill at the smell of alcohol is another.

8. The law of special economy**:** The vital organism under favorable condition stores up all excess of vital funds above the current expenditure as a "reserve fund" to be employed in time of special need.

9. The law of vital accommodation**:** The response of the vital organism to external stimuli is an instinctive one based upon a self-preservative instinct which adapts or accommodates itself to whatever influence it cannot destroy or control. The ability of the living organism to adapt and tolerate is necessary to sustain life in the face of adversity and to prolong the life of the organism.

10. The law of stimulation of dual effect**:** Whenever toxic or irritating agent is brought to bear upon the living organism, the body puts forth vital resistant which manifests itself in an action at once accelerated, but also impaired. This resistance diminishes the bodily power precisely to the degree to which it accelerates action. The increased action is caused by the extra expenditure of the vital power called out, not supplied, by the stimulatory process. In consequence, the available supply of power is diminished by this amount. This law applies directly to the use of drugs and medicinals as well as the effect of toxic herbs and many of our condiments. The drugs and herbs may stimulate body action; the condiments may stimulate our sense of taste and make dull foods come to life but in the end, they are nutritional materials and must be resisted by the body.

11. The law of compensation or law of repose**:** Whenever action in the body has expended the substance and available energy of the body, sleep and/or rest is induced in order to replenish the body substance and nerve energy.

12. The law of selective elimination: All injurious substances which gain admittance by any means into the living organism are counteractive, neutralized, and expelled as fully as the bodily nerve energy supplies allow by such means and through such channels as will produce the least amount of harm to the living structure. Common roots of elimination are urine, feces, breath, sweat and skin.

13. The law of utilization**:** The normal elements and materials of life are all that the living organisms are ever capable of constructively utilizing whether it is well or sick. No substance or process that is not a normal-factor-element in physiology can be of any value in the structure of the living organism; and that which is unusable in a state of health is equally unusable in a state of illness.

14. The law of quality selection**:** When the quality of nutriment being received by the living organism is higher than that of the present living tissue, the organism will discard lower grade cells to make room for appropriating the superior materials into new and healthy tissue. Since every cell in the body, including the bones, is changed out over a seven-year cycle, if we provide superior nutrients, we gain a new and superior body on a continuing basis. Provide the body with inferior nutrients and you get a sicker and weaker.

15. The law of the minimum**:** The development of living organism is regulated by the supply of that element or factor which is least abundantly provided or utilized. The element or factor in shortest supply determines the amount of development. This particularly applies to the fetus.

16. The law of development: The development of all or any part of the living organism is measured in direct proportion to the amount of vital forces and nutritive materials which are directed to it and brought to bear upon it.

3.2.4.2 Concept of disease and health

Naturopathy recognises that disease is the result of the violation of natural laws. It holds that there exists within the body the power to overcome disease. When the natural laws are obeyed, health follows. The cure of the disease, calls for the correction of the non-observance of natural laws and for the application of such methods as will assist the healing power of the body to overcome disease. According to Naturopathy, acute diseases are understood as healing crises. It is a condition whereby the system endeavors to throw off the accumulation of poisons caused by wrong living over a period of time. Acute diseases, therefore, are beneficial. By treating them in the natural way, the naturopath observes and assists the process of self-healing (Moyle, 1950).

According to Naturopathy, the study of disease per se leads to chaos. Only knowledge of health – study of health – can give true knowledge of disease (Moyle, 1950). Health is normal vital action – "the normal play of all the functions"; and this means that state or condition in which each organ and part performs its own proper duty. Disease is just the opposite – abnormal vital action; and this means a state or condition of unbalanced circulation, in which some organs and part do more and others less than their own appropriate work.

Disease is the result of the transgression of the fundamental laws of Nature. According to naturopathy, disease owes its origin in the human body more to wrong habits of living than to anything else; and the remarkable curative value of naturopathy lay first in the fact that it allowed the body to cleans and purify itself internally, and thus throw off the impurities and waste matter which years of wrong living had accumulated therein, and which were interfacing with proper functioning. Disease is something which arises in the system solely as result of the body's attempts to rid itself of obstacles to its proper functioning, these obstacles originating in the first place from factors to work within the body of the individual concerned, and not from factors outside. Thus, instead of disease being looked upon as something inimical to the organism, and having to be fought against, as in the popular view, it is recognized as being in reality nothing else than the body's attempts – blind and unconscious though they may be – at self – cleansing and self – healing (Benjamin, 1946).

Disease is regarded, therefore, as being something directly connected with the life and habits of the individual concerned as the direct outcome of these same ways and habits of living, in fact, and not as something apart from, or foreign to them.

3.2.4.3 Body heals itself & disease is a self-healing process:

The body contains within itself the power to bring about a return to that condition of normal well-being known as health, provided the right methods are employed to enable it to do

so. The power to cure disease lies not in the hands of the doctor or specialist, but within the body itself and every living matter (cell) is endowed with the instinct of self-preservation. Where there is some damage or injury, that vital force comes into play and heals it. Disease is not inimical to the system, something to be fought against, but it is a self-healing crisis brought about by factors, which the system finds a hindrance and impediment to proper functioning. As diseases are nature's attempt at self-healing, it must never be thwarted, fought against, checked or suppressed, but helped (as it were) out of the system by an understanding of the real causes at work and by active or passive collaboration as the case may be. Disease, in short, is the result of man's own follies and mistakes which Nature is doing her best to rectify for him. Disease is nothing more or less than Nature's blind attempt at are. (Benjamin, 1946)

According to Benjamin (1946), orthodox medical treatment and Nature cure work on two completely divergent philosophies. One is based upon a philosophy which looks upon disease as something which "happens" to man by ill-luck, accident, or chance' something which enters the body from without germs or microbes and has to be fought against and defeated. The others is based upon a philosophy which realizes that all disease emanates from within the body, is self – generated as a result of individual mistakes and errors of living, and is Nature's blind attempt at self – healing.

3.2.4.4 Co-existence of health and disease

Diseases come and go, but underneath them all, and in between, Health endures continuously, more or less. Disease has no existence apart from health because it is only an outward, visible and tangible form of ill-health which is only a diminution of Health. It may be called disease in its latent or seed form, the former being the patent, visible form of the diminished health.

All diseases become possible only on the basis of health: for health in some degree must be present as the substratum (or substance) of any and every diseases. When health is completely lost, death ensures and then there is an end of disease also. Health is really indistinguishable from Life, and hence, so long as life continues, health also must exist, more or less. Health and disease are thus like the two sides of a single coin. Both health and disease subsist in Life: the positive essence of Life is health: the negative aspect of it is its diminution, that is, disease. For this reason we regard disease as inseparable from health, and therefore to be treated as a diminution of health, rather as something existing independent of it. Thus is established the doctrine of unity of Health and Disease, and this unity is verified by the cure of all diseases alike by a single process of restoring health.

That disease is not an entity which means that it has no independent existence apart from Life's healthward efforts – has been realised by Dr. Carrel who wrote in his book that disease is "the struggle of the body against a disturbing agent." Since no disease exists apart from Health, Which is its substratum, it logically follows that all diseases are one: Their apparent diversity is an illusion. All diseases alike are also one because they are Nature's efforts to raise the health to its previous high level. So disease processes. Vital processes in a body not encumbered with toxic filth are called diseases. That is all the difference. Since diseases are vital processes, to fight them with drug poisons is criminal folly(Sarma & Swaminathan, 1986).

To the Naturopath, all diseases in the same organism are related. There is a connection, and a most definite one, a connection of cause and effect all the time (a connection of wrong treatment plus wrong living in a gradually more devitalized organism).

The value of symptomatology

Sir James, when living, was probably the greatest clinician of the English-speaking world; yet he had not outlived the medical superstition that disease is a positive entity, and that the way to find disease is to trace symptoms to their source.

But if a symptom is traced to its source, what of it?

The first symptom we have of any chain of symptoms is discomfort or pain. In any stomach derangement we have pain, more or less aggravated by food. If we analyze the symptoms from the first pain and catarrh in the stomach, we shall kind the chain of symptoms running along. The first symptom to be noticed is pain. On examination, we find a catarrhal condition of the stomach; and this catarrhal condition is not a disease—it is a symptom. Catarrhal inflammation continues, with the thickening of the mucous membrane, which finally ends in ulceration. Ulceration is not the disease; it is only a continuation of the inflammatory symptom. If the ulcer is removed, it does not remove the disease; it only removes a symptom. These symptoms continue until there is a thickening and induration of the pyloris, which is called cancer. And yet we have not discovered anything but symptoms from beginning to end. By removing the cancer, the question of what the disease is has not been answered. Cancer being the end-symptom, it cannot be the cause of the first symptom.

The proper way to study disease is to study health and every influence favorable or not to its continuance. Disease is perverted health. Any influence that lowers nerve-energy becomes disease-producing. Disease cannot be its own cause; neither can it be its own cure, and certainly not its own prevention (Tilden,1971).

Section III:

3.3 Thematic analysis of the concepts of health and illness in medical sciences

The different theoretical conceptions of health and illness held by Allopathy/ Psychiatry, Ayurveda, Homeopathy and Naturopathy in the above section provides us an overall picture on the notional positions of the four medical sciences. In this section I would be doing a thematic analysis of these concepts and through the categories emerged each concept would be compared with the other ones in other disciplines with supportive and contradictory arguments.

After deriving the categories for analysis, each argument would be presented, supported with the previous studies or researches and offered systematically. Many of the arguments given in this section has been already existed in each medical system since its inception and its writers and theorists have been attempted to answer them also. The practise of conceptual analysis would not be completed without touching its philosophical foundations. The researcher also observed a similarity between many of these issues in Medical sciences and Psychology which had ultimately ended up in the search of its philosophical roots.

Andrew Weil (1983) began studying various systems of medicine since 1970. From the vast experience of observation of many different therapeutic systems, interviewing patients and reading the works of the inventors of the methods, he attempts to summarise them on the basis of their similarities.

a) No system of treatment has a monopoly on cures**:** *Every* system cures some of the people some of the time. However strange, confused or inconsistent with scientific fact, all formal therapies produce some cures. The frequency of such cures is unknown, because no research exists on the question. Dramatic, clear-cut cures of advanced disease following applications of medical treatments are not very in any school of therapy.

b) No system of treatment has a monopoly on failures: Every system fails to work some of the time, regardless of how logical scientifically sound its theory, how careful its application, and how strong its indication for a particular problem or patient. The question of why treatments fail, when theory and experience predict success, is as important as question of why treatments work when science can demonstrate their theories to be fallacious.

c) There is great inconsistency among existing systems of treatment: In both theory and practise, rival systems of medicine are often -irreconcilable. The existence and

success of therapeutic systems based on mutually inconsistent theories and methods must be accounted for by any general theory of health and healing. It suggests that factors other than theories and methods determine whether medical interventions succeed or fail.

d) New systems of treatment work best when they first appear**:** An inspired medical heretic and prophet is often able to produce dramatic cures of many kinds of illness. The founders or the proponents of each systems of medicine may be able to communicate their skills to one or Two generations of students, but overtime, and especially after their deaths, the overall efficacy of their systems declines, even though the same methods remain in use, applied according to the master's directions.

e) Belief alone can elicit medical cures**:** Cures of organic illness following visits to miracle shrines, faith healers and Christian science practitioners demonstrate that belief alone, without any physical intervention, is enough to bring about therapeutic success. This fact must also be included in any comprehensive theory of health, healing and the role of treatment.

f) Belief in treatment is a unifying variable that ties together the five previous conclusions**:** Belief in system of treatment varies from practitioner to practitioner and patient to patient. Such variation can explain why any system work sometimes and not others (Weil, 1983).

Before I present my analysis of the concepts of health and illness, let me dwell upon the common questions revolved around these concepts based on the philosophy of medicine. Sadegh- Zadeh's (2008) reports that some of the philosophical questions presented in relation to the questions of *What is disease? Where do diseases come from? Are they value-free, natural phenomena or are they man-made, value-laden artifacts?* present recalcitrant problems both to medicine and its philosophy. As a result, there is as yet no generally

accepted concept of disease. Rather, almost every physician and every philosopher of medicine takes her private stance on what disease might be. This overabundance of positions reflects a semantic chaos that prevents any advance in the philosophy of disease.

These queries show that there were conceptual issues on the nature of the terms health and illness itself. The medical philosophers were still could not arrive at consensus regarding these concepts and vagueness still prevails in determining the nature of these concepts. I would be explaining the conceptual errors of the terms and then let me present the categories that I derived from the raw data obtained through Textual analysis and Interviews. They are categorized under the following heads:

Table 3.2 Thematic analysis of the concept of health and illness: major categories emerged

Medical Systems		**Research Question**	
•	Allopathy/ Psychiatry	**The concept of health and illness**	
•	Ayurveda		
•	Homeopathy		
•	Naturopathy		
Result of thematic analysis (Major categories emerged)		**1.**	Is disease a general category or an individual one?
		2.	Are the terms 'health and illness' dichotomous and opposite?
		3.	Biological origin of mental illness
		4.	Are the concepts of health/ illness reducible?
		5.	Mental illness are problems of living
		6.	Are diseases physical or mental?
		7.	Does the concept of 'health' is the basis of medical sciences?
		8.	Are diseases social and / or cultural?
		9.	Does the medical theory match with the lay concept of health and illness?
		10.	Is the medical system pragmatic?
		11.	Dissatisfaction with the present system

The Western philosophy of medicine found that there are many philosophical issues, errors and mistakes in the concepts of health and illness. Sadegh- Zadeh (2008) demonstrates what it means to say that the concept of disease is not a classical one as is traditionally believed, but a nonclassical one and, therefore, requires another method of inquiry than is usually taken. A concept is a classical one if it denotes a category whose members have a number of identical properties, say a common nature. Otherwise, it is said to be a nonclassical one. His prototype resemblance theory of disease undertakes a reconstruction of disease as a category that in contradistinction to traditional views is not based on a set of common features of its members, that is individual diseases, but on a few best examples of the category, called its prototypes, and a similarity relationship such that a human condition is considered a disease if it resembles a prototype. It enables new approaches to resolving many of the stubborn problems associated with the concept.

Leo (2004) argues that the language of biological psychiatry is filled with "implications," "maybes," and "possibilities" but short on documentation.

3.3.1 Is disease a general category or an individual one?

Does mental illness refer to a unitary concept or to an artificial grouping of basically different specific disorders? Sadegh- Zadeh's (2008) prototype theory of disease states that the concept of disease does not denote the individual diseases. Its referent is the general category, disease. According to Nordenfelt (2000), Sadegh-Zadeh is highly critical of earlier attempts to define concepts in particular in the medical field. He indeed attributes elementary philosophical mistakes to them. A concept of disease-in-general must, therefore, precede the inclusion and exclusion of phenomena as individual disease entities. That means that the question of "What is disease?" can only be decided prescriptively, not descriptively; i.e., it must be tackled axiomatically, not empirically. Thus it could be said that the prototype theory

of disease puts forward a probabilistic idea of health and illness. In such case, the feature of typicality might be varied which implied that disease is one, not many.

The unitary view of the mental illness is also expressed by Schneider (cited by Scott, 1961): "The major 'cause' of mental disease is seen as some form of disorientation between the personality and society." But Gordon (cited by Scott, 1961) explains the specific view of mental illness: "What we choose to call mental disease is an artificial grouping of many morbid processes. The first essential, in my opinion, is to separate the various entities, and in the approach to an epidemiology of mental diseases, to center attention on some one condition, or a few selected conditions, which have **functions in common** with other mass diseases well understood in their group relationships." McQuitty (cited by Scott, 1961) offers empirical evidence in favor of a specific view and speculates that "one might expect that mental illness might develop within any one or more patterns. In order to understand the mental illness of a particular subject, we must isolate the pattern or patterns of characteristics to which his mental illness pertains."

Thomas Sydenham, an English physician of the late seventeenth century, argued that physical disease could be reduced to certain and determinate kinds with the same exactness as we see it done by botanic writers in their treatises on plants (Taylor, 1972 cited from Shepherd, 1974). He stressed the importance of differentiating illness from each other and pioneered the idea of specific pathology underlying each disease. Diseases were envisaged as having some form of autonomous existence with natural histories of their own, as beings invading the body from without or as parasites growing within it.

The positions of Ayurveda, Homeopathy and Naturopathy taken on the general Vs. individual nature of disease. Ayurveda conceptualises illness as *dukha* (pain or unhappiness) in its general meaning and cure is termed as *duḳhanivrtti* (i.e., alleviation of pain or unhappiness). Diseases has a much broader and genera notion in this approach. At the same

time, *Ëyurveda* conceives diseases into manywhere they are basically classified based on the *tridoÀa* theory of disease. Apart from this classification, mental illness is again grouped under *Bh£tonmada*. Such a perspective of health and illness could develop the inference that *Ëyurveda* maintains a general as well as individual notions of illness which could further be understood in a metaphysical dimension too.

Homeopathy disagrees with the naming of diseases. In the Materia Medica, a number of drugs and their symptoms are given, which are used to identify the diseases. Homeopathy strictly follows an individualised line of diagnosis and treatment where the totality of symptoms of an individual patient determines the nature of disease. The notions of general Vs. specific concepts of diseases are intelligently integrated into the system of Homeopathy. The researcher could say that Homeopathy follows a comprehensive stand in this issue.

Naturopathy has clear perspective on the general view of diseases. The unity of illness, its cause and treatment makes Naturopathy unique among the other medical systems. It does not talk about the individual diseases or artificial grouping of diseases into many. According to them, diseases are only one and not many. Therefore, any treatment should focus on the unity of illness and its management. As Nature is one and only one, its mechanisms in one's body also could have unitary manifestations.

3.3.2 Are the terms "health and illness" dichotomous and opposite?

The philosophical history of the dichotomous nature of the concepts could be traced back to Cartesian dualism. According to Burwood, Gilbert and Lennon (2003), Cartesian turn in philosophy exposes an extremely important feature of dualistic thinking: it does not consist simply in the positing of a dichotomy between the mental and the physical, but involves notions of exclusion, autonomy and privilege. The dichotomies mind/ body and health/ illness have been seen as exclusionary (that things are one or the other but not both), autonomous (each exists separably without the implication of the opposed term), and that the first term in

each case is in some sense (philosophically) privileged (that it is of primary importance and something to which the second term plays a secondary and oppositional role).

Nordenfelt (2000) quotes Sadegh-Zadeh who criticizes the present discussion within philosophy of medicine in the following sweeping way:

"Something omitted in the controversial debate is the logical analysis of the three notions mentioned [health, illness and disease]. It is this omission that has led the discourse to a dead end. A logical analysis of these three notions reveals a misconception underlying almost all philosophy on health, illness and disease in the past. The misconception may be described as follows. First, it is commonly assumed that the concepts of health, illness and disease are amenable to classical, bivalent mode of reasoning of the Aristotelian type based on the principles of excluded middle and noncontradiction. According to this assumption (1) an individual is healthy or she is not healthy, but not both at the same time; (2) an individual is ill or she is not ill, but not both at the same time; and (3) an individual has a disease or she does not have it, but not both at the same time. According to a second, also widespread assumption*, (4) health and disease are opposites in that they are dual and mutually exclusive attributes. It is said that health is the absence of disease and vice versa"*

I shall suppose that health and illness definitely understood as dichotomous concepts in Allopathy and even in Homeopathy. The co-existence of both the concepts is not much stressed by these systems. Very clearly in Allopathy, illness is something which repels the presence of health and health and illness cannot exist in one's body at the same time. The researcher considers that both the concepts compete each other in order to win its position in the body. But Nordenfelt (2000) quotes Sadegh-Zadeh who introduces interesting conceptual novelties. One of them concerns the application of fuzzy logic to disease hood. The idea here is that one can have a particular disease to some extent. But Nordenfelt (2000) objects clarifies Sadegh-Zadeh by saying that in such a position one must distinguish between having various degrees of health, and having a disease to various extents. The normal understanding has been that a person either has or does not have a disease. The logic of the traditional

concept of disease is of a bipolar kind. Even though Homeopathy does not take an extreme stand, it does not believe in the harmonious existence of health and illness in a person.

Whereas, Ayurveda and Naturopathy take an opposite stand, Samkhya philosophy explains the mutual coexistence of trigunas, which is the basic notion in Ayurveda. Like Purusa and Prakrti, everything exists together in the universe and everything can be influenced by everything. Naturopathy does not believe that disease is an entity. Health and illness are states/ conditions that can occur in the same individual at the same time. Both are considered as normal, therefore natural. Here **normal equates with natural**.

Sadegh- Zadeh (2008) strongly proposes that disease **is not identical with nonhealth.** Usually health and disease are construed as conceptual opposites in that it is said, for example, that health is the absence of disease. Deviating from this traditional view, it has been argued that the opposite of health, that is " unhealth, " is not disease, but *malady* .Malady is a broader category than disease. It comprises, besides disease as one of its subcategories, also many others such as injury, wound, lesion, defect, deformity, disorder, disability, and the like. An individual need not necessarily have a disease to lack health. Based on these considerations, we may metalinguistically state that the antonym of the term "health" is the term "malady" and not the term "disease." Every disease is a malady, but not vice versa.

According to Nordenfelt (2000), most theorists assume that health is a dimensional concept. (Pörn, 1993 and Nordenfelt, 1987/ 1995.) One can certainly be either more or less healthy. At a particular moment one is more or less far from being in perfect health. Moreover, one can be more healthy in one respect and less healthy in another.

"We need a clear description that clarifies the phenomena unmistakably. One quality is constant and an invariable concomitant, cause or result of the neurotic process; it sets a normal act apart from one that is a manifestation of this process. Thus the essence of

normality is flexibility, in contrast to the freezing of behavior into patterns of unalterability that characterizes every manifestation of the neurotic process, whether in impulses, purposes, acts, thoughts or feelings".

Kubie (1954, cited from Wurmser, 1978)

The same concept is as the dimensional perspective, which applies the logic of quantitative gradation to and individual variation to psychiatric disorder. It grapples with patients who cannot be placed in clear and distinct categories but can sometimes be comprehended in their vulnerability to mental distress from their individual position on psychological dimensions that are analogous to physical dimensions such as height or weight. He says that the disease perspective rests on categorical logic. It attempts to cluster patients into separate groups, each group defined by the distinct features that are the defining characteristics of the disease. This perspective rests upon the fact that signs and symptoms of some disorders tend to cohere in recognizable cluster or syndromes that progress in characteristic ways.

3.3.3 Biological origin of mental illness

Birth of scientific psychiatry happened from the boundaries of modern medicine. It discarded the non-medical ways of dealing with the mental patients and the perfections of primitive healing procedures. It constitutes and laid the systematic bodies of knowledge and the foundation of a rational medical art, severed from religion and superstition. The basic tenet of biological psychiatry is that mental illness is an "organic" disease, meaning that the patient has too much or too little of a neurotransmitter, too much or too little of a receptor, or an overactive or underactive neuronal circuit. Whatever the problem might be, it is "biological" and biological problems are best treated with drugs. As everyone now knows, clinical depression is just like diabetes; one patient is short of insulin, another is short of serotonin; one patient needs insulin, another needs Prozac--and so the story goes (Leo, 2004). Leo

(2004) quotes Elliot Valenstein, who has found that the evidence for the biological basis of mental illness was weak--much weaker than we are commonly told. In his book *Blaming the Brain: The Truth about Drugs and Mental Health,* he documents that there are major flaws in the theory that depression is due to a shortage of serotonin, or schizophrenia to an excess of dopamine, or attention deficit disorder to a shortage of dopamine. These flaws, while often subtly acknowledged in professional journals by psychiatry researchers, are simply glossed over in presentations to the general public. In his words, "What physicians and the public are reading about drugs and what causes mental disorders is by no means a reflection of all the information that is available."

Many critics have said that the chemical theory of mental illness is a grand oversimplification of a very complex issue. According to Nordenfelt (2000), all the holistic theorists such as Whitbeck (1981), Fulford (1989), Pörn (1993) and Seedhouse (1986) deny the position that brain disorder as mental illness. He continues that, health, at least in its basic sense, is something over and above the absence of disease. The absence of disease does not guarantee health. On the other hand, health, even complete health, is compatible with the presence of some (mild or lanthanic) disease (cited from Nordenfelt, 2000).

According to Ludwig (1975, cited from Engel, 1978), the medical model premises “that sufficient deviation from normal represents disease, that disease is due to known or unknown natural causes, and that elimination of these causes will result in cure or improvement in individual patients.” Ludwig (1975) acknowledges the fact that most psychiatrists diagnoses have a lower level of confirmation than most medical diagnoses. He says that mental and physical illnesses are not qualitatively different provided that mental disease is assumed to arise largely from ‘natural rather than metapsychological, interpersonal or societal causes. “Natural” is defined as “biological brain dysfunctions, either biochemical or neurophysiological in nature.” On the other hand, “disorders such as problems of living, social adjustment

reaction, character disorders, dependency syndromes, existential depressions and various social **deviancy** conditions (would) be excluded from the concept of mental illness since these disorders arise in individuals with presumably intact neurophysiological functioning and are produced primarily by psychosocial variables." Such nonpsychiatric disorders are not properly the concern of the physician-psychiatrist and are more appropriately handled by nonmedical professionals (Ludwig, 1975 cited from Engel 1978).

3.3.4. Are the concepts of health/ illness reducible?

Philosophy of psychiatry has been explored the conceptualization of medical model of mental illness by taking two major positions – the reductionist and the exclusionist position. Reductionist says that all behavioral phenomena of disease must be conceptualized in terms of physicochemical principles. Therefore, psychiatry's field should be limited to behavioral disorders consequent to brain dysfunction. Philosophy of science explains that as per scientific reductionism, higher-level theories can be reduced to lower-level theories. In psychiatry, it underpins the claims to preeminence of biological psychiatry and the assumption that brain-imaging techniques are ipso facto ways of seeing the mind (Posner, 1993 cited from Thornton, 2004). Thornton (2004) reviewing the works of Jaspers (1974) brings out a few basic questions in this regard:

a. Can its methods and its subject matter be unified in order to reduce it to lower-level scientific description?
b. Can disorder be reduced to more basic scientific terms or does it presuppose a special kind of intelligibility?

The reductionist assumption is still widespread that psychiatry and psychology will eventually be reduced to biology (which might be construed as physiology or evolutionary biology), biology to chemistry and chemistry to physics. Thornton (2004) quotes Oppenheim and Putnam (1958) in the following paragraph:

"It is not absurd to suppose that psychological laws may eventually be explained in terms of the behavior of individual neurons in the brain; that the behavior of individual cells – including neurons – may eventually be explained in terms of their biochemical constitution; and that the behavior of molecules – including the macromolecules that make up living cells – may eventually be explained in terms of atomic physics. If this is achieved, then psychological laws will have, in principle, been reduced to laws of atomic physics."

This approach shows as how the most basic level can assume a metaphysical role. Thus, only what can be reduced can be real. This is explained in "philosophical naturalism." According to the late American philosopher, V.W.O. Quine, naturalism was primarily an approach to philosophical method; namely it was in continuity with science. But he also mentions its metaphysical view that nature is identified with the subject matter of physics. Philosophical naturalism is thus construed as a project of showing how features of the world can be related to physics. Reductionist naturalism in psychiatry assumes that unless its basic categories can be systematically related to more basic scientific categories, then it has no right to think that it "cuts nature at the joints" (Thornton, 2004).

An alternative, reductionist response is to argue that the antecedent of the conditional – the claim that diagnostic judgments are evaluations – is false. If psychiatry follows a descriptive account of mental illness, then the status of psychiatry as a discipline that at least aspires to be a descriptive science of objective and worldly phenomena can be preserved. Thornton (2004) quotes accounts by Kendell (1975), Boorse (1975) and Wakefield (1999) in this regard. Wakefield (1999) attempts to characterize disorder through the notion of failures of function. "Failure of function" can itself be explained in purely descriptive terms using the idea, gleaned from the evolutionary theory, of natural, biological, or proper functions (these different terms are used by different philosophers of biology). Wakefield further explains that illnesses are harmful failures of function. Medical science not only aims at an understanding

of the functioning (and failures of functioning) of the body and mind; it also aims to intervene to cure those failures that are harmful (Thornton, 2004).

Thornton (2004) brings out two difficulties of Wakefield's approach.

1. For a successful reduction of disorder to biological functions, such functions have to be cashed out in terms of a more basic vocabulary. Psychiatry is to be explained in terms of biology. But, if it is so explained, the biological account has to be able to justify the invocation of a pattern of explanation that mirrors a pattern in the "space of reasons" but that is built "bottom up" from biological happenings.
2. If disorder is explained as failure of function, then the problem is that there are far too many such failures. For example, most sperm fail in their biological function; but this does not require that nature is an efficient engineer. In other words, there is no general reason that most traits should behave according to their function. So, to identify disorder with such failures is to see them widespread in nature. This is implausible (Thornton, 2004).

In contrast to the reductionist conceptions of health and illness, Ayurveda, Homeopathy and Naturopathy, acquires a holistic perspective. The individualistic nature of the illness is stressed by all these systems, the person is more important than the disease, disease is not located to any particular organ or tissues but the whole body of the person is treated. Such an approach matches with Foucault's (1973, cited from Shepherd, 1974) conception of disease.

"Disease is no longer a bundle of characters dissociated here and there over the surface of the body and linked together by statistically observable concomitance and successions; it is a set of forms and deformations, figures and accidents, and of displayed, destroyed or modified elements bound together in sequence according to the geography

which can be followed step by step. It is no longer a pathological species inserting itself into the body whenever possible, it is the body itself which has become ill."

3.3.5. Mental illnesses are problems of living

"Madness need not be regarded as an illness.

Why shouldn't it be seen as a sudden – more or less sudden – change of character?"

Ludwig Wittgenstein (1980, cited from Bentall, 2003)

Philosophy of medicine also approaches mental illness taking an exclusionist position. Shagass (1976) brings out two leading arguments that psychiatry should abandon the medical model. According to Szasz (1974), there can be no mental illness since disease or illness can affect only the body (Shagass, 1976).

"The term 'mental illness' is a metaphor. Bodily illness stands in the same relation to mental illness as a defective television set stands to a bad television program. Of course, the word "sick" is often used metaphorically. We call jokes "sick", economies "sick", sometimes even the whole world "sick", but only when we call minds "sick" do we systematically mistake and strategically misinterpret metaphor for fact and send for the doctor to "cure" the "illness"! It is as if a television viewer were to send for a TV repairman because he dislikes the program he sees on the screen"

(Szasz, 1972 cited from Shepherd, 1974)

He claims that the concept of mental illness is based on confusion. (The belief in mental illness) rests on serious, albeit simple error; it rests on mistaking or confusing what is real with what is imitation; literal meaning with metaphorical meaning; medicine with morals. Szasz says that there cannot be mental illness, literally speaking, because it is no more than a metaphor. He argues that by definition, "disease means bodily disease" and further, the mind is not literally a part of the body.

He views that psychiatric diagnoses as stigmatizing labels and sees no justification for psychiatric hospitalization or treatment.

Szasz' critique of the foundations of psychiatry generated debate over the following issues:

- Is it true that disease, by definition must refer to bodily disease?
- Is it true that the mind is not literally part of the body? Couldn't the mind be identified with the brain or the neural system?
- Is it true that medicine is, intrinsically, not about the moral evaluation of behaviour, even if it might be used instrumentally as part of a moral evaluation?
- Is it true that psychiatry is founded on pseudoscience?

The criticism of Szasz over the reality of mental disorders turned more empirical issues on psychiatric concepts than philosophical ones.

3.3.6 Are diseases physical or mental?

Gert & Culver (2004) evaluate the essential features of the definition of mental disorders in Psychiatry. Mental disorders involve behavioral or psychological features, rather than the physical features of the person. This demonstrates that a disorder is classified as a mental disorder rather than a physical disorder on the basis of its symptoms, nor its cause or etiology. Thus, apart from their primary symptoms, there is no essential difference between mental and physical disorders. Now even genetic causes and structural neurological abnormalities are discovered as causes for mental disorders. Many of the disorders, for example dementia, have both behavioral and psychological symptoms and physical symptoms. It is often *arbitrary* whether these disorders are classified as mental or physical and most often the classification depend on historical precedent. Psychiatry does take a double stand in this issue; at the same time, its biomedical model reduces the illness into biological or physical. Ayurveda, Homeopathy and Naturopathy conceptualise health and illness in its physical and mental dimension. The theories of causation, classification, diagnosis and treatment also encompass both these dimensions very well. The *triguna* and *tridosa* concept of diseases in Ayurveda is an example for this. More than its interaction, even the Samkhya philosophy places mind with the universal consciousness. The supreme power of Manas in one's life and existence imply its importance in maintaining health and curing illness. Mind, Body and Soul are not considered as separate, but closely interrelated and integrated.

Homeopathy also visualises the interrelation between mind and body. The concept of vital power even equals with mind in determining one's health. The importance given to subjective symptoms also make sure that Homeopathy also places mind as the prime organ in the body which controls all the bodily functions. The concepts of health and illness and its manifestation could not be completely understood until and unless a medical system accepts

the coexistence of mind and body.

The researcher could not find much literature on the mind body dualism in Naturopathy. But we can infer from the concept of unity of disease that Naturopathy, too, gives equal importance to body and mind in the conceptualisation of health and illness.

3.3.7 Does the concept "Health" is the basis of medical sciences?

Health is indicated in different terms like

- Absence of gross symptoms in the processes of brain, statistical average, normality and adjustment by Allopathy,
- Foundation of the fulfillment of Purusartha; Balance; Happiness by Ayurveda
- Vital force; Balance by Homeopathy; and
- Vitality; Balance; Equilibrium by Naturopathy.

William A. Scott (1961) elaborates a serious obstacle to research in the area of mental illness as the lack of a clear definition of the phenomenon to be studied. The term "mental illness" has been used by different researchers to refer to such diverse manifestations as schizophrenia, suicide, unhappiness, juvenile delinquency and passive acceptance of an intolerable environment. Whether some or all of these various reactions should be included in a single category of "mental illness" is not clear from a survey of the current literature. Theories describing the nature and antecedents of one sort of disturbance rarely relate it to another and there is a paucity of research evidence indicating the extent to which such manifestations are empirically inter-correlated.

Redlick (1957) expressed dissatisfaction with the concept of normality being equated with the absence of symptoms and urged psychiatrists to study non-patient population in order to obtain more understanding of normality. Too many theories of what is normal have been

inferred and extrapolated from studies of patients. Various studies have been done using a normal control group, which implies that the members of the group are not under active psychiatric treatment, or are not grossly disturbed and do not have the disease being investigated. Levine (1942, cited from Cavenar & Walker, 1983) feels normality is (1) nonexistent in a total form but is relative (2) in agreement with statistical averages for specific groups (3) physical normality (4) intellectual normality (5) absence of neurotic or psychotic symptoms and (6) emotional maturity. Ryle (1947, cited from Cavenar & Walker, 1983) notes that normality in medicine is a difficult concept because variation is so constantly a force in humans that no rigid pattern of normality is conceivable. He stresses that the study of human variability within a normal range is important as a fundamental biologic concept to supply standards in medicine for the recognition of health and illness in borderline states. While concluding the chapter on concept of normality, Cavenar & Walker (1983) emphasizes that the most prevailing view in psychiatry appears to be that freedom from disabling symptoms is normality and health. Thus it has been observed that even though the WHO's definition of health speaks of a holistic picture of health and illness, the clinical practice understands mental health as absence of psychopathology. They also justified their stand by saying that many of the notions of normality are abstract and theoretical concepts, which are most difficult to apply clinically. But Offer & Sabshin (1974) admits the fact that we cannot provide a definitive answer to the question, "what is mental health or normality?" since such an answer must eventually evolve out of new research and new experiences. *"Because cultural and personal values are so intimately tied to one's conception of normality, it is doubtful, whether even in the long run, we will have one definition of normality."* Psychiatry takes a similar stand to that of General Medicine in terms of the concept of health. As health is something determined by the brain activities, mental health is also viewed as normality of the brain. Even if the biopsychosocial model is claimed to replace the traditional biomedical model, the psychiatric practice is still observed to be based on the biomedical model. Even the

psychopharmacology looks at mental illness as something, which can be treated with medicine, that acts on the neurochemicals. This can be further explained on the basis of the philosophical position, Reductionism, wherein a complex concept is reduced to its basic structure and explain them only as its property and not as a holistic entity, which might have a comprehensive meaning.

Other than this mainstream conception of mental health, Ayurveda puts forward a different theory of health and disease. Mental health is conceptualized based on the Triguna principle. Mental health is explained as decreasing Rajasic and Tamasic qualities and increasing the Sattvic qualities of a person. At the same time, the harmonious nature of Vata, Pitta and Kapha also should be maintained. Therefore, we could see a co-existence between body and mind in determining the mental health of a person. More than any other medical science, Ayurveda, the science of life is rooted on the principles of health and harmony with nature or universe. Ayurveda takes a peculiar position wherein its principles are not pathology oriented. I could say that the concept of health is the foundation of the Ayurveda theory of disease. While the balance of Vata, Pitta and Kapha indicate health, its disharmony is disease. The cosmic nature of human existence as indicated in the Vedas, Upanishads and Darsanas talks about 'health' much beyond the Tridosha principle. Astanga Hrdaya, one of the classic textbooks of Ayurveda, starts with praise to God seeking his blessing where God is considered as the synonym of 'perfect health'. Therefore, we could reflect that the mere balance or harmony among the Tridosa is not in itself enough in understanding the Ayurvedic concepts of health. It talks about a concept, which is superhuman, cosmic and eternal. Even if it is based on one's cultural and religious beliefs, Ayurveda implies health, which is unique, compared to the other medical sciences.

Health is also something, which is a means to arrive at 'moksa'. 'Moksa' is considered as the final end of the human existence wherein the human consciousness is in liaison with

the universal consciousness. Good health is a must for anyone who wants to achieve 'moksa' which means there is something beyond than being healthy and conducting one's healthy life in this earth.

Homeopathy and Naturopathy understand 'health' as vital force/ vitality and harmony/ balance. Even though these systems are very much influenced by the Allopathic concepts, both of them stress on vital force, which is energy or power of one's body. I could observe that Homeopathy and Naturopathy focus more on the vital power of persons rather than their symptoms or problems presented before the doctor. Homeopathy claims itself as a system, which attempts to act on and improve the vital force of the people. But I could not see their criteria for how to maintain a healthy personality and how to prevent illness. At the same time, Naturopathy calls itself as a lifestyle approach wherein a theory of health is presented to its followers. This position makes the people responsible for their healthy and diseased states. At this point, I can say that, Naturopathy shares a similar trend with that of Ayurveda. "How to live healthy?" is the fundamental question addressed by both the systems. Following these principles will ensure health, or otherwise, disease. Naturopathy also understands health as balance or harmony with nature. The deviation from Homeopathy occurs here. "Going back to one's own natural habitat, especially food habit will make you healthy" is the basic stake of Naturopathy whereas Homeopathy does not describe this aspect of health. Even if, Homeopaths acknowledge the environmental determinants of health, it stresses much more on how to support and increase one's own vital force. The textual analysis of Homeopathy and Naturopathy could not offer much on its concept of mental health. This might be because of the fact that these two systems do not clearly delineate physical and mental illnesses separately and also deal them accordingly. So I reason that its theory of general health could also be applied to both physical and mental health.

3.3.8 Are diseases social and/ or cultural?

Childs (1999) in his book *Genetic Medicine: A Logic of Disease*, says that all diseases has a social component. If human open systems are congruent with experiences of the physical and social environment, and if disease is a consequence of incongruence stemming from variably adaptive unit steps of homeostasis, then every disease has a social component that cannot be denied.

The concept of disease should be, as Sadegh-Zadeh says, "*lifeworldly* grounded" And we must use a "paradigmatic-extensional approach" to the definition of health and disease. This means that Sadegh-Zadeh distances himself from the bio-statistical analysis of disease, which is partly based on the idea of biological evolution. According to Christopher Boorse, the major protagonist of this theory, the diseased organ is one that makes a statistically subnormal contribution to the survival of the individual or the species. No other considerations can, according to Boorse, play a role in the determination of diseasehood. Sadegh-Zadeh, in contrast, wishes to base the medical web of concepts on "what people unquestionably count as diseases". But a majority of the public believe, in spite of Sadegh-Zadeh's dictum, that the concept of disease is a technical concept and that the doctor knows what it means and that he or she knows it better than the public does. Sadegh-Zadeh agree that the public is here mistaken.

According to Angel & Thoits (1987), the subjective experience of illness is culture-bound and that the cognitive and linguistic categories of illness characteristic of any culture constrain the interpretative and behavioral options available to individuals in response to symptoms. Kirmayer (2004) also notes that there is cultural diversity in the meaning of healing.

Dixit (2005) The notion of mental illness may be closely related to the social values pertinent in any social context. The meaning of mental illness rooted in everyday social psychological processes may be different from scientific and clinical understanding. In order to

examine the common meaning of mental illness, the relationship between individual knowledge and implicit social knowledge needs to be explored. Social representation of mental illness was structured in terms of social understanding of the causes and consequences of mental illness. Further, mental illness derived its meaning from the expectations and norms of society. Mental illness was generally labelled as a form of social deviance and viewed as including an element of volition. The social definition of mental illness appeared to be rooted in the social value that non–normative behaviours that are not in line with the expectations of society are related to mental illness. An interesting feature that was observed was the use of narratives to explain the meaning of mental illness.

3.3.9 Does the medical theory match with the lay concept of health and illness?

Some of the authors opined that the medical practitioners need to understand the Patient's Disease and the disease state of a patient is something different from both an individual disease and the general category.

Nordenfelt (2000) cites what Sadegh-Zadeh himself proposes in the following paragraph:

Any concept of disease that, in medical literature and communities, may underlie medical practice and research, exists for the sake of the public, not for medicine's own sake. In order for a linguistic definition of such a concept to be comprehensible to the public and to guide their social definition, it should orient itself to their real life world, needs and interests. According to this axiom of functionality, it is advisable to ground the disease language of medicine not on abstract, "unworldly" concept such as quantum field theory or the evolutions of the species, that the common sense would be unable to assess, but on something that people unquestionably consider a disease. In this way, all philosophical pseudo- problems that medicine and some of its philosophers generate in connection with the concept of disease will disappear.

