Revisionist Theory for Integration

references to behavioral medicine - nonpharmacological approaches to chronic pain and depression; biofeedback treatment of headaches; behavioral modification of obesity; use of hypnosis in clinical practice
these no longer appear worthy or feasible objectives in the main
~~pri~~
emphasized that physicians and psychologists are not two distinct species; still agree with this, but for different reasons; at the time, I had in mind the idea that we all shared certain basic emphasis on caring and compassion toward patients
now I am struck by how easily psychologists are seduced into the medical medel because it enables them to avoid dealing with these issues
in fact, psychological training emphasizes scientific inquiry, research methodology and in this sense is very compatible with the rationist, deductive approach to medicine
I lauded family medicine for making room for psychology, in distinction with other specialties
however, I am increasingly impressed by the gap between rhetoric and action; between the way we talk at conferences and the way we function in clinics
to borrow an analogy from family therapy, this article is about joining maneuvers; I condemned behavioral scientists for psychological arrogance
discussing differences in priorities, I fault the valuing of medical knowledge over psychological knowledge; I still beieve this is a grave problem, although clearly it is a function of the medical system, not the individual resident; and, I would argue, even a function of the larger society, of which the medical system is only a part
I go on to criticise the self-righteousness of psychologists in defining behavioral science as an "ethical imperative" in family medicine
I think the slef-righteousness stems from the possessive territoriality involved in claiming certain aspects as one's own; but I am more and more convinced that ethical imperatives do exist in medicine, in fact they are at the core of medicine, and they must be focused on and taught, not only by behavioral scientists, but by physicians
I point to psychological-mindedness as a potential source of conflict, and define it as a sensitivity to process, to the analysis of interaction patterns between human beings, to implicit meanings
this is a point of conflict, but it is impossible to back down and say this doesn't matter, we' ll ignore this because it makes you feel uncomfortable
the value/action dilemma still exists; family physicians feel because they are nice people and have good values that they will instinctively act in caring and compassionate ways toward patients
beh sci, in the interests of time efficiency and simplicity, may reduce such qualities to a set of profficiency skills, with insufficient attention to the person who is supposed to implement these skills
core of the emphasis is expressed in the rather understated remakk that physicians tend to be som ewhat resistant to introspection, and suspicious of looking inward; I would extend this claim backgard through medical school, and forward through practice; it is a characteristic not unique to physicians; in fact, many psychologists also resist this practice
the difficulty of unrealistic expectations still exists - group facilitator, family therapist, health educator, marriage counselor, etc,
but there is one expectation which supercedes all other considerations - that is for the physician to be able to encounter his or her patient in an authentic, real, and compassionate fashion
the more it becomes apparent the pressures, demands, and values of the

system in which residents function (and by this I mean not only the much maligned medical system, but our entire social fabric), I can only feel increasing compassion and love for the residents, who struggle imperfectly and idealistically to uphold some of their origianal notions about the practice of medicine; and this compassion does not allow my one whit to lower my expectations for what must occur between a physician and a patient

in this regard, I have become less enamored of the flash, the sizzle of family therapy; I am less impressed by residents who jerk family members around from seat to seat, who expriment with family sculpture on home visits, who require patients to complete genograms to while away the two-hour wait in the reception area

all of these are rich and wonderful techniques - but they are just that, techniques; and physicians (indeed Smericans in general) have a fatal weakness - we love gadgets, tricks, technology; and technology exists in the field of family therapy with a vengeance

what still often is missing is a context for the practice of medical and psychological technologyd - a context of caring, understanding, really entering into an I-Thou relationship with patients (by the way, with reference to families, I think it is impossible to fully develop such a relationship without an empathic awareness of family, community, cultural, and intergenerational factors)

this is what I see - doctors, who are really only young men and women, afraid to care, afraid to love (resident wanting to hug child, but afraid)

I think the greatest priority in behavioral science is not teaching trhese residents to help their patients, but is teaching these residents to help themselves

