
Epistemology, politics, emotions and counter transference: Around "The Biopsychosocial Model 25 Years Later: Principles, Practice and Scientific Inquiry".

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Send response to journal:
Re: Epistemology, politics, emotions and counter transference: Around "The Biopsychosocial Model 25 Years Later: Principles, Practice and Scientific Inquiry".

Email Jorge L. Tizón

The excellent and well-documented work presented by doctors Borrell- Carrió, Suchman, and Epstein (1) has the merit to introduce rigorously and radically the discussion about the current prevalence and validity of the model proposed by Engel 25 years ago. Thus, since the work merits it, and without trying to be too systematic in my commentary, I would like to add a series of contributions.

First, I think that today, it is worthwhile to re-examine the model with an open mind taking a serious and well-founded perspective as these authors do. The title of their work can give us an idea of that in-depth examination of the topic: principles, research, and practice.

And to join in the discussion, I would say that today;

1) The Biopsychosocial model is being applied neither at a scientific nor technical level except in very limited circles, at least in the technologically developed countries in the world. 2) Although there are worthwhile groups and organizations that try to develop it at a clinical and practice level, 3) its principles continue to be reiterated, although they should be revised and updated from the four-sided perspective of every scientific or technological discipline of the model: theoretical, technical, epistemological and practical or pragmatic. 4) The model has a limited application today in scientific research, except in the field of primary care. 5) It calls special attention to the lack of theoretical and technical application in the field of mental health.

It is my understanding that the causes for this situation would have to sought in: 1) The biases of extreme biological reductionism that are re-emerging in the different specialties in medicine. 2) Extremely mechanistic theoretical and epistemological empiricism of this theoretical re-imposition.

In a first approximation, both phenomena can only be explained by:

a) A decrease in the mental abilities of the doctors and researchers in the field of medicine and health care. b) A cultural and ideological imposition and even of a power derived from the domination of the medical-industrial complex. Today, the imposition of these not only invades health care, but also the critical thinking capabilities, autonomous ethics and clinical approach to the consultation process of a great part of our teachers, administrators and researchers.

Since it can be foreseen, I emphasize (provisionally) the second hypothesis to explain to myself that abnormal re-introduction of the "one- dimensional thinking" embodied by the triple biological reductionism, the mechanistic empiricism and the "health care free trade". A theoretical trilogy and diametrically opposed to Engel's proposal, of course.

However, that ideological and social reality is impeding us, as far as I know, from executing the application of the biopsychosocial model in broader, less limited circles. Also, it is impeding us from performing a critical re-evaluation.

Along the lines of the authors, I would propose a re-evaluation in those four fields that categorize any scientific or technical discipline: theoretical, technical, practical and epistemological: I will provide some of my views in those areas:

I) In the epistemological and theoretical area

1) As the authors indicate, Engel was quite radical when he criticized the dualistic nature of modern medicine. But today, the concept is expanding and the practice of "biomedicine", a way, as far as I know, of radicalizing its biological content, in a consequent anti-Engel spirit.

2) In terms of the materialist reductionism criticized by Engel- in a way that today we could understand as something naïve – is even more omnipresent, and in an even more reductionist version. The "gene" is pursued to explain each illness, trauma or even individual and social behavior , because once that agent is found "everything will be resolved". How many "holistic", "global", "biopsychosocial", "anthropological" and other thoughts are thrown overboard in the process?

3) The influence of the observer in what is observed was in its time an excellent remembrance of Engel, who relied on the pioneering contributions about the topic – in chronological order – psychoanalysis, physics of relativity, cybernetics and general theory of systems. However, we are further away from having developed, with any depth, at a theoretical and technical level, this epistemological perspective.

According to my understanding, at that theoretical and

epistemological level, the consequent development of the biopsychosocial model would suggest today at least the following ideas:

1) The development of the epistemological model, based on contemporary epistemologies, such as the "non-representative realism", "critical realism" or "constructivism".

All theoretical approaches insist that in our approximation to the knowledge of any reality, we must take into account the study of its genesis as of its structure, as well as the subject-object relationship that we establish in its knowledge. More reason to do it in the field of technologies of health care. I have, in my writings, tried to apply those post-empirical epistemologies, initially developed by Popper, Piaget and later by authors such as Burge, Chalmers and others (2), to the field of mental health then, to the field of primary care. Without much success, of course: The forces that have impeded sufficient development of the application of the biopsychosocial model in the case of authors and experts such as Engel tend to be more directed toward authors and experts, but much less relevant to and at the periphery of the Empire.

