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Mental Disorders and Social Mimicry in the Context of Everyday Functioning

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Abstract

The most important characteristic of contemporary society is continuous change; however, imposed social circumstances have not altered the distinctions in defining scientific knowledge in relation to other forms of acquired knowledge. Mental disorders are health conditions described through a causal relationship between human neuropsychology and social interactions; they are predominantly externally invisible, do not affect all aspects of life, occur in waves (better and worse periods), and individuals can function despite the internal struggles that mental disorders initiate. The subject of our research is the systematization of triggers (social "triggers"), manifest symptoms, and social mimicries (adaptive strategies) which, in individuals with mental disorders who function in everyday life, initiate the transition (identified through manifest symptoms) from the so-called "good period" to the "bad period," during which, in the majority of cases, they become more or less socially dysfunctional. Based on our direct and comparative examinations, observations, and perceptions, we focused on individuals who, in certain social interactions, exhibit a clear transition from psychological difficulties to mental disorders, the causality of which we infer from the consequences produced for themselves, other people, and the broader environment.

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Introduction

Contemporary social changes manifest themselves in all spheres of life and, as causes, result in individual and social adaptations to those changes. Emotional adaptations of individuals to change are diverse (anger, joy,

sadness, fear, disgust, surprise), but socially induced changes consequently initiate emotional changes as well [1]. Likewise, the process of adaptation or functioning of an individual within a social environment is determined by their thoughts, feelings, and actions; therefore, the terms "mental health" and "behavioral health" often refer to the cognitive, behavioral, and emotional state of an individual [2]. Mental health is a state of social and psychological/emotional balance of the individuals, in which they successfully realize their constitutional capacities, buffer stresses/traumas, and successfully express themselves in life and professionally, to personal satisfaction and to the benefit of the social environment in which they live. However, individuals who have psychological difficulties and disorders, in many social situations, function in a customary, that is, normal manner. Where is the boundary between "mental health" and "mental illness," at what point does what we consider healthy transition into illness, and where does that distinction become blurred?

The German philosopher Immanuel Kant (1724 - 1804), in the preface to the first edition of his book "Critique of Pure Reason" states that the human mind has a strange destiny: it is disturbed by questions that cannot be ignored, because the nature of the mind asks them by itself, but which it cannot resolve, because they exceed the power of the human mind. On the other hand, the British philosopher and mathematician Bertrand Russell (1872 - 1970) observed that scientists who believe they are examining a simple phenomenon eventually come to realize that a question such as "why is the sky blue?" is far more complex than initially assumed. In the same way, the question of what we mean by "mentally healthy individuals" yields answers marked by indeterminacy and resists clear and transparent definition in the manner characteristic of concepts in the natural sciences.

A person lives along a temporal continuum and has a subjective perception of the passage of time. Along this timeline, impressions are formed from early childhood (disappointments, excitements, stressors, traumas, suggestions about life…). Everything an adult does is determined by prior impressions, which may be forgotten (repressed), yet remain ever-present in the subconscious. Certain impressions produce stress-defined as a set of emotional and physiological responses to disturbing external events, aimed at overcoming the situation. In contrast, trauma is a psychological adaptation to the impact of one or more severe stressors. While every trauma has stress at its core, not every stressor makes up psychological trauma [3].
The concept of "mental or psychological health" is a dynamic process that entails continual adaptation to social circumstances. Mentally healthy individuals are not perpetually happy, nor are they free of problems; rather, they have developed the capacity to live with difficulties in a manner that allows for adaptive adjustment without enduring adverse consequences.

The above is explained by the fact that each individual has his own way of perceiving and acting in certain situations, and his temperament is responsible for that, i.e. external attitude towards the world and character. In the context of our analysis, the crucial determination is the character of an individual, which implies to his inner, i.e., mental, motivational-emotional, social, cognitive characteristics, which determine reactions to certain events or situations. This is the matter of patterns of behavior, manner of thinking, self-control, etc. Specifically considered, the character of an individual, but simultaneously because of the environment in which the one is situated in, an individual determines the principles and rules of life which the one adheres to in interaction with the other people. Character is not an easy component to assess, because its peculiarities are most often revealed in specific circumstances [4].

