
Therapeutic Dimensions

A 42-year-old married white man was admitted to the hospital with high fever. Subsequent workup showed that he had aspiration pneumonia (pneumonia due to aspiration of a foreign substance such as food into the lungs, usually in a state of intoxication or coma). History revealed and highlighted the fact that the patient had increased his alcohol intake considerably in the last two years. He had been divorced four years ago and remarried two years ago. His second wife had turned out to be an alcoholic.

In addition to aspiration pneumonia with secondary staphylococcal infection, liver function tests showed abnormalities indicating early liver disease, probably due to excessive alcohol consumption. The pneumonia was treated with antibiotics. The high fever was treated with aspirin and alcohol rubs. His wife was interviewed by the doctor and the social worker. As the pneumonia subsided, the doctor had a serious talk with the patient and his wife concerning the role of alcohol in the patient's medical condition. It was decided that both the patient and his wife should join Alcoholics Anonymous. Also, arrangements were made for them to see the social worker on a regular basis for couples therapy. They were also directed to take multivitamins.

Management plans must be directed at all three dimensions—the biological, the personal, and the environmental. In the foregoing vignette, the main biological treatment for the disease, pneumonia, was antibiotics. To prevent the vitamin deficiency syndrome that often occurs in alcoholism, multivitamins were also prescribed.

Alcohol rub for the fever was a treatment directed at the heat interchange between the patient and the physical environment. Air conditioning and humidification of the room are also examples of therapy in this dimension.

The physician was able to diagnose a disorder at the personal level in this patient—alcoholism (or the pattern of excessive alcohol intake). Further, he found that this disorder was shared, and probably encouraged, by the patient's wife. The management plans thus included treatment for alcoholism in the environmental and personal dimensions through Alcoholics Anonymous, the social worker, and couples therapy.

We will now briefly consider some common therapeutic modalities as they are directed primarily at each of the dimensions of the patient system. It will be clear in each section, however, that the actual therapeutic effects interact extensively across dimensions.

APPROACHES IN THE BIOLOGICAL DIMENSION

Broadly considered, any therapeutic intervention works through the biological system, including interpersonal interventions and those directed at the personal dimension, since even symbolic transactions occur through perceptual and cognitive processes the substrates of which are physicochemical. In the discussion that follows, treatment at the biological level is considered in a narrower sense, that is, biological treatment of the disease, such as treatment directed at eradicating its etiological cause (e.g., the use of antibiotics, potassium administration to correct hypokalemia, and surgical correction of tetralogy of Fallot). Most medications are used with the expectation that the biological effect will result in cure, reversal, or amelioration of the disease process. Despite such expectations of biological efficacy, physicians should recognize that many drugs also work through the expectancy effect (personal dimension). Furthermore, medications with proven biological effects may, in addition, have *side effects in the personal dimension* (Chapter 21). The side effects on the personality may be mediated through the drug's biological effect on the central nervous system or through its symbolic meaning. For example, although methadone is a potent analgesic biologically, some patients for whom it is prescribed may become anxious because they identify it with drug addiction, and they may experience little pain relief, especially if it is administered without adequate explanation and reassurance. Many drugs cause psychological effects. (For example, depression is a relatively common side effect of certain medications, such as reserpine, a drug used in management of hypertension.)

Surgery is a definitive intervention in the biological dimension. However, it is important to recognize that surgery may also have placebo effects. For a while many years ago, ligation of the internal thoracic artery

was considered to be effective in the treatment of angina pectoris, and, in fact, many patients seemed to benefit from it. Eventually, however, the procedure turned out to be without long-term benefit. The beneficial effects experienced by patients were due to the placebo effect.

Some medications and surgical procedures have major interpersonal side effects (side effects in the environmental dimension). For example, foul-smelling ointments, loss of hair due to chemotherapy, and mutilating operative procedures may restrict the patient's social contact. With some biological treatments, such as a plaster cast, the patient's mobility is greatly compromised.

Surgical procedures are often associated with personal fantasies unrelated to their biological effects. For example, the frequent confusion between the kidney and genital organ functions may lead some patients to have fears concerning sexual potency after nephrectomy. Many women have the notion that their sexual enjoyment and libido will cease following simple hysterectomy. In fact, because of this expectation in some patients, there may be changes in sexual behavior and experience after hysterectomy even though the external genitals and ovaries are intact.

