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Towards functional-contextualistic understanding of health problems

Funkcjonalno-kontekstualne rozumienie problemów zdrowotnych

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Summary

The article focuses on the role of general practitioners and pediatricians in prevention and treatment of children's mental health problems. The authors emphasize the role of communication between clinicians and parents of child patients. Practitioners' attitude to and understanding of the nature of treated problems is thought to have a significant impact on children, their parents and other caregivers, and can be crucial for treatment outcomes. Nowadays, the most popular understanding of psychiatric and psychological disorders, which is shared by care providers, patients and their families, is the biomedical model. Modern medicine delivers the message that psychological problems are similar to medical illnesses. Physical health is seen as the absence of disease and, similarly, mental health is seen as the absence of abnormal processes. Current approach to mental health may result in stigma, rejection, devaluation and labeling of patients. The purpose of this article is to introduce an alternative, functional-contextualistic approach to mental health, which situates psychological problems within the context of personal history and current life circumstances of an individual. Presented symptoms are seen as behaviors which have developed in the course of life as an apparently unsuccessful way of coping with life problems. The paper presents fundamentals of functional-contextualism and contains a discussion of their implications for understanding of health problems. The article concludes with advice regarding practical applications of functional-contextualistic philosophy of health to the relationship between clinicians and parents.

Key words: functional contextualism, experiential avoidance, clinician-patient communication, child and adolescent mental health, symptoms

Streszczenie

Artykuł poświęcony jest roli lekarza pierwszego kontaktu oraz pediatry w zapobieganiu i leczeniu problemów psychicznych i zaburzeń rozwojowych u dzieci. Autorzy zwracają szczególną uwagę na znaczenie komunikacji między lekarzami i rodzicami pacjenta. Sposób podejścia do zgłaszanego problemu reprezentowany przez lekarza może mieć znaczny wpływ na dziecko, jego rodziców i opiekunów, przyczyniając się do powodzenia lub niepowodzenia leczenia. Obecnie, najbardziej popularnym podejściem do problemów psychiatrycznych i psychologicznych jest model biomedyczny. Tak widzą te problemy zarówno lekarze, jak i pacjenci, ich opiekunowie oraz rodzice. Zawdzięczamy to współczesnej medycynie, która utrzymuje, że problemy psychologiczne i choroby somatyczne mają taką samą naturę. Zdrowie somatyczne to, według tego podejścia, brak choroby. Analogicznie, zdrowie psychiczne to brak niewłaściwych (będących przyczyną choroby) procesów. Takie podejście do zdrowia psychicznego może prowadzić do stygmatyzacji, odrzucenia czy dewaluacji i etykietowania pacjenta. Celem artykułu jest przedstawienie funkcjonalno-kontekstualnego podejścia do zdrowia psychicznego jako alternatywy dla modelu biomedycznego. Podejście funkcjonalno-kontekstualnego umieszcza problemy psychologiczne w kontekście indywidualnej historii życia i aktualnej sytuacji życiowej pacjenta. „Symptomy” widziane są jako rozwinięte na przestrzeni życia zachowania stanowiące – najwyraźniej nieudaną – próbę radzenia sobie z problemami żywymi. Artykuł przedstawia podstawy funkcjonalnego kontekstualizmu i jego implikacje dla zrozumienia problemów psychicznych. Artykuł kończą wskazówki praktyczne dotyczące zastosowania funkcjonalno-kontekstualnego rozumienia zdrowia do relacji między klinicystami i rodzicami.

Słowa kluczowe: funkcjonalny kontekstualizm, unikanie doświadczenia, komunikacja pacjent-lekarz, zdrowie psychiczne dzieci i młodzieży, symptomy

INTRODUCTION

The role of general practitioners (GP) and pediatricians in prevention and treatment of children's mental health problems is crucial. The GP is most frequently the first choice for parents when their child is having a physical or a psychological problem (1). In Poland, where access to psychological care and psychotherapy is limited due to financial restraints, pediatricians have to provide for the psychological needs of patients and their families (2). The effectiveness of treatment relies – among others – on the quality of communication with parents. Pediatricians can model how the child's problem is seen and treated by the parents (3) and thus have a major impact on children's and their families' health and well-being.