The World Health Organization (WHO) defines health as "a state of complete physical, mental, and social well-being, and not merely the absence of disease" [5]. From the WHO definition of health arise three basic concepts essential to health promotion [6]: ● mental health is an essential component of overall health, ● mental health encompasses more than the mere absence of disease, ● mental health is closely linked to physical health and behavior. Defining mental health is important, but it is not necessary for its improvement. Value differences among countries, cultures, social classes, genders… are too significant to allow for the derivation of a universal definition. However, just as age and wealth have different manifestations around the world while retaining a basic universal meaning, mental health can likewise be defined without restricting its interpretation across different cultures [7].

In this sense, Sigmund Freud (1856 - 1939), an Austrian neurolog and the founder of psychoanalysis, a clinical method for the assessment and treatment of pathologies arising from conflicts within the psyche, defines mental health as "the capacity to love and to work" [8]. We have expanded this definition as follows: "mental health entails satisfaction with life and with oneself, together with the capacity to love, to work, and to cooperate with others".

However, not all individuals possess the emotional capacities required for love, because in order to be able to love, one must first cultivate an awareness of respect (which also entails gratitude) toward the person one loves. When we say that we "love someone", we simultaneously respect them; however, when we respect someone, we do not necessarily love them (for example, we may respect an opponent for being courageous, yet we do not love him because he is our opponent).

In the same way as psycho-physical capacities [9], emotions are likewise determined by our innate "emotional capacities," inherited at birth, which cannot be altered over the course of life.

Every individual possesses each of the basic emotions (anger, joy, sadness, fear, disgust, surprise, ambivalence), but in his subjective and expressive manifestation, one of these emotions is dominant from birth, i.e. the most pronounced. If the basic emotion of "joy" is expressively dominant in an individual from birth, it will additionally manifest itself in situations of sadness and vice versa. For example, the source of sadness due to the loss of a close person is the most often manifested physiologically through a decrease in heart rate, rapid breathing, quieter and slower speech, crying, raised eyebrows, lowered lips, etc. However, an individual whose dominant emotion is joy will overcome the state of sadness faster than an individual whose dominant emotion is anger, sadness, fear, disgust, surprise or ambivalence. An individual whose dominant emotion is joy does not suppress sadness, but "shows it to himself" by arguments initiated by the dominant emotion, i.e. joy. Dominant joy transforms sadness into a milder expressive manifestation (e.g. if a person dear to us has died, the arguments of a person whose dominant emotion is joy are most often: "she has gone to a better place", "the life of the dead remains in the memories of the living ones, while we remember them, will live with us" etc.) [10].

Based on our research, we conclude that possessing the capacity for respect (toward oneself and others), as a prerequisite for the ability to love, represents one of the fundamental characteristics of a mentally healthy individual. Their self-respect is not grounded in fantasy but in real experience; therefore, mentally healthy individuals are able to accept criticism without withdrawing into themselves, and setbacks do not lead to a collapse of their identity. In the absence of the capacity for respect, a sense of devaluation (belittlement, humiliation, denigration) necessarily develops, which in turn initiates a chain of causal reactions that are reactively transferred into a wide range of psychological difficulties and disorders.

Compensating for the desire to be loved is the desire to be better than the others, to amaze the other people and to be significant. Life's journey is a constant proving, in order to gain respect, admiration or approval. In order to be able to realize and feel psychologically healthy, we need to realize our constitutional possibilities. A realized man has the ability to separate himself from his surroundings and live according to his inner laws, rather than under the external pressures. Cognition begins in the early childhood, when through learning and experience we discover our psycho-physical capacities acquired at birth and not significantly changed during the life [11].