2) The development of the biopsychosocial model implies an intrepid work to the re-instatement of models that are more globalizing and anti- reductionist in the theory and practice of today's medicine. That activity of theoretical expansion will be impossible without actively combating the uninspiring pseudo-materialistic empiricism that dominates it today.

3) And, it will be impossible without an active and ample participation of the people in the profession, the population and the politicians that may try, at an ethical, theoretical, clinical and political level a re-formulation of that disturbing dominium that the pharmaceutical industry has extended to medicine and to contemporary health care. I insist that on the political issue, in fact, it is about a fight of power.

II) At a technical and pragmatic level, the authors purpose seven principles to complete and develop the model. I think that in this part, they refer fundamentally to the application of it, in other words, its practice. Those principles or pillars are:

1) Self-awareness (why not "insight"?) 2) Active development of the truth, 3) A new emotional style based on emphatic curiosity, 4) Self- calibration to reduce gaps, 5) Educating the emotions, 6) Use of informed intuition, 7) Communication of clinical evidence to stimulate dialog, not only as a mere application of a protocol.

Starting with my basic agreement with these proposals, I would like to combine them here with a series of

schematic contributions:

I agree with the authors in that, a basic topic today in the study and practice of the supporting disciplines consists in how to develop a theory and practice that includes emotions in the clinical relationship. How to introduce and to take advantage, in clinical practice, of emotional functions such as solidarity, contention, hope, and trust. How to use them to maintain an efficient and effective medical attitude precisely because it is unifying, attentive to the relationship. At an elemental level, I tried to make a series of concrete proposals for years, and I also proposed a qualification for that manner of exercising medicine: "health care centered on the care-seeker" (3) an application and development of the model of Balint of "patient-centered medicine" (4) furthermore, the model can be expanded to "health care centered on the care-seeker (while member of a community)" (5). A basic element in that tradition is the introduction and re-introduction in the biopsychosocial model of the basic psychoanalytical contribution. In fact, for complex problems of scientific empirism and of struggles of power, I think today, psychoanalysis is excessively isolated from medical theory and practice. However, it is precisely the technological orientation that has most taken account the study and the technical use of emotions and attitudes of health care personnel and of the mutual emotional influences between clinician and the care-seeker. The struggles of power between the theorists in technical-behaviorist and systems approaches against psychoanalysis (and vice versa) have impeded the pursuit of the potentialities of the latter in this field; today those contributions have greater potential precisely because of the importance that the interpersonalists and intersubjectists possess in modern psychoanalysis.

Precisely, a consequence of the application of the model of Engel and of the seven proposed principles by Borrell et al., would be to force an improvement in our systems of education of health care personnel taking into account this relational constructivist, intersubjective perspective. This would involve, for example, an increase in the practice of diverse types of personal therapy for clinical doctors, as much to promote their self-knowledge and dominium of their own blind spots as to facilitate a personal livelihood of the processes of psychological change that could later be applied to its clinical practice. I am referring here, for example, to personal psychotherapy, to group psychotherapy and group techniques, to specific techniques such as "grief groups" or "reflection groups" and "Balint groups", etc. that have proved for many years of their potential to increase the capacities of emotional awareness (as much about the professionals themselves as of the consultants). Such techniques, combined with others that are more cognitive, could be basic in maintenance and improve several of the aspects of the proposed changed by Borrell et al.: Seen in depth, several of such principles are found connected with countertransference, if we utilize a

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traditional concept. Firmly, the principles that the authors enumerate and label as (1) self- awareness (2) active development of the truth (3) an emotional style based on emphatic curiosity (4) self-calibration to reduce biases and (5) education of emotions. Five of its seven principles have to do, as I understand, with the ability to use one's own emotions, feelings, attitudes and ethics (ability that is based, or course, in the ability to be in contact with them, in other words, in the ability of "insight").

And all of them, without forgetting the political and organizational context that has changed in an important way from the proposals of Engel: for example, a great part of the present and future care is being done in groups, in teams. This means obvious changes not only in the external setting of our practice, but also in the internal setting. On the other hand, at a political level, the advancement of certain health systems in the world seems evident. With time, its bureaucratic excesses will try to remedy themselves through the introduction of internal competition, the competition with the private sector and certain principles of the market. But new unresolved problems emerge: for example, the tendency of the private systems and the law of the private welfare to infect in different ways, those supposedly public systems. But this topic is too complex for us to be able to analyze it in such a superficial way. Thus, I think I will be content with mentioning it briefly and I give thanks again to the authors and the magazine "Annals of Family Medicine" for providing us the possibility of this open discussion.

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