BJPsych | The British Journal of Psychiatry (2017)
210, 3–5. doi: 10.1192/bjp.bp.116.182873

Editorial

Reassessing biopsychosocial psychiatry

Will Davies and Rebecca Roache

Summary
Psychiatry uncomfortably spans biological and psychosocial perspectives on mental illness, an idea central to Engel's biopsychosocial paradigm. This paradigm was extremely ambitious, proposing new foundations for clinical practice as well as a non-reductive metaphysics for mental illness. Perhaps given this scope, the approach has failed to engender a clearly identifiable research programme. And yet the view remains influential. We reassess the relevance of the biopsychosocial paradigm for psychiatry, distinguishing a number of ways in which it could be (re)conceived.

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Psychiatry uncomfortably spans biological and psychosocial perspectives on mental illness. As a branch of medicine, psychiatry is under pressure to conform to a biomedical model, on which genuine mental disorders are classified as diseases, to be characterised primarily in biological terms. Contemporary psychiatry also draws heavily on psychotherapeutic approaches, which focus on the psychosocial factors involved in mental disorder. Here concepts of abnormal or impaired belief, experience and social structure take priority over concepts of neural dysfunction. This heterogeneity continues to generate much uncertainty concerning the conceptual foundations for psychiatry. What exactly is psychiatry a science of? Mind or brain? Individual or society? Dysfunction or deviance? These questions are as much philosophical as empirical.

Psychiatry evidently adopts many different levels of explanation, customarily divided into the categories of the biological, psychological and social. The view of psychiatry as holistic dates back to Hippocrates, but today it is strongly associated with Engel's[1] biopsychosocial paradigm. The biopsychosocial paradigm was as broad as it was ambitious: Engel sought an all-encompassing framework for clinical practice, along with a non-reductive metaphysics for mental disorder. Given its intended scope, it is not surprising that this proposal failed to engender a clearly identifiable research programme. Engel did not provide details as to how biological, psychological, and social factors should be combined in diagnosing, describing, explaining, and treating mental illness.[2,3] And yet the conception of psychiatry as a biopsychosocial discipline remains influential. As Gabbard & Kay[4] observe, 'almost all psychiatrists . . . endorse the notion that psychiatrists are distinct from all other mental health professionals in that their training and expertise allow them to be the ultimate integrators of the biological and psychosocial perspectives underlying diagnostic understanding and treatment'. The biopsychosocial paradigm is, in a sense, everywhere and yet nowhere.

There is significant need for a reassessment of the biopsychosocial paradigm. In what follows, we assume a minimal, vague, conception of 'biopsychosocial' as signifying any approach that (a) spans multiple levels of explanation, and (b) is opposed to bioreductionism. Our aim is to distinguish a number of ways in which this minimal view could be refined, developed, and implemented, across different explanatory domains. Our concern, then, is not so much retrospective as prospective. How should we understand the legacy of Engel's biopsychosocial paradigm for psychiatry present and future? In what differing ways can we conceptualise the links between biological, psychological and social factors in explaining mental disorder? Can these conceptualisations help capture the elusive influence of the biopsychosocial paradigm in psychiatry? Answering these questions requires philosophical as well as empirical nous.[5]

In this editorial, we distinguish four possible (re)conceptualisations of the biopsychosocial paradigm. The paradigm could be viewed as a guide to: (a) which factors are relevant in identifying or classifying psychiatric disorders; (b) the range of possible causes of such disorders; (c) strategies for effective prevention and treatment; or (d) the metaphysics of psychiatric disorder. Let us take a closer look at each of these conceptions in turn.

Psychiatric classification

The biopsychosocial paradigm can be conceived as an approach to the classification of mental disorders. Practitioners require diagnostic categories that facilitate shared, reliable standards for identifying mental disorders. The biopsychosocial paradigm has clearly been influential in the production of such classificatory systems. For example, psychosocial factors were explicitly referenced in the axial system of DSM-IV under Axis IV. DSM-V no longer adopts this axial system, but still reflects the perceived importance of social, cultural and environmental factors in accurate diagnosis and classification. In the past few years the DSM has been challenged by the Research Domain Criteria (RDoC), which seeks a new taxonomy of mental disorder based on neurobiological measures. At least for now, however, the biopsychosocial-style approach to psychiatric classification remains orthodoxy.

