Social sciences and medical humanities: the new focus of psychiatry

Dinesh Bhugra[1] and Antonio Ventriglio[2]

[1]Professor of Mental Health and Cultural Diversity, Institute of Psychiatry, King's College London, London, UK, email dinesh.bhugra@kcl.ac.uk

[2]Honorary Researcher, Department of Clinical and Experimental Medicine, University of Foggia, Foggia, Italy, email a.ventriglio@libero.it

The clinical practice of psychiatry should incorporate a biopsychosocial model of illness, acknowledging both cultural and social influences on the patient's experience. Medical humanities include a number of academic disciplines that complement the clinical practice of psychiatry. The medical profession, including psychiatry, has a social responsibility to study the psychosocial context within which people become ill and have to be treated. Although the biopsychosocial model of illness has strong theoretical foundations, its application in clinical practice is limited. A new approach would be to restructure medical student teaching to include medical humanities in the first year, and to share such education with other professions.

Psychiatry is the branch of medicine which deals with the aetiology, diagnosis, management and prevention of mental illness, mental disorders and emotional and behavioural disorders. The basis of diagnosing and managing psychiatric illness is in using the biopsychosocial model. The medical model is often a reductionist one, arguing that medicine can only be biological, whereas all medicine arguably is social (Bhugra, 2014). Social factors may be determinant in triggering psychiatric disorders and should be considered for therapeutic intervention in order to improve patients' well-being. Moreover, social and cultural factors affect our cognitive schema as well our child-rearing patterns. The understanding and expression of emotional distress is extremely culturally influenced. Thus, medical students, and especially psychiatry trainees, need to have a broad training. The integration of psychiatry and medical humanities, in particular, may improve the understanding of mental illness and support more effective interventions.

Current conceptual models in psychiatry

Although the biopsychosocial model has been well theorised and accepted, its application in clinical practice remains uncertain and heterogeneous (Engel, 1980).

In fact, psychiatry, like the rest of medicine, largely adopts the *disease* model. Disease is defined literally as *dis-ease*, illustrated by pathology, and its social impact on functioning is defined as *illness*. Having made this distinction, Eisenberg (1977a) suggested that while doctors are interested in disease, patients are interested in illness. In a later article, Eisenberg (1980) reminded us that when persons become ill, they become patients; when they become well, they revert to being persons again. These are related to social decision points in help-seeking rather than boundaries determined by shifting biological equilibria.

Social stress can influence host resistance. Becoming well is not simply a matter of cure of the disease process which made the person ill. However, often medicine, including psychiatry, focuses on disease and reduction of symptoms. We all know patients who, in spite of their symptoms (representing disease), continue to function well, and others whose symptoms have been eliminated but whose functioning remains a problem. Disease and illness do not always have a clear one-to-one relationship. Similar levels of pathology in different individuals elicit different responses to the symptoms as well as to therapeutic interventions. This clearly suggests that the biological model offers limited understanding of the functional aspects of psychiatric syndromes, which seem to be more influenced by social, environmental, educational and socioeconomic factors than by symptoms.

The discrepancy between the viewpoints of patients and their clinicians is strongly influenced by a number of factors on both sides of the equation. For example, the psychiatrist may see something simply as being caused by medical factors, whereas the patient may see it as being caused by supernatural factors. Such discrepancies will have a negative influence on therapeutic engagement and alliance. Furthermore, patients may be interested in regaining full functioning in spite of their symptoms (which they could well live with if they can function), whereas psychiatrists may be more focused on symptom reduction, as our training often emphasises. A newer model should consider that the cognitive distance between the patient and the psychiatrist may be unbridgeable. The emphasis on the aetiology, symptoms and healing process may greatly impoverish any therapeutic interaction, resulting in poorer adherence to therapy. Also, new technology and investigations, increasingly influencing clinicians' evaluations, should be integrated with cultural and socioeconomic determinants in an appropriate contextual manner.

What can medical humanities contribute?

Fenton & Charsley (2000) point out that sociology and epidemiology are 'incommensurate games'. Kleinman *et al* (1978) highlighted that cultural patterns of disease and sickness influence social

systems and, in return, are influenced by the very same social systems. Similarly, as mentioned above, cultures dictate child-rearing patterns and influence child development and development of cognitive schema. The new focus of modern psychiatry should be the integration of qualitative and quantitative aspects of research and practice. Biomedicine should integrate traditional approaches aimed at dealing with the person and the illness.

In fact, the new approach should comprise cultural and social constructions, as both influence the understanding of illness, explanatory models and pathways to care, as well as patients' expectations. Eisenberg (1977b) suggests that all human diseases reflect the outcome of an interaction between biology and social organisation, with culture as a mediator. Social environments affect cultural attitudes to illness experiences, as well as engagement in the therapeutic process.

Moreover, in rather old studies from the USA, it was shown that 70–90% of all illness episodes are treated in personal, folk or social sectors (Zola, 1972). There is little to suggest that this may have changed dramatically in recent times.

Integration of medicine and humanities: a new focus for psychiatry and psychiatrists

The medical profession has an ethical obligation to provide equity of access to all, that is, across all ages and social classes. However, in order to deliver physically and emotionally accessible services to all, those responsible must take into account local cultural and social factors and needs.

Medical humanities include a number of academic disciplines (Greaves & Evans, 2000) that complement the clinical practice of psychiatry, which should, though, still be seen as a natural science (Rutherford & Hellerstein, 2008). As Hankir & Zaman (2013) point out, the health humanities have a role to play and can be beneficial for both service providers and service users. Understanding cultural and illness narratives can bring them together, to produce better outcomes and higher levels of patient satisfaction.

Fathalla (2000) argues that medicine has lost its pastoral role – providing care to the anxious patient – because it has developed too much of a technical orientation, which has led to a reduction in levels of social consciousness on the part of doctors. It is not, though, a question either of technical orientation *or* social consciousness, but both. The medical profession, including psychiatry, has a social responsibility to study the psychosocial context within which people are ill and have to be treated. Anderson *et al* (2005) remind us that social and economic conditions affect health, disease and the practice of medicine, and the health of the whole population is a social concern. Rosen (1974) emphasises that society needs to promote health through both individual and social means. Storington & Holmes (2006) add a dimension

to the doctor–patient relationship: the culture of medicine itself. This culture, too, is strongly influenced by external social factors and social determinants of health.

Conclusion

Psychiatry is an extremely competitive field. We select students but then expect them to give up their competitive nature and work in teams. A revolutionary idea would be to restructure undergraduate training by sharing the learning of medical humanities in the first year with other professions. This will help trainees to understand what the local social context in which they will be practising is likely to be, and so improve the quality of services. It is conceded that one limitation of such integration of medical humanities within psychiatric training might be the enlargement of the gap between psychiatry and the other medical disciplines, when psychiatry is still seen as a branch of medicine that lacks the backing of scientific evidence. This stigmatising view needs to be discouraged by further evidence and clinical application of the biopsychosocial model.

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