Applications of Behavior Therapy to Medical Settings: The Life and Times of a Behaviorist in a Department of Family Medicine

This paper deals with an increasingly important conceptual issue: How can psychology, and behavior therapy in particular, be integrated into medical settings? The focus of this presentation is on the problems, pitfalls, and potential confronting the behaviorally-oriented psychologist who functions in a medical context.

Initially, ways of identifying and dealing with the different world views and priorities of physicians and behaviorists will be explored. Both groups are pragmatic, comfortable with crisis management, and committed to problem-solving interventions. However, physicians tend to focus on illness, behaviorists on the context of illness. Physicians still often stress rehabilitative and palliative medicine, while behaviorists tend to emphasize preventive aspects of treatment. Physicians often regard the information provided by a behavioral perspective as of secondary importance, a frill to "real" medicine, while behaviorists, in their enthusiasm for the ABC's of "illness behavior," sometimes discount the presence of actual disease-producing pathogens.

It is not unusual for the two disciplines to hold unflattering stereotypes about each other, which need to be examined and reevaluated. Behaviorists, having frequently been patients themselves, are quick to see the physician as callous, mechanistic, or even worse, the dupe of a manipulative patient. Physicians, on the other hand, tend to be more comfortable with psychodynamic interpretations of patients' psychosomatic symptoms, and feel behavior mod can be manipulative and unethical.

Next, the problems arising from a lack of a common language shared by the two groups will be considered. Superficially, physicians and behaviorists appear to speak the same language. But, just as closer examination revealed somewhat divergent values and priorities between the two groups, so too apparent similarities in language contain unexposed discrepancies. For example, although both physicians and behaviorists speak of "treating the whole family," the phrase takes on a very different meaning depending on who speaks it.

Part of the world view of the physician derives from his or her reliance on the medical model for understanding illness and pain. This presentation will briefly discuss an alternative model, which is based on a functional analysis of illness. This model, building on the work of Fordyce, interprets illness as an operant behavior maintained by both direct and indirect reinforcement, and stresses the importance of developing appropriate contingencies to develop and maintain wellness behavior.

Finally, four examples of specific applications of behavior therapy to patient care will be presented:

1. A comparison will be made between the medical interview and behavioral patient assessment, with recommendations for incorporating aspects of the latter into the former.

2. Ways of teaching a physician how to do a functional analysis of patient symptoms will be discussed. This analysis will facilitate a total environment approach to patient health care, with special emphasis on understanding and utilizing the family's pivotal role as an effective change agent.

3. Time will also be spent examining applications of self-management strategies to:
   A. Patient care: eg., adherence and compliance, management of chronic illness.

   B. Physician well-being: facilitating increased self-understanding and self-change.

   In this context, an example of physician self-monitoring will be elaborated as it relates to improved physician-patient interaction.

4. Behavioral groups for patients and physicians will be considered. A physician self-help group, with appropriate model target objectives and intervention strategies, will be described, as will the use of patient groups for the management of particular clinical problems: eg., obesity, hypertension, diabetes.

SEMINAR PROPOSAL

The Integration of Behavioral Sciences in Departments of Family Medicine: Hazards and Possibilities

Among the medical specialties, family medicine has been among the most receptive in welcoming behavioral scientists into its midst. As a discipline it views itself as humanistically and holistically oriented, and thus compatible with those refugees from the social sciences who end up in medical settings. An increasing number of family medicine departments throughout the country can boast at least one behavioral scientist among its faculty. Behavioral scientists placed in these positions are given the vague but impressive tasks of "training residents in the behavioral sciences" (whatever those might be); "coordinating interdisciplinary research", etc.

Behavioral scientists have tended to respond with a somewhat fervid enthusiasm. The pioneering spirit seizes hold, and they frequently begin to hallucinate that singlehandedly they can slay the technological, dehumanizing Goliath of the modern American medical system.

However, mutual disillusionment rapidly sets in. Busy physicians feel that the behavioral scientists whom they were so proud to acquire become pushy and demanding once they achieve faculty status. They are confused by what they perceive to be the intrusions of the behavioral sciences into the more fundamental aspects of patient care. Further, although family physicians acknowledge the importance of physician self-awareness and sensitivity to the patient's emotional responses, behaviorally these areas are sometimes neglected.

As for the behavioral scientists, they frequently exhibit a psychological arrogance which assumes the primacy of their own specialty. They begin to feel isolated and displaced, their skills devalued, their insights ignored, and one may begin to notice them pouting in little-used corridors. Theoretical principles and research findings which they have been trained to respect are ignored by physicians seeking immediate and practical solutions.

This presentation will focus on a close examination of the pitfalls and challenges in attempting to successfully integrate two related but disparate disciplines -- family medicine and psychology -- without attempting a superficial grafting on the one hand or the training of minipsychotherapists on the other. Major points of consideration will be the following:

1. Dealing with the different world views and priorities of psychologists and physicians.
    A. Developing psychological-mindedness within a medical community.
    B. Developing a common language; reducing anxiety in both groups.
    C. Clarifying the stereotypes which physicians and psychologists hold about one another.
2. Specific ideas about behavioral science curriculum development and implementation.
    A. Structural and institutional issues
    B. Integration of theory and research with a technique-oriented approach.
    C. How to develop a true expertise among family physicians regarding family structure and dynamics.
    D. Cross-cultural considerations.