Much has been written about the arrested emotional development of residents and medicl students; but we, as their educators, are often guilty of condemning and rejecting them for this (conveneiently forgetting for the moment that we are part of the system that has created them); we attempt to handle them with behavior modification, rules and regulations, and we forget to love them, to nurture them, to help them grow as human beings

I think we are there less to teach "the subtleties of psychological principles," as I phrased it in my article, and more to teach them some of the subtleties about themselves

if this sounds uncomfortably like therapy, I hink that is because it is uncomfortably like therapy; however, often what has become relegated to the psychotherapy office is nothing more than an authentic, I-Thou encounter between two human beings; this is so rare in our society that it feels instinctively that only an expert should be in charge of making something like this happen; in fact, I think it is a part, an essential part of psychologists' humanness, physicians' humanness, and humans' humanness

What was said about the distancing of physician and patient still seems accurate, and it is this which I feel needs to be focused on and understood much more

the reality is that there is not much time for behavioral science; therefore, lists of curricular objectives are fine, but don't mean much; I think there needs to be one primaty focus, and that is not how to ~~reduce~~ protect this distance, but to teach residents safely how to reduce it

Now at a stage in my career where joining has been successful; I think the family trusts me; and I am eager, indeed I see it essential in some part to hang onto the isolation, the outsider quality, the differentness which bothered me so much eight years ago

it is easy to become coopted by this system, to get lost in discussions of the cholinergic system, or the effects of amitriptyline or imipramine

communication - problem is not simply that doctors and psychologists speak different languages, this is true, although programs like health psychology are narrowing the gap (and they are narrowing it exclusively in the direction of psychologists adapting the langusge of medicine)
it is alsoo that neither group is willing a utilize ak third language of available to them - a language of genuiness and transparency, a language of dself-disclosure, a language of emotional authenticity; this is the basis for true encounter and for true teaching

unresolved issues related to resident's family of origin can interfere with working with families of pts. - before they can learn about family systems theory, have to learn about their own families

Michael Crouch wrote a beautiful article about a yer ago in Family Medicine chronicling his own struggle toward intimacy, independence, and resolution with his own family of origin - examining themes of death, specialness, and openly expressed affection; modeling like this, articles like this indispensable to the development of our physcians in training

speaks openly of how his own issues (from a family perspective) detracted from his practice as a physician - overxxxxxxfunctioning with female patients, needing to save patients, needing to be special to patients

awareness during pt. visits of being too close or too far from patient to be effective

when doctor-patient relationship is unsatisfactory, useful questions: how might my own family patterns be playing a part? how can I change my part of interaction to avoid repeating dysfunctional family patterns?

consistent problems in doctor-patient relationships - consistent criticism of physicians as emotionally neutral, uninformative, ; physicians seen as maintainin high control in interactions; ignoring the life world of the patient; becoming trapped in power-struggles with patients, the more physician tries to help, the more symptoms patient provides - each attempted to control the other by controllin the symptom

creating intimacy and reciprocity in the clinical relationship through use of self - acknowledging shared, common humanity with patient, despite necessity of divided function and unequal roles

importance of functioning as wounded (not perfect) healer - allow recpiprocity for healing in dr-pt relationsip

difficulties in dr. pt relationship result from clash between interlocking psychologies of dr. and pt.

when pt's anxiety makes physician intolerably anxious (depressed patient stirs up physician's own unresolved loss), that physician may comply inappropriately with pt's wants, rather than needs

more closely physician listens to patient, more they incorporate contexts of pt's and family's life into their clinical thinking, the more they can distinguish between their own difficulties and those of the patient

disinction between interviewing and dialoguing

avoid reduction of interpersonal encounters to depersonalized - mechanistic, technique-oriented model

importance of appropriate emotional, psychological, perceptual context (example of pt. with melanoma - resident instructed to ask about feelings after communicating diagnosis: Resident: So, how are you feeling about all this? Mother: Silent, tears in her eyes Daughter: Oh, well, we are Christians. We believe it is in God's hands. Resident: Oh, good (relieved). End of dialogue)

must deal with residents split off from their wholeness, completeness, integrity, emotions, wholeness, humanity

shamming and fakery: re self-disclosure (Pt. mentions recent return from fishing trip; Resident: I think fishing's great!; later, revealed resident had never been fishing in his life - artificial and uncontexted effort at bonding)

emphasis on accumulation of ready formulas, which interfere with relly being present with a particular patient; response must be based on patient's needs rather than resident's defenses

goals of beh sci teaching: 1) lifting of repression, insight, integration 2) differentiation of self 3) greater tolerance of anxiety 4) greater mutuality authenticity, openness of communication