Physicians should *explore* the patient's fantasies and ideas concerning any proposed biological intervention and *clarify* them with adequate and lucid information.

APPROACHES IN THE PERSONAL DIMENSION

Therapy in the personal dimension is geared toward the *patient's illness behavior, general health* (including habits), and the *meaning of illness* and psychological reactions to it. Reduction of the suffering aspect of the disease (illness) is essential for good collaborative work between the doctor and the patient. As we examined in Chapter 3, the immediate expectations of the patient in the consulting room are primarily concerned with reduction of suffering (personal dimension).

Biological treatment modalities that may be used for treatment in the personal dimension include *drugs, physical therapy, and electroshock treatment*, as well as psychotherapy and psychosocial interventions. Unlike biological treatment in the biological dimension, in which etiological factors are the main target, biological treatment modalities in the personal dimension are primarily directed at modifying *feelings* and at the general functional capacities and well-being of the patient. Accordingly, drugs used in symptomatic treatment, for example, to relieve pain

and anxiety or to reduce fever and inflammation, are included in this category.

As discussed in Chapter 17, the *doctor-patient relationship* is a powerful therapeutic tool operating in the personal dimension. The placebo aspects of being treated by a doctor are often powerful, at least initially, no matter what the doctor actually does to treat the disease. Newly "discovered" medications and procedures often seem especially efficacious as a result of this effect—thus, the admonition, "You should treat as many patients as possible with new drugs while they still have the power to heal," which has been attributed to Trousseau, Osler, and Lewis (Shapiro, 1960). Physicians should be aware of this temptation and weigh the possible expectancy effect (beneficial) of a new medication against possible, yet unreported, adverse effects. The potency of the healing effect of the doctor-patient relationship can be increased by the physician's interest, empathy, and competence. It can be neutralized by a lack of interest in attempting to understand where the patient's distress and concerns are focused.

Psychotherapy in Medical Settings

Psychotherapy conducted by the physician consists of the application of psychological techniques within the context of the doctor-patient relationship, usually with specified and limited goals in mind. A more general and detailed discussion of psychotherapy is beyond the scope of this book; the interested reader should refer to standard psychiatric texts. The brief discussion that follows deals with psychotherapeutic principles and techniques that nonpsychiatric physicians should understand and be able to use effectively in clinical practice.

The doctor-patient relationship renders any and all actions and ministrations of the physician psychologically influential, whether they are explicitly intended to be or not. In turn, their psychological impact can and often does influence the course of illness and the patient's response to treatment. The physician who understands the psychological meaning of his work with patients can wittingly, judiciously, and deliberately utilize the psychotherapeutic potential inherent in the doctor-patient relationship to promote healing and maximize the beneficial effects of his medical treatment. Consider, for example, the psychological aspects of history-taking, physical examination, ordering of diagnostic tests, prescription of medication, and scheduling and conduct of follow-up visits.

The friendly and nonjudgmental, but at the same time professional, interest and concern that are manifested toward the patient by the physician in the process of skillful *medical history-taking* provide an interper-

sonal base for reassurance and for the relief of tension that occurs in the patient when he can share with the doctor personal worries, problems, guilts, and anxieties that he had not shared with anyone previously and so had carried as private personal burdens. And, as the patient is encouraged to review possible contributing factors to disease, important facts concerning personal habits (e.g., smoking, alcohol), occupational stresses, interpersonal tensions, and other problems may emerge that will be relevant to formulating the nature of the clinical problem and the therapeutic approaches that will be required to deal with it.

Similarly, it is easy, on reflection, to appreciate the anxiety-relieving value of a thorough *physical examination*, skillfully and systematically conducted in an appropriate, dignified, and comfortable setting. This is important in setting the basic tone for the developing doctor-patient relationship. Readers might think back on some of their own personal experiences as patients undergoing physical examination.

It is important for the physician not only to plan a program of *diagnostic procedures* in advance but also to share its rationale, strategy, and meanings with the patient. The physician's medical knowledge and skill are often crucially tested when he has to decide when and whether to dispense with further diagnostic tests. The way in which differential diagnosis is pursued can reinforce previous good developments in the relationship and can be particularly important in imparting to the patient the belief that the doctor is competent, concerned, and trustworthy.

