

In Search of *Mental Health's Holy Grail*: The Era of Biology, CBT, and Other “Empirically-based” Recipes

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Abstract

This article explores some of the existent biases in mental health practice in the U.S.A. that limit the ability of the mental health professions to adopt a true biopsychosocial approach in the diagnosis and treatment of mental disorders. A tendency is evident to highlight the role of biological and cognitive-behavioral processes in the etiology and treatment of most mental health conditions. Some of the apparent underlying factors are briefly discussed, such as psychiatry's professional identity as a medical subspecialty, the financial priorities of the health care insurance and pharmaceutical industries, the search for a sense of efficacy and concrete guidance among mental health clinicians, and factors associated with a sense of agency and responsibility among consumers of mental health services. This has led to an incomplete picture of the etiology of mental disorders and a selective bias and reductionism in our treatment approaches. Popular empirically-based treatments (EBTs) fall significantly short in the implementation of a true biopsychosocial practice in mental health. Suggestions are offered toward the development of a more comprehensive integrative mental health theory and practice that more adequately reflects the biopsychosocial model.

Keywords: mental health practice; integrative psychotherapy; empirically-based treatments (EBTs); biopsychosocial model; USA.

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Despite the general acceptance of the biopsychosocial model of health in medicine and mental health, treatment approaches that integrate biological, psychological, and social aspects of mental illness are scarce. Dominant approaches to treat mental health problems tend to emphasize the role of biological (i.e., psychopharmacotherapy) and cognitive-behavioral factors, while other psychological factors (e.g., emotions, non-conscious mental processes, the therapeutic alliance, patients' and therapists' characteristics, etc.), and in particular social factors receive less attention. This article explores multiple factors that may underlie the professional dominance of biological and cognitive-behavioral models in the practice of diagnosing and treating mental illness. The central argument is that such selective bias in clinical practice promotes a compartmentalized and incomplete view of mental illness that over-medicalizes mental health problems and essentializes them into a discrete set of presumed biologically-rooted cognitive-behavioral processes. The development of more comprehensive theoretical and treatment approaches that more adequately address the complex interactions among biological, psychological and social processes is essential for a more adequate integration of a true biopsychosocial model in mental health practice. Successful integration of the biopsychosocial model can lead to the development of more effective mental health interventions. Several factors will be discussed that may help explain some of the existent biases in contemporary mental health practice, as well as suggestions for successful implementation of a true biopsychosocial model. In line with the goal of this special issue of *Rivista di Psicologia Clinica*, the purpose of this essay is to provide a critical reflection of particular interpretive models of mental health in the U.S.A. that result in a biased and incomplete mental health practice. In particular, these models highlight social and professional attempts to negotiate the relationship between individual (biological and psychological) experience and social context. The hope is that comparing and contrasting commonalities and differences across diverse professional-cultural experiences will contribute to our general understanding of how best to meet the universal social demands for adequate mental health care.

The BIO-Psycho-social Model in Theory & Practice: Supremacy of Biology

George Engel (1977; 1980) highlighted the urgent need for a new biopsychosocial paradigm to more accurately represent the true nature of mental health conditions. Although Engel wasn't clearly the first to suggest this idea, his writings became very influential in popularizing the biopsychosocial model in contemporary psychiatry and the other mental health disciplines (clinical psychology, psychiatric nursing, clinical social work and mental health counseling). Yet, decades after the popularity and apparent widespread acceptance of the biopsychosocial model, we are still quite far from having successfully incorporated a true biopsychosocial approach to guide mental health practice.

The influence of the U.S. health care insurance industry on clinical practice

In the U.S.A. the treatment of mental health conditions is significantly influenced by the allocation of benefits for mental health services by the health care insurance industry. Decisions made by these third-party payers regarding what types of clinical interventions are covered follow assumptions stemming from categories such as "biologically-based mental illness" (BBMI) as a way to determine "medical necessity" for treatment. Yet, despite some apparent consensual agreement regarding the robustness of these categories, empirical evidence supporting them is weak (Seidel, 2005). Ironically, strong emphasis on the biological basis of these categories seems counter to the very notion that all health conditions, but in particular mental health ones, are in essence biopsychosocial. Thus, based on their largely presumed

biological nature, BBMs are granted a higher level of medical legitimacy that results in prioritized allocation of benefits to cover treatments for these conditions. Unsubstantiated faux dichotomies often stem from such rigid categorization, which are reflected in clinical practice. For example, clinicians, in particular medical providers and psychiatrists, often make a differential diagnosis between a “biological depression” and a “situational depression”. Based on this distinction clinical decisions are routinely made about whether to treat a depressed patient with psychopharmacotherapy alone (for the biological subtype) or with a combination of psychopharmacotherapy and psychotherapy (for the situational subtype). In fact, failure to respond to psychopharmacotherapy is often used as the primary determinant to confirm the presence of the situational depression subtype. However, despite the routine practice of this differential diagnostics, evidence is lacking to support this presumed dichotomous categorization. Depression, the most prevalent mental disorder worldwide, is a clear example of the biopsychosocial nature of most, if not all, mental disorders (Hasler, 2010).

Even when clinicians may endorse a biopsychosocial view of mental disorders, it is common for the biological factors to be assigned greater prominence. Reflecting on my years of training as a clinical psychologist in a major teaching hospital in Boston serves as testimony of this existent bias in clinical practice. During a psychiatric emergency room (ER) rotation at this hospital we interviewed numerous distressed patients who would come to the ER in the midst of severe crises, typically feeling depressed and suicidal. After conducting a relatively brief interview, we were instructed to call the attending psychiatrist to provide a clinical disposition to the patient. The attending psychiatrist would routinely proceed to explain to these patients that they were suffering from clinical depression, which was a biological disease caused by a neurochemical imbalance in the brain. A recommendation would typically follow explaining that the most effective way to treat depression was with antidepressant medication. Patients who displayed a high level of safety risk typically would be admitted to the inpatient psychiatric ward, where the primary treatment goal was to find an effective medication regimen to stabilize the patients’ symptoms and discharge them as soon as possible. Patients who were considered safe to be discharged from the ER would typically leave with a short-term prescription of a common antidepressant, as well as a referral to a psychiatrist for follow-up psychopharmacological treatment. In some cases, somehow arbitrarily decided by the attending psychiatrist, the patients would also be told that some may find counseling helpful for treating depression as well. Clearly, routine psychiatric practice endorsed a biased view that psychopharmacotherapy was the primary treatment for clinical depression, while “counseling” (a term typically used loosely and inaccurately to mean “psychotherapy”) was described as a possibly helpful adjunctive intervention. The problem with such recommendations, which are routine practice in many clinical settings, is that they aren’t well supported by the existent treatment outcome research for depression. The general consensus from this vast body of research is that most cases of depression are best treated with a combination of psychotherapy and antidepressant medications (Pampallona, Bollini, Tibaldi, Kupelnick, & Munizza, 2004). Moreover, recommendations for interventions that address the role of social factors reinforcing the depression were rarely included in prescriptions offered to these patients.

