

# **The Biopsychosocial Model of Clinical Practice in Functional Gastrointestinal Disorders**

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**THE BIOPSYCHOSOCIAL MODEL OF CLINICAL PRACTICE** was defined by George Engel<sup>1-3</sup> as an alternative to the conventional biomedical model. The differences between the biomedical and the biopsychosocial models rest on the distinction between disease and illness. Disease connotes objectively demonstrable tissue damage and associated organ malfunction. Illness connotes the patient's subjective sense of feeling unwell, suffering, or being disabled.<sup>4</sup>

The biomedical model limits the role of the physician to the diagnosis and treatment of diseases. It fails when applied to patients whose symptoms cannot be reduced to physiochemical terms or "cured" by technologic means.<sup>5</sup> Such patients, however, comprise the majority of those encountered in clinical practice.<sup>6,7</sup> The biopsychosocial model expands the role of the physician to that of coping with illness and searching for conditions that contribute to the patient's suffering. Disease is viewed as only one of several potential components of illness, and the diagnosis and treatment of disease is viewed as one part of the effort to overcome illness and enhance well-being. Healing, which encompasses more than curing disease, is the process of overcoming illness and enhancing wellbeing. The term clinical process theory is intended to encompass the principles and definitions by which clinicians make the distinctions between what is therapeutic, nontherapeutic, and counter-therapeutic in managing illness.

The biopsychosocial model is particularly useful in functional gastrointestinal disorders because — unlike giardiasis, for example — functional

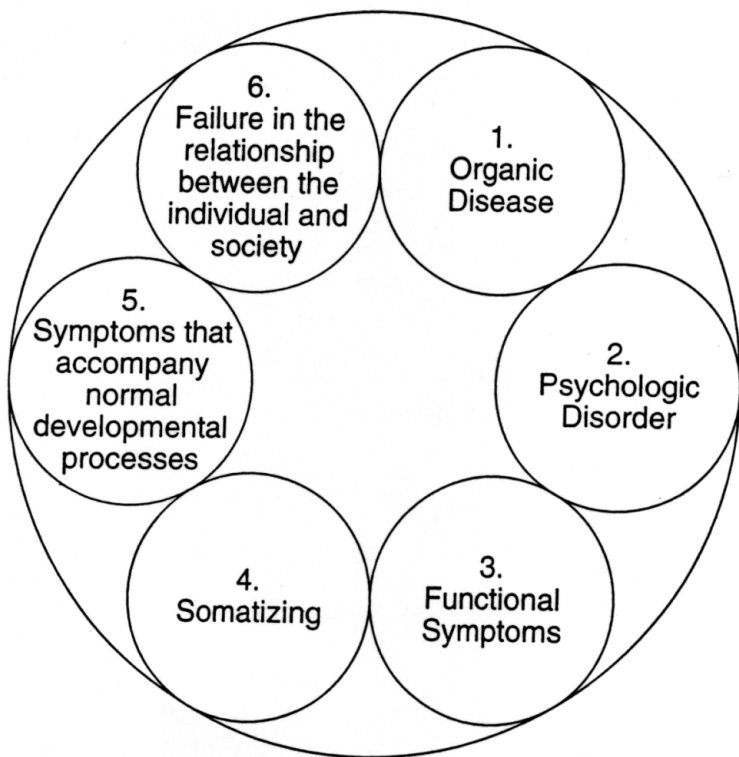
disorders are seldom amenable to passively received “cures.” How severely functional disorders impair well-being often depends not on symptom severity but on the worries they cause the patient.<sup>8</sup> Successful management of these disorders requires attitudinal changes in the child or parents and, in some cases, dealing with an unrecognized need within a family for the child to be sick (ie, “abnormal illness behavior”<sup>4</sup>). Eliciting positive change requires the time and communication skills characteristic of the biopsychosocial, rather than the biomedical, model.

Mounting pressures to see more patients in less time reduces the clinician’s ability to establish rapport, inhibits physicians from asking open-ended questions, and promotes pre-judgment of patients’ illnesses.<sup>9</sup> Applications of the biomedical model include attempts to streamline the clinical process by imposing algorithmic “pathways” inferred from patients’ chief complaints. Such strategies are based on the perilous assumptions that, (1) the chief complaint truly indicates what is causing the patient’s distress, (2) the cause of the distress can be diagnosed by tests for diseases, and (3) the patient’s illness can be successfully managed with disease-specific medications or surgical procedures.<sup>8,10,11</sup>

## **BIOPSYCHOSOCIAL THEORY**

The biopsychosocial clinician is often able to help patients who feel unhelped after encounters with biomedical physicians. However, the biopsychosocial approach requires conceptual tools and practical skills that are not taught in most undergraduate or postgraduate training programs. One such tool is a scheme that aids in identifying the factors contributing to illness.<sup>12</sup> In this scheme, illness may comprised one or more of six categories (Figure 1).

1. Disease is defined as “organic deviations involving structural change.”<sup>13</sup>
2. Psychologic Disorder is defined as a clinically significant behavioral or psychologic syndrome or pattern that is associated with distress and disability and does not result from a normal response to a particular event, such as the death of a loved one, but rather from dysfunction.<sup>14</sup> Included in this category are the disorders commonly managed by mental health professionals, that is, disorders of mood, thought, attention, personality, as well as family or marital dysfunction, eating disorders, and the somatoform disorders.
3. Functional symptoms are caused by events that are in the repertoire of responses inherent in organs free of disease.<sup>12,15</sup> This definition purposely avoids the implication of psychogenicity for two reasons: (1) organ dysfunction may be caused by factors that are not psychogenic, and (2) “psychogenic” is heard as “psychopathologic” and may offend patients by implying that their functional symptoms are caused by “something



**Figure 1.1.** A schematic representation of illness and its potential constituents. This concept may aid in discovering factors comprising an illness and in planning management.

wrong in the head.” The simplest example of a functional symptom is a runner’s leg cramp. The pain is real, not delusional. It is caused by fatigue-induced muscle spasm. The potential for such a spasm is inherent in healthy muscles and it involves no pathologic (ie, structural) change.