When these initial steps have gone well, the patient's trust and confidence are based on reality as well as on positive transference phenomena that, of course, reinforce his trust and confidence.

At this juncture, the issue of *sharing information* with the patient and of *reassurance* warrants discussion. Reassurance should never be "hollow" or insincere; that is, the physician should not make explicit assertions that he knows to be unfounded. When it is necessary to spare the patient undue worry and anxiety, it is usually better for the doctor to carry the burden of leaving some things unsaid until such time as the patient may be ready to cope with them. Most often, the patient's fears are much worse than reality—providing the physician with considerable room for positive, explicit, factual explanations that will be reassuring. As we have noted earlier, sharing information is important, and in doing this, the doctor should take into consideration the patient's personality type, habitual defenses, and ways of coping in order to provide the information in a way that will be most helpful and useful to the patient (Chapter 18).

Hospitalization may be psychotherapeutic in several ways. Despite the *anxiety and adjustment process* inherent in this major environmental

change for the patient (see Chapter 19), hospitalization (if prepared for thoughtfully) means a definitive step for the patient in his commitment to fight the disease process. The hospital environment, once its disturbing features have been dealt with, provides the patient with a safe place where competent professionals will help him to get well. In fact, for some patients, the hospital may provide a needed temporary respite ("vacation") from pathogenic stressful life situations with which they have not yet been able to cope successfully. Complex and imposing hospital equipment may be seen as reassuring. Without trust in the physician and the hospital (based on careful preparation or a preexisting good relationship or both), the same equipment may be frightening. Hospitalization may provide legitimate opportunities for gratifying dependency needs, and this may relieve a chronic state of frustration or deprivation that may even have contributed to predisposition or vulnerability to disease. Some patients may, for the first time, gain a perspective on their lives and learn better ways of coping or relaxing during the course of hospitalization.

Follow-up appointments manifest that (1) the physician is interested in the patient's course and recovery and (2) the physician feels some hope about the patient's future and, in any case, will not abandon him. The latter is especially reassuring to seriously ill patients, including terminal cancer patients (Abrams, 1966). *Physical therapy* may provide a sense of mastery and hope for paralyzed patients. *Drugs*, as we have seen, are potent psychotherapeutic as well as pharmacotherapeutic agents, and not only because of placebo effects. In addition to the fact that it is reassuring for the patient to know that there is a drug for his illness, the doctor's "giving" of the medication often gratifies basic dependency needs and is received in the context of the patient's trusting relationship with the physician. On the other hand, if drugs are given casually and haphazardly, the patient may consider the drug as a poor substitute for the physician's interest—an antipsychotherapeutic effect (see Chapter 21).

Psychotherapeutic *techniques* that may be used by the general physician in the context of medical management of patients include the following:

Reassurance. This consists of a general optimistic and hopeful attitude and specific statements, based on data or experience or both, designed to allay exaggerated or unfounded fears of the patient. For reassurance to be effective, the physician should know the sources of the patient's fears. They are often based on an incorrect understanding of the disease or proposed procedure.

Sharing life's problems. The doctor is a person in whom many patients can confide and to whom they can talk about things that they may feel embarrassed or fearful to discuss with anyone else. The simple act of verbalizing an emotionally taxing thought or situation can relieve chronic anxiety (and physiological activation that accompanies it). After such verbalization, the patient may achieve a fresh outlook and be able to cope with the situation. The process of talking about an emotionally charged situation or thought, with expression of the emotion, has been called "ventilation"; we consider the term "sharing life's problems" to convey its nature more correctly.

Guidance and advice. Judicious advice and guidance based on sound medical knowledge carry authority and often achieve readier acceptance by the patient than if they had been offered by a parent or employer. This is especially true when the advice is directed toward a possible contributing factor to disease, such as alcohol. For example, an alcoholic patient who has just recovered from an exquisitely painful episode of pancreatitis is more likely to heed the physician's advice (rather than a relative's) to join Alcoholics Anonymous.

Education. Through an educative process involving questions and answers and, possibly, reading material suggested by the doctor (bibliotherapy), the patient can learn about his medical condition and the doctor's strategy in treating it. This can reduce unnecessary anxiety and reinforce positive aspects of the doctor-patient relationship. This may also foster the adaptive defense mechanisms of sublimation and intellectualization (Chapter 5). Education may also be directed toward behavioral changes to reduce contributing factors to disease, for example, the dangers of smoking and the early warning signs of cancer requiring checkup.