McGuire et. al. (2002) also note that disease has private and social perspectives. Nordenfelt (2000) cites Sadegh-Zadeh on the social definition of disease. He calls for the public to do the job of defining the concepts of health and disease. A definition must be based on the public's views. And, he says, to a great extent the public is already performing this job. He offers the following example: *"[B]y their opposition against classifying several types of sexual deviation as diseases, people in Western societies have changed medicine's concept of disease during the last four decades. This political behavior of the public demonstrates a social definition of the notion of 'disease'.*

3.3.10 Is the medical system pragmatic?

The history of medicine indicates that once a discovery meets the pragmatic criterion of being useful it is incorporated without much concern about the school of thought in which it originated. Medicine is pluralistic in its theoretical structure; it accepts multiple causation and diverse views without pathogenesis. Siegler and Osmond argue that 'schools of quackery' follow a single theory to account for all illnesses whereas medicine has diverse theoretical views. But both medical conservatism and its ability to incorporate diverse theoretical views,

opined by Shagass (1976), stem from its foundation in rules of conduct for fulfilling a social responsibility.

Shagass (1976) says that medicine's main criterion for accepting new knowledge is pragmatic. Does it work? Does it do any good? How is "good" defined? Without attempting to define the undefinable, it can be said that "good" pertains to clinical medicine's main functions of relieving suffering, ameliorating disability, and saving life, without doing more harm than good. When new knowledge can help to accomplish any of these purposes it acquires pragmatic relevance. In addition to effectiveness, the criterion of pragmatic relevance is strongly governed by such matters as the expenditure of time and money involved in a treatment. The suffering person wants relief as quickly and inexpensively as possible.

The conflicting evidence on the pragmatic basis of the clinical medical model is brought out by Shagass (1976). He explains with the help of some major antipsychotic agents. These drugs do not seem to "cure" psychosis; rather their mode of action is still purely understood after two decades of intensive psychopharmacological research. Nevertheless, they are widely used because they meet the pragmatic criteria of quickly achieving desirable effects in the realm of suffering, disability, and social disruption.

3.3.11 Dissatisfaction with the present system

According to Barton Childs (1999) research in biology and events in society have made clear that traditional medical thinking is not enough; new ideas are needed. One set of ideas has to do with how medical care is made available and paid for. Another has to do with squaring new procedures and treatments with ethics and social mores. Still another has to do with accommodating the individuality of disease.

While evaluating medical model in psychiatry, it has been found that the medical model in psychiatry has become a controversial topic especially when the conception of mental illness itself is conflicting. The validity of psychiatry's status as a specialty within medicine is being questioned more than ever before in its modern history (Shagass, 1976). While evaluating medical model in psychiatry, some questions need to be addressed.

1. Is the medical model really responsible for psychiatry's errors and failures?
2. Is the logic of psychiatric diagnosis and treatment in congruence with the logic of medical model?
3. Does the medical model any longer adequate for medicine?
4. Is the medical model with an organic orientation sufficient to address the dilemmas faced by the medical system?
5. Can psychiatry continue to base the conceptual, etiological and treatment issues of mental illness on the medical model (as long as psychiatry needs to be a part of western medicine)?

Shepherd (1974) reports a series of questions asked by Szasz about the nature, scope, methods and values of psychiatry.

1. Is the scope of psychiatry the study of medical conditions or the study of social performance?
2. Is the aim of psychiatry the study of human behavior or the control of human misbehavior?
3. Is psychiatric practice composed of listening and talking or 'prescribing drugs, operating on the brain and imprisoning persons labeled as "mentally ill"?

Kety (1974) put the contrasting approach of medical model in psychiatry. "According to the medical model, a human illness does not become a specific disease all at once and is not equivalent to it. The medical model of an illness is a process that moves from the

recognition and palliation of symptoms to the characterizations of a specific disease in which the etiology and pathogenesis are known and treatment is rational and specific." (cited from Balis, 1978) Thus, taxonomy progresses from symptoms, to clusters of symptoms, to syndromes, and finally to diseases with specific pathogenesis and pathology. This sequence accurately describes the successful application of the scientific method to the elucidation and the classification into discrete entities of disease in its generic sense. But the distortions introduced by the reductionist tendency to regard the specific disease as adequately, if not best, characterized in terms of the smallest isolable component having causal implications, for example, the biochemical, needs to be scrutinized. Even the designation disease does not apply in the absence of perturbations at the biochemical level (Engel, 1978).

But Torrey (1974) in his book *The death of psychiatry*, asserts that psychiatry as a medical specialty is dying. He concedes that some major psychoses may have an organic cause, but states that should an organic etiology be proved schizophrenia would become a neurological as distinct from psychiatric disease. He proposes an **educational model** to replace the medical one for most current psychiatric efforts and argues that behavioral scientists will do a better job than psychiatric physicians. Torrey counters objections that non-physicians will fail to diagnose organic diseases by stating that anyone with a behavioral science background can be trained within a few weeks to detect true brain disease. He contends also that the use of psychoactive drugs could be learned in an equally short time . (Shagass, 1976).

Siegler & Osmond (1974) point out that chronic illness present difficult problems for the medical model. The critical question is if anything more can be done. If everything possible has been done and the patient is in a state of permanent impairment but his life is no longer in danger, the doctor's active treatment role should end. It can continue only so long as there is hope for improvement by treatment, or the danger of death. Permanent impairment

involves a transition from the sick role to the impaired role from the application of the medical model to use of a model that has been called the “impaired model.” To be treated as impaired in an institution ostensibly for the sick and organized with the trappings of the medical model certainly involves confusion of role (Shagass, 1976).

Several viewpoints have been put forward in attempting to explore the challenges brought by biomedicine to the current medical demands. Engel (1978) analyzes this crisis by bringing the psychiatrist’s cry to the limelight. “Please take us back and we will never again deviate from the “medical model.” This statement makes us think that the role specified for a psychiatrist as physician in the medical model does no longer exist. With the advent of a biopsychosocial model, they are seemed to be in between the medical model and medical-behavioral model. Ludwig (1975, cited from Engel, 1978) puts it, “psychiatry has become a hodgepodge of unscientific opinions, assorted philosophies and ‘schools of thought,’ mixed metaphors, role diffusion, propaganda and politicking for ‘mental health’ and other esoteric goals.” So the only solution for this crisis is to returning to the medical model of disease with its enormous technological resources and a record of astonishing achievement in elucidating mechanisms of disease and devising new treatments.

For Hunter (1966, cited from Shepherd,1974), mental symptoms and abnormal mental states do not constitute mental illnesses in themselves but are the ‘epiphenomena’ of underlying physical disturbances. The organic view of mental illness is impressively explained in such comments. It goes on stating that the discovery of a physical abnormality offers the possibility of treatment before the abnormality can produce psychological disturbances. Medawar (1972, cited from Shepherd,1974) argues for a biomedical approach to the treatment of mental illness by saying that physical abnormality is ‘not so difficult and much more realistic than, say, to abolish all family life as one “existential psychiatrist” is alleged to have recommended because some families create an environment **conductive** to mental disorder.’

But Engel (1978) strongly comments, “One need not accept such a premise. Rather, all medicine is in crisis, and further, medicine’s crisis derives from the same basic fault as psychiatry’s, namely, adherence to a model of disease no longer adequate for the scientific tasks and social responsibilities of either medicine or psychiatry.” He continues his argument. Medicine’s crisis stems from the logical inference that since disease is defined in terms of somatic parameters, physicians need not be concerned with psychosocial issues which lie outside the medicine’s responsibility and authority. At a Rockefeller Foundation Seminar (1976, cited from Engel, 1978) on the concept of health, one authority **urged** that medicine “concentrate on the ‘real’ diseases and not get lost in the psychosociological underbrush. The physician should not be saddled with problems that have arisen from the abdication of the theologian and philosopher.” Another participant called for “a disentanglement psychosocial elements of human malfunction,” arguing that medicine should deal with the former only. With all the logical fallacies, biomedical model is still practiced as the base for the definition, classification, diagnosis and treatment of mental illness by the psychiatrists

Writings on medical model evaluated its advantage and limitations. The questions on abandoning medical model from psychiatry and looking for a new model are very much prevalent all through the literature. As the call for the integration of psychosocial factors into medical models becomes strong, documented correction of medical model making it into “biopsychosocial model” is also criticized. Engel (1978) even quotes the attempts in the mainstream medicine of making medical model as a folk model. He states from Fabrega (1975 cited from Engel, 1978) that “in modern Western society, biomedicine has become a culturally specific perspective about disease, that is, a folk model. Indeed the biomedical model is now the dominant folk model of disease in the Western world. This is how a medical theory is replacing the folk theory of disease.

Considering the flaws and mismatches in the medical model, Kety (1974) looks out for

the emergence of a new medical model to tackle the prevailing issue. Torrey (1974, cited from Shangass, 1976) cites loose criteria, cursory psychiatric examination or no examination at all, casual court proceedings, and absence of legal counsel for the patients. When a psychiatrist contributes to injustices resulting from involuntary commitment, he usually is deviating from the clinical medical model in one of the following ways; insufficiently careful diagnostic examination; disregard of evidence or failure to acknowledge lack of evidence; making a moral instead of a medical judgment about the patient's conduct; or defining the problem as disposition rather than care, thereby failing to consider more helpful alternatives (Shangass, 1976).

In short, it seems that psychiatrists have been pressured to abandon the clinical medical model by demands arising both within and without the profession (Shangass, 1976). Professional dominance of biomedical model "has perpetuated prevailing practices, deflected criticism, and insulated the profession from alternate views and social relations that would illuminate and improve health care" (Holman, 1976 cited from Engel, 1976). Holman (1976) argues that "the medical establishment is not primarily engaged in the disinterested pursuit of knowledge and the translation of that knowledge into medical practice; rather in significant part it is engaged in special interest advocacy, pursuing and preserving social power" (Holman, 1974 cited from Engel, 1978).

In search of a new model, psychiatry opted a mixture of biological- social- psychological factors, (known as Biopsychosocial model) which is then integrated into the traditional biomedical model. Such an approach evokes a lot of questions, confusions and mismatches in the way psychiatric disorders were treated. In her article on *150 Years of Freud-Kraepelin Dualism,* Katharina Trede (2007) states that Emil Kraepelin and Sigmund Freud wrote about the importance of integrating their respective approaches into the study of the **mind/ brain problem.** Psychiatry today continues to struggle with the integration of the biological and psychodynamic approach. In the words mind/ brain problem, the word 'body' is

replaced by the word 'brain'. Could their non-existent relationship be seen as a metaphor for the difficulties psychiatry encounters when it attempts to integrate the mind and brain? A superficial mixing up the bodily and mental factors is found to be inadequate within the frames of the traditional biomedical model.

"The concept of disease is a subject of continuing discussion in the philosophy of medicine. The opinions about what disease may be, however, are still very divergent. The discussion has ended up in a blind alley and has become sterile".

Sadegh-Zadeh (2008)

Thus, it could be seen from the result of thematic analysis of the concept of abnormal behaviour that the conceptualisation of disease (both physical and mental) is very important as far as medical sciences are concerned because their theories on causality, classification, diagnosis and treatment would be based on these conceptualisations. The need to include the social and cultural factors into the conceptualisation is being emphasised by the four medical systems. The broader issues on the biopsychosocial model put forward by Psychiatry would be dealt in the coming chapters in detail.

Chapter IV

CAUSES AND CLASSIFICATION OF ABNORMAL BEHAVIOUR

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"[S] how me how you are searching and I will tell you what you are looking for."

(Wittgenstein,1975 cited from Pickering, 2006)

"If any man were bold enough to write the history of psychiatric classification he would find when he had completed his task that in the process he had written a history of psychiatry as well".

Robert Kendell (1975, cited from Bentall, 2003).

In any course of human existence and even in the invisible metaphysical phenomena occurring around us, we could see a deterministic control and regulation. Gupta (1977) notes that every event seems to be related with an invariable, unconditional and immediate antecedent, which may be named as the cause of event. It is even said that the task of science is the discovery of causes. Toulmin (1960, cited from Gupta, 1977) says, "*the causes are the concern of the applied sciences. In works on engineering, perhaps in medical sciences containing whenever the sciences are applied to practical purposes, there one finds talk of causes and effect*." The problem of determining 'what causes what?' applies to all the disciplines and it goes beyond philosophical speculation (Halpern, & Pearl, 2005).

In this chapter of Causes and Classification of abnormal behaviour, I would like to present the philosophical dilemmas in determining the causes and classifying diseases in the medical context. After conceptualizing what is health and illness, how does it occur and how it can be viewed need to be looked into.

Bem & de Jong (2006) note that the notion of causality is a 'notorious problem' in philosophy. The philosophy literature has been struggling with this problem of defining

causality since at least the days of Hume (1739), who was the first to identify causation with counterfactual dependence. To quote Hume (1748, section VIII, cited from Halpern & Pearl, 2005):

'We may define a cause to be an object followed by another . . .

where, if the first object had not been, the second never had existed.'

The philosophers have been puzzled with the metaphysical foundations for the notion of cause. Do causes really exist as a part of the composition of the world? The answer to that question is still debated. Therefore, Bem & de Jong (2006) remark that in practise, what counts as a cause depends on the **context and the explanatory interests of the investigator**. Usually, phenomena are the products of a web of causes; what we single out as 'the' cause depends on what sort of 'why' question we like to be answered, and what counts as the most relevant or conspicuous factor depends on a point of view. One person's cause would be another one's background assumption.

For example, in one context, we can say that genes cause depression, in another context that neurotransmitter deficiency causes depression, or that maternal deprivation causes depression. All these are legitimate answers to the question why an individual is depressive.

Lewis (1973) gives a counterfactual interpretation of causality. The problem is that effects may not always counterfactually depend on their causes, either directly or indirectly. In addition, causation is not always transitive (cited from Halpern, & Pearl, 2005).

SECTION I

4.1 Philosophy of causality and classification

4.1.1 Causality in medical sciences

In medical sciences, causal laws explain, diagnose and predict the pattern of health and illness. Causes distinguish real laws from accidental generalizations and they determine or necessitate the effect. Nagel (1961) lists four conditions for causal laws.

- First, there must be an invariable relation between cause and effect; the cause must be both a necessary and sufficient condition for the effect.
- Second, cause and effect must be in the same spatial domain, or there must be an intermediate chain of causes connecting them across space.
- Third, the cause must precede the effect and be temporally close to it.
- And fourth, the relation must be asymmetrical: sunlight causes shadow, but not otherwise.

According to these criteria, *many laws of nature are not causal*: it is a law that water is H_2O, but this is not a causal relation. Bem & de Jong (2006) suggest a partial solution as the notion of *ceteris paribus law*s: the effect follows only when the circumstances do not change. But even then, *many laws are only statistical*: it is pretty sure, and very important to know that smoking causes cancer, but the latter does not always follow from the former, only more frequently. It seems then that the notion of causal laws satisfies our intuition that, unlike accidental generalizations, real explanations show how the effect follows with physical necessity from the cause, but that it is unclear how to delineate causes and necessity (Bem & de Jong, 2006).

4.1.2 Method of science in causality

Carter (2003) uses history and philosophy of science in approaching disease. One can say that the social approach has dominated the history of medicine, while the analytic approach has been dominant in the philosophy of causality.

Bird (1998) argues that the optimistic view of scientific method is mistaken. There is

no unique method that characterizes science, explains its successes, and is general in its application. In so far as there are knowledge-producing methods in science, and there many of them, they tend to be specific in their application and are discovered a posteriori.

Paul Feyeraband (1995, cited from Bird, 1998) in his book *Against method*, seeks to show that no general methods, principles of inference, or rules of investigation are exceptionless. For various plausible proposals for such principles, he shows that there are instances where science has been advanced by going against them. He concludes that no method should be discarded by science. "…..there is only *one* principle that can be defended under *all* circumstances and in all stages of development. It is the principle: *anything goes*." But Bird (1998) also argues that if science needs to be defended, the notion of scientific method needs defense also.

Method of Induction

Medicine uses the method of induction as the general rule in developing theories of health and illness. Induction is the reasoning process or argument in which an empirical conclusion (or generalization) is inferred from empirical premises, that is observation statements. Unlike deduction, induction is non-demonstrative; its conclusions are not logically certain. The conclusion of an inductive argument is *probable, supported* by the premises. It is also seen as the agreement that takes you from particular statements to generalizations.

But in Deduction, a conclusion is logically drawn, or deduced from a set of premises. Deduction is demonstrative: its conclusion follows with logical certainty, on pain of contradiction. It is also seen as the argument that takes you from general statements to particular conclusions (Bem & de Jong, 2006).

Empirically, induction has been used to name a more specific kind of scientific argument. For the further explanations of the causes and classification of diseases, the terms **a priori and a posteriori knowledge** need to be clarified. According to Bird (1998), a priori

knowledge is obtainable just by pure thinking without the need for experience. But experience is required for a posteriori knowledge. Pure mathematics and logic are usually taken to be examples of a priori knowledge, whereas most of chemistry and biology are a posteriori. Another concept used in this connection is that of an empirical proposition. **Empirical propositions** are those truth or falsity of which can only be known a posteriori. All typical generalizations of science are empirical.

It is often said that a priori knowledge is certain, and by implication empirical propositions cannot be known with certainty. “Certainty” is a slippery concept and is related to an equally slippery concept, “probability”. One reason why a priori knowledge is thought to be certain in a way that a posteriori knowledge of empirical generalizations is not, is that the former is gained through reasoning while the latter requires inductive reasoning. If the premises of a deductively valid argument are true, the conclusion must be true too, while the premises of an inductive argument might be true yet the conclusion still false (Bird, 1998).

4.1.3 History of the causal concepts of mental illness in the West

It frequently happens in the history of thought that when a powerful new method emerges the study of those problems which can be dealt with by the new method advances rapidly and attracts the limelight, while the rest tends to be ignored or even forgotten, its study despised.

Lakatos (1963–64,cited from Gillies,2007)

Concepts of mental illness have undergone many changes since the earliest periods in the history. Prior to the period of modern medicine, most theories of disease had a magical or religious orientation. Folk medicine is thus developed as a system of medical beliefs and practices based on magic, religion and empiricism. This **magicoreligious view of disease** was challenged by Hippocrates, who was the first to describe disease as a natural phenomenon. In his book, the Sacred Disease (believed to be epilepsy), Hippocrates emphasized the importance of observation and logical reasoning in the analysis of disease,

especially with regard to its diagnosis and prognosis (Braunstein, 1981). This advancement follows the **humoral theory of disease** proposed by Galen (a Roman physician), which elaborates health as proper balance of four humors – blood, phlegm, yellow bile, and black bile while disease was felt to be due to an imbalance (Braunstein, 1981).

With the advent of the Renaissance and the emergence of anatomy and physiology, **Iatromechanical or iatrophysical and iatrochemical theories of disease** arose in the early part of the seventeenth century, as the consequence of scientific advances in physics and chemistry. Iatrophysicists held that the body was a machine and disease could be best explained in mechanical or physical term. Iatrochemists pictured the body as a "test tube" with disease being the consequence of abnormal chemical reactions.

Gillies (2007) says that Codell Carter (2003) notes a few historical periods of medicine in the causal concepts of diseases. In this section, the researcher traces history of causation of diseases combining Codell Carter's (2003) and Braunstein's (1981) findings.

The first is concerned with the invention and establishment of the **bacterial theory** for a variety of diseases. This occurred during 1860s and 1890s and involves such figures as Davaine, Pasteur, Klebs and Koch. Within this domain, the etiological perspective gained most support. **Cellular theory of disease** proposed by Virchow and the **science of bacteriology** of Pasteur and Koch in the seventeenth and eighteenth centuries began the understanding of the modern concept of body function. The causal approach of bacteriology also influenced Freud's attempts to clarify the nature of hysteria (in causal rather than merely symptomatological terms). **Germ theory** based on the work of the early bacteriologists, Pasteur and Koch was a significant development in the medical history during the latter half of the nineteenth century. It stressed the role of infectious agents (i.e., bacteria) in the etiology of disease and suggested that treatment depended on the control of these agents. The germ theory was expanded as a result of studies on the epidemiology of the tropical diseases and

the emergence of the new specialty of preventive medicine at the turn of this century. In the **epidemiologic model of disease**, disease is attributed to the interaction a causative (e.g. infection) agent, the environment and the host. The **cellular concept of disease**, originally proposed by nineteenth century pathologists, gained wide acceptance in the early part of nineteenth century. This concept focused attention on the structural abnormalities in the tissues and organs of the body as a result of disease. Even today physicians continue to think of disease primarily as a pathologic entity, thus diagnose a disease from a tissue specimen (Braunstein, 1981).

The theories formed by Freud and Breuer to explain **hysteria as an illness caused by pathological ideas are also considered as a milestones in the history of causation**. **Theories of animism and vitalism** were also prevalent among public during the same time. According to animism, a soul or anima was present in everyone as the source of all vital function and as a protection against disease. Theory of vitalism held that a "vital principle" existed in a person as the primary factor responsible for health and illness. This substance was felt to keep the body in a state of tonic equilibrium, with disease resulting from an excess or a deficiency of tonus.

The third trend was concerned with **protozoal and viral theories of disease**, which were of course developments of the bacterial theory.

The fourth approach deals with the **nutritional deficiency theories** developed for scurvy and beriberi. The discovery that biochemical abnormalities are associated with clinical disease led to the development of the **molecular model of disease**. This model looks at disease in terms of the changes in body chemistry, deficiency of body nutrients and biochemical defects. Thus, a new group of diseases, called the "inborn errors of metabolism," was identified. **Physiological or mechanical model and the immunologic model** were also developed in this century. The first model is concerned with the pathophysiological

abnormalities that occur during the course of a disease. The immunologic model is dealt with the role of the body's immune system in the cause of disease. A new group of diseases, called "autoimmune diseases" were described in which a disturbance was thought to occur in the body's immune mechanisms, resulting in self-destruction of body tissues and organs (Braunstein, 1981).

Codell Carter says that scientific medicine began, not with pathological anatomy, but: '. . . with the rise of a research programme focusing on causes of disease'. Thus there have been many different concepts of disease, but the medical model of explaining both somatic and psychopathologic disease seems to pertain in the Western medicine.

The notion of multiple causes

Historically, the search for causes of disease marks the development of the notion of multiple causes. This idea of multiple causation was characterized with the symptomatic understanding of diseases.

James L. Bardsley in a Cyclopaedia of Practical Medicine of 1845 (cited from Gillies, 2007) says:

". . . in his account of diabetes, Bardsley identified the following causes: frequent exposure to sudden alterations of heat and cold, indulgence in copious draughts of cold fluid when the system has been over-heated by labour or exercise, intemperate use of spirituous liquors, poor living, sleeping out the whole of the night in the open air in a state of intoxication, checking perspiration suddenly, and mental anxiety and distress [. . .]. Similar lists can be found for virtually any disease in most German, English, or French texts from the period."

The invention of single cause

In the 1860s, a revolutionary change occurred in the concept of cause, which was monovalent rather than plurivalent. Each disease was considered to have just one single cause, which was regarded as being both necessary and sufficient for the disease. To implement this new concept, it became necessary to re-classify diseases, and diseases had to be classified not by symptoms and pathological lesions, but by causes. It appeared first in Pasteur's researches on fermentation and putrefaction and was then transferred into medicine. Codell Carter (2003) points out that at first Pasteur thought that the most important thing in establishing that something was a cause was to show its necessity:

". . . Pasteur's arguments for causality took this form: he found some organism regularly present in an organic process and concluded it was the cause of that process".

Later Pasteur realized that establishing necessity was not enough since an organism might always accompany a process without being its cause. He therefore sought to establish sufficiency as well as necessity. Codell Carter quotes the following passage published by Pasteur in 1878 which defines his mature notion of causality:

"Two phenomena are in a relation of cause and effect if when one of the two exists the other follows. This theory has a historical analysis of any relevance to contemporary discussions of causality as this bacterial theory of a range of diseases laid the foundations of the modern theory of causality of diseases". Codell Carter notes that modern plurivalent concept of causality is not the same as the early 19th century concept, which was rejected by Pasteur and Koch. The main difference is that the modern concept is closely tied to probability and statistics. Pasteur's concept of causality, though it tends to be overlooked by contemporary philosophers of causality, may not have entirely disappeared from medicine".

Davaine, who was the first one to apply Pasteur's concept of causality claimed that the micro-organism 'bacteridium' is the cause of anthrax, a disease which mainly affected cattle and sheep. Yet this claim was not accepted by the majority of his contemporaries.

Codell Carter explains this historical failure as follows:

"Causation is ultimately a theoretical relation, so causal claims can never be justified in the absence of a theory. To say a set of conditions causes an event is to say our theories connect the conditions with the event in a certain ways [. . .]. Without a theoretical context to warrant these connections it is impossible even to conceive of causation, and it is impossible, in principle, to advance beyond such empirical correlations as necessity or sufficiency to justify a causal claim. Regardless of how much empirical evidence Davaine may have accumulated, in the absence of a shared theoretical framework his critics could never have been persuaded."

Codell Carter's historically based claim that theory as well as empirical evidence is needed to establish causality.

Codell Carter (2003) brings out that Freud shifted to the aetiological standpoint, regarding hysteria and similar conditions as caused by ideas rather than bacteria.

" Charcot—like most other late 19th century physicians who dealt with nervous disorders—started with symptoms and ended up with total chaos in the discussion of causes. As a result there were no coherent explanations of anything. By starting with causes, Freud was able to explain the symptoms as well as many other facets of the nervous diseases . . ."

4.1.4 Eastern concept of causality

The eastern theories of causality takes completely different turn which is directly applied in the *Ëyurveda* system of medicine. *Ëyurveda* considers the subject of causes

of diseases from different angles, each angle has got its own importance and utility. According to Gupta (1977), the account of origin in Ayurveda begins with the investigation of the nature of causes (*hetu*) and reasons (*linga*) for legitimate inference in connection with the enquiry into the causes of diseases. There are four main currents on causation theory in Indian philosophy belonging to *Vedanta*, *Buddhism*, *Nyaya-Vaisesika* and *Samkhya* systems, and these laws are called as *Vivartavada*, *Sunyavada*, *Arambhavada* and *Parinamavada* (Satkaryavada) respectively (Gupta, 1977). Among the four theories, *Satk¡ryavada* has been utilized to lay down the fundamental principles of *Ëyurveda*.

4.1.4.1 Sat – Karya – Siddhanta (The law of the identity of cause and effect)

Ayurveda, developed philosophically from *Samkhya darsana* follows a theory of causality-*Sat – K¡rya – Siddhanta*. This law says that what is called the cause is the unmanifested state of what is called the effect, and what is called the effect is only the manifested state of what is called the cause; their substance is one and the same; differences of manifestation and non-manifestation give rise to the distinctions of Cause and Effect. The effect, therefore, is never non-existent; whether before its production, or whether after its destruction, it is always existent in the cause. For, nothing can come out of nothing, and nothing can altogether vanish out of existence (Sinha, 1979). The effect is only the modification (*Parin¡ma)* of cause, and both are ontological realities and are identical, the effect being the cause. *Charaka* seems to adopt in essence the application of *Satk¡ryavada* in reference to the diagnostic purposes when he observes that a disease which is at first only an effect of some other causes may act as a cause of other diseases and it may thus be regarded both as an effect and a cause. There is, therefore, no absolute difference between a cause and an effect; and that, which is a cause, may be an effect and that which is an effect may also in turn be a cause (Gupta, 1977).

Caraka defines birth as the mere transition of one existent thing into another state. This concept is also based on the *Satkaryavada* of *Samkhya*. He says "....man revolves from birth to death like a wheel." He further says that those who are attached to *trigunas* are subject to creation; but not those who are unattached. *Susruta* also regards that an effect is uniform in virtue to its precedent cause '*Karananurupam karyamitikrtva*'. His theory of evolutionary process is dependent on the *Samkhya* concept of cause and effect. (Gupta, 1977).

Definition of Cause and Effect in the Eastern way

One thing is said to be the cause of another thing, when the latter cannot be without the former. In its widest sense, the term, cause, therefore, denotes an agent, an act, an instrument, a purpose, some material, time and space. In fact, whatever makes the accomplishment of the effect possible, is one of its causes. And the immediate result of the operation of these causes is their effect. Time and Space, however, are universal causes, inasmuch as they are presupposed in each and every act of causation.

Causes Upadana and Nimitta**:** *Upadana* ie., the material, which the *Naiyayikas* call *Samavayi* or Combinative or Constitutive, and *Nimitta* ie, the efficient, formal and final, which may be variously, though somewhat imperfectly, translated as the instrumental, efficient, occasional or conditional, because it includes the instruments with which, the agent by which, the occasion on which, and the conditions under which, the act is performed.

There is a real distinction between the *Up¡dana* and the *Nimitta*: the *Up¡dana* enters into the constitution of the effect, and the power of taking the form of, in other words, the potentiality of being re-produced as, the effect, resides in it; while the *Nimitta*, by the exercise of an extraneous influence only, cooperates with the power inherent in the material, in its reproduction in the form of the effect, and its causality ceases with such re-production.

The arguments which establish the Samkhya theory of causality are:

1. There can be no production of what is absolutely non-existent;
2. There must be some determinants material cause for every product;
3. The relation of cause and effect is that of the producer and the produced, and the simplest conception of the cause as the producer is that it possesses the potentiality of becoming the effect, and this potentiality is nothing but the unrealized state of the effect;
4. The effect is seen to possess the nature of the cause; and
5. Matter is indestructible; "destruction" means disappearance into the cause.

4.1.5 Classification of abnormality

"Basic to the study of the natural history of disease is the process of classification. The orderly arrangement of facts so as to bring out the relationships among them …….. is the essence of classification and underlines the clinician's concern with the problems of diagnosis and prognosis ……."

Moriyamma (1960, cited from Brill, 1965)

All classification systems have a variety of functions. Manschreck & Kleinman (1977) give a tentative list of functions of classification system: to indicate etiology,to predicate rational treatment, to indicate prognosis, including complications, and to suggest pathogenesis to aid communication, as a 'short hand' description of behavior for a specialized language, to influence social or legal decisions, to provide a basis for research investigations and to increase the confidence of professionals and the patient. According to Carson & Butcher (1992), classification involves the description of various types, or categories, of maladaptive behavior. Classification is necessary step to:

- Introduce some order into the discussion of the nature, causes and treatment of such behavior.

- Enable communication about particular clusters of behavior in agreed upon and meaningful ways.
- Enable adequate statistical counts of the incidents of various disorders
- Meet the needs of medical insurance companies (which insist on having formal diagnosis before they will authorize payment of claims).

4.1.6 Approaches in Classification

According to Widiger & Frances (1985, cited from Carson & Butcher, 1992), there are three basic approaches to classify abnormal behavior: the categorical, the dimensional and the prototypal.

A **categorical approach**, assumes that a) all human behavior can be sharply divided into the categories normal and abnormal and b) there exist discrete, over-lapping classes or types of abnormal behavior, often referred to as 'mental' illnesses or diseases. The categorical approach bears a close affinity to the identification of diagnosable physical illnesses and some theorists believe that this approach is inappropriate for most types of mental disorder, which do not seem to be discrete.

In a **dimensional approach**, it is assumed that a person's typical behavior is the product of differing strengths of intensities of behavior along several definable dimensions, such as mood, emotional stability, aggressiveness, gender identity, anxiousness, interpersonal trust, clarity of thinking and communication, social introversion, and so on. In this conception people differ from one another in their configuration or profile of these dimensional traits (each ranging from very low to very high), not in terms of surface indications of some presumed 'illness'. Normal could be discriminated from abnormal, then by precise statistical criteria applied to dimensional intensities. e.g. DSM III-R, Axes IV & V. The limitations of this approach include, a) some profiles tend to cluster together in types, b) some of these types

are correlated, though imperfectly, with recognizable sorts of gross behavioral malfunction, such as anxiety disorders or depression. It is highly unlikely, however, that any individual's profile would exactly fit a narrowly defined type, or that the types identified will not have some overlapping features.

A prototype is a conceptual entity depicting an idealized combination of characteristics, ones that more or less regularly occur together in a less perfect or standard way at the level of empirical reality. No item in a prototypally defined group may actually have all of the characteristics of the defining prototype, although it will have many of the more central of them. By adopting a **prototypal approach**, we could wed some of the advantages of the categorical and the dimensional approaches while avoiding the disadvantages of each. This approach, however, requires much blurring of the boundaries between diagnostic groupings (Carson & Butcher, 1992).

In a **multiaxial classification**, several kinds of disorder are considered in every case and recorded on 'axes'. The usual axes are clinical syndrome, personality disorder, physical disease, severity of stressors and disability. In everyday practise only the first three axes are used commonly – psychiatric disorder, personality and physical disease. These three diagnoses can, of course, be recorded without assigning them to separate axes, but the axial system ensures that they are considered in very case. Multiaxial classification is more often used in child than in adult psychiatry with intelligence taking the place of personality. (Gelder, Mayou & Cowen,2001).

SECTION II

4.2 Causes and classification of abnormal behavior in medical sciences

The system of causes and classification is considered as the backbone of any medical sciences. The way doctors diagnose and treat mental illness is purely based on how do they attribute its cause and how do they categorize them. This section describes the causes and classification systems of Psychiatry, Ayurveda, Homeopathy and Naturopathy.

4.2.1 Allopathy/ Psychiatry

"Any man who goes to see a psychiatrist should have his head examined."

(Samual Goldwyn quoted in N.Zierold, 1991 cited from Bentall, 2003)

Psychiatric researchers of the nineteenth century period spent much of their time staring down microscopes at postmortem brain tissue in the hope of discovering the biological basis of mental illness. In the process, they made many important discoveries about the structure of the human nervous system. The historian Edward Shorter has dubbed this era 'the age of the first biological psychiatry' to contrast it with our own times, in which a biological approach is also dominant (Bentall, 2003).

Etiology, or causal pattern of abnormal behaviour is associated with chronological classification of causes and individual causes. The psychiatric classification system is developed in the symptomatology of the clinical picture of the disease. A psychiatric disorder in a single patient can have multiple causes. They are predisposing, precipitating and perpetuating factors (Puri, Laking & Treasaden, 1996).

A **predisposing cause** predisposes a person to vulnerability to psychiatric disorders; parental rejection could predispose a child toward difficulty in handling close personal relationships later. It increases susceptibility to psychiatric disorder, which operate throughout

patient's lifetime. A **precipitating cause** arises just before a psychiatric disorder starts, and which appear to have precipitated it. It determines its time of onset. A **perpetuating (maintaining / reinforcing) cause** tends to maintain maladaptive behavior that is already occurring. It delays recovery from illness.

In a given case, a primary cause may be either absent or unknown, or two or more factors may share primary responsibility. Likewise, the exact patterning of primary, predisposing, precipitating and reinforcing causes may be far from clear; a given factor or even may contribute to a disorder in more than one way (Carson & Butcher, 1992).

4.2.1.1 Biological causal factors

Psychiatric classification primarily looks into the biological causation of mental illness. The causes include Genetic defects: Chromosomal anomalies, faulty genes; Constitutional liabilities: Physique, physical handicap and Brain dysfunction. Significant damage or loss of brain tissue places a person at risk for psychopathology.

4.2.1.2 History of psychiatric classification

The history of medicine had seen several abrupt leaps and shifts wherein one theoretical framework was eventually abandoned in favour of another, incompatible, framework. According to Kuhn (1970, cited from Bentall, 2003), each science begins in fits and starts until researchers eventually accept a common paradigm (framework or set of assumptions about the nature of their subject matter). While tracing the developmental history of psychiatric classification, one can find different traditions, which marked various attempts to classify abnormal behaviour throughout the ages. The pre-nineteenth tradition includes Celsus (20 BC –AD 40), Aretaeus (30-90), Galen (130-200), Barrough (1560-1590), Cosin (1549-1597), Cullen (1710-1790) and Pinel (1745-1826) and their classification remain unchanged until the beginning of the nineteenth century. This system divides mental illnesses into Delirium, Dementia, Depressive illness, Mania schizophrenia, Neurological conditions, Developmental disorders and neuroses (Cutting, 1997).

Attempts to categorise disease is primarily began from the classification of plants into species. Thomas Sydenham of seventeenth century believed that disease could be classified in much the same way, as Linnaeus would later group plants. In the oft-quoted passage Sydenham (1848 cited from Hudson, 1993) wrote the following:

"Nature, in the production of disease, is uniform and consistent; so much so, that for the same disease in different persons the symptoms are for the most part the same; and the self same phenomena that you would observe in the sickness of a Socrates you would observe in the sickness of a simpleton. Just so the universal characters of a plant are extended to very individual of the species; and whoever… should accurately describe the colour, the taste, the smell, the figure, etc., of one single violet, would find that his description hold good, there or thereabouts, for all the violets of that particular species upon the face of the earth."

As Henry Siegerist (1971, cited from Hudson,1993) puts it, “Hippocrates wrote the history of sick persons, but Sydenham wrote the history of diseases”. In the eighteenth century, Linneaus, a medically qualified professor of botany devised a less well-known classification of disease in which one major class was mental disorders (Gelder, Mayou & Cowen, 2001). The greatest attempt to accomplish the goal of classification that Sydenham espoused came in the eighteenth century at the hands of Francois Boisser de Sauvages when he published *Nosologia methodica*, in which disease were divided into ten classes, fourty orders, and so on, 2,400 species (Sauvages, 1768 cited from Hudson, 1993). For the most part he was unwittingly describing symptoms and syndromes, not disease entities.

Nineteenth century

During the nineteenth century, French psychiatrists mainly Pinel (1801), Esquirol (1838), Morel (1860), Falret (1864) and Magnan (1893) put forward four categories of psychiatric disorders –Delirium, Dementia, Manic –depressive illness and Schizophrenia (cited from Cutting, 1997). The neurological illness (epilepsy), developmental disorders (idiocy) and neuroses (hysteria and hypochondriasis) have been included outside these categories. Benedict Morel insisted that a true classificatory system in Psychiatry should be based empirically on the cause, the symptomatology, the course and outcome of a disease (Shepherd, 1971). Bayley's (1799- 1858) discovery provided three seemingly incontrovertible facts about the nature of madness. (1) Brain disease could definitely give rise to madness (2) If there were varieties of madness, then these, like physical illnesses, would have their own unique 'life cycles'. With phases (development, progression and decay), which might well, throw up different symptoms and obscure any essential quality of an individual variety.(3) The very existence of discrete varieties of madness, based on some enduring quality through these phases, was not at all ensured , because the enshrined varieties (melancholia, mania and dementia) appeared to be but phases of the same brain disease observed at different times.

Neurosis and Psychosis

In the past, the concept of psychosis and neurosis were included in most of the classification. But neither these terms are used as an organizing principle in ICD-10 and DSM-IV. In practise, however, these terms are still used widely; hence it is of practical importance to understand their history and usage. The term *neurosis* was introduced by Cullen to denote disease of the nervous system. Gradually the category of neurosis narrowed, first as neurological disorders with a distinct neuropathology (such as epilepsy and stroke) were removed, and later with the development of a separate category of psychosis. Feuchterleben

who suggested the term psychosis wrote that psychosis denotes severe mental disorders. *"Every psychosis is the same time a neurosis but not every neurosis is psychosis"*. In modern usage, the term psychosis refers to severe forms of mental disorder such as organic mental disorders, schizophrenia and some affective disorders. The terms neurosis and psychosis, which was a fundamental classificatory principle in ICD-9, as abandoned in DSM –III and subsequently in ICD-10 because first, the conditions embraced by the term have little in common and second, it is less informative to classify a disorder as psychosis than it is to classify it as a particular disorder within the rubric of psychosis. Although these terms have little value in a scheme for classifying mental disorders, it is still in everyday use as a convenient term for disorders that cannot be given a more precise diagnosis because insufficient evidence is available, for example, when it is still uncertain whether a disorder is schizophrenia or mania (Gelder, Mayou & Cowen, 2001).

Kraepelin's turn in Psychiatry

The first systematic classification system of psychiatric disorders belongs to the German psychiatrist Emil Kraepelin. Emil Kraepelin born in 1856 was much influenced by his older brother Karl, a respected biologist who made contributions to the classification of plant species. Kraepelin rejected the nineteenth century scheme and identified grouped different mental disorders on the basis of their symptoms. What is remarkable about Kraepelin's system is how closely it resembles the pre- nineteenth century system and he brought together different concepts of disease into a single entity

Once Kraepelin had decided that the psychoses fell into a small number of discoverable types, the next step was to establish exactly how many different types there were. He recognized that symptoms changed with time, and therefore that patients should be observed throughout their lifetimes, made Kraepelin to collect thousand and more case studies. And it was on the basis of these case studies that he began to conclude that different

groups of symptoms followed characteristically different courses. Kraepelin assumed that there were a discrete and discoverable number of psychiatric disorders. Although he recognized that some symptoms could occur in more than one disorder, he argued that each disorder has a typical symptom-picture. He also believed that the different disorders were associated with different types of brain pathology and with different etiologies. On this view, the first step towards discovering the causes of mental illness was to identify the different disorders on the basis of their symptoms (Bentall,2003).