4. Somatizing is the conscious or unconscious use of physical symptoms for psychologic purposes or personal advantage.<sup>4</sup> Attention is shifted away from distressing thoughts or emotions, toward physical symptoms for the purpose of keeping those thoughts or emotions out of awareness. Symptoms caused by emotional stress or excitement, for example, getting diarrhea before final exams or developing a tension headache associated with nerve-wracking work, are not necessarily somatizations. The term becomes applicable only when such symptoms are used to avoid recognizing unpleasant emotions or obligations. If they are not so used, the symptoms are functional.<sup>12</sup> Somatizing, in contrast to the classic

somatoform disorders, is ubiquitous in clinical practice and has probably been employed to some extent at some time by almost everyone who has been ill. The biomedical model is inadequate for the patient whose illness has a substantial somatizing component.<sup>4</sup>

5. Symptoms that accompany normal developmental processes. If the physician is uninformed regarding normal development, he or she may reinforce unnecessary concerns about disease instead of relieving them. Examples include adolescent gynecomastia mistaken for possible breast tumor, or crying during the night by a 20-month-old with age-appropriate separation anxiety mistaken for abdominal pain.<sup>12</sup>
6. Failure of the normally supportive relationship between society and the patient. Patients who have no health insurance or lack access to medical care or social services have a component of illness that may override all other aspects of clinical importance.<sup>12</sup>

This biopsychosocial scheme for the analysis of the factors contributing to illness is useful because it obviates the need for the "physical vs. psychologic" dichotomy and helps in formulating a comprehensive therapeutic plan.<sup>12</sup> Additionally, the scheme prompts the clinician to explore areas of illness that are often neglected in the standard biomedical model. For example, an elderly man is repeatedly hospitalized for episodes of congestive heart failure (disease) that respond to medical management but continue to recur. Is he not doing well because of unrecognized anxiety (psychologic disorder)? Are some of his attacks of light-headedness due to hyperventilation (functional)? Has he recently been widowed and is he living in social isolation? If so, does the fact that he only feels cared for when an ambulance fetches him to the emergency room where he receives medical attention play a role in his frequent relapses of congestive heart failure (somatizing)? Might he be suffering from persistent sadness due to losses of significant people in his life (a result of normal developmental processes)? Has he never spoken with a social worker and is he unaware of the existence of a community day-activities program for the elderly (absence of social support)?

Assessment based on the biopsychosocial model would require the clinician to be caring and to have the communication skills necessary to develop rapport, elicit trust, offer continuity of care, provide ongoing accessibility, and to learn about the conditions of the patient's life. Management might then include: (1) digoxin and diuretics for his disease; (2) diagnostic interviews that discover clinically relevant anxiety and some of its origins and permit reflective discussion, enabling the patient to recognize the anxiety as a component of his suffering. Remedial measures might consist of a referral to a mental health professional, if he were able to accept such help, or an anxiolytic medication and/or continued supportive follow-up if he could not accept the referral; (3) the physician could explain that light-headedness need not be due to disease of the heart or brain, but could result from hyperventilation which, in itself, is not dangerous; (4) a series of scheduled



appointments with time for genuine communication might replace the patient's need to get sick in order to feel cared for;<sup>16</sup> (5) the physician could help the patient verbalize his thoughts, recognize his sadness, and hear it validated and taken seriously; and (6) a call to the social services department might help the patient gain access to resources in his community by which he could make social contact with peers and engage in useful, pleasant activities.

This illness scheme is also useful in the negotiation of a working diagnosis with the patient.<sup>17,18</sup> For example, a bright 9-year-old girl was brought for evaluation of recurrent abdominal pain that caused her to miss 3 weeks of school. Her symptoms became disabling sometime after the onset of her mother's episode of anxious depression, for which treatment was not sought. The child also developed worries about her parents' safety when they traveled away from home. She began to insist on sleeping on the couch closer to her parents' bedroom, rather than in her own room. At the time of the consultation, the mother stated that she was sure there was an organic cause for her daughter's abdominal pain. Moreover, she was certain the pains were severe, since the child's behavior in the past had indicated a high pain threshold ( "...so when she actually complains, I know she's really hurting!"). When the consultant asked the mother what she had been told by several previous physicians, she said that of the many diagnostic procedures performed, none had found anything physically wrong. Some had recommended counseling. The mother, who said she didn't have much faith in psychologists, could not accept previous doctors' diagnoses or recommendations. To do so would have made her feel as though she was abandoning her role as protector of her child's health and concurring with the insulting implication that her daughter was faking illness.

In fact, this child had a real illness. It did not involve disease, but it involved three identifiable elements: (1) a functional disorder (irritable bowel syndrome[Ibs]); (2) psychiatric difficulty (separation anxiety); and (3) somatizing (the use of physical symptoms to avoid recognition of her anxiety and so remain in the comforting presence of her mother and the mothering environment).