Nowadays, the most popular understanding of psychiatric and psychological disorders, which is shared by care providers, patients and their families, is the biomedical model. Modern medicine delivers the message that psychological problems are similar to medical illnesses. Physical health is seen as the absence of disease. Similarly, mental health is seen as the absence of abnormal processes, processed that are caused by assumed bioneurochemical abnormalities. This view leads to syndromal thinking, which means looking for signs and symptoms that should be changed, fixed or treated with medications (4). As a consequence of such thinking, the number of people convinced that drugs should be taken to treat mental health problems is growing (5). Parents often expect that they will get a ready-made solution, or a "magic pill", for their children's psychological or developmental problems (1, 6).

Current approach to mental health may result in stigma, rejection, devaluation and labeling (7-10). Furthermore, the medical model implies that "disability is 'located' within individual children's bodies" (11). The patient becomes an "object" for the treatment, which results in patient passivity. Treatment focused on symptom reduction "downplays functional and positive markers of psychological health" (4). Moreover, impact of such treatments on life quality and social functioning is often questionable (4, 10).

The purpose of this article is to introduce an alternative approach to psychological disorders and to show its implications for practitioners, whose attitude to and understanding of the nature of the treated problems can have significant impact on children, parents and other caregivers. As the authors of the article believe, general practitioners and pediatricians can initiate a major shift in attitude to mental health problems within the public health care system, a shift which may create space for new approaches and better treatment outcomes.

The article presents fundamentals of functional-contextualism and their implications for understand-

ing of health problems. The authors propose practical applications of functional-contextualistic philosophy of health to the relationship between clinicians and parents of child patients. The paper concludes with practical advice to practitioners based on three major aspects of functional-contextualistic approach to health: (a) the role of environmental context in psychopathology and treatment outcomes, with the focus on parental experiential avoidance; (b) functional-contextualistic understanding of disability and impairment; (c) functional-contextualistic understanding of treatment goals.

FUNCTIONAL – CONTEXTUALISTIC APPROACH TO HEALTH

During the last two decades a series of new therapies emerged in the area of psychosocial interventions, and gradually started to gain empirical support and worldwide attention. Although the new approaches differ significantly from each other in many theoretical and practical aspects, interventions such as functional analytic psychotherapy (12), dialectical behavior therapy (13), integrative behavioral couples therapy (14), acceptance and commitment therapy (4) and mindfulness-based cognitive therapy (15) share certain distinctive features that set them apart from other treatments. On the basis of their similarities, the new treatments are collectively called the third wave or the new wave therapies. This means that they might be seen as a second (after the cognitive revolution of the 1960s) major shift within the cognitive-behavioral tradition (16).

The rise of the new therapies originates, among others, from research results showing that many treatments (both pharmacological and psychotherapeutic) designed for highly specified syndromes have much broader effects, and that pathological processes tend to be similarly broad in their prevalence and impact. This proved the need for more general models and a more transdiagnostic approach to psychopathology and created the stage on which the new treatments began to emerge. Their strategies – that balance direct change with acceptance and didactics with experiential learning – did not fit into post-rationalism and constructivism, which form philosophical framework underlying CBT. Thus, functional contextualism was proposed as the explicit or implicit philosophical foundation for the third wave therapies (16).