It is important to distinguish two possible interpretations of this approach. On a conceptual interpretation, biopsychosocial factors determine the content or meaning of psychiatric categories. 'Major depression', for example, might be analysed as meaning 'the condition characterised by biological, psychological and social factors X, Y, and Z'. On an epistemic interpretation, in contrast, biopsychosocial factors merely provide clinical signs or evidence for classifying a patient under a certain psychiatric category. This latter interpretation seems more appropriate in understanding the influence of the biopsychosocial paradigm on the DSM. Further

philosophical development is needed, however, to clarify the commitments of the approach.

Psychiatric causation

A second conception of the biopsychosocial paradigm relates to the study of psychiatric causation. The past few decades have seen an explosion of research on the relationship between environmental 'stressors' or 'insults' and the development of mental illness. Epidemiological studies indicate that for most disorders, the risk of developing the condition is not determined by biological factors alone. There is complex interplay between causal factors at biological, psychological and social levels. To pick just one example, perceived parenting style is associated with risk of various psychopathologies in adulthood, including major depression and anxiety disorders. Gene–environment interactions and correlations present further intricacies, which are only just beginning to be understood.

In this context, the biopsychosocial paradigm can be developed via the claim that the causes of mental illness are spread over multiple explanatory levels. This sort of approach is discernible, for example, in Kendler's[6] description of the 'dappled' nature of psychiatric causation, a term he borrows from Cartwright. Once again, however, this merely marks the beginning of a view; more philosophical focus is needed. What is the operative notion of causation here? How should we make sense of claims such as that socioeconomic inequality can be a cause of schizophrenia? What causal mechanisms are involved? These remain some of the most challenging conceptual questions currently facing psychiatry.

Prevention and treatment of psychiatric disorder

The foregoing biopsychosocial-style view of causation may influence the ways in which clinicians intervene to prevent or treat these psychiatric disorder. Leff and colleagues[7,8] for example, investigated the links between relapse rates of people with schizophrenia and their social environment. They found that 'Relapse of schizophrenia is more likely if patients live with relatives who are excessively critical and/or over-involved. Such relatives are designated as high EE [expressed emotion]'.[7] This causal insight led Leff and colleagues to devise a programme of social interventions that significantly reduced relapse rates by reducing relatives' expressed emotion and/or reducing patients' social contact with high expressed emotion relatives. But the proposed biopsychosocial conception of prevention and treatment is not merely an extension of a 'dappled' view of causation: the approach raises distinctive and challenging questions regarding social policy and the ethics of healthcare interventions. What types of psychological or social intervention are permissible in the prevention of mental disorder? How should we adjudicate between pharmacological and psychosocial treatments? These philosophical issues demand closer scrutiny.

Metaphysics of psychiatric disorder

Our final conception of the biopsychosocial paradigm relates to the metaphysics of mental disorder. By way of background, the philosophical mind–body problem concerns the nature of the relationship between mental states – notably qualitative states of phenomenal consciousness – and states of the brain. Psychiatrists sometimes write as if the only two views of this relationship are reductionism and dualism, and as if a denial of reductionism is tantamount to embracing dualism. Yet the current orthodoxy in philosophy of mind is neither reductionist nor dualist, but rather non-reductive and monist. Glossing over many important details, this position maintains that descriptions and explanations expressed in the language of psychology are irreducible to descriptions and explanations expressed in the language of biology, while insisting that mental states are nonetheless entirely physical in nature.