The diagnosis offered to the mother was IBS. The clinician described the condition, including its high prevalence in healthy school children. The clinician took time to explain that IBS is caused by interactions among sensitive but healthy sensory and motor nerves in the gastrointestinal tract. Like a runner's leg cramp or a swimmer's shiver after a cold dip, functional symptoms are part of how a normal body works. Although the child's IBS caused pain, it neither resulted from, nor caused disease. The functional nature of the girl's pain explained why diagnostic tests for diseases were negative. The functional etiology permitted the mother and the physician to avoid the "physical vs. emotional" controversy.

The mother was relieved to learn that her daughter's pains, although often severe, were not dangerous. She abandoned her insistence on more invasive, stressful diagnostic tests. She no longer felt that the doctor didn't

believe her or take her daughter's symptoms seriously. The physician discussed measures she could try that might ameliorate her daughter's pains. Making use of their rapport, the physician then reviewed, in a reflective, nonjudgmental, concerned manner, all the emotional stress they had suffered as a family and how any normal child might have reacted to it with anxiety. At this point in the consultation, the mother was ready to hear the thoughts of the physician regarding emotional difficulties. She was also ready to shift her concerns away from the hidden malignancy that she feared was causing her child's pains toward the damage accruing as a result of missed school. Once reassured, she became ready to place an expectation on her child to return to school, even though the child still had some pain. The physician made himself available to the parents, the child, and the school nurse to support efforts at returning the child to regular school attendance.<sup>12</sup> Although the child's anxiety disorder could not be treated at the time, the somatizing and the additional anxiety caused by the use of this psychological defense were brought under control.

Biopsychosocial management might take more time, initially, than the biomedical approach. The physician, however, who manages illness comprehensively is more likely to enhance the patient's well-being rather than participate in perpetuation of the illness. The physician will have a more satisfying experience and the patient's care will be more conservative of scarce medical resources.

## **THE BIOPSYCHOSOCIAL MODEL, CHILDREN WITH FUNCTIONAL GASTROINTESTINAL DISORDERS, AND THEIR FAMILIES**

We use the term "pediatric patient" to mean not just the child, but the child-parents unit. Whereas the adult patient has experiences and makes decisions independently, in the case of the pediatric patient, these experiences and decisions are distributed among the constituent members. For example, both an adult patient and a child patient may experience the pain of acute appendicitis, but while the adult decides to consult a doctor and does so, the child may wish to avoid medical care, yet is brought to the doctor by his or her parents. The parents choose the healthcare venue and give the history, but it is the child who is examined. The child has no say in the decision for appendectomy, but nevertheless undergoes it. As much as the parents might wish to, they cannot suffer the post operative pain for their child. Parents feel bad because their child is sick. The child is troubled by his parents' anxiety. If the parents perceive their child's illness as worsening, then regardless of objective evidence to the contrary, they will not feel better. No plan of management can succeed if the parents aren't

convinced it is worthwhile, nor can the child fully recover until the parents perceive the recovery. Therefore, treatment success depends on how much the child and the parents improve and feel helped.

Good physician-parent rapport is required for successful management. Therefore, always begin by assuming that the parents want what's best for their child, as evidenced by their seeking help. Care and empathy are necessary in wording questions so that they are not heard as critical or offensive.<sup>19-21</sup>

Establishing doctor-patient relationships with adolescents requires the recognition of their emerging independence, their need to be their own spokespersons, and the importance of genuineness, respect, and confidentiality in gaining their trust. Younger children aren't as focused on the issue of independence, but they, too, should be treated with genuine respect and be offered the opportunity to be heard. All illnesses, other than those amenable to passively received cures, require the participation of the child in the process of recovery. This is especially true of functional disorders, such as functional fecal retention syndrome.

We usually chat with the child alone, provided the parents don't object and the child is able to briefly separate from the parents and talk with the doctor. The purpose of this chat is to obtain the child's perception of symptoms and the reason for the visit. It is also an opportunity to gently question the child about abuse or victimization. If nothing else, it is our opportunity to show our respect and caring attitude toward the child. Establishing rapport with the child permits us to ask for cooperation in the process of getting better; without it, we are more likely to be ignored. We often have a second private chat with the child at the end of the visit to explain what we think the problem is and how to overcome it. We then top-off our effort to build rapport by giving the child our business card, writing his or her name on it, and inviting the child to call should he or she want to talk with us. Parents have told us that their child kept the card for years, as though it were a treasured possession.

Physicians must be wary of over-identification with the child and of showing anger toward parents who misunderstand their child or fail to recognize harmful parenting practices.<sup>21</sup> In cases of criminal abuse or neglect, the clinician must protect the child from the parents. Unless abrogation of parental rights is a desirable and realistic option, however, the only way to help the child is through a collaborative relationship with the parents.

In defining the pediatric patient as the parents/child unit, we don't mean that they should always be together during clinical work. Whether to take a history from the parents with their child in the room or out of earshot may seem to be a minor question of procedure, but it has far-reaching implications.<sup>21</sup>

According to the biomedical model, diagnosing the child's disease is most important. What the child hears, sees, or thinks while listening to his parents and the doctor talk is less important. According to the biopsychosocial model, the well-being of the child is most important; the importance of the

diagnosis and treatment of the disease or disorder is relative to its impact on the child's well-being.

