Guiding Paradigms in Mental Health:
Examining the assumptions, implications & empirical evidence

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"The problem is never that we know too little, but rather that we know so much that just ain't so! Mark Twain

Guiding narratives as to the nature of mental health difficulties convey specific perspectives and beliefs which influence how people understand mental health difficulties and their expectations prevention and treatment. Additionally, they have a significant impact on guiding public policy and the status of mental health professionals.

Historically, there has been considerable diversity in the narratives on mental health both across cultures and across time. Differing religious and social beliefs, social customs, and scientific findings have all contributed to forming these guiding narratives. As Bankart (2009) has noted in his book on the history of western and eastern psychotherapies, the assumptions, goals and methods of every form of counselling or psychotherapy ultimately reflect the hopes and beliefs of the times in which they are derived. Counselling theory and practice inevitably reflects the historical, political, economic and cultural forces which shape our view of human behavior and mental health.

Accordingly, it seems imperative that counsellors continually reflect upon, examine, and question their own guiding assumptions and practices. What historical, political, economic and cultural forces currently impact our counselling assumptions and practices? How do these assumptions impact our clients? And, perhaps even more importantly, what empirical evidence exists to support or question these very assumptions?

Today, two narratives are predominant in our understanding and treatment of behavioral and emotional adjustment difficulties. These are the **a)** biomedical narrative as put forward by the psychiatric field's Diagnostic & Statistical Manual (DSM) and **b)** the psychosocial-developmental narrative guiding most counselling theories and practices. In this issue of the IAC newsletter, we'll focus solely on the historical, political, economic, cultural forces and empirical evidence at the foundation of the biomedical narrative. In the next issue, we'll turn to examining the same forces and evidence at the foundation of the social-developmental narrative.

The Biomedical Narrative

The biomedical narrative, as put forward by the psychiatry field, is based in the 19th C writings of Emil Kraepelin who suggested all psychological problems are "*diseases of the brain".* Neurological dysfunction is considered to be the etiology of mental, emotional and behavioral problems. To the general public this would appear to suggest that one "possesses" or "suffers from" some neurological dysfunction, similar to other medical diseases and thus in need of medical intervention. This has led to direct brain-focused treatments such as lobotomy or Electro Convulsive Shock Therapy in decades past and today via chemical methods with pharmaceuticals.

But, where does this narrative place counselling? What role does talk therapy (counselling), a non-medical profession, have in assisting those experiencing neurologically based mental health difficulties? What are the implications for the layperson's understanding of their difficulties, their expectations for treatment and their hope for mental health and wellbeing? How is an individual impacted by being told, often at a very young age, that there is something permanently wrong with their brain?

Examining the Empirical Support

The guiding assumptions of the biomedical narrative become even more disconcerting when one discovers that it has never been based in any sound, widely supported empirical evidence. No etiological 'pathogens' or "chemical imbalances" have ever been found as being the causes of mental health difficulties! As a consequence, no valid, objective diagnostic tests exist for the DSM based disorders!

A "diagnosis" merely provides a label for commonly observed behavioral, cognitive and emotional patterns *or adaptive behaviors coping with the traumatic systems* (i.e. symptoms). In physical medicine, a physician forms a diagnostic "hypothesis" based on the symptoms and then employs objective tests (blood, x-ray, MRI, etc.) to confirm or refute, that hypotheses. Such is not the case in diagnosing mental health disorders. Individuals with similar symptoms are considered as "having" the same problem and thus require the same treatment thereby ignoring the role of personal history and social contexts!

The validity of a DSM diagnosis is thus highly questionable. Studies on inter-relater reliability coefficients for DSM-5 diagnoses are overwhelmingly only in the 0.3 to 0.5 range (Kappa Score). A reliability Kappa score of 0.7 or higher is universally considered the minimum standard for reliability. As one learns in any introductory research course, *"without reliability there can be no validity".* Only one DSM-5 diagnosis actually reaches this 0.7 minimum standard, Dementia.

