Patients suffering from mental disorders are often not treated on an equal basis with patients suffering from organic diseases. In Germany, for example, alcohol-dependent patients will be detoxified on a clinical ward to ensure that they survive acute alcohol withdrawal; however, medical insurances often do not cover treatment costs for a therapy for the addictive behavior that underlies the acute alcohol problem. While patients suffering from diabetes mellitus can also display personally harmful choices and, for example, consume sugar although they know that this is detrimental for their health, medical insurances pay for the acute hyperglycemic shock treatment as well as for dietary and medical treatment of the underlying disorder, diabetes mellitus. Not so in alcoholism, where emergency treatment for delirium tremens (a form of severe alcohol withdrawal) will be covered but not psychosocial and medical treatment for the addiction itself. Problems of stigmatization and discrimination obviously play a role in this context. However, nicotine addiction is an example that clearly shows that the disease status of mental disorders itself is controversial—Is nicotine
consumption always a lifestyle issue, or can smokers become as severely
dependent on nicotine as heroin consumers become addicted to opiates?
If the latter is the case, then why is a certain behavior a disease and not just
an unconventional choice? That is, which criteria do not just characterize
a certain disease (e.g., addiction) but instead define whether a condition or
set of symptoms (syndrome) characterizes a disease?

Most authors try to answer this question by pointing to criteria that
characterize organic disease, pointing to some kind of anthropological
norm from which a condition differs fundamentally and which is nega-
tive for the patient, who feels sick and wants to return to a healthy condi-
tion. However, in psychiatric disorders, patients often do not feel sick but,
rather, persecuted or enlightened, and—as we discuss below—the question
of adequate norms is much more complicated than when we discuss, for
example, liver function and dysfunction. Psychiatry and psychology have,
for about a century, tried to answer the question about health and disease by
pointing to an evolutionary understanding of human development. Health
is then defined as a functional level at the top of the evolutionary pyramid,
while disease is a breakdown of such higher functions.

However, this whole construction is based on a unilinear concept of
human development and history and tends to mistake cultural differences
for evolutionary stages. In this essay, we will first reflect on these traditional
criteria and then discuss the possibility to define minimal anthropologi-
cal functions, which are supposed to characterize mental health in different
cultures and which in case of impairment can be used as symptoms of a
psychiatric disease. We will do so by keeping in mind that modern moral-
ity does not endorse the limiting of individual choices about how one lives
one's life (at least as long as these choices do not harm others). Thus, we
are looking for functions that are necessary for being able to choose what to
do in one's life; we are not looking for indicators that classify certain goals
or choices of life as symptoms of a pathological process (Tugendhat 1984).

Degeneration, Dissolution, and Regression—Evolutionary
Concepts of Mental Health

A traditional view held that God created man in a perfect state but that degen-
eration, understood as a “fall from God’s grace” (Topsell 1607), has deterior-
rated human capacities. In the eighteenth century, Blumenbach (1795) and
other anthropologists reasoned about racial hierarchies, with Blumenbach being rather critical of the usual tendency to assume that “Ethiopians” or “Negroes” are more degenerate than “Mongolians,” with Europeans for some reason always ending up at the top of the rank order (Figure 1). In the nineteenth century, Morel (1857) applied the concept of degeneration to mental disorders and suggested that a multitude of environmental and constitutional factors (smog, alcoholism, uncontrolled desires) can induce degeneration, which manifests itself as minor disorders (libertinage, nervousness, anxieties) in the first generation, with the second generation showing more serious problems (alcoholism, neurosis), the next generation suffering from severe mental disorders, and finally the family dying out due to cretinism and other forms of severe handicap (Figure 2). Syphilis seems to represent the paradigm for such explanatory models, which tried to explain the devastating health condition of the industrial proletariat in the new urban centers. Until the early twentieth century, the bacterium causing early and late stages of syphilis was not identified, so doctors could only observe that a moral transgression (e.g., sleeping with a prostitute) can years later lead to a mental disorder (e.g., mania due to the neuronal manifestation of the disease) and even to handicapped children (due to intrauterine infection of the fetus, which of course was unknown in the nineteenth century).

