CONCEPTUAL BASES OF PSYCHIATRY FOR THE PERSON

Social Perspectives on Psychiatry for the Person

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Introduction

Today, in a social and societal perspective, mental ill health and stress-related *community syndromes* involving disorder and death can be identified and their dysfunctional consequences for societies as well as for the individuals living in and exposed to them become clearly evident.

Thus, a societal syndrome of stress related morbidity and mortality including increasing mortality figures due to suicide, violence and homicide not only leads to socio-economic consequences, but also afflicts the very fabric of a society, its moral and ethical values and its social structure. This was dramatically exemplified in the drop in life expectancy, the premature death and the depopulation phenomena observed in Europe's transitional societies during the nineties.

Here, the challenge is to identify societal settings and individual life courses that support resilience and salutogenesis, but also pathogenic factors as helplessness, loss of existential cohesion, social disruption and violations regarding integrity, autonomy, dignity and identity. Population directed approaches are demanded [1].

A need for innovative strategies

Until now, professional and political strategies in preventing mental ill health and disorders and promoting health and resilience have often aimed at "healthy choices" to be made by individuals, i.e., individual responsibility. A focus often lacks on the responsibility and obligations of societies and their political decision makers - to make political "healthy choices" and to regard the implications of political decisions and policy changes on public mental and physical health at a population level.

It appears that a new paradigm must be introduced, one that underlines a political duty to facilitate individual "healthy choices" through promoting autonomy, meaningfulness, pluralism and social cohesion as well as identity and integrity on a societal level [2].

Today, mental health professionals seem often defensive and appear to have abdicated from political discussion. Consequently, we often find adverse results from ill-informed political action, consisting of stress and mental illness related mortality patterns, involving violence, suicide, risk taking behaviour, addiction, and stress related somatic vascular and endocrine morbidity [3].

Regressive societal phenomena can be found as a consequence of poorly-analysed policies and politically provoked societal stress. Scapegoating, intolerance, lack of pluralism, black and white thinking, simplistic solutions, fundamentalism and regressive totalitarian tendencies can be seen in posttraumatic societies after times of split, internal conflicts and warfare, leading to a breakdown of societal cohesion, violence, and dehumanization.

International migration, mental disorder and psychiatry for the person

The growth of international migration is one of the important aspects of globalization and has a significant social impact in many countries in the world. Over 200 million estimated international migrants exist today and

they comprise 3 % of the global population. In 2007, the global number of refugees was estimated at 11.4 millions. International migration may benefit the migrants as well as the countries that receive them and the countries they have left. However, migration has social and economic costs too, and these may be high. Factors such as language and cultural barriers, social isolation, discrimination, unemployment, and poverty can lead to a sense of frustration and identity confusion with a risk for developing mental illness [4].

The relationship between *migration* and *mental* health has been studied since 1880 [5]. Research shows that migrants and refugees often have a higher incidence of psychiatric disorders. Psychiatrists who regularly deal with migrant or refugee patients, need a holistic approach to their patients' mental disorders. They encounter not only language and culture barriers but also biological (genetic and metabolic), spiritual, and social challenges. Patients often present many disturbances that are psychological or psychiatric but also physical and social. Social stigma related to psychiatric disorders and severe social disapproval often affect many migrant groups and can lead to their marginalization. Refugees can be more difficult to understand because of traumatic experiences they do not want to talk about nor seek professional help for. An integrated diagnostic and treatment framework for understanding the complexities of migration /acculturation is needed. It should encompass biological, psychological, social (including traumatic stress), and spiritual dimensions for better identification of both problems and resources.

Beyond the biopsychosocial model and the initial cultural formulation

Psychiatrists and psychologist dealing with groups with high risk for mental disorders, such as unemployed and minority populations, have been frequently working with the bio-psycho-social paradigm proposed by psychiatrist George L. Engel [6]. This posits that biological, psychological, and social factors play a role in disease development. New concepts including, but not limited to, patient empowerment (for which improved communication, health literacy, patient safety, spiritual and cultural resources are required), enhanced doctor-patient partnerships, strengthened patient organisations and patient education, are being advanced and these demand an updated paradigm and a new working model.

The Cultural Formulation published in DSM-IV has provided an extended theoretical framework and has been a crucial tool for clinical care for over a decade. The Formulation, however, must be developed further by attending to migration and acculturation processes for an early identification of risk situations.

The prevention of mental disorders by reducing risk-factors and identifying protective ones seems more feasible than ever before. Migrants and refugees are exposed to easily identified risk factors, and efforts in this direction may lead to primary and secondary prevention initiatives that will diminish and limit suffering. The innovative concept of psychiatry for the person can here serve as a promising new working model that encourages psychiatrists and other health professionals to adopt a preventive and holistic paradigm for diagnosis and treatment.

Person-centered public mental health in developing countries

For the period 2005-2050, nine countries are expected to account for half of the world's projected population increase. They are India, Pakistan, Nigeria, Democratic Republic of Congo, Bangladesh, Uganda, United States of America, Ethiopia, and China, listed according to the size of their contribution to population growth [7].

All these countries, with the exception of the USA, are developing ones. These economies are grappling with issues of poverty, rapid urbanization, poor infrastructure, and deeply deficient health care services.

India, experiencing rapid urbanization and a burgeoning economy, is heading towards definite industrialization. However, the effects of development are still to percolate to the grassroots level and to those who need it the most [8].

Psychiatry for the person holds a unique perspective for India and similar countries as ancient medicinal practise emphasized treating the person as a whole rather than only as a carrier of illness. Therefore, it can be submitted that some of the principles of person-centered psychiatry and medicine are being already practised through the deeply ingrained Ayurvedic medical system, which promotes a highly personalized approach for the treatment of specific diseases and the enhancement of quality of life [9].

It should be noted, however, that in contrast to the Western world, doctors in India are still placed on a 'higher moral pedestal' and are often expected to make unilateral decisions regarding patients' health rather than consulting them or their family members. On the other hand, "managed care" with its pernicious commercialization of care is still limited to metropolitan areas in developing countries.

The provision of mental health care in developing nations is seriously limited by poor institutional infrastructure, lack of trained mental health professionals, and difficult communication between urban centres and remote areas. On the other hand, positive factors include the availability of community support for patients and for mental health services, increased cohesion in patients' families, and simple ways of life that more easily accommodate patients' rehabilitation and community reintegration. Community tolerance of patients seems to be growing [10].

The National Mental Health Programme launched by the government of India in 1982 envisaged the concept of integrating mental health and primary health for more efficient care. Countries such as Iran, Colombia, Sri Lanka, Bangladesh, Egypt, Nepal, Pakistan, and Indonesia, have also experimented with this integration of care [8]. These efforts may take a long time to show clear results and what is required is a persistent will to evaluate and innovate as needed at clinical and public health levels.

Conclusions

New and improved health strategies and policies are being formulated. The advancement of comprehensive clinical studies, attending to biological, psychological, social, cultural, ecological and spiritual concerns are promising to deal more effectively with ill-health challenges and positive health opportunities. Models of good practice, with a person-centered perspective, are beginning to emerge.

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