Functional contextualism* is a modern philosophy of science with its roots in pragmatism. The core unit of analysis in contextualism is the "ongoing act in context" (17). Contextualism focuses on any analyzed event as a whole that cannot be better understood by breaking it into pieces. For example, an organism always interacts with the environment as a whole organism and not as a sum of its parts, like brain, muscles, senses, emotions, thoughts etc. Any of those parts can

*A discussion of different types of contextualism is beyond the scope of the present paper and would not be relevant for the main topic. The authors, however, would like to point out that functional contextualism is not the only form of contextualism and that the term *contextualism* in this article refers to *functional contextualism*.

be analyzed separately, as a “smaller whole”, and can become the subject of interest. However, the results of such analyses cannot be simply summed up in order to understand and explain the way in which the whole organism reacts. By that, contextualism rejects any form of reductionism, such as for example biological reductionism that attempts to understand and explain behavior by analyzing bio-chemical processes in organisms. The core unit of analysis in contextualism is a whole. The parts can be derived from the whole, but the whole cannot be derived from the parts. This principle applies to any psychological event and any behavior. It is the whole organism that responds to its environment, while thoughts, emotions or physical reactions are just different modalities of that response. According to this principle, any behavior can be meaningfully analyzed only together with its antecedent and its consequence that establish the function of behavior.

According to another important principle of contextualism, behavior can only be understood in the context in which it occurs. By “context” we mean both actual, i.e. situational context, and historical context that includes learning history. Behavior viewed in isolation from its contexts loses its meaning. Thus, any analysis of a problematic behavior should include analysis of contexts in which the behavior occurs. Only in that way problematic behaviors can be fully understood, their functions identified and solution to problems found.

Contextualists oppose meaningless comparing of a patient’s behaviors (called symptoms) separated from their contexts with likewise separated behaviors of other people. Such “classifications” of behaviors or matching them to “criteria” bring no understanding of the nature of presented problems and thus cannot lead to solutions. Stated in a different way, contextual variables are seen as an integral part of the clinical problem and should be treated as the problem itself.

Clinical implications of contextualistic philosophy were appealingly reviewed by Perez Alvarez (18). They can be summed up and commented upon in the following major points:

- 1) Psychological disorders should be seen in the context of personal circumstances (both historical and present) and not as an internal biological or psychological malfunction. In other words, problems are not caused by “failure” within a patient but by “failure” within circumstances.
- 2) “Symptoms” are not emanations of underlying causes, but would be seen as (often dramatic) actions that develop in the course of life. Symptoms, like all behaviors, result from the patient’s learning history and have been shaped by circumstances.
- 3) “Symptoms”, like all behaviors, have their functions understood only in the context in which they occur. The function of a symptom cannot be discovered by analyzing the symptom itself, but only by analyzing it within its historical and situational context.
- 4) “Symptoms” are to be seen as failed attempts to solve life problems. Patients try to live their lives

as well as they can. Problems originate from faulty strategies, not from false intentions.

- 5) Chronification could be seen as an installation of a person in the “symptom” rather than as the “symptom” installed in a person. It is not the patient that persists in her symptomatic behavior, but it is the context that sustains the “symptom”.
- 6) Treatment is a task consisting – above all – in helping patients solve their problems. The therapeutic stance consists neither of attempts to solve problems for clients, nor of regarding clients as “objects of treatment”.

The aim of interventions is “strengthening people”, in contrast to the tendency to convert them into consumers of remedies and treatments that promote helplessness.

In the field of psychosocial interventions, Acceptance and Commitment Therapy (ACT) can be viewed as the most advanced representative of functional-contextualistic approach to health problems (4). ACT originates from an over 70 year old tradition of empirical behavior science initiated by B. F. Skinner. The works that have directly contributed to the development of ACT can be dated at the early 1980s, when American psychologist Steven C. Hayes and his colleagues started to examine possibilities of applying Skinner’s conceptual work on verbal behavior and rule-governed behavior to clinical issues (19). Despite its “young age”, ACT has already gained a strong empirical support and the body of evidence for its effectiveness with wide range of disorders and health problems is rapidly growing (20, 21).

