Paradigm of mental health

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“ Mental health disorders are amongst the leading causes of ill health and disability worldwide” (Prentice & Beusenberg 2001). A paradigm is an unanimously recognized scientific accomplishment that provides a conceptual framework for seeing and making sense of the social world (Kuhn, Thomas S., 1970) For the researcher it is important to recognise their paradigm, it allows them to identify their role in the research process, determine the course of any research project and distinguish other perspectives. There are many approaches to the development and treatment of mental health disorders. Clinicians and researchers use ‘ biological’ psychiatry which describes mental disorders as dysfunction of the brain physiology, learning behavioural and cognitive (CBT) scientist regard the learner as an active interpreter of the situation, Cognitive Behavioural Therapy (CBT) used for changing a pattern of thought that causes a disturbed emotional behaviour, developed by Aron Beck (1976) and the psychoanalytic approach, developed by Sigmund Freud which was based on the assumption that psychopathology resulted from unconscious conflicts in the individual, it is often known as the ‘ talking cure’. However some social circles consider this therapy as outdated. Contrary, a very popular and widely used approach is the bio psychosocial which is evidently supported towards the development and treatment of mental health disorders. It highlights the unique interaction of biology, psychology and social factors to better understand the development and treatment of mental heath disorders. All three factors contribute towards the likeliness of mental health disorders. Currently the overarching paradigm for mental health problems is the Medical Model and thus this paper will focus on the Medical Model and

Bio psychosocial model for development and treatment of mental health disorders.

Genetic paradigm is a scientific process with illness understood in terms of causation and remediation in contrast to holistic and social models (Shah, 2001). Recent research has shown that it is a combination of both nature and nurture that is responsible for human behaviour. Throughout life it is the environment that shapes how the genes are expressed, hence our genes also shape our environment. Psychopathology is proven to be polygenic during development and is the essence of genetic vulnerability (Kring, M. A, Davison, G. C, Neale, J. M & Johnson, S. L, 2007). Adoption studies have been carried out to research on the gene-environmental interaction. Recent longitudinal studies have looked at depression on a large sample of children in New Zealand. From 5 years to mid 20's. Early childhood maltreatment was assessed with depression in adulthood. The research concluded that having a gene is not enough to predict early depression nor is early life stress but both work together. (Caspi, A., Sugden, K., Moffitt, T. E., Taylor, A., Craig, I. W., Harrington, H, 2003) The basic idea is that genes do their work via the environment. These recent research have made it clear that it is not just gene association.

The neuroscience paradigm also part of the medical model states that mental disorders are linked to aberrant processes in the brain (Kring, M. A, et al. 2007). Recent research focuses largely on the possibility that neurotransmitter receptors are at fault in some psychopathology. Therefore the implication for this paradigm is that treatment of mental disorders should be through brain alteration. However neurobiological interventions have not

been derived from what causes a given disorder. Use of psycho active drugs increases hugely during 1988-2000, anti depressant drugs tripled (National Centre for Health Statistic, 2004)

Although early theories of eating disorders focused on aversive family and socio-economical factors as fundamental to the development of these problems however a progression of family, twin and molecular genetic studies by Bulik, C. M (2005) has demonstrated a significant role of genetic factors in the development of anorexia nervosa, bulimia nervosa and related traits. This is predominantly relevant today as clinicians are reporting a greater number of patients presenting this problem. An absolute understanding of the causes of eating disorders must take in to account how sensitive he or she is to the effects of the environment. Genetic studies enhance understanding of risk and protective environmental factors.

Over the past 3 years this development in neuroscience has been viewed in a positive light since it has made great progress in elucidating brain behaviour and the research is rapidly proceeding on both cause and treatment. However this paradigm of mental health disorders has said to be reductionist. (Kring, M. A, et al. 2007) The reductionist view on psychopathology is that it will ultimately be nothing but biology. Another criticism for the medical model is that other complex behaviour such as hallucinating involves brain and nerve impulses, it is not likely that the knowledge for disorder can be captured by knowing nerve impulses. In the field of psychopathology, problems such as delusional belief, dysfunctional attitudes, and catastrophising cognition may well be impossible to explain

neuro biologically, even with detailed understanding of individual neurons (Turkheimer, E., 1998).

