



## ICPCM Newsletter – November 2015

### **Integrating subjectivity and narratives in Primary Care**

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#### **Integrating mental health in primary care**

It has been extensively shown that mental health problems or symptoms are frequently brought up in the context of primary care either as the main reason to consult or as a concomitant symptom. This is at the heart of the WHO WONCA report “Integrating mental health into primary care” (WHO-WONCA 2008) and also extensively demonstrated by several well-designed studies more or less in line with the Alma Ata declaration on primary health care (see for example Berkel et al, 2004 and Hickie, 2004). Hence, it can no longer be disputed that primary care is the best setting to ensure that people get the mental health care they need, not only because “it is accessible, affordable, acceptable and cost effective“ but also because while promoting “early diagnosis, respect of human rights and social integration”, “primary care also helps to ensure that all people are treated in a holistic manner, addressing both their physical and mental health needs” (WHO-WONCA 2008). To the point that - even if there is still a lack of evidence - this holistic ambition is fulfilled in this perspective<sup>1</sup>, many countries have tried more or less successfully to restructure their organization based on these principles including practical, rather than conceptual, adaptations to their cultural and socio economic context. In many cases their main objective is to find the most cost effective and sustainable way to diagnose a nosographic mental disorder using brief evidence based screening for such conditions (Spitzer et al, 1994). In this type of adaptation “holism” is limited to the integration of a somatic and mental disorder centered appraisal of

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<sup>1</sup> Mainly because there is a lack of criteria and metrics to evaluate these aspects

the health status without real consideration of the person as a whole including his values, expectations and subjective aspects. An apparent unanimity on benchmarked principles hides a profound heterogeneity of their definitions and, not surprisingly, a strong implicit tendency to maintain the health organizations in their usual biomedical type of approach to physical and mental health: a disorder centered approach. Various indicators, and particularly criticisms and complaints coming from users and stakeholders show that this perspective is far from satisfactory.

### **Why a Person Centered Psychiatry?**

One of the main problems health professionals have to face when dealing with mental health or psychological issues is the fact that - maybe more than other medical disciplines - Psychiatry and Mental Health are exposed to the negative effects of a disorder centered approach. Because of the many competing theories about the very nature of one's mental life a disorder-centered approach risks neglecting many of the non-objective aspects of the person's mental health, including key aspects such as subjectivity and psychodynamic dimensions. The implicit or explicit tendency is to mimic the paradigm based on the biomedical classifications in other medical disciplines.

The first stake of a person-centered perspective is to fight against this abusive reductionism that leaves us "with half a science" (Strauss, 2005) and landmarks not well adapted to clinical practice (Mises et al, 2002). The objective of this paper is to briefly consider and discuss the process allowing a professional to access subjective and psychodynamic dimensions of the patient's health status and consider how this process could be integrated into primary care. In this perspective, the modernity and originality of Person Centered Medicine (PCM) reside in the fact that it does not satisfy itself with asserting its principles but strives to define conditions for the effective implementation of this ambition, in each medical situation. What counts most here is to meet real patients' needs and not those of more or less paradigmatic entities defined by each medical speciality which trigger the reductionist approach imposed by the research methodology in a "classical" Evidence-Based Medicine approach.

Three conditions must be met to reach this goal (Mezzich et al, 2010; Botbol, 2012):

- To take into account the whole being of the patient (I am myself and my context (Ortega y Gasset, 1914).

- To consider the diagnosis and therapeutic choices as a joint process involving the person of the patient, the persons of the carers (family and caregivers in general), and the person of the clinician
- To consider as essential the subjective aspects of the person's health situation, and not only the objective aspects of the illness.

This last condition is the topic of this brief paper, starting with the idea that, in addition to the attention paid to the medico-biological aspects of the person's health status, a person-centred assessment needs to give enough consideration to the patient's subjective feelings. Whether or not we suspect a psychic or psychosomatic causality to the disorder that a patient brings to us, it is essential to keep in perspective the factors involved in the patient's health situation.

“Beyond reasserting this principle, we need to utterly enhance the methodology for accessing these subjective dimensions among different partners involved in the diagnostic process and the therapeutic relationship” (Botbol et al, 2013). For the professionals, the only way to access these subjective dimensions is through what the patient (and or his carers) says in words or shows in acting, as long as these words or acts can trigger in the professionals enough empathy to approach the patient's subjective feelings to which these expressions are related.

At first considered as the professional's ability to listen sympathetically to the comments of the patient and to integrate his wishes and needs, the notion of empathy has gradually widened to include representations that the physician (or the health professional) makes of the clinical situation in which the person in need of care is involved. In short, these are representations that the professional makes of the health situation of the person suffering through his/her (the professional) own empathy, triggered by the words and the acts of the patients and their caregivers. This mechanism is well described by the concept of “metaphorizing-empathy” proposed by Lebovici (1999) from his work with babies and their mothers. It is also close to the notion of “narrative empathy” proposed by Jacques Hochmann (2012) based on his work with autistic children and on the philosophical ideas brought by Paul Ricoeur, a famous French phenomenologist, in his book “Time and Narrative” (Ricoeur, 1983). It is also consistent with Kleinman's assumptions (1988) on illness narratives. This important development in PCM marked the full recognition of the role of the physician's subjectivity as a diagnostic and treatment tool in the physician-patient relationship.

