COMMENTARY

Biopsychosocial Assessment: Why the Biopsycho and Rarely the Social?

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Introduction

As a social worker involved in providing clinical assessment and intervention with children and parents, I will outline my concerns over the accuracy of our use of the term "bio-psycho-social" to describe the content of work undertaken in conventional child and adolescent mental health environments or in counselling work involving families in the child welfare system. My own involvement in service delivery over a thirty year period, has included work as a clinical social worker, at an MSW level in a wide variety of settings, including child welfare, mental health crisis assessment, adult psychiatry, and adolescent and family counselling.

My interest in the bio-psycho-social model in particular arose over the past 6 years working closely with psychiatrists in a major psychiatric hospital, primarily intervening with individuals suffering from severe personality disorders in the Cluster B spectrum. In that setting, I grew to respect some of the strengths of the so-called 'medical model'. I observed that some of the biological and psychological assessment tools and practices, used to analyse the history and behaviour of patients, were often of considerable assistance in understanding the messages encoded in those behaviours. Having been trained as a social worker, I knew that the social work critique of the medical model tends to devalue those tools and practices that I was actually learning from and finding useful. On the other hand, I was aware that my own profession has some history of rejecting or underestimating the need for incorporating the biological and psychological, in favour of a frequently exclusive emphasis on the social. The goal of this commentary is to urge inclusivity and complexity – that is, the actual utilization of all three components by all practitioners, regardless of their professional origin or training (Barkley, 1999). The focus of this contribution is to use case examples to call for such inclusivity, in particular the need for conventional mental health practice to be enriched by a broader application of the 'social' in the bio-psycho-social.

The attempts I've observed in conventional practice to use a bio-psycho-social model have continued to neglect a broader conceptualization of what "social" actual represents. Attempts to apply the model are often restricted to collecting information on family composition, child and adolescent school performance, income, and even sometimes exploring the family narrative. Incorporation of the "social" may even sometimes go so far as to explore family dynamics, family or origin, discipline styles or income and social "risk factors". But my proposal calls for a deeper reach, an exploration of the social conditions, the dominant ideologies, and the sociology of the culture in which the persons we work with and we ourselves are located. I'm positing that our practice needs to incorporate information and exchange of ideas with our clients which explore our embedded social and cultural belief systems as a subject of relevance to the day to day parenting and mental health issues faced by our patients/clients, and ourselves.

Through an examination of two cases, I will attempt to articulate the need for/and benefits of, a broader, more in depth, social analysis in helping people to become empowered to change behaviour.

In both of the cases under discussion, I saw clients on an outpatient basis. The clients were referred by child welfare social workers. In Nova Scotia, due to long wait lists in the public mental health system, much of the mental health service delivery as well as services mandated through the courts required for provision to child welfare clients (parents and/or children) is contracted out to private therapists registered by the provincial department of community services through the provision in the Family and Children Services Act known as section 75. In these cases, both clients provided verbal consent, with the caveat of strict confidentiality, to have relevant aspects of our mutual involvement and case progression discussed for the purposes of this article. One of the clients, Ms. M, stated when asked permission for this article; "I just think education is so important. I hope they can learn something from all this."

Case 1

Ms. M is a 40-year-old unmarried woman, referred by the child welfare worker after a Parental Capacity Assessment suggested the need for counselling and inferred the presence of personality traits in the Cluster B spectrum. Ms. M had given birth to 6 children, all of whom she'd "given up" to family or child welfare services for placement. Only T. I., now age 12, was in the home and Ms. M was hoping to keep him with her, and to raise him, despite the current involvement of child welfare.

Child welfare was involved due to serious concerns regarding lifestyle (many years of work at varying levels of prostitution and contact with persons with violent and criminal behaviour), serious transience and instability, and recent (summer of 2007) severe partner violence observed by the child still in the home. Ms. M's involvement with child welfare agencies has gone on intermittently over the past 10 years. Most recently, Ms. M was resentful of child welfare involvement, but supported the recommendation of the parental capacity assessment that she obtain counselling to address the "personality characteristics" which have led her to her present circumstances, including issues of dependency, insecurity, antisocial, and narcissistic traits. In addition, she had tendencies to externalize responsibility for poor decisions or become overwhelmed with guilt - all issues identified in previous assessments and mental health interventions.

