



Contextualized understandings of health and illness in psychology: the example of domestic violence.

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Abstract

Psychological approaches usually highlight individual characteristics such as personal strengths and abilities and their biological correlates in brain functions and neurotransmitter levels. This individual-oriented understanding may blur the social constructivist nature of images of health and illness and impact the type of health care service that is delivered. Thresholds for intervention tend to be lowered and this may result in higher levels of medical and/or psychological dependency and risk. This article examines different perspectives on health and applies a contextual and structural approach using the cumulative advantage/disadvantage model (CAD) for a more nuanced understanding. The issue of domestic violence and its impact on women's health serves as an example to illustrate the need for contextualized approaches in order to account for adequate health care treatment.

Understandings of health and illness are closely interrelated with understandings of healing trajectories and with the types of clinical and public health interventions provided. The health system is reliant on the precise description of symptoms and explanations in form of specified physical diseases or mental disorders in order to decide which treatment is adequate.¹ Furthermore, health psychologists assume that individuals' ideas of health and illness exert an influence on their health attitudes and behaviors.² Most psychiatric approaches are based on universal constructs and highlight biological correlates in brain functions and neurotransmitter levels.³ This article argues for a more explicit inclusion of cultural, social, political and economic dimensions of health and illness in order to counterbalance the current biological predominance with

a tendency to de-contextualize. Starting with examining different definitions of health and illness, the need for contextualized understandings is shown using the example of domestic violence.

Contextualizing health and illness

Definitions of health differ depending on the time and its related dominant paradigm as well as on the disciplinary perspective. Seedhouse⁴ distinguishes several clusters of theories of health. One cluster describes health as an ideal state as is the case with the definition of health formulated by the WHO representing a public health perspective: "Health is a state of complete

physical, mental and social well-being and not merely the absence of disease or infirmity".^{5 (p.11)} Another cluster of definitions refer to levels of functioning, to physical and mental fitness to do socialized daily tasks. Medical and psychological approaches usually highlight individual characteristics, which are personal strengths and abilities and their biological correlates in brain functions and neurotransmitter levels.⁶

The WHO definition refers to an idealistic state as the majority of the population mostly is not in a state of complete wellbeing and therefore encourages a medicalization of our society. It goes hand in hand with the tendency of medical technology and drug industries to expand the scope of health care systems. Thresholds for intervention tend to be lowered which may result in higher levels of medical and/or psychological dependency and risk.⁷ For example, women's health has generally been equated with reproductive functions for a long time.⁸ The term of women's health conveyed a legacy of the medical conceptions of women's health that emerged in the second half of the 19th century when ideas about biological determinism and fundamental differences between the sexes were becoming prominent. The international women's health movement of the 1960s and 1970s challenged the medical perspective on women's health and related health care practices. Expanded definitions that focus on health through the life span and in the context of women's multiple roles and diverse social circumstances were produced.⁹

In this article, definitions or understandings of health and illness are considered as social constructs containing culturally-bound values.¹⁰ Seedhouse's¹¹ classification of theories of health contains Western notions emphasizing the individual and neglects other life dimensions. Indigenous perspectives understand health as equilibrium within environment, capability, and as a possibility of living one's own spirituality: "So, being in good health means having a good relationship with the land, having access to good foods, but also having access to traditional culture".^{12 (p.4)}

Health and disorders are not ontological facts but contain moral codes of a current society. Phenomena formerly described as mental disorders like homosexuality today are socially accepted and not regarded as a health problem. Transsexuality, however, is still a diagnostic entity in the International Classification of Diseases, ICD, or the Diagnostic Statistic Manual, DSM. Another example is the pathologising of grief: In

the DSM-IV, a person in grief (i.e. after the loss of a child) could be diagnosed with a major depression after two months, whereas in the DSM-V, this period was shortened to two weeks.¹³ In the view of sociological systems theory, the construction of the semiotic reality is realized by observation: defined as an operation of distinction and designation.¹⁴ In the context of health and illness, it is usually professionals that make a distinction of what is regarded as "normal": "Health, therefore, is a constantly renewed construction, realised by different observers (e.g. individuals or health professionals) and influenced by their cultural context or the time they live in. The observation of health can focus either on the health side or on the health impairment-side of the continuum".^{15 (p.438)}