This leads to the logical conclusion that a DSM diagnosis is based largely upon the bias of the examining mental health professional. For example, the interrater reliability score for the DSM-V diagnosis of depression is 0.32. In other words, 7 of 10 professionals would likely have given a different diagnosis and perhaps treatment! But unfortunately, based on that medical professional's opinion, a client then leaves believing they "have" a mental disorder/neurological dysfunction or their child "has" a disordered brain and thus in need of medications to alter their malfunctioning brain. Social environment factors are largely ignored.

Research evidence increasingly questions the efficacy of pharmaceutical based treatments. Numerous researchers have refuted the biomedical narrative's assumptions and pharmaceutical based treatments such as: J. Moncrieff's award winning, "*The Myth of the Chemical Cure: A critique of psychiatric drug treatments*", I. Kirsch's, "*The Emperor's New Drugs: Exploding the antidepressant myth"*, J. Hari's "*Lost Connections: Why you're depressed and how to find hope"*, R. Whitaker's "*Anatomy of an Epidemic: Magic bullets, psychiatric drugs, and the astonishing rise of Mental Illness in America",* or A. Schwarz's *"ADHD Nation: Children, doctors, big pharma and making of an American Epidemic"*.

So how has this narrative become one of the predominate influences in mental health worldwide? Perhaps as noted in the opening two paragraphs of this article, economics and politics play a significant role. Annual worldwide sales of $1.25 trillion (USD) in psychotropic medications may have something to do with it. As medication treatments have grown more profitable, diagnostic rates have increased and new "diagnoses" have been advanced. With substantial financial resources made available from the profits, marketing strategies for the biomedical narrative are extensive and daunting. This marketing in turn impacts our collective understanding of mental health difficulties worldwide.

Even Dr. Allen Frances (Chair of the DSM-IV task force) wrote recently of his concerns that the goal seems to be "*No child left undiagnosed*", noting that by age 21, 81% of all youth qualify for at least one

DSM-V mental disorder diagnosis. Thus, being mentally healthy or "normal" is now statistically abnormal! And what are the implications for increasingly administering brain altering medications (e.g., amphetamines, antidepressants, antipsychotics, etc.) to adults, young children and adolescents with such questionable empirical support and often significant side effects? Should this not concern us all?

How should our counselling organizations respond to this issue? To paraphrase Alfred Adler, the *honest counsellors cannot turn their heads to those conditions which adversely affect their clients.* Indeed, the United Nations has already taken the lead in questioning the biomedical narrative in mental health. In its 2017 statement for World Health Day, the UN's official position read , "*the dominant biomedical narrative of depression*" is based on the "*biased and selective use of research outcomes*…[that] *cause more harm than good, undermine the right to health, and must be abandoned"*. A rather strong position statement!

The alternative psychosocial-developmental paradigm

So, let's now examine the historical and cultural forces and the empirical evidence underlying the psychosocial-developmental narrative in counselling. This paradigm, or narrative, emphasizes the promotion of psychosocial wellbeing. Based upon the broader research from anthropology, human development, and cultural psychology, its emphasis is upon psychosocial etiologies for client difficulties rather than neurological.

The psychosocial-developmental narrative focuses upon those factors which lead to wellness, resilience, mental health, and social well-being. The role of positive cognition, social-emotional competencies, and the availability of positive, supportive social environments (e.g. home, school, community, culture, and workplace) in mental health is of primary concern. Mental Health difficulties are thus viewed as consisting of counter-productive, adaptive responses to experiencing social contexts that impede mental health, resilience, and social wellbeing.