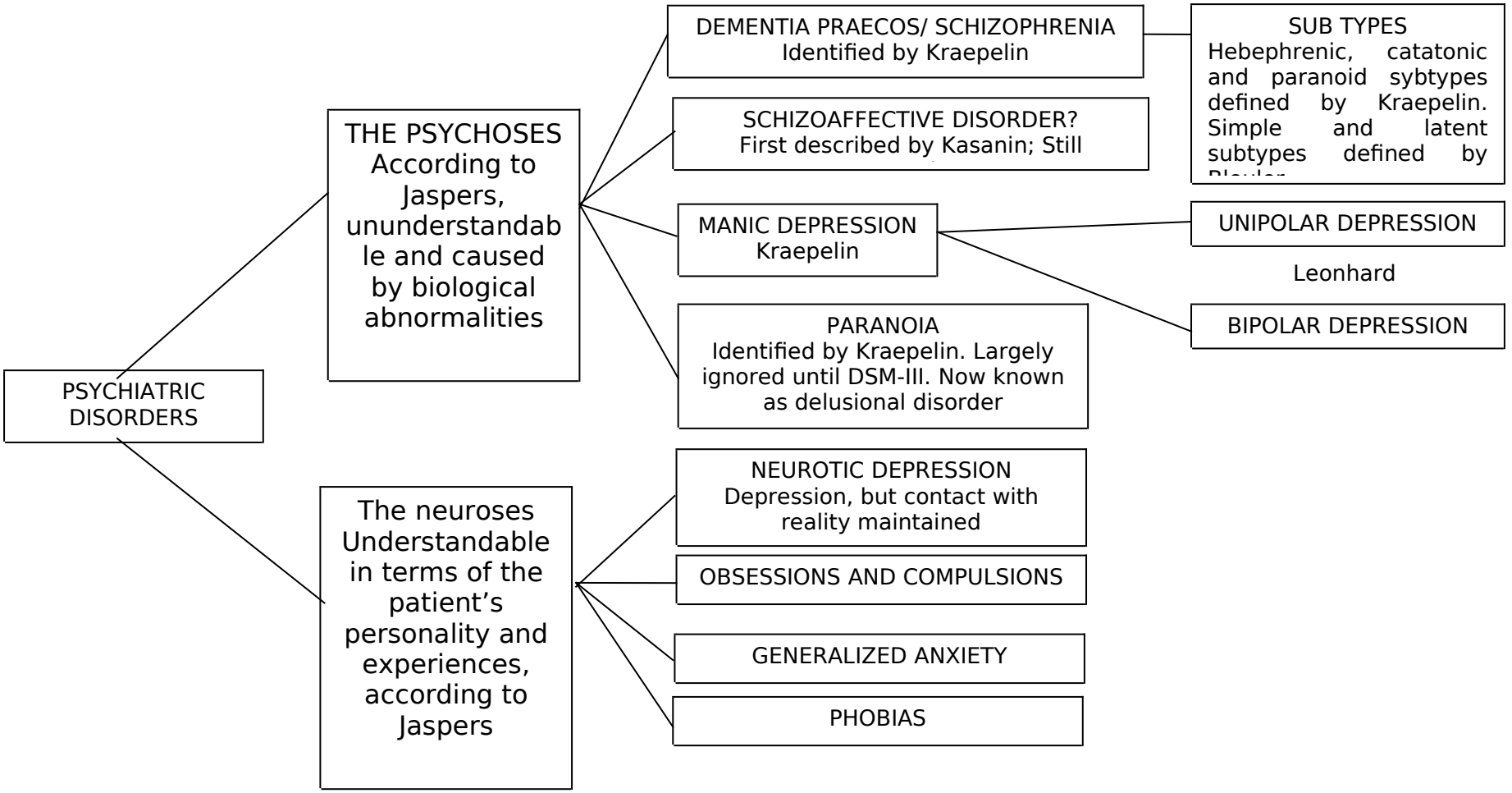
Between 1893, when he published the fourth edition of the Textbook and 1915, when the eighth edition was published, Kraepelin began to group together illnesses described by other researchers that apparently had a poor outcome. He included catatonia, a disorder characterized by stupor and abnormal postures. Also included was hebephrenia, a disease that struck during adolescence and which led to a rapid deterioration of mental functions. Next was **dementia praecox**, a disease which again led to rapid deterioration, but which was characterized by bizarre fears of persecution. Finally, he grouped all mood disorders into the single category of **manic depressive illness**, which features a recurrent or 'circular' disorder of mood in which episodes of illness were followed by periods of normal functioning. He included disorders in which there are episodes of depression but no episodes of mania, which would now be described as unipolar depression. He also included illnesses in which the individual experienced only one episode followed by a complete recovery. A final category of illness, described by Kraepelin, but given less attention by later historians of psychiatry, was **paranoia**. This term was used to refer to a chronic illness characterized by delusional beliefs in the absence of significant changes to the patients' personality. (Bentall,2003).

Kraepelin's approach was uncompromisingly medical:

"*Judging from our experience in internal medicine, it is a fair assumption that similar disease processes will produce identical symptom pictures, identical pathological anatomy*

and an identical etiology. If, therefore, we possessed a comprehensive knowledge of any of these three fields – pathological anatomy, symptomatology, or etiology – we should at once have a uniform and standard classification of mental diseases. A similar comprehensive knowledge of either of the other two fields would give us not just as uniform and standard classifications, but all of these classifications would exactly coincide." (cited from Bentall, 2003). Figure 4.1 summarises the psychiatric classification followed during 1970s'.

Fig 4.1 Psychiatric classification during 1970s' (cited from Bentall, 2003)



Twentieth century / After Kraepelin

The chief events in this century have concerned mainly with the rapidity with which Kraepelinian system was accepted among the psychiatrists all over the world. Proposals and alternative views have been arose to revise this system. The most notable revisions of the dementia praecox concept was its renaming as schizophrenia and recommendations to include a particular set of deficient mental functions together with the presence of delusions and hallucinations as first rank symptoms of the condition. Anti-Kraepelin trend took a different direction (by some Scandinavian and German psychiatrists).

Another trend in the psychiatric classification prominent in the Soviet Union and the United States was the undue diagnostic weight given to the social consequences of madness. The last half of the twentieth century witnessed the formation of American Psychiatric Association's Diagnostic and Statistical Manual for psychiatric diagnosis. Cutting (1997) says that there is a certain amount of sniping and chipping away at some of the assumptions, but Kreapelin's edifice, and by extension the pre-nineteenth system is stronger today than it has ever been.

Shepherd (1971) notes that Robert Kendell's (1972) view in this context that:

"Although few contemporary psychiatrists are content with depressive illness or schizophrenia as disease entities in the traditional sense, we continue to use this Kraepelinin edifice if only because it is familiar and we have nothing better to put in its place".

Bentall (2003) gives four observations to show how Kraepelin's diagnostic system remains still unchallenged within the mental health profession as a whole. First, modern textbooks of psychopathology, whether written by psychiatrists or psychologists, almost without exception, are organized according to some variant of Kraeeplin's system, with chapter headings on 'schizophrenia' (renamed for dementia praecox by a Swiss psychiatrist,

Eugen Bleuler) ‘manic depression’ and so on. Second, the official diagnostic systems currently advocated by influential bodies such as the WHO and the APA are similarly organized in a way that reflects Kraepelin’s assumptions about the nature of madness. Third, most research in psychiatry 9whether conducted by psychiatrists or psychologists) is based on Kraepelin’s paradigm. Finally, clinicians throughout the world typically employ Kraepelin’s diagnostic concepts during their routine work, for example, when explaining to patients what is wrong with the, and when deciding what treatment should be offered. Figure 4.1 explains the psychiatric classification followed during 1970s.

4.2.1.3 Diagnostic classification

DSM, the official classification system for mental disorders in the United States and elsewhere, has undergone many revisions. This frequent alteration of the taxonomy of recognized mental disorders, while to some extent justified by increase knowledge and understanding of the manner in which psychological problems manifest themselves. American Psychiatric Association’s Diagnostic and Statistical Manuals (DSMs) and the World Health Organization’s International Classification of Diseases (ICDs) are considered as the official classification systems for Psychiatry and General Medicine respectively. Compared to the concept of classification in other medical systems, these documents represent a unique portrait of current psychiatric understanding as it follows an evidence- based methodology and findings, the periodic changes they have undergone with new editions. One of the main goals of the periodical revision is to coordinate the DSM diagnostic categorization system with the ICD. Another reason is that using diagnostic systems reveals their inadequacies in terms of reliability and validity. Thus there is a need to incorporate refinements in the system that improve the understanding of patient problems and enable the communication of ideas and research findings through an agreed upon language. One important goal in the revision of

DSM III R is to incorporate an ongoing, multisite research program to make revision in the system (Spitzer & Williams, 1988 cited from Carson & Butcher, 1992) .

The distinctive innovation in DSM-III (and DSM-III R) is its attempts to use only 'operational' criteria for defining the different disorders included in the classification systems. This innovation means that the DSM system specifies the exact behaviours that must be observed for a given diagnostic label to be applied. In a typical case, a specific number of signs or symptoms from a designated list must be present before a diagnosis can properly be assigned. In other words, efforts have been made to remove subjective elements from the diagnostic process. To the extent this goal can be achieved, diagnostic reliability is substantially improved. On the other hand, the use of stricter criteria can cause much abnormal behavior to be assigned to 'waste basket' or residual categories such as 'psychotic disorders not elsewhere classified'. When this occurs, validity suffers, since a category so broad can give only generalities about disorders within it.

DSM-III-R evaluates an individual's behavior according to five dimensions, or axes. The first three axes focus on an individual's present condition. (I) The particular maladaptive symptoms, or clinical psychiatric syndromes, such as schizophrenia. (II) Any long-standing personality problems (adult) or specific developmental problems (children and adolescents) (III) Any medical or physical disorders that may also be present. (IV) The severity of psychosocial stressors. (V) The level of adaptive functioning

More than one diagnosis may be recorded on Axes I and III, and in exceptional instances, on Axis III. A person may have multiple psychiatric symptoms or medical diseases (Axis I and III, respectively), and may have more than one personality disorder diagnosed on Axis II. The last two DSM-III axes are used to asses broader aspects of an individual's situation, one dealing with the stressors that may have contributed to the current disorder and the other dealing with how well the individual has been coping in recent months.

Axis I & II containing several broad groupings, each containing several subgroupings:

1. Organic mental disorders refer to disorders involving gross destruction or malfunctioning of brain tissue (as in Alzheima's disease) and a wide range of other conditions based on brain pathology.
2. Substance use disorders involve problems such as drug and alcohol abuse.
3. Disorders of psychological or socio cultural origin has no known brain pathology as a primary causal factor, as in anxiety, psycho physiologic, psychosexual, and personality disorders. The functional psychoses - that is, severe mental disorders for which a specific organic pathology has not been demonstrated such as major mood disorders and schizophrenia, are also traditionally included here, although it appears increasingly likely that certain types of brain dysfunction sometimes help cause them.
4. Disorders usually arising during childhood or adolescence include mental retardation and special problems, such as early infantile autism and pervasive developmental disorders, that may occur in children and that warrant separate categorization, as well as other problems of childhood, such as hyperactivity and conduct disorders.

Axis III of DSM-III-R is often used in conjunction with an Axis I diagnosis of psychological factors affecting physical condition. An Axis III diagnosis, which requires a medical examination, is used when a diagnostician has reason to believe that a psychological factor is contributing in some way to a physical disease. Axis III itself can be used for any physical disorder that accompanies a psychiatric one, whether or not the two are related. Axis IV and V are significant additions. Some clinicians, however, object to the routine use of these axes for insurance forms and the like on the grounds that such use unnecessarily compromises a patient's right to privacy. Because of such concerns, Axis IV and V are now considered optimal for diagnosis and in fact are rarely used in most clinical settings.

Criticisms to DSM

"We are not interested in the fact that the brain has the consistency of cold porridge."

(Alan Turing quoted in A. Hodges, 1983 cited from Bentall, 2003)

DSMs- has been subjected to unrelenting critique, much of it by philosophers, since the 1970s and 1980s, which framed as flawed science or as repositories of dangerous social power. Bentall (2003) says that whatever flaws they contain, however, the presence and influence of these classifications are evident in every facet of the research field. Not all writers and practitioners subscribe to the DSM classification system and critics to DSM system view it from somewhat different perspectives and with different degrees of respect for their utility.

Biochemical explanation is not suffiecient

Engel (1978) brings out Kety's (1974) argument here. A specific biochemical abnormality capable of being influenced pharmacologically exists in schizophrenia as well as in diabetes, certainly a plausible possibility. In the biomedical model, demonstration of the specific biochemical deviation is generally regarded as a specific diagnostic criterion for the disease. Yet in terms of the human experience of illness, laboratory documentation may only indicate disease potential, not the actuality of the disease at the time. The abnormality may be present, yet the patient may not be ill. Otherwise, the abnormality may not be present, yet the patient may be ill. Thus the presence of the biochemical defect of diabetes or schizophrenia at best defines a necessary but not a sufficient condition for the occurrence of the human experience of the disease, the illness.

One of the major problems in the DSM classification system is that *the categories describe rather than explain*. When the term schizophrenia is applied to an individual's behavior the pattern of the disorder is not mentioned, but the person's behavior resembles that of individuals is used to define schizophrenic.

A second limitation is that *only individual behavior is covered.* Disturbed families,

delinquent subcultures, and violent - prone societies show maladaptive behavior that does not fit into a scheme made for classifying individuals. Classifying only individual behavior as abnormal implies that when individuals do not fit smoothly into their social milieu, it is the individuals who are at fault and must change. This attitude casts the mental health profession in the role of preserving the status quo, no matter how abnormal the status quo might be.

Psychiatry's theories ion causation and classification of abnormal behavioural raises many conceptual issues as per the above descriptions. The frequent changes in the DSM & ICD classification systems also could not provide a flawless notion of abnormal behaviour. Analysis of Ayurveda, Homeopathy and Naturopathy in this context would give new intuitions into some of the dilemmas faced by Psychiatry.

4.2.2 Ëyurveda:

Ayurveda explains the causes and classification of abnormal behaviour based on its philosophical roots.

4.2.2.1 Causes of diseases

Caraka attributes the causes of diseases to *ayog¡* (deficient), *atiyoga* (excessive), and *mithayog¡* (perverted) condition of *artha*, *karma*, and *kal¡*. These have been called *trividharog¡yatan*, i.e., *asatmendriy¡rtha samyoga*, *prajn¡paradha* and *parin¡ma* as the abode of diseases. In *Ëyurveda*, the *sam¡yoga* of *indriy¡rtha, parin¡ma*, and *prajna* is regarded as the cause of health. Whenever the *sam¡yoga* (equability) is disturbed, then they become the cause of diseases. Each factor needs to be explained separately.

Asatmendriy¡rtha Samy°ga: *Indriy¡rtha samyoga* are the cognitive processes through which a man becomes aware of both the external and internal environment. The deficient, excessive and perverted use and incidence of senses, i.e., the five organs of senses and five organs of action might lead to diseases. These diseases, which occur due to *asatmendriy¡rtha samyoga* are known as *aindriykha vy¡dhi*.

Prajnapar¡dha: *Prajna* or *buddhi* is called '*sad-asad vivekini*.' The perverted use of *manas*, *prajna*, *sar¢ra*, and *v¡k* is responsible for the *ay°ga, atiy°ga* and *mithay°ga* of *karma* which stimulate the occurrence of disease. It is the fault of understanding or volitional transgression. While explaining the cause of *karmaja r°ga* in the context of *Unm¡da*, *Caraka* says even the *karmaja rogas* are due to improper wisdom or judgments. *Caraka* says that wise men when inflicted with disease which arise from *prajnaparadha* and is the result of his own *karma*, then he should not rail against the gods etc. *Karma* has been also regarded as one of the *ayatan* of *rogas* and the vitiating effects of it in connection with producing diseases have been mentioned in *Ëyurveda*. The activity of speech, mind and the body is known as *karma* (Gupta, 1977).

While describing the epidemics, *Caraka* holds that the general deterioration of atmosphere factors like wind, *de¿a, k¡la*, and *jala* happens due to *adharma* or *purva jamakrta karmas* and the cause of both of them is *prajn¡par¡dha*. So, the ultimate root of all disease producing factors has been told to be *prajnaparadha*. It is the unique principle of Ayurveda, which gives great steers on this fundamental factor for the occurrence of disease (Gupta, 1977).

Parinama: *Parinama* includes the deficient or excessive or perverted incidence in the seasons (*kala*). The derangement in the seasons is also responsible for the occurrence of diseases. The *sancya* and *prak°pa* of *dosas* depends upon the seasons, then there is greater possibility of occurrence of diseases, due to the upsetting of the normal equilibrium of *dosas*. Now if a season is marked with an exaggeration as its characteristics, it is spoken of as seasonal excess, if it is marked with a deficiency of its traits, it is spoken of as seasonal deficiency, and if the season is marked with characteristics, that are contrary to its true nature, then it is spoken of as seasonal abnormality (C.S. I. 11.42, cited from Gupta, 1977).

Dosas: Intrinsic causes of diseases

The disease in *Ayurveda* is defined as *DoÀa dh¡tu sammurc¡nam* which is the morbid interaction between the vitiated *doÀas* and the *dhatus* (body tissues). According to *Caraka*, these *dosas* moving in the whole body produce good and ill effects on the entire system, according as they are normal or provoked. When normal, they produce good effects, whereas when they become abnormal, they produce *vik¡r¡s*.

When an obstruction takes place in the *¿rotas*, a series of changes follow. *Kriy¡k¡la* describes the mode and stages of the developments of disease. *Caraka* and *Vagbhata* have described three broad based consecutive steps, viz., *C¡ya*, *prakopa* and

prasamana, however, *Su¿ruta* describes them into six distinct stages, viz., *C¡ya, prakopa, prasara, sthanasamacaya, vyakti*, and *bheda*.

Su¿ruta says that a physician should carefully study advancement of the disease. The deranged *doÀas*, if checked in the *cayavastha,* may not be able to proceed with subsequent evolutive changes. If left neglected, they may intensify in the course of their development. These various *kriyak¡l¡s* represent the incubation periods, specific modes of spread and manifestation, localization, quiescence, activity etc. *Caraka* clearly mentions that the physician should not wait until full-fledged disease is established with all its symptoms. He should not waste time in searching the name of disease and he should not allow the disease to progress from the earlier to the next stage.

Other causes of diseases

Some other factors in *Ayurvedic* literature is also explained as the cause of diseases. *Susruta* regards diseases of four kinds viz., (1) *Ëgantuka* (2) *áaririka* (3) *M¡nasika* (4) *Sv¡bh¡vika* and he mentions different causes for different types of diseases. *Agantuka* diseases are caused due to traumatic factors like injuries affected by weapons or some other external causes. The *saririka* diseases happen due to the use of deficient, pervasive or excessive food. *Caraka* stressed on the diet factor for preserving health or causation of diseases and a detailed dietic regimen has been prescribed by him according to the *prak¤ti* of the person and different reasons. The *¿¡r¢rika* diseases are produced to the unwholesome combination of *doÀas*. According to *Su¿ruta*, the *m¡nasika rogas* are caused by the psychic and emotional *doÀas* like *k¡ma, krodha, bhaya, harsa, visada, irsya, manodainya, iccha*, and *dvesa* etc. and the last category of *rogas*, i.e., *sv¡bh¡vika* are hunger, thirst, old age, and death.

Ayurveda also gives importance to the necessity of practicing the *svasthav¤tha*. These are the rules which have been prescribed in *Ayurveda* for attaining ideal health and they cover all the aspects of personal hygiene consisting of all the health making regimens of diet and conduct. *Caraka* declares that diseases occur in those men, who do not observe the rules of healthful living. Besides, these various nature of causes of disease, *Caraka* describes the causes of the epidemic diseases (*janpadoddhvamsa*) as the contamination or vitiation of *v¡yu, desa, k¡la*, and *jala*. These four factors when in normalcy are beneficial; otherwise when vitiated they produce the epidemic diseases.

4.2.2.2 Classification of diseases

Is disease one type or many?

Ayurveda puts forward two dimensions of the concept of disease. Diseases are of one group in view of the pain as common factor to all. But *Caraka Samhita* also states that multiplicity of the classification of diseases may be numerable or innumerable. Their numerablity has been described in the 19th chapter of Sutrasthana and their innumerability on the basis of variations in pain, color symptoms etc. has been described in the 18th and 20th chapters of that section (Sutra 18:42 and Sutra 20:3.[3]) (Sharma & Dash, 2008).

Various arguments concerning the criteria of classification can be found in the chapter of Caraka Samhita on the "Determination of the specific characteristics of diseases." In some cases the criterion of classification may appear to be the same as the previous one but the specific feature of each of these criteria should be observed in deciding about the validity of this classification. But grouping of diseases is explained both as numerable and innumerable. These two terms, numerable and innumerable, stand contrary to each other and how these mutually contradicting meanings stand together can be applied to the same thing, disease. If the same criteria are followed for classification, any change in the number of groupings will be incorrect. On the other hand, if the criteria of classification are different, the change in the

number of groupings is quite justifiable and this does not involve any contradiction. Applying each of the criteria of prognosis, intensity, location, nature of the causative factors and the site of origin, *dosas* are of two categories. All these criteria are taken together, diseases are of ten categories.

Diseases are classified into two groups each on the basis of the five different criteria as follows:-

Criteria of classification	Groupings of diseases
1. Prognosis	Curable (sadhya)
	Incurable (asadhya)
2. Intensity	Mild
	Severe
3. Location	Mental (manodhistan)
	Physical (sariradhistan)
4. Nature of the causative factors	Endogenous
	Exogenous
5. Site of origin	Having origin from *amasaya* (stomach)
	Having origin from *pakvasaya* (colon)

Even though diseases are of two groups each according to prognosis, intensity, location, nature of the causative factors and site of origin, still by different permutations and combinations they may be only of one group or many groups. All diseases may be of one group because manifestation of pain is common for all. They may be of many groups on the basis of their ten-fold classification according to different criteria.

4.2.2.3 Physical and psychic *doÀas* and their vitiators:

Because of their highly multitudinous nature, diseases are innumerable. On the other hand, *dosas* are numerable because of their limitation in number. So only some of the diseases will be explained by way of illustrations whereas *doÀas* will be explained in their entirety.

Rajas and *tamas* are the *dosas* pertaining to the mind and types of morbidity caused by them are *kama* (passion), anger, greed, attachment, envy, ego, pride, grief, worry, anxiety, fear, excitement etc. These two *doÀas* are in eternal union with each other. *Tamas* cannot manifest its actions without Rajas. *V¡ta*, *pitta*, and *kapha* are three *doÀas* pertaining to the body. Diseases caused by them are fever, diarrhea, edema, consumption, dyspnea, *meha*, *kustha* etc. Thus *doÀas* in their entirety and diseases in parts are explained.

Both these types of *doÀas* have three types of etiological factors, viz. (1) unwholesome contact with the object of senses, (2) intellectual blasphemy and (3) seasonal vagaries.

The term '*roga*' may be applicable to both the *doÀas* and *vy¡dhi* but there is difference between the latter two, in as much as *doÀas* are numerable and diseases are innumerable. One *doÀa* may be responsible for the causation of many diseases, hence in comparison with diseases, *doÀa* are a few in number. As it is impossible to describe all the diseases in view of their innumerability, only some of them are explained which are discovered by ancient sages. *DoÀas* pertaining to mind are given priority in the order of their description because they are comparatively smaller in number.

All the diseases caused by the aggravation of *kapha* and *pitta* are included under diseases origin from *amasaya* (stomach). Similarly, all diseases caused by the aggravation of *vata* are included under the groups of diseases having origin from *pakvasaya* (colon). Even

though, *dosas* themselves are of limited in number compared to diseases, the concept of dosas is the fundamental theory of Ayurvedic understanding of health and illness. Sutra 18-45 narrates that because of the variations in the causative factors and the tissue elements afflicted by them, *doÀas* when aggravated manifest innumerable types of diseases.

Co-existence of 'psycho' and 'somatic diseases: When psychic and somatic diseases become chronic due to their intensity, they may get combined with each other. Such combinations rarely occur when the disease is manifested only for a short period. Such combination of diseases belonging to one group may also result in the combination with diseases of another group when they allowed to persist for a long time.

Combination of physical dosas: The three somatic *doÀas* located in the same place and having identical attributes mostly combine with one another (*samsarga*) or with all taken together (*samnip¡ta*). Attributes of *doÀas* resemble those of the factors which vitiate them. One substance may vitiate many dosas, eg., substances having sour, salient and pungent tastes vitiate *pitta*, but those of sour taste vitiates *pitta* as well as *kapha*, those of salient taste vitiates *kapha* as well as *pitta* and those of pungent taste vitiate *pitta* as well as *v¡ta*.

Similarly, spring season which normally aggravates *kapha* also aggravates *pitta* and *v¡ta*, because of its *¡dana* nature (property of absorbing water from the earth). *Pitta* accumulated in the rainy season gets aggravated during the autumn but there is simultaneous aggravation of *kapha* also. Similarly in the summer, due to unctuousness, *v¡ta* gets aggravated in view of the unctuousness of the season and simultaneously there is slight accumulation of *pitta* due to seasonal heat.

4.2.2.4 Primary and secondary diseases *(anubandhya and anubandha):*

DoÀas vitiated during the process of manifestation of a disease may be of primary or subordinate in nature. The primary disease manifests its own symptoms independently; this morbid condition is caused by factors specific to the manifestation of disease (if various factors which vitiate different *doÀas* are responsible for the vitiation of a *doÀa*, that particular *doÀa* should be treated as of primary nature). Such primary *doÀas* manifest their respective diseases when they get aggravated. This can be cured by the therapies prescribed for the vitiation of that particular *doÀa*.

On the other hand, subordinate *doÀas* manifest their respective symptoms only when they are stimulated by the *doÀa* of primary nature to do so. If all the three *doÀas* are primarily vitiated at a time, the condition is known as *samnip¡ta*. If only two of the *doÀas* are vitiated, it is called *samsarga*. In view of their unmanifested (not well manifested) symptoms, subordinate *doÀa* do not get aggravated by the factors responsible for their aggravation as mentioned earlier nor do they get alleviated by the therapy prescribed specifically for them. They get alleviated only when the therapy prescribed for the other *doÀa* of primary nature is administered. That is to say the aggravation and alleviation of subordinate *doÀas* are affected by the causative factors and therapies, other than their own. This is because they share the attributes of the *doÀa*, of primary nature to some extent. For example, in the autumn season *pitta* is vitiated primarily. Therefore we can say that in Ayurveda diseases are considered to be interconnected.

4.2.2.5 Classification of insanity (Unmada)

Unmada is of five types. They are due to *V¡ta*, *Pitta*, *Kapha* and *Samnip¡ta* (combined vitiation of all the three *doÀas*) and *Bh£tonm¡da* (exogenous). The four

types of *Unmada* (Insanity) caused by the vitiation of *doÀas* manifest themselves quickly in the following circumstances;

- When an individual is timid;
- When his mind is afflicted by the predominance of *Rajas* and *Tamas*;
- When *doÀas* in his body are aggravated and vitiated;
- When he takes food consisting of unwholesome and unclean ingredients possessing mutually contradictory properties or touched by the clean hands of persons suffering from contagious disease like leprosy, neglecting the prescribed dietic rules (viz. conformity with nature etc., of the ingredients);
- When he resorts to such regimens and actions as are not conductive to good health;
- When his body is exceedingly depleted;
- If he is not in proper state of health due to other diseases;
- When his mind is afflicted over and over again by passion, anger, greed, excitement, fear, attachment, exertion, anxiety and grief;
- When he is subjected to excessive physical assault.

Insanity manifests itself immediately after the appearance of the above-mentioned premonitory symptoms; the distinctive types of insanities are as follows:

Vatika Type: The symptoms of *v¡tika* type of *unmada* include:

Constant wandering, sudden spasm of eyes, eye brows, lips, shoulders, jaws, forearms and legs; constant and inherent speech; coming out of froth from the mouth; always smiling, laughing, dancing, singing and playing with musical instruments in appropriate situations; riding undesirable vehicles; adoration by such things as are not needed for ornaments; longing for eatables not available; emaciation and roughness; projected and

reddish eyes; and aggravation of the condition by such of the regimens as are not wholesome vata.

Paittika type: *Paittikonm¡da* has many symptoms. They are irritation and anger; excitement on inappropriate occasions; inflicting injury on own people or on others by weapons, brick bats, whips, sticks and fist; feeling and desire for shade, cold water and food having cooling effect; continous state of anguish; havinf ferocious eyes of coppery, green or yellow colour; and aggravation of the condition by such regimens as are not wholesome for pitta.

Slaismika type**:** *Slesmikonm¡da* or *Kaphajonm¡da* has the following symptoms.

Staying in one place and observance of silence; occasional movement; discharge of saliva and nasal excretions; delineation for food and love for solitude; frightening appearance; aversion for cleanliness; remaining always sleepy; oedema in the face; white and timid eyes with excreta adhered to them; and aggravation of the condition by such regimens as are not wholesome for kapha.

Samnip¡tika type

In the insanity caused by the combined vitiation of all the three dosas, all the symptoms mentioned above are simultaneously manifested. This type of insanity is considered to be incurable.

Exogenous insanity:

The type of insanity having etiology, premonitory symptoms, actual symptoms, pain and homologation (*upasaya*) different from those of the types of insanity caused by the

vitiation of dosas is known as ‘exogenous’. Some scholars hold the view that this type of insanity is caused by the effect of the sinful activities of the past life.

The premonitory symptoms of the exogenous type of insanity caused by the ill effects of anger of the gods etc. are as follows

1. Desire for inflicting injury upon the gods, cows, Brahmins and ascetics;
2. Anger and liking for mischievous work;
3. Disliking attitude and impairment of ojas, colour complexion and physical strength; and
4. Abuse and incitement by the gods etc.

Insanity manifests itself immediately after the occurrence of these premonitory symptoms. The causative agents of the exogenous types of insanity initiate their action as follows

1. The gods produce insanity by their vision;
2. Preceptors, elders, adepts and ascetics by their curse;
3. Ancestors by exhibiting themselves;
4. Gandharvas by their touch;
5. Yakas by seizure;
6. Raksasas by making the patient to smell the odour of their body; and
7. Pisacas by riding and dividing their victims

Objectives in causation of insanity

Insanity is caused by these agents with three objectives, viz. (1) to inflict injury (2) to play and (3) to offer prayer. Their intentions can be judged from the characteristic features of the patient. When the intention of the afflicted agents is to inflict injury, then the patient enters into fire sinks into water, falls into a pit, strikes himself with weapons, whips, sticks, brick bats, his own fist etc. he may also adopt such other means for killing himself. This type of insanity is

incurable. If the intention of the causative agents is the remaining two i.e., to play or to offer prayer, then this is curable. The gods etc., by themselves do not enter into the body of the patients. Only their subordinates having identical nature affect the patient in order to cause insanity.

Classification and prognosis

Insanity along with its five types, classified as endogenous or curable and incurable, are again grouped into two. At times, due to the combination of etiological factors (of endogenous and exogenous types), they are manifested in a combined form. There is combination in their premonitory as well as actual symptoms. Combination of the incurable varieties or the curable andincurable varieties results in the incurability of the condition. Combination of the curable varieties, however, results in the curability of the condition. For the treatment of this (last mentioned) condition, there should be the combination of therapies

Combination of the endogenous types of insanity caused by the simultaneous vitiation of all the three dosas with the exogenous type caused by the agents having intention to inflict injury illustrates the combination of incurable types. Combination of the endogenous type of insanity caused by the vitiation of only one of the three dosas with the exogenous type caused by agents having intention to inflict injury illustrates the combination of curable and incurable types. When two curable types of insanity are combined, it results in curability and not incurability.

Misdeeds as causes of insanity

Thus it is said “neither the gods, nor gandarvas, nor pisacas nor raksasas afflict a person who himself is free form misdeeds. The primary causes of insanity in an individual are his own misdeeds and other agents like the gods etc. act only as the consequence of these misdeeds.

There cannot be the manifestation of anything which is already manifested. Thus, verily the gods etc., are not causative factors of insanity in human beings".

It is only when incited by the misdeeds of the individual that the gods etc., produce insanity. If they could produce insanity irrespective of the deeds of the individuals everybody should suffer from this disease. So the sufferings one undergoes due to insanity are the results of his own actions and not those of the gods etc. The gods etc. The gods etc., no doubt help in the production of insanity. But they are subordinate to the actions of human beings. Things already manifested cannot again be manifested. So insanity having been caused by the misdeeds of the individual cannot again be caused by subordinate factors, viz., the gods etc. Thus the gods etc., are not to blame.

Causes and observance of wholesome regimens

The wise man should not blame the gods, ancestors or raksasas for diseases caused by his own misdeeds due to intellectual blasphemy. One should hold himself responsible for his happiness and miseries. Therefore, without apprehension one should follow the path of propitiousness. Prayer to the gods etc., and resorting to wholesome regiments act as antidotes to the misdeeds of the individual. Thus the power either to avert or invite the attach of insanity rests with the individual himself.

4.2.3 Homeopathy

Homeopathy, is developed with a criticism against the Orthodox medicine. Although they have developed under the patronage of Samuel Hahnemann, the current understandings of the Orthodox medicine have always been influenced the theories of causes and classification of Homeopathy.

4.2.3.1 The law of causation

The science of logic has an important relation of medicine in the matter of assigning the causes of disease, upon which, as far as possible, treatment is based. Many of the mistakes and failures in medical treatment are due to the failure to comprehend and correctly apply the principle of logic known as the *Law of Causation* (Close, 1984). *"Every effect must has a cause; every effect has a number of causes, all of which must be taken into consideration if correct conclusions are to be formed."*

"The theory of Induction is based upon the notion of cause. The truth that every fact which has a beginning has a cause is co-extensive with human experience. The recognition of this truth and its formation into a law, from which other laws are derived is, a generalization from the observed facts of nature, upon which all true science is based".

"In the law of causation, the invisible antecedent is termed the cause; the invariable consequent, the effect. The real cause is the whole of these antecedents, and we have no right, philosophically speaking, to give the name of the cause to one of them, exclusively of the others".

"Homeopathy does not direct its efforts primarily or solely to the destruction of the proximate physical cause of the disease (the micro-organisms), but against the disease itself; that is, the morbid vital process as manifested by the symptoms, using symptomatically similar medicines capable of causing a counter action of the organisms similar in nature to that of the pathogenic agent, neutralizing its effects and thus restoring systemic balance or health.

4.2.3.2 Causes of the diseases

The living organism may be acted upon or affected primarily in three ways: (1) Mechanically (2) Chemically (3) Dynamically. The causes of diseases fall naturally under these three heads.

Under the head of **mechanical causes of disease** come all traumatic agencies, such as lesions, injuries and destruction of tissues resulting from physical force; morbid growths, formations and foreign substances; congenitally defective or absent organs or parts, prolapsed or displaced organs etc. These conditions are related primarily to surgery, physical therapeutics and hygiene. **Diseases of chemical causes** include the destructive action of certain chemical poisons such as the acids and alkalies. They require the use of chemical poisons such as the acids and alkalies. They require the use of chemical or physiological antidotes, combined in some cases with measures for the physical expulsion of the offending substances, and followed by homeopathic treatment for the functional derangements, which remain or follow. **Dynamical causes of disease** is meant all those intangible and medicinal or toxic agents which primarily disturb the vital function of mind and body. These are very

numerous, but they may be roughly classified as (1) mental or physical, atmospheric, thermic, electric, telluric and climatic. (2) dietic, hygienic, contagious, infectious and specific - the last three including all disorders arising from the use or abuse of drugs, and from all bacterial agents, or pathogenic microorganisms which produce their effects through their specific toxins or alkaloids.

4.2.3.3 The theory of miasms of chronic diseases

The study of disease in homeopathy divides disease generally into two district classes.

1) Acute miasms[4]
2) Chronic miasms

An **acute miasm** is one that comes upon the economy, passes through it regular prodromal period, long or shorter, has its period of progress and period of decline, and in which there is a tendency to recovery. A **chronic miasm** is one that has its period of prodrome, period of progress and no period of decline; it is continuous, never ending except with the death of the patient. The acute diseases need much less study than the chronic. They are all such as are contagious or infection, such as have a maismatic character and are capable of running a definite course (Kent, 2004)

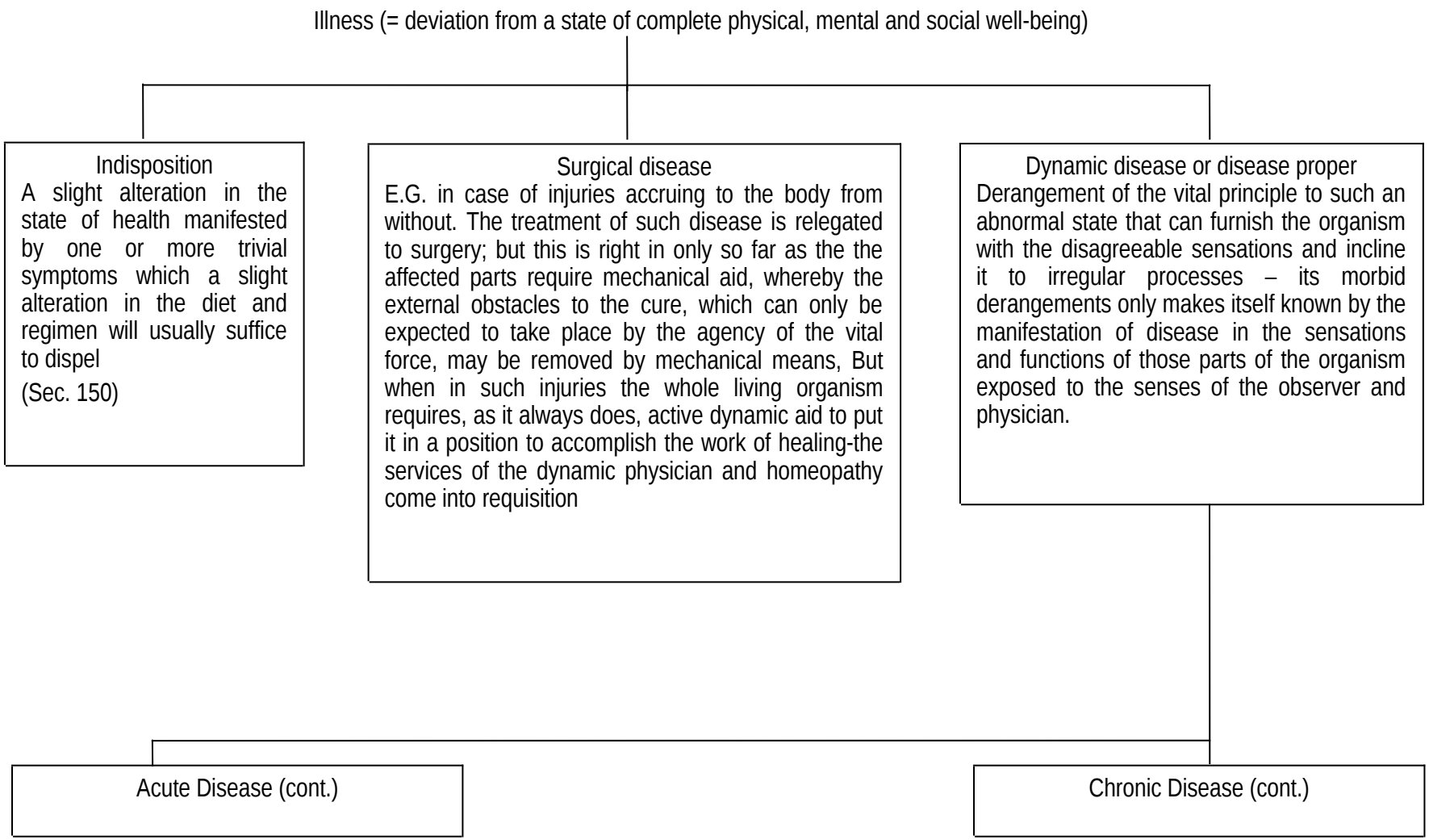
Homeopathy is very effective in treating the acute diseases. But the chronic and degenerative diseases like bronchitis, tuberculosis, asthma, arthritic and rheumatic disorders, cancer and tumours, veneral and skin disease, show little or no tendency to clear up spontaneously, and which tend to stay with a person for many years or even their whole life. Hahemann spent 12 years to the problem of chronic diseases: its treatment and its origin during which time he carefully researched many family medical histories in an attempt to understand the origin of such diseases. He formulated the theory of Miasms in 1816-17 as a

[4] During Hahneman's time the morbific agents which are causally connected with production of diseases, were designated by a general term, "miasma or miasm" – which literally meant "any noxious emanation or effiivia of polluting factor".

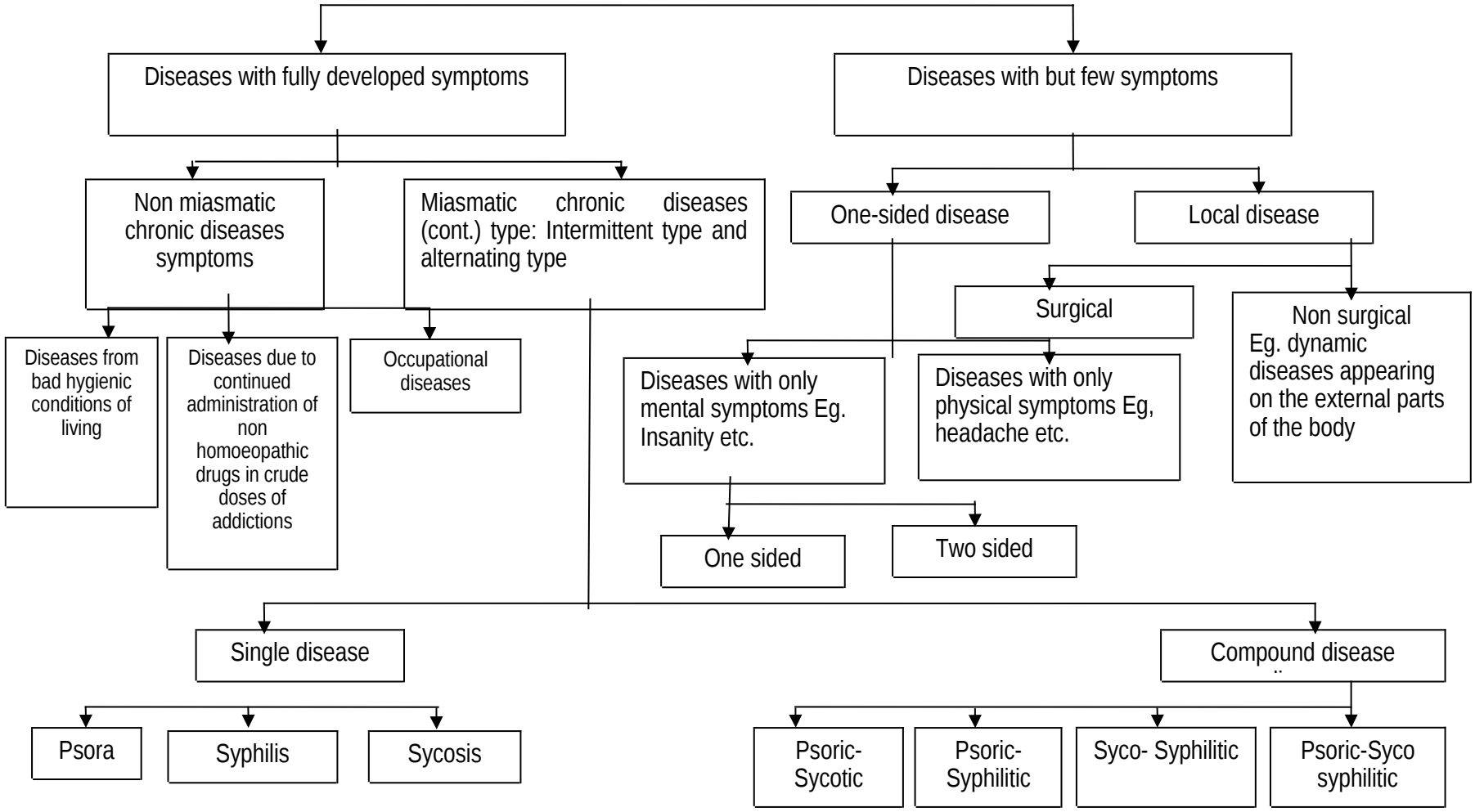
result of this work, and published a book in 1828, 'The *chronic Diseases, their peculiar Nature and their Homeopathic cure'.*

He carefully mapped every chronic disease and saw it as a very small part of a much wider disorder within the human race. By proceeding in this methodical way and piecing together these individual diseases, he proposed that an overall view of the complete disorder can be obtained. This process is directly analogous to the piecing together of a drug picture from the symptoms of individuals. He regarded chronic diseases as either venereal in origin or derived from suppressed skin eruption (in self or ancestors), especially Itch or Scabies, Plague or Leprosy. Hahnemann claimed that 85% of such chronic diseases derived from the latter source (Morrell, 2004). He found that the acute disease always tend to recover; the chronic diseases have no tendency what ever to recover, but a continuous progressive tendency; they are far deeper miasms (Kent, 2004). Hahnemann believed that many so-called individual diseases are in fact, manifestations derived from Psora, Syphilis or from Gonorrhoea. For example, he proposed that many forms of blindness and many eye and vision defects, deafness, some forms of insanity, ulcers, alcoholism, exercise salivation and sweating, insomnia and tone disorders could be traced back to a case of syphilis in an ancestor or the in an ancestor or the individual when younger. Likewise, warts, cystitis, asthma, catarrhs, etc., could be traced back to a case of gonorrhoea. His concept of Psora was really that a great many disorders could be traced back to suppressed skin diseases could, in their turn be traced back even further to a case of scabies in an ancestor or oneself as an infant (Morrell, 2004). Figure 4.2 represents the clinical classification of diseases according to Hahnemann.