ACT proposes experiential avoidance as a critical mediator in development and maintenance of various forms of psychopathology and psychological vulnerability (22). Experiential avoidance can be defined as attempts to control or alter the form, frequency, or situational sensitivity of internal experiences (i.e. thoughts, feelings, sensations or memories), even when doing so causes harm (23).

Experiential avoidance is thought to be built into human language and to be a basic component of the human condition (23). It is based on natural, non-pathological processes and results from human ability to evaluate, predict and avoid unwanted events. As Relational Frame Theory (24) – on which ACT is based – points out, bidirectional properties of human language make humans respond to symbols (e.g. thoughts) as if they were what they symbolize. Verbally ascribed properties of an event become inseparable from the event itself (someone’s “hearth is broken” in the same sense as “grass is green”). A situation that is verbally “a danger” elicits the same emotional and physiological response as if life was physically threatened. Relating an unwanted physical event to an internal experience (e.g. danger to fear), humans tend to treat the latter as if it were the former. Then they try to change the related private experience (i.e. thoughts, feelings, bodily sensations) utilizing the same controlling strategies as if it were an external problem. But while strategies for

avoiding unwanted physical events usually work, strategies for avoiding one's own experience bring paradoxical effects by increasing the importance, intensity and frequency of what has been avoided (4, 25), additionally causing behavioral damage in one's life. As research has shown, experiential avoidance leads to a sense of being inauthentic or disconnected from oneself (26) and interferes with the pleasures of being fully immersed in any activity, which results in less frequent positive events and dampened positive emotions (27).

The role of experiential avoidance in parenting was investigated in several studies. Parental experiential avoidance has been linked with poor monitoring, low parental involvement and inconsistent discipline among parents of adolescents (28), and with stress and adjustment difficulties in mothers of preterm infants (29). Studies suggest that experiential avoidance may be transmitted from the parent to the child through modeling, which provides a potential path for the spread of psychopathology (30). Parents' acceptance of own emotions is important because it leads to their acceptance of the child's emotions. On the other hand, parents' desire to attain relief from their own feelings that have been caused by their child's negative emotions results in attempts to terminate the unwanted emotional reactions in the child. Parents' acceptance or rejection of the child's emotional reactions may model the child's attitude toward those emotions.

IMPLICATIONS FOR PRACTITIONERS

The authors of this paper are convinced that medical practitioners have a key role to play in modeling parents' attitudes toward children's problems and that those attitudes will in turn impact the way children perceive their own problems. The possibility of a direct influence on parents has been shown to be of importance among others in the light of a recent 6-year longitudinal study that has proved strong relationship between parenting style and experiential avoidance in children (31). Results of the study confirm the critical role of social and verbal context in which the child is raised for the child's future psychological wellbeing.

The authors are fully aware that in everyday clinical reality general practitioners can only spend very short time with one patient (often not more than 10 minutes). But even in so limited time one can consciously choose a strategy for communication with patients and their parents. We suggest that a strategy based on functional-contextualistic approach to health, which promotes more flexible attitude towards health problems, is an option worth considering.

Firstly, the practitioner is advised to look at complaints brought by the patient from a broader perspective, as the presented problems are always only a part of a whole organism living within a certain context. Psychological problems should be seen, understood and treated only in relation to the patient's biological condition, and – likewise – biological problems should not be separated from related psychological processes.

The border between those two domains has merely an arbitrary character.

Moreover, the patient lives in a certain social and cultural context. The patient's problems, as well as the treatment itself may have a huge impact on other people's lives (e.g. family members) and other people's behavior can – in turn – facilitate treatment or sustain pathology. In this sense, the patient's problems always lie to some extent outside of the patient herself. This applies to psychological and somatic conditions alike.

