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Beyond the *DSM*: The *Perspectives of Psychiatry* Approach to Patients

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Abstract

This article presents an alternative approach to the *DSM* for the understanding and treatment of patients with psychiatric conditions. This alternative approach, based on *The Perspectives of Psychiatry*, requires a systematic consideration of the patient's psychiatric condition from 4 perspectives: disease, dimensional, behavior, and life story. The *Perspectives* approach offers a way of understanding the nature and origin of clinical presentations and provides a clear structure for developing personalized treatment plans. Although the approach was originally articulated at Johns Hopkins University, a review of the literature shows significant dispersion of elements of the model to other institutions in several countries. The *Perspectives* approach is increasingly used as a method for the diagnosis and treatment of patients with psychiatric disorders and is a valuable educational tool for teaching psychiatry to students.

The anticipated publication of the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) in 2013 provides an occasion to consider an alternative, more personalized approach to understanding and treating patients with psychiatric conditions. To be sure, the creation of distinct categories of psychiatric conditions based on outward appearance in the *DSM* has allowed researchers to reliably study similar groups of patients. This reliability, in turn, has led to numerous advancements in the treatment of patients. In addition, the *DSM* has provided a vernacular that may be used by any clinician, including nonpsychiatrists and nonphysicians, to describe a collection of symptoms displayed by a patient and “assign” a diagnosis on the basis of what is observed. However, a disorder of mental life and behavior does not occur in a vacuum but is always embedded in the life and identity of a patient. With this fact in mind, it becomes clear that thinking of all psychiatric conditions simply as diagnoses, whether categorical or dimensional, is inadequate.

In other areas of medicine, the approach to every case includes a consideration of the medical condition's various origins (eg, vascular, infectious, toxic, autoimmune, metabolic). *The Perspectives of Psychiatry*[1] advocates a similar approach for psychiatry. Borrowing from concepts developed by Adolf Meyer, MD, and Karl Jaspers, MD, in the early 20th century and based on what is currently known about the generative mechanisms underlying psychiatric conditions, the *Perspectives* approach presumes that different psychiatric disorders have different natures (eg, schizophrenia and anorexia nervosa are fundamentally different in their causal origins). The approach acknowledges what is known, as well as the vast amount still unknown, about biological contributions to personality and behavior. But, the approach also stresses that understanding the brain will never lead to a causal understanding of all mental illness, since most psychiatric disorders—even personality and behavior disorders—are not the direct result of a broken brain but of other processes. Thus, the *Perspectives* approach to each case considers whether the psychiatric condition is best understood as originating from something a patient has, is, does, and/or encounters.

In order to understand the origins of a patient's troubles in this way, plus develop a robust formulation and prescribe appropriate treatment using the *Perspectives* approach, the clinician must perform more than a checklist assessment. The clinician must conduct a thorough psychiatric evaluation that includes the important details of a patient's life (eg, family history and social background, birth and development, childhood home atmosphere, education, occupations, sexual experience, marriage, religion, medical and surgical illnesses, habits, and personality characteristics). The sequential and thorough nature of the *Perspectives* approach alone distinguishes it from the *DSM* multiaxial system. But how does the *Perspectives* model differ from Engel's biopsychosocial model?[2] Both models remind clinicians to consider the multiple and complex aspects of an individual. Both models offer a complete list of ingredients relevant to psychiatric diagnosis. However, only the *Perspectives* model tells us how to bring together the ingredients of the biopsychosocial model in order to help patients. In other words, the *Perspectives* model provides the recipe necessary to turn the biopsychosocial method's essential ingredients into integrative and rational formulations and treatment plans for individual patients.

Clinical Points

The *Perspectives* approach to the understanding and treatment of patients with psychiatric conditions offers an alternative to the *DSM*.

The *Perspectives* approach requires a systematic consideration of the patient's psychiatric condition from 4 perspectives: disease, dimensional, behavior, and life story.

Although originating at Johns Hopkins University, the *Perspectives* approach has dispersed to other institutions and several countries.

