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Discourse

The Biopsychosocial Perspective in Psychiatric Nursing: Myth or Future Reality?

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As psychiatric nurses enter the new century, we can reflect on some important achievements, including establishment of an advanced-practice-nursing role within mental health services and development of a broad range of skills that enhance our contributions to the care of severely mentally ill adults. Changes in psychiatric nursing practice are informed by the dramatic advances that have occurred in psychiatric treatment over the past decades. In the realm of psychopharmacology, "third generation" medications offer a range of safer and more tolerable alternatives for care than older agents. In the psychosocial arena, clinical research has identified conditions that increase vulnerability to acute psychotic illness as well as protective factors that prevent or delay relapse and promote coping and social function. These new understandings have provided the impetus for innovative programs (such as family psycho-education or intensive case management) demonstrated to be efficacious under the strict conditions of clinical trials (Lehman, Steinwachs, et al., 1998). Without trivializing the continuing impact of

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severe mental disorders, it is probably fair to say that, because of access to appropriate care, many severely mentally ill adults can now anticipate more satisfying, "normal" lives with reasonable control over their symptoms.

This has important ramifications for mental health providers, who can move beyond a preoccupation with relapse prevention and reduced re-admission to hospital. As our treatment expectations evolve, we can also focus on broader quality-of-life issues that affect the well-being of patients and their families (Ricard, Bonin, & Ézer, 1999). The term *quality of life* has crept into our lexicon, sometimes without very clear definition. Generally, it refers to both objective and subjective appraisals of living conditions across domains such as housing, income, occupational activities, social relationships, and general health. The implicit assumption is that these are the areas that make life worth living. Many rehabilitation programs target quality-of-life outcomes — for example, cooperative housing or supported employment programs. However, the domain of general health status has received relatively superficial attention, on the part of researchers as much as mental health clinicians.

This phenomenon is astounding for several reasons. First of all, it seems to underplay the well-known effects of major mental disorders on physical function, including appetite, sleep and wakefulness, energy level, and motor behaviour. Also, it fails to acknowledge the centrality of medication in the lives of the mentally ill. Mentally ill adults live with complex regimens that have powerful effects on the body. Even "novel" agents touted because of favourable side-effect profiles can contribute to very serious obesity and to the associated problems of cardiovascular diseases and new-onset diabetes (Casey, 1999). Finally, severe mental illness sometimes leads to lifestyle risk factors such as smoking, poor diet, sedentary lifestyle, and substance abuse. These contribute to a variety of chronic illnesses, including cardiovascular diseases (Hayward, 1995). As people age, they may experience the impact of these health risks as well as other chronic medical problems.

The mentally ill homeless represent the extreme case, at risk for all the problems associated with unsafe living conditions and extreme poverty. These include respiratory infections, problems related to hygiene and nutrition, injuries, and exposure to diseases such as tuberculosis (White, Tulsky, Dawson, Zolopa, & Moss, 1997; Zolopa et al., 1994). Substance-use disorders often coincide with severe mental illness, adding to the risk of medical problems. In addition to some of the well-known effects of long-term alcohol abuse or dependence, drug use appears to incidence the risk of HIV/AIDS among the mentally ill in

some settings (Cournos et al., 1994; Empfield et al., 1993; Susser et al., 1996). In sum, psychiatric illness, its treatment, and associated lifestyle factors as "patienthood" can contribute to medical morbidity and mortality (Jeste, Gladsjo, Lindamer, & Lacro, 1996; Simpson & Tsuang, 1996).This point is brought home forcefully in a recent report in the *British Journal of Psychiatry* (Harris & Barraclough, 1998). The authors point out that, given the improvements in psychiatric treatment, it is time to critically examine the issue of physical illness among the mentally ill. Their meta-analysis of 152 English-language reports published between 1966 and 1995 identifies deaths from both "unnatural" (suicide and other violence) and "natural" (medical) causes. Based on these data, they identify "excess mortality" among the mentally ill, or their risk of dying from a specific cause compared to expected mortality among similar age groups in relevant countries. The highest rates occur among groups with eating disorders and substance abuse. However, the rates in schizophrenia are significantly higher than those in comparison samples, and, while many excess deaths reflect suicides, 62% are due to medical illness. For all affective disorders, the figure is 45% (major depression alone did not produce statistically significant findings). These figures provide stark documentation of health risks among the mentally ill, independent of factors such as suicide. They are probably also conservative, since they describe samples with single diagnoses rather than the extensive comorbidity that we observe today. For example, some of the cases with schizophrenia lived in institutions that controlled diet and restricted access to cigarettes.