The seminar will be practical and solution-oriented in emphasis, aimed at defining a common territory between physicians and psychologists, getting both groups back in touch with the great possibilities inherent in mutual collaboration.

A Revisionist Theory Regarding the Integration of Behavioral Sciences in Departments of Family Medicine

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However, mutual disillusionment rapidly sets in. Busy physicians feel that the behavioral scientists whom they were so proud to acquire become pushy and demanding once they achieve faculty status. Immersed in their own worldview, they often resent the intrusions of the behavioral sciences into what they perceive to be the more fundamental aspects of patient care. Although they verbally acknowledge physician self-awareness and sensitivity to the patient's psychological state as critical to effective patient care, privately they may feel uncomfortable with these concepts.

As for the behavioral sicentists, often they are beset by a psychological arrogance which assumes the primacy of their own specialty. They begin to feel isolated and displaced, their skills devalued, their insights ignored, and one may begin to notice them pouting in corridors and skulking along little-used passageways. Theoretical principles and research findings which they have been trained to respect are ignored by physicians seeking immediate and practical solutions.

This presentation will focus on a close examination of the pitfalls and challenges in attempting to successfully integrate two related but disparate disciplines -- family medicine and psychology -- without attempting a superficial grafting on the one hand or the training of minipsychotherapists on the other. Major points of consideration will be the following: 1) dealing with the different world views and priorities of psychologists and physicians 2) developing psychological-mindedness withint a medical community 3) developing a common language 4) integration of theory and research with a technique-oriented approach 5) clarifying the stereotypes which physicians and psychologists hold about one another 6) specific ideas about behavioral science curriculum development and implementation 7) how to develop a true expertise among family physicians regarding family strutture and dynamics.

Professional Issues for Psychologists in Medical Environments

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Clinical psychologists typically work in a psychiatric or mental health setting. Recently, however, there has been an increase in the number of psychologists who work in medical environments. The functions carried out by psychologists in medical settings are quite varied, including teaching, training, applied and basic research, consultation to medical and surgical services, providing direct psychological intervention for patients with physical and psychosomatic illnesses, consultation with medical and paramedical staff regarding both staff and patient issues, program development, and intervening in hospital and health care systems. Psychologists are employed in a variety of health care settings, including community hospitals, clinics, and university medical schools and medical centers, with each environment placing differing demands upon the psychologist. The increase in numbers of psychologists working in medical settings has resulted in national attention to professional identity, training issues, and organization of psychologists in medical settings. The subspecialty has been variously identified as "behavioral medicine," "health psychology," and "medical psychology."

The purpose of this presentation is to delineate the nature of some of the professional issues raised by the practice of clinical psychology within a medical environment. Among the issues which will be discussed are included:

(1) the psychologist's lack of experience in the medical milieu; (2) the professional relationship between the physician and psychologist; (3) the "graduate student" vs. practitioner issues in the hospital; (4) the difficulties associated with interdisciplinary team functioning; (5) difficulties in full development of professional activities; (6) the problem of the psychologist as panacea; (7) the psychologist's lack of training and knowledge in medical and health related areas; (8) the difficulty of an independent practitioner working in a medically dominated field; (9) pitfalls in relationships with peer "allied health" professionals and technicians. Reinforcers and punishers for psychologists working in medical settings will be discussed.

Training Physicians in Behavioral Sciences: Theoretical Challenges and Practical Possibilities

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Voices challenging traditional medical training have become increasingly vociferous in the past 10 years. Paradoxically, as medical care has improved from a scientific and technological viewpoint, patient dissatisfaction has increased. The post-Flexnerian emphasis on technical competence and scientific expertise has been supplemented recently by demands that attention be paid to the doctor-patient relationship, to the family context of the patient, and to the importance of psychosocial factors in truly adequate medical care.

For several years primary care specialties such as family medicine and pediatrics have recognized the relevance of insights and skills from other disiplines to the practice of medicine. Nevertheless, the relationship between medicine and the behavioral sciences continues to lack definition. In particular, it is unclear whether the emphasis of this relationship should be on improving liaison and referral activities between disciplines, or on directly incorporating aspects of the behavioral sciences into medical training.

Although these two approaches are not mutually exclusive, they do presuppose somewhat different theoretical rationales. This presentation attempts to develop a heuristic model to define the latter possibility: how psychology can be directly integrated into a traditional medical curriculum. This is accomplished through an examination of two areas: 1) the doctor-patient relationship, 2) the psychosocial context, (particularly the familial), in which illness and health occur.

First, the medical significance of the doctor-patient relationship will be analyzed, and two interrelated factors of importance to physicians will be explored: a) the development of "psychological-mindedness" in physicians, including an awareness of the importance of self-understanding in any process of patient treatment; b) the development of communication and interviewing skills in physicians to facilitate increased patient satisfaciton as well as to provide the physician with more complete and more accurate information.

Next, practical methods of accomplishing a behaviorally-oriented psychosocial assessment of the patient in his or her family context will be presented. Then, a more problematic question will be addressed: to what extent should the physician actually attempt to deal directly with patients' psychological problems and problems in living? In conluding, the applicability of various short-term psychotherapies will be reviewed, and specific skills necessary to formulate intervention strategies will be identified.