Patient-centred care and the biopsychosocial model

KEY WORDS

- Biopsychosocial model
- Carl Rogers
- Mental health
- Person-centred care
- Self-awareness

In my last series of articles for *Wounds UK* last year, I introduced the Person-centred approach, and took each of the core conditions (genuineness, acceptance and understanding) to look at how we could use these to inform our approach to the COVID-19 pandemic. This year I am hoping to write a series of articles, that still use my experience as a psychotherapist, and my passion for the person-centred approach, to look at some other areas of life, which aim to enhance our approach and outlook in both personal and professional areas. I would like to use this initial article to begin exploring the relationship that we create with patients, as it is so central to the care we offer and the quality of relationships that we create.

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In psychotherapy, there are many different approaches, behavioural, psychoanalytical and humanistic to name a few schools. However, the one thing that continues to be shown in research, is that the quality of the relationship between therapist and client, is one of the leading factors of the outcome of therapy, even over and above the techniques and approach we offer (Cooper, 2008).

Even beyond the world of psychotherapy, especially in helping professions, I think that the relationship is paramount to the patient's experience and outlook in a range of treatments and interactions. Indeed, there has been an ongoing development and prioritisation of the patient's care in the helping professions and medical model over the last centuries, with a particular focus on the patient-centred approach in the last 20 years.

Throughout this article, I will be exploring the idea of patient-centred care, as well as an awareness of the biopsychosocial model, in our work with patients, in the hope of enhancing the experience of treatment and outcomes for all involved.

Patient-centred care

While there are differences in approach and practice between person-centred psychotherapy and patient-centred care, one of the core principles that lies at the centre of both, is prioritising the patient/client's experience and needs.

As an interesting side note, Carl Rogers (the founder of the person-centred approach to psychotherapy) tended to refer to his patients as clients and initially named the approach "Client-centred Therapy" This was to hallmark the switch of the "doctor-patient" relationship of Freudian times and move towards seeing the "client" as an equal, who in fact, is better placed than the professional, to determine the direction and nature of treatment.

This may not always be the case in other caring professions, for example, a nurse may be better placed to recommend medical treatment of an illness, we can still keep this attitude in mind when thinking about our approach and the needs of our patients. While there may be a recommended or most successful treatment for a given situation, the options that we give, the approach we take and the attitudes we hold towards the patient can greatly enhance both their experience and treatment.

There can sometimes be a tendency, especially in the medical model, to have a hierarchy of expertise, and while, as health professionals, we are likely to have more expertise of the processes that we use (e.g. wound dressing, medical knowledge, the process of therapy etc.), with this hierarchical structure, we can also risk losing sight of the person-hood of the patient, and that they are much more than just the ailment they present with.

The biopsychosocial model

The development and appearance of the biopsychosocial model, since being introduced by

George Engel in 1977, argues for the awareness and relating to patients in a way that encompasses the whole of their person and experience, rather than the isolated focus on illness that is associated with the biomedical model.

As the name suggests, the biopsychosocial model takes into account the person's biological, psychological and social factors when engaging with and treating them. This is a more holistic approach, which sees a person as a whole organism, impacted by many factors, as opposed to the difficulty being treated as an isolated problem.

Even in my own, non-medical, experience as a psychotherapist, there is a clear link with psychological difficulties (often as a result of environment) and medical/physical conditions. This seems to indicate that the treatment and relationship with the person, as a whole, may provide a better understanding, and therefore, a better treatment for those on the receiving end.

Of course, this is no small ask and an undertaking that takes intention and effort, which can be easier said than done. Also taking into account the limited time and stresses we may be facing in our workplace, it can be hard to maintain this approach. I believe that this approach does take a conscious effort and putting more focused attention into our patients, but I believe that the outcomes and improved patient experience will hopefully give us motivation for this endeavour.