Figure 1: Miroslav Kuka, MY WORLD c. 2009. Private collection - Genoa / Italy

Based on our research, we have systematized the core characteristics of psychologically healthy individuals as manifested in social interactions: ● psychologically healthy individuals are aware of their psycho-physical capacities and limitations and align their aspirations with both their personal resources and the opportunities of their living milieu, ● psychologically healthy individuals develop a personal conception of success and maintain confidence in their ability to achieve it (I want, I can, I will), ● psychologically healthy individuals are not excessively preoccupied with analyzing their thoughts and emotions or with a persistent search for deeper meaning-excessive introspection is not healthy, ● when obstacles interfere with goal attainment, psychologically healthy individuals identify alternative pathways toward goal realization and (they persist despite initial or ongoing setbacks in goal pursuit), ● psychologically healthy individuals regulate their behavior and emotional responses in accordance with situational demands, while maintaining empathy toward others (emotions are experienced freely, behavior is self-regulated), ● psychologically healthy individuals demonstrate organizational capacity and systematic action aimed at productivity, while adhering to ethical principles and the social norms of their environment, ● psychologically healthy individuals maintain an optimistic orientation without engaging in catastrophic expectations across social domains, ● psychologically healthy individuals respect authority and institutional frameworks while protecting their personal integrity when it is legitimately threatened by abuses of power, ● psychologically healthy individuals experience themselves as autonomous (they rely on their own assessments and viewpoints) and possess the capacity to draw conclusions and make decisions independently, ● psychologically healthy individuals establish high-quality interpersonal relationships, engage in compromise (trust, tolerance), while also asserting and protecting their own views and interests, ● psychologically healthy individuals do not fear change or life challenges, perceiving change as a potential source of improved quality of life, ● psychologically healthy individuals are not preoccupied with the past-they live in the present and orient toward the future while integrating past experience, ● psychologically healthy individuals are not envious of the success of others and learn from personal experience in order to avoid repeating the same mistakes.

Methodology

In medical and psychosocial discourse, the term "mentally ill people" is not used, particularly when individuals demonstrate adequate social functioning, as this term is stigmatizing and imprecise. Depending on context, preferred expressions include "persons with mental disorders," "persons experiencing psychological difficulties," and "persons with psychiatric diagnoses." These medical diagnostic categories (terms) are often prefixed with qualifiers indicating that the individuals are "high-functioning" or "function well in everyday life". In public discourse, emphasis is often placed on the person rather than the diagnosis; accordingly, person-first expressions are used, such as "persons with lived experience of mental health difficulties" and "persons living with mental health challenges" [12].

In everyday discourse, mental disorders are often conflated with psychological difficulties; however, within a professional and clinical context, a distinction exists. Every mental disorder involves psychological difficulties, but not every psychological difficulty constitutes a mental disorder in clinical terms.

Mental disorders are clinically defined and classified in the International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM). They encompass disturbances in emotional, cognitive, and behavioral functioning, including manifestations such as anxiety, depression, emotional instability, attention disorders (ADHD), eating disorders… These conditions may persist over extended periods and can significantly impair functioning in educational settings, the workplace, family life, and broader social functioning. Psychological difficulties, by contrast, represent transient reactions to stressors or some changes that may resolve spontaneously or with environmental support (e.g., stage fright, short-term sadness, exam-related nervousness, conflict-related stress). Psychological difficulties are most often not classified as disorders and therefore do not involve a formal clinical diagnosis.

Most mental disorders manifest in cyclical patterns (alternating periods of improvement and exacerbation). They do not affect all domains of life and do not

necessarily imply a loss of contact with reality. However, among individuals with mental disorders who maintain adequate everyday functioning, we identified a predominance of egoistic - egocentric personality type, expressed in social interactions through persistent defensive positioning aimed at protecting a perceived threat to personal identity. In many cases, their identity is not genuinely threatened; rather, it is perceived as threatened due to dominant egoism - that is, an attitudinal or behavioral pattern in which experiences are viewed exclusively from one's own perspective, with one's own needs, interests, and desires placed markedly above those of others and often to their detriment [13] - as well as egocentrism, defined as the inability to perceive the world from another person's perspective, accompanied by fixation on one's own viewpoint, which is regarded as the only correct one.. Egocentrism is developmentally typical in early childhood, approximately until the age of six, during which empathy develops; when present in adulthood, it indicates psychological immaturity and mental difficulties [14]. In addition to this identity-related projection, individuals with mental disorders often exhibit a pronounced superiority complex - a psychological mechanism of self-deception in which abilities and talents are unrealistically overestimated. This mechanism masks a deeply rooted inferiority complex, characterized by insecurity and low self-confidence, and is expressed through arrogance, boastfulness, and a tendency toward manipulative behavior aimed at reinforcing a sense of superiority. Fundamentally, such individuals experience difficulties comparable to those associated with an inferiority complex, albeit manifested through an oppositely projected psychological pattern [15]. However, beyond inherited or early childhood–acquired predispositions, external contextual factors also shape mental health.

