A CLOSER EVALUATION OF CURRENT METHODS IN PSYCHIATRIC ASSESSMENTS: A Challenge for the Biopsychosocial Model

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ABSTRACT

The biopsychosocial model, the current method in psychiatric assessments, is reviewed and critiqued. The history and original intents leading to the conception of the biopsychosocial model are briefly discussed. Five inherent problems with the use of the biopsychosocial model in psychiatric assessments and training programs are presented. Two alternative approaches are discussed and promoted for clinical, educational, and research practices in medicine.

INTRODUCTION

Presently, medical schools and psychiatry residency programs use the biopsychosocial model to train and teach medical students and residents. Both the American Psychiatric Association and the American Board for Psychiatry and Neurology endorse this approach.1,2 The genesis of the biopsychosocial model can be credited to George Engel who, in 1977, wrote “The Need for a New Medical Model: A Challenge for Biomedicine.”3 Engel was a revered physician among his colleagues. He was an internist who completed psychoanalytic training at the Chicago Psychoanalytic

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The concept was originally intended to encourage nonpsychiatric physicians to see patients as a whole, a counterpoint to the increasing focus on molecular biology in medical school education. It was to help conceptualize patients not just as organisms with diseases, but as individuals with complex behaviors and emotions that affect their physical ailments.1–3

The biopsychosocial concept became increasingly popular and then the standard for teaching as evidenced by widely used basic textbooks in medical schools, such as Human Behavior and Clinical Psychiatry by Stoudemire.4–6 Unfortunately the biopsychosocial model has been “relegated to political lip service” as stated by Gabbard and Kay in “The Fate of Integrated Treatment: Whatever Happened to the Biopsychosocial Psychiatrist?” published in the American Journal of Psychiatry in 2001.7,8 The problem with reinforcing the stigma associated with mental health. Engel thought that all medical illnesses should be seen in a biopsychosocial concept. He would not have thought that his concept could reinforce the stigma associated with mental health; however, albeit unintentional, the biopsychosocial concept, in hinting that biology is distinct from psychology, indirectly re-enforces the stigma that psychiatric diseases patient suffer from are volitional and not medical issues. This misconception for psychiatric disorders, which have strong evidence for a disease model, meaning a distinct pathophysiology, by no means helps us advocate for our patients and has negative implications in research and clinical practice. Some of these diseases, which have had enough scientific evidence for their known deviations from normal physiology and their pathogenesis, have been salvaged from the erroneous scrutiny and stigma given to psychiatric diseases. Examples are Alzheimer’s, epilepsy,
and schizophrenia (unbelievably, schizophrenia is still debated by some, but thankfully they are a minority now). Other disorders have strong findings and presumptive evidence for a disease with an underlying pathophysiology. It is now widely accepted in the medical and scientific community that affective disorders like bipolar and major depressive disorders fit the disease model due to evidence suggesting heredity and neurophysiologic findings.\textsuperscript{17,18} Muddying the waters further with terms like macrocultural variable\textsuperscript{19} hinders progress in diagnosis, treatment, and research; disease states like schizophrenia and bipolar disorder have remarkably similar core symptoms in any corner of the world, regardless of race, color, or ethnicity.

The problem with implying that poor behavior is a disease and the impact on society at large. By definition, disorders with behavioral problems as the predominant feature do not have strong evidence for an underlying pathophysiology. Problems arise when behavioral disorders are categorized as biological with attempts to treat such conditions solely in a medical model. Just as when one can overlook a disease state (e.g., schizophrenia) and categorize it as a psychosocial phenomenon, one can turn and excuse poor behavior (e.g., antisocial behavior) as a disease with the notion that it can be treated in a medical setting. Examples of these behaviors are theft and violent acts, which are often attributed by the perpetrator to some mood or thought disorder. If such misconduct is attributed to a disease state, this will have significant negative impact on the image of psychiatry and the wellbeing of society in general.