It seems apparent that severely mentally ill adults require access to the appropriate general health services that can address their particular profile of needs. However, the mental health clinicians who provide their ongoing care frequently come from social-rehabilitation backgrounds and have limited knowledge of general health care. At best, they depend on referrals to community medical providers. Certain patients, because of their symptoms or their cognitive or functional deficits, may not be able to negotiate appointments, to clearly express their complaints, or to tolerate stressful interview and examination procedures. Failure to complete an appointment, communication difficulties, or interpersonal withdrawal may be misunderstood and mislabelled as "non-compliance" and "poor motivation for treatment." Further, even the most interpersonally sensitive primary care providers may lack knowledge about psychiatric regimens that should be considered in a total plan of care.

It will be difficult to improve this situation in a climate of cost containment, with its emphasis on brief treatment of acute psychiatric

problems and rapid return to the community. Resources seem to be limited for health maintenance, promotion, and prevention among mentally ill adults. Moreover, whether they receive care in an institutional or a community setting, these patients are followed by highly specialized teams lacking the preparation and experience to link their psychosocial approach with the primary care that takes the complex needs of this population into account.

As nurses, when we search for solutions our tendency is to promote psychiatric nurses within the mental health teams, extolling them as the only mental health professionals with a truly biopsychosocial tradition and orientation. However, we should look very critically at these kinds of beliefs and assumptions. True, psychiatric nurses in traditional settings have long been responsible for the physical well-being of their patients and for a holistic view of self-care. However, advanced-practice nurses such as Clinical Nurse Specialists have sometimes abandoned the traditional nursing focus on almost exclusive adoption of psychotherapeutic treatment models. This narrow focus may have actually impeded efforts to define advanced-practice psychiatric nursing and to develop our role among the mental health disciplines (McBride, 1990; McEnany, 1991).

Today, a certain amount of progress has occurred with general recognition of the neurobiological bases of mental illness and the importance of biological treatments. In fact, psychiatric nurses have become highly competent in the management of psychotropic regimens, while responding effectively to the psychosocial needs of severely mentally ill adults. Nevertheless, it is important to ask if this neurobiological sophistication is sufficient. A genuine biopsychosocial perspective for care of the mentally ill should be much broader and should encompass the effects of psychiatric illness on every dimension of the individual's health, and not psychological function alone. This means that the patient should be able to find comprehensive services within the same program: services for health maintenance and promotion as well as treatments directed at psychiatric illness and at psychosocial rehabilitation.

Such an orientation would obviously require psychiatric nurses to develop new kinds of clinical expertise. One option would be development of graduate nursing programs to prepare advanced-practice psychiatric nurses with skills in the domain of primary care. Is it possible to develop and combine these two domains? Is there a danger of promoting primary care competencies at the price of psychiatric skills? Would this broad and comprehensive type of education be so demand-

ing in terms of course work as to erode the clinical teaching that should produce therapeutic use of self and psychotherapeutic competencies? All of these outcomes are possible.

However, if we continue to frame our discussion in terms of these kinds of questions, we reinforce the body/mind dichotomy that has thus far obstructed development of holistic nursing models for severely mentally ill adults. It is vital to think, instead, in terms of constructing new nursing models for the management of severe mental illness, ones that respond to new understandings about the clinical complexity of our patients as well as the forces shaping new and emerging systems of health care.

In the United States, Delaney, Chisholm, Clement, and Merwin (1999) report a growing trend towards integration of physical assessment, pathophysiology, and pharmacology in graduate education in psychiatric nursing. A number of universities have established "psychiatric nurse practitioner" programs to combine psychiatric and primary care. These include the University of California at San Francisco (Chafetz & Collins-Bride, 1997), the University of Pittsburgh (Dyer, Hammill, Regan-Kubinski, Yurick, & Kobert, 1997), and the University of South Carolina at Columbia (Williams et al., 1998). These experiences can certainly enrich discussion in the Canadian context, where in many provinces there is an increasing focus on development of advanced-practice nursing, such as projects by the Canadian Nurses Association (1999) and the Canadian Association of University Schools of Nursing (Giovanetti., Stuart, Tenove, & vanden Berg, 1996) that should lead to proposals for a framework of reference as well as recommendations for educational and research programs.