Environmental manipulations (see also the section on Approaches in the Environmental Dimension). When it becomes clear that certain stressful factors in the environment (e.g., occupational, interpersonal) are participating as serious vectors by precipitating or accelerating the disease process, it may be wise for the physician to suggest changes in the environment if such factors can be avoided (e.g., change of job and avoidance of mother-in-law's visits).

Limited interpretations. This consists of judicious sharing with the patient the observation that certain stressful life situations are regularly associated with flare-up of disease or with incidence of symptoms. For example, the physician may note that many of a patient's attacks of migraine headache have regularly followed periods of intense, pressured work to meet deadlines. The patient may be unaware of this fact and, if made aware, may be able to rearrange work schedules to avoid

repetitions of this situation or develop better ways of coping with the stress, for example, by finding tension outlets at such times in exercise or the practice of relaxation techniques. Obviously, the physician must know his patient quite well and have a good basic relationship in order to apply his own "insight" into the patient's problems in this way. The same holds true for environmental manipulation.

What may all the foregoing accomplish, particularly for patients for whom psychosocial factors may play relatively minor roles as etiological, pathogenic, or influencing factors? For many patients, the doctor's expectations of realizing direct positive benefits for the patient may be quite limited. Still, some very worthwhile limited goals may be realized:

1. Varying degrees of symptom relief
2. Giving up of secondary gain
3. Improvement in morale and overall quality of adjustment to illness and maintenance of hope
4. Improvement in general life adjustment, interpersonal relationships, and quality of life
5. Achievement of good compliance with the medical regimen

Noncompliance is a major problem in medical care (Sackett and Haynes, 1976), particularly in chronic diseases that are relatively asymptomatic for long periods, but nonetheless dangerous if untreated, for example, essential hypertension. Perhaps one of the major benefits of good psychologically oriented medical management is realized in prevention of serious noncompliance.

For patients for whom psychosocial stresses may play contributing etiological, pathogenic, or influencing roles, some additional benefits may be realized to the degree that the measures discussed above enable the patients to manage their lives more effectively (i.e., to avoid stressful situations, where possible, and to understand, defend, or cope better); the rate of progression of the disease process may be slowed and complications or exacerbations delayed and possibly, in some cases, avoided.

Often, the physician who works in this way with a patient will find that problems persist to the degree that the patient needs more advanced or specialized psychotherapy. This may be either because his life-adjustment problems are serious enough in their own right to require it or because the doctor judges that they are seriously aggravating the disease. Here is where another benefit of working psychotherapeutically is realized—the patient can be expected to react positively to the suggestion that he have a consultation with a psychiatrist. The physician is in a position to make an effective and comfortable referral. For example:

Mrs. Jones, it is clear from our discussions that your ulcer flared up when things got tense at home between you and your husband. The problems in your marriage that you are telling me about touch on issues that may be beyond my technical competence as an internist. But since they, like the foods you eat, and so on, play an important part in healing or failure to heal, I think it would be a good idea for you to see Dr. Smith, a specialist in psychiatry, for a consultation. He has been helpful to me before in evaluating such situations and in helping to reach an opinion on the advisability of undertaking a course of psychotherapy. In any case, I will continue with your medical treatment and follow-up

Such a referral does *not*: (1) say to the patient, "It is all in your head"; (2) reject the patient; (3) leave the patient without hope.

Formal Psychotherapy

Formal psychotherapy may be classified in a number of (frequently overlapping) ways:

1. According to the number and types of patients treated, e.g., individual, couples, family, and group therapies.
2. According to theoretical paradigms on which the therapeutic method is primarily based, e.g., psychoanalytic, interpersonal, behavioral, or cognitive.
3. According to special techniques that are used, e.g., formal psychoanalysis, psychoanalytically oriented (psychodynamic) brief psychotherapy, behavior therapy, cognitive therapy, sex therapy, psychodrama, special relaxation techniques such as hypnosis and meditation.

At times these approaches may be modified and used in combinations; and, when indicated, medication may be used in conjunction with them.