Thus, an incomplete explanatory model of depression as a neurochemical imbalance has been established in widespread fashion across medical and mental health settings. This clinical myth exerts a significant influence in the routine conceptualization and treatment of depression. It also serves as an important determinant to monitor authorization of services by health care insurance company gatekeepers. As an illustration of the existent bias, if a patient suffering from major depressive disorder is receiving psychotherapy services without taking antidepressants, it is not uncommon for insurance company case managers to contact the treating clinician, and oftentimes the patient, to inquire about the absence of pharmacotherapy in this patient’s treatment plan. Yet, the reverse seldom takes place; that is, if the

depressed patient is being prescribed antidepressants alone without receiving psychotherapy, a case manager would rarely contact the prescribing clinician to inquire about the absence of psychotherapy in this patient's treatment plan. Again, this contradicts the strong empirical evidence that supports that the most effective way to treat most cases of major depression is through a combination of psychotherapy and antidepressants.

Discrepancies also exist among different health care insurance companies, and even among various states in the U.S.A., regarding what mental disorders make it to the BBMI or "medically-necessary" list (Seidel, 2005). These categorizations are often more strongly influenced by health care insurance companies' policies and financial strategies than based on robust empirical evidence. A case in point is the inclusion of post-traumatic stress disorder (PTSD) into the BBMI category. Given the obvious nosological association of PTSD with environmental factors (i.e., a traumatic event), there was initial resistance to grant this disorder the biologically-based label. Besides the emerging research supporting the biological correlates of PTSD, significant advocacy by PTSD researchers and specialists was essential in order to grant it inclusion as a BBMI. Once assigned the biologically-based label, this resulted in greater legitimacy as a medically-necessary condition that ensures treatment coverage by health care insurance carriers.

The genomic revolution

It would be difficult to overestimate the invaluable contribution to science that stemmed from the revolutionary discoveries associated with the Human Genome Project that resulted in the mapping of the human genome in the 1990s. At last, we attained the long-awaited goal to pierce directly into our DNA to decipher the genetic influences that are associated with many human diseases. Moreover, we gained the ability to preview some of the disorders one may be likely to develop in the future. Such monumental advancement in scientific knowledge has led to a greater understanding of the nature of so many of our physical and mental disorders, which, in turn, has opened doors to new possibilities in their treatment. However, the genomic revolution has led, particularly in the case of mental health, to the overestimation and unrealistic expectation that the essential secrets to explain most, if not all, mental disorders lie deep in our genes. A more realistic conclusion is that understanding the particular genetic patterns or mutations that show a positive correlation with the presence of various mental disorders, although important, represents only part of their pathophysiology. In other words, genetic factors appear to be associated with a greater vulnerability to develop certain mental disorders. But, this "genetic loading" only explains part of the variance for the onset of mental illness. Other factors, many of these complex processes associated with environmental interactions throughout an individual's lifespan, appear to be involved in triggering the actual onset of most mental disorders (Tsuang, Bar, Stone, & Faraone, 2004).

A common misconception among non-genetic experts is to equate the term "genetic" with "hereditary". Perhaps one of the most exciting current areas of research interest in genetics is elucidating the factors that lead to the activation or actual expression of various genes. Interestingly, many of the factors that appear to be involved in the process of "turning on" various genetic expressions seem to be indeed environmental. In other words, scientific evidence confirms that the "nature vs. nurture" debate represents an outdated model for most physical and, in particular, mental disorders. A better depiction of the actual process is "nature via nurture," which supports the adequacy of the biopsychosocial paradigm of health. But, despite clear confirmation of the inadequacy of the nature vs. nurture debate, clinical practice continues to be significantly influenced by such an archaic dichotomy. An illustration of this is the common unsubstantiated differential diagnostic practice described earlier to discern between a biological and situational depression.

Another example of the way in which clinical practice fails to integrate biological, psychological and social processes is the tendency by many medical practitioners to refer patients to mental health treatments only after medical or organic factors have been completely ruled out. In other words, medical patients are most often referred to mental health treatment after it has been determined that physical factors fail to explain the presenting symptoms. Thus, patients are referred to mental health practitioners only for the “psychological”- i.e., “non-physical”- problems, and leave out in the referral any reference to interactions between physical and psychological problems. In the practice of behavioral medicine¹, mental health clinicians undergo specialty training to implement behavioral interventions that target a variety of medical conditions significantly influenced by psychological factors. A solid body of research confirms the significant role that psychological and other lifestyle factors play in the onset and maintenance of many, if not most, common medical conditions, such as cardiovascular, gastrointestinal, respiratory, dermatologic, neurologic, autoimmune, sleep, sexual, and chronic pain, among others. Yet, medical practitioners often underutilize this invaluable aspect of behavioral medicine specialty services and refer their patients to behavioral specialists only for the specific psychological (i.e., “non-physiological”) problems.

Falling short in the quest for “*mental health’s Holy Grail*”

Despite significant efforts in mental health research, particularly that promoted by psychiatry, to elucidate the biological correlates of most mental disorders, evidence confirms the adequacy of Engel’s biopsychosocial model. The tendency to emphasize the role of biological factors over psychological and social ones simply isn’t supported by the existent clinical literature. Yet, efforts appear unrelenting to find empirical validation for the dominant role of biological factors. An illustration of this is the recent development of the DSM-5 diagnostic and statistical manual of mental disorders (5th ed.; American Psychiatric Association, 2013). A major quest in the development of DSM-5 was establishing greater empirical support for the biological bases and neural substrates of most mental disorders. However, researchers and consultants who participated in the development of DSM-5 generally fell short in the quest to establish robust evidence in support of a predominant biological basis for most mental disorders. The training of psychiatrists, at least in the U.S.A. and probably in many other countries, clearly prioritizes the refinement of skills in the assessment, diagnosis, and treatment of those mental disorders with greater support for a biological basis (i.e., BBMIs). Psychiatrists undergo more intensive training learning how to accurately assess the following: mood disorders (in particular depression and bipolar disorders), anxiety disorders (in particular panic disorder, obsessive compulsive disorder, and post-traumatic stress disorder), psychotic disorders (primarily schizophrenia and schizoaffective disorder), substance abuse disorders, eating disorders (in particular anorexia and bulimia), and others like dementia, delirium, attention-deficit hyperactivity disorder (ADHD), and autism spectrum disorder (ASD). What all

