psychosocial basis of medical practice

AN INTRODUCTION TO HUMAN BEHAVIOR

Second Edition

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PREFACE TO THE SECOND EDITION

Our returning with a second edition is a testament to the favorable reception of the first edition. The audience for the book has been broader than anticipated, with students using it as a text in undergraduate courses preparatory for health careers and in social work, dental, allied health and nursing school courses. We are pleased that students and instructors have seen the general importance of psychosocial variables and relationship skills in patient care and realized that we were not addressing only medical students, but all health professionals. Physicians in practice, especially those in primary care fields and those working with patients with chronic diseases, have also shown an interest in the book. The book's main impact has been on behavioral science courses in medical schools, where to some degree it has helped to define the field of study.

We prefer to keep the second edition reasonably short rather than to try to treat a subject area comprehensively. The brevity of the text is such that most instructors will want to amplify on materials in certain sections. We believe instructors can better complement this core material with the most recent findings or with material relevant to their particular setting and objectives.

Aside from the basically highly complimentary responses of readers and reviewers, two criticisms of the first edition stand out. We are viewed as male chauvinists and the publishers as money gougers. We have reviewed the use of pronouns and eliminated sexual references where the syntax did not suffer. In some cases we have continued use of the generic *he,* because alternatives seemed stylistically awkward. We intend no sexual implications by the use, and hope the reader will be charitable toward our dilemma.

Price is the publisher's dilemma. Costs have greatly risen in the publishing field in recent years. As authors, we have avoided the use of illustrations and graphs in the text, which raise publishing costs, and have tried to make every word count.

Many sections of the text have required only minor modification. The childhood development sections have been expanded in terms of common adaptational problems of specific age periods and the psychosocial history. We have added some of the ethological data which offer firm scientific support for human behavioral principles. Issues of patient compliance, stress disorders, disorders of habit and sociocultural factors which influence health

and health economics are elaborated on. Ethical aspects of patient care are considered in more detail.

The references were selected for their particular relevance as further readings, because specific reference is made to them or because material in the text has been taken from them.

We are again pleased to acknowledge the contributions of our colleagues, Doctors Leon, Meyer and Turnbull. We have taken responsibility for most of the alterations in sections which they initially wrote, to bring greater cohesiveness to this second edition. In this context, we are, of course, responsible for any shortcomings of outlook, scope or execution.

We especially thank Dr. Harry Martin, Professor and Chief of the Division of Sociology, who, as director of the first-year medical student course in behavioral science in San Antonio, has had a rich and continuing influence on our views and the emphases in this book. Bertha Freeburn has our special gratitude for coordinating our revision of the text and doing much of the typing. Nancy Migl also helpfully assisted in the manuscript preparation.

CHARLES L. BOWDEN, M.D.
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Introduction

One way of perceiving a book's organizational plan is to review its table of contents. This introduction is intended to provide the reader with a different kind of overview—a conceptual one—of our text. We would like to summarize here the main foci of the book, its methodology and its core assumptions.

1. Recognition and management of common emotional reactions among nonpsychiatrically ill patients. This section will focus on improving the student's observational skills and on placing the data that he gathers in an adaptive frame of reference pertinent to concepts of health and disease. The adaptive mechanisms used by patients with common emotional reactions and the early life experiences which predispose to these reaction patterns will be considered. Finally, practical ways the physician can put his knowledge to work in dealing with his patients will be discussed.

2. Understanding all of the factors which influence the doctor-patient relationship. The physician needs to develop his interviewing and observational skills so that he can utilize the personal doctor-patient relationship for more effective patient care. In addition to covering this subject, the factors which influence the doctor's own adaptation to the role of physician will be discussed.

3. Growth and development across the life cycle. This will emphasize stage-specific tasks as a primary developmental concern. Healthy adaptation and minor adaptive dysfunction will also receive attention.

4. Preparation for a richer, more ready understanding of the traditional second-year course in psychopathology. Many of the points touched on in Sections 1 and 3 above will be particularly useful in this regard. For example, the adaptive, or defense, mechanisms are key tools for the understanding of the psychiatric disorders.

Methods

1. By focusing on characteristic emotional responses of patients, the text encourages and is compatible with early patient exposure at a level commensurate with the stage of knowledge and the needs of the first-year student.

2. The focus on common emotional reactions in nonpsychiatrically ill patients, and relating those reactions to early life experiences, as well as the attention to adaptive dysfunction across the life cycle, makes the relevance of growth and development more obvious. It also naturally emphasizes the importance of having a holistic view of the patient within his biopsychosocial environment.