Formal psychoanalysis helps the patient develop understanding of his/her unconscious conflicts and mental operations—*both* how they operate in generating current symptoms and life difficulties *and* how they are amplified and complicated by their psychogenic roots in unresolved early life problems and conflicts. In this way the patient achieves a more informed resolution of pathogenic conflicts and difficulties; a more mature resolution that will permit continued cognitive-emotional growth, and through it achievement of a more satisfactory life adjustment.

Most psychodynamically oriented psychotherapies range in their aims along a spectrum from mainly "insight-oriented" at one end to mainly "supportive" at the other, although almost invariably, these are

somewhat overlapping aims with differing primary emphasis on one or the other aspect. While psychodynamically informed supportive techniques aim primarily at increasing the patient's defensive and coping abilities, the use of supportive measures is not necessarily simpler, since they must be individually tailored to the patient's personality and life situation—based upon *insight*, i.e., the *therapist's insight* into and understanding of the patient's difficulties (Werman, 1984).

Self-Regulatory Techniques (Biofeedback, Relaxation Response, Self-Hypnosis). Biofeedback, relaxation and meditative techniques, and self-hypnosis are geared toward "self-regulation," that is, the maintenance of adaptive changes in the body through self-generated behaviors (Leigh, 1978). Through these techniques, the patient can control maladaptive or potentially maladaptive physiological activation, produce a state of relaxation, and increase his coping abilities.

Biofeedback is a technique by which the patient learns to acquire control over bodily functions that are usually not controlled voluntarily, such as skin temperature, heart rate, blood pressure, and tones of certain muscles as recorded by EMG. This usually involves the use of electronic equipment that monitors the organ system to be controlled, the activity of which is "fed back" to the patient in the form of signals indicating the success or failure of the attempted control. For example, blinking green lights from a polygraph may indicate a decrease in heart rate. The subject may then attempt to increase the frequency of the green light if he is to learn to decrease his heart rate. Biofeedback is based on operant conditioning principles.

Operant conditioning (sometimes called "instrumental" conditioning) was first described by B. F. Skinner in the 1930s (Skinner, 1938). Learning by operant conditioning, unlike Pavlov's classical conditioning (see Chapter 4), involves behaviors that are learned in response to *reward* or *punishment*. For example, a hungry rat in a cage equipped with a lever will, at some point, lean on the lever (spontaneously emitted behavior, or "operant behavior"). If food is given to the rat each time it leans on the lever, the animal will increase the frequency of lever-pressing. The food in this case is a *positive reinforcer*, a stimulus that increases the probability of the operant behavior if the stimulus is given after it. A *negative reinforcer* is a stimulus the *removal* of which following an operant behavior increases the probability of that behavior. For example, if a rat can turn off continuous electric shock by pressing a lever, the shock is a negative reinforcer for the operant response of pressing the lever.

Operant conditioning was initially considered to be a higher type of learning than classical conditioning, and the autonomic nervous system,

being more primitive phylogenetically than the voluntary somatosensory nervous system, was considered to be incapable of operant conditioning. The pioneering work of Miller (1969) and his colleagues showed, however, that the autonomic nervous system could indeed "learn" from reward and punishment. For example, Miller was able to show that animals could, among other things, increase or decrease blood pressure and pulse rate, and increase or decrease glomerular filtration rate in response to reward. Biofeedback is the clinical application of this principle. Biofeedback has been shown to be effective in a variety of stress-related disorders such as migraine headaches, Raynaud's disease, certain cardiac arrhythmias, and tension headaches (Blanchard and Young, 1974; Task Force Reports of the Biofeedback Society of America, 1978).

The *relaxation response* is defined by Benson (1977) as a set of integrated physiological changes that may be elicited when a subject assumes a relaxed position and engages in a repetitive mental action, passively ignoring distracting thoughts. The physiological changes include decreases in oxygen consumption, heart rate, respiratory rate, and blood lactate; slight increases in skeletal muscle blood flow; and an increase in EEG alpha waves. This response is presumed to be an integrated hypothalamic response that functions as a protective mechanism against overstress and as a counteraction against the fight-flight response (see Chapter 4).