In our first session, while exploring possible causes for the years of choosing dangerous partners and the sex trade, we discussed the relationship between victim and perpetrator realities. Ms. M was encouraged to understand the universality of the human experience of both, and to outline in detail lists of her own examples in both categories. The intention of the exercise was to help the client examine larger social causes, articulate feelings about injustice experienced by her, and demedicalize (or de-psychologize) these experiences, while simultaneously proceeding to accept personal responsibility for choices made of how to respond to the social issues outside of her direct agency. Ms. M described this early process as freeing her of guilt, while assisting in stopping the externalizing which was preventing her from acknowledging, and moving on to change, her own behaviours. During this process, Ms M disclosed previously unacknowledged experiences of abuse that provided her with insight about her chronic instability with sexual relationships.

In subsequent sessions, we discussed the tendency in our *culture* (not just in her personal psychological makeup) to bifurcate or split options between all or nothing. We discussed the limited identity options available to poor women from isolated working class communities: "wild biker bitch" as alternative to "diaper-washing wife". Ms. M grew interested in these grand narratives, and was able to relate to varied new ways of understanding her perceived limited choices: i.e., passive or aggressive, overwhelmed with guilt or externalizing, and idealizing or demonizing institutions and help providers. Using scaling techniques, historical information on women and culture, and discussion of economic injustice, Ms. M wrote extensively in her "homework" journal about her observations of these ideas in her own thoughts, history and behaviours.

In many of our sessions, I repeatedly reviewed the location of the individual in the society we live in, and how all citizens are influenced by larger conceptual frameworks and structures of power. We discussed who names the problem. At the same time, avoiding the overemphasis of the victim role that is often put forward by progressive and feminist colleagues, we discussed how Ms. M is not helpless to make decisions within the limitations and injustices of her own circumstances. She described this process as empowering, as it validated her experiences of marginalization while simultaneously challenging her own decisions within the options available to her. In addition, she was able to see how she effectively or ineffectively utilizes her own psychological structure, otherwise understood as "personality".

As she made progress in a number of areas, specifically her attitude toward child welfare, defensiveness, generalized and diffuse anger, avoidance, and boundaries, she was able to return to a detailed report written about her, and place its content in context. Ms. M had long ago written angry notes in the margins, defending herself and externalizing responsibility for her actions. When she returned to the same document, her homework was to review her earlier notes and write new ones in the other column, articulating her new insights. She was then able to differentiate victim from perpetrator experiences and how this contrasted with her prior conceptualization. She was able to "socialize" her history and "personalize" her behavioural responses.

One of the issues in the document she'd been given mentioned anti-social personality traits. We reviewed in detail the definition and symptoms of anti-social personality disorder, and discussed the meaning of terms such as social norms, and what it means to violate the latter. Ms. M began to see that as a mother, she strongly values pro-social norms for her son, but as a poor woman, has repeatedly violated social norms in not seeing herself as a citizen invested in and validated by the overall culture of our society. Ms. M has continued to struggle with renegotiating her rightful place as a mother, woman and citizen in this culture. The changes she has undertaken in the psychological realm may empower her to seek economic and social justice, but they cannot resolve the injustice that she is left to struggle with. Nevertheless, her improvements in the psychological realm *combined* with her improved ability to analyze her place in the social realm, up to now appear to be contributing to strengthening her parenting abilities, her confidence, and her chances of keeping her child.

Case 2

The second case presented here for discussion, concerns Ms. H, the single mother of a 12 year old boy, R. R. has a considerable history of involvement with the mental health system, beginning with behavioural problems assessed when he was 3 years old. Diagnoses over subsequent years have included Attention Deficit Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD), and anxiety. He has participated in all of the major services, residential and outpatient, offered to children under

12. The child welfare agency was engaged over the need for assistance in placement when Ms. H could not manage her son's behaviour in the home. They also assisted in foster placement and placement in two group homes, as well as additional supports. Over many years, Ms. H was often described as defensive, guilt-ridden, and overwhelmed, as well as tending to medicalize her son's behaviour by describing him as unable to control himself, focusing on diagnoses and medication, and minimizing her own ability to take control of his behaviours. Ms. H was referred to me for assistance in addressing her role as a parent in managing her son's behaviour.