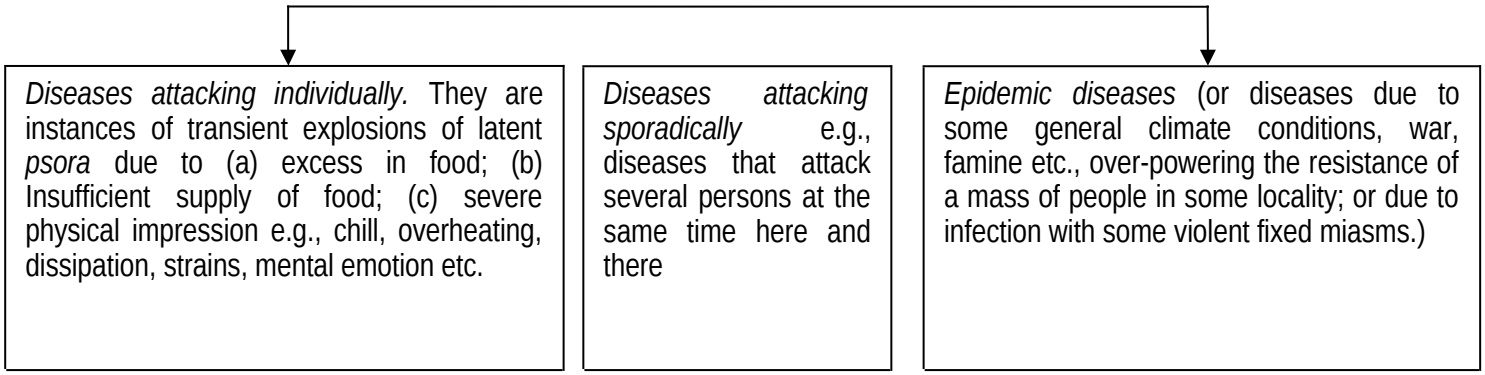
Fig. 4.2 Clinical Classification of Diseases (according to Hahnemann)



Contd. …. Fig. 4.2. Clinical classification of diseases (according to Hahnemann)



Contd. …. Fig. 4.2. Clinical classification of diseases (according to Hahnemann)



4.2.3.4 Are mental illnesses suppressed skin diseases?

Hahnemann's theory of miasmas and chronic diseases brings lot of insights into the understanding of insanity in homeopathic context. He attributes the causes of chronic diseases into three-psora, syphilis and sycosis where psoric diseases are suppressed skin diseases, suppressed gonorrhea leads to sycosis and stranger leads to diseases of syphilitic origin. Hahnemann's hypothesis of constant suppression of symptoms leads to chronic diseases is considered as a great invention among the homeopaths.

He says that *mental diseases* are of *psoric origin, termed* one-sided, which appears to be more difficult to cure in consequences of this one-sidedness, all their other morbid symptoms disappearing, as it were, before the single great, prominent symptom. One-sided diseases are diseases with no symptom or few symptoms and they are diseases, which manifest in one plane either physical or mental.

Mental diseases do not constitute a class of disease sharply separated from all others, since in all other so-called corporal diseases the condition of the disposition and mind is always altered; and in all cases the cure is to the state of the patient's disposition, along with the totality of the symptoms. Almost all the so-called mental and emotional diseases are nothing more than corporal diseases in which the symptom of derangement of the mind and disposition peculiar to each of them is increased, whilst the corporeal symptoms decline (Hahnemann, 1982).

In this manner they become transformed into a one-sided and, as it were, a local disease, in which the symptom of the mental disturbance, which was at first but slight, increases so as to be the chief symptom, and in a great measure occupies the place of the other, corporeal symptoms, whose intensity is sub due in a palliative manner, so that, in short,

the effections of the grosser corporeal organs become as it were, transferred and conducted to the almost spiritual, mental and emotional organs. (Hahnemann, 1982).

According to Hahnemann, in his time, **the most troublesome chronic diseases were those that had been complicated with drugs**. Kent (2004) through his lectures on homeopathic philosophy reports, *"whenever we come in contact with chronic sickness, we come in contact also with chronic drugging and its effect upon the vital force".* During eighteenth century, Hahnemann reports that the standard practice was to revile the mental patient with provocative language with more of the same or use crude cranial surgery and criminal punishment. Hahnemann approached mental diseases as the same as a physical disease and asked for isolating patients, boiling utensils, elimination of hydrotherapy and fresh air. Figure 4.2 shows the clinical classification of diseases according to Hahnemann.

4.2.3.5 Classification conveys nothing for Homeopathy

Homeopathy holds a unique perspective on the causes and classification of diseases. Homeopaths have their own reservation in classifying and labeling a disease. According to Kent (2004), if the physician were simply to make a study of the disease, and after studying it were to give it a name and let that name constitute the record, physician thereafter, in referring to this record, would know nothing about its nature.

Thus, homeopaths say that the name conveys no idea of the nature of the sickness, only it place in a general classification. Knowledge of the nature of individual sickness is necessary for a prescription, and this depends upon the ascertainment of the details. Hahnemann maintains a view that Nature has no nomenclature or classification of disease. Disease is not a fixed entity but an ever changing process like that of the life itself. The diseased individuals are of more important to the Homeopaths who are the units of Nature. So Hahnemann criticised all the nosological methods and exposed their inherent contradictions,

absurdities and infractuousness (Hahnemann, 1982). Kent (2004) brings forth two kinds of study, one with a bearing toward the classification that the diseases belong to, and one with reference to the remedy that the patient needs. Kent prefers to settle the patient just as to the remedy he needs, and this has very little to do, with the classification, except in a general way. He further states that "*we have none of the enormous classification in the study of homeopathy that are resorted to in traditional medicine; they should not appear in the study of applied Homeopathy*."

4.2.3.6 Insane diathesis

Dr. Andrew Combe defines insanity to be a "*prolonged departure without an adequate external cause, from the states of feeling and modes of thinking usual to the individual when in health. This is the true feature of disorder in mind*". (cited from Talcott, 1999).

According to Talcott (1999) 'The Insane Diathesis' is a state or condition in mental pathology corresponding to those diatheses so common in physical pathology, namely, the scrofulous, the cancerous, the scorbutic, the gouty and the calculus. The insane diathesis is a general term applying to all those conditions, which tend to the inception of and growth of mental unsoundness. This diathesis may be either inherited or acquired. Talcott (1999) says that mental abnormality is always due to either imperfect or eccentric physical development, or to effects of inborn or acquired physical disease, or to injurious impression, either anti-natal or post-natal, upon that delicate and intricate physical structure known as the human brain.

Causes of the insane diathesis are developed from the parent's unclipped imagination, or sordid desire, or base motive, of succession of mean action, or trail or fear, or passion of remorse, or undue gratification of the appetites or depletion of the bodily system through over-use, or from any perversion of the physical, mental or moral powers. The insane diathesis is a product of all those forces, which tend to rack and wreck the minds and bodies

of those whose lives do not conform to the highest percepts of the laws of nature (Talcott, 1999). Fast living, physical imperfections, bodily ailment, effects of some brain impressions, state of mind (emotions) of parents at the supreme moment of conception and their unfortunate passions and conditions. Methods of life of parents – wrong living and wrong thinking in the early lives of the parents can also contribute to the mental illness. Burton, in his *Anatomy of Melancholy,* states *"if a drunken man gets a child it will never likely to have a good brain"*. Communities are sometimes affected by some intense emotion, which pervades the minds of all the inhabitants of the country. Esquirol remarks that the children born soon after the horrors of the French Revolution turned out to be weak, irritable, susceptible and liable to be thrown by the least excitement into insanity (cited from Talcott, 1999).

Insane diathesis may be acquired as well as inherited by the following means: 1) By imperfect nutrition 2) By slight and almost imperceptible injuries to the brain- blows or falls, 3) By those fears which are sometimes excited in the minds of young children for purpose of government, 4) By overtaxing the undeveloped physical powers 5) By unwise forcing of the mind in its immature and underdeveloped stage 6) By premature and unnatural excitement of the sexual organs of the young 7) By suppression of the ambitions, and powers, and tastes, and desires, of the enthusiastic adolescent.

Talcott (1999) summarizes that insanity is a result of a diseased condition of the brain, either functional or organic, and it manifests itself most frequently by mental disturbance or distress, and by the expression of delusions or hallucinations.

4.2.3.7 Classification of insanity

Analysing the British and American classifications, homeopathy divides insanity into four. They are **Melancholia, Mania, Dementia and General paresis**

1. Melancholia, which includes all forms of mental depression
2. Mania, which includes all forms of mental excitement
3. Dementia, which includes all forms of mental weakness or failure, except idiocy and imbecility
4. General paresis, which is a distinct form of mental disease possessing certain characteristics which demand that it shall be classified separately. Conditions of mental depression, mental excitement and mental weakness.

To conclude, the homeopathic classification system is based on the criteria of symptoms, but more than the mere listing of symptoms, the Totality of Symptoms is stressed. The totality of the symptoms cannot be removed without removing the cause and causes are considered as effects or results. Disease cause is known and known only, from its effects; it is not capable of investigation by the natural senses and can only be investigated as to its results. Everything that can be seen, is but an ultimate, a result. It is only by the understanding by reasoning from first to last and then back again, we can perceive that disease causes through the symptoms. (Kent, 2004).

4.2.4 Naturopathy

Regarding the theory of cause and classification of diseases, Naturopathy holds a completely unique model, which is not shared by the other three systems. According to Benjamin (1946) **the universe is a unit. It is the effect of one cause. And if the Universe is under the control of one Law, how could some parts of it be under the control of some other law? The body, likewise, is a unit, and it is the effect of one cause.** The

names of diseases are multitude, but in reality, their basic and fundamental causes are the same in every case. Thus naturopathy believes that **all forms of disease are due to the same cause.** The main causes are **Toxemia** and **Enervation**.

4.2.4.1 The name of the disease and its causes imply nothing for Naturopathy

"Cause is constant, ever present, and always the same. Only effects, and the object on which cause acts, change, and the change is most inconstant."

(Tilden,1971)

Cause is one thing and effect is another. The difference between the two is similar to the difference between preceding and subsequent, or between that which forms and that which is formed. Effects may be studied to eternity, but such process will not reveal the cause. That is why all medical practice books state that: "the cause of disease is unknown". (Tilden,1971). A more intense and minute study of the early symptoms of disease will reveal the cause. There is, however, one great reason why it cannot, and that is that all symptom-complexes—diseases—from their initiation to their ending, are effects, and the most intense study of any phase or stage of their progress will not throw any light on the cause.

<u>Against nosological arrangement of diseases</u>

When a man's knowledge is not in order, the more of it he has, the greater will be his confusion. (Herbert Spencer cited from Tilden,1971 Confusion worse confounded is the only explanation that can be given of the theory and practice of medicine. Benjamin Rush, a physician, a luminary that brought distinction to medical science records that: "Much mischief has been done by the nosological arrangement of diseases. . . . Disease is as much a unit as fever. . . . Its different seats and degrees should no more be multiplied into different diseases than the numerous and different effects of heat and light upon our globe should be multiplied into a plurality of suns".

Benjamin Rush continues that:

"The whole materia medica is infected with the baneful consequences of the nomenclature of disease; for every article in it is pointed only against their names. . . . By the rejection of the artificial arrangement of diseases, a revolution must follow in medicine. . . . The road to knowledge in medicine by this means will likewise be shortened; so that a young man will be able to qualify himself to practice physic at a much less expense of time and labor than formerly, as a child would learn to read and write by the help of the Roman alphabet, instead of Chinese characters."

"The physician who can cure one disease by a knowledge of its principles may by the same means cure all the diseases of the human body; for their causes are the same. There is the same difference between the knowledge of a physician who prescribes for diseases as limited by genera and species, and of one who prescribes under the direction of just principles, that there is between the knowledge we obtain of the nature and extent of the sky, by viewing a few feet of it from the bottom of a well, and viewing from the top of a mountain the whole canopy of heaven."

He takes an extreme position in the following paragraph and calls the attention of human species to protest:

"....reason and humanity awake from their long repose in medicine, and unite in proclaiming that it is time to take the cure of pestilential epidemics out of the hands of physicians, and to place it in the hands of the people."

"Dissections daily convince us of our ignorance of the seats of disease, and cause us to blush at our prescriptions.... What mischief have we done under the belief of false facts, if I may be allowed the expression, and false theories! We have assisted in multiplying diseases. We have done more—we have increased their mortality."

If we know all about one disease, we know all about all diseases.

4.2.4.2. Toxemia: the universal basic cause of all so-called diseases

"What more can be asked by any doctor or layman than
a philosophy of the cause of disease that gives a perfect
understanding of all the so-called diseases?"

J.H.Tilden (1971) in his Prefatory Suggestion to his book *Toxemia: the cause of disease*

Naturopaths consider J.H. Tilden's (1971) book as the textbook in understanding the theory of disease causation. According to naturopathy, disease is in essence something which arose in the system as a result of the accumulation of toxins and impurities generated therein through years of wrong habits of living, and that the only real basis of cure lay in these same habits being rectifies, and the body thus allowed an opportunity to cleanse itself and put itself right again internally. Tilden (1971) says: "*The periodicity, which characterizes all functional derangements of the body, lends color to the claims of cure-mongers that their remedy has cured their patients, when the truth is that the so-called disease "ran its course." The truth is that the so-called disease was a toxemic crisis, and when the toxin was eliminated below the toleration point, the sickness passed—automatically health returned. But the disease was not cured; for the cause (enervating habits) is continued, toxin still accumulates, and in due course of time another crisis appears. Unless the cause of Toxemia is discovered and removed, crises will recur until functional derangements will give way to organic disease".*

<u>What is Toxemia and crises of Toxemia?</u>

Toxin is a stimulant and a natural product of metabolism. In the process of tissue building— metabolism—there is cell building— anabolism—and cell destruction—catabolism. The broken down tissue is toxic and in health when nerve energy is normal, it is eliminated

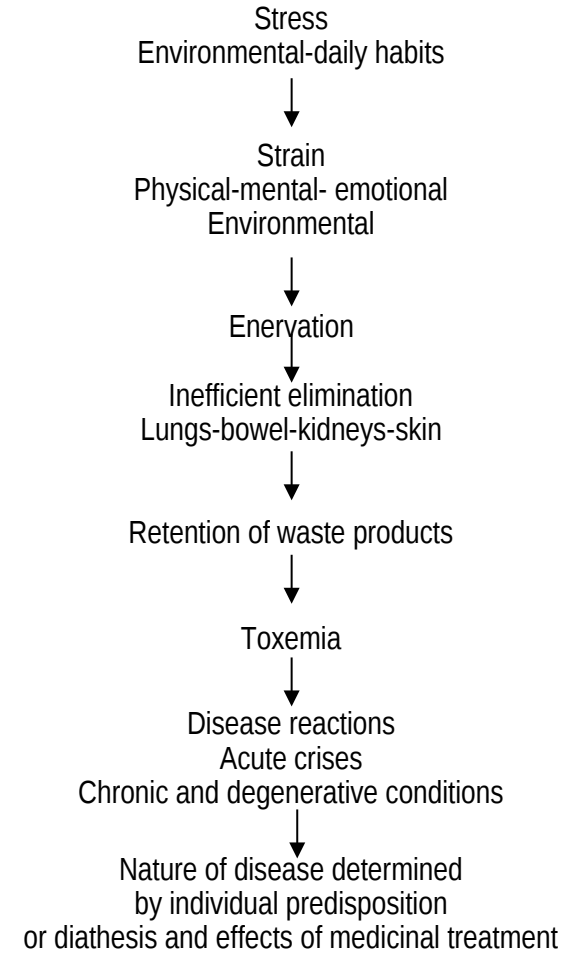
from the blood as fast as evolved. When nerve energy is dissipated from any cause, physical or mental excitement or bad habits, the body becomes enervated. When enervated, elimination is checked, causing retention of toxins within the blood and tissues, which is named as **Toxemia**. This accumulation of toxin when once established will continue until removing the causes and restores nerve energy. Diseases, so-called are Nature's effort at eliminating the toxins from the body. Such disease reactions are **crises of toxemia** (Tilden, 1971). According to the Toxin Philosophy, every so-called disease is a crisis of Toxemia; which means that toxin has accumulated in the blood above the toleration-point, and the crisis, the so-called disease—call it cold, "flu," pneumonia, headache, or typhoid fever—is a vicarious elimination. Nature is endeavoring to rid the body of toxin. Any treatment that obstructs this effort at elimination baffles nature in her effort at self-curing.

According to the Philosophy of Toxemia, nomenclature (naming disease) every symptom-complex goes back to the one and only cause of all so-called diseases—namely, Toxemia. Therefore, it is illogical to treat catarrh of the nose as a local disease. Rest and total abstinence from food, liquid and solid, and reforming all enervating habits, will restore nerve-energy; the elimination of toxin through the natural channels will take place, and full health will return. Every so-called disease has the same inception, evolution, and maturity, differing only as the organic structure involved differs. Treating the various symptom-complexes as distinct entities is fully as scientific as salving the end of a dog's tail for its sore ear.

All diseases are the same fundamentally. The cause travels back to Toxemia, caused by enervation, which checked elimination; and enervating habits of body and mind are the primary causes of lost resistance enervation. Every chronic disease starts with Toxemia and a toxemic crisis. The crises are repeated until organic changes take place.

Fig. 4.3 Diagram of the retentional theory of disease causation

(cited from Bentall, 2003)



4.2.4.3 The Unity of the cause of disease:

Tilden (1971) quotes the remark made by a distinguished biologist. *"When once you interfere with the order of nature, there is no knowing where the results will end."* The cause of disease, the transgression of natural laws, is left untouched (and is, in fact, made worse) by medical attention. The repeated suppression of acute diseases gives rise to chronic disease (Moyle, 1950) The causes of disease are:

1. Primary cause: violation of the Law of Life.
2. Primary effect: toxemia – enervation.
3. Secondary cause: the body's reaction to the internal danger.
4. Secondary effect: symptom complexes called diseases.

Wrong feeding, improper care of the body, habits of living tending creates a body clogged with waste materials and impurities tending to set up enervation and nervous exhaustion, such as worry, fear, overwork, excesses of all kinds, sexual abuse, temperamental and environmental difficulties etc. The poise of the person is also important. The subconscious builds health or disease according to the kind of impulses we send. The impulses of irritation, discontent, unhappiness, complaining, hate, envy, selfishness, greed, lust, etc., creates discomfort and ill health. It is these main factors, coupled with hereditary and predisposing influences, such as physique, personal peculiarities, and the like, which decide exactly what form of disease will take in any given individual. No matter what any disease may be described as in medical terminology, in essence **"**disease" is the same in every case, because the underlying causes, which determine the condition, in the first place are identical, although the superficial symptoms and manifestations appear in so many different guises. (Benjamin, 1946) To "treat" any "disease" means to "treat" nothing but the effects of the body's reaction to the dangerous internal condition that threatens its destruction and such course hinders Nature's work. So the only way in which disease can be cured is by the introduction of methods, which will enable the system to throw off these toxic accumulations.

All symptoms of all so-called diseases have one origin. All diseases are one. Unity in all things is nature's plan.

And why Dr. Osler, England's greatest physician, declared: "**of (the cause of) disease we know nothing at all".**

4.2.4.4 The process of disease is based on Toxemia

All disease, of whatever nature, was of slow development; that without systemic preparation even so-called acute systemic diseases could not manifest.

"*A disease, however much its cause may be adverse to the human body, is nothing more than an effort of Nature, who strains with might nut main to restore the health of the patient, by the elimination of the morbific matter".*

Three-quarters of a century later, Henry Lindlahr, M.D., voiced the same doctrine in these words: "Every acute disease is the result of a cleansing and healing effort of Nature. All acute diseases are uniform in their causes, their purpose, and, if conditions are favorable, uniform also in their progressive development . . ." *(Nature Cure,* 1922, cited from Tilden 1935)

Dr. Lindlahr explains "chronic diseases," as follows: "To check and suppress acute diseases . . . means to suppress Nature's purifying and healing efforts, to bring about fatal complications, and to change the acute, constructive reactions into chronic disease conditions." Knowing that the body is a unit, we know that the law, which governs the whole, governs every part. When any part shows signs of sickness, such as throbbing heart, rapid respiration, rising temperature, and so on (which medical men term and treat as disease), we should know that the whole is affected.

Acute disease is a remedial effort. Acute disease itself is a cure to the body. Deposit of toxins may be tolerated to a certain extent, but when they exceed the limit of tolerance, the body takes an extraordinary step to throw them out as otherwise they may be dangerous to life. Hence fever, pain, headache, diarrhea etc. are the processes that purify the body. The body is always striving for the ultimate good of the individual no matter how ill-treated it may be; and that all acute diseases – such as fevers, colds, diarrhoeas, skin eruptions of all kinds, inflammations etc. are nothing more than self – initiated attempts on the part of the body to throw off the accumulations of waste material which are interfacing with its proper functioning, and that all chronic diseases – such as valuable disease of the heart, diabetes, kidney disease, rheumatism, bronchitis, etc. are really the results of the continued suppression of

these same acute diseases (or self – initiated attempts at body – cleansing) by orthodox medical methods of treatment.

Progression of Disease / Three Stages of Disease

Diseases are not many. There is only disease all though life, from birth to death. But this one disease appears and again out of an inward abnormal condition, and reappears from out of it but with a progressive change in its outward features and symptoms, in the degree of its seriousness and in the difficulty of its cure. This progressive change falls into three distinct stages: **acute, chronic, and destructive**, according to the three stages of disease-progression, which is what takes place when unnatural treatments are resorted to. In the first stage the disease is transient. There is a considerable degree of health and vitality. Hence it is possible to cure it by removing the cause, the internal condition. Such a cure is possible only in a natural way: it is not at all possible by drugging, nor by any other method which does not consist in making amends for past mistakes and in reforming one/s mode of life afterwards. Usually an acute disease is suppressed by medical violence, whereby it is driven in, to merge into its cause, the abnormal condition. In this process the abnormality of that condition is greatly increased, and hence worse and more difficult disease forms arise out of it, leading the patient to the second stage. Now the diseases are apparently milder; but they are more deep –rooted and obstinate. These are called chronic diseases. The same mode of antiviral treatment being followed, the third stage is reached, of destructive disease. Medicos call them degenerative diseases. For a long time there has been a steady increase in the incidence of these diseases. When this stage is reached, death is near at hand. But every hour is full of pain, and death does not come soon enough.

In the retrogression of disease, at first the patient goes from the destructive to the non-fatal chronic stage, and later from this to the acute stage, and finally to health. In this progress back to Health the suppressed disease of the past may and often do return, but in

the reverse order. This is clear evidence that those diseases were not radically cured, but only suppressed earlier by the drug system.

Suppression of Symptoms is not the removal of cause

The allopathic treatment of acute disease consists of suppressive measures, since the main object of medical treatment is the recognition and suppression of symptoms only. Making a person live in her natural way is cure, which is a radical one, whereas medical cures are as a rule just suppression, which leads on to the next, the second stage and, finally, even to the third and last stage, which is degeneracy, in which destructive diseases inevitably arise. Suppressive treatments are those that eliminate symptoms without acknowledging the cause of the problem. It must be understood that every suppression of Nature's efforts for health causes a fall in the health level. Thus ill health grows and health declines until the stage is reached when death is sure, unless warded off by a timely return to Nature. If a disease is wrongly treated or suppressed in one organ or part of the body, it will only crop up again in another and more serious form in another organ or part later on. By suppressing the symptoms, real underlying causes of disease are completely neglected, which are thus left to go on unchecked and unhindered. An "acute disease" is therefore merely a violent effort on the part the nature to expel toxic material; a "chronic disease" is a condition in which this underlying toxemia is constantly present. There is no fundamental difference between the two, save that the former represents a violent remedial effort, while the latter is a state of tolerance. As Dr. age expressed it: *"The various acute diseases, so-called, are in point of, act acute remedies for chronic disease"*. Due to the depletion of the vital energies, the system is unable, for the time being, to make the required effort. It therefore retains its toxins – and the patient is constantly ill. Therefore, suppression is the cause for many diseases.

Germs are not the cause : Fallacy of Germ Theory

"Bernard was right, the germ is nothing – the milieu (the environment within) is everything".

Louis Pasteur (on his death bed, cited from Moyle, 1950)

Naturopathy talks about the germ theory proposed by Pasteur as a totally flawed one. Germs and bacteria do of course, exist. But it is contended that germs and bacteria are not the cause of disease, but that the body must be in a depressed state of health before germ contact (infection) can bring about disease.

Dr. Beddow – Bayley (cited from Moyle, 1950) quotes an illustration of the complete fallacy of the germ theory in the following instance: *"The celebrated professor PettenKoffer, to show his disbelief in the then recently mooted germ theory, swallowed a test – tube of cholera germs supposed to be sufficient to kill a whole regiment of soldiers – before a classful of gaping students. Nothing happened! As Pettenkoffer maintained, in support of his amazing act, "Germs are of no account in cholera". The important thing is the disposition of the individual".*

Germ infection can take place only when the body is already clogged with an accumulation of poisons and there is a fertile ground for the multiplication of the germs (Moyle, 1950). Since Nature Cure does not believe in the germ theory – regards acute disease as attempts by the body at self – cleansing and submits that disease is the result of wrong dieting, back of exercise, excesses and bad environment (mutation of natural laws) – then it is obvious that all disease is regarded as one. Any disease, therefore, it is claimed, springs from a system poisoned with an accumulation of toxins arising from disregard of the true laws of Nature, (Moyle, 1950).

"Many forms of diagnosis are dependent upon what germ life exists, and its existence in the body usually indicates a bad state of deterioration. Disease germs are natures undertakes".

Bernard Jenson, The Science and Practice of Iridology.

Germs are the result of disease

"…. Depending on its inner state, germs arose within the body itself that, in Rije's opinion, germs were not the cause but the result of disease states"

150 years of suppression, by Christopher Bird, 1991.

Our bodies are always full of germs and bacteria; they play a most important pact in the working of the body, especially in the destructive processes. When any living matter dies, it immediately begins to disintegrate into the simple chemical elements of which it is composed; and it is in breaking down dead organic matter into its elemental constituents that germs and bacteria a are always employed by Nature. Germs are part of the result of disease, not its cause. Germs and microbes take pact in all disease phenomena because these are processes requiring the breaking down or disintegration of accumulated refuse and toxic matter within the body, which the system is endeavoring to throw off. No one would say that because the decaying body of a dead dog is full of bacteria, the bacteria the cause of the dog's death; they are there as a pact of the natural disintegrative process taking place as a result of the death of the dog. And so it is with germs and disease. Germs are part of the result of disease, not its cause.

"The nutritive medium on which the germs thrive determines the type of development they will undergo".

Saul Pressman

According to Saul Pressman, the so-called 'bad' bacteria and circuses that modern medicine fights with its huge arsenal of pharmaceutical drugs of life live in symbiosis with the nutritive medium that constitutes our body, allowing it to be built up and later decomposed, to be metamorphosed and recreated. These germs are pleomorphic shape shifters who are controlled by the medium in which they live.

"Germs are not something separate, isolated, unfriendly and coniums from without, but are rather the foundation for all life. Without germs, there is no life. Their number is infinite. Their function is varied. Germs can change shape, join together, separate again and return to their primordial condition. Viruses, bacteria and fungi are various developmental forms of germs. The nutritive medium on which the germs thrive determines the type of development they will undergo".

Naturopaths shift one attention from germs as causes of diseases to the environment in which the germs are actually lay in(Benjamin 1946). This proves that there must be some predisposing factor present in the body before an attack of any acute disease is possible. Given this predisposing factor, the germs become active; without it, they are harmless. This predisposing factor is in every case a lowered vitality, and a body clogged with waste materials and impurities.

Against Calorie Theory

The calorie theory proclaims – irrespective of the condition of the body – that every individual 'needs' a certain minimum number of calories (heat-units) to keep himself going, that persons of different age groups and following different vocations require specified amounts of food capable of giving specified heat-units to the body. The calorie theory does not take into account the needs of the individual, nor his assimilative capacity. This reveals its hollowness. (Sarma & Swaminathan, 1986). The calorie theory, again, is the result of

averages worked out on observations on men accustomed to conventional ways of living, which can, by no means, be regarded as healthy or hygienic. Such results can have no validity for a man who has made up his mind to live the hygienic way. A high-calorie diet will always be an unbalanced diet. Those foods which are supposed to be rich in calories contain very little, or note, of the mineral salts, vitamins, trace elements, enzymes, etc. needed by the organism. They may not supply the body with all the essential aminocids. Again most of them may be predominantly acidic.

A large number of patients taking to Nature Cure adopt fasting, or reduce their food intake (in the words of experts, take to "low-calorie" foods) and recover their health. All of them disprove the calorie theory. Even after getting radically cured, such people continue to eat little and maintain their health, again disproving the theory. On the other hand, those who eat according to the calorie theory continue to be ill and become worse progressively, instead of becoming more and more energetic. This again disproves the calorie theory. Once it is realized that energy does not come from food but that, in a limited sense, food acts as its medium of expression, in the human body, the calorie tables and all the present attempts to put dietetics on a calorie basis will be found useless. Dr. Dewey demonstrated the utter stupidity of the calorie theory. He pointed out the significant fact that '*Food is a tax on vitality*.' He also showed that the assumption underlying the calorie theory was absurd, because if it was correct there would be no cause for fatigue (Sharma & Swaminathan, 1986).

SECTION III

4.3 Thematic Analysis of the Causes and Classification of Abnormal Behaviour

The researcher senses that the fundamental base of any medical system is the means by which they conceptualize and organize disease. Such theories would clearly describe and verify the diagnosis and treatment methods followed in those systems. The dialogue on causes and classification handles many different dimensions – philosophical,

psychological, historical, sociological and political at the same time. In the following section, I attempt to analyse some of the universal questions on causality and classification derived from thematic analysis that have been asked in the philosophy of medicine and some observations while comparing the four medical systems also have been included. Let me, first of all, list them below in the table 4.1.

Table 4.1 Thematic analysis of the causes and classification of abnormal behaviour : major categories emerged

<table>
<tr><th colspan="3">Medical Systems</th><th colspan="3">Research Question</th></tr>
<tr><td>•</td><td colspan="2">Allopathy/ Psychiatry</td><td colspan="3" rowspan="4">Abnormal Behaviour: Causes & Classification</td></tr>
<tr><td>•</td><td colspan="2">Ayurveda</td></tr>
<tr><td>•</td><td colspan="2">Homeopathy</td></tr>
<tr><td>•</td><td colspan="2">Naturopathy</td></tr>
<tr><td colspan="3" rowspan="10">Result of thematic analysis (major categories emerged)</td><td>1.</td><td></td><td>Disease-categorical or singular?</td></tr>
<tr><td>2.</td><td></td><td>How do the medical systems conceive cause and effect?</td></tr>
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4.3.1 Disease- Categorical or Singular?

Whether disease is a categorical one or of a singular nature is a major conceptual question in the philosophy of medicine. Pickering (2006) gives us the role and nature of

categorical concepts. 1) categorical or classificatory concepts play an organizing role in our experience of, responses to, understanding and explanation of the world, and 2) are not (ultimately) given to us by the evidence of our senses (though of course we have to learn to use the concept from other people). These two statements say that the claim that mental illness is a classificatory concept is not an empirical claim, not a claim based upon observations or upon experiment and evidence. Rather, it is conceptual claim.

Plato pointed out the deficiencies of compartmentalizing human illness. In Charmides he has Socrates say the following: *"If his eyes are to be cured, his head must be treated; and then again they say that to think of curing the head alone and not just the rest of the body also, is the height of the folly. And arguing in this way they apply their methods to the whole body, and try to treat and health whole and the part together"*

And a bit further on, *"The great error of our day in the treatment of the treatment of the human body (is) that physicians separate the soul from the body"* (Jowett, 1892 cited from Hudson, 1993).

On the general level, Pickering (2006) says that, a view has been developed by philosophers that, if we did not have a range of concepts with which to organize our experience, it would be difficult to know just what our experience would be like. Indeed, it might be hard to say if we would have any experience at all, without the use of some set of classifications.

Jaspers (1963) states:

"From ancient times the question of disease entity has been answered along two different lines. The one involved the theory of unitary psychosis, that is, there are no disease entities but only varieties of madness with fluid boundaries…. which merge into each other every where……. The other involved the theory that the main task of psychiatry is to find

natural disease entities which are different form each other in principle….. in which there are no transitions".

DSM attempts to treat mental disorder as consisting of a variety of discrete (discontinuous) categories. This idea says that each of the categories has a unique underlying core and a definable boundary separating it from other categories, as in the case of true diseases. The fact that we cannot identify the features of the core except by uncertain inference from surface characteristics is attributed to a temporary lack of knowledge. Meanwhile, the exact boundary of each category will remain uncertain and will have to be approximated by somewhat arbitrary rules to achieve a satisfactory separation from other categories (Carson & Butcher, 1992).

According to Carson & Butcher (1992) a **categorical approach**, assumes that a) all human behavior can be sharply divided into the categories normal and abnormal and b) there exist discrete, over-lapping classes or types of abnormal behavior, often referred to as 'mental' illnesses or diseases. The categorical approach bears a close affinity to the identification of diagnosable physical illnesses such as pneumonia, coronary thrombosis, diabetes, and so on. Some theorists believe that this approach is inappropriate for most types of mental disorder, which do not seem to be discrete. It is, however, the one officially used.

Brill (1965) puts forward two criticisms against the classification systems: (1) that no system of diagnosis or nomenclature is useful and that we should accept the fact that psychiatric disorder is a completely individual matter and that meaningful groupings among patients and among disease entities are to be ruled out a priori, and (2) that because the present generally accepted system has defects, we should abandon it and replace it for general use with another based perhaps on some single axis of classification (a single theory consistent within itself). This is in connection with the discussion of whether mental illness is a single or a multiple entity. In this area lie some of the most fundamental questions in

psychiatry. To this day, especially among some of the psycho dynamically oriented, there is learning toward a unitary theory. From their point of view, the mental disorder is the same whether released by syphilis, brain injury, alcohol, or psychogenetic factors.

Madness can be divided into a small number of disease (for example, schizophrenia and manic depression) is a false assumption hold by the orthodox approach, according to Bentall (2003). Carson & Butcher (1992) say that there is considerable disagreement and doubt about the possibility of a precisely definable and constant array of causal factors at the core of each mental disorder included in the DSM classification. The only exceptions may be those relatively few disorders that are in fact related to brain diseases, the so - called organic mental disorder. Thus, lacking a constant core for each purported disorder, it becomes difficult to know if our efforts to differentiate one sort of disorder from another are in fact correct or even meaningful.

A categorical view of diseases is also much discussed in the Ayurveda classic texts too. Caraka Samhita notes the kind of discussions happened towards classificatory system in Ayurveda and finally resolves the issue by dividing the diseases based on a few criteria. But we can assume that the whole concept of health, illness, cause and classification is built on the harmony-disharmony principles. Homeopathy, too, takes a simpler approach in the classification. Limiting the causes of all the diseases into Psora, Syphilis and Sycosis and dividing them primarily into acute and chronic (based on the onset of diseases), it still lies in the categorical approach. Moreover, this system also maintains that each disease has its own individuality and specific path to follow.

Naturopathy, on the other hand, argues for a singular approach of disease. The unity of the concept of health, illness and causes are very well stressed. They are against naming, labeling and classifying disease as they believe that such a practice will not offer anything new to the system.

Karl Jaspers (1963) argues that the opposition of the unitary psychosis view versus the discrete disease entities view remains largely unresolved. The latter view has been correct in so far as the idea of disease entities has led to fruitful investigations; yet the former is also correct in that no real disease entities which Kraepelin have been elucidated. Even for general paresis of the insane, Jaspers holds, no consistent psychological form has been determined; furthermore, no one has yet diagnosed with certainty a known somatic disease using only psychological data, Jaspers states his own conviction that the fundamental groupings of Kraepelin have been different from prior classifications in that, with Kraepelin's notion of disease entity, these groupings have provided a useful and productive basis for promoting psychiatric investigation. Jasper's own view represents a harmonizing alternative to the unitary psychosis/ disease entity dichotomy: Disease entity has proved to be a powerful concept in psychiatry, and it is not to be abandoned. (Manschreck & Kleinman, 1977)

A prototype is a conceptual entity depicting an idealized combination of characteristics, ones that more or less regularly occur together in a less perfect or standard way at the level of empirical reality. No item in a prototypally defined group may actually have all of the characteristics of the defining prototype, although it will have many of the more central of them. By adopting a **prototypal approach**, we could wed some of the advantages of the categorical and the dimensional approaches while avoiding the disadvantages of each. This approach, however, requires much blurring of the boundaries between diagnostic groupings (Carson & Butcher, 1992).

Comparing the four medical systems, the researcher considers that the prototype approach would best be suited for the classification purpose. The hypothetical or apriori nature of the disease concept is best explained by this approach. Empirically, all the medical sciences fail to give a typical example of disease, not only to mental illness, even to physical ones. When Psychiatry keeps biomedical model as a standard (which is pathology oriented),

Ayurveda, Homeopathy and naturopathy look out for establishing the harmony, balance or deviation, which is altered in the form of illnesses. I would say that without the definite conceptualization of health and wellness, the prototypal explanation of illness cannot develop.

4.3.2 How do the medical systems conceive cause and effect

The bacteriology theory in the nineteenth century could be traced as the beginning of a systematic theory of causality in Allopathy. It has been influenced by the philosophical position then i.e., dualism. As the mind and body were considered and treated as two separate entities, the symptomatological classification was much easier. The biochemical model is also formed as a result of this trend. This model is much prevalent in Psychiatry as well. The conception of the brain as the cause of mental disorders clearly maintains this distinction of body and mind. The psychiatric conception of mental illness is reductionist in such a way that mind and its processes are reduced to the level of brain (body). According to Kraepelin, *mental illnesses fell into a small number of discoverable types and these could be independently identified by studying symptoms, by direct observation of brain diseases or by discovering the etiologies of the illnesses* (for example, by finding out whether they ran in families and were therefore determined by heredity). Bentall (2003) says that on Kraepelin's analysis, an understanding of the language of symptoms would allow the researcher to decode both the biological underpinnings of madness and their origins.

The Ayurvedic theory of causality dates back to centuries before. Sat-Karya-Siddhanta observes cause and effect in a continuous and not as opposite and dichotomous ones. The cause and effect were pre-existent in nature; both of them mutually contribute each other. The metaphysical dimension of causality has also been explained here. 'Cause-effect relationship is predetermined and is eternal. Nobody can remove anything from the universe which is already existing'. Ayurvedic theory, as it has been mentioned in the textbooks, approaches any disease in a holistic manner. The whole person is treated, not his symptoms.

Through the symptoms, doctor can understand more about the disease. Therefore, symptoms are only a means to get a picture of the illness/ cause.

Homeopathy gives a very important role to the symptoms. Symptoms are considered as the fresh and first-hand information of the illness. Homeopathy philosophy says that as the patient is 'worried' or understands her illness only through the symptoms, they give undue reverence to symptom listing. The mental symptoms are given equally more relevance like the physical ones. The case history taking of a homeopath spends a huge time in taking down the symptoms of the patient. 'Totality of symptoms' is finally taken out to get an overall concept of the patient's illness. The same method is followed in both physical and mental illness and symptoms are looked up in finding out the cause.

Naturopathy, on the other hand, strongly and simply believes in the unity of cause in health and illness. Toxemia, the deposit of toxins in one's body and enervation, the fatiguing of nerves are the one and only cause for any illness. It does not give any importance to *symptoms* in the process of determining cause and it doesn't classify the disease too. "All the causes are one; therefore all the diseases are one" is the theoretical stand of Naturopathy. Thus, we could se that the concept of cause and classification followed in Naturopathy completely stands out in comparison with other three medical systems. Naturopaths strongly criticize the Orthodox Medicine by saying that it does not have a clear understanding about causes of illness.

4.3.3 Criteria of Classification System

The researcher attempts to understand the criteria followed by the medical systems in classifying the disease. Whitehead (1929, cited from Manschreck & Kleinman, 1977)) points out a few criteria, which should be the basis for assessment of any particular belief. They are: 1) Conformity with intuitive experience. 2) Clarity or propositional content 3) Internal logical consistency 4) External logical consistency 5) States of a logical scheme with (a) Widespread conformity to experience (b) No discordance with experience (c) Coherence among its categorical notions (d) Methodologic consequences

In this analysis, the researcher checked the three criteria such as symptoms, causes and treatments that would have determined the system of classification in each system.

Psychiatric classification is based on the symptoms of diseases. Kraepelin's system is founded on the large listing out of these symptoms of mental patients. He believed that symptoms would tell us about the brain pathology, etiology of disease and finally, the disease process. He expected that any classification system, which could include all the symptoms of disease, would be a uniform and standard one. This statement shows us that all the diseases can be included less than one classification system rather than various systems with various criteria of classification. James Mackenzie (cited from Gelder, Mayou and Geddes,1999) wrote: "Disease is made manifest to us only by the symptoms which it produces; the first object in the examination of a patient is the detection of symptoms, and therefore the symptoms of disease form one of the main objects of our study." According to Zigler and Phillips (1974) in physical medicine, a clear distinction has been made between a symptom, which is defined as a subjectively experienced abnormality, and a sign, which is considered an objective indication of abnormality. (Holmes, 1946 cited from Zigher & Phillips, 1974). This differentiation has not, however, been extended to the sphere of mental disorders. A source of difficulty may lie in the definition of what is psychologically abnormal. In psychiatric terminology, symptoms include a wide range of phenomena from the grossest type of behavior deviation, through the complaints of the patient, to event almost completely inferential in nature.