According to estimates by the Sidran Institute [16], as many as 61% of adult citizens in the United States have experienced at least one traumatic event in their lifetime (violence, abuse, or neglect). However, not all traumatic events lead to the development of post-traumatic stress disorder (PTSD). It is estimated that about 20% of people who experience trauma may develop PTSD, and that women are at twice the risk of developing PTSD compared to men. In one general classification, traumas can be divided into three types [17]: ● Emotional trauma: feelings left by traumatic events (e.g., insecurities that can lead to an all-encompassing sense of hopelessness), ● Complex trauma: a series of traumatic events that can have a lasting impact on life, ● Secondary trauma: refers to situations where a person is a witness to trauma, which can significantly affect emotional health. Traumatic experiences in early childhood are the most important because they are determinative, especially in terms of their frequency and intensity.

Similarly, if the frequency and intensity of trauma are not reduced (analogous to the way computational systems are optimized through information processing capacity), the traumatic algorithm may, over time, become increasingly optimized and capable of assuming control over a person's behaviour. Even if an individual responds with apparent awareness, an individual may become, in psychological terms, compromised-unable to understand or regulate one's behaviour by one's conscious will (retroactively, through the consequences of one's deeds). An optimized traumatic algorithm capable of assuming control over a person-beyond their conscious will-refers to the traumatic reprogramming of an individual's character. In comparison with a computer, the traumatic algorithm resembles a computer virus: a malicious program or code that replicates autonomously within other systems, causing damage or disrupting normal functioning. The traumatic algorithm acts as a "virus" that independently replicates within the framework of a person's emotional–motivational, social, moral, and conative traits or capacities, reprogramming their behaviour, thought processes, and emotional regulation. An individual in whom this algorithm has become optimized may subsequently transmit the trauma reactively to others [18].

Figure 2: Miroslav Kuka, ABYSS c. 2005. Private collection - Belgrade / Serbia [25]

The most common forms of PTSD (anxiety, depression, attention disorder, bipolar disorder…) which may have other causes as well, do not deprive a person of the ability to function normally in the so-called "good period," i.e. to go to school, go to work, have friends, interests, conduct normal conversations… but only until the moment when the "good period" is suppressed by the "bad period," when, in the largest number of cases, social dysfunction occurs.

Anxiety is considered a psychological (mental) disorder, but only if it is pronounced, long-lasting and interferes with everyday functioning. Normal anxiety is a natural psychological reaction to stress, danger or uncertainty (an exam, a job interview, a health fear). Symptoms vary from physical (increased heart rate, trembling, sweating, nausea) to psychological (excessive worry, irritability, problems with concentration), and they can also manifest as panic attacks, phobias or generalized anxiety disorders [19].

Depression is a psychological (mental) disorder which manifests through long-lasting sadness, loss of interest in an activity that previously existed, a drop in energy, problems with sleep, appetite, difficulties in thinking, a feeling of hopelessness, worthlessness and guilt, which disrupts everyday functioning and can lead to serious consequences, including suicidal thoughts [20].

ADHD (attention deficit hyperactivity disorder) is a neurodevelopmental disorder characterized by an attention disorder [21], hyperactivity and impulsivity, which affect everyday functioning. Symptoms of ADHD can last from childhood to adulthood, often causing difficulties in organization, focusing, self-control, but potentially can also lead to pronounced functioning through hyperfocus on interesting contents [22].

Bipolar disorder is a psychological (mental) mood disorder (of complex causes: biological, genetic, social), characterized by extreme changes in mood, energy and activity (euphoria, excessive energy, impulsivity) and depression (sadness, lack of will, fatigue), which can manifest separatly or mixed, significantly interfering with everyday life, relationships and functioning [23].