The relaxation response was identified by Benson (1975) when he was studying the physiological changes accompanying meditative techniques. Thus, the self-regulatory physiological effects of meditative techniques are considered to be mediated by the relaxation response. The relaxation response seems to be a useful adjunct in the management of essential hypertension (Benson, 1977; Blanchard and Miller, 1977; Jacob *et al.*, 1977).

Self-hypnosis may also be used to bring about muscular relaxation and emotional tranquility. Hypnosis seems to elicit beneficial physiological effects through vivid imagery and, in highly susceptible individuals, through a change in perception (Hilgard, 1965, 1975; McGlashan *et al.*, 1969). Self-hypnosis is also useful in pain control, habit control (such as smoking and overeating), and anxiety control (Spiegel and Spiegel, 1978). Interestingly, hypnoanesthesia is not reversed by naloxone, unlike acupuncture anesthesia or placebo anesthesia (Goldstein, 1976).

Behavior therapy is a spectrum of therapies loosely based on classical or operant conditioning and learning theory principles. The term *behavioral modification* is sometimes used interchangeably with behavior therapy. The self-regulatory therapies described above thus fall under the

rubric of behavior therapy, as well as *systematic desensitization, flooding, implosion therapy, assertiveness and social skills training, sex therapy, token economy, and aversion therapy* (Lazarus and Fay, 1984). Behavior therapy principles and techniques are used in a variety of emotional-behavioral conditions and states.

Cognitive therapy is geared to changing patients' distorted cognitions (thoughts and images) that reflect unrealistic (usually negative) views of self, world, or the future. The patients are taught to identify their stereotyped and automatic views they take on various events that color and distort their perceptions, then they reality-test and correct these views. They also learn to identify distorted unconscious beliefs on the basis of their thoughts and behaviors. The patients then practice various cognitive and behavioral responses to anticipated stresses. Eventually, new beliefs and assumptions are generated and applied to actual and anticipated situations (Beck, 1976; Rush, 1984). Cognitive therapy is especially useful in the treatment of depression in conjunction with pharmacotherapy.

APPROACHES IN THE ENVIRONMENTAL DIMENSION

Any treatment modality involves some environmental change, including the contact with the health-care system for the patient. As noted above, simply being in the hospital is often helpful for the patient, because of both the expectations of forthcoming help and a sense of being "in good hands." Beneficial effects may also arise from the distancing of the patient from possibly pathogenic physical or interpersonal situations by admission to the hospital.

A change in the environment other than that of hospitalization may be indicated in some patients. Until recently, rest cure was an important treatment modality very commonly prescribed by physicians. We are all familiar with the revitalizing effects of a vacation away from home.

Environmental change may be necessary specifically to avoid pathogens, as in the case of severe allergies to endemic allergens. This may involve, for some patients, giving up pets, and for others, moving to a different climate.

Interpersonal changes may involve family (e.g., divorce, marriage, family planning), school, occupation, or type of work. For example, a patient with serious heart disease may have to be transferred from a physically strenuous job to a less strenuous one.

Another interpersonal change may involve *changes in approach* to the patient. The hospital staff's learning how to approach a patient while taking into account his personality needs can result in a therapeutic environmental change. In the case of the "sick Tarzan," this played a very important role in the management strategy (see Chapter 22).

Often, strains and tensions among the *staff* contribute to behavioral and psychological problems of patients. For example, when excessive staff turnover and low morale have generated interpersonal difficulties between members of the hospital staff, measures taken to improve morale and communication between and among the different groups (Chapter 19) will often, if successful, produce a better environment for patient care and amelioration of what appeared to be patient problems.

The *physical environment of the hospital room* can be therapeutic. A bright and cheerful physical environment contributes to a hopeful and optimistic psychological set. Respecting the patient's wishes concerning a multibed or private room can increase his sense of control and so lessen anxiety (Leigh *et al.*, 1972).

It is essential that the hospital environment provide patients who have a tendency to be confused and irascible (Chapter 8), especially those with chronic organic brain syndrome, with cues for orientation: a large calendar, a clock, and a radio or television. Staff members should also introduce themselves each time they touch the patient or perform procedures, since the patient may have forgotten that he is in the hospital and may develop delusions about what the staff is doing. Night-lights are also helpful for these patients, since they may become completely confused and agitated on waking up at night in strange surroundings. Familiar objects from home (e.g., framed photographs, books) should be brought to the hospital and kept next to the patient's bed. Family and friends should be encouraged to visit. This will reduce the patient's anxiety by providing a sense of security and familiarity.

