



Biopsychosocial Health System; Resources and Barriers

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Editorial

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The holistic and biopsychosocial (BPS) approach has been emphasized for years in psychiatry education syllabus for the recognition and management of psychiatric, psychological, and psychosomatic problems.

Physicians and psychiatrists are aware of the important role that psychosociocultural factors play in the formation and duration of various illnesses and diseases. Thus, they study the multifactorial etiology of many biomedical diseases in medical training. Moreover, they learn that there is a need for an integrative and community-based approach toward health promotion in order to achieve a balanced growth in psychophysical health of the society. In this educational process, "disease", as destruction in structure or function of different systems of the organism, has become the major focus of attention and the "patient", as a human being with "one pain", but "many sufferings", is underemphasized. During their medical career, physicians have to pay attention to an abundance of signs and clues which introduce the "patient" as an "ill person" and

they have to see these signs as serious in their therapeutic and diagnosis program.

Unfortunately, there is not sufficient time during physicians' education and training period and treatment process for contemplation on systemic and holistic discussions. To practice in these domains, not only is there a need for the students to receive specific education and trainings, but the programs should be affordable and beneficial for both parties.

Clinical studies and experiences have shown that ignoring or underestimating this approach from the onset of anamnesis, diagnosis, treatment, and management, and even after the outset of the disease may influence patients' and physicians' psychobehavioral condition and ultimate salutogenesis and pathogenesis outcomes. Furthermore, burnout and unpleasant feelings in the therapeutic climate spread to all of the members of the therapeutic team and also to patients. In the following, an instance of a common therapeutic setting experienced by most therapists (general physicians, family physicians, specialists, and psychiatrists) will be discussed. Physicians (therapists) observe some signs in their encounter with their clients. These signs may

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bring some questions to their mind, sometimes consciously and sometimes unconsciously. They may not pay attention to these signs, and consequently, not enter the domain of holistic interventions due to their lack of competence or skills in coping with and managing the situation.

A. Situation: It is 9.30 pm. The last client who refers to the therapist is a woman of 40 years. She has tightly covered her hair and is dressed elegantly, is calm, but seemingly tired, enters the office, and after common greetings, complains of her long (many years) history of headaches and migraines. In spite of trying various methods of treatment, she still has severe headaches twice a week.

B. The first proposal: The first treatment program that comes to the doctor's mind is a quick neurologic evaluation, medical history examination, medication commencement, and healthcare advice provision. The physician intends to ask questions about therapeutic history, examine tests and imaging, and write a prescription for the patient. Suddenly, the patient puts a long list of drugs she has used on the table and points out their side-effects, duration, and dose of use. She provides all her neurologic medical history including brain imaging, electroencephalogram (EEG), and even a referral note from a neurologist. In this state, therapists often view the client as a competitor in the treatment process; this may be the starting point of the patient-physician rapport damage.

C. A transition in the interview process [considering psychological, social, and cultural factors]: The client is a married woman with 3 children [a 16-year-old daughter and 2 twin boys, one of which has cerebral palsy (CP)]. Her husband is strict and serious, but caring. There is no history of migraine headaches in her maternal family. She herself has no history of psychiatric disease. Major psychosocial clues which may have caused persistent stress, and consequently, her migraine include chronic stress due to having a child with CP, and

probably an unpleasant marital relationship with her husband.

D. The second proposal: It seems that psychosocial interventions, training of skills for coping with stress, family counseling, and complementary treatment methods are needed. In response to the physician's question, the client states that she has had some sessions with a psychologist. She has had Botox injection once or twice and she cannot afford to continue such costly treatments anymore. Moreover, the responsibility of caring for the children (especially the child with CP) is hers completely.

Clinical note: The therapist feels unequipped; while the therapist knows what services the client needs for an integrative management of the disease and care, limitation in his patient's financial resources and her situation restrict the choices.

E) The third proposal: The therapist thinks of the actions he can design to help the client. In such cases as this, there is seemingly a jigsaw puzzle with lost (or inaccessible) pieces. The client points out that she likes improving and reading books. She is a compliant patient.

The strong point [resources] at this stage is that these findings help the physician to give services other than medication. The therapist can provide complementary therapeutic interventions with the biopsychosocial approach and guide the client through the therapy process.