Discussion

In our research to date, we have examined hereditary and developmental interrelations among psycho-physical, cognitive, conative, and emotional capacities in humans, in relation to the attainability of value-based goals in contemporary society. The selection of this research problem was influenced by a range of factors that required harmonization. These factors do not occur in isolation but rather in mutual interaction, with practical needs representing the most significant factor within which the others operate. The identification of practical needs is determined by a subjective criterion, reflecting our personal judgment, and an objective criterion concerning the actual needs of practice. The more objective criterion involves the selection of the research problem based on neuropsychological literature, which, through its content, presents current and relevant issues. After determining the research problem, we proceeded to its specification, that is, to defining the subject of the research. The precise determination of the subject of research (phenomena, models, systems, concepts, factors), that is, its formulation, constituted our primary research task.

The subject of our research is the systematization of triggers (social "triggers"), manifest symptoms, and social mimicries (adaptive strategies) which, in individuals with mental disorders who function in everyday life, initiate the transition (identified through manifest symptoms) from the so-called "good period" to the "bad period," during which, in the majority of cases, they become more or less socially dysfunctional. The subjective criterion for the selection of this research is derived from our decades-long experience of

collaboration with a large number of individuals within our professional engagements (organizers and leaders of numerous international projects involving several hundred collaborators, owners of several private companies with a larger number of employees, and decades-long leadership positions at higher-education institutions and universities).

Based on our direct and comparative examinations, observations, and perceptions, we focused on individuals who, in certain social interactions, exhibit a clear transition from psychological difficulties to mental disorders, the causality of which we infer from the consequences produced for themselves, other people, and the broader environment. Our research did not involve a specifically delineated sample defined by age, sex, or social or socioeconomic status… that would be subjected to a pre-designed experimental protocol; rather, the research was conducted within the so-called general social population, over decades of descriptively recording and systematizing impressions and manifest phenomena into related categories.

Individuals with mental disorders who function normally are not daily exposed to impressions that serve as "triggers" for their social dysfunction - impressions that "mentally healthy individuals" readily buffer. For example, remarks made by collaborators, regardless of position (colleague, supervisor…), such as "I disagree with your position; I believe it is incorrect because…" or "due to certain omissions you have made, we are constrained by time, so by the end of the week you should complete the analyses that were submitted," may be sufficient "triggers" for individuals with mental disorders to enter a so-called "bad period," through a self-representation of a supposedly undermined identity, during which, in the majority of cases, they become socially dysfunctional. How is this possible?

Figure 3: Miroslav Kuka, SCREAM c. 2007. Private collection - Nancy / France

Mental disorders are health conditions described through a causal relationship between human neuropsychology and social interactions; they are predominantly externally invisible, do not affect all aspects of life, occur in waves (better and worse periods), and individuals can function despite the internal struggles that mental disorders initiate. As long as external influences (any social interaction) do not begin to undermine the egocentric-egoistic integrity of individuals with mental disorders, they control their behavior in public, concealing symptoms (e.g., aggression, sadness, fear, confusion), that is, they behave in the manner that is "expected." This adaptive strategy in individuals with mental disorders is most often accompanied by chronic exhaustion or symptom exacerbation due to loneliness. In psychology, the concept of adaptive strategy or mimicry is used to denote behavior that serves a similar purpose; for example, social mimicry involves the imitation of certain behavioral patterns prescribed by social conventions for specific situations. Multiple theories address this phenomenon; for instance, behavioral mimicry, in a broader context, represents a form of interpersonal coordination, encompassing verbal, facial, and emotional behaviors with corresponding emotional and psychological convergence [24]. Studies in social psychology define human mimicry as the unconscious or automatic imitation of gestures, behaviors, facial expressions, speech, and movements (e.g., during conversation, two individuals may be unaware that they have adopted the same posture and display identical forms of nonverbal communication: facial expressions, gestures). However, our focus was on conscious mimicry, employed by individuals with mental disorders in order to behave as "expected" for as long a period as possible.