Having the child present while the physician elicits the history may hinder the clinical process and impair the child's well-being in at least three ways: First, the parents may not be as communicative—verbally or emotionally—and may avoid talking about personal fears, marital issues, or subjects that evoke tears or anger because it might upset their child. Second, children lack mature judgement and may become unnecessarily troubled by what they think the adults are talking about, even though the topic seems innocuous to others. Third, whether or not children should be excluded from the consultation room during history-taking and discussions of management depends on what effects the child's illness has had on parenting.<sup>12</sup>

The parent-child relationship normally requires parents to set limits and place expectations on their child that foster development and protect from harm. When a child becomes ill, the obligations of school and chores are put aside. Parents become more attentive and compliant with the child's wishes. If the illness is prolonged or perceived as potentially tragic, the parent-child relationship changes. The child begins to make demands he or she would not have made before becoming ill. The parents find themselves accepting limits imposed by their sick child, such as cancelling vacations, taking time off from work to stay home with their child, or tolerating misbehavior they would never have put up with previously. These changes are driven by parents' realistic or unrealistic fears and guilt.

Management may require that the parents oblige their anxious child to do something the child does not want or feels unable to do, such as return to school after a long absence for complaints of abdominal pain.<sup>12,22</sup> When parents are told to ignore their sick child's protests, the advice seems hard-hearted. Parents may feel guilty if they comply. Human behavior tends to be influenced more by emotional forces than by cognition and rationality. Therefore, in order to comply, the parents have to "feel right" about the doctor's recommendations. The physician has to bring about changes in the parents' attitudes toward their child.

The parents must come to accept the diagnosis of a harmless (functional) etiology for their child's pain. They need to recognize their child's emotional distress, which they may not have done previously because of their preoccupation with the possibility of serious undiagnosed disease. They may, after reflective discussion with the physician, consider obtaining psychologic help for their child. But in any case, they need to shift their worry away from the nonexistent intestinal malignancy they feared toward the increasing damage done to their child's development by prolonged school absence, incapacity out-of-proportion to objective evidence of pain, and ongoing stressful and unproductive diagnostic procedures.

Bringing about changes in the way parents feel toward their child is a therapeutic challenge. It could be made more difficult were the child present, intruding into the discussions of adult-level concerns. However, once the parents have made these attitudinal changes and have become aware of the

irrational guilt that they, like all loving parents, are prone to, then exclusion of the child from the room is no longer necessary. Indeed, discussion of the findings, the more realistic concerns, and a clear statement as to what the child must do to get well might better be done with the parents and child together. This lessens the possibility of misunderstanding regarding the child's, the parents', and the physician's stated responsibilities during the course of the child's rehabilitation.

Whenever a child's illness has caused distortions in the parent-child relationship, successful illness management includes the restoration of a more normal parent-child relationship, along with measures aimed at the illness. The distinctions between adult-level concerns and child-level concerns and the roles of the parents and the child should not be blurred, but instead made clear and exemplified at the outset of the clinical encounter.

## **THE PRACTICE OF BIOPSYCHOSOCIAL MEDICINE**

Some of the conditions necessary to implement the biopsychosocial model include: (1) knowledge of the model, (2) relevant attitudes, skills, goals and responsibilities, (3) the ability to tolerate the emotional strain, and (4) appropriate compensation.

### *Knowledge of the Model*

The biopsychosocial clinician's work is based on three fundamental values: the intrinsic worth of the individual, acceptance, and the patient's right of self-determination.<sup>23</sup> Belief in the patient's worth is necessary for developing an attitude of commitment and trust. Acceptance allows the physician to be committed to helping the patient regardless of whether the patient is attractive or unpleasant, or whether the complaint is interesting or mundane. It is this value that helps the clinician be nonjudgmental. The patient's right of self-determination implies that physicians don't "own" patients. We are hired by patients to engage in a collaborative effort aimed at overcoming their illnesses. It also implies that the treatment plan is arrived at through a process of negotiation between doctor and patient, both of whom are experts: The physician is an expert in disease and other constituents of illness, and the patient is an expert in his or her own unique life and illness experiences. Without the patient's contribution, the physician is at risk for insufficiently informed diagnosis and treatment which, although it may conform to a community standard for the patient's condition, may not benefit the individual who is being treated.<sup>24</sup>

Management tends to break down when treatment proceeds based on the clinician's idea of what is best for the patient, irrespective of the patient's knowledge or attitudes. Patients seldom change their attitudes simply by being instructed to do so by an authoritative physician, even after being presented with all the "facts" in support of a proposed treatment plan. For example, patients with chronic ulcerative colitis seldom agree to colectomy because their doctor recommends it, even after they've been presented with the statistics regarding morbidity and mortality. Patients generally agree to surgery only after they have been unable to work, sleep, or eat comfortably long enough for their attitude toward colectomy to change from viewing it as a mutilation to viewing it as a rehabilitative procedure. The biopsychosocial clinician is patient and supportive while the patient goes through the emotional struggle necessary for the proposed colectomy to become acceptable.

Another example of the value of the patient's right of self determination involves mental health referrals. The fact that the physician has identified a component of psychiatric disorder in the patient's illness is not enough to justify referral for psychiatric help. Many patients, especially patients who somatize, cannot see the relevance of psychologic factors in their illness. Biomedical clinicians tend to make the referral because psychiatric problems exist, regardless of whether the patient can acknowledge their existence. Such referrals are often nonproductive and damage rapport. The biopsychosocial physician avoids letting the patient's refusal of a mental health referral become a roadblock. Instead, he or she avoids the "physical versus psychologic" controversy and uses the rapport developed during management of the patient's physical complaints to concurrently manage the psychosocial components of the illness. By avoiding psychologic jargon and other connotations of the mental health professional, the physician is able to approach mental health issues in patients who would have rejected such attention were it offered by a psychiatrist. The biopsychosocial physician should be trained to provide supportive psychologic care while remaining alert to opportunities for lessening the patient's resistance to a needed mental health referral. At the same time, the physician continues to protect the patient's health from chronic and/or intercurrent disease and ill-advised procedures and provides nonfragmented care—even to psychologicly troubled patients who may never be ready for formal psychotherapy.