**FIGURE 1.** In the eighteenth century, the concept of degeneration was based on the idea that God created man in a perfect way and that contemporary human beings display different degrees of degeneration. While Blumenbach (1795) suggested that major ethnic differences can be observed with respect to beauty, other authors insisted on much more profound “racial” inequalities. Of course, all authors were Europeans, and it may not come as a surprise that the top of the hierarchy is always occupied by Europeans (or “Caucasians,” as Blumenbach named them because he felt that they are the most beautiful human beings and the founding population of Western populations).
However, evolutionary ideas soon questioned such doomsday models of human degeneration. Rather than being created in a perfect state, mankind originated on a much more primitive level and subsequently climbed up on the evolutionary ladder (Figure 3). Nevertheless, not all was lost for degeneration theory: it still tried to explain mental disorders as manifestations of degeneration, but now this fall from perfection would occur as a movement down from the acquired evolutionary stage into a more primitive condition, thus inducing the remanifestation of a phylogenetically older condition of mankind (Figures 4 and 5). One of the eminent neurologists and psychiatrists of the late nineteenth century called this pathological degeneration “dissolution” (Jackson 1884), while Freud (1911), who was well aware of J. H. Jackson’s concepts, named it “regression.”

Needless to say, in the view of contemporary European colonialists colonized people were again identified as examples of such phylogenetically older stages of human development—thus mistaking cultural diversity for evolutionary age and basically denying the historical development of non-European populations (Heinz 2002). Moreover, since Ernst Haeckel assumed that individual development (ontogenesis) is a short recapitulation

**FIGURE 2.** In the nineteenth century, the concept of degeneration was used to explain mental disorders that appear in increasing severity in each new generation (Morel 1857). Motivated by the devastating life conditions in the newly industrialized urban centers, this concept suggested that environmental and constitutional factors induce minor disorders in the first generation, more serious problems in the second generation, severe mental disorders in the third generation, and mental retardation in the last generation, which will thus be unable to procreate.
In the second half of the nineteenth century, an evolutionary concept of human development suggested that mankind originated on primitive level and subsequently climbed up on the evolutionary ladder. It assumed that this development is reflected in a hierarchy of brain centers, with presumably older and more primitive centers informing the developmentally younger and more complex brain centers, which in turn inhibit these primitive centers. This model strictly and exclusively relies on top-down control of brain functions, with no “bottom-up” regulation capacities located in older brain areas. Jackson (1884) explicitly stated that this concept was modeled according to social hierarchies and compared higher brain centers with the government, which needs to control the potential (primitive) anarchy of the masses. Jackson’s concepts influenced both Freud and modern brain research (Heinz 1998).

A place for degeneration in the new evolutionary model of brain functions: While the concept of degeneration was no longer used to explain normal human development, it was now applied to describe a pathological state, in which the functions of higher brain areas are lost due to mental diseases, resulting in a reversal of evolution. This presumed “dissolution” or “regression” was supposed to
be caused by (1) the loss of functions of evolutionary higher brain areas, manifested as negative symptoms, i.e., symptoms of lack of function; and (2) the disinhibition of evolutionarily older brain areas, resulting in positive symptoms, i.e., the manifestation of otherwise obsolete, primitive behavior patterns. Jackson (1884) compared this situation with political turmoil, in which we lose our government (negative symptom) and experience the anarchy of the disinhibited population (positive symptom). Note that in all related models of the brain and mind, loss of higher control will result in the manifestation of presumably primitive drives and desires—not the first model that clearly separated between a “higher” good and a “lower” evil side.

**Figure 5.** A (post)modern view of mental disorders emphasizes interaction between neuronal networks rather than hierarchical top-down modulation of neuronal information processing.

of phylogenesis (a view that current biology limits to certain aspects of intrauterine development), both psychoanalysts and psychiatrists tried to compare mental diseases (as manifestations of pathological dissolution or regression to a more primitive level of human development) with the behavior of colonized populations (as examples of a phylogenetically primitive condition), children (ontogenetically on a more primitive level), and women, who for some reason failed to reach the evolutionary top stages of rational development (Heinz 2002).