F. Preparing-training-therapeutic agreement: It seems that every physician should be able to prepare patients who suffer from long-term chronic problems, functional disorders, and psychosomatic problems which require care and must be managed. They should also be able to provide the necessary training for the client and come to an appropriate therapeutic agreement for the next stages. In the jigsaw puzzle of such patients, we have some pieces, but some other pieces are lost or not accessible. Here some questions arise: What are the main problems of the general medicine and

residency program education system in our country? Which theoretical or practical deficits give rise to weaknesses in integrative management function of the therapeutic system? What are the practice domains and job descriptions of general practitioners, family physicians, or psychiatrists in biopsychosocial approach and management? Which weaknesses exist in the system of medical education, treatment, and health care which deprive the patient of receiving integrated and multidimensional services? Which factors cause the therapist to have problems with presenting the right serious biopsychosocial services which are needed and make him feel unequipped in terms of resources?

Influential factors of weaknesses in medical/psychiatric education in the contemporary educational system:

Educational aspects

1. Emphasis on education of the biological aspects of health and psychological health problems and limited emphasis on psychosocial and cultural aspects

2. Limited feasibilities for education of integrative interventions, limited and incoherent education during the training period of general medicine and psychiatry residency program

3. Focus on diagnosis of the "disease" versus "illness", and "pathogenesis" versus "salutogenesis"

4. The tendency for medicalization of all aspects of modern medicine and attempts to find clear causes for all medical disorders (not only in physical dimensions, but also in all psychosocial dimensions)

5. Shortage of skilled trainers and teachers to manage the psycho-pathologies embedded in family and society, and to employ integrative intervention modalities (Consequently, the systemic approach loses its right place.)

Treatment aspects

1. Deficiencies in appropriate referral health

systems and experienced family physicians in the treatment systems of Iran or some other countries, and thus, inappropriate distribution of patients in specialty or super-specialty centers in addition to hindrance of the provision of the right integrative specialty services due to limited time and financial resources

2. Shortage of or non-proportionate financial support or distribution in integrative and systemic community-based health procedures, especially in terms of insurance organizations

3. Shortage or loss of various groups which provide systemic services and also inappropriate social, financial, and spiritual coverage and support of these groups including family physicians, clinical psychologists, systemic psychotherapists, and experienced family therapists (It is worth noting that no significant relationship between the intervening components of the system is defined in health programs.)

4. Briefly, lack of a system including efficient family physicians, who can intervene in and treat the patient and the family simultaneously, and shortage of specialists (psychiatrists) who do not have enough time for or interest in multidimensional management is an important deficit.

Health care system

1. Primary prevention is costly and yields in the long-term. Training for prevention is mainly emphasized at the second and third levels. For instance, there is much investment on treatment and rehabilitation of addicted patients, while the vicious circle of drug dependency at the community level is ignored. Healthy lifestyle, the raising, educating, and bringing up of children and adolescents, psychological health of youth, pathology of marriages and families, and etcetera are among factors which require investment to prevent social and clinical vulnerabilities. Thus, for instance, insurance companies never consider family care and

family therapy as a critical issue for preventing addiction in society, while in the long term it may be cost-effective for their own systems.

2. The role of physicians as the efficient managers and messengers of health in the community is underestimated in the health and education system.

3. The importance of training lateral skills such as problem-solving and stress management skills, familiarity with the basics of psychology within the society and community-based medical education has been underemphasized during the training period of physicians. As a consequence, physicians have serious difficulties in achieving these skills.

4. Considering the lack of above-mentioned skills, young physicians have a high stress and tension level when they enter the medical practice. This accelerates their early job burnout. Paradoxically, those who are to be protectors of health within the society, often encounter difficult conditions in medical practice.

5. In the conversion of health and medical education into a more specialty-based education, the tendency toward diagnosis and intervention tools, underestimation of community-based medical education and internal and general majors, and training of generalists limit the medical practice and activity within the biopsychosocial, spiritual, and cultural atmosphere.

Conclusion

There are numerous factors which hinder the use of the biopsychosocial approach in health and medical care training and practice. Some of these factors are mentioned above, but a deep assessment and study in this regard is necessary. It is worth noting that historical and global experiences indicate that expert doctors in different health care levels can arrange holistic care settings in their medical practice. This is an obligation in industrialized and developing countries in which the patterns of "diseases" and "illnesses" must undergo substantial changes.