With a contextualized understanding of health and illness, power differentials within societies can be made visible that account for an unequal distribution of health resources within a society. The access to and the control over health resources affect habitus, life styles as well as health behavior throughout the lifespan. In this article, the following definition of health is used: Health is a product of cultural, social, economic, political and psychological factors, as well as its biological correlates, above all a product of structurally embedded social inequalities that range around dimensions of gender, socioeconomic status, ethnicity etc. (see Schwarz¹⁶ for intersectional approaches within psychology). Therefore, health is not only the fulfillment of societal notions of normality but the ability to self-determined participation in public and private life, the labor market, profit-sharing, and the capacity for well-being, among other things. Health is associated with the opportunity for a well-balanced living within one's social surrounding and a living in line with one's spiritual and worldly beliefs, without having to fear discrimination. Understandings of health are linked with human rights and political as well as socioeconomic dimensions of life (see also the approach critical community psychology formulated by Kagan et al.).¹⁷

In order to embed understandings of health into their structural contexts, life course models are a suitable approach. They focus on the connection between individuals and the historical and socioeconomic context in which these individuals live,¹⁸ in particular one theoretical framework called the cumulative advantage/disadvantage (CAD) model: "much of the interest in CAD derives from a recognition of the power of social processes and forces to regulate and shape not

only individual lives but the distribution of opportunities among individuals”.¹⁹ (p.332) Similar to psychoanalytical approaches, life course models put an emphasis on early experience which differentially marks individuals in ways that shape their understanding of the world, their development of skills, and their opportunities in ways that are seen to shape later life course outcomes. However, instead of only looking at internal psychological variables, the CAD approach assumes processes by which the effects of early economic, educational, and other advantages can accumulate over the lifespan. From a psychological standpoint, the availability of educational, economic and other resources impacts the availability and control over specific coping resources. It leads to a contextualized understanding of coping processes instead of focusing on personal attitudes only such as hardiness, optimism or the person’s belief in his or her self-efficacy. In the psychotherapeutic setting this translates into the reconstruction of the development and maintenance of illness that is not confined to individual factors but rather focuses on structural embeddedness of individuals within their contexts. Furthermore, it calls for policy interventions alongside person-centered counselling. In case of political violence and related traumatization, this contextualized and human rights approach is more acknowledged compared to the general field of mental health. For example, narrative exposure therapy (NET) is a treatment approach that is based on both cognitive behavioral treatment of PTSD and testimony therapy (20). There is evidence that NET is associated with significant reductions in PTSD symptom severity (see Robjant & Fazel²¹, for a review).

The distribution of structurally embedded coping resources parallels with the distribution of stressful or traumatic life events and their impact on health trajectories. Hatch and Dohrenwend²² examine the distribution of such events in general as dependents of demographic variables such as ethnicity, socioeconomic status, gender and age in a review of literature from 1967 to 2005. The study does not exclusively focus on the relationship between psychological and physical disorders and symptoms of traumatic and stressful events. The authors illustrate how a context-oriented understanding of coping resources can be implemented in research. They close their review with the following conclusion: groups with a low socio-economic background, ethnic minorities and young people are increasingly exposed to traumatic and stressful events

with corresponding health trajectories.²³ According to a life course perspective, cumulative inequality interacts with one’s ability to mobilize social, economic, and psychological resources, together with human agency (i.e., the ability to change one’s environment), in shaping the individual’s mode and level of functioning throughout the course of life.²⁴

A contextualized understanding of health, illness and related coping resources may explain why studies of gender and mental health consistently show that women exhibit higher rates of affective disorders like anxiety and depression, while men exhibit higher rates of behavioral disorders like substance abuse and antisocial personality responding to stressful life events.^{25, 26} This does not mean that affective and behavioral disorders are functionally equivalent indicators of misery.²⁷ It rather points to the embeddedness of individuals within their structural and moral contexts. The next section applies a contextualized understanding by examining the distribution of domestic violence within our society and by considering its effects on health trajectories.