The present classificatory system, is organized primarily around symptom manifestation. This would be adequate for a descriptive system if this principle were consistently applied to all classes of the schema and if the symptoms associated with each diagnostic category were clearly specified. There is some question, however, whether the system meets these requirements (Phillips & Rabinovitch, 1958). The criticism has been advanced that the present system is based on a number of diverse principles of classification. Most classes are indeed defined by symptom manifestation, but the organic disorders. For example, tend to be identified by etiology, which such other factors as prognosis, social

conformity, etc., are also employed as classificatory principles. Etiology and prognosis would be treated not as inherent attributes of the various classifications, but rather as correlates of the particular classes to which their relationship is known. They would, thus, not be confounded with the classificatory principle of the system (Zigler and Phillips, 1974).

In terms of Psychiatry, DSM-IV classification system is based on five Axioms, which emphasizes the symptoms of disease. But I could say that such a 'well-proclaimed' system is not built on the causes of the disease and for the treatment purpose, another system of criteria is followed which I shall be discussing in the next chapter. The major question one can raise in this context, is "how do the discipline of Psychiatry determine the causes of illness and what is their importance in the process of illness?"

Kanfer & Saslow (1974) note that the Kraepelinian system and portions of the 1952 APA classification emphasize etiological factors. They share the assumption that common etiological factors lead to similar symptoms and respond to similar treatment. This dimension of diagnosis is considerable more fruitful when dealing with behavior disorders which are mainly under control of some biological condition. When a patient's known to suffer from excessive intake of alcohol his hallucinatory behavior, lack of motor coordination, poor judgment, and other behavioral evidence of disorganization can often be related directly to some antecedent condition such as the toxic effect of alcohol on the central nervous system, liver etc. For these cases, classification by etiology also has some implications for prognosis and treatment. Acute hallucinations and other disorganized behavior due to alcohol usually clear up when the alcohol level in the blood stream falls. Similar examples can be drawn from any class of behavior disorders in which a change in behavior is associated primarily or exclusively with a single, particular antecedent factor. Under these conditions this factor can be called a pathogen and the situation closely approximates the condition described by the traditional medical model.

In the case of Ayurveda, much more elaborate categories are used for classifying disease. Caraka Samhita has mentioned five major criteria, which are prognosis, intensity, location, nature of the causative factors and site of origin. Diseases are grouped vividly in terms of many other criteria, which are mentioned in Susruta Samhita and Astanga Hrdaya too. But even limiting ourselves to the classification criteria in Caraka Samhita, would show that Ayurveda's concept of disease, cause and classification system are very well connected. For instance, the *tridosa principles of Vata, Pitta and Kapha* are the foundation of the concept of health and disease. Causes are further explained on this basis as the ones, which aggravate Vata, Pitta and Kapha and knowing about them make a person abstain from these vitiators. Tridosa is interrelated where a substance which vitiate Vata might affect Pitta or Kapha too, depending on its nature. The same principles have been adopted for classifying the diseases also. Based on the nature of illness (intensity, location & site of origin) and causative factors the classification system has been formulated. The physical constitution of the patient, the time/ duration, the onset, causation etc. are taken onto consideration. "What does the patient say about her illness?" is given more importance than mere symptom listing. Symptoms, the patient's report, the doctor's inferences (anumana) together with the cultural and environmental factors make diagnosis in Ayurveda. Unlike Psychiatry the prognosis of diseases (curable/ incurable) is very well expected and stated in the Ayurveda theory so that Ayurveda does not make any power claim to 'cure' all illnesses under the sun.

Homeopathic philosophy has its own reservation in classifying and labeling a disease. It places vital force in its center; all the acute or chronic miasms act on vital force and create morbid vital processes, which are manifested as symptoms. The major classification system divides disease into two- acute and chronic where mental illness comes under chronic diseases with but few symptoms which are one-sided (means, having only mental symptoms). But the miasmatic classification- Psora, Syphilis & Sycosis is also applicable to mental illness where mental illness is considered to have a psoric origin. Homeopathic classification system

is also based on symptoms. A detailed symptom listing could give an overall picture of the illness, they believe. But unlike Psychiatry, they introduce another concept known as 'Totality of Symptoms'. All the mental and physical symptoms are considered for its totality, which determines the disease, an individual specific one. For example, the so-called fever or depression might not be similar in each and every individual. After the detailed case history taking, the large group of symptoms and its totality make each disease specific for the individual. The totality of the symptoms cannot be removed without removing the cause. Disease cause is known and known only, from its effects; it is not capable of investigation by the natural senses and can only be investigated as to its results. Everything that can be seen, microscope, is but an ultimate, a result. It is only by the understanding by reasoning from first to last and then back again, that we can perceive that disease causes are invisible (Kent, 2004). Homeopathy, as far as I could understand with the available literature and discussion with the experts, does maximum justice to their concept, causes and classification systems.

Naturopathy again travels their own path of looking at the causes and classification of disease. Even if they accept and even sometimes use the Allopathic names of disease, they are against such kind of classification systems. As a lifestyle approach, Naturopathy philosophy does not propose a system to classify disease. As they believe in the unity of disease and cause, its singular approach does not offer any space to accommodate an elaborate system of classification. But I could say that the nature cure methods go in tune with their theory of causes.

The term 'disorder' indicates that the symptoms are caused by an abnormality although this is not necessarily the organic pathology implied by the term 'disease'. Such a loosened structure about the causes of mental disorder gives flexibility to a psychiatric doctor. Gelder, Mayou & Geddes (1999) signify that this term is chosen because only a minority of psychiatric conditions have an identified physical pathology so that the term 'disorder', as used

in general medicine, is not strictly appropriate. The question here, in the case of psychiatric disorders, is that whether this so-called “symptom-etiology” chain is followed in the diagnosis and treatment too. What I mean is whether the symptomatological categorization of diseases and then its etiological roots is same or different in treating the mental patients or does this process end there itself. This question would further taken up in the next chapter of diagnosis and treatment of abnormal behaviour.

Cause of disease is being looked for everywhere, and no less a personage than the late Sir James Mackenzie, in “Reports of the St. Andrews Institute for Clinical Research,” Volume I, declared: “The knowledge of disease is so incomplete that we do not yet even know what steps should be taken to advance our knowledge.”(Gelder, Mayou & Geddes, 1999). There is also the issue of “unknown” causes.

Lloyd (2000) notes that the causes of most psychiatric disorders are unknown, yet there is considerable information concerning the range of factors, which are regarded as important etiologically. Manschreck (1977) notes the problem with the definition of disease entity lies in its nosology and causality. Kraepelin could not offer a complete understanding of the concept of psychiatric disorder in his popular classification. The researcher feels that even if, psychiatric classification is modified to DSM IV, it failed to give a clear explanation to the causes and most of the psychiatric disturbances are marked with ‘unknown causes’. Manschreck notes that psychiatrists have confused the concept of disease with a rigid notion of what reality is and what constitutes causes (i.e., biological events). Here, the possibilities of the explanatory power of the disease is lost which might provide a means to organize our understanding of the relationship between various factor. Manschreck (1977) explains that Medicine, unlike other sciences, exists in a context of expectation and value. Health and illness lie at the core of this expectation. These concepts are not merely descriptive, but in fact, normative.

4.3.4 Natural vs. artificial system of classification

Farlet (1864, cited from Cutting, 1997) comments:

"What should be sought is the progression and the various stages of the true species of mental disorders which are still unknown to this day but which the close study of the successive phases of these disease will enable us to discover. For the notion of a natural form implies that of a well-defined course, and vice versa the notion of a natural course that can be predicted presupposes the existence of a natural species of disease with a pattern of development. It is here, in our view, that the most important advance is to be made in our special field".

The term 'natural' in this context has two meanings. According to Naturopathy, 'natural' is something which follows laws of nature. Thereby, the conceptualization of any medical system needs to follow those laws in order to be simple, cohesive and comprehensive in its notions. Another meaning of 'natural' is a standard followed by the natural sciences like physics, chemistry and biology. 'Natural kind' is a technical term used by philosophers to refer to the kinds of thing or stuff studied by the natural sciences. Sodium, fleas, dandelions, and electrons are all examples of natural kinds. Members of a natural kind are thought to be naturally similar to each other because they are alike at fundamental level. (Cooper,2004). When this concept of mental illness is claimed to have a 'natural' origin, we can assume that a medical standard has been used here. Rachel Cooper (2004) mentions that DSM-IV attempts to explain mental illness as a natural one. According to her, while natural kinds are objective, human kinds are affected by ideas and so subjective, and that thus human kinds cannot be natural kinds. In order for types of mental illness to be natural kinds it must be the case that instances of the disease are all similar to each other in some fundamental sense.

Unfortunately, many mental disorders are insufficiently well understood for it to be possible to know whether or not this criterion is met.

Naturopathic philosophy demands, “the procedure must be natural; and, being natural, results are and must be favorable and permanent”. They hold the view that disease is a natural process; therefore it is normal (Moyle, 1950)

4.3.5 Causal & classificatory dualism

Mind-body dualism has been one of the hottest topics in the philosophy of medicine. Michael Sharpe (2004) says that dualistic thinking encourages the view that the origin of psychological symptoms lies in mental pathology and that of somatic symptoms in physical pathology. Difficulties arise however when clinical problems are encountered that do not fit into this dichotomous view.

Tilden (1971) comments that the medical world has built an infinite literature without any (except erroneous and vacillating) ideas of cause. The late Sir James Mackenzie—while living, the greatest clinician in the world— declared: “In medical research the object is mainly the prevention and cure of disease.” If cause is not known, how is prevention or cure possible? If prevention and cure mean producing disease, surely prevention and cure are not desirable. If prevention can be accomplished, then cures will not be needed. Vaccines and autogenous remedies are made from the products of disease, and the idea that disease can be made to cure itself is an end-product of pathological thinking. This statement is not so incongruous after we consider the fact that all search and research work to find cause by medical scientists has been made in dead and dying people. As ridiculous as it may appear, medical science has gone, and is still going, to the dead and dying to find cause. Medical science is founded on a false premise—namely, that disease is caused by extraneous influences, and that drugs are something that cures or palliates discomfort. The term “medical”

means pertaining to medicine or the practice of medicine. Anything used in a remedial way carries the idea of curing, healing, correcting, or affording relief, and this doctoring is all done without any clear understanding of cause.

Table 4.2 Traditional 'dualistic' categories of mental and physical illness

Traditional 'dualistic' categories of mental and physical illness		
	Mental symptoms	Physical symptoms
Bodily pathology	Comorbidity	Medical condition
No bodily pathology	Psychiatric condition	Somatisation

The first problem posed by patients who have somatic symptoms but no evidence of bodily pathology. It is unclear whether their illness should be categorized as mental or physical, and whether they are psychiatric patients or medical patients. As a result they are often regarded as being *neither* and are banished to a medical 'no-man's land'. They can only be regarded as mentally ill by proposing the concept of somatisation (Murphy, 1989 cited from Sharpe (2004) in order to explain how mental pathology could lead to bodily symptoms. This scheme leads to a disregard of the patient's somatic symptoms in favour of psychopathology. They can only be accepted as physically ill if they are regarded as having actual, albeit undetected, bodily pathology. Consequently they may either be diagnosed as having a 'functional' medical condition or be subjected to relentless medical investigation – a process that may lead to iatrogenic harm.

Patients who have both prominent psychological symptoms and definite bodily pathology pose the second problem. They fall into both mental and physical categories. They are consequently regarded as being both physically and mentally ill, a situation referred to as co morbidity (Mayou & Sharpe,1995). While they may be accepted as both medical and as psychiatric patients, their needs may not be fully met by either specialty, a focus on one

aspect of their illness leading to neglect of the other. For example, the widespread neglect of depression in patients with medical disease.

Classification dualism emerges from the conceptual dualism. Sharpe (2004) notes that separate classifications for psychiatric and medical conditions consequently poorly understood conditions may attract either no diagnosis or diagnosis from both medical and psychiatric classification, the choice depending only on the doctor's belief about the nature of the illness. For example, a patient with medically unexplained gastroenterological symptoms may be diagnosed as having neither a 'medical' irritable bowel syndrome or a 'psychiatric' anxiety disorder, depending on the preference and theoretical orientation of the doctor (Tollefson et al., 1991 cited from Sharpe, 2004). Patients who have symptoms of both a medical condition and a psychiatric disorder also give rise to diagnostic conundrums: for example, should a given symptom be attributed to the medical condition or to the psychiatric disorder; should the mental disorder be regarded as being caused by the physical order (and then be called an organic mental disorder) or as a separate entity/ (Sharpe, 2004).

The history of psychiatric classification notes the different trends and forms of this discussion evolved during the later part of the nineteenth century. Starting from the genetic predisposition to madness, psychiatrists during that time had given very little weightage to this possibility compared with a host of other possible causes. Esquirol, regarded is as 'remote cause'. But by 1886 Magnan was referring to it as:

"the *almost unique efficient cause of mental alienation*…. The habit is to invoke a variety of causes that are only commonplace… If, however, these do come into play they can do so only by virtue of another cause, more essential and inherent in the constitution of the subject himself – that which is called *predisposition*" (Magnan, 1886, cited from Cutting, 1997).

The change of emphasis paved the way for the endogenous- exogenous dichotomy of madness. Cutting (1997) notes that these terms are introduced by Mobius (1893). The best elucidation of their meaning is provided by Jaspers (1913) and Lewis (1971). Jaspers commented:

"In so far as we divide the whole unity of life into outer and inner world and both are broken down into factors, we attribute the phenomena of life either to causal factors of the outer world, which we call *exogenous*, or to those of the inner world, which we call *endogenous*."

Exogenous generally refers to identifiable causes situated outside the mind (untoward body or brain events), and endogenous covering both unknown causes (assumed to be inherent in a person's genetic make-up or personality) and world events impinging on them. However, it was clear that untoward world events constituted a different class of possible cause from those attributable to inheritance or personality, and deserved their own name – hence the term *psychogenic* (which was introduced by Sommer, 1894). The term *psychogenic*, as defined by Sommer, referred to 'disease states evoked by perceptual representations'.

However, this distinction is only valid within a Cartesian framework. Therefore any untoward bodily event (e.g. thyrotoxicosis) or brain event (e.g. cerebral tumour) is a potential exogenous cause of psychosis, even though the body or brain event, as itself largely independent of the environment. But events occurring in the outside world may be potential endogenous or exogenous causes, according to whether they are deemed to affect the mind through the body and then the brain (e.g. contracting typhoid fever from contaminated water- exogenous) or the mind directly (e.g. the aftermath of experiencing an earthquake- psychogenic, which is a subclass of endogenous in Jaspers' scheme).

However, the distinction is profoundly unsatisfactory, even to a Cartesian, because the large majority of people who become psychotic are neither identifiable endogenous or exogenous causes of the above type. The term endogenous is simply applied to those instances of psychosis where the cause is unknown. It is assumed to be endogenous, and this itself is assumed to be a blend of inherited predisposition (to what?) and acquired personality traits. But it is not at all clear, within a Cartesian framework, whether the predisposition acts via the brain on the mind (in which case it should be an exogenous effect) or whether it sets up a fragile mental attitude (in which case it is genuinely endogenous).

According to Carson & Butcher (1992) it must be admitted that even where the existence of a somatic factor is clearly defined, as in the case of syphilis, we have no understanding of by what process and according to what laws the brain disease might be transformed into psychic symptoms. This would seem to be a part of the larger unsolved problem of the entire relation between brain and mind. Dimensional approach has been put forward as an alternative conception to the causal and classificatory dualism.

In a **dimensional approach**, it is assumed that a person's typical behavior is the product of differing strengths of intensities of behavior along several definable dimensions, such as mood, emotional stability, aggressiveness, gender identity, anxiousness, interpersonal trust, clarity of thinking and communication, social introversion, and so on. In this conception people differ from one another in their configuration or profile of these dimensional traits (each ranging from very low to very high), not in terms of surface indications of some presumed 'illness'. Normal could be discriminated from abnormal, then by precise statistical criteria applied to dimensional intensities. eg. DSM III-R, Axes IV & V (Carson & Butcher, 1992).

Dimensional classification rejects the use of separate categories. In the past it was advocated by Kretschmer and other psychiatrists. It has also been strongly promoted by the psychologist Eysenck, who argues that there is no evidence to support the traditional grouping

into discrete entities. His theory of dimensions- psychoticism, neuroticism and introversion-extroversion locates patients on each of these dimensions.

The limitations of this approach include, a) some profiles tend to cluster together in types, b) some of these types are correlated, though imperfectly, with recognizable sorts of gross behavioral malfunction, such as anxiety disorders or depression. It is highly unlikely, however, that any individual's profile would exactly fit a narrowly defined type, or that the types identified will not have some overlapping features.

Manschreck & Kleinman (1977) view causality as a relationship. They say that the discipline of psychiatry revolves around the pragmatic relevance of its concepts. Here causality is viewed as a relationship not a thing. As a relationship concept, the notion of cause may lead to fruitful understandings of the development, perpetuation, and progression of disease in psychiatry.

4.3.6 The blurred boundary of "organic" and "functional" mental illness

The present day classification system (ICD-10) categorizes diseases into organic and functional. Cutting (1997) points out that the historical beginning of this category was necessarily vague. Moreau (1859) had talked much about the functional illness and at various times he refers to it as a 'diffuse pathological state', 'a disequilibria', 'a neuropathic diathesis', 'a morbid modification', and 'a nervous dynamism' (cited from cutting, 1997). Despite the crude nature of the concept - formulated with the help of hypothetical notions drawn from pathology, physiology and psychology – the dichotomy between an organic and a functional psychosis soon became an established principle. Organic means observable brain disease at autopsy, and functional means assumed, bout unobservable, brain dysfunction.

In this scheme an organic psychosis was on in which an abnormality of the brain was discernible at autopsy with then naked eye, or elsewhere there was good reason to suppose

that some chemical toxin (heavy alcohol consumption, illicit drug ingestion) had produced temporary brain damage. A functional psychosis was one in which, although anatomical or biochemical evidence of the brain damage was lacking, it was assumed that there must be something amiss with the functioning of the brain. It was further assumed that this must be of a similar nature to that produced by an observable autopsy lesion, or why else should organic and functional psychoses, defined as above, be so similar in form? 'Functional' and 'endogenous' are not synonymous terms. They share the property of applying to psychoses of uncertain cause, but whereas 'functional' refers to the hypothetical sate of the brain in such cases, 'endogenous' refers to hypothetical causes in these cases. The history of twentieth century have been marked with the attempts to reinterpret 'functional', not as referring to an organic brain dysfunction that is yet to be found – an untoward brain event- but as referring to a psychogenic cause- an untoward world event affecting the mind. Third conceptual metamorphosis, 'organic' brain damage → 'functional' brain dysfunction → 'psychogenic cause, was completed in the case of the neuroses. The same process took place in the case of schizophrenia in the first and middle third of twentieth century, although recently this trend has generally been reversed.

This historical shows us that psychiatry is still very vague in categorizing diseases into organic and functional. Whether the brain influences the mental functions or the mind influences the brain processes is still an unresolved issue. This means that the process of disease, therefore, its classification, diagnosis and treatment conceptualizations are debated, to date.

4.3.7 Reliabilty & Validity issues

The usefulness of a classification system is judged on its **Reliability & Validity.** Reliability is a measure of the extent to which different observes can agree that a behavior 'fits' a given diagnostic category. If observes cannot agree, it may mean that the classification criteria are not precise enough to determine whether the disorder is present or absent. In

contrast, validity is determined by whether the diagnostic category tells us something important or basic about the disorder. Validity presupposes reliability.

Unfortunately, both reliability and validity have proven extraordinarily difficult to achieve in the classification of psychiatry. But it is also due to our having chosen an inadequate model for describing behavioural abnormalities. This model is essentially a medical or disease metaphor for conceptualizing abnormal behavior (Carson & Butcher, 1992).

4.3.8 What's the role of 'person' in the process?

The orthodox approach, according to Bentall (2003) is based on another false assumption, which also needs to be rejected i.e., the manifestations of 'symptoms' of madness cannot be understood in terms of the psychology of the person who suffers from them. Engel (1974) brings out Kety's (1974) argument which says that establishing a relationship between particular biochemical processes and the clinical data of illness requires a scientifically rational approach to behavioral and psychosocial data, for these are the terms in which most clinical phenomena are reported by patients. The biomedical model ignores both the rigor required to achieve reliability in the interview process and the necessity to analyze the meaning of the patient's report in psychological, social and cultural as well as in anatomic, physiological or biochemical terms. The model also fails to account the patient's verbal expressions of his illness experience. The biochemical defect may determine certain characteristics of the disease, but not necessarily the point in time when any individual enters a health care system and becomes a patient.

Kreapelin, himself has found that the disease process does not uniquely determine the patient's symptoms. Rather, the symptoms brought out by the disease depend on the individual nature of the patient. He found that by the methods of comparative psychiatry,

varying manifestations of a disorder can be studied in different people and different circumstances. Studies of this kind revealed that symptoms were affected by personal and social factors such as sex, age, and culture (Bentall, 2003).

The positions of Ayurveda, Homeopathy and Naturopathy in this argument is quite interesting. The researcher could undoubtedly say that enough and more significance is given to the 'person' dimension of the disease, as proposed by the theories of these systems (Here, I want to make it very clear that this research is primarily based on the textual analysis; therefore, I do not want make any comment on the current practise of these systems). The 'Holistic' approach used by these systems gives undue importance to the individualistic and context-specific. The habit of an individual, the life style, disease history, upbringing, the socio-economic conditions and cultural variables are especially important in determining the causes and classification of Ayurveda and Homeopathy. In Naturopathy, I could not find much data on this dimension. But I assume that the role of individual factors in the process of disease is much emphasized by Naturopathy too.

Braunstein (1981) comments that it is important that health professionals know as much as possible about how people think about health and illness. Unless these views are recognized and taken into account during the course of medical evaluations and treatment, however, it is unlikely that a satisfactory physician-patient relationship will develop. In such a situation, with the patient having one set of ideas about health matters and the physician another, communication between them is difficult and the patient compliance is bound to suffer. Therefore, concepts of health and illness have important implications for the delivery of medical care.

4.3.9 What's social and cultural about the causes of disease?

The criticisms against the classification widely talks about how does the naming of disease results into social labeling and stigmatization. Cutting (1997) while tracing the historical origin of causes of madness, says that a relatively new dimension was added to psychiatry during twentieth century. A consideration of social factors has been very much emphasized especially while observing the etiological factors of madness. The social causes, social consequences and social conditioning of madness have been given more importance than the organic pathology. The anti-psychiatry movement has also contributed to this trend of madness as a social artifact. Such a trend gave an opportunity for the psychiatrists to relook into the theoretical background of the discipline. The researches and writings of the twentieth century were very well oriented or aware of this inclination. Engel (1974) brings out Kety's stand that (1974) medical model does not stress on the role of psychosocial variables in disease causation. Psychophysiological responses to life change may interact with existing somatic factors to alter susceptibility and thereby influence the time of onset, the severity and the course of a disease (cited from Engel, 1974).

DSM II of APA (1968) operates from a reductionistic orientation toward human behavior. The seemingly inherent principle in each nosological category is to see that category as derived from 'internal factors', "be they somatic, dynamic or habitual. There is no place for a contextual or environmental factor to be seen as operative, except perhaps in the "transient situational disturbances" (Panzetta,1974, cited from Manschreck, 1977)

Panzetta (1974) argues that biological events must be conceptualized as being influenced at multiple levels of organization: " It is no longer to explain cellular metabolism excessively in terms of intracellular and infracellular events. The context of the organism is as important as the component parts of the organism in understanding the behaviour of the organism". (Panzetta, 1974, cited from Manschreck, 1977).

Seymour Kety (1974) of the Massachusetts general Hospital has stated that "Psychiatry is in an identity crisis precisely because it is not especially qualified to handle… community, national and international affairs, poverty, politics and criminality. In each of these areas, we have responsibilities as citizens and human beings; we have get to demonstrate any special competence as psychiatrist". Sir Aubrey Lewis (1967) has stated succinctly "The pretentions of some psychiatrists are extreme". Those who teach psychiatric residents from this vantage point often encourage tough mindedness and skepticism in their student (Manschreck & Kleinman, 1977).

Manschreck (1977) summarises that significant parallels between the problems of DSM II and the problems of psychiatry itself, specifically, DSM II has the following shortcomings:

1. The lack of a clear definition of what constitutes psychiatric disturbance
2. The lack of clear delimiting criteria to separate classes of disorder, such as neurosis and personality disorder.
3. The lack of guidelines to determine which diagnosis applies in cases where clinical conditions suggest two different possibilities – which takes precedence? should the two be chosen together?
4. The lack of objective criteria for defining disturbance, including exclusive and inclusive criteria.
5. The lack of single model conceptual rigor – e.g., we have mixed together disease, reaction, alcoholism.
6. The lack of time framing in the definition of psychiatric disturbances
7. The tendency towards reductionism.

Manschreck & Kleinman (1977) further say that psychiatry is all right within the methodological and biological context of medicine. It is safe in the rigid concept of medicine.

However, medicine is a narrowly conceived basis on which to examine and understand all forms of health and human behavior; and the medical models seems to lock psychiatry into a paradigm already discovered as too limited by medicine itself, and certainly too limited when applied to psychiatric issues. Studies of diagnosis have demonstrated frequently the drawbacks of nosology and the unreliability of psychiatric ratings of psychopathology.

4.3.10 The not-much visible factors in causality and classification of diseases

Codell Carter (2003) writes:

"…Today's historians look, instead, at the power structures of medicine (professional organizations, medical schools) and at medicine among the unempowered (irregular practitioners, treatment of the insane, the Poor Laws). As a result, we know less about the nature and origin of the medical theories that affect our lives than about, say, 18th century quackery or the average income of general practitioners in Victorian England. And that, I think, is an abrogation of responsibility".

Cooper (2004) comments that DSM has been and continues to be affected by pressures stemming from medical insurance. Leo (2004) notes the scenario of the powerful decision making of market on the medical system in United States. According to the editors of the LA *Times,* "Drug company funding is corrupting medical research" and they call on the National Institute of Health "to counter the influence of private funding on science" (24th February 2003 cited from Leo, 2004). An example of how the chemical theory of mental illness can be used as a marketing pitch is the web site *mental-heatth-matters.com* which has pharmaceutical advertising right alongside articles such as "The Chemical Imbalance in Mental Health Problems" by Joseph Carver. Readers of Carver's article, with no medical background, would assume that scientists have proven that the cause of every mental disorder is nothing than neurotransmitter levels which can easily be fixed with a pill--and

naturally the companies making the pills are just a mouse click away. The article contains statements such as, "As research in neurotransmitters continued, studies between neurotransmitters and mental conditions revealed a strong connection between certain neurotransmitters in the brain and the presence of psychiatric conditions," or "Research also tells us that several neurotransmitters are related to mental health problems-dopamine, serotonin, norepinephrine, and GABA. Too much or too little of these neurotransmitters are now felt to produce psychiatric conditions such as schizophrenia, depression, bipolar disorder, obsessive-compulsive disorder and ADHD." Carver has provided a nice side-by-side listing of transmitters and disorders, but no evidence that any of these disorders can be linked to any specific transmitter--but this is only the beginning. Leo (2004) criticized the psychiatric literature by asking that: "Where is the evidence that mental illnesses are caused by biological deficits?" Of course people suffer, and people sometimes need help, but to say that emotional distress is due to an underlying biological defect that can be "cured" by taking a pill is a grand oversimplification of human nature.

Traditionally, the study of abnormal behavior focuses on three distinct but overlapping categories (a) the nature of the abnormality (b) the factors that cause or influence its occurrence, and (c) the methods developed for reducing or eliminating the behavior. Although much of the discussion is organized around these categories, and the categories are readily defined, it is still often difficult to understand completely the nature, causes and treatment of abnormal behavior. **(**Carson & Butcher, 1992). Thus, it has been seen that shifts in conceptualizing illness changes the way we classify them. The concept of illness has eventually undergone changes, once the classification system has been established and the way we classify disease definitely reflects the way we look at it.

(Sharma & Dash, 2007).

According to Ayurveda, the functioning of the mind and nerves is dependent upon Vayu or Vata. All the functions of the body, according to Ayurveda are controlled by three elements, which in ayurvedic parlance are called dosas. There are vary or Vata, Pitta and Kapha or Slesma. Among these dosas, Vayu is the most important because it controls all types of sensation and motor actions which are the functions of the nerves controlled by the mind (Sharma & Dash, 2007).

Diseases caused by Vayu are classified into two broad categories, viz., (1) Nanatmaja or those caused by Vayu alone, and (2) Samanyaja or those caused by Vayu in association with other dosas. Nanatmaja type of Vatika diseases are of eighty types which are already enumerated in Sutra 20:10. Apart from some of those enumerated in Sutra 20:10, new Vatika diseases are also described with reference to their diagnosis, pathogenesis and treatment.

Vayu gets aggravated to cause a disease in two different ways, viz., (1) by dhatu-ksaya or diminution of tissue elements and (2) by marga avarana or obstruction to its channel of circulation (vide verse no. 59). Nerves including the cells in the brain and spinal chord are the pathways through which Vayu moves. Thus Vayu, the moving material or the neuro-humoral transmission of sensation, is different from the nerves through which it moves. Any damage or decay of these nerves will, however, cause impairment of the functioning of Vayu resulting in the manifestation of several diseases described in this chapter. Improper food and regimen may also cause diminution of tissue elements resulting in the morbidities of nerve cells to give rise to such diseases. Thus, the line of treatment involves the removal of obstruction in the nerves of their cells, and restoration of the normalcy of these cells by appropriate nourishment. Diagnosis and treatment of these Vatika diseases like hemiplegia, multiple sclerosis, paraplegia and facial paralysis are described in Caraka Samhita.

Diseases described here carry a name. But the physician will be required to treat several other ailments, which are not named. In fact naming a disease is not very important for its treatment.

The individual is composed of five consecutive layers called kosas. These are (1) anna-maya-kosa or the physique composed of tissues, (2) prana maya kosa or t he layer of elan vitae, (3) mano maya kosa or the layer of psyche, (4) vijnana maya kosa or the oayer of intellect and (5) ananda maya kosa or the layer of bliss. For health and illhealth of an individual, the harmonious and disharmonious states of all these five kosas are responsible respectively. Modern research is mostly confined to the anna maya kosa or the physique, while the layer of psyche is receiving scant attention. Ayurveda, on the other hand, emphasizes upon the psycho-somatic concept of the disease. The mind is closely related to the body and vice versa. In addition, the three remaining kosas are examined by the ayurvedic physicians which are almost neglected in modern medical research. (Sharma & Dash, 2007).

Chapter V

DIAGNOSIS AND TREATMENT OF ABNORMAL BEHAVIOUR

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"Reason is, and ought only to be slave of the passion,

and can never pretend to any other office than to serve and obey them".

David Hume (1739-40/1888, cited from Bentall, 2003)

In a layperson's term, any medical system is evaluated on the basis of its efficacy with which it can diagnose, treat and cure diseases. The third and fourth chapters described and discussed the theoretical positions of Psychiatry, Ayurveda, Homeopathy and Naturopathy in terms of the conceptualization of health and illness, causes and classification. Very much related to them is how do they diagnose and deal with disease. Physical and psychological treatments of mental illness, its prevention, community intervention and maintenance of health and well-being are unique and different in each system.

Manchreck (1977) refers diagnosis to: a) classification system or nosology, b) the process of deciding which nosological entity is appropriate for a given case, and c) and the decision, opinion or 'label' resulting from that process.

Dorland's Medical Dictionary defines diagnosis as "(1) the art of distinguishing one disease from another. (2) The determination of the nature of a case of disease" (Taylore, 1988 cited from Sadler, 2004). The etymology is mostly Greek, gnosis meaning "investigation" or "knowledge" and dia-meaning "thorough" or "apart". This suggests that diagnosis a thorough investigation or knowledge-gaining procedure, perhaps one that involves a taking part or a breaking down into smaller components. One of the foremost diagnosticians of twentieth century American psychiatry, Robert L. Spitzer, provides his own etymology, that of agnosis, meaning "not knowing", and di meaning "two", so "diagnosis" means "doubly ignorant"!. But conventional use of the term "diagnosis" indicates that it is both a noun and a verb, a

proclamation and a process people do. The dual meaning of diagnosis-as-epitemic-act and diagnosis-as-a-denotative-signifier are important in understanding the debates about diagnosis (cited from Sadler 2004).

Sadler (2004) comments that the criticism of diagnosis in mental health care is a recent phenomenon in the history of medicine and the history of madness, even considered against psychiatry's own short history as a defined medical specialty.

Kanfer & Saslow (1974) say that a clinical diagnosis often is a summarizing statement about the way in which a person behaves. On the assumption that a variety of behaviors are correlated and consistent in any given individual, it becomes more economical to assign the individual to a class of persons than categorizing all of his behaviors. The utility of such a system rests heavily on the availability of empirical evidence concerning correlations among various behaviors (response-response relationships), and the further assumption that the frequency of occurrence of such behaviors is relatively independent of specific stimulus conditions and of specific reinforcement.

SECTION I

5.1 Philosophy of diagnosis

5.1.1 Purposes of diagnosis

According to Gelder, Mayou & Cowen (2001) diagnosis is the process of identifying disease and allocating it to a category on the basis of symptoms and signs. It involves four major components:

- The interviewing technique of the psychiatrist
- The perception of the patient's speech and behavior.
- A complicated series of processes by which the psychiatrist sorts out the available information and decides how to use it and what task to perform next

- A final stage in which the psychiatrist chooses one or more terms from a stated classification of psychiatric disorders.

5.1.2 The process of diagnosis

The process of diagnosis is deciding which nosological entity best fits a given case of complex. There are three stages in this process: (1) Observation, (2) Interpretation and (3) Class allocation.

Observation refers to the part of the diagnostic process in which skilled selective perception occurs. It is skilled in that its quality depends on personal experience, expectation, and purpose. Because perception is not total, but focused mainly as a function of factors in the observer, observers operate from their peculiarly subjective standpoints (using tacit or personal knowledge), and when they deal with complex phenomena, the likelihood of disagreement increases. **Interpretation** is the translation of the data of observation into the constructs of psychopathology (depersonalization, anxiety, obsession, compulsion, and the like). **Class allocation** is the fitting of observed and interpreted data to classes of disease. Rarely, if ever, in actual practice can there be an ideal fit; usually, the fit is within an acceptable range of variance from the standard. Clearly, there is room for error or other variations in each of these stages (Manschreck, 1977).

5.1.3 The logic of diagnosis

According to Schleifer & Vannatta (2006) the diagnostic process has been referred to as "hypothetico- deductive" reasoning. Diagnosis has at least three elements. They are a large **knowledge base**, (empirical knowledge about illnesses and their symptoms.), a "method" of **hypothesis formation**, (a procedure for beginning diagnosis.) and **reflection**.

Hypothesis formation: The initial element of diagnosis is the logic of hypothesis formation. The American philosopher Charles Sanders Peirce studied and attempted to formulate the reasoning of hypothesis formation in what he called the logic of "abduction." Abduction seeks an explanation of a particular fact by finding some salient features of the particular that allow it to be explained by some more general causal principle: "abduction," Peirce writes, "is the process of forming explanatory hypotheses" (1931–1935, 1958, cited from Schleifer & Vannatta, 2006).

The aim of abduction is not the logical definition of a particular instance (Deduction) or the articulation of a general rule (Induction). Rather, its aim is to define the relationship between instance and rule, the discovery that a "fact" is a "case," and for this reason abduction calls for the rewriting of the assumptions brought to a situation in order to situate those assumptions in historical time ("in this class"). As Peirce himself describes it: deduction "is merely the application of general rules to particular cases" and induction "is the inference of the *rule* from the *case* and *result*" (1992, cited from Schleifer & Vannatta, 2006), while abduction is concerned with the manner in which the rule manifests itself as a cause in a temporal sequence.

Physician's knowledge: Schleifer, R. & Vannatta (2006) suggests that second-order knowledge is important because it is necessary to validate old hypotheses and to generate new ones by suggesting the possible frameworks of understanding that infuse meaning into

otherwise trivial signs. It is the job of medical training to give physicians possession of such "second-order" knowledge.

Reflection: The third element of diagnosis is reflection. The physician needs to attend to the manner of their own interpretive action as well as the condition of the patient. The process of playing one's hunch or hypothesizing a connection between a particular instance and a particular rule must be followed by testing the validity of that connection in relation to some overall "meaning" — the "aboutness" of a narrative, the particular "illness" behind symptoms — in which the instance is seen to be a Case.

Abduction and diagnosis: These three elements of diagnosis — hypothesis formation, testing against a knowledge base, and reflective understanding of the process — nicely fit into the schema of logical inferences of *invention, testing*, and *explication.* But equally important, they also describe what we do when we read and what physicians do when they encounter the patient's history of present illness.

Thus in an interview Dr. Rita Charon(cited from Schleifer & Vannatta, 2006) has noted that:

"stories have plots. Illnesses have symptoms. In a strange way, when a doctor is trying to diagnose a patient, when a doctor is hearing about many symptoms, events, sensations, feelings, things out of the ordinary from a patient describing new symptoms, in a funny way what the doctor does in diagnosis is pretty much what he or she does in reading for the plot …. Now, … whether it's a joke somebody tells me or a long, complex novel like Beloved, the activity of the reader is to register each event, whether or not they're told chronologically, and to reconfigure them using our imagination and our memory so that they make at least provisional sense. And, so, isn't that what we do, again, as I'm sitting in the office listening to the woman with abdominal pain …. [A]nd I, as the diagnosing doctor, have to somehow register these events, configure them in my mind so that they make provisional sense."

Charon is describing the ways in which readers and doctors both make hypotheses about what they hear and encounter, gather new evidence, and reflectively reconfigure understanding, again and again. The hypothesis-generating process of diagnosis — a process that informs the history of present illness— is closely connected to the manner in which that narrative discourse creates meaning or significance. For this reason, it is believed that physicians can learn significant skills — they can, in fact, acquire the reflective "experience" in relation to diagnostics — by studying narratives (Hunter, 1991; Hunter, 1999; Charon et al., 1995; Charon, 2004, cited from Schleifer & Vannatta, 2006).

A doctor is a witness who learns from the narratives he or she encounters: inhabiting a world of rules, a system of general classes and subclasses of diseases, the physician is presented with a particular narrative (explicit and implied) and physical evidence (a symptom or set of symptoms) which need to be apprehended as connected to a particular rule, to be seen as a Case of a particular disease or condition.

SECTION II

5.2 Diagnosis and treatment of abnormal behaviour in medical sciences

This section deals with the various theoretical positions held by Psychiatry, Ayurveda, Homeopathy and Naturopathy on how to diagnose and treat diseases. Each systems hold strong or weak theories about the importance, process, approaches and limitations of diagnosis and treatment of mental diseases. All the four medical systems are analyzed to trace the system of diagnosis and treatment methods.

5.2.1 Allopathy/ Psychiatry

"The first principle in the psychic treatment of mental patients is frankness and unconditional love of truth. It is just in this point where laymen and doctors make serious mistakes."

Emil Kraeplin (1899/ 1990, cited from Bentall, 2003)

Diagnosis and treatment in psychiatry is mainly focus on Psychopharmacology. Psychopharmacology is a special discipline within Psychiatry, which refers to the study and use of drugs that influence behaviour, emotions, perception and thought by acting on the central nervous system. After identifying the symptoms of the patient, the doctor compares them with that of the theory to name and diagnose them and finally, decide the remedies to be chosen. Close (1984) says that this a logical process which needs to be carefully planned and executed. In Psychiatry, the biomedical model encompasses other psychological and social factors too (theoretically) in defining the concepts of causes and classification. But does the processes of diagnosis and treatment follow a different path?

5.2.1.1 The process of diagnosis

The process of diagnosis in psychiatry has several implicit features:

1. The precise characterization of the difficulties encountered by the patient
2. A concern for avoiding premature closure with facile diagnostic conclusions; this implies an openness to and responsibility for the clinical presentation.
3. A recognition that diagnosis is the logical beginning of clinical practise and not the terminal point in describing a patient (Maher,1970; Jaspers,1963, cited from Manschreck, 1977).

5.2.1.2 Approaches in Diagnosis

There are six major approaches for diagnosis found from the review of psychiatry textbooks. They are Symptomatological approach, Categorical approach, Hierarchies and Co-morbidity, and multiple diagnoses.

a) Symptomatological Approach

Ledley & Lusted (1959, cited from Kanfer & Saslow, 1974) differentiate between a disease complex and a symptom complex. While the former describes known pathological processes and their correlated signs, the latter represents particular signs present in a particular patient. The bridge between disease and symptom complexes is provided by available medical knowledge and the final diagnosis is tantamount to labeling the disease complex. However, the current gaps in medical knowledge necessitate the use of probability statements when relating disease to symptoms, admitting that there is some possibility for error in the diagnosis. Once the diagnosis is established, decisions about treatment still depend on many other factors including social, moral and economic conditions of the individual patient, his family and the society in which he lives. The proper assignment of the weight to be given to each of the values must in the last analysis be left to the physician's judgment (Ledley & Lusted, 1959)_

Categorical Approach

Diagnostic classification involves the establishment of categories to which phenomena can be ordered. The number of class systems that potentially may be constructed is limited only by man's ability to abstract from his experience. Related to the nature of the classificatory principle are the implication to the derived from class membership. Class membership may involve nothing more than descriptive compartmentalization, its only utility being greater ease in the handling of data. Obversely, the attributes or correlates of class membership may be widespread and far-reaching in their consequences. The originators of a classifying scheme may assert that specified behavioral correlates accompany class membership. Another aspect is when a phenomenon is assigned to a class, certain individual characteristics of that phenomenon are forever lost. No two-class members are completely identical. Indeed, a single class member may be viewed as continuously differing from itself over time. It is this loss of uniqueness and an implied unconcern with process that has led

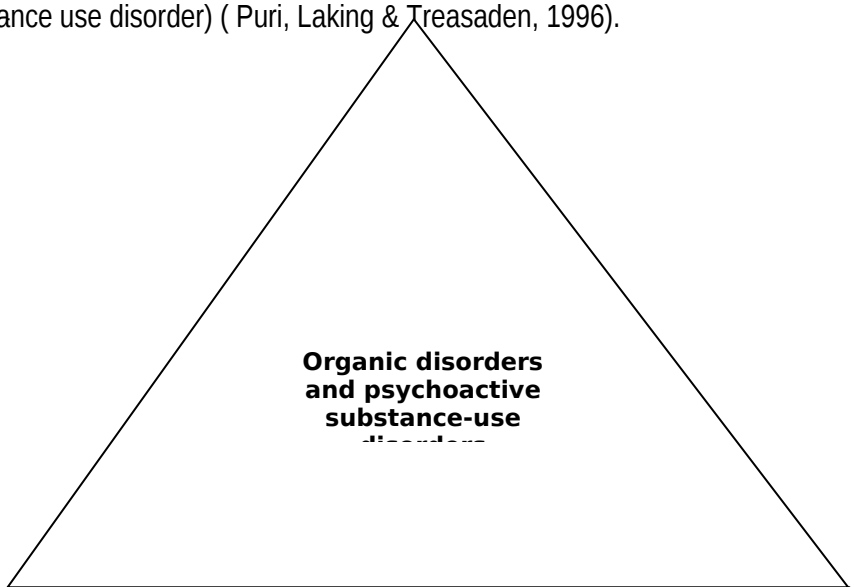
many clinicians to reject classification in principle. Therefore, a plea for broader and more meaningful classificatory schemata has been raised. (Zigler & Phillips, 1974).