Many examples of predominantly behavioral disorders exist in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV). However, some argue that these disorders are mainly biological problems. For example, they may point to the heritability of alcoholism and claim it as a disease process and attempt to control it by medications alone. Other examples include the hysterical behaviors of those who claim they have been abused and short-changed by society and they are backed by psychiatrists who have assigned them a list of disorders endorsing their victimized state. Later, it is discovered that they have a bad temperament and exaggerated response to any mild notion of threat, and the only ones being abused and short-changed are the rest of us in the community at large. Further examples of such socially constructed disorders, erroneously endorsed by some medical doctors in psychiatry, are multiple personality disorders, dissociative identity disorders, and recovered memory controversies of the early 1990s.\textsuperscript{20}

The problem with the psychosocial paradigm and related terminology. Another problem with the biopsychosocial model is the elusive psychosocial paradigm and related terminology that cause further confusion. The term psychosocial history is used often in communication with residents, students, and nurses. The meaning of this term becomes obscure as it is difficult to make sense of what aspects of a patient’s social history are not part of his or her psychological history. Moreover, categorizing and splitting a patient’s social history further into his or her birthplace (geosocial), religious beliefs (religiosocial or spirituosocial), and financial situation (economicsocial) becomes impractical.

During my tenure at Wilford Hall, I had an excellent nurse practitioner who worked with me on the consultation-liaison service. He was very interested in the cultural aspects of the patients on the service. He was adamant that he was onto something by adding another sphere to the biopsychosocial model circles and calling it the biopsychosociocultural sphere. One of my better and more vocal residents never gave up teasing my nurse practitioner by coming up with more spheres to add to the model. The final rendition was the biopsychosocioculturugeoethnicspiritual model! Ultimately, I believe psychosocial history is really the patient’s background data and his or her life story, perhaps better categorized as simply social history.

The problem with teaching and communicating using a concept that is fundamentally weak. Another problem lies in difficulties in teaching this concept to medical students and residents, despite intensive efforts.\textsuperscript{21-23} Inquisitive students hesitate to grasp the biopsychosocial concept readily, question its fundamentals, and soon realize the flimsiness of the concept. Since this model has become the basic foundation of psychiatry, it can turn eager medical students away from the field of psychiatry from the start.

A related problem is faced by our colleagues in other medical and surgical disciplines.\textsuperscript{24,25} The biopsychosocial model actually antagonized what it was intended to do in the first place by helping physicians focus on patients’ psychosocial backgrounds. What it actually does is discourage them from incorporating their patients’ emotional states as part of their overall assessment due to the confusion that the concept causes for most physicians. They become frustrated, avoidant, and less effective in treating their patients with emotional issues. It may be more effective to simply teach our physician colleagues to make note of their patients’ behavioral and emotional symptoms on the same problem list they are used to creating for their patients’ general medical conditions.

In the past several years, while performing mainly outpatient care and being on the other side of the fence from the inpatient hospital environment, I have observed that the biopsychosocial model affects inpatient psychiatry and consultation-liaison work very badly. The concept
is often used improperly and without much thought. It hampers communication and relationships with our medical colleagues when taking care of mutual patients.

On numerous occasions, I have received discharge summaries regarding the inpatient care of my patients that state “the biopsychosocial milieu was used to treat the patient,” with no additional information. This treatment plan has little sense and less content. It does not offer anything specific or useful for a patient’s care and coordination of it with his or her team of physicians.

**TWO ALTERNATIVE APPROACHES FOR PSYCHIATRIC ASSESSMENTS**

Psychiatric assessments using an already established model in general medicine for “case formulations.” Psychiatry, just like any other medical discipline, uses historical data, medical examination, and a variety of studies to reach an impression, diagnosis, and treatment plan for a patient. Why should this age-old approach to treating ailing patients be any different in the field of psychiatry? Why is there a need for “case formulation” rather than assessment based on data gathered through history of present illness, past illnesses, family and social history, review of systems, physical exam including mental status exam, information from collateral sources, laboratory data, radiological studies, and oftentimes, psychological testing?

A patient’s chief complaint of “depression” can be triggered by the anniversary of a spouse’s death or due to cocaine withdrawal—both causes can be gathered through careful history and exam and neither require antidepressants. But in another patient, the same chief complaint of depression may not be linked to any identifiable triggers or it may present itself with almost universally associated neurovegetative symptoms markedly affecting physical health. At the present, the scientific knowledge of more specific etiologies is lacking in order to use the same approach in general medicine in producing a sound differential diagnosis for the patient’s clinical state of depression; however, with proper direction in psychiatric assessments and further advances in research, one day we will be able to state with more confidence if a patient's depression is due to an autoimmune process versus a viral infection versus a collagen vascular disease.