3. The approach described allows the student to learn "without realizing it" in certain areas. There is often considerable resistance to the recognition of the existence of unconscious mental processes and adaptive ego mechanisms. A baldly intrapsychic, didactic approach is not very effective. Describing these processes and operations in real patient situations, coupled with giving the student an opportunity to experience them in the relationship with a patient, then relating what he has learned to psychodynamic concepts minimizes the resistances.

Assumptions

This text is rooted in the following assumptions. Curriculum time for behavioral science courses has increased in recent years. Part I of the National Board Examinations now includes a behavioral science section. The format utilized here developed from our generally successful experiences in implementing such a course and out of our growing feeling that current texts for first-year courses are not satisfactory.

Basic to the text design is our view of the physician as the person in our society most saliently identified with health and illness care. The role of the physician has changed over the past 50 years from one of concern with acute, life-threatening infectious and traumatic disorders to concern with chronic diseases involving multiple, interactional causative factors. This change necessitates having an approach which recognizes and makes use of the broad interrelationships that affect health. The physician must master behavioral and interpersonal skills which tend to get lost in the technique- and disease-oriented, overcompartmentalized medical curriculum.

Psychiatric material is difficult to learn because it may run counter to a person's own biases, stir up conflicts, evoke painful memories and temporarily diminish some of the security of the embryo physician. A principle of learning which has validity in general, but especially in areas in which repression is operative, is that of working through. Educationally, this requires repeatedly going over the basic material within different contexts and at different points in the curriculum. This text lends itself to that. Aspects of sexuality and anxious patients, to take two examples, could be covered in the first-year course, the second-year course in psychopathology and again in the clinical clerkship. Reteaching could and should also go on outside psychiatry course offerings, for example, in liaison service conferences.

Neurobiological material is presented only when it naturally fits in. In many ways, it fits in much better with the psychopathology course, when it is relevant to learn of the limbic system and sleep centers as they influence schizophrenia and disorders of sleep, respectively.

We are aware of the "softness" of the material in a book such as this. The laboratory has not produced significant support for major theories of the mind. Our approach is to emphasize empirical data where they do exist, to teach action skills and to define terms operationally, such as the adaptive mechanisms.

For the student who has been immersed in a welter of objective facts, and who has learned that the memorization of discrete bits of data makes a successful student, we have three special cautions.

First, do not reify these concepts. We have described and named hypothetical events in a way which can be useful, but these events remain hypothetical, not real. They are best regarded as a useful metaphor, rather than as an underlying reality.

Second, do not reject the notions that we describe, despite their "softness," out of scientific or personal skepticism. If the notions seem plausible, engage in the willing suspense of disbelief long enough to test their usefulness in practice. You will find that the point of view we offer is relevant to and useful in the practice of medicine generally.

Third, do not assume that, because much of the material in this book is abstract or not immediately clear, it is over your head. Do not engage in the "I'm just a country boy" defense. Much of the material is refined, applied common sense, and all of it is relevant to medical practice. You can be optimistic about increasingly full cognitive mastery of it as you work at becoming a physician over the next few years.

In conclusion, we wish to emphasize what the preclinical contribution of psychiatry to the student's first exposure to the study of human behavior in medicine should and should not be. It should not be a summary teaching of basic psychoanalytical concepts or a course in the sociology of medicine. It should not be an introductory course in any one of the other psychological theories—behavioral, common sense, etc.—or a course in the neurobiology of behavior. As we conceive it, it should not be a course in psychiatry per se.

It should be a course exploring the ways in which the physical well-being of patients is embedded in and interconnected with their psychological state and sociocultural condition. It should be a demonstration that the skillful use of one's own observational skills and personality can enhance patient care, whereas ignoring those factors can undo the most carefully planned therapeutic regimen. It should be a course which helps to teach the art of medicine.

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CONTENTS

PART 1

WORKING WITH PATIENTS

CHAPTER 1

THE THERAPEUTIC RELATIONSHIP: I THE PHYSICIAN, THE PATIENT AND THE DIAGNOSTIC PROCESS

CHARLES L. BOWDEN, M.D.