¹ Behavioral medicine is the interdisciplinary field concerned with the development and integration of behavioral, psychosocial, and biomedical science knowledge and techniques relevant to the understanding of health and illness, and the application of this knowledge and techniques to prevention, diagnosis, treatment and rehabilitation (Schwartz & Weiss, 1978; Society of Behavioral Medicine, 2014). The majority of behavioral medicine practitioners are mental health clinicians, with a predominance of clinical psychologists. Although behavioral medicine clinicians are typically trained as general psychotherapists, they stand out from other mental health clinicians, like clinical psychologists, in their specialized training in treating the psychological aspects of a variety of medical conditions. Behavioral medicine has been influenced by diverse psychological theories, although the primary influences in contemporary behavioral medicine practice are behavioral and cognitive behavioral theoretical models.

of these conditions share in common is evidence that biological factors appear to play an important role in their etiology. Not surprisingly, some of these are also conditions that tend to show greater response to pharmacotherapy - a biological intervention. By contrast, psychiatrists and other mental health clinicians, in general, receive little or no training in diagnosing and treating conditions such as adjustment disorders or the “V code” diagnoses, which are marginalized at the end of DSM-5 under the heading “Other conditions that may be a focus of clinical attention.” These are often referred to by clinicians as “soft diagnoses,” in contrast to the more hardcore BBMIs. Thus, an implicit assumption is that disorders in which the role of environmental factors appears more prominent lack scientific strength or validity. In fact, in the general introduction to this diagnostic category in DSM-5 it explicitly states that these are not mental disorders. Although psychiatry as a discipline has the greatest influence setting the standards of mental health diagnostic practice, many mental health professionals, including clinical psychologists, clinical social workers, psychiatric nurses, and mental health counselors, adhere to some extent to this biased clinical practice.

In the U.S.A., there’s a cynical attitude shared by many mental health clinicians, although some may feel uncomfortable acknowledging it, that diagnosing in “the real world” becomes more of a strategic practice than an empirically-based scientific endeavor. Thus, mental health clinicians routinely adjust their diagnostic practice to guarantee that services will be authorized by health care insurance companies. Most clinicians who engage in such “strategic diagnosing” probably feel justified in doing so in the service of guaranteeing that their patients will receive the services they need. An opinion that’s commonly shared by these clinicians is that patients’ problems may be adequately classified into different diagnostic categories. Strategic diagnosing then becomes the practice of selectively classifying patients’ problems into the categories with greater likelihood of guaranteeing coverage of services for their patients. Nonetheless, ethical dilemmas may still arise when a clinician may feel that there is a diagnostic category that best fits a patient’s particular symptom profile (e.g., adjustment disorder), but also knows that this diagnosis will likely lead to very limited authorization of services. Such dilemma results from a basic divergence between the mental health clinicians’ professional assessments and the health care insurance company’s predetermined formulae as to what constitutes a medically-necessary condition that warrants prioritized intervention. Unfortunately, this cynical diagnostic practice routinely carried out by so many mental health clinicians is reinforced and perpetuated by the health care insurance industry’s persistence to hold on to a weakly substantiated classification of BBMI upon which to base selective decisions that target the restriction of services covered.

The Era of CBT and Other Fashionable Prescriptive Treatments

Quest for an empirically-based practice

A trend in U.S. mental health practice clearly prioritizes psychopharmacotherapy and cognitive-behavioral therapy (CBT) interventions for the treatment of the most common mental disorders. In addition, dozens of new interventions have emerged in recent decades, such as dialectic behavioral therapy (DBT) (Linehan et al., 1999), motivational interviewing (MI) (Miller, 1983; Miller & Rollnick, 1991), acceptance and commitment therapy (ACT) (Hayes, Strosahl, & Wilson, 1999), and Barlow’s unified protocol for transdiagnostic treatment (Barlow, Allen, & Choate, 2004), among others. These interventions, many of which are influenced by principles of CBT, seek to provide more empirical support and accountability in the treatment of mental disorders than previous popular psychotherapeutic interventions, most of which were derived from psychoanalytic and psychodynamic models. Another important aspect of this new generation of interventions is that they provide greater structure than the

older models to guide practitioners in the implementation of particular techniques. Even popular interventions that derive from psychodynamic models, like emotional focused therapy (EFT) (Greenberg & Johnson, 1988), internal family systems (IFS) (Schwartz, 1995) and accelerated experiential dynamic psychotherapy (AEDP) (Fosha & Slowwiaczek, 1997), share the characteristic of providing greater structure than more traditional psychodynamic therapies. This is quite attractive to mental health clinicians, who often crave concrete tools to guide their clinical work. These structured interventions provide them with a clearly spelled out operational manual for carrying out behavioral health treatment protocols in a manner that's easy to follow and routinize in their work. Moreover, given their highly structured nature, it is much easier to operationalize these interventions to evaluate their effectiveness. Thus, the modern era of empirically-based mental health practice has arrived. Mental health clinicians now have at their disposal concrete guidelines to adhere to in seeking to attain the highest possible standards in their clinical practice. And health care insurance companies can implement concrete measures to assess treatment outcomes more objectively, which is presumed to guarantee more effective treatments. A knowledge base of empirically-based interventions can also lead to better accountability, allowing health care insurance companies to ensure that clinicians are adequately trained and actively implementing state of the art empirically-based interventions. And lastly, objective outcome measures provide clear markers from which health care insurance companies can base their decisions to more tightly regulate behavioral health benefits, which translates into substantial savings for these companies—not an insignificant gain. Thus, it should come as no surprise that the health care insurance industry in the U.S.A. has been at the forefront promoting the implementation of empirically-based treatments (EBTs).

The managed health care movement in the U.S.A., more commonly referred to as “managed care,” refers to a variety of programs and initiatives that were developed starting in the 1970s, but becoming more popular in the 1980s and 1990s, to restrain the fast growth of health care cost (National Council on Disabilities 2013). Central to managed care was the creation of for-profit health care corporations, called Health Maintenance Organizations or “HMOs,” to stimulate competition in the health care market offering outpatient alternatives to expensive hospital-based treatments. Some of the primary target areas for managed care strategies are: 1) tightly regulating health care benefits (in theory, to avoid unnecessary overspending), 2) reducing and fixing reimbursement rates paid to health care providers, and 3) prioritizing allocation of benefits for particular interventions with empirical support for their effectiveness. This last strategy, unfortunately, also translates into a selective bias for simpler protocol-based short-term mental health interventions over more comprehensive longer-term ones.