In this approach, the inclination to treat psychiatry differently from its sister disciplines is questioned. The mind-brain argument becomes arbitrary for the sake of practical approaches to patients, and it may be better suited for philosophical and existential discussions. Perhaps the mind-brain dilemma is not a good reason to complicate psychiatric assessments by implementing convoluted and novel ideas for the sake of “formulating a case.” It is best kept simple and to the standard used in any other discipline in medicine. Although, if a framework is indeed necessary to help habituate future psychiatrists in making coherent assessments of their patients, the perspectives model maybe a better alternative to the biopsychosocial model.

**Psychiatric assessments using the perspectives model.** In 1986, McHugh and Slavney wrote *The Perspectives of Psychiatry,* with a second edition of the book being published in 1998.29 This book proposes a framework to tackle the dilemma, conceivably more unique to psychiatry than other medical disciplines: the mind-brain problem. This dichotomy is ultimately the reason why many refer to psychiatric assessments as “case formulation,” therefore, much debate follows in how we summarize our patients’ histories and exams in order to be directed toward appropriate treatment options.

The perspectives model proposes four areas to be assessed by the psychiatrist. A thorough review of the perspectives model is outside the scope of this article; however, in the following each perspective is briefly explained.

The disease perspective: *what a patient has.* In every patient we evaluate, we are searching for a disease. This should be our first task, to decipher what is the pathology underlying a patient’s ailment. This category includes patients with Alzheimer’s, schizophrenia, and bipolar disorder, i.e., patients who have structural or functional pathologies affecting their brains.29

The dimensional perspective: *what a patient is.* Some patients deviate to some extreme of psychometrically measurable dimensions like temperament and intellect.29 Gathering data about these dimensions through direct questioning, in-depth psychological testing, and information from collateral sources is essential to a comprehensive psychiatric evaluation. It is difficult to categorize a patient’s innately intense affect and introversion in the biopsychosocial model: Are these traits biological because they are innate or psychological because they are features of one’s mental concept?

The behavioral perspective: *what a patient does.* The behavioral perspective looks at the goal-directed, goal-driven features of human life. Some behaviors depend not on a physical drive but on a combination of psychiatric vulnerability and social learning, which then becomes fixed and warped, e.g., alcoholism, drug addiction, hysteria, suicide, sexual...
paraphilia, and eating disorders.

McHugh explains, “What these individuals ‘have’ and what they ‘are’ may enhance their vulnerability to the behavior, either by triggering or sustaining it, but primarily their conditions are tied etiopathically to what they choose, how they responded to that choice, and why, for them, such choices led to a driven habit.”

The life story perspective: what a patient encounters. To understand a person’s life story and the meaning he or she assigns to events in his or her life is essential in psychiatry.29 Sometimes just the act of listening and the intent to understand our patients in and of itself is therapeutic enough to relieve whatever symptoms or grief are ailing them.30

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The following example is to illustrate how the perspectives model is used in a clinical scenario: A 32-year-old man had schizophrenia (disease), was unsociable and frequently aggressive, and psychological testing revealed an IQ of 81 (dimension). He resorted to drinking excessive alcohol and smoking marijuana (behavior). He came from an impoverished background, raised in an urban area with a family in a low economic class, and while growing up he was repeatedly beaten by his abusive father (life story).

In this example, this patient’s schizophrenia and poor coping by using alcohol and marijuana may be the more pressing and urgent issues to treat, but all aspects of the perspective approach are important to note when addressing this patient’s needs.

CONCLUSION

The genesis of the biopsychosocial model was to help us better assess our patients and to remind our colleagues about their patients’ other aspects of life besides their biology. During several decades of popularity, it has morphed into the standard of how psychiatrists assess patients and how they are examined for board certification. This model is used to communicate with our physician colleagues, ancillary staff, and even society at large. Somehow the biopsychosocial approach became hard science with presumed clinical efficacy in patient management. Any deviation from or challenge to it will call for questioning of one’s competence. Confronting the strength of this concept has caused concern and at times outrage, as if it is improper to promote a different way of thinking about our patients. I hope that with this article I have been able to highlight some of the concept’s weaknesses.

The biopsychosocial model, however unintentionally, promotes an artificial distinction between biology and psychology, and this does not help our cause in trying to destigmatize mental health. Let us not make arbitrary distinctions between organic and nonorganic. We are ultimately organic. The perspectives model does not make that arbitrary distinction. We are biological beings—some are afflicted with diseases, born with innate temperament and style along with different intellectual features. We have choices in how we behave and have each faced a unique set of circumstances in life—each with a distinct life story.

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REFERENCES