It is becoming evident that these kinds of programs can produce a new kind of advanced-practice psychiatric nurse who would make a unique contribution to the care of severely mentally ill adults and heighten the visibility of nursing within health-care systems. However, it is too early to determine the impact of their contributions on the health of severely mentally ill adults. Despite beliefs about the importance of a biopsychosocial perspective, its impact remains an empirical question. The evaluation of these innovations will constitute a turning point for the development of advanced-practice nursing. This is a time of exceptional opportunity for nurse researchers, who should be able to consolidate their resources and develop well-designed studies on outcomes of advanced nursing practice. These studies might be able to provide solid evidence of the ways in which we can improve the health

of severely mentally ill adults and the ways in which wellness can enhance the quality of their lives.

References

Canadian Nurses Association. (1999). *A proposed framework for advanced nursing practice — Preliminary draft.* Ottawa: Author.

Casey, D.E. (1999, May). *Optimizing wellness across the life cycle of schizophrenia.* Paper presented at the annual meeting of the American Psychiatric Association, Washington DC.

Chafetz, L., & Collins-Bride, C. (1997). The case for comprehensive role preparation. In A. Burgess (Ed.), *Advanced practice psychiatric nursing.* Stamford, CT: Appleton & Lange.

Cournos, F., Guido, J.R., Coomaraswamy, S., Meyer-Bahlburgh, H., Sudgen, R., & Horwath, E. (1994). Sexual activity and risk of HIV infection among patients with schizophrenia. *American Journal of Psychiatry, 151,* 228–232.

Delaney, K.R., Chisholm, M., Clement, J., & Merwin, E.I. (1999). Trends in psychiatric mental health nursing education. *Archives of Psychiatric Nursing, 13*(2), 67–73.

Dyer, J.G., Hammill, K., Regan-Kubinski, M.J., Yurick, A., & Kobert, S. (1997). The psychiatric-primary care nurse practitioner: A futuristic model for advanced practice psychiatric-mental health nursing. *Archives of Psychiatric Nursing, 11*(1), 2–12.

Empfield, M., Cournos,. F, Meyer, I., McKinnon, K., Horwath., E., Silver, M., Schrage, H., & Herman, R. (1993). HIV seroprevalence among homeless patients admitted to a psychiatric inpatient unit. *American Journal of Psychiatry, 150,* 47–52.

Giovanetti, P., Stuart, M., Tenove, S., & vanden Berg, R. (1996). Rapport du groupe de travail de l'Association Canadienne des Écoles Universitaires de Nursing sur la Formation Avancée en Sciences Infirmières.

Harris, E.C., & Barraclough, B. (1998). Excess mortality and mental disorder. *British Journal of Psychiatry, 173,* 11–53.

Hayward, C. (1995). Psychiatric illness and cardiovascular risk. *Epidemiological Reviews, 17,* 129–138.

Jeste, D.V., Gladsjo, J.A., Lindamer, L.A., & Lacro, J.P. (1996). Medical comorbidity in schizophrenia. *Schizophrenia Bulletin, 22,* 413–420.

Lehman, A.F., Steinwachs, D.M., & the co-investigators of the PORT project. (1998). *Schizophrenia Bulletin, 24*(1), 1–10.

McBride, A.B. (1990). Psychiatric nursing in the 1990's. *Archives of Psychiatric Nursing, 4*(1), 21–28.

McEnany, G.W. (1991). Psychobiology and psychiatric nursing: A philosophical matrix. *Archives of psychiatric Nursing, 5*(5), 255–261.

Ricard, N., Bonin, J-P., & Ézer, H. (1999). Factors associated with burden in primary caregivers of mental illness patients. *International Nursing Studies, 36,* 73-83.

Simpson, J.C., & Tsuang, M.T. (1996). Mortality among patients with schizophrenia. *Schizophrenia Bulletin, 22,* 485–499.

Susser, E., Miller, M., Valencia, E., Colon, P., Roche, B., & Conover, S. (1996). Injection drug use and risk of HIV transmission among homeless men with mental illness. *American Journal of Psychiatry, 156,* 794–798.

White, M.C., Tulsky, J.P., Dawson, C., Zolopa, A.R., & Moss, A. (1997). Association between time homeless and perceived health status among the homeless in San Francisco. *Journal of Community Health, 22*(4), 271–282.

Williams, C.A., Pesut, D.J., Boyd, M., Russell, S., Morrow, J., & Head, K. (1998). Toward an integration of competencies for advanced practice mental health nursing. *Journal of the American Psychiatric Nurses Association, 4*(2), 48–56.

Zolopa, A.R., Hahn, J.A., Gorter, R., Miranda, J., Wlodarczyk, D., Peterson J., Pilote, L., & Moss, A.R. (1994). HIV and tuberculosis infection in San Francisco's homeless adults. *Journal of the American Medical Association, 272*(6), 455–461.