This imaginary evolutionary hierarchy offered a simple tool to identify a mental disorder—the disease state is characterized by its difference to qualities regarded as central marks of distinction between a contemporary Western man and his children, colonial subjects, and women. Social anthropology, women’s liberation, and anticolonial struggles have since revised
this concept and assured the diversity of human cultural development, gender roles, and children’s development (Heinz 2002). What was lost in this process was a set of criteria that define mental disorders. Instead, psychiatry tended to focus on symptoms of individual diseases, not on the question of how to define mental disorders per se (Jaspers 1946). Nevertheless, the disease status of a certain condition became the object of legal struggles, for example, when Holocaust victims wanted to receive compensation for mental disorders acquired during internment in concentration camps. Originally, traditional psychiatry held the view that a person has to be (genetically/by one’s constitution) predisposed to develop a mental disorder under stress, and it was a social struggle to define something like a “post-traumatic stress disorder” as a psychiatric disease that follows severe trauma in otherwise healthy individuals, who can demand compensation for their suffering. The question then is, What criteria could be acceptable and useful for determining if a condition could be named a “disease” or “mental disorder,” and, conversely, how can mental health be defined?

Mental Health: Criteria and Resources

A straightforward view would suggest that mental health is simply the absence of any kind of mental disorder or disease. As such, it would be an ideal example (an Idealtypus according to Jaspers [1946]), which may not conform to the statistical norms but, rather, to an ideal norm (since mental problems are very widespread). However, we often speak of “healthy aspects” or “resources” of a patient even if he or she is rather severely ill, indicating that there may be other dimensions to mental health than simply the absence of a defined mental disorder. Also, the World Health Organization’s (1946) definition of health demands complete well-being, which points beyond freedom of disease. An example may illustrate the problem that we have in mind: imagine two concentration camp guards, one of whom will become depressed because of his actions—clearly, he now has a defined mental disorder; but would we really call the other guard “healthy”? Or does he lack a fundamental aspect of mental health—the ability of empathy—which may not suffice to define a certain disease but clearly makes him fall short of any useful concept of mental health? How, then, could mental health be defined?
Some years ago, we attempted to define mental health on the basis of therapeutic goals shared among different psychotherapeutic approaches (Heinz 1994). Keeping in mind that modern ethics would not permit defining one particular way of living as “healthy,” these aims should define functions required for the ability to choose individual goals rather than specific behaviors or character traits. We suggested that “flexibility of behavior,” “empathy,” and “self-efficacy” could be such criteria of mental health that define functions required for a healthy living rather than demanding a particular way of life. Flexibility of behavior does not require that a person change his or her behavior all the time; rather, it implies the ability to reverse a course of action if necessary. Loss of flexibility of behavior can thus appear in the form of a repetitive compulsion, be it in obsessive-compulsive disorder or compulsive drug taking, or as a rigid ideation, which is defended in spite of all available evidence (e.g., the idea that “Jews harm the German population,” which at one time dominated German politics).

Empathy was likewise chosen for this functional reason; its absence not only characterizes a form of “antisocial personality disorder” but also impairs social interactions at a fundamental level. Moreover, in comparison with concepts that emphasize cognitive abilities as criteria of mental health, the ability to empathize is not associated with individual variations in IQ or other more or less useful measures of cognitive capacities. Indeed, it appears nonsensical to limit the status of mental health to subjects with a certain test performance.

Finally, self-efficacy entails the feeling that a person can successfully interact with the world. Loss of self-efficacy can manifest as alienation, a concept that once was used to describe all mental disorders, before Griesinger and other pioneers of psychiatry replaced the concept of alienation (Entfremdung) with degeneration (Entartung [Heinz and Kluge 2008]). Alienation is a philosophically challenging concept, because it appears to define a set of “essential” feelings, wishes, or behaviors that are supposedly normal (“nonalienated”), thus violating the modern ethical demand that each subject should freely choose what is best for her or him. However, philosophers such as Jaeggi (2005) have suggested defining alienation as a form of unsuccessful interaction with the world, in which a subject expresses whatever feelings, wishes, or goals he or she has.

Alienation is then a description for a failed process rather than an evaluation of the content or goal implicated with the behavior. Alienated behavior may thus be characterized by inflexibility or an inability to
express one’s desires in a way that fits with the previous life narration and self-concepts of a person. Of course, social factors may enforce such alienation, for example, when strict gender or social roles limit the ability of a subject to be involved with projects in the world and to express him- or herself in such projects. In psychiatry, alienation is found in the symptoms of depersonalization and derealization, the first one describing an alienated feeling toward one’s own self and the second toward the world. Such symptoms can occur in a series of mental disorders, for example, when a psychotic patient experiences profound changes in the way he experiences the world and his own emotions and thoughts or when a victim of rape and social exclusion can no longer relate to her feelings and status as a person.