A physician's technological, disease-oriented skills must be used within the context of clinical observation and human interaction. Engel emphasizes three aspects of the physician's activity related to patient care. The first is the ability to get the patient to respond appropriately through interview, examination and personal relationship. The second is the ability to observe and accurately record behavior, which yields the history of the patient and his illness and the manifestations thereof. The third is the ability to translate these data into pertinent frames of reference, which constitutes the diagnostic process. As Engel stated, "These skills are basically behavioral and call for scientific strategies that utilize the tools of the behavioral sciences, rather

than the traditional laboratory approach to the causes and mechanisms of disease. An essential task of medical education, then, is to develop the physician as the most effective and reliable observing instrument possible."

This chapter focuses on the doctor-patient relationship. The roles of the physician and the patient and the factors that influence each throughout the vicissitudes of the therapeutic relationship are analyzed. The components of the diagnostic process and the concepts of normality and abnormality conclude the chapter.

The Physician

The physician's own personality influences how he will respond to the stresses of the medical profession. A recent study at our institution indicates that only one trait—the need to understand, to seek cognitive closure—is correlated with physician excellence. We did not find any particular personality style or cluster of traits with such a correlation. Many different types of people can make good doctors. Perfectionism and the need to achieve on a high level, which are common in physicians, can cause difficulties in the doctor's personal life when they are coupled with strong external pressures toward overestimations of one's skills and personal importance. In general, the direct patient-care specialities, particularly those in which a sustained, intense relationship with the patient exists, such as psychiatry and pediatric hematology, are associated with such pressures. A more detailed description of factors influencing the physician's own role adaptation is found in Chapter 20.

Factors Affecting the Student Physician

Role Insecurity. Several factors influence the medical student's behavior with patients. Foremost is his insecurity in his new role. He is often torn between his needs to learn and his feelings of being an unnecessary burden to the patient or to the more experienced health-care team members. In fact, the student's educational goals and the patient's needs are usually complementary, not antagonistic. The patient benefits from the opportunity for human interaction. The student, with his ready access to other members of the health-care team, is an important means of communication to and from the patient. Medical students also may serve as a crucial link in transmitting new basic science information to clinical practitioners, to the benefit of the patients.

A student should act confidently, not diffidently or apologetically. In so doing, he will be more successful in establishing the type of relationship that will both further his own learning and provide the best care for the patient. Youth and inexperience are not as much a barrier to an effective relationship as most students think. Some patients are especially able to confide in the

younger physician, with whom they are able to relate comfortably and warmly, as they would with a son or daughter.

Embarrassing or Repugnant Areas. Some patients may have symptoms or behave in ways which the student finds conflictful. Frank or covert sexual invitations may generate conflict and embarrassment. Symptoms such as alcoholism may generate disapproval. Social prejudices may be strongly felt; vomits, feces, or odoriferous lesions may generate feelings of disgust. When the student becomes aware that subjective reactions are interfering with his function, he must attempt to rectify the situation. If he is intensely attracted to or repelled by a particular type of patient, a likely source of the feeling is an unresolved personal problem. Predisposition to biases and to unrealistic attitudes is common to everyone; such characteristics can often be diminished through self-assessment and self-discipline. If the inappropriate reaction persists, or if attention is called to it by an instructor, the student should consider seeking advice. Many times, the problem can be alleviated by discussing it with a more experienced physician.

Conflict between the Needs for Closeness and Distance. Student physicians are pulled by emotional crosscurrents in their work with patients. They need to learn as much as they can of the facts of the patient's life and the meaning of his symptoms to him. Yet the closer students come to the secrets and meanings of the patient's life, the more they risk overinvolvement and, with it, the loss of perspective and objective judgment necessary to help the patient. If they are emotionally overinvested in the patient, there is a tendency to avoid questioning or treatment which might cause pain, embarrassment or other distress to the patient and, in turn, to the overinvolved physician. If they have had previous experiences of similar interpersonally shared pain and disappointment, whether in their own childhood, adult personal relationships or with their patients, they may try to shield themselves from these painful memories by being aloof and uninvolved with their patients.

This conflict operates in yet another direction best summed up in the adage "familiarity breeds contempt." To know extensive and intimate details about the patient places physicians in a role of considerable power, a role which they may eschew or may misuse to the detriment of a patient. There are no easy answers concerning these issues, but awareness of the difference between empathy and sympathy and of the different modes of doctor-patient interaction (a topic of Chapter 3) can help the physician toward confident, mature responses in this area.

The Physician Role

The physician has the unique right and the responsibility to make a personal inquiry into the history of his patient's life (including the most intimate and private details), to examine his body and to carry out treatment. He or she is required to be professionally competent and to have special