The biopsychosocial physician learns communication skills and the techniques of interviewing.<sup>25-28</sup> The clinician must understand Szasz and Hollender's three basic types of doctor-patient relationship: the activity-passivity model (the prototype of which is the parent-infant relationship), the guidance-cooperation model (the prototype of which is the parent-child relationship), and the mutual participation model (the prototype of which is the relationship between two adults).<sup>29</sup> Each of these models is useful when applied appropriately.<sup>21</sup>

Unfortunately, the guidance-cooperation model is often misapplied because many clinicians assume it is the only way doctors and patients work

together.<sup>30</sup> Such misapplication may foster adversarial interaction. Patients may react to perceived patronization when they are "talked-to" before being "listened-to", or when they are told what to do (ie, how to "cooperate") without being given the opportunity to understand and contribute to the reasoning upon which the physician's directives are based. The costs of such actions and reactions, in terms of suffering, wasted medical resources<sup>31</sup> and unnecessary malpractice litigation, are enormous and preventable.<sup>18</sup>

The biopsychosocial physician understands and recognizes somatizing and views abnormal illness behavior as a legitimate, challenging clinical problem rather than a time consuming waste of energy. The clinician needs to have the conceptual equipment necessary for managing somatizing.<sup>4</sup> Many patients, especially those who somatize, fall into the gap created by the dualism separating organic medicine and the mental health professions.<sup>12</sup> This gap is exemplified as follows: The biomedical physician is equipped to work with patients who have manageable diseases and who want to get better. The somatizing patient may or may not have disease, but clings to illness.<sup>4</sup> This frustrates the biomedical physician. He or she recognizes the somatizing and attempts to help the patient with a referral to a mental health professional. The patient who complies will encounter a clinician who is equipped to work with patients seeking help for emotional pain. However, the somatizing patient typically says, "I'm fine. It's just my stomach that's bothering me," and wonders how a psychologist can help with a stomach-ache. The patient then falls into the gap created by the biomedical physician's inability to resolve the abdominal symptoms and the psychologist's inability to overcome the patient's psychologic defense against recognizing emotional pain. The patient then seeks another doctor who can diagnose the disease.<sup>12</sup>

Can somatizing children and adolescents benefit from psychologic evaluation and treatment by mental health professionals? That depends on the extent to which the patient and family cope with emotional distress by somatizing.

Patients whose illnesses include somatizing are of three types: The first is characterized by a patient whose premorbid psychologic health and level of functioning were normal and whose family is not prone to somatizing. The initial anxiety that may have triggered somatizing may have been relatively commonplace and unnoticed. For example, a child with mild recurrent abdominal pains begins to complain more intensely some time after his mother's return from an emergency visit to her critically ill father in another state. Her sudden departure and her worried affect upon returning causes separation anxiety in the child, who begins to stay home from school because of abdominal pain. His parents' increasingly worried preoccupation with his health, his absence from school, and his exposure to repeated medical evaluations result in further anxiety. The anxiety caused by the child's somatizing adds to, and may become more intense than, the original separation anxiety.

Successful management requires a clinical encounter during which the



child's pains are evaluated. If the correct diagnosis is functional abdominal pain, its benign nature and favorable prognosis are made clear. The sources of his initial anxiety are explored. The parents' concerns are shifted away from their child's nonexistent disease toward the damage that is accruing to his development because of abnormal illness behavior. Effectively reassured, the parents, with the collaboration of the physician and school nurse, are able to place an expectation on him to cope with his physical discomfort and return to school.<sup>12,22</sup> He initially resists and tests his parents' resolve, but is soon convinced that he must resume normal functioning. He reintegrates into his peer group, the somatizing ceases, and the anxiety created by it subsides. Having learned of his separation anxiety, the parents are able to discuss with him the frightening events that caused it and relieve his unrealistic fears. In this type of case, the biopsychosocial clinical encounter restores emotional well-being and there may be little need for further psychologic treatment.

The second type of somatizing is exemplified by families who routinely and unconsciously use somatic symptoms as a way of coping with emotional distress. Serious psycho-pathology or family dysfunction may exist, but the family regards psychologic concerns as irrelevant to their child's abdominal pain. Referral to a mental health professional is therefore futile. The biopsychosocial physician uses the same techniques as described above to reassure the parents of the safety of their child's complaints and to shift their concerns toward the damaging effects of continued school absences. Progress can be made, but complete resolution of somatizing is less likely. The biopsychosocial physician provides regular follow-up appointments, all somatic complaints are carefully and conservatively evaluated, intercurrent organic diseases (eg, colds or acute appendicitis) are identified and appropriately treated, and ill-advised medical procedures are avoided.

The biopsychosocial management of this second type of somatizing was eloquently summarized by the psychiatrist, Charles V. Ford:<sup>4</sup>

Referral to a psychiatrist is frequently not well accepted and not necessarily of benefit...Despite the severity of the underlying psychopathology, these patients may do better with a primary care physician with whom they can have a long-term relationship, than with a psychiatrist...As the doctor becomes better acquainted with the patient, there can be increased recognition of the patient's use of physical symptoms as a metaphor. Symptoms are often attempts to convey feelings of hurt, needs for affection, anger, and a wish for help in an ongoing psychosocial crisis. The physician's ability to communicate that these feelings have been recognized, without ever directly confronting the patient concerning the symptoms, may alleviate the need for the symptom. With receptive encouragement extending over time, the patient may gradually learn to express emotions and needs more directly, thereby making somatization unnecessary.