It is important to recognize that the managed care era has resulted in significant advancement in helping identify interventions that may be potentially effective in treating particular mental disorders. This knowledge represents an invaluable asset for mental health clinicians providing them with a knowledge base that can act as a tentative blueprint to guide their practice. But, the quest for empirical support for mental health interventions has also resulted in the promotion of highly structured treatment protocols that are often excessively manualized and over-prescriptive. This runs the risk of essentializing complex mental health problems into reductionistic symptom-focused clinical formulations that fail to capture the inherent complexity of most mental disorders. Many of the mental health interventions that carry the “empirically-based” stamp of approval fall short in their ability to adequately address the complex biopsychosocial nature of most mental disorders. Thus, the parallel quests for implementing a true biopsychosocial framework while attaining an empirically-based mental health practice, as currently conceptualized, seem difficult to integrate and often appear to be moving in opposite directions.

It's difficult to challenge the obvious value of building on our knowledge base of EBTs. However, a selective bias in what constitutes "empirical evidence" limits their value. The term "empiricism" is all too often wrongly equated with evidence derived from data obtained exclusively through strictly controlled quantitative research methods. Empiricism refers to the acquisition of knowledge through evidence stemming from sensory experience of natural phenomena (Fumerton, Encyclopedia Britannica, 2014). Data obtained through sensory observation using qualitative research methods are generally wrongly assumed not to represent empirical evidence. Similarly, rigidly-designed experimental models that rely on observations recorded in non-naturalistic settings are often indiscriminately presumed to apply to the natural world. Much of the so-called EBTs that have been tested with particular groups of individuals in experimental settings are presumed to apply to other individuals and contexts beyond those studied. Such unsubstantiated assumption constitutes a violation of the external validity of the research findings. Thus, ironically, much of the clinical research in mental health violates the very core principles of empirical validation that it seeks to attain.

Another major short-coming of highly structured psychotherapies is that they seek to come up with the best recipe for treating mental disorders based on an outdated treatment paradigm of "intervention X to treat mental disorder Y". Treatment outcomes research with mental disorders has clearly demonstrated the multiple factors and complex interactions at play that lead to positive therapeutic outcomes (Beutler & Forrester, 2012; Duncan et al., 2009). Type of intervention and type of disorder treated are obviously important, but represent only two of the relevant variables that affect treatment outcomes. This simple bivariate model is the standard in the treatment of medical conditions. Even in biomedical practice, where it may seem more appropriate, there are multiple variables that affect treatment outcomes. Matching an intervention with a particular disorder, especially in the treatment of mental disorders, explains only part of the variance of what leads to effective change. Thus, over-reliance of highly structured interventions under the presumed legitimacy of the "empirically-based" classification often results in simplistic recipes to treat complex mental health conditions. Not surprisingly, this often leads to ineffective, or at best, partially effective treatments.

Other factors that have been clearly shown to significantly influence psychotherapy outcomes include: quality of the therapeutic alliance, levels of distress and impairment, patient's characteristics (i.e., motivation and coping style), therapist's characteristics (i.e., perceived warmth, acceptance, trustworthiness), among others (Beutler & Forrester, 2012; Duncan et al., 2009). The influential work on stages of change by Prochaska & Di Clemente (1983) and others in the field of motivational interviewing (Miller 1983; Miller & Rollnick, 1991) clearly demonstrated the limitations of the "treatment X to treat condition Y" design to guide research and treatment. Their work demonstrated the role of an individual's readiness for change and level of motivation in effecting treatment outcomes. But, readiness for change and motivation are just two of the multiple variables that seem to influence therapy outcomes. There's an urgent need for researchers and clinicians to work together to develop more comprehensive research and treatment designs that more adequately address these complex multifactorial causal pathways (Beutler & Forrester, 2012; Castonguay & Beutler, 2006; Goldfried, 1980; Norcross, 2011). Although it may seem daunting to develop such complex designs, it seems reasonable to assume that doing so will likely lead to more comprehensive and, consequently, more effective interventions. Once these multifactorial therapeutic mechanisms are better elucidated, integrative treatment approaches that consider these can be described with a certain level of structure and operationalizability. These comprehensive integrative interventions can then be tested to determine their effectiveness and establish their empirical support. However, the multivariate complexity of such models that go beyond the simpler bivariate intervention-disorder ones will require more complex designs to operationalize them. They will also require a more

sophisticated level of clinical training and supervision, as well as greater flexibility and creativity from clinicians.

Missing ingredients in the basic psychotherapy recipe

The era of managed care has been characterized by an emphasis on operationalizability, accountability, and empirical support in mental health practice. This brought about recognition and status for interventions like CBT, given their highly structured nature, which made them amenable to test in strictly-controlled quantitative research designs. There was a clear shift in mental health practice in the U.S.A. to favor CBT models over psychodynamic ones, which are less structured and less fitting for quantitative research. Although the popularity and professional acceptance of CBT has helped highlight the “psycho” part of the biopsychosocial model, a selective bias dictates what particular psychological factors receive prioritized attention, namely behavioral patterns and rational conscious cognitive processes. Among the psychological factors that receive much less attention in popular EBTs is emotions. CBT interventions address the role of emotions in therapy, but these are treated primarily as unidimensional variables that are monitored and analyzed in typical behavioral assessments. Less emphasis is given in CBT models to working with various aspects of emotions (i.e., emotional style, expressiveness, intensity) and working with emotions actively in the therapeutic dyad. Emotionally-focused therapy (EFT) is a particular psychotherapeutic approach that emphasizes working with emotions in a much more dynamic and experiential manner in the therapeutic relationship. But one of possible shortcomings of interventions like EFT or motivational interviewing (MI) is that a decision is made a priori about what particular aspects of a patient’s experience need to given prioritized attention, namely, emotions in EFT and motivation in MI. A substantial body of research documents the significant role that attachment history and relational dynamics - both past and present - play in patients’ mental health problems. Moreover, the significant contribution of the therapeutic alliance in therapy outcomes has been well documented (Beutler, Machado, & Neufeldt, 1994; Duncan et al., 2009; Horvath & Symonds, 1991). Yet, most popular interventions that carry the empirically-based official stamp fail to pay sufficient attention to the role of relational aspects of behavioral health problems. These interventions also tend to give less emphasis to the role of the therapeutic relationship in the treatment. The centrality of relationships is obviously core to most psychodynamic psychotherapies, in particular relational and interpersonal psychotherapy. However, with the exception of some short-term psychodynamic models (e.g., short-term dynamic psychotherapy, AEDP) these interventions tend to be less structured, less symptom-focused, and thus, less popular in the climate of managed-care and empirically-based practice. In addition to the quality of the relationship, research findings suggest that various characteristics of patients (e.g., coping style, emotional expressiveness) and therapists (e.g., level of directiveness) exert a significant influence on treatment outcomes (Beutler & Forrester, 2012; Duncan et al., 2009). This challenges the empirical robustness of the “treatment X to treat condition Y” design, reminding us that not all therapists and patients are created equal. The “one size fits all” approach that works, to a certain extent, in medical practice poses significant limitations in the treatment of biopsychosocially-rooted mental disorders.