THE *PERSPECTIVES* APPROACH

The *Perspectives* approach has as its intention "to consider and render explicit the basic patterns of thought and explanation by means of which psychiatrists arrive at diagnostic and therapeutic assertions."[1(p3)] By considering a patient's psychiatric presentation from each of the 4 perspectives, the clinician can better understand the nature and origin of the patient's problems and develop a comprehensive and personalized formulation and treatment plan. The 4 perspectives are disease, dimensional, behavior, and life story (Figure 1). For most patients, more than 1 of these perspectives shed light on the condition for which they seek medical attention. So, in practice, the clinician must consider every patient who presents with psychiatric symptoms from all 4 perspectives. For each case, all 4 perspectives must be utilized and integrated to develop a comprehensive, synthesized formulation and coherent treatment plan. For the purpose of elucidating the critical concepts of each perspective, the 4 perspectives will be outlined independently here.

Disease Perspective

From the disease perspective, the etiology of a patient's troubles is understood as arising from structural or functional pathology within a specific organ or organ system, in this case, the brain, which leads to the presenting syndrome (see Figure 1). For example, dementia due to Alzheimer's disease may best be understood as developing from physical changes in the brain that are increasingly being defined. The disease perspective can also be usefully applied to conditions such as schizophrenia and bipolar disorder that are increasingly presumed, on the basis of indirect evidence, to be at least partly driven by brain pathology, even if the etiologic and pathologic nature of these disruptions is not fully understood. The questions one asks when approaching a patient from the disease perspective include, "What is the patient's lesion or broken part?" and "What disease, if any, does the patient have?"

Dimensional Perspective

For many psychiatric conditions, the disease perspective is inadequate to fully explain the distress with which patients present. The dimensional perspective assumes that, within populations, there is a natural distribution of both physical and psychological attributes. An individual's dimensional endowments may increase his/her potential to react to a certain provocation with a particular set of pathologic responses (see Figure 1). Individuals on the extremes of these dimensions are classified as having personality disorders by the *DSM*. Such a patient's troubles do not necessarily stem from a "broken part" in the brain and should not be treated as such. Rather, a clinician can best serve this type of patient by asking, "How can I best guide my patient toward success based on the kind of person he/she is?"

Behavior Perspective

The behavior perspective is based on the concept that an individual's psychological drives, which are shaped partly by conditioned learning, influence the choice of whether or not to engage in a particular behavior (see Figure 1). Recognizing maladaptive behavior in patients and considering

the factors that can initiate and sustain such behaviors are critical to treating many psychiatric disorders including addiction, paraphilia, and anorexia nervosa. The behavior perspective demands that clinicians ask of certain patients, “How can my patient's distress be explained by what he/she does and how can I help him/her by changing what he/she does?”

Life Story Perspective

Finally, some individuals who seek treatment for psychiatric conditions are troubled, not by a disease they have, who they are, or things they do, but by what they have encountered in life. The life story perspective uses the logic of narrative, a sequence of events within a particular setting that leads to a specific outcome, to understand a patient's psychiatric presentation (see Figure 1). For example, a recently widowed patient may seek treatment for feelings of loneliness and sadness following the loss of her husband. Her clinician understands her symptoms as arising from loss and uses psychotherapy to help the patient “rescript” her life story and regain a feeling of mastery over her circumstances. With the life story perspective, the clinician must ask, “How can I best understand my patient's symptoms based on what he/she encounters?” Different versions of life stories—Freudian, Jungian, etc—can be told; however, the type of story told may be less important than the therapeutic relationship and other factors.

Mastery of the *Perspectives* approach allows one to perform a comprehensive evaluation and consider a patient sequentially from all 4 perspectives: disease, dimensional, behavior, and life story. This understanding then serves as the basis for formulating a diagnosis for a given patient to a depth and breadth beyond what can be achieved using the *DSM* and/or the biopsychosocial framework. Although all 4 perspectives may not be necessary to illuminate all aspects of every patient's condition, using this formal approach when thinking of a patient's presentation leads to a more cohesive and accurate view of the patient's psychiatric illness. This approach ensures a more personalized and nuanced treatment plan.