Cowen & Kilmer (2002) criticised the medical model insufficient as a comprehensive societal model. It is limited in its reach and applicability to diverse groups in need. The dominant paradigm of mental health disorders, biological psychiatry, describes mental disorders as dysfunction of the brain physiology. If a biological treatment works it does not prove that the etiology is biological, conversely psychological treatment does not disprove a biological etiology (Oslen D. P, 2000). For example a Benzodiazepine will lessen the symptoms of grief, but no one would say grief is caused by a chemical imbalance. Policy should be grounded in the higher purpose of caring for others. In 1999, Stoil J. M stated in the Washington Insight that very little federal money was given towards investigation specific behavioural therapies and that ‘ reimbursement policies favour medication over talking therapies’, due to this model offering a quick reduction of symptoms. However, Shah, Mountain, (2007) claimed that the benefit of the medical model is that it justifies expanding non pharmalogical as well as drug treatment. Since treatment in medical model primarily is medication; efficient for various disorders however this does not necessarily treat the cause of the problem. Although brain plays a huge role in our understanding of the cause of psychopathology, one must be careful to avoid reductionism.

A more comprehensive approach for the development and treatment of mental health disorders is the bio psychosocial model, which emphasizes the unique interaction of biology, psychology and social factors to better understand the development and treatment of mental heath disorders.

These risk factors have been placed into a simple bio-psychological model known as the Diathesis-stress model. It does not accept that mental health problems can be the result of stress or negative events alone without there being a biological predisposition to respond to stress in a way that leads to mental health problems. Hence the Diathesis model accepts the medicalization for mental health disorders (Bennett, P, 2005), and despite this it remains the pre-eminent overarching model of development of mental health disorders. The BPS perspective has paralleled the evolution of scientific thought in medicine, the dominating perspective that mind and body function separately and independently changed recently and affected the understanding of the relationship between mental health and pain (Gatchel, R. J., 2004). A range of psychological and socio-economic factors can interact with physical pathology to modulate a patient's report of symptoms. Gatchel, R. J., 2004 states the interrelationships among biological changes, psychological status and socio-cultural context need to be considered…any model or treatment approach that focuses on only one of these core sets of factors will be incomplete. Ray, Q. (2004) provided an excellent overview of mind body relationships and how social and behavioural factors can act on the brain to influence health, illness and even death. The treatment effectiveness approach to pain has consistently demonstrated the heuristic value of the BPS model.

There has been a major paradigm shift from the outdated biomedical reductionism approach to a more heuristic and comprehensive BPS model which emphasizes the unique interaction amongst biology, psychology and social factors which need to be taken in to account to better understand the

development and treatment of mental health disorders. Another reason for the heightened acceptance of the BPS model is the major increase in the country in chronic medical illness (Gatchel, R. J., 2004), since chronical illnesses are mostly accompanied by co morbid mental illness problems.

Mauksch, L. (2005) stated in his article that Herman (1989) identified 3 essential barriers to the practise of BPS care: 1. applied BPS science is not easily taught 2. It is hard to apply selectively under conditions of stress 3. It lacks nosological glossary that can help the ordinary doctor feel comfortable with it. However in defence of these claims Mauksch (2005) claimed that recent medical school research showed that majority of graduates were never observed by an attending physician; however the University of Washington recently instituted direct observation to enhance student's opportunity to learn the BPS skills embodied in patient-centred care model. Secondly all conditions are harder to apply under stress and a newer health care model emphasizes sharing responsibility with patients, families, communities and colleges. We are not in the same place as we were decades ago due to system designs and enhanced provider skills training. Thirdly research has elucidated BPS models for IBS and heart diseases. Being a BPS practitioner implies possession of a defined classification of attitudes and skills that can be measured with established competency criteria.