The significant influence of nonconscious mental processes on our behaviors is well documented (Sheeran, Gollwitzer, & Bargh, 2013). Whether one adheres to a belief in the “unconscious” and repression as conceptualized in psychoanalytic theoretical models, or to a more neutral notion of subconscious or “non-conscious” processes, the evidence is quite clear that much of what influences our behaviors is associated with mental processes that operate largely beyond conscious awareness. These nonconscious processes also tend to receive inadequate attention in most popular EBTs. Clearly, nonconscious processes are difficult to assess and monitor with concrete tools. It typically takes time, flexibility and creativity in the part of the clinician, as well as a keen attunement to aspects of the therapy

that may not be readily evident through objective techniques. The relative lack of interest in nonconscious processes in EBTs is, at least partly, likely related to the lesser status assigned to psychodynamic models in this classification. Insufficient attention to covert nonconscious processes and psychodynamics underlying mental health problems limits the potential of many popular EBTs.

In addition to the influence of biological and psychological factors, the significant role of social factors in both the onset and maintenance of mental disorders is well established (Desjarleis, Eisenberg, Good, & Kleinman, 1996; Kleinman, 1988/2008). Yet, psychopharmacotherapy, CBT, and other popular EBTs fail to adequately address social factors. CBT models emphasize the role of environmental factors; but, in these models the environment is typically reduced to a restricted setting composed of situational triggers and factors that reinforce the continuous re-enactment of particular behaviors. Other relevant aspects of the social world, such as the role of culture, poverty, prejudice, migration, social neglect, exposure to violence, economics, politics, spirituality, etc. tend to receive little to no attention. Thus, the social component of the biopsychosocial model is mostly left out of the equation in most contemporary EBTs. Moreover, mental health clinicians will often argue that dealing with the social aspects of mental disorders goes beyond their scope of practice. But, failing to adequately address the social factors that may be involved in the etiology of mental disorders seems like a salient omission in the implementation of the biopsychosocial model in mental health practice.

Factors Underlying the Existent Professional-Clinical Biases

Complex factors underlie the existent biases that grant biology, CBT, and other highly structured EBTs a privileged position in mental health practice. Some of these factors will be considered, including professional validation and legitimacy, health care economics, individual agency and responsibility, and culture.

Professional validation & legitimacy

The tendency to categorize complex phenomena into discrete categories that can be readily processed and acted upon has obvious adaptive value. However, in the process of categorizing human experience into tangible constructs we run the risk of essentializing and oversimplifying naturally occurring complex phenomena. The etiology and pathophysiology of most mental disorders are inherently complex and involve an intricate interplay of biological, psychological, and social factors throughout development. Consequently, interventions to treat mental disorders should seek to address as many of these factors as possible.

Mental illness is characterized by an inherent invisibility that makes the elucidation of etiological processes challenging to the scientist and practitioner. It lacks the more objective and tangible quality characteristic of physical illness through the identification of tissue damage or particular pathophysiological mechanisms that may be dysfunctional in the various organ systems. Although medical practice still relies largely on subjective patient reports of symptoms, at least it has at its disposal concrete objective tools to support diagnostic assessments. Behavioral assessments lack the objectivity of blood and urine tests, scans, and other concrete diagnostic tools used in medicine. Not surprisingly, mental health clinicians often feel the need for objective measures to make accurate assessments, as well as concrete tools and protocols to guide their interventions. The appeal of pharmacotherapy, CBT and other highly structured treatment approaches is precisely that they bring an objective quality that is so often lacking in mental health practice. This is particularly alluring to psychiatry, as a subspecialty of

medicine, given the lack of objective evidence that's more characteristic of biomedical practice. In search of establishing professional legitimacy within biomedical culture, contemporary psychiatry places its greatest value on psychopharmacotherapy, a biological intervention, for the treatment of mental disorders. In addition, the training of psychiatrists prioritizes developing proficiency in the clinical assessment and diagnosis of BBMIs, which are those disorders with evidence supporting a significant role of biological factors in their etiology. Thus, psychiatrists tend to feel greater legitimacy in diagnosing conditions like schizophrenia, bipolar disorder, panic disorder, obsessive-compulsive disorder (OCD), attention deficit hyperactivity disorder (ADHD), or autism spectrum disorder (ASD) than diagnosing an adjustment reaction, which is regarded as a "soft" psychiatric diagnosis.

In the U.S.A. there has been an explosion of almost epidemic proportion in the incidence of various mental disorders, including ADHD, bipolar disorder, OCD, and more recently, ASD (Frances, 2013). What these conditions share in common is evidence that confirms the significant role that biological factors seem to play in their etiology. Some suggest that actual prevalence has remained constant, but our diagnostic precision and ability to adequately assess these conditions have become more sophisticated. Others have proposed that certain environmental changes, like toxins in the case of autism, may also be associated with some of the higher prevalence rates. Less attention has been focused on a selective professional-cultural bias, supported by both mental health clinicians and consumers alike, to highlight the role of biological factors over psychological and social ones. The adaptive value of such bias is that clinicians feel more efficacious treating patients with concrete familiar tools (i.e., medications and CBT), while patients are relieved of any direct responsibility in the development of these conditions. In addition, inclusion criteria for these diagnostic categories have become more liberal; thus, more cases can now meet criteria for these disorders than in the past. Again, one way to possibly explain this is that we've become more attuned and sophisticated in our precision and ability to identify these disorders. But, as in the case of statistics, loosening the inclusion criteria of significance (increasing p value) also increases the risk of false positives. In other words, less restrictive criteria for conditions like ADHD, bipolar disorder and ASD leads to the grouping of individuals with a much greater range of symptomatic severity into the same diagnostic category. Thus, increased awareness and more inclusive diagnostic criteria also increases the risk of potential overdiagnosing. Whether one concludes that more subtypes of these disorders with varying degrees of severity are now being identified or that we're overdiagnosing subsyndromal conditions is ultimately a question of nosological definitional criteria. What is clear is that mental health clinicians have become much more liberal in diagnosing these disorders than in the past.

Health care economics

As briefly discussed earlier, the economics of the U.S. health care industry play a significant role in shaping mental health practice in this country. Although attaining a higher level of accountability in the allocation of economic resources to treat mental illness is an important goal, doing so at the expense of quality of care becomes problematic. The managed care era followed a period characterized by looser authorization of mental health services with little gatekeeping of types of interventions utilized and accountability for treatment outcomes. But, the pendulum seems to have swung too far in the opposite direction. Managed care introduced an array of rigid formulae and guidelines to oversee the implementation of short-term symptom-focused interventions that would yield measurable treatment outcomes.