Hierarchies and Co-morbidity

Some patients have more than one disorder. When this happens one of two approaches can be followed. The first is to use a hierarchy in which some diagnoses take precedence over others. The alternative is to diagnose all conditions that meet diagnostic criteria. This approach is used in the American classification, DSM-IV (Gelder, Mayou & Geddes,1999). The International classification, ICD-10, adopts an intermediate position.

Diagnostic hierarchy

Figure 5.1 shows the diagnostic hierarchy used in Psychiatry for the organic disorders, psychoactive substance use disorders, functional disorders (schizophrenia and mood disorders) and neuroses. In this hierarchy the highest level takes precedence over those below it when the latter are secondary to the former. For example, if an otherwise well patient presents with symptoms seen in acute schizophrenia, which turn out to be *secondary* to intravenous amphetamine abuse, then the diagnosis is psychoactive substance use disorder and not schizophrenia. Similarly, if a patient with chronic schizophrenia has secondary depressive symptoms, the diagnosis is schizophrenia rather than a mood disorder. On the other hand it is possible for primary diagnoses to coexist. For example, people with schizophrenia may abuse drugs, the diagnosis is still schizophrenia (and psychoactive substance use disorder) (Puri, Laking & Treasaden, 1996).



Schizophrenia

Mood disorders

Neuroses

Fig. 5.1 Diagnostic hierarchy used in Psychiatry

Clinicians are advised to make as many diagnoses as they consider necessary to describe the case completely. When this advice is not followed, not all co-morbid conditions are recorded.The same theory is followed in system too.

Multiaxial classification

In a Multiaxial classification, several kinds of disorders are considered in every case and recorded on 'axes'. The usual axes are clinical syndrome, personality disorder, physical disease, severity of stressors and disability. In everyday practise only the first three axes are used commonly – psychiatric disorder, personality and physical disease. These three diagnoses can, of course, be recorded without assigning them to separate axes, but the axial system ensures that they are considered in very case. Multiaxial classification is more often used in child than in adult psychiatry with intelligence taking the place of personality. (Gelder, Mayou & Geddes,1999).

Multiple diagnosis

A widely used practical solution and circumvention of the difficulty inherent in the application of the medical model to psychiatric diagnosis is offered by Noyes and Kolb (18). They suggest that the clinician construct a diagnostic formulation consisting of three parts: (1) A genetic diagnosis incorporating the constitutional, somatic, and historical-traumatic factors representing the primary sources or determinants of the mental illness; (2) a dynamic

diagnosis which describes the mechanisms and techniques unconsciously used by the individual to manage anxiety, enhance self esteem i.e., that traces the psychopathological processes; and (3) a clinical diagnosis which conveys useful connotations concerning the reaction syndrome, the probable course of the disorder, and the methods of treatment which will most probably prove beneficial. Noye's and Kolb's multiple criteria (18) can be arranged along three simpler dimensions of diagnosis which may have some practical value to the clinician: (1) etiological, (2) behavioral, and (3) predictive. The kind of information which is conveyed by each type of diagnostic label is somewhat different and specifically adapted to the purpose for which the diagnosis is used. The triple lable approach attempts to counter the criticism aimed at use of any single classificatory system.

5.2.1.3 Diagnosis in Psychiatry

As with other branches of medicine, a systematic approach to interviewing, history taking, clinical examination and investigations is necessary in psychiatry in order to make an appropriate differential diagnosis (Puri, Laking & Treasaden, 1996). The most important aims of psychiatric interviewing are to obtain information, to assess the emotions and attitudes of the patient and to supply a supportive role and allow an understanding of the patient. This is the basis of the subsequent working relationship with the patient.

a) Psychiatric interviewing and history

According to Schleifer & Vannatta (2006) without question, the most frequent procedure a doctor performs is a patient interview. Interviews occur over 200,000 times in the professional lifetime of a physician. This verbal and nonverbal interaction forms the backbone of the patient-doctor relationship. The processes followed in psychiatric interviewing and history taking are given below.

1. Begin by using open questions

2. The psychiatric history: Reason for referral, Complaints, History of presenting illness, Family history, Family psychiatric history, Personal history: Childhood, education, occupational history, psychosexual history, children, current social situation, Past medical history, Past psychiatric history, Psychoactive substance use: Alcohol, tobacco, illicit drug abuse, Forensic history and Premorbid personality.

b) Mental state examination and descriptive psychopathology

The mental state examination is an extremely important part of the psychiatric examination, which should be practiced repeatedly after carefully observing how trained psychiatrists carry it out. It covers the psychiatric symptomatology ('signs' of illness) exhibited at the time of the interview. In addition to recording information obtained from the interview itself, the mental state examination should also use information obtained by others, such as the observations of nursing staff in the case of an inpatient. This is important because the patient may not always be forthcoming about his or her symptomatology (Puri, Laking & Treasaden, 1996).

The mental state examination

An MSE include 1) Appearance and behavior (General appearance, Facial appearance, Posture and movements, Social behavior and Rapport) 2) Speech (Rate and quantity, Neologisms, Accent, Form and Record a sample if abnormal) 3) Mood (Objective, Anxiety, Subjective and Affect) 4) Thought content (Preoccupations, Obsessions, Phobias and Suicidal and homicidal thoughts) 5) Abnormal beliefs and interpretation of events (Referred to the environment – persecutory delusions, delusions of reference, ideas of reference; Referred to the body – hypochondriacal and nihilistic delusions; Referred to the self – passivity phenomena, delusions of poverty.) 6) Abnormal experiences(Referred to the environment – hallucinations, illusions, derealization, déjà vu;Referred to the body – alterations in somatic

sensations, somatic hallucinations; Referred to the self – depersonalization) 7)Cognitive state: (Orientation in time, place and person, Attention and concentration, Memory-immediate recall, registration, short-term memory, memory for recent events, long term memory and General knowledge and intelligence.) 8) Insight

c) Physical examination

A full physical examination should routinely be carried out at the time of admission of a psychiatric patient.

1. A physical examination may allow organic causes of psychiatric symptomatology to be found.
2. If an organic cerebral disorder is suspected, a fuller neurological examination should be carried out, including tests of level of consciousness, language ability, handedness, memory, apraxia, agnosia, number functions, right-left disorientation and verbal fluency. (Puri, Laking & Treasaden, 1996).

d) Investigations

First line investigations, which need to be, carried out on admissions to psychiatric inpatient units from relatives, GP (family doctor), other professionals sucha s social worjers, community psychiatric nurses and psychologists and previous medical and psychiatric case notes.

1. Blood tests: full blood count, Urea and electrolytes, thyroid function tests, liver function tests, vitamin B_{12} and folate levels, syphilis serology
2. Urinary drug screening

Second line investigations, which can be carried out, as indicated by the history and/ or mental state examination and/ or physical examination, include special blood and urine

tests (e.g. HIV serology), EEG, psychiatric testing, neuroimaging, HLA typing, genetic tests and sleep laboratory studies.

5.2.1.4 History of physical treatments

Physical treatments have been applied to patients with psychiatric disorders since antiquity, though, in retrospect, the most that could be claimed for the best of these interventions is that they were relatively harmless. Of course, the same holds for the management of patients with general medical disorders, for which similar treatments, such as bleeding and purging, were often used regardless of diagnosis. It is wise not to be too censorious about the treatment of disorders of which the aetiology is still largely unknown, but to bear in mind that 'it may well be that in a hundred years current therapies, psychotherapies as well as physical therapies, will be looked upon as similarly uncouth and improbable' (Kiloh et al. 1988, cited from Gelder, Mayou & Cowen, 2001).

Historically, physical treatments can be divided into two main classes:

- Those that were aimed at producing a direct change in a *pathophysiological process*, usually by some alteration in brain function:
- Those that were aimed at producing symptomatic improvement through a *dramatic psychological impact.*

Drugs that produce changes in the function of the central nervous system, such as opiates and anticholinergic agents, have been used in the treatment of mental disorders for hundreds of years. Whilst some of these drugs may sometimes have had calming effects, they were of no specific value in the treatment of psychiatric disorders. Often a physical treatment was used, not because of proven efficacy, but because it was recommended by an eminent and vigorous physician. Also, the assessment of efficacy depended almost entirely on uncontrolled clinical observation.

The aetiology of some disorders in psychiatry may be obscure and outcome may vary widely, even amongst patients with the same clinical syndrome.(Gelder,Mayou&Cowen ,2001)

Table 5.2.History of physical treatments in Psychiatry

Year	Introduction of Treatment
1934	Insulin coma treatment (Sakel)
1936	Frontal leucotomy (Moniz)
1936	Merrazole convulsive therapy (Meduna
1938	Electroconvulsive therapy (Cerletti and Bini)
1949	Lithium (Cade)
1952	Chlorpromazines (Delay and Deniker)
1954	Benzodiazepines (Sternbach)
1957	Imipramine (Kuhn)
1957	Iproniazid (Crane and Kline)
1966	Valpromide (valproate) in bipolar disorder (Lambert et al.)
1967	Clomipramine in obsessive-compulsive disorder (Fernandez and Lopez-Ibor)
1971	Carbamazepine in bipolar disorder (Takezaki and Hanaoka)
1988	Clozapine in treatment-resistant schizophrenia (Kane et al.)

Other agents that revolutionized psychopharmacology were introduced about this time. Their efficacy and their indications were first recognized through clinical observations, and were subsequently confirmed by controlled clinical trials. None of these agents was introduced on the basis of aetiological hypothesis.

There may now be grounds for more optimism about the prospects for advances in psychopharmacology. There is increasing knowledge as to how the neurotransmitters and neuromodulators may modify behavior through their interactions with specific brain regions and distributed neuronal circuits.New compounds are likely to differ from current drugs in their range of behavioural effects. These new preparations are likely to lead to important new developments in psychopharmacology.

5.2.1.5 Drugs used in Psychiatry

Psychotropic drugs are those which have effects mainly on mental symptoms, they are divided into six groups according to their principal actions. Several have secondary actions used for other purposes. For example, antidepressants are sometimes used to treat anxiety (Gelder, Mayou & Geddes, 1999).

Table 5.3. The types, indications and classes of psychotropic drugs

Type	Indications	Classes of drug
Anxiolytic	Acute anxiety	Benzodiazepines Azapirones
Hypnotic	Insomnia	Benzodiazepines Cyclopyrrolones
Antipsychotic[1]	Delusion and hallucinations Mania To prevent relapse in schizophrenia	Zopiclone Phenothiazines Butyrophenones Substituted benzamides Tricyclics MAOIs[2] SSRIs[3]
Antidepressant	Depressive disorders Chronic anxiety Obsessive-compulsive disorder Nocturnal enuresis	
Mood stabilizer	To prevent recurrent mood disorder	Lithium Carbamazepine
Psycostimulant	Narcolepsy Hyperkinetic disorder in children	Amphetamine

1 Antiparkinsonian drugs are used to control side effects of antipsychotics.
2 MAOIs, monoamine oxidase inhibitors.
3 SSRIs, specific serotonin reuptake inhibitors.

1. Anxiolytic drugs reduce anxiety. Because they have a general claiming effect, they are sometimes called *minor tranquillizers* (major tranquillizer is an alternative name for antipsychotic drugs). In larger doses these drugs produce drowsiness and for this reason are sometimes called *sedatives*.

2. Hypnotics promote sleep; many hypnotics are of the same type as drugs used as anxiolytics.
3. Antipsychotic drugs control delusions, hallucinations and psychomotor excitement in psychoses. Sometimes they are called *major tranquillizers* because of their claiming effect; or *neuroleptics* because of their parkinsonian and other neurological side effects. (*Antiparkinsonian* agents, are sometimes employed to control parkinsonian side effects.)
4. Antidepressants relieve the symptoms of depressive disorders but do not elevate the mood of healthy people. Antidepressant drugs are also used to treat chronic anxiety disorders, obsessive-compulsive disorder and, occasionally, nocturnal enuresis.
5. Mood-stabilizing drugs are given to prevent recurrence of recurrent affective disorders.
6. Psycho stimulants elevate mood but are not used for this purpose because they can cause dependence. Their principal use in psychiatry is in the treatment of hyperactivity syndromes in children.

Ethically patients would be given of important points concerning therapeutic effects, the compounds in most frequent use, side effects, toxic effects, and contraindications. General advice will also be given about the use of each group of drugs, but specific applications to the treatment of individual disorders will be found in the chapters dealing with these conditions, while prescribing the psychiatric drugs, the principles of drug interaction and deny withdrawal are to be kept in mind .

Drug interactions:

When two drugs are given together one may either interfere with the other, or enhance its therapeutic or unwanted effects. Interactions can take place during absorption, metabolism, or excretion; or at the cellular level. For psychotropic drugs most pharmacokinetic interactions are at the stage of liver metabolism, the important exception being lithium for

which interference is at the stage of renal excretion. An important pharmaco-dynamic interaction is the antagonism between tricyclics and some antihypertensive drugs. When prescribing a psychotropic and another drug the manufacturer's literature or a work of reference should be consulted to determine whether the drugs interact (Gelder, Mayou & Geddes, 1999). The "Drug index followed while prescribing psychotic drugs caution the psychiatrists about drug interactions.

Drug withdrawal

When some drugs are given for a long period, the tissues adjust to their presence and when the drug is withdrawn there is a temporary disturbance of function until a new adjustment is reached. This disturbance appears clinically as a withdrawal syndrome. It has been noted that among psychotropic drugs, anxiolytics and hypnotics are most likely to induce this effect.

General advice about prescribing psychotropic drugs:

There are many guidelines to be followed while prescribing psychotropic drugs .They are given below.

Use well-tried drugs: When there is a choice of equally effective drugs, it is generally good practice to use the drugs whose side effects and long-term effects are understood better. Also, well-tried drugs are generally less expensive than new ones. Clinician should become familiar with a few drugs of each of the main types–antidepressants, antipsychotics, and so on. In this way they will become used to adjusting dosage and recognizing side effects.

Change drugs only for a good reason: If there is no therapeutic response to an established drug given in adequate dosage, it is unlikely that there will be a better response to another from the same therapeutic group. The main reason for changing medication is that side effects

have prevented adequate dosage. It is then appropriate to change to a drug with a different pattern of side effects; for example, from an antidepressant with strong anticholinergic effects to another with weaker ones.

Combine drugs only for special reasons: Generally, drug combinations should be avoided. However, some drug combinations are of proven value for specific purposes, for example, benzodiazepines and antipsychotics to control acute symptoms of schizophrenia, and lithium and antidepressant for drug-resistant depressive disorder. Usually, drug combinations are initiated by a specialist because the adverse effects of such combinations can be more hazardous than those of a single drug.

Adjust dosage carefully: Dose ranges for some commonly used drugs are indicated. Within these ranges, the correct dose for an individual patient is decided from the severity of the symptoms, the patient's age and weight and any factors that may affect drug metabolism or excretion.

Plan the interval between doses: Less frequent administration has the advantage that patients are more likely to be reliable in taking drugs. The duration of action of most psychotropic drugs is such that they can be taken once or twice a day while maintaining a therapeutic plasma concentration between doses.

Decide the duration of treatment: The duration depends on the risk of dependency and the nature of the disorder. In general, anxiolytic and hypnotic drugs should be given for a short time--a few days to two or three weeks—because of the risk of dependency. Antidepressant and anti psychotics are given for a long time—several months—because of the risk of relapse.

Advise patients before giving a first prescription for a drug, The doctor should explain the following points :1)The likely *initial effects* of the drug (e.g. drowsiness or dry mouth) 2) The *delay* before therapeutic effects appear (about two weeks with antidepressants) 3)The

likely *first signs of improvement* (e.g. improved sleep after starting an antidepressant) 4) *Common side effects* (e.g. fine tremor with lithium) 5) *Any serious effects* that should be reported immediately by the patient (e.g. coarse tremor after taking lithium) 6) *Any restrictions* while the drug is taken (e.g. not driving or operating machinery if the drugs reduce alertness) 7) How long the patient will need to take the drug: for anxiolytics, the patient is discouraged from taking them for too long: for antidepressants or antipsychotics the patient is encouraged to continue after symptoms have been controlled.

The diagnosis and treatment methods in Psychiatry strictly followed a Biomedical model. It could be clearly observed from the methods of physical investigations and examinations as well as the physical (drug) treatments used in Psychiatry .The mode of action of drugs in turn determine the etiology of mental illness and not the other way around. These analyses would be further explained and discussed comparing the other medical systems in the next section of this chapter.

5.2.2 Ayurveda

"*O Almighty! Let us see for one hundred autumns (years), let us live for one hundred autumns (years), let us hear for one hundred autumns (years), let us serve the society for one hundred autumns (years), make us free from miseries for one hundred autumns (years) and for more than one hundred autumns years".*

(cited from Caraka Samhita , trans. by Sharma & Dash ,2007)

Ayurveda's conception on the diagnosis and treatment of mental disease (Manoroga) shares a lot with that of the physical diseases. The *Cikitsa-sthana* (section of therapeutics) deals with the therapeutic measures for all the diseases. It constitutes the most significant secret of this treatise (Caraka Samhita). In this section, treatment of some specific (named) diseases is described. According to Caraka Samhita, even the unspecified (unnamed) diseases can also be treated following the lines suggested in *cikitsa sthana*

Ayurveda is considered as an *Upanga* or *Upaveda* of *Ayurveda*. A distinctive part of Vedic medicine is its pharmacopoeia, especially its rich description of these substances and its knowledge of the local flora. This botanical wisdom occurs largely in the hymns of the *Atharvaveda* and is connected to a tradition of healing plant goddesses. The healing hymns of the *Atharvaveda* reveal one of the earliest forms of folk healing of Indo-European antiquity.

5.2.2.1 Mental diseases are diseases caused by Vata

According to Ayurveda, the functioning of the mind and nerves is dependent upon *Vayu or Vata.* Among these *dosas, Vayu* is the most important because it controls all types of sensation and motor actions which are the functions of the nerves controlled by the mind (Sharma & Dash, 2007).

Diseases caused by Vayu are classified into two broad categories, viz., (1*) Nanatmaja* or those caused by *Vayu* alone, and (2) *Samanyaja* or those caused by *Vayu* in association with other dosas*. Nanatmaja* type of Vatika diseases are of eighty types which are already enumerated in Sutra 20:10. Apart from some of those enumerated in Sutra 20:10, new Vatika diseases are also described with reference to their diagnosis, pathogenesis and treatment.

Vayu gets aggravated to cause a disease in two different ways, viz., (1) by *dhatu-ksaya* or diminution of tissue elements and (2) by *marga avarana* or obstruction to its channel of circulation are the pathways through which *Vayu* moves. Any damage or decay of these nerves will, however, cause impairment of the functioning of Vayu resulting in the manifestation of several diseases. Improper food and regimen may also cause diminution of tissue elements resulting in the morbidities of nerve cells to give rise to such diseases. Thus, the line of treatment involves the removal of obstruction in the nerves of their cells, and

restoration of the normalcy of these cells by appropriate nourishment. Diagnosis and treatment of these *Vatika* diseases like hemiplegia, multiple sclerosis, paraplegia and facial paralysis are described in *Caraka Samhita.*

5.2.2.2 Aim of Ayurvedic Treatment

Sharma & Dash (2007) say that. Ayurveda lays a great deal of emphasis upon the preservation and promotion of positive health, which is its primary objective. Prevention and cure of disease are only the secondary objective of *ayurveda.* For the preservation and promotion of positive health, several rules are prescribed in ayurveda which include *acara-rasayana* (codes of conduct), *rtu - carya* (regiments for different seasons), *dina - car*ya (regiments for different parts of the day) and *ratri-carya* (regiments for different parts of the night). If these rules are violated, then a person suffers from various diseases, and the secondary objective of Ayurveda is to prevent and treat these diseases.

Ayurveda emphasizes upon keeping the body barren, i.e., maintaining a strong immunity system of the body. Ayurveda describes drugs, diet and regimens of preserve and promote this immunity to prevent and cure diseases. (Sharma & Dash, 2007). While curing the disease, the strong immunity developed by ayurvedic therapies prevents the reoccurrence of the same disease, and attacks of other similar diseases. Ayurveda stands for longevity and simultaneous promotion of the quality of life.

5.2.2.3 Treatment of mental diseases in Ayurveda

The process of treatment of mental diseases follows a comprehensive course in Ayurveda. Amma (2001) says that in the treatment of mental disease the body is also given attention. As the theoretical postulates of Ayurveda, talks about the coexistence of mind, body and soul the management of mental disease include all these levels. Thus, it is believed that providing nourishment to the body stimulates mind and soul, for example.

Classical treatment adopted for *Manoroga* starts with purificatory measures, which, along with elimination of bodily impurities help to regain the normal state of mind and the faculties *(indriya).* The employment of purification therapy, of course, should be with necessary modifications according to the associated symptoms and the predominance of humors. As a general rule in psychoses, according to the predominance of humor, Ayurveda suggests *Shehana* (oilation) with mild *Svedana* (purgation) in *Vaata, Svedana* (purgation) in *Pitta* and *Vamana* (Vomiting) in *Kapha.*

The treatments for the mental disease may be classified into six groups:

1. Drug therapy
2. Classical five fold therapy *(Panca karama)*
3. Palliative treatments *(Upasamana)*
4. *Satvaavajaya Cikitsa*
5. Preventive measures: Bring *Prasaada* state of mind by several methods like purification processes, consolation, counseling, yielding desirable subjects to the patient; Enrich the *Satva Bala* (mental strength) of the patient by educating him in desirable and non-desirable things and disciplining the mind to get self- control.
6. Dietary regimen (*Bhojana Vidhhana*)

5.2.2.3 Drug therapy

Physical treatment of mental illness is essential along with the psychological therapies. Ayurveda uses a wide range of single drugs and formulations in the prevention and cure of mental diseases. Amma (2001) notes that Ayurveda has the general concept that the drugs are to be used 'as a whole' and the diseases are also to be viewed as an integral whole. Most of the Ayurvedic medicines are formulations containing many ingredients. Such combinations have an internal balance that minimizes the chances of side effects. But at the

same time, the drugs used in allopathic treatment of mental disorders have many side effects, as they are synthetic materials or active principles derived from plant sources. For example, the continuous use of Reserpine, an alkaloid extracted from Rawolfia serpentina, precipitates suicidal tendencies. On the other hand the use of the whole drug will reduce when as a powder or in the form of crude extracts such as decoction (Amma, 2001).

Drugs have been chosen based on its potency (*Prabhava*) and taste (*Rasa*). Drugs act by virtue of these qualities. When a drug is having some special action that is not attributable to the known properties of the drug, that pharmacological action is said to be due to the potency. Amma (2001) mentions that Ayurvedic classics are unable to draw correlation of the classical pharmacological categories of drugs such as potency and taste and make concrete theories about the action of drugs on mind from the Ayrurvedic point of view.

Therapeutic measures using drug- materials are called *Dravya Cikitsa*. The basic view of Ayurvedic pharmacology is that every material in the universe is created with different kinds of combinations of *Panca mahabhoota* and each material is viewed according to its elemental constitution. Among the five divisions of substances, elements predominant in *Vaayu* act in mind level. In the same way, out of the six tastes bitterness in described in *Medhyaa*. This relationship can be more emphasized on analyzing the tastes used in psychic disorders. (Raghunadhan, 2001).

Other properties like *Aayusha* (property to lengthen the life span), *Balya* (to strengthen), *Ojasya* (to increase the vital strength) and *Pushtikara* (to nourish) are also present in the medicines advocated for mind.

According to Raghunadhan (2001), drugs advised for mental purpose are divided into two groups:

1) Drugs advised in normal mind

2) Drugs advised in diseased state

a) Drugs advised in normal mind

Certain drugs are advocated to promote different faculties of mind. These can be used even in the normalcy of the mind. They are:

Drugs to promote acuity of the mind: *Medhaa* is the term used to denote acuity of mind.Most of the drugs explained under this group, found used in Ayurvedic psychiatry. Examples of such drugs, are, Centella asiatica, Clitora ternatea. Under the *Rasaayana* group of medicines a separate subgroup is dealt for promoting the acuity of mind (*Medhya Rasayana*). These drugs are advised in obsessive psychosis (*Atatvaabhinivesa*).

Drugs to promote intellect: Certain drugs are detailed as the promoters of intellect (*dhee, amti* or *buddhi*). They are Terminalia chebula (*Hareetakee)*, *Mahaa paisaacaka ghrtam*.

Drugs to promote memory: *Smrti* (memory) is explained as the mental capacity to recollect the past events.There are many drugs under this topic. Bacopa monieri *(Brahmee*), Clitora ternatea (*Sankha pushpee*), Celastrus paniculatus (*Jyothishmatee*) and Acorus calamus (*Vacaa*) are some examples under single drugs and three myrobalans *(Triphalaa*) *Brahma rasaayanam* and *Amrtaraasaghrtam* are some among the compound drugs.

Will power (*Dhrti or dhairya*) is another faculty of the mind, which can be promoted only by self- training. This mental faculty plays a major role in concern with all diseases and that is the basic concept of *Savaajaya cikitsaa*, one branch among the three divisions of treatment methods classified as per the role of mind in therapeutics. All these mental faculties except acuity of mind are the pillars of the normal health, blemishes on these causes the provocation of disease.

b) Drugs advised in diseased state

Bhoota hara drugs: In different contexts, certain drugs are explained destroying *Bhoota* or *Rakshas*, which are the main concern in *Bhoota Vidya*.[5] Entering of evils spirits as the cause of disease is now considered as controversial in the present Ayurveda treatment. Acorus calamus is the drug of choice under this group.

Unmaada Hara Drugs**:** Many medicines are dealt with this property i.e., to cure insanity, either in single or compound forms. Clarified butter kept for years (at least for ten) is the best among these drugs.

Apasmaara Hara Drugs: Even if *Apasmaara* (epilepsy) is not directly considered under *Unmaada* conceptually, its treatment is very much similar to that of *Unmaada*. Great number of drugs can be seen as *Apasmaara hara* (ant epileptics) in the classics. Bacopa monieri is the best one according to descriptions. It is a natural fact that drugs promoting *Smriti* (memory) are advocated mostly in *Apasmriti* i.e., epilepsy.

Sanjnaasthaapana Drugs: These are medicines ascribed to recover the lost consciousness. *Caraka Samhita* gives a group of ten drugs having this efficacy.

Miscellaneous drugs: One can see some other properties of drugs that are related with mind. *Paapa hara* (abating the guilt complex), *Amangalya Nivaarana* and *Alakshmee hara* (removing inauspiciousness) are some of the examples. *Sukumaara ghrtam, Kalyaanaka ghrtam* are dealt possessing these qualities (Raghunadhan, 2001).

[5] Is the specialty in Ayurveda which deals with mental illness. The last type of mental illness is also called ' *Bhootonmada'*.

Therapeutic measures using drug- materials are called Dravya Cikitsa. The basic view of Ayurvedic pharmacology is that every material in the universe is created with different kinds of combinations of Panca mahabhoota and each material is viewed according to its elemental constitution. Among the five divisions of substances, elements predominant in Vaayu act in mind level. In the same way, out of the six tastes bitterness in described in Medhyaa. This relationship can be more emphasized on analyzing the tastes used in psychic disorders. (Raghunadhan, 2001).

Other properties like Aayusha (property to lengthen the life span), Balya (to strengthen), Ojasya (to increase the vital strength) and Pushtikara (to nourish) are also present in the medicines advocated for mind.

5.2.2.3.2 Pancakarma

Pancakarma viz. *Vamana* (vomiting), *Virecana* (purgation), *Aasthapana* (decoction enema), *Anuvaasana* (Oil enema) and *Nasya* (nasal medication) are used for *Unmada* (Kumar, 2001).

Though ***Virecana*** **(purgation)** is the specific purification in disease with predominance of *Pitta*, in practice, due to its high practicability, its range includes other types of disease too. Moreover the influence of *Saadhaka Pitta* over mental functions also suggests the significance of purgation in madness. It is common practice to purge the patient before internal unction, aiming at de-worming and attainment of a state of 'dryness' *(Rookshata)* in the gastrointestinal tract (*Koshtha*). In Psychoses, selection of the purgative should also be judicial. The physician should consider co-existing conditions too in the selection of the purgative.

After the purification procedures, *Snehana* (oilation) and *Svedana* (purgation), ***Vamana* (vomiting)** is done. Medicines for inducing vomiting can be selected according to the associated symptoms and condition of the patient.

***Aasthapana* (decoction enema) and *Anuvaasana* (Oil enema)** have both purification and mitigation functions. With numerous combinations enema can produce a surprising range of actions. Its action includes mitigation of three humours (*Tridosha haratva*), addition (*Brmhana*), reduction (*Karsana),* aphrodisiac (*Vajeekarana),* nutrition of the eyes (*Chakshupreenana)* etc.

***Nasya* (nasal medication),** acts as a general purificatory aid, especially of the head where the major sensory faculties (*Indriya)* are located. The clarity of the faculties (*Indriya prasaada*) generated by nasal medication leads to the clarity of mind (*Manahprasaada*) also. The medicines act to stimulate the mental and physical functions through their inherent property of cleansing the channels.

5.2.2.3.3 Palliative treatments (*Upasamana*)

Apart from the drugs advised to improve the mental clarity, palliative measures in Ayurveda include *Dhoomapana* (inhalation), *Dhoopana* (fumigation), *Anjana* (collyrium), *Lepa* (daubing with medicinal paste) and *Dhaara* (irrigation). In mental disease not amenable to ordinary treatment, rejuvenation therapy (*Rasaayana*) may be prescribed (Sankar,2001).

5.2.2.3.4 *Satvaavajaya Cikitsa*

Seema (2001) says that *Satvaavajaya Cikitsa* described in Ayurveda can be equated with psychotherapy. This may be considered as a part of the *Yuktivyaapasraya Cikitsa*. It is a mode of treatment without drugs and uses only *Upaaya* (techniques). Some procedures of *Daiva vyapaasraya cikitsa* (providential treatment) could also be incorporated in the treatment

of mental diseases. The action of such treatments is said not to be explained logically. The treatments for Bhootonmada are one among them.

The methods or techniques described in classics for the treatment of psychic disorders are *Jnaana* (knowledge), *Vijnaana* (scientific knowledge), *Dhairya* (willpower), *Smrti* (memory), *Samaadhi* (balance of mind), *Tapa* (penance), *Seela* (habit), *Santwana* (consoling), *Daana* (donation), *Dayaa* (kindness), *Japa* (chanting), *Homa* (sacrifice in fire), Bali (sacrifice), *Vrata* (vows), *Tarjana* (threatening), *Traasana* (shock), *Harshana* (pleasing), *Bhayadarsana* (frightening), *Vismaapana* (astonishing),*Vismarana* (forgetting), *Kshobhana* (agitation), *Bhartsana* (scolding), *Peethana* (torturing), *Bandhana* (confinement), *Svapna* (sleep), *Samvahana* (massage), *Trivarga aveshanaa* (consideration of the triad of duty, wealth and longings , *Virodhi Bhavana* (inducing opposite emotions) etc.

5.2.2.3.5 Preventive measures

Treatment against causes of the disease and avoidance of etiological factors is of paramount significance in the context of treatment of psychoses. The etiological factors of mental illnesses are more related to the socio- cultural circumstances of the person and the physical factors in the etiology are comparatively lesser. Thus, Kumar (2001) says that the development of the total personality of the patient is very essential in the context of treatment. Some techniques are:

- Bring *Prasada* state of mind by several methods like purification processes, consolation, counseling, yielding desirable subjects to the patient;
- Enrich the *Satva Bala* (mental strength) of the patient by educating him in desirable and non-desirable things and disciplining the mind to get self- control.

Importance of Prasaada in therapy

Prasada is clear state of mind featured with satisfaction and optimism. The prior important thing while treating mind is to bring this state using various methods. In the *dosa* point of view, great care for *Vata* is to be taken since it has the major influence on the mind to entangle it. Inconsistent mind (*Anavasthita Cittata*) is one among the eighty Vata diseases. The concept of control on *Prana* in *Raja Yoga* by the methods like *Pranayama* and *Pratyahara* is only to keep the *Prasada* state of mind. *Sreemad Bhagavat Geeta* states that by the proper control of mind over sense faculties, mind yields *Prasada* by which one gets rid of all worries and then the intellect will function in the proper manner.

Adravya chikitsa a therapy using different methods where no materials are directly applied. Most of the methods under *Daiva Vyapaya Cikitsa* (a branch of therapeutics where the invisible efforts of the deeds of a person is depended) come in this context. Conducting rituals, observing certain regimens, pilgrimages, chanting some mantras and prayers, wearing particular jewels and drugs, kneading, consolation and in certain cases threatening, turmoil etc., are included in this. The principle in these methods is that by these, nervous system of the patient is stimulated, vigil is recovered, and the bodily channels are cleansed well. Automatically then the mind does function in proper way (Raghunadhan, 2001).

5.2.2.3.6 Dietary regimen (*Bhojana Vidhhana*)

Dietary restrictions become an inevitable part of any Ayurvedic treatment. They are divided into *Pathya (*wholesome regimen) and *Apathya* (unwholesome regimen). *Pathya* foodstuff includes rice, wheat, green gram, milk, leafy vegetables etc. and *Apathya* food substances are those are incompatible, contaminated, unhealthy and unaccustomed. They include alcohol, fish, meat etc. Excessive consumption of food is also unwholesome (Sankar, 2001). Dietary restrictions are done considering the etiological and pathological factors in mental illness and the action of specific foodstuffs over them (Kumar, 2001).

5.2.2.4 Treatment of unnamed diseases

There are several other diseases, which are not described in *Caraka Samhita* with names and forms. Even such diseases are to be treated on the lines suggested in *Caraka Samhita* after examining the *dosas* and such other factors involved in their manifestation.

Therapeutic measures are suggested to be administered after examining *dosas* and such other factors involved in the manifestation of the disease. These 'other factors' referred there imply *dusyas* (tissue elements) and causative factors. Alternatively these 'other factors' refer to *bhesaja* (therapeutic measures) *desa* (location), *kala* (time), *bal*a (strength), *sarira* (physical features), *ahara* (diet), *samya* (wholesomeness), *sattva* (mental attitude) *prakrti* (constitution) and *vayas* (age).

5.2.2.5 Line of treatment in general

Therapies which are opposite to the properties of the *dosas, dusyas* (tissue elements) and etiological factors involved in the causation of the disease are certainly useful to cure it. If appropriately used, such therapeutic measures will cure all the diseases whether they are named or not in the text. Therapeutic measures possessing attributes opposite to *dosas, dusyas* and *nidana* (etiological factors) are stated to be administered. The *dosas* are *Vayu, Pitta* and *Kapha.* The dusyas are Rakta (blood) etc., Nidanas (causative factors) are the intake of ingredients which are unctuous, etc. Therapeutic measures which are opposite in properties to all these factors collectively or individually are to be administered.

If appropriately used, such therapeutic measures cure diseases, which are described with name, and also those, which are not described with names and form (signs and symptoms). *Therapeutic measures which are opposite to nidana (causative factors) are necessarily opposite of the dosas*. For example, vayu *g*ets aggravated by the intake of ununctuous ingredients. Administration of unctuous ingredients (which are opposite of

ununctuousness) will also alleviate vayu, Even then in the aforesaid statement, *nidana* and *dosas* are mentioned separately in order to indicate the need for therapeutic measures which are opposite to not only a part of the dosa but to the whole of it. For example, when *vayu* is aggravated in its entirely, then oil which is opposed to the entire *vayu* should be administered. When only the cold attributes of *vayu* is aggravated, then oil need not be used, and for this condition, only hot ingredients which are opposite to the causative factors *(nidana*) and only hot (*hetu viparita*) in effect are to be administered.

By mentioning *dosas* and *dusyas,* the disease, which is caused by their vitiation or aggravation, is also included. Thus, therapeutic measures opposite of the disease (*vyadhi-viparita*) are also included in this statement.The term '*viparita'* refers to the 'antagonistic measures' and not simply 'those having opposite attributes'. Thus, therapeutic measures which are not actually opposite in attributes but act in an antagonistic way (*viparitarthakari)* are also included in *Caraka Samhita.*

Diseases are caused both by the aggravation and diminution of *dosas* as well as *dhatus*. If these elements are diminished in quantity, then for their augmentation, therapeutic measures which are similar in property are to be given. Such therapeutic measures given for the augmentation of the *dosas* and *dhatus*, though similar in property, cure the disease. Thus, these are to be treated as of opposite nature (*viruddha).* In such condition, therapeutic measures, which are opposed to dosas, are not to be given but those which are opposed to the diminution of *dosas* (these are obviously possessed of attributes which are similar to the *dosas* and *dhatus*) are to be administered.

Appropriately administered, these therapeutic measures are stated to correct *dosas*, etc. Thus drugs having similar properties work in an opposite manner, and there is no contradiction in the above statement.

5.2.2.6 Appropriate use of therapeutic measures

Therapeutic measures should be appropriately used keeping in view of the following;

(i) *Desa* (location)

(ii) *Kala* (time)

(iii) *Pramana* (dose)

(iv) *Satmya* (wholesomeness); and

(v) *Asatmya* (unwholesomeness)

Otherwise, even a useful therapy *(pathya*) may turn out to be harmful *(apathya).*

The term ***Desa*** means both the patient's body (*deha - desa*) and the place of habitation. In the present context, this term refers to the physique of the patient. The place of habitation will be described under the category *satmya* (wholesomeness). ***Kala*** or time has six aspects. viz., day, patient, medicine, disease, signs of proper digestion and season – vide verse no 296. The times of administration of medicine are of ten types. The term *kala* (time) in the present context has reference to (a) *Dina* (different parts of the day), *Atura* (nature of the patient), *Ausadha* (time of taking medicine), *Vyadhi* (nature of the disease), *Jirna – linga* (stage of the digestion of food), and *Rtu* (nature of the season). Administration of therapeutic measures without careful examination of the six conditions of *kala* (time) leads to harmful effects as the unseasonal rain damages the crops.

The ***Pramana*** (dosage) is of three types, viz., (1) small dose (2) big dose and (3) moderate dose – vide verse nos 313-314. The term ***Satmya*** or wholesomeness refers to the place of habitation *(desa-satmya*) and the physique of the individual (*sarira-satmya*). Wholesomeness to the disease *(vyadhi-satmya*) is included in the category of medicine. Wholesomeness to season *(rtu-satmya)* is already included in the category of time.

Wholesomeness of the dosage is covered under the category ‘appropriate method of administration’ *(samyag-yoga).*

Dose of medicine

As small amount of water cannot extinguish fire, similarly medicine in small quantity cannot cure a disease. As irrigation with overflood is harmful for the crops, similarly medicine in excessive quantity (dose) is harmful for the patient. Therefore, after carefully examining the strength of the diseases and the medicine, the remedial measures should be administered in a quantity (dose) which is neither too large not too small. The dose should be or moderate in nature.

Usefulness of therapies generally considered as harmful

If the morbidities have afflicted the deep-seated organs like those in the *kostha* (thorasic and abdominal *visceras*) and joints, at times, for their cure, therapeutic measures generally considered as contradictory (*virudha*) may be useful. If pitta is deep seated and located in the internal pathway (*thorasic and abdominal visceras*), then by the application of hot fomentation, *seka* (affusion) and *upadeha* (hot poulitices), it comes out to the exterior of the body resulting in the alleviation of *pitta* or heat. (Thus, heat-producing therapies may cure *pitta*, which is hot in nature).

By the application of external therapies like *seka* (affusion) etc., which are cooling in nature, the external heat is pressed to go inside, and cure the deep seated *kapha* in the internal path way (thorasic and abdominal *visceras).* Thus a cooling therapy may cure *kapha* which is cold in nature. Sandalwood is cooling in nature. But if it is made to a fine paste and applied over the skin in thick layer, it causes burning sensation (heat production) by obstructing the evaporation of heat from the skin.

Therefore a wise physician should carry out treatment after examining carefully the diseases and drugs with reference to ten items (vide commentary), and not only by recipes (described with reference to the diseases in the classics).

Reoccurrence of disease

Even if a disease is cured, it may reoccur by minor form of etiological factors because by the earlier disease the body has become already weak, and the channels for the manifestation of the disease have already become vulnerable. This reoccurrence takes place like the flaring up of a small quantity of residual fire (after the main fire is extinguished). Therefore, the body should be immune from such reoccurring attacks of the disease by the continuous use of effective and otherwise harmless drugs, which were used before for the treatment of the primary disease.

The term *nivrtta* (cured) does not imply complete cure of the disease but incompletely cured disease with minor residual morbidities. If the disease is completely cured then there is no possibility at all of its reoccurrence because of minor forms of etiological factors. This type of interpretation is supported by the citation of the simile of residual fire. The term *margikrta* implies the susceptibility of the channels afflicted earlier because of the non-development of the power of resistance (*vyadhi apratibandhakataya*) as if the path is patient for the reoccurrence of the disease. If the disease, which is incompletely cured earlier, reoccurred because of minor etiological factors, then it has the tendency to be cured quickly *(prasamabhimukha).*

5.2.2.7 Doctor- patient relationship

Caraka Samhita says that the physician who very frequently keeps on observing the development of the disease and the conducts of the patient will not commit mistakes in treatment. The text also mentions about the **importance of the knowledge of physician in scriptures and their interpretations.** A physician who is not well versed in the scriptures and their interpretations should not attempt treatment of diseases as a painter without eyesight should not attempt painting a picture (Sharma & Dash, 2007).