We suggest that the biopsychosocial, rather than the biomedical model is the sine qua non of the primary care physician's extraordinary therapeutic success.<sup>32</sup>

The third type of somatizing patient has significant psychologic difficulties and can be helped to recognize not only their underlying emotional pain but also their somatizing. Once such patients have been assured that their physician is willing to take their concerns about their physical health seriously, they can be motivated to seek psychologic treatment and may be ideal candidates for referral to a mental health professional.

### *Relevant Attitudes, Skills, Goals, and Responsibilities*

Rotor & Hall wrote that "... for many physicians, technology, and the scientific method, divorced from issues of the therapeutic relationship, are viewed as the sine qua non of medicine. In the real practice of medicine, many maintain, the issue of the doctor-patient relationship is an inconsequential and unscientific, low-priority concern."<sup>18</sup> The attitude described above is probably an attempt to improve medicine by defining it as science.<sup>33</sup> Unquestionably, critical scientific thinking is indispensable to good clinical practice. Science begets clinical progress and clinical experience begets scientific inquiry. Many clinical investigators practice both science and medicine well.<sup>34</sup> Nevertheless, however close the relationship of science and medicine may be, they are emphatically different in their goals and methods.<sup>10</sup>

The goal of the scientist is to create new knowledge by isolating a phenomenon of interest from its context and studying its properties. By contrast, the goal of the clinician is to improve an individual patient's well-being by working with her in the context of her existence to promote healing.<sup>35</sup> If we fail to recognize this distinction—between what is abstractly true and what is existentially real—then we will confuse the practice of science and the practice of medicine.<sup>36</sup> Such confusion fosters the use of the mantle of science to rationalize the avoidance of what is so demanding (and perhaps ennobling) about being a clinician: the work of genuinely caring about and remaining accessible to patients.

The biopsychosocial physician cares about patients as human beings and takes their subjective concerns and distresses seriously. Caring about a patient is a bit like loving someone; both kinds of feelings cause another's well-being to be overridingly important. The capacity for caring can be developed further in a milieu in which it is a highly regarded and an assiduously applied value by mentors, teachers, and peers.<sup>25</sup>

The biopsychosocial physician assesses every patient and each illness with an open mind, rather than attempting to apply predefined characteristics. When a diagnosis is based on the patient's elaborated chief complaint, without understanding what motivated the patient to seek care, treatment

may be misdirected and unnecessarily costly, because patients' chief complaints sometimes have little to do with what is troubling them.<sup>10</sup> If the complexity of the individual and the illness is limitless, then the potential for therapeutic success is also limitless.<sup>35-37</sup> Regardless of how severe a patient's illness may be, the possibility of improving well-being always exists for all patients, whether they can or cannot recover.

The biopsychosocial physician has personal warmth and an attitude of realistic optimism and encouragement.<sup>4</sup> An Irish proverb states, "Hope is the physician to all misery." Without hope, patients capitulate to illness and physicians' attempts at healing fail. There are several ways hope can be damaged. It can be replaced with anxiety if the clinician assumes that the patient is helped by being provided with as much factual information as possible, mindless of the fact that the patient is not a dispassionate sponge for knowledge, but a worried victim of illness. By using empathy and communication skills, the physician can provide enough (but not too much) information that is comprehensible and helpful to the distressed patient. Hope can also be destroyed if the clinician professes false optimism which, sooner or later, destroys the physician's credibility and leaves the patient bereft.

Another practice that destroys hope is when the physician's statements are biased towards how severe the illness is. Some physicians inadvertently create withering pessimism by presenting bad news in its worst light. In some cases, this is motivated by the notion that if the patient is told about the condition in the gravest terms, the physician will be immune to accusations when the patient does poorly or will appear skillful when the patient finally does well. In the former case, the physician's pessimism is likely to cause the patient anxiety and impel a search for another physician who can rekindle hope. If the patient and family are angry enough, no amount of "you can't say I didn't tell you" is likely to prevent their accusations of wrongdoing to justify their shift to another doctor. In the latter case, the hopelessness created by the "bad news" may be so profound that even the best of outcomes may fail to eliminate it. The patient may continue to be viewed by himself or his family as "vulnerable"<sup>38</sup> and less able to meet the challenges and experience the pleasures of life.

The biopsychosocial physician must have empathy—the ability to share patients' feelings as though they were her own.<sup>4</sup> The biopsychosocial physician must be free of alexithymia, which is the relative inability to use words to communicate emotional feelings or be psychologically introspective.<sup>4</sup>

Genuineness is an essential characteristic of the biopsychosocial physician. It has been defined as, "not pretending to be somebody or something other than who or what you are."<sup>26</sup> Is the physician someone who is superior to the patient in terms of learning? The physician's learning in medicine and related fields may exceed that of the patient. However, can it be said that the patient, who may be a commercial airline pilot or a farmer or an artist, has less knowledge or less important knowledge? Some patient's lives exemplify weakness, ineptitude, and failure. Is the physician superior? Suppose the physician had gone through the same ontologic process as the patient

and experienced the same frequency of hurt, mishap, and deprivation. Would the physician have done as well, or not nearly as well as the patient? To be genuine, rather than manipulative, one must feel respect, if not admiration, for the patient as a human being.<sup>26</sup>

Is genuineness equivalent to complete openness? Is it useful for the doctor to share personal troubles, worries, self-doubts, and pain with the patient? The doctor and patient engage in a formal relationship with the purpose of healing the patient's illness. The role of the physician requires that the energy and time expended in the doctor-patient relationship be directed toward healing. This contract is reflected in the fact that the patient pays the physician to engage in the relationship rather than the other way around. Openness is appropriate only when it contributes to healing; otherwise, it may be an exploitation of, rather than a contribution, to that process.