There is no doubt that lack of accountability in the pre-managed care era made it difficult to evaluate treatment effectiveness and quality of care in the provision of mental health services. It also seems reasonable to assume that the general lack of accountability and objective evaluation of treatment

progress led to some abuses and misuses of valuable health care resources. The problem with managed care isn't its rationale or proposed intention, but rather, undertaking the challenging task of determining what constitutes effective treatment outcomes and an empirically based mental health practice. The idea that we can come up with simple lists of EBTs that can be matched with mental disorder categories in a clear-cut recipe-like fashion is problematic. Naturally complex conditions, like mental disorders, typically require more comprehensive interventions. The simplistic "one size fits all" approach in the treatment of mental disorders leads to essentializing conditions that arise from complex biopsychosocial interactions. But, acknowledging the complex nature of mental disorders doesn't preclude the quest for a higher degree of accountability through assessing the treatment effectiveness of particular interventions. Yet, it requires more comprehensive definitional criteria for therapeutic factors and treatment outcomes that more adequately represent the complexity of mental disorders. It also requires more complex and sophisticated treatment outcomes research designs from which we can establish a true empirical base. But, this scientific agenda clashes with the financial priorities of the health care industry that seeks short-term concrete interventions that result in substantial cost savings as quickly as possible.

The pharmaceutical industry, as briefly discussed earlier, also exerts a significant influence on mental health practice. Medications satisfy the health care industry's quest for concrete interventions that can be easily measured, prescribed, and regulated. In addition, medications provide psychiatrists and other prescribing mental health clinicians (e.g., prescribing psychiatric nurses) a sense of objectivity that is generally lacking in the treatment of mental disorders. And, of course, strong financial incentives for pharmaceuticals create a very powerful force that fuels extensive research and marketing programs to establish and advertise the effectiveness of psychopharmacological agents in the treatment of mental disorders. Thus, it appears as if health care insurance companies, psychiatrists, and pharmaceuticals all benefit from the disproportionately privileged position assigned to the role of medications in the treatment of mental disorders. However, patients aren't reaping the same benefits as they're being deprived of the best quality of mental health care possible.

The role of individual agency and responsibility

Blaming the health care industry, psychiatry and pharmaceuticals for some of the limiting professional biases existent in mental health practice in the U.S.A. represents an incomplete picture of the problem. One must also consider the significant role that U.S. mainstream culture, as consumers of mental health services, play in supporting these biases. The history of mental illness worldwide clearly documents the significant misconceptions, stigma, and abuses that have plagued these elusive conditions (Porter, 2002). Their general invisibility, given the absence of concrete objective medical evidence of causal pathogens and diagnostic tools, has led to a plethora of unsubstantiated explanatory models of mental illness causation throughout history. Many of these models placed fault on defective individuals or feeble characters. Such misconceptions lead to a sense of responsibility and blame wrongly attributed to the individual. The blame is also often placed on the parents or the environment that exerted influence on the development of a particular mental disorder. An illustration of this was the popular, but unsubstantiated, theoretical notion of the "schizophrenogenic mother" (Fromm-Reichmann, 1948) as the primary cause in the development of schizophrenia. But, even when there is evidence to support the assumption that the environment or social experience may be involved in the etiology of a mental disorder, there are consequences to social relations that often result from such acknowledgement. By contrast, emphasizing the role of biological factors relieves some of the blame typically associated with human agency in the development of these conditions. The determinism associated with biological processes allows for a more personally-detached attitude toward mental disorders. Individuals may still be blamed for carrying the

genes that may have led to passing on a particular condition, but there's no individual choice or free will associated with genetic loadings.

As an illustration, let's consider the hypothetical case of a child who displays significant attentional problems in school. A comprehensive evaluation may reveal the presence of significant psychosocial stressors at home associated with poverty, marital discord, unemployment, and living in a high-stress crime-plagued neighborhood. Conceptualizing this child's attentional problem from a biopsychosocial framework would highlight the potential role of these psychosocial stressors in the child's attentional difficulties. A pre-existing biological vulnerability for the development of an attentional disorder may still be considered as part of the biopsychosocial etiological formulation. But, acknowledging the significant role of psychosocial stressors in this child's attentional problem would suggest the need to intervene with the family to address some of the significant psychosocial factors that appear to be impacting on the child's condition. Parents may often feel blamed, or at least partly responsibly, for contributing to the child's problem. And clinicians may feel challenged, and often powerless, to effect any significant change in some of the social factors that may underlie the child's condition.

By contrast, endorsing a biological formulation for ADHD places the locus of primary causation within the physical body. The primary blame is instead placed on neurochemical imbalances or particular cognitive mechanisms that affect the child's attentional processes. Such a biologically- and cognitively-based causal model suggests the role of psychopharmacotherapy and CBT for treating this condition. Parents are spared of any responsibility in the development of the problem. And clinicians feel more efficacious to intervene with therapeutic tools, like medications and CBT, which are readily available in their clinical arsenal. However, although there is no doubt that medications and CBT are invaluable clinical tools in the treatment of ADHD, many cases don't seem to respond effectively to the combination of medications and CBT alone. Some of these treatment-resistant cases may be explained by a failure to address other psychosocial factors associated with the condition. This isn't to deny the important role of biological factors in many cases of ADHD. But, from a biopsychosocial perspective the contribution of psychosocial factors needs to be given as much weight as that of biology. Perhaps we also need to consider the possibility of multiple causal pathways in the development of an attentional problem. For comparison, if a patient complains of chronic headaches, a clinician may consider a variety of possible causes, including stress, sleep deprivation, dehydration, or a cerebral tumor. If we regard inattention like any other symptom, one may consider that some attentional problems may be associated primarily with internal biological and cognitive factors, while others may have been primarily shaped by external psychosocial factors. Whether a particular attentional symptom cluster meets diagnostic criteria for ADHD may be irrelevant to its etiology. Yet, it seems reasonable to assume that effective treatment for a particular ADHD condition may differ depending on the specific factors that appear to be involved in its development, just like a headache caused by stress would be treated quite differently than one caused by a tumor. In the case of this child, medications and CBT may still play an important role, but psychosocial factors should be the primary focus of treatment.