Murali (2001) elucidates the mutual relation between the doctor and the patient. A *Roga,* not well examined, not explained by the patient properly and completely, not well interrogated will confuse the physician. The treatment will be effective only if the physician builds a good rapport with the patient. Patient *(Rogi)* should be communicative (*Jnapaka).* He should have faith in the physician, that all of his symptoms are well interpreted by the physician to reach a diagnosis. That will make him disclose everything about his disease. The attitude of the patient is also important in the treatment. All the seers of *ayurveda* stress the importance of compliance to the physician *(Bhishak Vasyata*) from the part of the patient. Motivation without distraction (*Avyagryata)* makes medication easier. Patient, questioning the rationale of medication, as if he is an exponent of medical science *(Vaidyamaani)* may destroy the rapport. On recovery, the patient should be grateful to the doctor and should express it so as to maintain better relationship with the doctor.

The attitude and communication skills enable the physician to win the confidence of the patient. Doctor is to be motivated by true empathy toward the suffering man toward him. *Yogaratnakara* stresses the need for a peaceful and calm mind for the physician, so that he reaches a firm unbiased concussion on the abnormality under consideration. *Vagbhata* also emphasizes the need of intimacy to the sick. Along with this and sharpened clinical skill, physician as a *yogi* enters the inner soul in depth to find what went wrong.

Non-medical communications are also important. They have a direct relation with patient's satisfaction. Persuasive communication may also be necessary in certain occasions, perhaps in the form of fear provoking warnings. Finally, it is knowledge accompanied with clinical skill that makes a confident physician. A physician without these is compared to a coward facing a war. According to *Susruta Samhita*, valor (*Saurya)* and quick action (*Aasukriya)* are essential attributes of surgeon (Murali, 2001).

Seema (2001) says that in *Satvavajaya Cikitsa*, the purpose of the doctor is to increase the patient's self-knowledge. So he should have honesty, empathy, compassion, flexibility, self-confidence, intelligence, intuitiveness and genuineness. *Ayurveda* insists that a good doctor should have the following qualities:

1. Friendliness, compassion or warmth
2. Knowledge in the science of medicine
3. Precise in application of the therapy
4. Vast practical experience
5. Should not have ill feeling towards the patient
6. Speech should be gentle, pure, righteous, worthy, wholesome and moderate

Thus, it has been seen from the detailed description of diagnosis and treatment in Ayurveda, heavy stress is placed on the maintenance of health which could prevent and cure diseases .The all possible factors that affect health and illness, the possibility of unknown diseases and its cure, methods of using drugs and other therapeutics, dose of medicine and mode of action of drugs are given in Caraka Samhitha in detail. The treatment of abnormal behavior had also a psychological and metaphysical dimension as we could see in the *Satvavajaya Chikitsa*. Moreover, the relationship between the doctor /physician and the patient is considered as having a therapeutic effect too.

5.2.3 Homeopathy

Close (1984) says that the making of a good prescription, good examination and a good diagnosis depended upon *the correct application of the principles of logic*. He continues that homeopathy itself is founded and constructed upon logical principles and that all its processes may, and if they are to be correctly and efficiently performed must, be conducted under the principles and by the methods of good logic. According to Close (1984) *"for the logical process by which homeopathy was worked out and built up is applicable in every concrete case a homeopathic physician is called upon to treat".*

The use envisaged by Homeopathy is strongly rooted in the principle "diseases are cured by medicines that have the power to excite a similar affection." The symptoms of drugs and the symptoms of disease are always matched each, other which would give a logical basis for homeopathic cure. This comparison is done by giving a medicine to a healthy person and observes the effect, since a healthy person would be the only kind of a person in whom affection similar to disease could be excited.

The principles of determining the cure are the same with each case. They are:

- The examination of a patient
- The analysis of the totality of symptoms derived from such an examination
- The classification of symptoms for any purpose
- The selection of the remedy and the diagnosis of the disease

Thus we could see that naming of a disease, diagnosing it based on the characteristic symptoms and totality of symptoms and selecting a remedy are simultaneous processes in Homeopathy. The homeopath at first gather all the facts of a case and complete each symptom by careful inquiry into its origin, its exciting or occasioning cause or causes; its

history and duration; its relation to other symptoms and its modalities or modifying circumstances and conditions.

5.2.3.1 Symptomatology in diagnosis and treatment

A symptom is any evidence of disease, or change from a state of health. Hahnemann defines symptoms broadly as, “any manifestation of a deviation from a former state of health, perceptible by the patient, the individuals around him, or the physician”. He further defines symptoms as “evidences of the operation of the influences which disturb the harmonious play of the function, the vital principles as a spiritual dynamis”. Symptoms are divided into two: Subjective and Objective.

Subjective symptoms are symptoms, which are discoverable by the patient alone, such as pain and other morbid sensations of body or mind, presenting no external indications. Subjective symptoms naturally take their proper place in the study of the case. As expressions of the interior states of the organism, and particularly of the psychic and mental states, they take the highest rank. They enable the physician to view disease from the standpoint of the patient.

Objective symptoms: Hahemann defines objective symptoms as, “the expression of disease in the sensations and functions of that side of the organism exposed to the senses of the physician and bystanders.”

“Characteristic symptoms”: They are general symptoms or generalization, inferred or deduced from particular symptoms by the logical process of generalizing. These symptoms describe or epitomize those particular features, which characterize the patient as an individual; facts that are *true of the case as a whole*; or of a number of the particular symptoms of the case, considered as a group. In other words ‘characteristics’ are the individualizing factors of a case

or remedy. They are the points, which enable us to differentiate between similar cases and remedies.

5.2.3.2 Pathological unity of symptoms:

Pathological symptoms in definite diseases derive their meaning and, relative value from their connection with a definite, general pathological condition or state, exactly as pathogenetic symptoms derive their meaning and value from an individual definite day, the action of which upon the vital substance they manifest and express.

5.2.3.3 General symptoms

The patient sometimes correctly generalizes parts of his own case. This he may do unconsciously, as when he refers certain symptoms or conditions of symptoms to his inner consciousness by saying, "I feel" thus and so; "I am worse in rainy weather"; "I am sad, or depressed, or easily angered as the case may be. ***Nearly all mental symptoms are generals because mental states can only be expressed in general term*****s**. (Close, 1984). Because they express the man himself. *The mind is the man.*" *"Modalities, or conditions of aggravation and amelioration applying to the case as a whole, or the patient himself, are generals of high rank"* (Kent, cited from Close, 1984).

Absence of certain striking or customary features of a disease may be a general symptom of a case, which is called *negative general symptoms*. For example, fever without thirst.

5.2.3.4 Totality of the symptoms

The true 'totality' is more than the mere numerical totality or whole number of the symptoms. It may even exclude some of the particular symptoms if they cannot, at the time, be logically related to the case. Such symptoms are called 'accidental symptoms', and are not

allowed to influence the choice of the remedy. Close (1984) quotes Hahnemann (Org., Par.6). *"The ensemble or totality of these available signs or symptoms represents in its full extent the disease itself; that is, they constitute the true and only form of which the mind is capable of conceiving".* It represents the disease and it also represents the remedy.

Hahnemann (Org., Par. 7) calls the totality, *"this image (or picture) reflecting outwardly the internal essence of the disease, i.e., of the suffering life force".* The 'totality' is not, a mere haphazard fortuitous jumble of symptoms thrown together without rhyme or reason. The totality means the sum of the aggregate of the symptoms. It is the numerical aggregate plus the idea or plan which units them in a special manner to give them its characteristic form.

1. The totality of the symptoms means, first the totality of each individual symptom. A single symptom is more than a single fact; it is a fact, with its history, its origin, its location, is progress or direction, and its conditions. Every complete symptom has three essential elements: *Location, Sensation and Modality.*

Location means the part, organ, tissue or function of body or mind in which the symptoms appears. *Sensation* means the impression, or consciousness of an impression upon the central system through the medium of the sensory or afferent nerves, or through one of the organs of senses; a feeling or state of consciousness produced by an external stimulus, or by some change in the internal state of the body. A sensation may also be purely mental or physical reaction, such as fright, fear, anger, grief or jealousy. *Modality* refers to the circumstances and conditions that affect or modify a symptom, of which the condition of aggravation and amelioration are the most important.

2. The Totality of the Symptoms means all the symptoms of the case which are capable of being logically combined into a harmonious and consistent whole, having form,

coherency and individuality. Technically, the totality is more (and may be less) than the mere numerical totality of the symptoms. It is includes the 'concomitance' or form in which symptoms are grouped.

Kent (1993) opines that, *The Materia Medica* from this point of view becomes a portrait gallery of disease, by means of which we may identify the thieves who steal away one health and comfort and bring them to justice. In homeopathic practice, to carry out the simile, we merely "set a thief to catch a thief".

5.2.3.5 Individualisation

The practical work of the presriber in constructing the totality or "case" and selecting the remedy is governed throughout the by the logical principles of individualization. To individualize is to confer particular characteristics upon, distinguish. To select or mark as individual; note the peculiar properties of; particularize; characterize.

5.2.3.6 Generalizing

A generalization made according to the principles of inductive logic stands in direct and logical relation with the data from which it is drawn and includes them in their essential features. It is arrived through a series of steps or degrees, in which each conclusion rests firmly upon the preceding steps.

Generalizing the mental states is the most difficult of all and requires the exercise of the highest powers of the doctor. In difficult cases of nervous and mental disease the doctor must be a trained psychologist and a logician, as well as a most alert and accurate observer.

5.2.3.7 What is cure in Homeopathy?

Close (1984) says that Homeopathy is *"not a theory of disease, but a theory of cure".* One of the most famous laws of homeopathy is called Hering's Law of Cure after the

American homeopath Dr. Constantine Hering (1800-1880). The cure envisaged in Homeopathy follows Hering's Law of Cure, which is considered as the fundamental principle in cure.

"….cure must proceed from center to circumference… from the top downwards, from within outwards, from more important to less important organs, from the head to the hands and feet… symptoms feet….symptoms which disappear in the reverse order of their coming are removed permanently" (Kent,1900 cited from Morrell,2004).

This law states that far from being a haphazard process, cure operates on regular and predictable principles. These are from top downwards, from inside outwards, from present to past and from most vital to less vital areas.

"….the remedy acts first by taking hold of the innermost part of the human economy, and the symptoms leave the innermost, or more vital organs, moving from the interior to the exterior of the body; also, first from the head, then from the torso, and last from the extremities." (Weiner & Goss, 1980 cited from Morrell, 2004).

Homeopaths claim to observe during the treatment of a chronic condition, an improvement in inner, top and vital areas and a flow of the site of disease towards the peripheral and vital areas (e.g. the skin). They also claim to observe old dormant conditions return fleetingly and then disappear. Some homeopaths regard the body as a hierarchy of vital and less vital regions and organs. The brain, heart, respiratory, circulatory and endocrine systems are regarded as the most inner and vital centers, as damage here causes rapid death or major/ irreversible impairment in function. Next come the liver, kidneys, bladder, digestive and skeletal systems. Finally, the muscles and skin, these are seen as the least vital and occupy the outermost layer. Over and above all the body's hierarchy is that of the mind (i.e. consciousness), will, understanding, intellect, spirit and emotion.

This law is felt to be especially useful in confirming the choice of treatment or remedy. This law is also regarded as confirmation that disease has originally been suppressed inwards from the outer less vital areas by inappropriate medical treatments in one's past or in one's ancestors.

"Suppression, or palliation of disease, is the removal of the external symptoms of disease by external, mechanical, chemical or topical treatment; or by means of powerful drugs, given internally in massive doses…. The suppressed case always "goes bad". (Close, 1924, cited from Morrell, 2004).

"The Organon condemns on principle the removal of external manifestations of disease by any external means whatever" (Kent, 1900 cited from Morrell, 2004).

Cure from the homeopathic point of view, consists in "*the speedy, gentle and permanent restitution of health, or alleviation and obliteration of disease, in its entire extent, in the shortest, most reliable, and safest manner, according to clearly intelligible reactions".*

Homeopathy understands 'cure' as removal of cause. Hahnemann says that the **removal of the totality of the symptoms is actually the removal of the cause.** It may not be known that causes are continued into effect (ie., that causes continue in ultimate), but it is true that all ultimate to a great extent contain the cause of the beginnings. And since cause continues into ultimates and things in ultimates shadow forth cause, the removal of all the symptoms will lead to assume that the cause has been removed. For example, if a large number of symptoms manifest themselves through a diseased ovary, and that ovary is removed, the cause of the symptoms has not been removed and will manifest through some other part of the body. *It is a serious matter to remove any organ through which disease is manifest.*

When there are two or more of pathological conditions established upon the body and one is removed the other immediately becomes worse. For instance, if there is a structural change in the knee joint and the surgeon removes the knee, while there is a corresponding structural change in the kidneys or liver while he cannot remove, the latter immediately becomes worse and breaks down as soon as the knee joint is removed. Unless causes are removed from beginning to end the disease can reproduce itself (Kent, 1993). Whatever depresses the tissues of man, or his bodily functions, only acts temporarily, and is not capable of establishing a true disease. All diseases known to man are in the form of simple substance, an invisible something that cannot be detected by the chemist or the microscopist, and will never be detected in the natural world. Disease cause is known and known only, from its effects; it is not capable of investigation by the natural senses and can only be investigated as to its results It is only by the understanding by reasoning from first to last and then back again, that we can perceive that disease causes are invisible.

"Nor can any agency which is an ultimate act upon the human economy curatively, turning into vital order the innermost of life. Vital disorder cannot be turned into order except by something similar in quality to the vital force. It is not similitude in quantity that we want, in weights and measures, but it is similarity in quality, in power, in plane, that must be sought for Medicines, therefore, cannot affect the high Medicines, therefore, cannot affect the high and interior planes of the physical economy unless they are raised to the plane of similarity in quality" (Kent, 1993).

In acute diseases also crude drugs sometimes accomplish their purposes, because the outermost which they affect is only on the surface and the innermost has, in acute disease, the tendency to go away itself; if his life can simply be spared until the disease has run its course the patient will recover. But the chronic miasms are only reached as to their

ultimate symptoms, and there are caused to subside only temporarily or are suppressed by the action of the crude or ultimate forms of medicine.

Cure is health

When the ebb and flow of vital energy grows irregular it spells sickness, nothing lens and ineradicable except through similarity of action. If the earliest evidences of disease are disorderly vital action its finality must be an intensification of the same movement, partaking of the same nature, never being transformed into something else. Cure depends upon bringing this movement gently and safely, almost synchronously, back to normal again. Inferentially and practically, curing is a mild and gentle profess, devoid of suppressive measures, narcotics, etc.

"Now diseases are nothing more than alteration in the state of health of the healthy individual which express themselves by morbid signs, and the cure is only possible by a change to the healthy condition of the state of health diseased individual, it is very evident that medicines could never cure diseases if they did not possess the power of altering man's state of health, which depends on sensations and functions indeed that their curative power must be owing solely to this power they possess of altering man's state of health" (Organon, 19).

This statement is that medicines must be capable of effecting changes in the economy or they cannot restore order in the economy. If the medicine is too high to effect a disturbance in an irregularly governed economy it will be too high to effect a cure in that economy. The potency must be consistent with the degree of susceptibility that calls for the medicine.

5.2.3.8 Homeopathic prescription

The basis of homeopathic prescription is the totality of the symptoms of the patient as viewed and interpreted from the standpoint of the prescriber. A prescription can only be made upon those symptoms, which have their counterpart or *similum* in the *Materia Medica.*

Thus, it is advised that whenever a Homeopath is called upon to treat a case of mental case, he should make a careful examination.

1. As to the physical condition of the entire system.
2. Discover all abnormal states of body, which may by any possibility lead to a disturbance of the mind.
3. Discover the various departures on the normal mental status.
4. Make note of all the symptoms gathered, and having these as a basis for the prescription, one could seek to select the indicated remedy according to the Law of Similars.

Match between disease and drug as cure in homeopathy

Homeopathic physician needs to individualize between diseases and between remedies, the entire representation of a disease is the totality of the symptoms, and the entire representation of a drug is the totality of the symptoms. The effect that medicines have upon the sick in restoring order can best be observed by inducing the effects upon healthy individuals, which is known as **proving**. Every drug must be thoroughly proven upon the healthy so that its symptom image shall have been thoroughly brought out.

"Medicines will not act curatively or in a way to turn the body into order and turn off disease, unless potentized to correspond to the degrees in which the man is sick."

"Disease cause and the disease curing drug must be similar in nature; unlike causes would not produce like effect." (Kent, 1993).

5.2.3.9 Drug Action

Every drug produces an artificial disease. Like any other foreign material it provides a specific stimulus. Its only curative effect lies in eliciting a reaction from the organism. Knowledge of drug actions is obtained from the study of drug-induced diseases. Meuss (1981) demonstrates that Francis Bacon (1561- 1626) says drug actions meet the criteria for the category of stimulant therapy:

1. Every drug provides a specific stimulus and this is characteristic of that particular drug.
2. The stimulus has to be accurately defined to achieve a useful reaction.
3. The reaction depends on the initial sate of the organism.
4. Small stimuli have a stimulant effect due to a reactive response from the organism. More powerful stimuli force a direct primary effect. Massive stimuli are toxic.
5. It is the subject who determines the appropriateness of a stimulus by the nature of his response.

Homeopathic doctors consider the mental problems as the manifestations of the psoric miasm. They are treated with constitutionally selected high potency medicine. This high potency or highly energized Homeopathic Medicines are extremely beneficial in the treatment of mental problems because they can really penetrate into the higher dynamic or immaterial levels of the mind and emotions, and effect a curative action. But the use of tissue remedies like Kili.Phos., Mag.Phos., Calc.Phos., Nat.Phos., Kali Mur., etc. in lower potencies are also effective in addition to the constitutional high potency medicine (Kudiyat, 2001). Thus, there are no specific remedies in Homeopathy. Medicine which is found to be similar to the symptoms which characterize this disease is specific.

Specifics in Homeopathy

"Of all these medicines that one whose symptoms bear the greatest resemblance to

the totality of those which characterize any particular natural disease ought to be the most appropriate and certain homeopathic remedy that can be employed; it is the specific remedy in this case of disease". (Par.147).

This method can be applied to unique individuals as well as homogenous groups who suffer from diseases of common cause and similar symptoms. Hahnemann speaks of four major types of specificums in his writings.

1. The first and foremost specific is the constitutional specific chosen by the totality of the characteristic signs and symptoms of the individual suffer. This specific is chosen by the complete medical history (the pathogenic timeline), the aetiological constellation, the chronic *miasms*, and the constitutional factors and the objective signs, coincidental befallments and subjective symptoms.
2. The second specific is the anti-miasmic remedy for the individual person within a group of chronic anti-miasmic remedies. This specific is chosen by the fundamental cause, the miasmic syndrome and the symptoms of the individual suffering that genus.
3. The third specific is the genus remedies chosen by the totality of the symptoms of a group suffering from diseases of common cause and similar symptoms
4. The fourth specific is the acute intercurrent remedies for the treatment of the crisis during the constitutional and *anti-miasm* treatment. This specific is chosen by the exciting cause and its active acute symptoms in the individual.

"In the search for the *homeopathic specific remedy*, that is, in the comparison of the natural disease's signs with the symptoms of the available medicines (in order to find, among them an artificial disease potence that corresponds is similarity to the malady to be used), the more *striking, exceptional, unusual and odd* (characteristics) signs and symptoms of the disease case are to be especially and almost solely kept in view. These, above, all, must correspond to very similar ones in the symptom set of the medicine sought of it is to be most

fitting one for cure. The more common and indeterminate symptoms (lack of appetite, headache, lassitude, restless sleep, discomfort) are to be seen with almost every disease and medicine and thus deserve little attention unless they are more closely characterized". Homeopathic remedies are specific because they are individualized by the totality of symptoms.

5.2.3.10 Errors in Diagnosis

The textbooks on Homeopathy expect and write about the possible errors that can occur in diagnosis. It says that a homeopath should have clear understanding of the homeopathic principles. Otherwise, there is liability to err in several conditions.1)Error may arise in placing too much emphasis upon a single symptom, or perhaps actually prescribing on a single symptom as many thoughtlessly do.2)Error may arise in attempting to fit a remedy to a mass of indefinite, unrelated or fragmentary symptoms by a mechanical comparison of symptom with symptom, by which the prescriber becomes a mere superficial “symptom coverer’.3) Failing in both these ways the prescriber may fall to the level of the so-called “pathological prescribers,” who empirically base their treatment upon a theoretical pathological diagnosis and end in prescribing unnecessary and injurious sedatives, stimulants, combination tablets, and other crude mixtures of common practice. Homeopathy follows a simple as well as unique system for diagnosis and treatment .The specific, particular and individualized remedy is considered which could create a response in the patient’s body. Mental Symptoms are of high regard in this system which is a chief component in determining the totality of symptoms. Homeopathy stresses on cure as strengthening the vital power; not suppressing symptoms or treating one disease alone in a patient. It maintains clear and straight criticisms against the psychiatric methods of diagnosis and treatment, which would be discussed in the section of analysis in this chapter.

5.2.4 Naturopathy

"Where did we go wrong? The women on tablets, pills and tranquilizers, the men who don't feel human till they've had a drink."

Blackwell, Seabrook (1985,cited from Roberts,2001)

Naturopathy holds a philosophy of diagnosis and treatment, which is completely different and unique from Psychiatry, Ayurveda and Homeopathy. The proponents of Naturopathy, as stated, are staunch critics of Psychiatry's and/or Orthodox Medicine's reductionist approach. Benjamin (1946) comments that the medical profession continues to add error to error, and pile up enormity upon enormity, in attempting to "cure" disease by means of the administration of poisonous drugs and vaccines, and the very drastic employment of the surgeon's knife, without having the faintest idea that what it is inevitable doing is really adding to the disease complexity, rather than subtracting from it. He continues, although called a 'science', orthodox medicine has never been able to formulate any definite rules or principles governing the appearance of disease in the human body, and of how it might be overcome. It has always proceeded by the method known as "trial and error", with disease exerting a wider and ever firmer grip all the time. The medical science has no definite views and principles governing its actions in the field of disease.

5.2.4.1 Diagnosis: a medical delusion

Tilden (1971) comments that diagnosing according to modern medical science is a scheme of symptomatology that means nothing except a guide in discovering organic change —pathological change. The truth is that rheumatism, infected teeth, and sinus infections, as well as every other pathology found in the body, are effects. Symptoms without lesions represent functional derangements which have not been repeated long enough or often enough to cause organic change. If, as diagnosis goes, the cause is to be found in the disease, at what stage are we to look for it? Is it at the beginning, or in the fully developed

organic change, or in the dead man? Diagnosis is so fraught with the element of uncertainty that no reliance can be placed upon it.

Research occupies an army of laboratory experts in hunting the cause of disease, and also cures. They are doomed to fail; for how is it possible to find cause in effects? It is said that eighty per cent who fall sick get well, or could get well without the aid of a doctor. All so-called attacks of disease of whatever kind are crises of Toxemia, which means vicarious elimination of Toxin that has accumulated above the saturation (toleration) point. These crises may be symptoms which we call cold, "flu," tonsilitis, gastritis, headache, or some other light malady. They come today and are gone in a few days. If treated, we say they were cured. If they are not treated, we say they got well without treatment. The truth is that the surplus toxin —the amount accumulated above the point which can be maintained with comfort—is eliminated, and comfort returns. This is not a cure; it is one of nature's palliations. When the cause or causes of enervation are discovered and removed, the nerve-energy returns to normal. Elimination removes toxin as fast as developed by metabolism. This is health—this is all there is to any cure. "*In a few words: Stop all enervating habits; stop eating; rest until nerve-energy is restored to normal. When this is accomplished the patient is cured".* All other so-called cures are a delusion, and at the most a passing palliation.

5.2.4.2 The Toxemic philosophy of cure

The Toxemic philosophy is founded on the truth that there is no such thing as cure. In this stand, Naturopathy differs from all the so-called curing systems. Every pretense or promise of cure, in all lines of therapeutics, is false.

The medical world has been looking for a remedy to cure disease, notwithstanding the obvious fact that nature needs no remedy—she needs only an opportunity to exercise her own prerogative of self-healing. The power to cure disease is taken to reside always and only

within the body of the patient himself, and will manifest itself as soon as the wrong habits of living and harmful practices which have hampered its activity in the past and obscured its presence have been rectified, as a result of naturopath treatment.

5.2.4.3 Conservation of Energy: the Greatest Therapeutic Measure

Enervation is the source of the cause of the only disease (Toxemia) to which mankind is heir, it is easy to see that the so-called science of medicine, as practiced, is an ally extraordinary of all the causes of enervation, and becomes a builder of disease instead of curing or ameliorating man's sufferings. Every so-called cure in its very nature causes enervation. For example, even the drugs used to relieve pain end in making a greater pain, and sometimes kill. Rest from habits that enervate is the only way to put nature in line for curing. Sleep and rest of body and mind are necessary to keep a sufficient supply of energy (Tilden, 1971).

5.2.4.4 Suppression of symptoms create chronic diseases

From the Nature Cure standpoint, therefore, when a doctor "cures" a patient of an acute disease though the agency of drugs, sera, anti-toxins, etc., or though the medium of the "surgeon's knife", what he really does is to force the toxins (waste products), which the body is endeavoring to throw off, far there back into the system; and it is the concentration of these toxins (plus the drugs, etc. administrated by the doctor) in the vital organs and other tinctures which form the basis of future chronic diseases. Obviously, the form which chronic disease will take in any given individual will depend upon his bodily constitution and hereditary tendencies, but the main fact to be noted is that, according to Nature Cure, all chronic disease originates in the first place through the suppression, by wrong medical methods of treatment of acute diseases.

Drugs and serums do not and cannot act on the body. They are dead matter and dead matter is powerless to act. As Dr. Walter observes:

"…. If drugs are the real cause—that is, if they communicate the power which performs vital functions and produces vital vigor—there will be an "invariable connection" between the drug and the function. There will be no function with the drug; and there will be an increase or decrease of function corresponding to any increase or decrease of the drug. The absurdity of such a claim is evident; it rests only on superstition sustained by indifference…"

It is the body that acts, and not the drug, serum, or body waste. It is the danger inherent in the poisonous nature of these things that prompts the body to act. The action is in self-defense, and is produced by a calling out of the body's reserve forces; just as the danger of the enemy prompted the man to act in self-defense, and struggle until his strength was exhausted (Tilden, 1971).

Cure is something which terms disorder into order and makes man free. "By removing the signs and symptoms no longer have a cause for as we have already seen when the economy is turned into order it ceases to give forth symptoms), we place one patients in freedom, both physical and mental" (Kent; 1993).

5.2.4.5 The methods of nature cure

The treatment methods differ in various naturopathic school of thought. But these methods are all directed to the one end, i.e., the purification and regeneration of the bodily mechanism to allow the healing power latent within the body of the individual under treatment. This is an opportunity to assert itself and bring about a restoration of normal functioning.

1. Fasting: Fasting is Nature's most potent healing agency. Through the medium of the fast, waste products and impurities, which have sown the seeds of disease in the human body, can be removed in the simplest, easiest and most natural

way. Mental disorders are also curable by resort to fasting, because these are due to the presence of toxic foreign matter deposited. There is no need to employ a psychopathic physician. If some virulent poison, such as vaccine, has entered the brain, the cure of the disease may prove difficult, or even impossible.

2. Proper dieting: Wrong feeding is considered as the most potent factor in the causation of disease (far more so than any other); and through proper dieting, and proper dieting alone, can the further accumulation of toxic and waste matter in the system be prevented, the blood purified, and all bodily structures allowed to work at their highest level of efficiency.

3. Hydrotherapy: Through hydrotherapy, or water treatment, effete bowel matter can be removed from the system in the simplest manner possible, without having to resort to the use of any of the harmful and deleterious drugs and purges of orthodox medication; whilst in the form of *wet packs*, hydrotherapy offers a remarkably simple natural expedient for abating fevers and reducing pain and inflammation.

4. General body-building and hygienic measures: Only through proper exercise, deep breathing, use of sunlight, fresh air, etc. can the healing process taking place within the body of the individual undergoing natural treatment be given the fullest possible expression.

Naturopathy also stresses the importance of psychological elements in the treatment because the mental factor plays a part to a greater or lesser extent – in all diseased conditions, and properly applied mental therapy is, therefore, as necessary a factor in all natural treatment, which would be in the highest degree effective, as any of the measures indicated above.

Naturopathy itself follows different schools; therefore the treatment methods and its philosophy slightly vary from school to school which gives flexibility to the system. Even if,

Naturopathy derived its theory from the criticisms against Allopathy, it really puts forward and alternative explanation in the diagnosis and treatment of physical and mental illness.

SECTION III

5.3 Thematic analysis of diagnosis and treatment of abnormal behaviour

The analysis of the concepts of diagnosis and treatment are quite interesting and intriguing. After understanding the processes followed in four medical systems, the researcher assumes that the stages of diagnosis and treatment definitely determine the effectiveness of any medical system. In terms of curing the diseases, preventing them and promoting and maintaining health, the systems vary in their theories also. It has been found that as the most modern system of medicine, these concepts of Psychiatry are unconnected in many ways. Any coherent medical system would definitely be able to tackle the holistic conceptualization of health and illness.

It has been seen from the thematic analysis that there are number of studies which criticize the flaws in the diagnostic and treatment methods of Psychiatry. While reviewing them, the researcher could get a clear picture on the issues in the approaches of diagnosis and philosophical dilemmas of the drug treatment in Psychiatry. At the same time, Ayurveda, Homeopathy and Naturopathy either not attended thoroughly or considered “not worth to be attacked” by the mainstream research agencies. This shows that there is something more to say about the market demands, social factors and business aspects in the health care system. In the following section, the hard core intricacies of the medical systems are analyzed and discussed based on the following questions which are developed from the thematic analysis and emerged as categories of the analysis.

Table 5.4 Thematic analysis of the diagnosis and treatment of abnormal behaviour: major categories emerged

Medical Systems	Research Question

•	Allopathy/ Psychiatry	**Abnormal Behaviour: Diagnosis & Treatment**	
•	Ayurveda		
•	Homeopathy		
•	Naturopathy		
Result of thematic analysis (major categories emerged)	**1.**		Flawed diagnosis in psychiatry
	2.		Is differential diagnosis not required?
	3.		Cure or suppression?
	4.		Cure and health
	5.		About patient's theory of disease
	6.		Diagnose cultural and social factors?
	7.		Labeling and stigmatization
	8.		Subjectivity vs. objectivity in diagnosis and treatment
	9.		Consistency between classifications, diagnosis & treatment.
	10.		Can we really 'cure' disease? Medication and placebo
	11.		The market factors in diagnosis and treatment

5.3.1 Flawed diagnosis in psychiatry

Kanfer & Saslow (1974) say that there is room for error or other variations in each of the stages of diagnosis. For example, observers may vary in many ways, such as in orientation, training and value attributed to the diagnostic process; hence their observations may vary. Error may result from plain ignorance. And the same observer may differ from observation to observation. Indeed, several studies focused on this stage of the process have indicated that each of these factors may work against the attainment of reliable observations. Interpretation is a less studied part of the diagnostic process; obviously, the influence of variable definitions of psychopathological constructs contributes to the possibility of variation in observation. Furthermore, the lack of ideal fits between observed, interpreted data and classes of disease suggests the potential for a further type of variability, which in fact occurs.

Numerous studies document the lack of variability (interjudge disagreement, dissimilarity in diagnostic labeling frequencies, and the instability of clinical diagnosis over time).

Some of the results of these studies are given below (cited from Kanfer & Saslow, 1974): (1) Observer variation is due in large part to training and orientation, (Thorndike,1920; Newcomb, 1931; Grinker et al 1961; Kendall, 1968). (2) There is a lack of a common language for psychopathology, both in terms of description of abnormal behavior and the meaning of various diagnostic labels (Cooper et al., 1972). (3)The error due to patient variation is minimal (Ward et al., 1962). (4) Stability and frequency of diagnosis as means for studying reliability are indirect measures and less useful than looking directly at interjudge agreement (Spitzer and Fleiss, 1974). (5) When given similar definitions for psychopathologicl behaviors, clinicians improve their agreement on observation (Spitzer and Fleiss, 1974). (6) Agreement is even more likely if systematic interviewing schedules are employed that limit the range of observations to direct observations instead of interpretive ones (i.e., uconscious conflicts, repression, etc.)(Saghir, 1971). (7) Diagnostic agreement suffers when the criteria for placing a clinical state in one category as opposed to another category are not made explicit. Criteria for exclusion and inclusion obviate this difficulty (Ward et al., 1962; Spitzer et al., 1975 cited from Kanfer & Saslow, 1974)

These evidence suggests that diagnostic reliability need to be markedly improved in order to overcome its limitations. The problems of diagnosis derive from the nosology, or systems of classification, how it is organized and defined; and the process of diagnosis itself, which reflects attempts to apply the nosology in the clinical setting. The implications for clinical training in this context are many. Psychiatry needs to renew its involvement in psychopathology by teaching it, standardizing its definitions, and by so doing, ensuring greater reliability among its future clinicians. The mandate for learning the correlates of the defined nosological entities (or the investigation of validity) is also evident (Kanfer & Saslow, 1974).

Leo (2004) says that there are flaws in the diagnosis method followed by Psychiatry. He comments that blood tests, brain scans, or any other quantitative tests do not measure the low serotonin levels in depression. The scientific basis of the *Chemical Theory of Mental Illness* shows that, in laboratory preparations, drugs like Prozac increase the availability of serotonin--thus the term selective serotonin reuptake inhibitors (SSRI). Second, some patients report that they feel better after taking Prozac. The general public has the mistaken belief that doctors can measure serotonin levels with a blood test in the same way insulin is measured, but scientists have never documented low serotonin levels in humans diagnosed with depression. Leo (2004) also gives us an imaginary situation that if a psychiatrist says you have a shortage of a chemical, asks for a blood test and watches the psychiatrist's reaction. The number of people who believe that scientists have proven that depressed people have low serotonin is a glorious testament to the power of marketing.

"All drugs effect the brain (more than most psychiatrists concede), but what do these effects have to do with telling us about a biological causation of depression?"

Besides a patient history, at this point in time, psychiatrists have no biological or objective test to diagnose mental illness, and it has nothing to do with cost. Leo (2004) strongly puts it across to us that the PET scan and many other modern diagnostic methods fail to diagnose disorders such as schizophrenia, bipolar, ADHD, or depression. In a review article in the journal *Lancet,* even Nancy Andreasen stated, "diagnosis of schizophrenia relies on observation-based criteria," and this from a scientist whose expertise is the use of PET scans to study schizophrenia. He says that Psychiatry, being claimed itself as the most "scientific" one, does not stand the question "Where is the proof?" The problem is that a psychiatrist, given the brain scans of 100 psychiatric patients and 100 "normals," cannot differentiate between the two groups let alone identify a single one of the patients' brains as showing evidence of a psychiatric disorder.

Leo (2004) says that if you are wondering why scientists can be honest and direct in their journals while at the same time massaging the truth for the general public, Carver supplies one clue: "Technical aspects of neurotransmitter levels, the psychiatric symptoms they produce, and how medications have been developed to raise or lower the brain levels of these neurotransmitters can be very complicated" (and that the general public cannot understand the "technical aspects.") He goes on and explains this is why psychiatrists use simple analogies like comparing the brain and its chemicals to the oil in your car which can be measured with a dipstick. (Cited from Leo, 2004)

Rosenhan's (1973) famous study "On being sane in insane places" prove that there are a great deal of conflicting data on the reliability, utility and meaning of such terms as sanity, insanity, mental illness and schizophrenia. His field study with the pseudopatients would really tell us the shaky/ blurring base of the psychiatric diagnosis. Tilden (1971), a Naturopath theorist makes sharp criticism of medical inefficiency on the fallacy of medical diagnosis. He quotes Mackenzie who stated the following concerning diagnosis:

"But it appears to be unlikely that in the present state of medicine there would be any great dissimilarity in the proportions of diagnosed and undiagnosed cases in many series of investigation such as we have made. The proportion depends, not on the skill or training of individual practitioners, but on the unsatisfactory state of all medical knowledge. The similarity of the statistical records from the institute and from private practice goes far to support this view. In spite of the additional time given at the institute to the examination of cases which are undiagnosable in general practice, and the assistance given by the special departments—clinical groups—in their investigation, they remain profoundly obscure, although we know that it is from among them that there will gradually emerge the cases of advanced organic disease and the end-results which form so large a proportion of the inmates o f hospital wards. And the tragedy is that many of them suffer from no serious disabilities, and might, but for our

ignorance, be checked on their downward course. It means that diagnosis is a meaningless term; for, as used, it means discovering what pathological effects—what changes—have been brought about by an undiscovered cause. Diagnosis means, in a few words, discovering effects which, when found, throw no light whatever on cause. Sciences of medicine founded on no cause, or at most speculative and spectacular causes, as unstable as the sands of the sea, the doctor who cannot brook the bewilderment of vacillation is compelled to hide away from the voices of mistaken pedants and knowing blatherskites until stabilized" (Tilden, 1971).

Even more and more psychiatrists and other medical practitioners seem to doubt the usefulness of medical model in the treatment of mental illness. Holman (1976) finds some undesirable practices as unnecessary hospitalization, overuse of drugs, excessive surgery and inappropriate utilization of diagnostic tests as biomedical dogmatism/reductionism and the professional dominance of its adherents over the health care system. "While reductionism is a powerful tool for understanding, it also creates profound misunderstanding when unwisely applied. Reductionism is particularly harmful when it neglects the impact of nonbiological circumstance upon biologic process." Engel (1978) asks, "how ironic it would be were psychiatry to insist on subscribing to a medical model which some leaders in medicine already are beginning to question."

5.3.2 Is differential diagnosis not required?

A conceptually different type of argument against the use of any diagnostic classification has been made by the adherents of nondirective psychotherapy (Patterson, 1948; Rogers, 1946, 1951 cited from Zigler & Phillips, 1974). This position has advanced the specific contention that differential diagnosis is unnecessary for and perhaps detrimental to, successful psychotherapy. This attitude of the non directivists has been interpreted as an attack on the entire classificatory enterprise.

Manschreck (1977) brings out two key problems in the diagnosis of acute psychosis. They are the definition of acute psychosis and the breadth of the concept of schizophrenia. Because clinicians generally equate acute psychosis and schizophrenia, this breadth both obscures what schizophrenia is and prematurely closes the process clinical differentiation of acute psychosis. *In general, the diagnosis of acute psychosis is the differential diagnosis of a state.* This difficulty shows that Psychiatry needs some observable, objective features by which to define psychosis, which means lack of conceptual clarity, is an influencing factor in all through the diagnosis and treatment process. Moreover, much of abnormality is established through the imposition of social and cultural norms on behavior. Manschreck's (1977) argument proves that as the definition of abnormality is arbitrary, its diagnosis and treatment must follow a hypothetical structure.

Sharma & Dash (2007) state that the modern medical research has made a phenomenal progress during the last few decades. But instead of multi faceted and multi dimensional approach, it seems to be approaching the problem mainly through one direction. Specialization in the disease afflicting different parts/ organs of the body is increasing as a result of which the individual as a whole is losing his or identity. Zigler & Phillips (1974) criticized that in practice, such a descriptive effort allows no place for a process interpretation of psychopathology and that it has not encouraged the development of prevention and treatment programs in the mental disorders. As a result, there is an unwavering belief that some simple categorical system will quickly solve the mysteries of etiology (Zigler & Phillips, 1974).

But, Ayurveda considers different parts/ organs of the body as physiologically interconnected. Therefore, in addition to the afflicted part of organ, the entire body is examined, and the individual as a whole is treated. For some diseases, which are classified as metabolic, only palliative therapies are found in the store of modern medicine. To cite a few

examples, painkillers and anti-inflammatory drugs for arthritis, anti spasmodic and anti allergic drugs for asthma, and hypoglycemic drugs for diabetes are commonly used. With these palliative drugs, no doubt, give temporary relief, but slowly higher doses and potencies of these remedies become a necessary as a result of which the immunity of the body becomes very low, and the patient succumbs to the adverse effects of these so called wonderful remedies. These adverse effects become more painful than the original disease. Ayurveda has in its store, a lot of herbal and natural products for such metabolic disease and allergic manifestations. According to Ayurvedic principles, the actions of these natural therapies may be slow but their effects are stable. Differential diagnostic system and diagnostic hierarchy theorized by Psychiatry failed to classify abnormal behavior and its etiology in a holistic manner. At the same time, systems like Homeopathy and Naturopathy which has congruent diagnostic and treatment system that matches with their causation theories could explain many of the issues faced by Psychiatry in a simple and direct manner. This reminds the researcher the need to have more studies on the philosophical foundations of abnormal behavior envisaged by the medical systems.

5.3.3 Cure or Suppression?

The word “cure” is a tricky one and Psychiatry, Ayurveda, Homeopathy and Naturopathy have envisaged it in various ways. According to the diagnostic approaches followed in those systems, undue importance has been given to the symptoms narrated by the patient. But the way each system make use of symptoms for the treatment and cure purposes throws light into the basic theoretical difference among these systems.

Psychiatry approaches symptoms at a superficial level. As the biomedical observes, biological or physical symptoms are given high significance than the social, personal and cultural origin of abnormality. They depend on the symptoms and straightway prescribe the remedies. As per the diagnostic hierarchy shown in the previous section, multiaxial

classification, co-morbidity and multiple diagnoses did not “cure” the issue of cure for mental illness. Is Cure possible in the case of abnormal behavior? is still unanswerable for Psychiatry. Kraepelin’s system of classification is claimed to analyze the symptoms to know the causative factors of the disease. But it is very evident from the diagnostic and treatment plan of this discipline that they are not based on the causative factors. Critics from Homeopathy and Naturopathy commented that the remedies in Psychiatry merely suppress the symptoms rather than finding out the underlying ‘cause’ of the illness. This means, the symptoms are misunderstood as disease. Therefore, cure is symptom reduction in Psychiatry following the biomedical model of Orthodox Medicine. Samuel Hahnemann trained in orthodox medicine, deviated from its way of conceptualising disease and treatment on several grounds. He has diverse opinions in terms of suppression of symptoms using strong chemicals as drugs, blood-letting, polypharmacy, and barbaric treatment of the mentally ill patients. Hahnemann realised that allopathy is ineffective in curing many disease and it does not guarantee the cure of diseases at all. Through his unique method of observation and therapeutic experience with many cases, he realized the danger of suppression of symptoms by drugs. Allopathy successfully adopted removal of organs if it’s infected as cure of disease. Boger (1998) accounts that allopathy follows a materialistic viewpoint of life in general and disease in particular, leading as it must do, to attempt at forcible removal of what it cannot cure.