Practical considerations

> *"...one of the essential qualities of the clinician is interest in humanity, for the secret of the care of patients is in caring for the patient"* (Peabody, 1927)

Having looked at the theoretical models and reasonings behind the type of approach being argued, I will now move on to spend some time considering the practicalities of beginning to offer the type of patient care being put forward.

I believe there are two main points to focus on from the approach mentioned above. Firstly, valuing the patient with equal worth in the relationship. Secondly, an awareness and attention to the many factors that make up a patient's experience in the world, which may also include and/or contribute to their ailment.

Who is the expert?

It is understandable, in helping professions, when there exists a dynamic of knowledgeable professional and patient in need, that we can very easily slip into the expert role, and as mentioned above, sometimes this is accurate and necessary. However, there can be a risk in this dynamic of missing the expertise that the patient brings to each interaction. This expertise could be far reaching, but primarily I want to focus on the one thing that each patient is definitely an expert on, and that is themselves!

No matter how in need or vulnerable they may be, they are the one person in world who has privileged access to their experience and lives with themselves 24/7. This can present in many different ways, but one thing I am sure that it gives us, is insight into their experience, needs and preferences. I believe these areas can go a long way to deciding their treatment and how we relate to them in most interactions.

I think that merely holding this belief is a big part of putting it into action with our patients. A second way that we can use and pay value to this, is to also be actively curious and attentive to their experience. The patient may not be forthcoming with some of this information, but I believe if we pay close attention and listen well to what and how they are communicating, we will likely gain some insight into these factors.

For example, if we suggest a treatment plan and the patient verbally agrees, but equally seems uncomfortable and hesitant in tone and body language, this may be an opportunity to enquire further. By doing this, we will hopefully be able to understand (and ideally adapt to) some of these apprehensions. In addition to this, rather than just reassuring the patients apprehensions, we may also endeavour to understand as much as possible behind the reasons and meanings for the patient in relation to this. We can rarely know these things without further enquiry or a desire to understand, so this may often take active curiosity or questions to try and learn more about the patient's response and preferences.

The whole person

As mentioned above, this desire to understand also includes taking into account the whole person, where possible. There will likely be a whole host of experiences, beliefs, values, and impacts which contribute to how the patient presents and responds to many of the elements of our interactions. We can tend to see things in quite a black and white fashion,

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with a simple approach or answer. However, as complex humans, this is so rarely the case.

Many of the clients that I have seen are often in distress because of many conflicting responses and preferences, and this means it is rarely a case of merely feeling one way or another about things. This can be helpful to keep in mind alongside the elements of the biopsychosocial model that were outlined above. There will likely be biological, psychological and socially informed responses to each stage of their treatment.

Similar to the suggestions above, it can be helpful to be actively attentive and aware of these areas where possible. Some may be clear in our interactions, whereas others may need curiosity or an active desire to understand more. Although this may sound intrusive at times, I believe that patients are often more concerned with our intention and desire to understand for their benefit, which is mostly received with appreciation and welcoming.

We may also gain from actively engaging with learning more about the potential biological, psychological and social conditions that may impact each of our patients. This can be done through engaging with areas that we may feel a lack of understanding about (this may be through documentaries, films, literature, interactions etc.), while also not forgetting the uniqueness and subjectivity of each person, even within these conditions.

CONCLUSION

In this article, I have tried to look at the ways that we may improve our relationships with patients and ultimately, their care and experience. By respecting the expertise they bring on their own position, as well as seeing the person as a whole, I believe we give the best chance to provide a beneficial experience and treatment to each patient we encounter.

As mentioned above, this does take an active effort and engagement, which can be hard, among all the other demands that we face (we are a whole person made up of many factors too, remember!). But the hope is that the result of these active engagements will be worthwhile to all involved, and most importantly, provide a therapeutic and enhancing experience to both ourselves and our patients. Wuk

REFERENCES

Cooper M (2008) Essential research findings in counselling and psychotherapy: The facts are friendly. London: Sage

Peabody FW (1927) The Care of the Patient. *JAMA* 88(12):877–882. https://doi.org/10.1001/jama.1927.02680380001001