The psychosocial-developmental paradigm has long been proposed for understanding mental health and psychosocial wellbeing. In the early years of the 20th century, Frank Parsons, considered the 'father of the guidance movement', suggested that most clients were not 'mentally ill' but rather normal people experiencing adverse life circumstances. This view is central to Alfred Adler's Individual Psychology theory as well. We can even trace many of the ideas of the psychosocial-developmental narrative back to much earlier centuries such as Buddhist writings emphasizing the role of cultural and social contexts that influence how we perceive and live our lives. Ancient Greek philosophers as Plato and Aristotle emphasized the importance of cognition in behavioral and emotional health and their writings are foundational to today's ideas of mindfulness, flourishing and the cognitive therapies. Similarly, the idea that behavioral and emotional symptoms aren't the true "problem" but rather serve to alert us to deeper psychosocial needs and concerns (not neurological "illnesses) needing yet to be addressed can be found in early Native American and 7-10th C. Chinese cultures (Bankart, 2007).

And today, the research evidence of the past several decades has increasingly supported this psychosocial-developmental narrative. For example, the CDC-Kaiser-Permanente study identified a strong link between the presence of Adverse Childhood Experiences (ACEs) and the rates of learning difficulties, mental/emotional/behavioral disorders, and substance abuse/addictions for children, adolescents and adults (Anda & Felliti, 2006; Mate, 2010; Felliti & Anda, 2010). Living in stressful or emotionally toxic social ecosystems (e.g., high stress family, community, or organizational environments) appear to lead, over time to both cognitive and biological responses (e.g. dysregulation of the hypothalamic-Pituitary-Adrenal system and elevated Allostatic Load (stress) scores which lead to both physical and mental health difficulties (McEwen, 2000; Sapolsky, 2004).

For example, children experiencing 4 or more ACE's are 460% more likely to be diagnosed with depression than children with none and those with 6+ ACE's are 4600% more likely to experience drug/alcohol addiction. Research has demonstrated a powerful link between early life stressors and the mental health concerns of both youth and adults including depression, suicide, anxiety, substance abuse, addiction, academic performance, school drop-outs, domestic violence, teen sexual behavior, impaired worker performance. As the number, frequency and toxicity of adverse life experiences increase, so do both mental health and physical health problems.

While this growing body of research is quite compelling, it likely underestimates the impact of adversity on mental health. Recent studies have focused exclusively on just the ten most common childhood stressor experiences. If the myriad of additional Adverse Childhood Experiences as well as adverse Life Experiences were included, we'd likely see this rate increase dramatically! For example, the adverse effects of experiencing chronic discouragement or critical communication patterns or experiencing war, assault, violence or refugee status and poverty are not included in these studies.

The scientific support for the psychosocial-developmental paradigm appears far more compelling than that of biomedical paradigm. Adverse life experiences result in unmet mental health needs such as positive social connections, self-respect, healthy autonomy, a sense of personal competence or agency, meaningful contribution, feeling safe (physical and emotional) and being a valued, worthwhile person.

Instead, adverse experiences most commonly lead to unhealthy psychological responses such as : self-stigmatization (*I'm a flawed, terrible person*), loss of trust (*in self and in others*), self-blame (*it's all my fault*}, and lost hope or optimism (*life will never get better).* Mental health difficulties are thus seen as developmental issues not biological! The resulting behavioral and emotional patterns in turn lead to adverse responses from the significant others in one's life (parents, teachers, coaches, neighbors, etc.) creating a continuous circular causation process

Finally, the psychosocial-developmental paradigm directs our attention to the importance of examining cultural contexts to understand how clients experience life, behave, express feelings such as grief, suffering or depression and what their expectations are for help and "healing". As noted by Ethan Watters (2010), many of the mental "disorders" advocated by the biomedical paradigm are not applicable to, or manifest differently, in other cultures around the world as would be expected from a biomedical etiological perspective.

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The psychosocial-developmental paradigm suggests that counselling interventions should focus on assisting clients to heal from the adverse cognitive and emotional effects of their adverse life experiences and lead them toward developing healthier, more self-affirming, and fulfilling lives and relationships. Moreover, this guiding paradigm calls for counselors to give greater attention to preventive services advocate for healthier, more supportive social environments in the home, school, community and workplace as well as programs for developing positive social-emotional competencies (skills).

Resources

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