In our first session, Ms. H presented as very angry. She outlined what she felt "everyone [referring particularly to mental health and child welfare professionals] thinks that I'm not consistent, let R. get away with things, that I'm not tough enough, and that he knows how to play me", and added that those opinions made her feel very frustrated. Ms. H listed all the parenting education she'd participated in and insisted that "99% of my son's problem he was born with – he's very manipulative." Despite these points of view, Ms. H reluctantly agreed to a counselling plan that would include trying to develop more flexibility in her approach, learning new parenting techniques, struggling against her cynicism and lack of hope that anything could change, and examining the social context of contemporary parenting.

In our subsequent session, Ms H presented as even angrier than in the first session, suggesting she felt the child welfare worker was trying to "discredit" her as a parent, that the process we would be engaged in was a "joke", that she didn't need parenting counselling because "I've had that", that she didn't trust the child welfare worker, and did not feel comfortable with me. When I challenged her anger and externalizing, she raised her voice and almost wept. After considerable and conflicted discussion, she agreed to review one of the older reports written as a discharge summary from one of the mental health programs that outlined the parenting issues she disagreed with. This was done to undertake a common and very precise understanding of her point of view. We then agreed that the subsequent 2 or three sessions would focus solely on a sociological analysis of contemporary parenting rather than any discussion of her particular parenting methods.

The review of contemporary parenting began with discussions of history of parent/child relationships and philosophies in North America, analyzing whether there exists a larger crisis, economic, social and political contexts, gender in parenting, and individualism. Ms. H eagerly participated in review of these issues, engaged and gave her own opinions. We discussed perceptions over a 40 year period of then and now behaviours, adult/child social expectations and placed her own family of origin's style of parenting in the larger context. In this context she acknowledged her reaction to her father's physically abusive parenting, and how this left her with both an essential anger response to her son's poor behaviour, alternating with guilt and permissiveness to try to balance the temper she'd learned from her father.

We discussed authoritarian, permissive and authoritative parenting models, their cultural origins, and their impact on families and society. Her son was still in a group home at this point, however, and a March break pass to spend with her was coming so I began to carefully introduce the practical implications of the broader issues under discussion. We again reviewed the report which had so angered her, and she responded defensively, but was developing insight and willing to consider that some of the comments about her might have a social context, thus mitigating her intense guilt and feelings of personal failure. We then continued to review concepts such as the medicalization of anti-social behaviour, nihilism, all or nothing thinking (located in society, not just in her psychological make-up) and the commodification of parenting (Barkley, 1998).

After a successful March break in which she saw some small successes from changing her thinking and actions, Ms. H started to make significant progress. Her enthusiasm for doing her homework increased, and she would excitedly give examples of her ability to link theory and practice. She asked me to explain concepts such as oppositional defiant disorder, conduct disorder, and personality disorders and I reviewed with her the differences in Axis I and Axis II disorders, as articulated in the DSM-IV. We would then discuss what she understood these concepts to imply in relation to her son's mental health history and her own reactions.

When I asked Ms. H to do a homework assignment to observe and describe 5 pop culture examples of the undermining of legitimate parental authority, she came to the next session with 10, written out in detail, and stated "I can't believe it - everything is being turned into a mechanism for selling focused on children!" After a deterioration of R's behaviour in the group home, he returned home somewhat unexpectedly as his placement options had run out, and Ms. H resumed full time parenting. Our focus then moved from the general to the particular, with Ms. H keeping a detailed journal of his behaviours and how these related to her approach, mood and confidence. Her journal entries became an instruction manual for her, and the tool she would refer to when in crisis or in an escalation of R's inappropriate behaviour. Despite offering for her to call me for consultation between our sessions if a serious crisis should occur, she never did, instead using the concepts and practice she'd developed in the process up to then.