BEHAVIORAL SCIENCE REVISITED; THE ART AND THE SCIENCE

OUTLINE

I. MY BACKGROUND

II. PURPOSE OF PRESENTATION

Reexamination of themes of article looking at integration of behavioral science and family medicine

III. PITFALLS AND DANGERS

A. Seductiveness of the biomedical, high-tech model

1. system demands cures, efficiency, competency, solutions

2. Difference between what the physician wants and what he needs

B. Research as a method of propulsion toward legitimacy

1. Avoid becoming the research justification for a program

2. Avoid situations of parallel play, which give insufficient theoretical attention to the type of research which makes most sense in family medicine today; the models of health psychology may not necessarily be the most applicable

C.

IV. THE ROLE OF THE BEHAVIORAL SCIENTISTS

A. As visionary - unique situation in which a single discipline is driven at least theoretically by the input of two (or more specialties) (and theoretician) -, helping in the ongoing process of defining the field

If we abrogate this role, then we are hired hands, brought in for specific functions and tasks

B. As teacher - But what do we teach? - slide

1. Importance of a primary focus - very limited instructional time

2. Shift from focus on content (interviewing skills, diagnostic DSMIII skills, family therapy techniques) to focus on process; less concern about teaching residents about patients, than in teaching them about themselves, or about their patients in relation to themselves (Balint's two-person psychology)

3. The art of medicine is fast becoming anachronistic - various pressures mitigate against any serious attention in this area:

a. explosion of biomedical and biotechnical information

b. overwhelming economic pressures on an overburdened system

c. the rise of a fast-food consumer culture

4. Focus less on techniques, and more on the context for these techniques

1. Joining techniques: fusion/distance
2. where do we stand in relation to dept.
fusion vs. distance; gadfly, provocateur
- whole person vs. slate boards, subspecialties, fiscal opportunities
- fulfilling research funding
1. art of medicine
2. flexner
3. Research neglect
4. quotes - Shrasm, Napodano, Katz
5. Wounded Healer
6. NEJM/week
7. Limited impact of criticisms
8. self-understanding
9. Limits of high tech

these techniques

a. Avoid teaching only the technology of ~~medicine~~ psychology (self-disclosure; exploration of feelings)

b. Dinstinction between interviewing and dialoguing

c. Techniques (genograms, family sculpture) uninformed by a larger context of understanding, compassion are open to abuse and misuse

5. Concept of wounded healer - most residents wounded, yet we ignore their pain (example of looking for pt., for behsci teaching, resident bursting into tears)

6. How do we teach understanding, support, patience, compassion?

a. must start with the person of the resident and the family of the resident (Crouch example)

b. must develop some acquaintanceship with themselves as moral, emotional, spiritual, even physical beings

c. stop being obsessed with stuffing residents full of facts - this will not fill the void

d. need to justify ourselves - point to a curriculum and say, this is what I'm doing; may be more useful talking to a resident about who they are, now they got to where they are

Hispanic ♂ residents Jews are paranoid

7. Context for practice of medicine

a. from Flexner on, assumption of comitment, caring, compassion

b. Napodano: "Physician must be involved in the illness; that is, be able to take on some of the sufferings and concerns of the patient"

c. Katz: "What the physician fears in himself, he cannot allow the patient to express." intimate, anxiety producing, fateful encounters

8. Goals of behavioral science teaching should be:

a. Reintegration of residents with themselves, with their emotions, their wholeness, their humanity\

b. Deepening of insight and self and other awareness

c. Greater tolerance of ambiguity and anxiety

d. Increased acceptance of one's own limitations, imperfections

e. greater mutuality, authenticity, and openness