Viewed in this context, Engel's metaphysical aspirations for the biopsychosocial paradigm seem prescient, if insufficiently articulated. The paradigm was presented as an alternative to the 'reductionist biomedical model',[1] and thus naturally lends itself to integration with the anti-reductionist philosophical theories of mind that have prospered since the 1960s and 1970s. Most philosophers of mind today would think it uncontroversial that accounts of mental disorder must engage psychological-level concepts. Some 'vehicle externalists' even view the mind as partly constituted by processes within our natural and social environments.[9] Although much further discussion is needed, it is natural to see these theories as embodying biopsychosocial-style views of the nature of mental disorder.

Although highly theoretical, these metaphysical issues have major practical repercussions. For example, if some aspects of mental disorder are irreducibly psychosocial, then arguably our classificatory systems should reflect this. Insights from philosophy of mind therefore may inform the conflict between biopsychosocial-style systems and the RDoC, the latter clearly reflecting an ambitiously reductive view of mental disorder. More controversially, if vehicle externalism is true, then the psychiatric sciences will have to look outside the skin for a complete understanding of mental disorder. If my reasoning capacities are partly constituted by extrinsic processes, for example, then presumably these capacities may be impaired by changes in these processes. These suggestions are promissory and in need of significant development. They serve to illustrate, however, the continued relevance of the biopsychosocial paradigm to the foundations of psychiatry.

Conclusion

We have distinguished a number of (re)conceptualisations of the biopsychosocial paradigm, each relevant to different areas of psychiatry. The term 'biopsychosocial', which has seemed so familiar to many, permits a variety of interpretations that are of significance to contemporary psychiatry. Although much maligned, the prospects for the biopsychosocial paradigm, given more careful articulation, are not as bleak as some have claimed.[2,3]

Acknowledgements

We gratefully acknowledge the support of Pierre and Felice Loebel, and the Oxford Uehiro Centre for Practical Ethics, in the preparation of this editorial.

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First received 12 Feb 2016, final revision 9 Jul 2016, accepted 6 Sep 2016

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poems by doctors

The Not-Parents

Siân Hughes

taught me things I was not supposed to know. Until he threw
the television out the window
they taught me to watch old films late at night, and to notice
odd things in the background,
anomalies, plot-twists, the words to old musicals, how to be
alone in the woods after dark,
to be afraid of game-keepers, poisons, people at work, visits
from step-children, debt, divorce,
low cloud on the hill, the cliff-edge, a change in the weather
that stops the fire from burning.
They taught me things that I forgot, names of flowers, herbs,
all the different coloured drinks
they kept for decoration in cut glass decanters. How to make
good bread, keep a fire overnight.
How to watch. How to keep very still, downwind, and wait
for badgers under the trees.
That comfort smells of log fires, wet coats, good whisky, cigarettes,
that laughter is a trick
that cracks your voice open, then you spray it with a blue plastic
gun that lets you breathe.
When the stepson and his girlfriend were 'messing about' upstairs
they taught me
this was sex, and funny, and no reason to be shy. They taught
me to make pickles, put things by,
to love your animals because when you're waiting for the
ambulance at the end of the lane an
old cat is comfort, to marry someone who makes you laugh,
even if he throws the television
out of the window, then mixes so many pills with gin you have
to call the ambulance.
She taught me how easily we die. All you need is bronchitis,
asthma, hatred of hospitals
and half an hour alone. She taught me grief, all the time I knew
her, for the child she never had,
places she left, and felt she never could go back to. She did not
know how useful this would be
when she said 'you're a woman of the world, you know what
goes on' and I didn't know
what either of those things meant. She taught me love comes
in unexpected boxes,
left on the doorstep, fed with a bottle and returned to the wild.
It was love she taught me,
all the bad things she taught me, holding her old cat in the dark
under the trees,
waiting for the blue lights to flicker on the hedges and the pieces
of glass
where they fell among the nuts she left out for wild birds and
badger cubs, the night
the television went out of the window, and she waited under
the trees they taught me
everything they knew about love.

The British Journal of Psychiatry (2017) 210, 5. doi: 10.1192/bjp.bp.116.181602

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BJP 2017, 210:3-5.
Access the most recent version at DOI: 10.1192/bjp.bp.116.182873