ORIGINS OF THE *PERSPECTIVES* APPROACH

As mentioned previously, the *Perspectives* approach to psychiatric illness builds on ideas about the practice of psychiatry developed by Adolf Meyer and Karl Jaspers in the first half of the 20th century. Meyer, the first Henry Phipps Professor of Psychiatry at Johns Hopkins University School of Medicine, Baltimore, Maryland, felt that psychiatric disorders could not be properly understood without considering how they emerge out of the complex lives of individual patients.[3] He emphasized the importance of taking a thorough and detailed history in order to appreciate the full context of a patient's psychiatric distress. Jaspers, in his work, emphasized the importance of the methods used in the examination of a patient and the appropriateness of using multiple conceptual frameworks in the evaluation of a single patient.[4,5] Jasper stressed that, if one decides to take a multiconceptual approach, the strengths and limitations of each framework must be properly understood. By articulating explicit descriptions of the different kinds of causal models (often referred to as *natures*) used by psychiatrists to explain their patients’ disorders, the *Perspectives* approach builds on Jasper's emphasis on methodology, while retaining Meyer's emphasis on a complete and detailed history.

The Perspectives of Psychiatry[1] gives the *Perspectives* approach its name. Introduced to the writing of both Meyer and Jaspers while training at the Maudsley Hospital in London, England, Paul R. McHugh, MD, drew on this background as he began to teach US psychiatry residents how to examine psychiatric patients and how to think about the nature of their conditions. This clinical approach continued to be refined, and its theoretical underpinnings were eventually elucidated in the original book published in 1986. The 4 perspectives are detailed extensively in this book, which is now in its second edition.

Initially, the *Perspectives* approach was taught almost exclusively at Johns Hopkins University School of Medicine, as both McHugh and his coauthor Phillip R. Slavney, MD, were, and are, professors at this institution. The approach was first used as a tool to teach medical students and residents how to manage the psychiatric patient. However, the *Perspectives* approach is no longer limited to this role. It is now used in the medical literature as a way of discussing a range of patients in a broader context.

DISPERSAL OF THE *PERSPECTIVES* APPROACH

A literature search for references to the *Perspectives* approach in existing peer-reviewed medical literature (performed during the preparation of a *Perspectives* companion to be published by Johns Hopkins University Press in 2012[6]) found about 400 articles and book chapters, 100 of which use the *Perspectives* approach in a substantive way. The breakdown of articles by type is approximately 50% peer-reviewed journal articles, 20% books and book chapters, 20% book reviews/commentaries, and 10% case reports. An extensive discussion of these publications is beyond the scope of this article. Two points, however, are noteworthy.

First, approximately half of the identified works have been authored by former or current Johns Hopkins University School of Medicine–affiliated psychiatrists and/or psychologists. Second, the approach has been utilized in a wide variety of ways, demonstrating its versatility and relevance across a broad range of research and clinical areas. For example, several identified pieces employ all aspects of the *Perspectives* approach to discuss conceptual framework and treatment options for management of traumatic brain injury[7] and chronic pain/dizziness.[8–11] Others use the method in a more focused way. For example, one article uses the disease perspective alone to discuss features and explanations for various mood disorders with psychotic features.[12] A similar approach is seen in various books, including those on the topics of dementia[13] and the psychiatry of autoimmune deficiency syndrome.[14]

Although we have included these partial applications of certain elements of the *Perspectives* approach as an example of the dissemination of the model, they do not represent the fully integrated approach as taught at Johns Hopkins University School of Medicine. This fact is not surprising; as mentioned above, half of the publications discovered were written by psychiatrists who were not trained at Johns Hopkins University. Nevertheless, it appears that some version of the *Perspectives* approach has been utilized by clinicians in institutions around the world. This dispersal can, in part, be explained by the movement of Johns Hopkins University–trained psychiatrists to other institutions (eg, University of Iowa,[15] University of Ottawa[16]). However, it appears that at some institutions, the *Perspectives* method was discovered serendipitously and its use supported by its

demonstrated clinical effect. Literature utilizing the *Perspectives* approach was found from institutions such as Harvard,[17,18] the University of Pittsburgh,[19] and the University of California, San Francisco,[20] as well as in Australia[21] and Croatia.[22,23] This is not to say that the *Perspectives* approach is taught at the above institutions, but it is clear that faculty members elsewhere have discovered the *Perspectives* method and have found it helpful in making sense of clinical psychiatric presentations and guiding patient treatment.