One could list numerous examples of how the social and the family contexts impact the patient and the treatment. The authors believe that every practitioner could give examples from her own experience in order to illustrate that. A typical situation one may encounter while working with children is that of self-blaming parents ("What have we done wrong?", "What have we neglected?", "It's our fault"). Self-blaming often sets on a sequence of "compensation" behaviors ("I will make it up to you") which should be seen as a form of experiential avoidance (i.e. a way to escape unpleasant feelings and thoughts). The consequences of such a parental avoidant strategy of coping with guilt can be disastrous for the child. Parents may for example try to "protect" their children from normal and healthy environmental (mostly social) requirements, inhibiting in this way social learning and disrupting shaping of the child's behavior. In the extreme situation, parents can "ally" with their child in boycotting treatment regime. Such an overprotective attitude can in long run lead to the child's excessive dependence and inability to tolerate stress.

Whenever parental experiential avoidance shows up as a part of the context in which treatment is provided, the clinician's first step should consist of validating and normalizing of parent's reactions. This rule applies to any form and manifestation of the avoidant behavior on the part of the parents. Unpleasant thoughts (e.g. self-blaming, worrying, comparing with others) as well as uneasy feelings (e.g. shame, anger, despair, sadness, anxiety) should be seen as natural reactions and by-products of evaluative properties of language. Parents have no control over such thoughts and feelings and thus should not blame themselves for having them. They are, however, responsible for how they behave in the face of these internal events. The most fatal mistake they can make is trying to escape from their own experiences as if they were physical threats. Parents can be less prone to such a behavior if the clinician guides them through the process of realizing of short-term and long-term consequences of avoidant behavior. Helping parents to see how a temporary relief from uneasy thoughts and feelings (e.g. self-blame, shame, anger) backfires in a long run can be of particular importance here.

At the next stage the clinician can try to reduce parents' experiential avoidance by encouraging them to stop fighting against unwanted internal experiences (e.g. the feeling of guilt) and to reorient their attention

toward their values. For example, the parents can just be asked what is really important for them in their lives. If “being a good parent” appears as an answer, it can be genuinely paraphrased by the clinician as “doing what is really best for the child”.

Secondly, the practitioner is advised to not treat health problems and symptoms as a feature of the patient. The importance of this principle can be easily demonstrated with developmental disorders, when “disability” is often treated by the environment, including parents and clinicians, as an inherent attribute of the child. As a result, the child learns to treat its own limitations as a quality of a person, and this process leads to self-stigmatization. However, any problem, impairment and limitation – no matter how severe – can be viewed as such only in certain contexts and in fact functionally exists only in certain contexts. Sight impairment “exists” only when the child needs to look at something, but not when it has to listen to something. Intellectual disability “exists” only when the child faces intellectual tasks of some difficulty, but does not “exist” when the same child is playing with a dog. Thus, we suggest that clinicians advise the parents that the child’s impairments and limitations are not a quality of a person but a quality of a certain context. Of course, those problems can be viewed as concrete obstacles reducing life quality and – as such – can be targeted by interventions. However, the practitioner’s role in

communication with parents of disabled children can consist of emphasizing the difference between demanding contexts and personal defects. The aim here is to change parents’ attitude toward the child’s difficulties from evaluative to pragmatic.

Thirdly, we would like to advise clinicians against formulating treatment goals as located within the patient and against viewing health problems as “abnormalities” that have to be “fixed up”. The patient’s symptoms or dysfunctional behaviors should not be presented to parents as a problem per se or as a problem on the basis of diagnostic classification. Rather, they should be discussed, analyzed and evaluated as problems in the context of the patient’s desired life outcomes. For example, a patient with eating disorders can easily come to a conclusion that she has to eat more in order to satisfy others (e.g. doctors, parents) and that “something is wrong with her”. From the functional-contextual perspective, the clinician’s role should consist here of modeling an attitude where the patient’s problems are viewed and approached by the surrounding as obstacles in achieving what is important for the patient (e.g. academic performance, social network, intimate relationships). The doctor should avoid talking about what is “normal”, and instead choose to talk about what is “workable” in the context of the patient’s values. In effect, both practitioners and parents would be perceived by the patient as allies in her campaign for the desired life outcomes.

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