SUMMARY

Management of a patient involves intervention in three dimensions: the biological, the personal, and the environmental. Therapeutic modalities geared primarily toward the biological system often have additional or side effects at the personal and interpersonal levels. The *doctor-patient relationship* is a powerful tool in therapeutic management in the *personal* dimension. Insight-oriented psychotherapy, in general, aims at helping the patient develop an explanatory perspective concerning his sufferings.

Supportive psychotherapy is aimed at increasing the patient's coping ability here and now. Simply providing an opportunity for the patient to talk about his concerns and problems with the physician has major therapeutic impact. Many drugs and surgical procedures are used to alleviate discomfort and promote general health—measures directed at the personal dimension. *Environmental intervention is inherent* in any contact of the patient with the health-care system, but especially in the case of hospitalization. Changes in approach to the patient can play an important role. For patients with a tendency to confusion, provision of a stable and orienting environment is an important aspect of treatment.

IMPLICATIONS

For the Patient

Therapeutic modalities geared toward the environmental and personal dimensions may have the most obvious impact for the patient. Therapeutic modalities geared toward the biological dimension, if the results are not immediately obvious, may not be adequately appreciated by the patient unless sufficient information is given. The patient's fantasies and ideas concerning all therapeutic modalities are determined by his unique experiences and cultural expectations. His ideas concerning the nature and efficacy of the proposed modality may be entirely at variance with the physician's (e.g., the efficacy of laetrile, of electroshock therapy, or of a particular school of psychoanalysis).

For the Physician

The physician should determine rational management approaches to the patient directed at the *three dimensions* by using the systems-contextual framework and the Patient Evaluation Grid (PEG). The *priority of intervention* is determined on the basis of the gravity of the treatment objective and the immediacy of the problem. Physicians should be aware that the *doctor-patient relationship* is an important therapeutic tool in the personal dimension. We should also think about possible side effects of any proposed therapeutic modality in all three dimensions, for example, the side effects of a surgical procedure at the personal and interpersonal levels.

Psychotherapy is *not* a technique exclusively in the domain of the psychiatrist or psychotherapist. Whenever a physician talks with a patient, there is an element of psychotherapy.

For the Community and the Health-Care System

Medical education should emphasize the three dimensions of intervention for optimal treatment of patients. Physicians should be educated to play a central role in the three-dimensional management of patients. There has been a tendency for physicians to concentrate on the treatment of disease, while nurses and social workers have been concerned primarily with problems in the personal dimension and their interpersonal aspects. This is less than optimal, since medical knowledge and psychiatric skills taught to physicians are necessary in assessing the therapeutic needs of the patient in all these dimensions. The *primary evaluator* and *manager* of the patient should be the responsible physician, who can bring (and collaborate with) members of other disciplines and specialties into the specialized care of the patient.

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RECOMMENDED READING

- The American Psychiatric Association Commission on Psychiatric Therapies: The Psychiatric Therapies*. Washington, DC, American Psychiatric Association, 1984. This is a multiauthored, very comprehensive overview of somatic and psychosocial psychiatric therapies. Contains chapters on drug therapies, electroconvulsive therapy, nutritional therapy, psychoanalysis, group therapy, family therapy, milieu therapy, etc.
- Levine M: *Psychotherapy in Medical Practice*. New York, Macmillan, 1945. Although somewhat dated, this classic book shows the psychotherapeutic aspects of various ministrations by the general physician, as well as some techniques that can be used by more psychiatrically oriented physicians and psychiatrists.
- Shapiro AK: A contribution to a history of the placebo effect. *Behav Sci* 5:109-135, 1960. This is an excellent review of the prescientific doctor-patient relationship and the placebo effect in general. Highly recommended reading for any student of medicine.
- Strain JJ, Grossman S: *Psychological Care of the Medically Ill: A Primer in Liaison Psychiatry*. New York, Appleton-Century-Crofts, 1975. A concise and useful book on the psychological management of medically ill patients. Certain specific clinical issues, such as hypochondriasis, the dying patient, and the surgical patient, are discussed, as well as the function of the liaison psychiatrist in the management of medically ill patients. Good supplementary reading for the student interested in comprehensive care.