However, flexibility of behavior, empathy, and self-efficacy may be resources that enable a person to stay healthy in spite of severe traumatization or stress rather than representing criteria of mental health per se (Schramme 2000). Indeed, self-efficacy is known to positively influence treatment outcome, for example, in addictive disorders. Having a gold mine is a resource of wealth—can it also be a criterion for wealth? Or should these criteria be defined on a more abstract level, for example, “wealth is defined by the possession of certain resources,” of which gold mines are only one example among many? Mental health may then best be defined by pointing to all the resources that are known to positively affect disease outcome. However, even if we permit this idea, it leaves us with the following problem: whether or not mental health is simply the absence of disease, the question still remains how to define mental disorders or diseases.

Mental Disorders—Illness, Disease, Malady?

In English, several terms refer to a state of disease: illness is usually applied to describe the subjective state of feeling sick, while disease refers to the objective sickness; for example, lung cancer is the underlying disease, and feeling short of breath is the sickness. Usually, it is assumed that disease concepts, which describe nonmental disorders, should also be applicable to mental disorders. For example, Culver and Gert (1982) suggest that “malady” is a state of disease characterized by the negative state, an increased risk to die, a severe incapacitation or limiting of functions, and the absence of a sustaining outside cause. The latter criterion is necessary
to distinguish suffering when a person is subjected to torture (sustaining outside cause: no malady) from a post-traumatic stress disorder (suffering and incapacitation in the absence of a sustaining outside cause: a malady). The concept has strong prima facie validity because it defines malady as an undesirable state for all human beings—such a state is suffering, and indeed, who would choose to suffer or feel pain if one can avoid it? However, suffering is hard to measure, and some disease states such as mania can severely interfere with a subject’s abilities (e.g., to feel adequately sad if a friend dies) without evoking any negative emotions. Due to this inherent vagueness, Schramme (2000) suggests that this concept has its place in the world of everyday life of human beings (Lebenswelt), because suffering and other unpleasant states indicate to a person that he or she is sick and needs help but falls short of a scientifically useful definition of diseases.

An alternative concept was proposed by Boorse (1976), who suggests that any disease can be defined as a norm deviation—a deviation in the integrity of vital functions, which ensure either the survival or the procreation of a human being. The latter aspect of this proposal has been criticized because it could be used to (re)pathologize homosexuality, which has just been banned from the list of psychiatric disorders within the last decades (Heinz 2005). Moreover, it is unclear which mental functions ensure survival. Schramme (2000) suggests that vital mental functions could be defined using psychoanalytic categories of a fully functioning individual, however, these categories appear to be too complex and controversial to yield a description of mental functions that are vital across human cultures (Heinz 2005).

A Minimal Anthropological Concept of the Mind: Vital Mental Functions?

To define dysfunctions of vital capacities, Heinz and Napo (2008) have suggested looking at common practices of psychiatrists, who diagnose psychiatric diseases using a simplified set of psychopathological symptoms once canonized by Jaspers (1946; see Table 1). These symptoms are ranked in a hierarchical order, which does not reflect theory-driven attempts to imagine evolutionary brain mechanisms but, rather, clinical necessities: absence of a higher-ranked group of symptoms excludes a certain group of diseases and limits differential diagnoses to the remaining disorders.
For example, if a person is not awake, is disoriented about her name and place, or is unable to understand simple information, she will suffer from a kind of delirium (a term not limited to drug-associated states); however, if these functions are not disturbed, there is no delirium or related acute dysfunction of the brain (acute brain-organic syndrome or exogenous psychosis). Likewise, absence of dysfunctions in the areas of concentration and short- and long-term memory rules out any kind of dementia. Of course, a patient with dementia may also suffer from delirium (e.g., when he does not drink enough water), but then the delirium is the more pressing emergency and the dementia is a second-order concern. These symptoms indicate severe mental incapacity and appear to be applicable across different times and cultures. Indeed, there is no