In subsequent sessions, paced over a wider interval, she continued her enthusiasm, her lack of defensiveness, and her growing insight. Ms. H reported a dramatic increase in confidence, understanding her own risks of passive aggressive behaviour and the importance of

setting boundaries. Her natural sense of humour came through and she began to even sometimes enjoy the role of parenting a very difficult child. She prepared a list of priorities and then repeatedly adjusted to match changing circumstances and new challenges from R., demonstrating a newfound flexibility. Ms. H needed help to acknowledge that problems, mistakes, and failures would continue to emerge, but that a two steps forward/one step back model would better match her need for balanced confidence, even in normal setbacks. Ms. H's son is currently in another attempt, but with her support this time, to engage in a structured mental health program. Her relationship to the treatment team has improved with the reduction of her anger, reduction of her externalizing, and her newly acquired ability for analysis.

Discussion and Conclusion

Both of these cases serve to underline the risks of approaching our clients/patients unidimensionally. On the one hand, those of us in the helping professions who have challenged the medical model, often overemphasize the victim-of-social-conditions experiences of the persons we work with. We place so much emphasis on external (mostly unjust) forces, that we render people disembodied victims, non-citizens, lacking the ability to change and take responsibility for their personal choices within the larger social and cultural forces that have oppressed them. On the other hand, those of us in the helping professions who work in the medical model, tend to overemphasize internal, psychological, and biological experiences. Even when using a formulation model, the social aspect of predisposing, precipitating, perpetuating and protective factors is often restricted in practice to a narrow application, and dissociated from cultural, political and economic forces - the profound impact of sociology, not just personal social circumstances - on our ostensible "personal" behavioural choices. In the practice approach I suggest, we are obliged to relate to ourselves and to our client/patients as citizens, as individuals located in a culture and engaged in a fluid, active relationship to our society in all its dimensions. Neither the personal domain, nor the social domain are diminished, but in a dialectical relationship to each other.

Using this model, the individual and their personal choices are located in the core of a series of concentric circles, with the next influences being their family and neighbourhood, followed by urban, suburban, rural circumstances, then their province, country and so on. Their experience is infused with class, gender, ethnicity, age, and ability issues, and then interacts with the dominant culture's positive or negative portrayal of these. Not only is the client/patient person then located in this model, but so is the helping professional, with all the same variables influencing the process for the therapist, as for the client. In the model I suggest, the process involves analysis, leading to shared goals for change, but not based on the kind of false equality which ignores existing power dynamics between a paid (usually well paid) professional, and the client/patient (often low income and powerless). In this model, it becomes necessary to view the person receiving service as not only a psychological and emotional being, but also as an intellectual person. This is not just another form of cognitive therapy, but a process that engages the person in the realm of ideas and in the intellectual exploration of their experience in the society we live. What is being suggested here is that "holistic" is a larger concept that is not often applied in practice, but when it is applied without complexity or unidimensionally, can be dangerously disempowering by relieving the person of any responsibility for their choices in the past and their agency for the future.

The methodology proposed here also provides the opportunity to use clinical and scientific language and the benefits of these, while simultaneously demystifying them as inaccessible and powerful tools of exclusion. We don't need to abandon the expertise or the years of training we've brought to the process. But we do need to explain, teach, and decode the language we use. We should remove its secrets – sharing it with the patient/client to use for their own analysis, whether they agree or disagree with its content as applied to them.

And finally, in North America, we live in a highly individualistic society, with patients/clients suffering extreme alienation and social isolation. If individualism is part of the problem and at the core of anti-social and/or self-destructive behaviours, then our interventions need to challenge individualistic practice by re-interpreting ourselves and our patient/clients in the collective and social realm. The famous Marshall McLuhan quote, "The medium is the message" applies not just to insights about our cultural and technical instruments of communication, but as well to our social interaction. If we practice individualistic therapy, removed from examination and location in social conditions, it's unlikely we can empower patient/clients to change.

References and Additional Readings:

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