In reviewing the literature published by other institutions on the *Perspectives* approach, it is evident that the focus is mainly on the disease perspective. In fact, many of the articles do not even mention the other 3 perspectives other than to say they exist. However, one of the main teachings of the *Perspectives* approach is that no one perspective is meant to be used in isolation when considering a patient's presentation; all 4 perspectives must be considered. Although the dissemination of the *Perspectives* approach is significant and important, clinicians/researchers utilizing this method may require more understanding of how it can be used most effectively.

THE *PERSPECTIVES* APPROACH IN CONTEXT

As with virtually all practicing US clinicians, those who have found the *Perspectives* approach helpful also use the *DSM* and biopsychosocial frameworks. The 3 approaches can complement one another and together enable richer descriptions and deeper understanding of patients' conditions. What distinguishes the *Perspectives* is its comprehensive, sequential, systematic approach to understanding the nature and origin of each patient's presentation and its focus on the integrative, holistic formulation of the patient and his/her treatment plan.

The *Perspectives* approach also provides a useful framework for developing research hypotheses regarding the nature of different conditions listed in the *DSM*. These hypotheses may be widely accepted, for example, that dementia of the Alzheimer's type is caused by a disease and that substance abuse is a behavior subject to the influences of both conditioned learning and personal choice. Other times, there is uncertainty about the underlying nature of a patient's condition, but the *Perspectives* approach can help us think clearly about different possibilities. For example, the *DSM-III* and *DSM-IV* provide definitions of *dissociative disorders*, but there is disagreement as to whether these conditions are best understood as maladaptive conditioned behaviors or as a natural response to certain traumatic life events.[24] When confronting a patient with such a condition, the *Perspectives* approach might help to avoid falling into the trap of confusing a descriptive term taken from the *DSM* with an explanation as to how the patient came to exhibit his/her particular signs and symptoms.

The *Perspectives* approach helps clinicians recognize that patients presenting with dissimilar signs and symptoms (carrying different *DSM* diagnoses) can have conditions with common underlying mechanisms requiring similar approaches to treatment. The *Perspectives* approach also helps clinicians see the flip side—that patients presenting with similar signs and symptoms (carrying the same *DSM* diagnosis) can have psychiatric conditions with very different underlying mechanisms requiring different approaches to treatment. For example, patients experiencing grief may meet diagnostic criteria for major depressive disorder, but many believe that fundamentally different

underlying processes explain these 2 conditions. Thus, while the *DSM* provides us with a set of reliably identifiable clinical syndromes, the *Perspectives* approach offers a way of talking about and thinking about the nature of these syndromes, as well as their similarities and differences.

CONCLUSION

Although at different career stages, the authors of this article appreciate fully the clinical utility and strength of the *Perspectives* approach. By examining systematically each patient from 4 perspectives (disease, dimensional, behavior, and life story), a clinician can glean a deeper understanding of the patient to develop a comprehensive and personalized treatment plan. We recognize that the biopsychosocial framework is already familiar to most clinicians and that the *DSM-5* is on the horizon, but we hope that the *Perspectives* method will offer an additional, alternative way for clinicians to think about psychiatric conditions. When fully applied, the *Perspectives* approach has the potential to generate a more integrative and coherent formulation and treatment plan for patients. It seems plausible that, at some point in the future, the *Perspectives* approach may become a major organizing system for diagnostic classification and psychiatric education, as well as a powerful tool for developing more personalized patient care.

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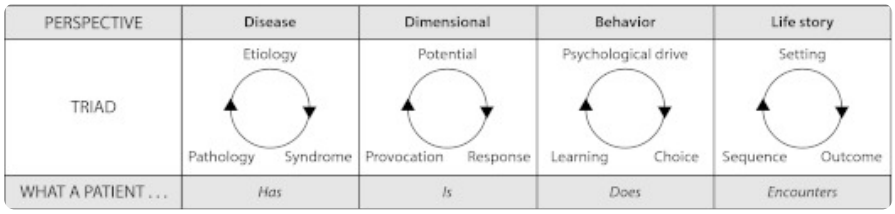
Figures and Tables

Figure 1.



The 4 Perspectives of Psychiatry