The role of cultural factors

There are also macrosocial cultural factors that seem to underlie the general preference to endorse biological models of mental illness. By far, the most common psychiatric problems brought to the attention of both medical and mental health clinicians are anxiety and depression (Kessler, Chiu, Demler, & Waters, 2005). Phenomenologically, depression tends to be associated with feelings of regret and lack of validation about the past, as well as feelings of emptiness and a lack of engagement in the present. Anxiety presentations are characterized by intense fear, nervousness, worries about the future and a

pervasive lack of a sense of control. In the U.S.A., a society that has undergone significant economic success throughout history, mainstream culture endorses core values of independence, individualism, and self-reliance (Spence, 1985). This general cultural sentiment is best captured by the notion of “The American Dream,” which reflects the ideal that anyone can achieve success, regardless of the starting point. Clearly, opportunities associated with living in this country have led to numerous success stories among so many immigrants and their offspring after centuries of migration from all corners of the world. Yet, many have fallen short of attaining the promise of the American Dream of success. This cultural ideal also fuels in many unrealistic expectations of greatness and specialness. But, as a popular saying goes “*if everyone is special, then no one is*”. Many individuals in the U.S.A. seek mental health services for feelings of depression associated with themes of an existential nature. Typical chief complaints include feeling ambivalent or dissatisfied with career and relationships. From a symptom-focused clinical perspective, these patients may endorse typical psychiatric symptoms of depression, such as: decreased energy, interest, sleep, appetite, and concentration. From a more experiential phenomenological perspective, these patients often describe feeling unappreciated and invalidated throughout their lives, and lacking a sense of purpose and connection with others. Using a psychoanalytic frame, one may conceptualize these patients as experiencing significant “narcissistic injuries” having felt ripped off from the promised ideal associated with expectations of greatness and specialness.

Endorsing a biological model that conceptualizes clinical depression as resulting primarily from a neurochemical imbalance in the brain, a treatment prescription will follow that prioritizes the role of psychopharmacological agents that target correcting the presumed chemical imbalances. Expanding the biological model to include the role of cognitive processes, primarily cognitive distortions that reinforce maladaptive behavioral patterns, the treatment approach can also include concrete CBT techniques that target restructuring the distorted cognitions. Relying on a combination of medications and CBT allows clinicians to utilize concrete protocols that can be easily operationalized, evaluated and regulated. A more comprehensive biopsychosocial approach, by contrast, would emphasize the role of social factors, as well as other more complex psychological factors, like the role of emotions, attachment history, relationships, and unconscious processes, among others. Conceptualizing the depression from this perspective suggests a more complex treatment approach. Focusing on psychological factors that go beyond concrete cognitive-behavioral patterns require more creativity from the clinician to craft an intervention from a patient-centered perspective. Moreover, considering the role of social and cultural factors often results in feelings of frustration among clinicians who may feel powerless to exert any significant influence over such powerful social forces. But, ignoring the potential influence of these factors, may lead to oversimplified reductionistic treatment protocols with limited success. Endorsing a biological and/or cognitive-behavioral model of depression often provides a legitimate justification for an otherwise demoralizing acknowledgement of an individual’s failure to attain the promised “American Dream”. Such medicalization of human experience depersonalizes it, yet it may help relieve a sense of responsibility or shame that may be associated with the failure to achieve culturally shaped unrealistic expectations.

Toward a More Truly Integrated Biopsychosocial Approach

As discussed previously, a discrepancy exists between the apparent widespread acceptance of the biopsychosocial model of mental illness and the selective attention on biological and cognitive-behavioral processes. This has resulted in a restrictive mental health practice that over-relies on medications and highly structured manualized treatments. But, many patients fail to respond to these interventions. At least some of these treatment resistant cases may be explained by the lack of attention to other relevant

psychological and social factors that may be at play in these conditions. The implementation of a more comprehensive biopsychosocial approach to assess and treat mental disorders holds potential value in their treatment. Adequate implementation of the biopsychosocial model would require that diagnostic assessments and formulations of mental disorders pay greater attention to the close interplay and complex interactions among biological, psychological, and social factors. It would also require that treatments for most mental health conditions intervene, as much as possible, at all these levels.

In actual clinical practice, all too often medical and mental health clinicians perpetuate the outdated mind-body split by routinely carrying out clear-cut differential diagnoses between a physiological or psychological formulation of a patient's presenting problem. So, for example, a patient complaining of chronic physical pain will routinely undergo extensive medical examinations initially with little attention to psychological factors. Once all options have been exhausted to find an adequate physical explanation for the pain, this patient may be referred to a behavioral health specialist. A typical explanation offered by the medical provider may be either that stress may be exacerbating the pain or, more bluntly, that there's no physical explanation for the pain, therefore, it's likely associated with psychological factors. Clinical formulations that suggest true biopsychosocial interconnectedness tend to be more the exception than the rule. Yet, from a biopsychosocial framework, acknowledging the psychological factors that may be involved in the patient's pain presentation, shouldn't preclude clinicians from confirming that the pain is physically real. Acknowledgement of the role of social factors contributing to physical pain, like social isolation, lack of social support, or disability aren't emphasized enough in routine formulations of pain conditions. A true biopsychosocial formulation would require that the significant role of contributing factors from all three domains - biological, psychological, and social - be considered as equally valid and worthy of clinical attention.

Ironically, the role of the environment on human biology is one of the most solidly established scientific facts. From Darwin's theory of evolution to the development of different racial groups, biological adaptations to the environment are the universal rule. Yet, at the level of clinical practice, it seems as if we continue to operate largely influenced by the archaic dichotomization represented by the nature vs. nurture question. A greater appreciation of the more accurate "nature via nurture" characterization of human-environment interactions would lead to more comprehensive integrative treatments that intervene at both levels.

But, what would an integrative biopsychosocial intervention look like in actual practice? Let's go back to the vignette described earlier during my clinical training while doing a rotation at a psychiatric ER. After having evaluated a patient, rather than providing the routine explanation "depression is an illness caused by a neurochemical imbalance in the brain," one could instead provide the more accurate explanation "depression is a disorder typically caused by a combination of factors, including past experiences and things that are currently going on in your life, the way you think and express your emotions, and some possible neurochemical imbalances in your body". From such a biopsychosocial explanation, a more adequate prescription could follow: "The best way to treat your depression is to engage in psychotherapy to help you better understand the factors that are reinforcing your depression, such as past experiences in need of further processing or the way in which how you think or express your emotions contribute to your feeling depressed. The therapy can also help you figure out some changes you may be able to make in your life that may help you feel less depressed. In addition, medications may be very helpful in improving your mood as you work on other skills and changes to better manage your depression". From this prescription, an integrative biopsychosocial treatment would follow that could include medication management and CBT, while also addressing other relevant psychological and social factors in the therapy.

In the U.S.A. primary care doctors are the largest prescribers of antidepressants (Beardsley, Gardocki, Larson, & Hidalgo, 1988), which in 2010 were the second most frequently prescribed class of medications after lipid regulators (IMS Institute for Healthcare Informatics, 2010). A routine practice in primary care is to treat many, if not most, depressed patients with medication management alone, and to refer to “counseling” only those patients who don’t seem to respond to medications or who appear to have the so called situational, as opposed to biological, depression. Practicing from a biopsychosocial model of depression, and supported by the empirical evidence for effective treatment of depression, all depressed patients can potentially benefit from a combination of psychotherapy and psychopharmacotherapy. Moreover, a comprehensive psychotherapy should be prescribed that goes beyond a restrictive focused CBT approach. A more adequate integrative psychotherapy could include a deeper exploration of other salient psychological factors, such as the role of attachment history and current relationships, the therapeutic alliance, the patient’s management and expression of emotions, and the influence of possible unconscious processes, among others. The integrative psychotherapy should also include a deep exploration of the role of social factors that go beyond a simple behavioral analysis of situational triggers and reinforcers, such as oppressive circumstances at work, marital distress, poverty, discrimination, racism, lack of social status, migration experience, etc.