Results

Based on our research, in the majority of cases we observed that individuals with mental disorders are: ● aware of their conditions and manifest symptoms, ● often highly intelligent and reflective (frequently examining their own thoughts, less often their attitudes, with the aim of understanding), ● They are exceptionally sensitive (emotionally sensitive), capable of assessing and anticipating forthcoming circumstances in order to develop timely strategies of adaptation (acceptable social mimicry).

In order to flexibly present external adaptation, individuals with mental disorders resort to: ● strictly established routines in social interactions, ● anticipation and prediction of future events so as not to be caught unprepared, ● due to awareness of their condition, they often deliberately avoid social triggers that could initiate the manifestation of symptoms of mental disorders, ● frequent use self-regulation techniques (proper breathing, music, intensive movement). This external functionality results in "internal" struggles, such as: ● chronic fatigue without concrete work activities that would account for it, ● frequent withdrawal and establishment of social distance when there is no obligation for social engagement, ● persistent fear of making mistakes and a tendency towards constant perfectionism, ● frequent insomnia, apathy, lack of motivation and loss of appetite, ● forced humour that conceals responsibility and seriousness, ● self-encouragement through slogans such as "I'm fine, nothing is wrong with me", "I'm just a little tired, it will get better"…

Social dysfunctionality in persons with mental disorders is reflected in frequent and intense conflict situations: ● internal (intrapersonal) and interpersonal conflicts, ● conflicts of values (persistently divergent attitudes and beliefs), ● emotional conflicts (intense feelings of love, anger, jealousy, etc.), ● conflicts of interest (constantly opposing life, professional and other goals), ● role conflicts (clashes between roles, such as being a good marital partner, parent, colleague or friend while simultaneously adhering to the rules associated with each role), ● communication conflicts (misunderstandings arising from misinterpreted words or tone of speech). These conflict situations are, to a large extent, influenced by an egoistic-egocentric personality type, complexes of superiority, and PTSD-related conditions (anxiety, depression, attention disorder, bipolar disorder…) in persons with mental disorders.

In collaboration with these individuals, it is important: ● to ensure presence and patience, ● empathy, ● listening without interruption, ● encouragement in the form of understanding and validation such as "I see that you are struggling and that it is not easy for you" and "I am here if you need anything", ● normalisation or revision of attitudes towards mental health, and a normal relationship, without treating the person as if they are ill.

Conclusion

Growing up and expressing ourselves in a broader social environment, we "seek" for social values that are aligned with our affinities, while their realization is determined by our inherited and essentially unchanged capacities. We express ourselves psycho-physically and emotionally through processes: 1. cultivation - i.e. developing fundamental human abilities such as: learning languages and communication methods, taking an experience from a given culture and training for an independence, 2. socialization - i.e. the process by which the child is introduced into the rules of social life, but at the same time creating his or her own standards and criteria of behavior, 3. individualization - i.e. the process by which one develops an internal system of motivation in accordance with one's own personality characteristics. However, considering the generational exposure of man to permanent social changes, those changes also initiated changes in a contemporary man: ● change of previous perception to social reality, ● change of previous adaptation to permanent social changes, ● change of subjective and expressive manifestations according to performed adaptations, etc. [25].

Social reality increasingly and more directly initiates individual medical conditions that may have a range of neurocognitive, psychosocial and functional implications, such as: ● ability to recognise and express one's own emotions, as well as empathy towards others, ●functioning within social roles and the ability to cope with adverse events, ● harmonious relationship between body and mind, which represents an essential component of mental health and contributes, to varying degrees, to internal balance.

Mental disorders represent a dynamic process of

continuous re-establishment of disturbed internal balance, enabling individuals to use their capacities in alignment with social values. In this paper, we have systematised triggering factors (social "triggers"), manifested symptoms and social mimicry (adaptive strategies) which, in individuals with mental disorders who are functionally active in everyday life, condition the transition from a so-called "good period" into a "bad period", when, in the majority of cases, they become socially dysfunctional. The imperative of social functionality for as many individuals as possible refers to empowering vulnerable persons to perform their roles and tasks effectively and without obstruction, and to contribute to the healthy functioning of the wider community, which includes effective communication, mutual support and fulfilment of social expectations within the family, the workplace or the broader social environment.

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