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Symptom Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delirium</td>
<td>State of consciousness (awake/somnolent/comatose)</td>
</tr>
<tr>
<td></td>
<td>Orientation (person/place/time)</td>
</tr>
<tr>
<td></td>
<td>Understanding of simple communication</td>
</tr>
<tr>
<td></td>
<td>If no pathological finding: no delirium.</td>
</tr>
<tr>
<td>Dementia</td>
<td>Concentration (e.g., for simple repetitive tasks)</td>
</tr>
<tr>
<td></td>
<td>Short-term memory (delay shorter than ten minutes)</td>
</tr>
<tr>
<td></td>
<td>Long-term memory</td>
</tr>
<tr>
<td></td>
<td>If no pathological finding: no dementia.</td>
</tr>
<tr>
<td>Schizophrenic</td>
<td>Ideation</td>
</tr>
<tr>
<td>Psychosis</td>
<td>Formal aspects (speed, coherence)</td>
</tr>
<tr>
<td></td>
<td>Content: delusional perception,* other forms of delusion</td>
</tr>
<tr>
<td></td>
<td>Hallucinations (e.g., commenting voices,* voices in dialogs,* imperative voices,* other hallucination)</td>
</tr>
<tr>
<td></td>
<td>Ego disorder* (e.g., thought insertion, thought broadcasting/telepathy, thought blockade, etc.)</td>
</tr>
<tr>
<td></td>
<td>If no pathological finding (particularly no first-rank symptoms): no schizophrenic psychosis.</td>
</tr>
<tr>
<td>Affective</td>
<td>Mood disorder (e.g., depressed, manic, etc.)</td>
</tr>
<tr>
<td>Disorder</td>
<td>Motivational disorder (e.g., apathy)</td>
</tr>
<tr>
<td></td>
<td>Anhedonia (inability to experience pleasure)</td>
</tr>
<tr>
<td></td>
<td>If no pathological finding: no major affective disorder.</td>
</tr>
</tbody>
</table>

*First-rank symptoms according to Kurt Schneider.
controversy about whether dementia can be diagnosed in subjects living in China in the same way as among those living in the Brazilian rain forest. Therefore, the mental functions described so far are good candidates for a set of vital capacities, whose dysfunction indicates deviation from a norm—mental health.

However, this is not as clear when the next group of diseases (endogenous psychoses) is addressed. Symptoms of schizophrenic psychoses and of affective (including bipolar) disorders appear to be much more culturally embedded. Diagnosis of schizophrenia, for example, is to date strongly based on the work of Kurt Schneider (1942), who criticized that symptoms that guide diagnostic decisions are usually based on controversial impressions and evaluations of the respective psychiatrist. Without explicitly using the concept of reliability, Schneider instead suggested that diagnosis of psychosis should be based on symptoms that are reported by the patients themselves. These include hearing voices that comment on what the patient does or that speak with each other (i.e., certain types of acoustic hallucinations), the experience that the patient’s thoughts are projected into his or her mind or taken away by external forces, or the notion that one’s thoughts are broadcast to other subjects (so-called ego disorders, because they concern ownership and authorship of one’s own thoughts).

With respect to delusions, defined as an unrealistic belief held against all evidence to the contrary (Jaspers 1946), one only has to think of anti-Semitic beliefs during National Socialism to understand that belief systems that fulfill the criteria of a delusion can be shared by a majority of subjects in a given population. Schneider suggested that such delusions are not a first-rank or leading symptom of psychosis, except when they appear in the form of a delusional perception. In this case, a perception shared by both the patient and the doctor is explained in a delusional way by the patient (e.g., “the redness of the car outside indicates that the Communist Party is spying on me”). Unlike in the case of ego disorders, both the doctor and the patient have equal access to the outer object, and the doctor can assess the plausibility of the patient’s explanation. Of course, the doctor may be wrong, and a political party may still be persecuting the patient; however, it is much more difficult for the doctor to err when shared perceptions are concerned than when a whole belief system is discussed in the absence of any perceivable evidence.
However, how could this criterion rule out that Giordano Bruno be declared insane when he claimed that the earth spins around the sun and not vice versa, although everybody can witness that the opposite is true? A criterion not discussed by Schneider (1942) is “subject centrism”—suggesting that in delusions, the subject usually posits herself at the center of attention. So if a patient claims that the sun spins around the earth, he is most likely not psychotic; however, when he claims that the sun and moon spin around him personally, he probably is. In Plessner’s (1928) view, this could be understood as a dysfunction of ex-centric positionality—the subject loses the ability to give up the central perspective and to view her relations to the environment from a quasi external point of view. Schneider’s criteria have successfully been applied to diagnose schizophrenia with comparable prevalence in cultures and settings so diverse as rural and urban Nigeria and India and several Western countries (Sartorius et al. 1986). Absence of evidence is not, however, evidence of absence; and substantial differences in local concepts of a human person and mind suggest that ego disorders may not impair mental functions that indeed belong to a set of vital functions universally shared by all healthy human beings (Heinz 2006).