As discussed earlier, clinicians often feel reluctant to discuss themes with their patients associated with social ills, such as poverty, racism, and discrimination. The common argument justifying this reluctance is that clinical interventions have no power to exert any influence over these social ills. However, if one believes that these factors play a central role in the development of a particular disorder, failing to acknowledge this in a clinical formulation represents a salient omission. Just like a clinician wouldn’t typically hesitate to tell a patient that genetic-hereditary factors may have contributed to the development of a disorder despite the fact that treatment will exert no influence over these factors. The same rule should apply to discussing any other factors involved in the etiology of a disorder.

A related dilemma that often emerges is whether it is within the scope of practice of mental health clinicians to intervene at a social level. Drawing from a similar example from medicine, a medical practitioner wouldn’t typically hesitate to prescribe an exercise and nutritional regime to a patient, despite the fact that these may not be that practitioner’s particular specialty areas. The typical justification is that general recommendations about exercise and nutrition are within the medical practitioner’s scope of practice because these are directly relevant to the disorder being treated. The medical practitioner would be able to assess when a patient may need a more intensive nutritional or exercise intervention that requires referral to a specialist. But, even in such case, the provider’s attention to these factors is essential in helping recognize that such a need for specialized services exists. Similarly, addressing the role of social factors that may be directly affecting a particular mental disorder seems, not just within the scope of practice of mental health clinicians, but a core area in need of clinical attention. Even when there may be little chance of effecting any direct change over these social factors, the mental health clinician can be very influential in helping the patient figure out ways to best address or cope with these factors. Regardless of the possibilities for resolution of pervasive social ills like poverty or racism, at the very least acknowledging their role in reinforcing a particular mental disorder seems essential in attaining a complete understanding of the problem. Appreciation of the role of these social factors that reinforce a particular mental health problem can also lead to setting more realistic expectations in treatment.

Adopting a true biopsychosocial approach in the treatment of mental disorders doesn’t diminish the value of existent therapies, like CBT and other EBTs. In fact, these interventions could be more effectively implemented from such an approach. In other words, from an integrative psychotherapy perspective one can utilize structured interventions (e.g., relaxation training, CBT, DBT, ACT, biofeedback, etc.) while

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considering other relevant factors (e.g., motivation, attachment history, quality of therapeutic alliance, emotional style, etc.) that can facilitate creating the fertile ground for these interventions to effect positive change. Thus, patients who feel a solid alliance with their therapists may feel more motivated and likely to follow-up concrete recommendations. Referring to popular EBTs as “structured” also creates the false illusion that more comprehensive integrative interventions will necessarily lack structure. One could apply a similar level of structure and objectivity to patient-centered integrative interventions that more adequately address the multifactorial processes at play in the development of mental disorders. But, doing so will require that psychotherapy outcome research transcends the dominant archaic design that matches diagnosis with intervention and moves on to more complex research designs that more adequately explore the complex causal pathways involved in the development and treatment of mental disorders.

Finally, although some mental health patients present with very specific symptoms suggestive of particular diagnoses (e.g., nervousness, inability to sleep, feeling down, panic, etc.), others present with more abstract complaints where the diagnostic association may not be as apparent (e.g., lacking direction in career or a sense of purpose in life, feeling ambivalent about relationships, feeling disengaged from the world, having a spiritual or moral crisis, etc.). One way to connect these apparently disparate types of complaints is by situating the core essence of mental health problems in a patient’s “quality of experience” in their lives. For some, this may be associated with concrete symptoms, while, for others, it may be related to more existential aspects of their lives. The problem lies in that, while both realms of experience can have a significant impact on someone’s functioning and level of emotional distress, only the former seem to possess the objective validity that meets the “medically necessary” criteria discussed earlier. This causes the false illusion that concrete objective symptoms are more severe and, therefore, should be prioritized in mental health treatments, while problems of a more existential nature aren’t as severe. Yet, one can argue that in the most severe cases of depression and even completed suicides the core essence of patients’ experiences is better characterized by existential feelings of isolation and demoralization than by more concrete depressive symptoms, like loss of appetite or energy. Obviously, objective symptoms are often a manifestation of a more existential internal dysphoric state. But, oftentimes problems of an existential nature aren’t overtly displayed as concrete symptoms. Models that more adequately capture the core essence of the most common mental disorders - i.e., anxiety and depression - need to be developed and should include other areas of personal experience, like feeling disconnected from others, lacking a sense of purpose, and having a spiritual or moral crisis, among others. Such expanded conceptual framework could guide interventions for the most common mental disorders using integrative treatment approaches that target an individual’s quality of personal experience, rather than simply decreasing frequency, intensity, and duration of symptoms.

Concluding Remarks

This article explored some of the existent biases in mental health practice that limit the ability of the mental health professions to adopt a true biopsychosocial approach in the diagnosis and treatment of mental disorders. A tendency is evident in mental health practice to highlight the role of biological and cognitive-behavioral processes in the development and treatment of most mental health conditions. Some of the apparent underlying factors were briefly discussed, such as psychiatry’s professional identity as a medical subspecialty, the financial priorities of the health care insurance and pharmaceutical industries, the search for a sense of efficacy and concrete guidance among mental health clinicians, and factors associated with a sense of agency and responsibility among consumers of mental health services. This has led to an incomplete picture of the etiology of mental disorders and a selective bias and reductionism in

our treatment approaches. The search for an empirically-based mental health practice has favored short-term focused manualized treatments over more comprehensive integrative treatments. Thus, popular EBTs fall significantly short in the implementation of a true biopsychosocial practice in mental health. Some suggestions were offered toward the development of a more comprehensive integrative mental health theory and practice that more adequately reflects the biopsychosocial model. But, implementation of these suggestions represents a daunting task that would need to address the powerful forces reinforcing the current “state of affairs” in mental health. A long road likely lies ahead before we will see the implementation of a true biopsychosocial mental health practice. Ultimately, dissatisfied consumers, treatment-resistant cases, and the realization by the health care insurance industry that limiting services short-term may not necessarily lead to significant cost savings long-term, will be among the factors likely to provide the needed impetus to develop more adequate models to guide a more comprehensive integrative mental health practice. In the end, everyone could benefit from the more effective treatment of mental disorders, and thus, the greater alleviation of human suffering.

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