The biopsychosocial model insists the patient too has knowledge, wisdom and responsibility, and hence rights and power, which can be shared with or withheld from the physician, as the patient chooses. The biomedical model leaves the physician in full control in the clinical situation (Antonovsky, A 1989) However patients in the 1980's had become more socialised in to

acceptance of the legitimacy of such a concentration of power in the doctors hand. However this has changed in the recent years. In defence of the medical model Shah, Mountain (2007) stated the medical model is not just about doctor power; medicine has always been about helping patients with ‘ taking care’ of their recovery. However the question in time is, how much ‘ taking care’ is one in control of? As the effects of drugs is what is controlling and taking care of the patient. Above all, a health care system which is conceptually based on the biopsychosocial paradigm in its fullest and most radical sense inevitably involves partnership with the patient and with non-medical practitioners and scientist.

On the contrary, psychological problems can bring out physiological changes and these can be bought on by environmental and socio-economic factors. The medical model also implies drug treatment to bring the body back to normal functioning. However this will not be effective without tackling the underlying problem. A number of factors cut across the paradigms, such as socio-cultural factors, Gender culture, ethnicity and social relationships also bear importantly on the description causes and treatment of different disorders. By contrast the socio-cultural approach to the development and treatment of mental illness assumes that external, social factors contribute to their development. This can range from families to wider socio-economic factors. Some were identified in the British Psychiatric Morbidity Survey (Jenkins, R. et al 1998) which revealed increased rated of depression or anxiety in women, those living in urban settings, unemployed people, and those who are separated, divorced or widowed. Social drift, social stress and lack of recourse model assume those who have lower socio- economic

conditions have fewer resources to help them cope. Poor mental health is perceived to be a direct consequence of a lack of resources (Kring, M. A, et al. 2007). All these factors themselves can cause psychological problems and hence can bring out physiological changes. Although Psychoanalysis and cognitive traditionally focus more on the individual rather than how the individual interacts with the world, this is now changing, for example, CBT is developed for people from different cultures and ethnicity.

A bps model is proposed that provides a blueprint for research, a framework for teaching, and a design for action in the real world of health care. Experimental studies in animal sample document the role of early, previous and current life experiences in altering susceptibility to a wide range of disease even in the presence of genetic predisposition (Engel, 1992). The FSGI family system genetic illness model addresses the psychological challenges of genetic conditions for patients and families and helps provide a biopsychosocial framework for clinical practise and research. Family knowledge of risk with some illnesses can lead to risk reduction or prevention (Rolland, J. S., 2006). The boundaries between health and disease are not yet apparent and are diffuses by cultural, social, and psychological considerations. The psychodynamic approach of Sigmund Freud and the research to life stress approach by Adolf Meyers and psychobiology has been seen to provide frames of reference whereby psychological processes could be included in a concept of disease. Psychosomatic medicine has become a medium whereby the gap between the independent ideology of medicine, the biological and psychological was to be bridged.

In conclusion, the medical model is essential for the organic disease for which a scientific approach applies. It gives an understanding and relieves of some symptoms of functional and psychiatric disorders, however is strictly a biomedical approach and leaves no room within its framework for social, psychological and behavioural dimensions of illness. Recent research has proven that a BPS model delivers a better service to patients to support them to cope with their mental disorders, rather than just relying on medication on its own.

Although the medical model view can be taken for disorders yet psychological interventions can be recommended, as psychological treatment may work synergistically with drugs. No one approach can entirely explain the development of any disorder, most result from a combination of factors. Furthermore psychiatry's best asset is being a medical speciality, in which the specialists understand and use holistic bio psychosocial approach. An important issue for future clinical researchers would be whether there are other types of biopsychosocial profiles that are more or less responsive to different treatment modalities. Cross cultural issues are paramount, what works in United States doesn't necessarily work in cultures with different cultural history