Applying contextualized understandings: the example of domestic violence

The term ‘domestic violence’ refers to any violation of the physical or mental integrity of a person by someone who is in a structurally stronger or more powerful position. Most often these acts are committed by men against women and children. Men are also affected, but not to the same extent or in the same way.²⁸ Available studies suggest that the types of violence women and men commit vary. Additionally, health consequences seem to be gendered as well²⁹ and although there is evidence to suggest that male victims also suffer psychological harm through partnership violence, studies find more negative mental health effects for women compared to men.^{30, 31, 32} Research has shown the unequal distribution of domestic violence and its health impacts. Domestic violence is the most common form of violence that women experience and it is further defined as “the range of sexually, psychologically and physically coercive acts used against adult and adolescent women by current or former male intimate partners”.³³ Men are the predominant offenders and women and children the ones affected by violence. The pattern of intimate partnership violence is not random, but research shows a

gender-based social structure for both the committing and the suffering of violence.³⁴

From a life course perspective, violence against girls and women can begin before birth and continue throughout their lives into old age: pre-birth violence entails sex-selective abortions, during infancy it includes female infanticides and neglects, during childhood violence starts from child abuse, to malnutrition up to female genital mutilation. During adolescence, violence encompasses forced prostitution, trafficking, forced early marriage, psychological abuse and rape. In the reproductive age, violent deeds start from honor killings, dowry killings, intimate partner violence, sexual abuse, homicides, sex work, trafficking, and sexual harassment that may continue into higher age.³⁹

The health consequences of partnership violence in general are complex and can be life-threatening. The world report on violence and health organizes the impacts on health into following groups^{40, 41}: Physical, sexual and reproductive, psychological and behavioral as well as fatal health impacts. Psychological and behavioral health impacts consist of alcohol and drug abuse, depression and anxiety, eating and sleep disorders, feelings of shame and guilt, phobias and panic disorder, physical inactivity, poor self-esteem, post-traumatic stress disorder, psychosomatic disorders, smoking, suicidal behavior and self-harm, as well as unsafe sexual behavior. They are all subject to mental health services. The fatal health consequences are AIDS-related mortality, maternal mortality, homicide and suicide.⁴² Data suggests that intimate partner violence during pregnancy is associated with a mother-to-infant bonding failure,⁴³ which in turn affects the mental health trajectory of the child.⁴⁴ Regression modeling indicates that posttraumatic stress in pregnancy, alone, or comorbid with depression is associated with postpartum depression. Postpartum depression alone or comorbid with posttraumatic stress was associated with impaired bonding.⁴⁵ The environment provided by the child's primary caregivers has tremendous impact on all aspects of child's early development as well as his or her later life. A cycle of violence within families has been well documented in the social sciences literature.^{46, 47} A family history of psychiatric disorders is also acknowledged in medical and psychological sciences as a risk factor for psychiatric diagnoses across the lifespan.^{48, 49}

Many affected women downplay or conceal the experience of violence in itself as well as related mental

and physical health consequences when talking to doctors and psychotherapists.⁵⁰ This climate of fear and silence is supported by social taboos: "Relationship violence is not perceived by the social environment. It is rarely questioned or trivialized by doctors and therapists, which leads to an underestimation of the debilitating consequences as well as misdiagnosis and improper treatment".^{51 (p.90)} All in all, this leads to the fact, that in the reality of psychotherapy, professionals hardly screen for domestic violence contexts.

When applying a contextualized understanding, mental disorders can be understood as problem-solving strategies and coping patterns of those who had to find a way of dealing with mostly long-lasting violent excesses of all kinds. A socio-critical attitude, as is the case of feminist movements, reflects the unequal access to and control over financial, political and symbolic resources. A sole focus on the pathology of individuals can contribute to a treatment that promotes normative behavior and leaves unequal power relations unchallenged. Many battered women feel guilty and responsible for the violence they have endured. This is a protective mechanism from the enormous powerlessness and helplessness they experienced. It is a time-consuming task to develop a sound relationship that eventually allows increased questioning of these self-representations, especially when working with complex traumatized women living in vulnerable conditions. Besides an emotional dependency, many battered women are also economically dependent on their partners, in particular those women whose residence status is reliant on the cohabitation with the perpetrator of violence. It is evident that sole psychotherapeutic interventions are not sufficient but that cooperation with other services is a matter of priority. This is consistent with the S3 guidelines which recommend organizing a psychosocial helper system.⁵² Unfortunately this is not encouraged by current financial reward systems in Germany and thus continues to be a matter of personal commitment on part of the psychotherapist.