Biopsychosocial clinicians have sufficient self-knowledge to recognize the many conflicts of interest that arise the moment they engage in practice. We all have financial needs, narcissistic needs, sexual needs, political needs, research needs, and voyeuristic impulses.<sup>25</sup> These personal needs are rarely discussed during conventional training, as if they were understood a priori and seldom caused problems. Unfortunately, physician's decisions sometimes have nontherapeutic or counter-therapeutic results due to lack of self-awareness and the failure to ask oneself, "Why am I doing this? Is it for the patient or is it for me?"<sup>26,39</sup>

When a patient is unreasonably demanding or behaves disrespectfully, for example, the physician may react as though it were a personal attack and retaliate in some way. Such a reaction might be appropriate in a social relationship, but it is usually inappropriate in a doctor-patient relationship and may cause its rupture. Instead, the physician suppresses the impulse to lash back. The relationship is preserved and, with it, the opportunity to examine the patient's inappropriate behavior as a symptom of illness. Is the patient's disrespect actually a projection of unconscious self-reproach? If the physician avoids being made into an adversary, he or she may be able to help the patient recognize and give up unrealistic self-reproach and move on to a better working relationship. The physician will gain the satisfaction of being an effective, rather than defeated, healer.

When the clinician presents a clear, rational explanation of the problem, but the patient rejects it, the physician might become annoyed and respond with a counter-rejection. However, if instead of feeling the patient's negative response as a rebuff, the biopsychosocial clinician attempts a nonconfrontational exploration of the sources of the patient's unwillingness to accept what seems reasonable, the physician avoids disrupting the doctor-patient relationship and preserves opportunities for better understanding the patient and resuming of the healing process. The biopsychosocial physician is able to forgo mastery over the patient in order to gain mastery over the illness.

Biopsychosocial physicians understand that doctors "are special, not because they are more intelligent, more capable, more trustworthy, or more anything else, but because the public has given them this extraordinary role

and they have accepted it,” along with “...the awesome responsibility that goes with that authority.”<sup>25</sup>

The biopsychosocial physician is familiar with the rudiments of psychiatric diagnosis and can recognize maladaptive behavior, neurotic patterns, disordered mood, thought, and personality in both children and caretakers.<sup>40</sup> “Familiarity,” however, is not equivalent to expertise. Few biopsychosocial physicians are trained psychotherapists. Medical practitioners are justifiably concerned about “getting in over one’s head” by trying psychotherapy to manage illness.

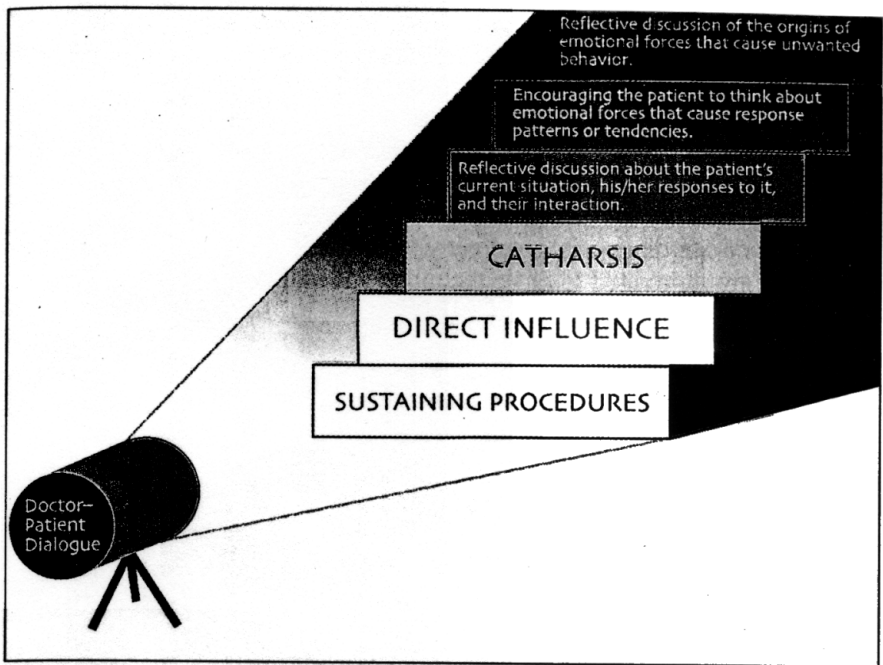
What is psychotherapy? An answer to this question can be derived from the work of Florence Hollis,<sup>23</sup> who reviewed transcripts of psychotherapies and identified the therapeutic events they contained. She grouped the events into six categories ranging from the most rudimentary to the most complex (Figure 1.2). We use Hollis’ classification, not because it is comprehensive or because we necessarily endorse its psychodynamic point of view, but because it exemplifies a conceptual guide useful to clinicians while listening and responding to patients. Its six levels are:

1. Sustaining procedures—demonstrating a caring interest, a desire to help, expressing confidence in the patient, and offering helpful reassurance
2. Procedures of direct influence—suggestions and advice
3. Ventilation or catharsis—encouraging the patient to pour out pent-up feelings to relieve tensions
4. Reflective discussions about the patient’s current situation—helping the patient to consider the effects of his actions on others or himself, and looking at relevant but withheld feelings, attitudes, and beliefs
5. Encouraging the patient to think about the emotional forces that cause response patterns that is thinking about feelings that cause unwanted behavior<sup>12</sup> and
6. Reflective discussions on the origins of emotional forces that cause unwanted behavior.