To approach the subjectivity of the person (in both its conscious and unconscious aspects) (Botbol et al, 2013) the physician has to use his personal commitment in the relation with the

patient and his metaphorizing empathy. This perspective is very consistent with the reality of medical practice that, in one form or another, must deal with this vital dimension in every patient. Moreover, by establishing the subjectivity of the physician as a tool for understanding the patient and his disorder, the subjective involvement of the professional regains positive status which was lost with the progress of objective technical medicine. In this perspective the subjectivity of the professional can be properly included in practice and training if enough space is given to work it through. Rather than training the professionals to fight against their subjective movements or to deny it and to prevent them from getting closer to the patient's personal needs, Person Centered Psychiatry (PCP) proposes to train them to use these subjective movements as their best tool to access the patient's subjectivity. Thus, PCP acknowledges relevance for clinical practice of the clinician's congruence in the relationship, (i.e. his or her access to experiences arising in resonance with the patient). A required condition is, for professionals, to be trained to work it through properly, and develop enough reflexive capacities. This would enable them to take subjectivity and intersubjectivity as one of the bricks of the therapeutic relationship, i.e. the interactive construction they should build with the patient and for him or her, involving all those who are contributing to their health care and health status (Botbol et al, 2013). Teamwork and peer supervision are crucial to enhance and sustain this interactive process.

### **What about subjectivity and narratives in primary care?**

Obviously, subjectivity is of crucial importance in primary care, not only because a primary care visit usually is the first contact with health professionals but also because it is the first step in a process transforming a suffering or a distress into a medical disease or disorder. In this complex process contributing eventually to the transformation of "pain into suffering" (Ricoeur)<sup>2</sup>, the proximity of primary care with the person's every day life can obviously be a major asset to take into account the subjective feelings induced by his/her health experience and status, and potentially their subjective determinants. It is generally considered and well documented that this asset contributes to the accessibility of care and their cost effectiveness in most medical conditions. However, there are emerging concerns that this asset could become an obstacle to care when proximal relations do not help the patient to address the subjective aspects of his health in relation or not with his/her somatic condition.

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<sup>2</sup> For Paul Ricoeur, there is a crucial difference between Pain and Suffering. In Pain, physical or psychical, painful experience suppresses all psychical representations and reduces communication with others, whereas in Suffering, the painful experience triggers psychical representations and the need to communicate with others (Botbol et al, 2005)

Schematically, three reasons can transform primary care proximity and generality into an obstacle for such subjective appraisal:

- The patient's fear to disclose a stigmatizing situation to a health professional integrated in his every day life;
- His difficulty to recognize subjective aspects and psychological distress related to health questions (physical, mental or both) due to the health problem itself, either when this difficulty is one of the symptoms of this condition (Alexithymia as symptom of various health disorders<sup>3</sup>) or when the pervasiveness of the somatic issues tends to mask the psychosocial aspects of the disease;
- In these various situations, the lack of time and expertise of primary care professionals to recognize and overcome adequately such obstacles in clinical situations.

In a person-centered perspective, these obstacles should be addressed in the situations in which they occur. While in many cases, this could be achieved through the better promotion of person-centered medicine principles (given that person-centeredness in medicine is not only an ethical stance but also a technical advancement), we have to study more closely if the current "WHO service organization pyramid for an optimal mix of services for mental health" (WHO-WONCA 2008, p16) is sufficiently adapted to tackle the problem raised by the integration of the subjective aspects of health into health care. To do so, there is an urgent need to elaborate relevant metrics to evaluate more thoroughly how this issue is tackled in the currently recommended health service models. My hypothesis is that, if we want to address seriously the problem raised by the integration of subjective dimensions into primary health care, we may have to consider amending this optimal model to make sure that renouncing the integration of subjective aspects of health into primary care will not be the price to pay to the cost effectiveness, affordability and transparency claimed by the model.

## **Conclusion**

PCP has brought back the person of the patient at the centre of psychiatry and mental health, allowing integrating the subjective dimensions of the patient's mental health into the psychiatric and mental health care from where they have been generally excluded by the disease-centered approach. For involving the personal commitment of the mental health

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<sup>3</sup> It can be related to various health issues or disorders: suffering Adolescents (Loas 2010), Psychosomatic conditions (Sifneos 1973), Personality disorders (Feldman-Hall et al 2012), or other medical or psychiatric illnesses (Taylor and al 1999)

professional and his empathic capacities the approach of this dimension needs time and specific training. As first interface between the patients and the health care system, primary care is of crucial importance for the implementation of person-centered principles into the health system. It is the reason why, after being the focus of the International College for Person Centered Medicine (ICPCM) during the last Geneva Conference, it is also going to be the topic of the 2015 ICPCM International Congress in London. The usefulness of the optimal use of primary care is well documented for its cost effectiveness and affordability; in contrast, however, more studies are needed to better know the conditions that primary cares have to meet to be person-centered, especially when it comes to integrating subjective aspects of health. This paper addresses particularly this last issue: it deals with the problems faced by the integration of a subjective dimension of health into the primary care setting. It claims that, besides the well-demonstrated usefulness of the primary care oriented model, there is still a long way to go to insure that this subjective dimension will not be lost in primary care.

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