# 3rd Place Winner of 2025 Te Tupu Whakaritorito (PIF New Zealand) Competition

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## Essay topic – 'Seeing the whole person beyond the diagnosis'

*"He aha te mea nui o te ao? He tangata! He tangata! He tangata!" - "What is the most important thing in the world? It is people! It is people! It is people!"*

**By Hayley Bennett**

### Introduction

The biomedical model conceives questionable behaviours or thoughts as mental health disorders or problems (Huda, 2021). This is the foundation of the Diagnostic and Statistical Manual of Mental Disorders 5th edition (DSM-5), which characterises clusters of behaviours into an objective common language of diagnoses (American Psychiatric Association, 2022). However, The DSM-5 does not allow for the subjective experience of the patient. The biopsychosocial model and the development of the 'four P's' (predisposing, precipitating, perpetuating and protective factors) examined from biological, psychological and social lenses go further than the DSM-5 to examine the context of the person's illness (Bolton 2014). These together however still do not fully capture the patient's experience and their interpretation of their disorder. Culture, ethnicity, and trauma also need to be considered. When clinicians do not take the full experience of the patients into account, they risk defaulting to a "cookie-cutter" approach to treatment, rather than effectively tailoring it to the needs of specific individuals.

This essay explores the definitions of the biomedical model and its limitations. It then explores formulation in psychiatry and finally how person-centred care facilitates different personal, whānau, cultural and ethnic interpretations of mental illness, particularly in Aotearoa (New Zealand).

### The biomedical model

The biomedical model reduces illness to a physical malfunction at a lower level of organisation, such as a mental illness being an imbalance of neurotransmitters (Rocca & Anjum, 2020). An example would be with attention deficit hyperactivity disorder, (ADHD). This is recognised as a difference in childhood behaviour but is explained as a neurobiological disorder that is primarily treated with psychostimulants (Rocca & Anjum, 2020). Karlstad et al 2017 however demonstrated that children born later in the school year had a higher chance of being diagnosed with the condition, suggesting that other social factors contributed to the diagnosis (Rocca & Anjum, 2020). This is where the biomedical model fails to take the whole person into account.

Using this model alone also risks overdiagnosis and mislabelling. This creates potential for children to be subjected to medication they do not need and may mean they are discriminated against due to psychiatric diagnosis.

Concepts such as disease and illness are also problematic in the biomedical model. The concept that illness is seen as the subjective experience of the disease, in contrast to the disease itself was first proposed by Kleinman in 1978 (Huda, 2021). The biomedical model therefore has been criticised as being reductionist, where treating patients' concerns in isolation may not reveal the source of the problem (Rocca & Anjum, 2020). For example, a person with severe depression can be prescribed medication but that will not address any underlying social or psychological reasons they were vulnerable to depression in the first place. These shortcomings led to the development of the biopsychosocial model of health.

## Biopsychosocial model

In 1977 George L Engel introduced the biopsychosocial model to help explain mental disorders (Engel, 1977). It illustrated the complex interaction of biological, social and psychological factors in the development of mental disorders (Engel, 1977). These elements interplay at various levels and are unique to each patient. This means they can be used to try to individualise treatment beyond medications (Mahapatra & Sharma, 2024). Indeed, research on epigenetics has demonstrated the interaction between genes and the environment. Environmental stressors can determine which genes are switched on or off, thus predisposing genetically vulnerable individuals to disease (Fiorillo & Giordano, 2022). This is demonstrated in both schizophrenia and cancer, which share several risk factors such as migrant status, alcohol consumption, and adverse childhood events (Fiorillo & Giordano, 2022). None of these on their own are sufficient for the development of the condition but are thought to make the genome more unstable and cause epigenetic changes (Fiorillo & Giordano, 2022). Thus, biology alone is inadequate to explain the development or course of a mental disorder. The Te whare tapa wha model which describes health as a wharenui/meeting house with four walls, can also be applied to the management of disease (Durie, 1985). It explores various aspects of a person's tinana (physical), hinengaro (emotional), wairua (spiritual) and whānau (family) health in relation to their mental health (Durie, 1985). This approach moves beyond risk factors towards balance and wellbeing. Using a biopsychosocial lens, treatment for people with schizophrenia may include weight management, supportive employment, family-based interventions and alcohol and drug recovery programs. (Mahapatra & Sharma, 2024).