Sustaining procedures and procedures of direct influence occur during most visits to a doctor. Ventilation or catharsis takes place whenever a physician gives the patient a sympathetic ear. Reflective discussions of a patient’s predicament is a procedure that physicians perform if they allow themselves to do so rather than feel that “it’s not really practicing medicine” or that it’s a self-indulgent lapse in the efficient use of time.<sup>21</sup>

Hollis’ sixth and most complex category of psychotherapeutic procedures, elucidation of the origins of pathologic response patterns, is the goal of analytic psychotherapy. The patient is helped to understand pathologic emotional forces as well as defense mechanisms that obscure their recognition and prevent change. This level of intervention requires psychologic training that is generally beyond that of medical practitioners.

Many medical practitioners incorporate psychotherapy into their practice. Knowledge of their limitations frees biopsychosocial physicians to



**Figure 1.2.** Hollis' six categories of psychotherapeutic measures in ascending order of complexity.

engage in healing beyond disease treatment and enables them to make referrals for psychologic care based on the patient's need and readiness, rather than the frustration and discomfort created in the physician by the patient's psychologic problems.

The biopsychosocial physician, in contrast to the mental health professional, must maintain enthusiastic interest and expertise in the diagnosis and treatment of diseases. Patients consult physicians because they are concerned about disease. The biopsychosocial physician looks for disease and, in addition, uses that process as an opportunity to search for psychosocial issues that contribute to the patient's illness. Patients reject a focus on psychosocial issues if they believe that it is replacing the search for disease, nor will they tolerate a doctor who seems more interested in psychosocial difficulties than in disease.

### *The Ability to Tolerate Emotional Strain*

It is easy to discuss biopsychosocial practice in the abstract. However, it may seem daunting to open one's self up to and take on the responsibility for coping with everything that might make a patient. One hears rationalizations such as, "I don't have the time to practice that way," or "I wish I had

the patience for it.” The biomedical model is comfortable for clinicians because it limits the extent of their clinical responsibility to the patient’s disease; aspects of the patient’s suffering that are contributed by psychologic, social and developmental factors are delegated to other helping professions.<sup>1</sup>

The price of this comfort is that it limits the clinician’s ability to understand and treat patients. Open-ended questions to explore patients’ associations, experiences, and feelings are avoided. Healing is impaired, notwithstanding accurate diagnosis and treatment of the patient’s disease.<sup>41</sup> Some physicians are motivated to enter technical specialties to avoid painful encounters with patients’ suffering they feel unable to “fix.” One such specialist admonished his daughter, upon her graduation from medical school, to avoid direct patient care because it meant having to get involved with patient’s troubles — as though these troubles might entrap and burden her rather than provide her with exciting and potentially rewarding challenges.

The apparent effort required to practice biopsychosocial medicine can seem overwhelming. Can one physician be sufficiently talented in organic diseases, psychologic processes, communication skills, and the spiritual leadership needed for patient care? The answer certainly is, “Yes.”<sup>21,32</sup> This model does not require the practitioner to have psychiatric expertise equivalent to that of a mental health professional, nor does it discourage requests for help from consultant specialists when needed. It does require the practitioner to be responsible for both coordinating and leading patient management. This obligates the biopsychosocial physician to remain accessible to the patient both in the office and by telephone. Such contracts can be opportunities for healing if they are not felt to be unnecessary intrusions or overutilization.

The biopsychosocial physician becomes a resource for the care of patients with serious illnesses that have eluded diagnosis, seem to be impenetrable tangles of biomedical and psychosocial elements, or are unresponsive to standard management solutions. In such cases, healing is a worthwhile but difficult achievement. It becomes possible only if the physician refuses to accept defeat, but accepts time as a therapeutic ally and creates new ways to problem-solve for the patient.

## *Economics*

Biopsychosocial management does take more time, initially, compared with the biomedical approach, but the more comprehensive assessment results in better informed management and greater patient satisfaction.<sup>18</sup> Unfortunately, there are not yet any outcome studies comparing cost effectiveness of biopsychosocial vs biomedical care. Quality of life is a less familiar measure than disease morbidity and mortality rates. We would expect that patients with normal illness behavior would be better satisfied by the biopsychosocial model and less likely to engage in the costly process of

doctor-shopping. The biopsychosocial physician would be more skilled at recognizing abnormal illness behavior in somatizing patients and less likely to utilize expensive, unnecessary diagnostic and therapeutic procedures.

The time necessary and the skills required are not yet appreciated or fairly compensated by third party payors. The biopsychosocial model can work only if those who practice this approach can earn a living.

## CODA

The biopsychosocial model is a break from the constraints of conventional biomedical thinking and a major contribution to clinical process theory. However, attempting to teach the biopsychosocial model through reading and lectures is like trying to teach someone to drive by having her study the principles of automotive engineering and the rules of the road without ever getting behind the wheel. Applying the biopsychosocial model requires a learning experience beyond those offered by most postgraduate training programs. Specifically, it provides the opportunity to study clinical process theory while caring for patients in a milieu that values and validates this model of practice.

The biopsychosocial model has the potential for making each clinical encounter an opportunity for mutually creative interaction between clinician and patient.<sup>34</sup> Its importance derives from the importance of human suffering itself. The biopsychosocial model must be applied, developed, and taught.<sup>42-44</sup> Its effectiveness and efficiency can be demonstrated only if we make the effort to do so.<sup>45-46</sup>



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