# BIOPSYCHOSOCIAL ASSESSMENT IMPORTANT IN DIAGNOSIS AND MANAGEMENT FOR FUNCTIONAL GI PATIENTS

Adapted from *Gastroenterology & Endoscopy News*, May 2003

The biopsychosocial model of chronic gastrointestinal (GI) disease may be a better approach to diagnosing and managing patients than the traditional biomedical model, according to presenters at the International Symposium on Functional Gastrointestinal Disorders, which was held in Milwaukee, Wisconsin, March 31 through April 4, 2003.

"The biopsychosocial model proposes that illness and disease result from interacting systems at the cellular, tissue, organismal, interpersonal and environmental levels," explained Douglas Drossman, MD, Professor of Medicine and Psychiatry in the Division of Gastroenterology & Hepatology (School of Medicine, University of North Carolina at Chapel Hill) and Co-Director of the UNC Center for Functional GI & Motility Disorders.

Physicians can integrate the biopsychosocial model into their practices by evaluating dietary and lifestyle factors, the role of stress, social support, life trauma (e.g., abuse history), and the patient's overall coping mechanisms. "For treatment, one should look at the severity of the condition, the biological and psychosocial factors that may be influencing the nature and severity of the symptoms, and let one's treatment decisions be guided by that," said Drossman.

Chronic GI illnesses (illness being defined as the patient's perception of ill health) are not fully explained by observable disease (defined as conditions externally verified with xrays, endoscopy, histology or other analysis), according to Drossman. In contrast, biomedical researchers are looking to explain illness based on the presence of an organic cause of a disorder. "From their perspective, functional GI disorders are defined as the absence of organic disease and, if disease is not found, as a psychiatric disorder," Drossman explained.

According to William B. Salt II, MD, clinical associate professor in the Department of Medicine's Division of Gastroenterology at Ohio State University in Columbus, there is growing evidence that functional GI disorders have biological and psychological influences where the interrelationship of environmental, physical and social factors is particularly relevant. "When practicing, I use a mind/body/spirit language to communicate with patients," said Salt. Using the word biopsychosocial can be confusing for some patients, he noted. However, using the term mind/body/spirit helps to create a common language for patients and doctors. "Patients respond well to the idea," he said.

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"It helps them become open and receptive to therapy." Nicholas Diamant, MD, professor of medicine and physiology at the University of Toronto in Ontario, Canada, believes the biomedical model tends to restrict one's view of the patient's condition to specific abnormalities, signs and symptoms, while the biopsychosocial model offers a more holistic approach. Diamant encourages doctors to think beyond the physical, neurological, pathological and biochemical aspects of treatment and to consider cultural and spiritual aspects of the patient. Some doctors are more comfortable with those aspects of disease they can define and measure. However, Diamant believes that patients appear to be seeking a harmonization of the mind, body and spirit, which is illustrated by the fact that 40 percent of Americans are using alternative medicine.

Definitions of illness and disease among health practitioners are important, said Diamant. "We need to be talking the same language when we are discussing (disease) models and the issues around our patients, but many times we are not," he said. "Illness and disease are often used as if they were the same thing; sometimes they may be, but other times they are not." Physician definitions of mind, psyche or self differ based on where they are coming from philosophically and biomedically, he added. Disease and illness do not always correlate when viewed solely through the biomedical model, because this model assumes all conditions can be linearly reduced to a single etiology and that illness and disease are either organic (having a defined etiology) or functional (with no specific etiology).

In the clinical setting, finding a specific disease that correlates with illness (i.e., the patient's perception of ill health) is challenging, said Drossman. Often, when disorders such as chronic abdominal pain or irritable bowel syndrome appear to have no biological cause, they are considered psychosomatic, which is defined as pain based solely on psychological factors. The use of this term questions the creditability of the symptoms, which are very real to the patient. Specifically, the biopsychosocial model for functional GI illness includes early life factors, either biologic or behavioral, and their later effect on psychosocial experiences, physiologic function or susceptibility to a pathological condition. "Early life factors might affect psychological factors and the physiology of the gut, and interact with each other to produce symptoms," Drossman said. "Psychosocial factors also play a role in terms of the [patient's] appraisal, perception and behaviors in response to the illness," said Drossman. "Psychosocial distress may lower pain threshold and may affect pain behavior and influence health care seeking." In fact, people with IBS who do not go to the doctor often have a psychological profile similar to non-IBS control populations.