Philips et al.⁵³ present a trauma-informed approach when working with survivors of domestic and sexual violence that promises to overcome current pitfalls in the health care system. Failure by professionals to apply an analytically orientated gendered analysis to the situations they encounter frequently serves to compound rather than address the violence experienced. How women who experience violence are viewed or constructed by doctors, psychologists, social workers and

other professionals is of crucial significance as the following example illustrates: A patient of a psychiatric clinic was obviously distraught before and after the visits of her partner, she looked very confused and troubled. Psychotherapeutic stabilization methods that were successfully applied in previous sessions were no longer effective. After several weeks, the patient was able to articulate that she wishes no further visits by her partner. She asked the ward staff to support her request. The nurses who had had domestic violence experiences of their own in particular were able to make the rest of the personnel understand and pushed to take the patient's request seriously instead of dismissing it as paranoia. Most of the medical staff members were little motivated to assist the patient with her request as she had had previous inpatient stays and had had several failed attempts to separate from her partner. The increased level of distress after the partner's visits was interpreted as paranoid symptoms.

Concluding remark

When framing women's experiences of partnership violence, the psychiatric and psychological perspective usually considers diagnostic labels. As a consequence, connections between the actions of the abuser and the resulting distress experienced by the affected woman are neglected. The diagnostic label implies that the victim has some pre-existing vulnerability which in turn detracts from acknowledging the traumatic impact of violence and abuse. Therefore this article presented a possibility for a more contextualized approach. Emphasizing the social constructivist nature of diagnostic entities and a life course approach such as the CAD can help balance the predominance of individualistic and biological perspectives. A socio-critical approach emphasizing contexts encourages work with a client's biography, cultural values and moral codes. It takes the social context and unequal power relations as the starting point for a partisan cooperation with the affected persons, which has implications for the understandings of disease and health, as well the therapeutic relationship and the applicable psychotherapeutic techniques. Mental burdens are understood as problem-solving strategies and coping patterns of those who had to find a way of dealing with mostly long-enduring violent excesses of all kinds and lack of other coping resources. The therapeutic task lies

in strengthening flexibility in applied coping strategies in order to avoid repetition of gender stereotypes.⁵⁴

There are manifold publications on biological insights that promise advances in the understanding and treatment of disorders. And although PTSD is still largely regarded as a psychological phenomenon, over the past three decades the growth of the biological PTSD literature has been explosive, and thousands of references now exist.^{55, 56, 57, 58} This article looked from a social standpoint on understandings of health and illness. The life course perspective seems to be a valuable contribution. Research showed that the experience of traumatic events in childhood has consequences for health in adulthood.⁵⁹ It suggests the need for public health expenditures on resources such as counseling and income supports to prevent or reduce psychological harm and chronic illness resulting from traumatic events. Overall, empirical evidence for the theoretical assumption of the CAD is contradictory.⁶⁰ Its usefulness for psychological traditions rather lies in its linked perspective on individual's health with their socioeconomic and political surrounding they live in.

As social beings, we need not only good material and safe conditions but, from early childhood onwards, we need to feel valued and appreciated and we need to develop in a safe environment. We need caring fathers and mothers, we need friends, we need more sociable societies, and we need to feel useful throughout our life span. Depending on our cultural background, this can mean different things to different people. What seems to be clear is that, without these things, we become prone to depression, drug use, anxiety, hostility, and feelings of hopelessness which all rebound on our overall health.⁶¹

Compliance with Ethical Standards

This article does not contain any studies with human participants or animals performed by any of the authors.

Conflicts of interest:

None.

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