Homeopaths were primarily critical of the suppressive nature of conventional drugs. Orthodox physician and companies disliked homeopathy because of their critique to the use of conventional drugs. They felt that they simply marked the person's symptoms, creating deeper, more serious diseases. Homeopaths also noted that this marking of symptoms made it more different for them ultimately to find the correct medicine since the person's idiosyncratic symptoms are the primary guide to the individual selection of the medicine. Any thinking or practice that is destructive and harmful or against nature, the vital force, natural

law, execution, elimination and detoxification has been subjected to critical attention from homeopaths (Morrell, 2004).

Morrell (2004) notes that some of the criticisms that homeopaths have made about modern medicine have also been made by other natural therapists, and have also come from other quarters, most notably social scientists. General practitioners are also seen by some critics as little more than 'pill-pushers', who see patients for an average of seven minutes (at best) and who prescribe only antibiotics, tranquillisers, hormones, or painkillers. Some feel that these drugs do not represent a real answer to health problems, that they suppress or obscure symptoms rather than truly curing them, and often produce unpleasant and sometimes dangerous side-effects for the patient. Widespread overuse of antibiotics and mass immunisation are also frequently cited as major causes of a chronic and almost universally widespread degeneration of the human defense mechanism (= vital force, natural healing power, etc), being claimed as the underlying cause behind the rise of many modern diseases (Vithoulkas, 1985 cited from Morrell, 2004).

Reviewing the concepts of diagnosis and treatment of *Ayurveda*, Homeopathy and Naturopathy the researcher realized that the three systems understand **"cure" as a process of purification**. Rather than reducing the symptoms of the patient, clearing the impurities both at physical and mental level is considered by these systems. Sometimes, it might take a metaphysical dimension too, as in the case of *Satvapajaya* Cikitsa in *Ayurveda*. According to Naturopathy 'cure' envisaged using physical drugs are not 'cure' at all. This system criticizes all the other systems of medicine which stress on 'cure' with drugs. They call it as artificial cure which may further lead to diseases. Cure in Naturopathy should be natural and should be initiated by the natural processes of the body.

Reductionism, particularly in reference to discussions about psychiatric diagnosis, takes on a negatively connoted evaluative meaning, where the epistemological necessity of

selective attention and interpretation is caricatured into a remote semblance of the phenomenon at hand. Here, the experience of depression becomes “little more” than a serotonin deficit. Antireductionist critics of psychiatric diagnosis are concerned that focusing on simple, generalizable elements in helping distressed people dehumanizes them and transforms them into objects of theoretical manipulation instead of seeing them as peer-agents to be collaborated with. These general concerns may be voiced as claims that diagnosis “silences” the dialogue, political or interpersonal, or marginalizes the social nature of mental disorders or facilitates the perpetuation of power structures (Sadler, 2004).

Sadler (2004) says that considerations of reductionism in psychiatric diagnosis generate manifold philosophical problems. “If we overlook or set aside aspects of clinical phenomena, how can we be assured that our understanding and explanation of them are correct?” “What is the moral and human significance of parsing out objectifying human experience?” “If the psychiatrists’ task is to interpret the patient’s experiences a new, isn’t reductionism the very undermining of this task of interpretation?”

5.3.4 Cure and health

What is the focus of cure in medical systems? Does it focus on health and illness?

There is a common observation made by the researcher that Ayurveda, Homeopathy and Naturopathy are focused their philosophy of cure to restoration of health and the treatment process is viewed as a purification procedure. *Ayurveda*'s aim itself is to promote and preserve health. The cure from disease should not only aim to reduce the unhappiness (*Dukha*) of the patient, but also lead him in the way to improve health which is a means to achieve *Moksa*. Cure deals Health and Illness at the same time. Homeopathy does follow a much simpler version of curing disease. It does cure disease. Cure is restitution of health, reinstituting the imbalanced vital force. The removal of the vitality of symptoms is considered as cure, according to homeopaths. This system also gives scope to the existence of "unknown diseases" and plans for its treatment too. Naturopaths do not even seem to believe in the terms 'cure' and 'treatment' etc. Making a person live in his or her natural way is "cure" for them. Thus, the treatment of any illness, should follow a normal and natural process. But by focusing their attention primarily upon the illness or infective agent' as the alleged cause of the problem, rather than the patient in his/her totality of symptoms, allopaths tend to be seen by natural therapists as 'barking up the wrong tree'. They also seem to have in advertently distracted themselves from looking at the whole person and a system of treatment to match. He who considers disease results to be the disease, is insane. It is an insanity in medicine, an insanity that has grown out of the milder forms of mental disorder in science, crazy whims" (Kent, 1900 cited from Morrell, 2004).

Some influential natural therapists (Vithoulkas, 1985 cited from Morrell, 2004) also tend to feel that there is a real deterioration of human health in the advanced countries that is occurring in spite of the most lavish and expensive health-care facilities on the planet. To natural therapists the evidence indicates a real decline in the power of the human defense mechanism, which is perceived by some as product of allopathic medicine and has been widely predicated within the natural health movement for at last a decade. However, these

worries are difficult to quantify into reliable and meaningful data. It is more of hinch at this stage (Morrell, 2004).

Allopathy is also under attack on a philosophical level as people increasingly consider; for example, that antibiotics do not cure the underlying cause of infection and that heart transplants are an inferior option compared with lifestyle changes which can prevent heart disease. Thus, the move towards natural health often consists of both a disaffection with allopathy itself and an increasing curiosity about the older and safer natural therapies (Morrell, 2004).

5.3.5 About patients' theory of disease

"Successful psychiatrists necessarily correspond in their natures to the needs and desires of 'nervous patients' since the mass of patients decide who is to be successful therapist and not the actual value or correctness of the doctor's own views or behavior. Obviously, therefore, the greatest successes of all have not belonged to psychiatrists but to the shamans, priests, leaders of sects, wonder-workers, confessors, and spiritual guides of earlier times"

(Jaspers, 1923, cited from Shepherd, 1974).

Shepherd puts Thomas Szasz as a radical spokesman for psychotherapy. Psychotherapy, in his view, is a human relationship characterized by certain aims and rules.

"In medical practice, when we speak of physical disturbances, we mean either signs (for example, a fever) or symptoms (for example, pain). We speak of mental symptoms, on the other hand, when we refer to the patient's communications about himself, others and the world about him..... The judgment entails, moreover, a covert comparison or matching of the patient's ideas, concepts or beliefs with those of the observer and the society in which they live. The notion of mental symptoms is therefore inextricably tied the ***social (including ethical) context*** *in which it is made in much the same way as the notion of bodily symptom is tied to an anatomical and genetic context"*

(Szasz, 1960 cited from Shepherd, 1974).

In Szasz' view, it is not logically acceptable to invoke the concept of physical illness, in the shape of disorders of what he terms 'the physico-chemical machinery of the human body,' to explain unusual mental functioning as, for example, occurs in delusional beliefs. Underlying his assumptions is the belief that it is the business of the physician to diagnose, treat, and occasionally cure medical, i.e. physical conditions, whereas it is the business of the

psychiatrist to concern himself with his client's "problems of living'; problems which, by Szaasz' definition, owe nothing to the client's physical state and are therefore in no sense 'diseases.'

According to Nathaniel Lehrman, the former clinical director of the Kingsboro Psychiatric Center, "We find ourselves in the increasingly difficult position because Psychiatry has badly mishandled depression in its all-consuming reliance on drugs as the first line of treatment." The only way to say that this person has a "disease" is to ignore her as an individual (cited from Leo, 2004).

What is felt by the patient, remarked by those around him and observations by the doctor herself gives a holistic conceptualization of health and illness. The researcher assumes that Homeopathy and Naturopathy offer a major role to the patient's theory of disease in the decision- making process. Especially, mind is considered to have a high rank among all the other organs in Homeopathy and what a patient has to say about his or her general symptoms, which constitute their emotions, will, intellect etc. is of prime importance. Subjective symptoms are given highest rank in Homeopathy diagnosis also. The patient's interpretation of the illness and its symptoms would provide his/ her theory which has given a prime importance in individualizing the illness and suggesting specific remedy for them. The patient variables are, thus, highly regarded as far as Homeopathic system is concerned. At the same time, Naturopathy also gives complete freedom to the patient by educating them the theory of disease and health and guiding them in the ways with which they can restore their natural health.

But Ayurveda takes a double position here. The Samkhya Darsana upholds a primary position to Manas in the Prakrti and in the maintenance of universal life and the theory of Ayurveda also rests on the mental realm of illnesses. But a clear hierarchy has been followed in the doctor- patient relationship. The patient is supposed to respect, obey and abide by the

commands of the doctor. Questioning nature and perplexed attitude from the part of the patient might destroy the rapport. The patient is also advised to be grateful to the doctor too. I would say that this relationship need to be understood in the social and religious context prevailed in those times.

5.3.6 Diagnose cultural and social factors?

It has been discussed in the previous chapters that the causal factors of mental illness are of primarily contextual in nature. The modification of the WHO definition of health further proves it. In such a case, how do we include the presence of contextual variables in the medical diagnosis of abnormal behavior?

Manschreck's (1977) notes that:

"When we cannot diagnose a disease, our diagnosis must be more tentative, reflecting the fact that we have lowered considerably our capacity to separate out homogeneous groupings. In other words, when disease, which represent the most validated entities, are ruled out, we step into an area of reduced validity and must consider syndromal or state diagnoses. This further reinforces the importance, in fact the mandate, to rule out known disease, which can mimic known specific states or syndromes before finalizing our diagnostic decision. Further diagnosis proceeds with considerable caution, skepticism (should always be a feature of any of those diagnoses) and concern for the error of premature closure. How then should we diagnose these nondisease entities – by what standards of validity?"

This illustrates that the whole concept of reliability and validity of diagnosis is very tricky to achieve and test. Validity assures that diagnoses (the named disorders) are not the specious manifestation of the doctor's whim or fancy but, instead, are relatively uniform

expressions of nature or culture (Sadler, 2004). If the known causes of disease are complex enough to establish, what about the issues "unknown causes, unknown diseases, and nondiseases"?

Let me take Manschreck's (1977) words once again: *"By pretending to know when we do not, we foster obscurantism and perpetuate confusion".* Zigler & Phillips (1974) in discussing the requirement for an adequate system of classification, suggest that an etiologically oriented closed system of diagnosis is primitive. Instead, they believe that an empirical attack is needed, using "symptoms broadly defined as meaningful and discernible behaviours, as the basis of the classificatory system". But symptoms as a class of responses are defined after all only by their nuisance value to the patient's social environment or to himself as a social being. They are also unreliable in predicting the patient's particular etiological history or his response to treatment. An alternative approach lies in an attempt to identify classes of dependent variables in human behavior, which would allow inferences about the particular controlling factors, the social stimuli, the physiological stimuli, and the reinforcing stimuli, of which they are a function. Opler 1957, cited from Kanfer & Saslow, 1974 has further shown the importance of cultural factors in the divergence of symptoms observed in patients collectively labeled as schizophrenic.

Medical systems require realizing their limited knowledge about their complicated subject matter, and should appreciate their limited ways of intruding into it. The best potential for correcting present abuses and meaningfully extending the frontiers of knowledge in the Psychiatry rests in their realization. Researchers also indicates that diagnostic system might be invaluable as social factors play a significant role in determining what is normal and abnormal (Ledly & Lusted, 1959; Kanfer & Saslow, 1974)

Analysis of psychiatric power in the process of diagnosis is significant in labeling, reductionism and medicalisation. Critiques of psychiatric diagnosis views it as a kind of

cultural imperialism, a tool of colonization, a factor in the repression of women's rights or equality or simply the expression of self-interested capitalist greed through the expansion of the health care market share. Psychiatric diagnosis, participates in the interplay of social and interpersonal power in various ways. Psychiatric diagnosis may close off opportunity in some sectors of society (through stigma and other mechanisms), but is also the occasion for economic opportunity and social assistance. According to Foucault (1990), power, including psychiatric power, embraces more than mere economic or political power; it takes on metaphysical power as well, influencing how we understand ourselves, how we think, and what the 'nature of things' is. Under Foucault's terms, whether psychiatric diagnosis is liberating, enslaving, or something in between depends on the complex interplay of social and metaphysical forces.

The critique of psychiatric power raises its own cluster of philosophical issues. "What is, and should be, the role of psychiatric diagnosis within society at large?" How should mental health clinicians be accountable to the social impact of their diagnostic efforts?" "What is the function and importance of psychiatric criticism?"

What often remains after considering the assorted meaning of psychiatric diagnosis is its proper place in society. This question, of course, is one for political and moral philosophy, social policy and government. The question of meaningful, moral and effective sociopolitical action regarding mental health care has a reach beyond the individual doctor-patient encounter, beyond diagnosis as act and signifier, and it will be a source of ongoing debate for years to come (Radden, 2002).

5.3.7 Labeling and Stigmatization

Mental disorders have a history of stigmatization and labeling. This feature involves the ambiguities around personal responsibility and volition posed by mental illness. As the philosopher-psychiatrist Bill Fulford (1994, cited from Sadler, 2004) notes, mental illness is

something, in the main, “I do”, not something “done to me” as an agent. In the case of mental illness, it is often, not clear when “I do” the illness and when the illness is “done to me”. The social power of psychiatry has a regulatory control which was prone to abuse and self serving interests. For instance, psychiatrists may in voluntarily (Coercively) seclude, and treat, their patients with the full aim of the law at their side. A clinical procedure as universal as diagnosis is both a literal and a symbolic instrument of this power. Diagnosis operates as a literal instrument when it fulfills a concrete requirement for services, confinement, reimbursement or opportunity. It operates as a symbolic instrument in parallel: when, for instance, societies treat the diagnosed differently than the undiagnosed, when the diagnosis means more, as it so often does, than the name of the condition to be treated (Sadler, 2004). The labeling theorists critiques raise ongoing philosophical difficulties with the psychiatric nosological task: “How are we to characterize mental disorders? As expressions of culture? Of nature?” “If psychiatric labeling services state or social interests, then what becomes of the moral task of psychiatric medical healing?” “Are mental disorder clinical, moral, political, or some combination?”

Compared to the social power assumed by Psychiatry, Ayurveda and Homeopathy do not label or stigmatize persons with abnormal behaviour. The normal or natural position given to illness by Naturopathy do not stigmastise the mentally ill patients in the social context. But the execution of power by Psychiatry is so strong that the society is conditioned to conceptualise and approach the mentally ill as ‘separate entities’.

5.3.8 Subjectivity vs. objectivity in diagnosis and treatment

The relationship between patient and physician has been played a very important role in the diagnosis and treatment of diseases. The behavior of the physician and the relationship between patient and physician powerfully influence therapeutic outcome. These constitute psychological effects, which may directly modify the illness experience or indirectly affect underlying biochemical processes (Kety, 1974 cited from Engel, 1974).

Analysing the four medical systems, the researcher feels that Ayurveda and Homeopathy have given excessive magnitude for this relationship. The *Cikitsa Sthana* of *Caraka Samhita* does state that the remedies prescribed and the treatment given can go wrong if this relationship is not formed or developed adequately. I could not find much information on this relationship in the case of Naturopathy. The healer has been called as 'unprejudiced observer' in Homeopathy. His subjective judgment, the logical principles he arrives and speculations he makes about the 'totality of symptoms' does decide the cure of diseases. Even Ayurveda appreciates the subjectivity of the patient and the doctor. What does the patient communicates about the disease is important there and the mental symptoms of the patient in any kind of disease is central for the homeopath too.

When looked for the doctor-patient relationship visualized by Psychiatry, I could get a few sentences emphasizing the importance of rapport establishing and considering the emotions of patient. (Client-centered approach of Carl Rogers has been found in few books of psychiatry). In most of the books, the need to diagnose 'quickly' and within 'less time' is stressed. Thus, I could say that the objectivity of the symptom listing, relationship, diagnosis and treatment is much more valued in Psychiatry just like the Orthodox Medicine than the subjective elements. This clearly contradicts with this discipline's claim on social and cultural concerns in terms of the origin of mental illness. This is supported by a recent study quoted by Leo (2004) which showed that it took three minutes for a patient to get a prescription for an

anti-depressant medication--about as much time as the typical person spends talking to a grocery store checkout clerk.

5.3.9 Consistency between Classifications, Diagnosis & Treatment?

According to Carson & Butcher (1992) a carefully planned assessment system is necessary to make generalization based on what has been observed. Granting that all *classification systems are fundamentally arbitrary*, some of them are much better than others in helping us organize and discuss our observations. As mentioned in the process of diagnosis by Manschreck (1977), disagreement or misfit between observed and interpreted data to classes of disease is an expected fact. But the degree of variation from the standard depends upon the strength of the classification system or nosological pattern and the methods of diagnosis. Medical sciences vary the way they find a consistency between nosological and treatment methods. In other words, the researcher can say that the mode of action drug determines or develops the etiological hypotheses in Psychiatry. For example, The dopamine for antagonist properties of antipsychotic drugs have given rise to the dopamine hypothesis of mania, whilst the action of tricyclics antipsychotic , and monoamine oxidase inhibitors in facilitating the effects of noradrenaline hydroxytryptamine (5-HT) has led to the monoamine hypotheses of mood disorders. Rather than finding the medicine that reduce or manage the causes of mental illness, the drugs that create neural changes are used to derive the etiology of mental illness. Gelder, Mayou & Cowen (2001) comments that Given the complex causes of psychiatric disorders, it seems likely that detailed knowledge of aetiology and pathophysiology may lag behind advances in therapeutics. Of course, this disparity is not uncommon in general medicine. It serves to reinforce the importance of randomized clinical trials in the assessment of new psychopharmacological treatments.The researcher has been curious enough to know how do each medical system conceive all the processes of health illness, especially the classification, diagnosis and treatment phases. It is found that Psychiatry follows two separate systems of classifications. DSM-IV is the officially recognized classification system, which has

an elaborate list of diseases. But the psychopharmacology follows a different system that follows a very simple division of diseases. It classifies disease into six based on the actions of drugs. It has been noted by Gelder, Mayou & Cowen (2001) that the etiology of some disorders diagnosed by Psychiatry may be obscure and outcome may vary widely, even amongst patients with the same clinical syndrome.

Classification by prognosis: To date, the least effort has been devoted to construction of a classification system, which assigns patients to the same category on the basis of their similar response to specific treatments. The proper question raised for such a classification system consist of the manner in which a patient will react to treatment, regardless of his current behavior, or his past history. The numerous studies attempting to establish prognostic signs from projective personality tests or somatic tests represent efforts to categorize the patients on this dimension suggest that The lack of reliable relationships between diagnostic categories, test data, demographic variables, or other measures taken on the patient on the one hand, and duration of illness, responses to specific treatment, or degree of recovery, on the other hand, precludes the construction of a *simple* empiric framework for a diagnostic prognostic classification system based only on an array of symptoms (Kanfer & Saslow, 1974).

Ayurveda, too, does follow humour-based classification in the diagnosis and treatment too. But it has been observed that internal medicine and other therapies are not always completely matched each other with the tridosa principle. For example, the palliative measures mentioned before, follows a general principle than a specific one. Homeopathy does make sure that there is always a match between disease and drugs. The ability to evoke the similar symptoms by the drugs and the disease are supposed to have the highest curative effect. The ability of a drug, which could make a response in a patient, is considered to be creative and effective. Same time, Naturopathy always stands firm in its unity of disease, cause and treatment. But there are individual specific treatments in Naturopathy.

5.3.10 Can we really 'cure' disease? Medication and placebo

There are arguments against the use of medicines itself. This enhances the relevance of Naturopathy in the twenty first century. The whole idea of treatment and cure as a "professional lie" has been stressed among the lay people. Studies against the influence of medicines on mental illness itself have been increased which primarily focus on the medication- placebo dichotomy.

Even if the biochemical theory of mental illness has never been proven correct many psychiatrists will say, "Theories aside, Prozac works." A recent study in the *Journal of the American Medical Association* examined the effect of St. John's Wort on depression (2002, Vol. 287, p. 1807, cited from Leo, 2004). The authors found that on most measures it was no better than a placebo. The authors say that "We are very heartened by the thoughtful responses to our article. Unlike some of the responses to a previous meta-analysis of antidepressant drug effects, there is now unanimous agreement among commentators that the mean difference between response to antidepressant drugs and response to inert placebo is very small" They go on to explain that this miniscule difference between placebo and medication is commonly referred to by researchers, FDA reviewers, and a small group of

critics as the "dirty little secret." The significant question here is if the effect of drugs and placebo is minimal, what kind of mechanism is working on in the treatment of mental illness? Are these any factors that influence the process of cure? If so, what would be the state of psychopharmacological studies, then? Does psychiatry need to develop new theories about drug treatment? Weil's (1983) research proves that belief alone can elicit medical cures and it is a unifying variable in treatment of abnormal behavior. This variable even determines why any system work sometimes and not others. Studies on placebo makes the 'scientific' data more conflicting, which brings challenges to the system of Psychiatry to broaden or elaborate their conceptualization of abnormal behavior itself.

5.3.11 The market factors in diagnosis and treatment

"One of the greatest marketing, feats of the past 20 years is the use of pharmaceutical companies' dollars to convince the mass media that psychiatrists who prescribe these companies' drugs are basing their treatment on anything resembling science".

Bruce Levine, psychologist and author of *Commonsense Rebellion* cited from Leo (2004)

Leo (2004) notes that the majority of the 28 million Americans taking an antidepressant, or similar drug, were told by a doctor that they have a genetic defect resulting in a shortage of a chemical, and that to rectify this chemical imbalance they need to take a pill. The basic tenet of biological psychiatry is that mental illness is an "organic" disease, meaning that the patient has too much or too little of a neurotransmitter, too much or too little of a receptor, or an overactive or underactive neuronal circuit. Whatever the problem might be, it is "biological" and biological problems are best treated with drugs. As everyone now knows, clinical depression is just like diabetes; one patient is short of insulin, another is short of serotonin; one patient needs insulin, another needs Prozac--and so the story goes. The trickier question is deciding how much of a role academicians in the American medical community, particularly those in medical school psychiatry departments, have contributed to

the problem. According to Nathaniel Lehrman, that the theory of Psychiatry is made to be in tune in such a way that it matches very well with the market needs created by the pharmaceutical drugs and insurance companies. According to the editors of the LA *Times* in America, "Drug company funding is corrupting medical research" and they call on the National Institute of Health "to counter the influence of private funding on science" (2/24/03, cited from Leo, 2004)

Even the Journal of the American Medical Association acknowledged that "the medical press profoundly under the influence of the proprietary interests (drug companies)" (Ullman, 1995). Behind all the criticism against Homeopathy also, we could see political undercurrents than its theoretical perspectives. Ullman (1995) quotes the words of one of the more respected orthodox physicians at an A.M.A. meeting. "We must admit that we never fought the homeopath on matters of principle; we fought him because he came into the community and *got the business"*. Although most physicians, past or present, won't as easily admit it, *economic issues* play a major role in what is practiced and what is allowed to be practised.

Many of the larger drug houses also make pesticides, the scourge of ecologists. (Vines, 1993, cited by Morrell, 2004). The testing of drugs on animals is also increasingly seen as inhumane or barbaric. Natural therapies seem 'gender' and more benign by comparison. There are also well-documented stories about pesticide, tranquilliser, hormone and antibiotic residues in one good (especially meat) with thus far indeterminate health effects, and which periodically give grave cause for concern (Morrell, 2004).

Robert Whitaker, an independent reporter in his recent book, *Mad in America: Bad Science, Bad Medicine and the Enduring Mistreatment of the Mentally Ill,* says about how the American psychiatric profession has treated people diagnosed with schizophrenia. Much of his book focuses on a study conducted by the World Health Organization (WHO), which

examined the outcomes for people diagnosed with schizophrenia throughout the world and compared the outcomes between poor countries such as Nigeria, India, and Colombia to the outcomes in the United States and four other developed countries. Surprisingly, on just about every measure, schizophrenics did better in the poor countries than they did in the rich countries. For instance, compared to the patients in the rich countries, the patients in the poor countries were less likely to become chronically sick; they were more likely to be fully recovered and faring well in society; and they were less likely to relapse. Why countries like Nigeria have a better success rate in treating people diagnosed with schizophrenia than countries like the United States is unclear, but it could be due to the fact that psychiatrists in the rich countries prescribe drugs much more freely than their colleagues in the poorer countries. As Whitaker points out, only 16% of the patients in the poor countries were maintained on neuroleptics, while in the rich countries 61% of the patients were kept on medications. The problem is that even if a patient recovers from schizophrenia, it is unlikely that the drugs will ever give up their hold so that once a patient starts down the medication road there is little hope, for any kind of recovery. (cited from Leo, 2004)

The editors of the journal *Lancet* recently posed the following question, "Just how tainted has medicine become?" Their answer: "Heavily, and damagingly so. A more important question arises: do those doctors who support this culture for the best of intentions--e.g., to undertake important research that would otherwise remain unfounded--have the courage to oppose practices that bring the whole of medicine into disrepute." (Leo, 2004)

While the issue of suicide and Prozac raises serious concerns about the integrity of American Science - even major medical journals such as *Lancet* and *The British Medical Journal* refused to publish papers by Healy suggesting that there *might* be a problem with Prozac, while the same journals had no problem publishing papers by pharmaceutical

companies downplaying problems with Prozac--there is no doubt that the drug companies are superb at taking results and spinning them into whatever message they desire. (Leo, 2004)

The above categories analyzed and described gave us an idea that a medical system cannot have different theories on the concepts, causes, classification, diagnosis and treatment of abnormal behavior. Even a mismatch between the classification and diagnostic system would create flaws in the way we deal with abnormal behavior. Studies also put forward a simple and straight word system of diagnosis and treatment, which could encompass all the etiological factors including social and cultural ones, thus developing an effective system of treatment.

Chapter VI
SUMMARY AND CONCLUSIONS

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If Science is a method of finding out the 'truth' then,
what should be the ways of searching it?

Philosophy of science is considered as the base of this research which look for the logical foundations of the concept of abnormal behaviour in Psychiatry, Ayurveda, Homeopathy and Naturopathy. Discussions on 'scientific', 'unscientific' and 'pseudo-scientific' can be proceeded only on the basis of some parameters. But to my surprise, the books on *Philosophy of Science/ Medicine* which I referred has always began or end with confusions on how to set the defining boundaries of science. See an extract from the book, *Theoretical issues on psychology*: *an introduction* by Sacha Bem and Huib Looren de Jong (2006).

"Strangely enough, philosophers of science have as yet failed to find out exactly what defines science and its methods, what accounts for its success, and how to make an airtight demarcation between science and pseudo-science. Even more surprising, in the light of the omnipresence of science nowadays, some reject the idea of the difference in principle between science and other social activities. Is alleged objectivity is just the self-contragulation of the establishment – whatever is accepted as truth is determined by power and propaganda".

Bem and de Jong (2006) bring out the theoretical dilemma in defining 'science' itself even in the midst of twentieth century philosophers' attempt 'to *set philosophy upon the sure path of a science'*. With *The Structure of Scientific Revolutions* (1970) by Kuhn,the empirical, positivist, objective foundation of science was replaced by the notion of the theory- ladenness of observation.*"It turned out, then, that science had its subjective side; though at the same time the rationality and objectivity of science were at stake".* (Bem & de Jong, 2006)

Therefore, many of the present day philosophers of science defend the view that scientific practice is *not* arbitrary and that scientific knowledge has a legitimate claim to *truth.* But at the same time, scientific practice is subject to a host of social, pragmatic and sometimes irrational influences, and scientific truth is not something separate from human concerns.

The research questions set for this particular study is not at all free from these philosophical debates. In one side, the so-called 'scientific', objective, methodologically correct and diagnostically equipped Psychiatry's advancement and on the other side, traditional, (sometimes 'Eastern') primitive, 'nonscientific/ pseudo-scientific', indigenous, simple and culturally rooted Ayurveda, Homeopathy and Naturopathy. (Now made all of them under the homogenous term 'CAM' – Complementary and Alternative Medicine). Moreover, the subject matter is abstract, value-laden and much debated abnormal behaviour. For a researcher who tries to address some fundamental questions that govern all the above can take only one approach: *relativism*; one theory is as good as the next one and preferences for any scientific approach are due to arbitrary irrational factors. While researching the conceptualisations of abnormal behaviour in the background of medical sciences, the epistemological position of the researcher is also subjected to the limitations and strengths of science and nature knowledge available.

The present research titled "Conceptual Schemes of Abnormal Behaviour: A Study on the Logical Foundations of Medical Sciences" is intended to study, describe and analyse the logical foundations of medical sciences i.e., Psychiatry, Ayurveda, Homeopathy, and Naturopathy in terms of the concept, causes & classification, and diagnosis & treatment of abnormal behaviour. The chapters are structured to address the following objectives formulated which are given below.

Objectives

1. To describe the concept of health and illness (both physical and mental) in Psychiatry, Ayurveda, Homeopathy, and Naturopathy.
2. To study the criteria used by medical sciences in the attribution of causes and classification of abnormal behaviour.
3. To understand the methods of diagnosis and treatment of abnormal behaviour in Psychiatry,*Ayurveda* ,Homeopathy and Naturopathy
4. To bring out the philosophical discussions, debates and issues on the concept, causes and classification and diagnosis of treatment of abnormal behaviour.
5. To compare the medical sciences on the conceptualizations of abnormal behaviour to evolve fundamental questions and contradictions on health and illness.

The researcher has taken the epistemological perspectives of Constructivism/ Interpretivism and Postmodernism for the present research. These paradigms allowed the researcher to approach the fundamental medical and philosophical concepts of health-illness, mind-body and normality-abnormality in its social, cultural and political frames. A post modernist perspective helped the researcher to deconstruct the meaning of abnormal behavior through the discourse of medical sciences. The multiple voices of Allopathy/ Psychiatry, Ayurveda, Homeopathy and Naturopathy an abnormal behavior were given equal importance in this research and no one view or group of views was considered privileged over any others. A qualitative research method is undertaken for studying the objectives of the present study. The research design adapted was an interactive (hermeneutic), descriptive, evaluative one, which offered a framework for seeking meaning and developing interpretive explanations.

The sampling technique undertook was theoretical sampling for matching with the conceptual, theoretical and philosophical nature of the research. The researcher used textual analysis, individual interview and paired (or triad) interview for collecting data. The texts related to each medical sciences, mainly the classic works, medical textbooks, original works of the important practitioners of each system, journal & magazine articles, research reviews

etc. were mainly used for the method of textual analysis. Interviews were conducted with the medical practitioners, philosophers, psychologists, clinical psychologists and medical students primarily to collect their meaning about the phenomena under investigation as well as to clarify the conceptual dilemmas faced by the researcher.

Each system is thus studied using the methodology mentioned above which has mainly focused on the description of concepts related to abnormal behavior from each medical science. The description and analysis of abnormal behavior in Allopathy/ Psychiatry, *Ayurveda,* Homeopathy and Naturopathy are arranged in the chapter 3 of Concept of Health & Illness, Chapter 4 of Causes and Classification of Abnormal Behavior and Chapter 5 of Diagnosis and Treatment of Abnormal Behavior.

After the description of the theoretical positions of the medical systems, thematic analysis of the concepts has been done. The raw data is managed by labeling or tagging data, sorting, summarizing or synthesizing them and finally generating categories or initial themes. Then in the next phase of explanatory accounts, patterns are detected through associative analysis and then developed explanation for these typologies. The categories or initial themes thus emerged are further refined and meaningfully analysed to arrive at more abstract concepts. This process of analytic hierarchy is explained and represented in tables in the following section.

Table 6.1 Major categories and final themes derived through thematic analysis

Research Questions	Major categories identified	
Concept of Abnormal Behaviour	1.1	Is disease a general category or an individual one?
	1.2	Are the terms "health and illness" dichotomous and opposite?
	1.3	Biological origin of mental illness
	1.4	Are the concepts of health/ illness reducible?
	1.5	Mental illnesses are problems of living
	1.6	Are diseases physical or mental?
	1.7	Does the concept 'health' is the basis of medical sciences?
	1.8	Are diseases social and/or cultural?
	1.9	Does the medical theory match with the lay concept of health and illness?
	1.10	Is the medical system pragmatic?
	1.11	Dissatisfaction with the present system
Causes & Classification of Abnormal Behaviour	2.1	Is disease singular or categorical?
	2.2	How do the medical systems conceive cause and effect?
	2.3	Criteria of classification system
	2.4	Natural Vs. artificial system of classification
	2.5	Causal & classificatory dualism
	2.6	The blurred boundary of "organic" and "functional"
	2.7	Reliability & validity issues
	2.8	What's the role of 'person' in the process?
	2.9	What's social and cultural about the causes of disease?
	2.10	The not-much visible factors in causes and classification
Diagnosis & Treatment of Abnormal Behaviour	3.1	Flawed diagnosis in Psychiatry
	3.2	Is differential diagnosis required?
	3.3	Cure or suppression?
	3.4	Cure and health
	3.5	About patients' theory of disease
	3.6	Diagnose social and cultural factors?
	3.7	Labeling and stigmatization
	3.8	Subjectivity vs. Objectivity in diagnosis and treatment
	3.9	Consistency between classifications, diagnosis and treatment
	3.10	Can we really 'cure' disease? Medication and placebo
	3.11	The market factors in diagnosis and treatment

The above table summarizes the results of thematic analysis of the concept, causes & classification and diagnosis & treatment of abnormal behavior envisaged by medical sciences. Apart from the discussions made under each category in the respective chapters, the researcher would like to focus on some crucial issues on abnormal behavior which are directly or indirectly related to the research objectives. Here, I would like to state that the four medical systems own a rich tradition of theories and philosophies. Therefore, an attempt to understand and analyse them based on the research questions planned demands a lot of responsibility from the researcher. Even if the researcher does justice to the analysis and findings made as part of the research, this piece of work needs to be considered and approached as an initial attempt as a student of psychology who is open to any constructive criticisms in this regard. I would like to state the inferences derived from this work in the form of hypothesis which should be further studied.

The first and foremost issue was that of the Biopsychosocial model proposed by Psychiatry. There was a cry for change in the Biomedical model followed by Psychiatry, which is reported by many researches. The integration of psychological, social and cultural elements into biological model was believed to solve all the conceptual problems of Psychiatry. Meanwhile, there were multiple views about the integration of these factors into the biology of mental illness too. Some researchers call this as “model muddlement” and some view this debate as much more political than therapeutic. Analyzing the reductionism followed by Biomedical model, the researcher assumes that the introduction of biopsychosocial model into medical model of Psychiatry does not change its theoretical approach. I can further say that a mere change of names of approaches did not do anything to the conceptualization and treatment of abnormal behavior in Psychiatry. The integration of biopsychosocial model appears to me as a ‘compromise’ rather than shifting over to a new medical philosophy.

The integration of Ayurveda, Homeopathy and Naturopathy into the mainstream/ powerful Orthodox Medicine/ Psychiatry is also another heated debate. It has been observed by the researcher that the issues are of same in nature as that of biopsychosocial model when it comes to 'integration of medical sciences'. *How could medical sciences which are theoretically and philosophically different and unique be integrated each other? Whose theory or philosophy of health and illness would be followed then? How do we understand such an attempt in the background of political, market and business factors in medicine, which is mentioned in the earlier chapters? Is it possible to create a 'whole knowledge' combining many partial or incomplete systems of knowledge?* The discussion with the experts shows that an interaction between medical sciences on the practical issues of a disease (physical and/ or mental) would be advisable and helpful because each medical system has its own possibilities and limitation on the knowledge of diseases. A sharing and interaction between them without loosing or sacrificing their theoretical as well as philosophical strength would enrich our process of dealing with health – illness dimensions. Arguing for the philosophical integration of all the medical systems of dissolving everything into a most powerful (which itself a relative term) system would be illogical exercise. An integrative perspective emerging from Biology, Psychology, Sociology and Philosophy is the need of the day. At present, such a perspective upon which the medical conception of health and illness - both physical and mental - rest, stands only as a future possibility.

Approaching Allopathy/ Psychiatry, Ayurveda, Homeopathy and Naturopathy on the platform of abnormal behaviour, the researcher was amazed with the tremendous number of researches and developments happened in the field of Allopathy/ Psychiatry. As Allopathy could effectively make use of today's technological advancement in their treatment of disease, psychiatry has also been witnessed many conceptual corrections in its history. Many of the theoretical advancements, which were previously considered 'groundbreaking', were now considered to be primitive and baseless. Even if other medical systems criticise the 'trial and

error' approach of Allopathy/ Psychiatry, it has taken an open position to be studied and researched. We could see many of the studies say about the biological origin of mental illness as 'still under research' or 'studies are progressing' etc. At the same time, the researcher has observed a trend followed by the pharmaceutical companies which 'silences' the fundamental questions on abnormal behaviour as they many hamper their business. Ayurveda, Homeopathy and Naturopathy are claimed having strong philosophical and conceptual positions. But the number of studies or researches, which would advance or modify their knowledge of health and illness are comparatively less. The researcher assumes that as health and illness, especially mental illness, is juxtaposed in its social and cultural origin, the medical systems need to expand their theoretical horizons alone with the changes happening in these dimensions. Ayurveda, Homeopathy and Naturopathy stand as 'closed systems' in this issue. For instance, their knowledge about mental illness is stratified and not as strong as that of physical illness. Analysing the health care scenario in Kerala it has been observed that there is only one Ayurveda hospital specialised for the treatment of mental illness. Other hospitals were either do not treat mental ill or treat them with their understanding on general principles of health and illness in Ayurveda. In Homeopathy also, the number of mental ill patients seeking treatment was less and specialised understanding about normal abnormal concepts are not much developed. Naturopathy, too, is reluctant about the treatment of mentally ill. This observation does not mean to say that mental illness needs to be a specialty and should be approached with different concerns compared to physical illness. People choose a medical system out of the available systems prevailing in their place. But in the context of Kerala, Psychiatry (and sometimes Clinical Psychology) is the most available and popular treatment system for mental illness. Ayurveda/ Homeopathy and Naturopathy stand as 'sidelined' with a criticisms of 'not-scientific'. But an indepth analysis would make anyone understand the fact that this criticism of "un-scientificity" is not satisfactory enough to explain the availability of other medical systems except psychiatry.

The conceptual questions on what is physical and what is mental are derived from the mind-body problem itself. The researcher could not gather a satisfactory answer even after the conceptual analysis of medical sciences in this issue. The physical illnesses are found to have mental and physical causes and mental illness are also having mental and physical causes. The sequence of its manifestation, process and complication are yet to be analysed in its philosophical roots.

As far as the drug action is concerned, Naturopathy criticises all the other systems, which rely on drugs. As an external thing coming out of the body and acting on the body, the action of drugs on the bodily and mental processes are not demonstrated effectively by any medical systems. Psychiatrists are advised to prescribe medicines whose drug action is thoroughly known and studied which presume this ethical issue. At the same time, the drugs used in Ayurveda and Homeopathy cannot be taken for granted. The action of drug on the human body needs to be known to the prescriber before it is given to the patient. How does it act on the symptoms, how are they reduced, how the balance of harmony or vital power or health is maintained and how does a drug create side effects are significant issues in the treatment of abnormal behaviour.

Another concern the researcher would like to raise in this context is that of the practice of Clinical Psychology on the management of abnormal behaviour. Psychology, which completely follows a different understanding on mind and mental processes, has strong background of Behaviourism and Psychoanalysis. They criticised the medical treatment of mental illness and developed new theories on the concepts, causes and treatment of it. Many of the schools of Psychology said even against medicine's role in dealing with mental illness. Being a medical doctor himself, Freud was skeptic about what medical science could offer to neurosis and its treatment.

"The neurotic (and the unconscious) is certainly an undesired complication ..... for medicine ..... But it exists and concerns medicine closely. And for ..... its treatment, medical training can give us nothing, but absolutely nothing". (cited from Bergo, 2004). It could offer nothing because either medicine was locked in psychophysical parallelism or it was materially reductionist.

Analysing the theoretical positions of Ayurveda, Homeopathy and Naturopathy the researcher takes a stand of how Clinical Psychology can be integrated with them rather than only with Psychiatry, which follows a biomedical model. In the present scenario of Kerala, we could see Psychiatrist and Clinical Psychologist work together or Clinical Psychologist work/ consult under the supervision of Psychiatrist. Ayurveda, Homeopathy and Naturopathy owe much scope for Psychology in conceptualising and dealing with abnormal behaviour. Their theoretical positions are extended to accommodate the social and cultural causes of mental illness, where a clinical psychologist can find his/ her own space comfortably. They can also free themselves from the biological reductionism of abnormal behaviour in Psychiatry, which is generally not stressed much in the training of clinical psychologist. Rather than the oversimplification of abnormal behaviour to its biology, Clinical Psychology needs to expand its treatment methods in liason with theories of other medical sciences that match well with Psychiatry.

Finally, the researcher feels that as far as a layperson is concerned, their requirements from a medical system are sometimes too distant from the conceptual issues brought in this research. Most of the people look for an immediate and speedy recovery, reduction of symptoms, easy availability of medical service, less cost or expense etc. Any system, which is against these demands, may not be appreciable and effective in his or her version. For example, many patients generally comment that the philosophy and methods of Naturopathy are not good enough as they are time consuming which may demand them to

change their life style or daily routine. In the case of Ayurveda also, *pathya* or wholesome regimen is not well accepted by the patients. At the same time, system of Allopathy/ Psychiatry permit the patient to lead their life in whichever way they want without much restrictions along with the drugs. The dynamics of colonial power was also found to be effectively used by the practioners of Allopathy/ Psychiatry. A clear power dynamics is executed in this system which the researcher has also experienced while approaching the Psychiatrists as part of the interviews for the research.

The questions are many and never- ending. But our curiosity to what is normal and abnormal still remains the same. A search for its intricacies would not complete until and unless we are ready to incorporate the version or theory or psychology of those who experience it. This dimension of subjectivity is not much explored even in the field of Psychology and such an enquiry even has the power to 'silence' all the other medical issues of abnormal behaviour. Let me conclude the thesis with a comment given by Virginia Woolf, the famous English poet who was a 'diagnosed' 'abnormal'.

As an experience, madness is terrific…"

Virginia Woolf (1978, cited from Bentall, 2003)

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