Even basic symptoms of clinical depression, such as apathy, anhedonia (the inability to experience pleasure), and severe negative mood appear to be universally experienced in all cultures. Kleinman (1980) suggests that, for example, in China multiple explanatory models of mental disorders differ profoundly from each other and from modern Western concepts and that patients often experience physical exhaustion and voice somatic complaints rather than feeling depressed, sad, or “empty,” as frequently described by Western patients.

Nevertheless, it does not appear too problematic to state that ownership of one’s own thoughts and the absence of severe negative mood states are vital mental functions, which are required for normal functioning of human beings. A minimal anthropological concept of the mind, one that aims to define vital capacities required for humans to live their life and select their actions, may identify these vital mental capacities with the previously mentioned functions of mind. But are these mental functions abstract and functional enough not to risk pathologizing the particular contents of human choices, as the openness of modern ethics requires? This is open for debate. However, it appears important, for example, that delusions affect no vital function and are therefore no first-ranking symptom
of psychosis, thus allowing for a widespread diversity in belief systems. On the other hand, first-ranking symptoms of mental disorders such as the inability to direct one’s thoughts (authorship) and to feel that they belong to the person who experiences those thoughts (ownership) do describe a certain function of thought control that is independent of the content of any specific idea.

**Mental Diseases and Variations of Human Experience: A Case for Suffering as a Criterion of Mental Disorders**

In classical psychiatric nosology, the above-named symptoms delineated the realm of mental diseases. Beyond, there was the ocean of human variation (see Table 2), subclassified into personality disorders (roughly characterized by persistent traits that do not undergo major changes during personal development) and neuroses, that is, syndromes characterized by some kind of conflict between a certain desire or feeling and social norms and regulations. A person with an obsessive-compulsive character would thus always feel that he is orderly while the rest of the world is not. In contrast, a person suffering from obsessive-compulsive disorder (neurosis) would at a certain time in her life start to experience the urge to repeat certain actions, often to make up for aggressive or otherwise unacceptable thoughts, which are clearly owned by the patient (and not experienced as an alien influence, as in the case of psychotic thought insertion) but nevertheless unwanted and uncontrollable. Such syndromes were called “variations” because they appear in close, often virtually inseparable relation to experiences of “healthy” human beings. So how should we decide whether they constitute a “disorder” that entitles the patient, for example, to psychotherapy paid for by health insurance?

It does not seem useful to extend the concept of vital mental functions to all kinds of mental experiences and expressions, such as a more or less rigid personality style. Instead, the degree of suffering subjectively

<table>
<thead>
<tr>
<th>Exogenous Psychoses</th>
<th>Endogenous Psychoses</th>
<th>Variations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delirium</td>
<td>Schizophrenic Psychoses</td>
<td>Neuroses</td>
</tr>
<tr>
<td>Dementia</td>
<td>Affective Disorders</td>
<td>Personality Disorders</td>
</tr>
</tbody>
</table>
experienced by the patient appears to provide a “lifeworld” concept of entitlement for therapy. Currently, in the Western world, criteria are rather liberal, and diagnostic entities (defined disorders) are multiplied in each new version of international catalogs classifying mental disorders. Moreover, the concept of “mental disease” was replaced, also for the above-described groups of exogenous and endogenous psychoses, by the term disorder. However, this loosening of the concept of disease occurred partly in parallel to a loss of entitlement for treatment of mental disorders, leaving (at least in the United States) many psychotic patients homeless or in jail. Current discussion about human rights in psychiatry, patient choices, and the mental capacities required for informed consent indicate that it may be time to revisit theoretical concepts of mental disorders and their ethical implications.

WORKS CITED

anthropological and evolutionary concepts