The biopsychosocial model is a more holistic take on patients' care, but it has been criticized for its inability to form measurable outcomes for interacting outcomes. This makes it difficult to study. It also does not account for subjective matters such as personal meaning and spirituality. (Benning, 2015). The importance of the doctor-patient relationship in disease outcome is also not addressed. (Ghaemi, 2011). Personal meaning and spirituality are essential in psychiatry. How patients view and find meaning in their illness can affect medication adherence, engagement with their clinician and their levels of distress.

## Case formulation and the 'four P's'

Engel's biopsychosocial model required a more applied approach that examined how a diagnosis arose, what maintains it and what limits wellbeing (Bolton, 2014). The four P model integrates these into a framework to apply the biopsychosocial model to patients at a personal level (Bolton, 2014). The four P's are predisposing, precipitating, perpetuating and protective factors. These are used to examine the biological, social and psychological domains to get a more complete picture of patients and individualise treatment plans. (Bolton, 2014). Although this is a more patient-focused approach, it is still not adequate to address patient needs. In-patient studies have shown that being perceived as a 'whole person' was particularly important (Eldal et al., 2019). Whole-person care is about looking beyond what characterises their status as a patient but also their subjective feelings and experience (Mezzich et al., 2016). Therefore, person-centred care is the next tier in patient care that enables patients to maintain their dignity and personhood rather than being reduced to a diagnosis. A person's worldview and interpretation of their illness can dramatically change any distress they feel, which in turn will determine if medication is required or not. Formulation still happens to the patient unless care becomes with the patient.

## Person-centred care and its use in Aotearoa

Person-centred care means treating each patient as a unique human being and an equal partner in their own health (Coulter & Oldham, 2016). This makes treatment personalised and unique to each individual where all aspects of their worldview are acknowledged and respected. An example of this is culture. Patients' culture directly impacts the meaning and manifestation of mental health for them. For example, using a te ao Māori lens (māori worldview), psychosis and schizophrenia are seen quite differently. Hearing voices could be considered normal, as if speaking to one's ancestors (Taitimu et al., 2018). Overly pathologising these experiences without assessing the whole person could lead to poor outcomes from unmet spiritual and cultural needs. In Aotearoa, this is also true of Pacific peoples. Cultural values on health have a considerable influence on Samoans' health seeking behaviours and engagement in the healthcare system (Mulipola, 2023). Integrating and respecting cultural and spiritual values into mental health person centred care is integral to ensuring Samoan people can engage and participate in mental health services (Mulipola, 2023). Different approaches to family discussions such as fa'afaletui (conversations) make patients feel more welcome and able to express their values. Consideration of culture therefore is not a luxury, but central to understanding patients' distress.

It is important for all patients, regardless of race, culture, and ideals to receive individualised care that is unique to their situation. Therefore, Person-centred care is essential in a multicultural society such as New Zealand to address any inequities in healthcare and ensure everyone has access to the best care possible.

## Conclusion

In a constrained health system person-centred care can seem like an impossible goal. However, to obtain the best outcomes for individuals and their whānau, taking the time to ensure that their needs are met and they are an active participant in their own health is essential to remove inequities and ensure everyone feels safe to engage in healthcare services. The biomedical and biopsychosocial models are not adequate to deliver individualised care. Healthcare professionals need to adapt their practice to see patients as unique individuals rather than a condition. Psychiatry is an ever-changing field that has begun to recognise the complex interplay between biological and human factors that cause disease. These factors also play an important part in treatment and recovery not only for the individual but for their whānau and communities. Therefore, person-centred care is the only way forward to be the best support for our patients. Whole person care must shape every clinical decision and make us better people as well as better clinicians.

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