
A Few Thoughts Concerning The Dimensions Of "Medical Treatment"

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Abstract

If we allow ourselves to think in terms of an active dynamic, medical therapy and "treatment" can be structured in three general dimensions: the Biological; the Personal, and the Environmental. Considering these in turn, I will attempt to interrelate today's reality of medical care. First, the Biological Dimension traditionally offers treatment in the form of "conventional medicine" (a tablet, a pill, a capsule), or at times, a little more invasively (i.e. surgery).

If we allow ourselves to think in terms of an active dynamic, medical therapy and "treatment" can be structured in three general dimensions: the Biological; the Personal, and the Environmental. Considering these in turn, I will attempt to interrelate today's reality of medical care. First, the Biological Dimension traditionally offers treatment in the form of "conventional medicine" (a tablet, a pill, a capsule), or at times, a little more invasively (i.e. surgery). In the treatment of mental illness, a medication is employed (an antidepressant, antipsychotic, or anxiolytic, to name but a few) with the expectation that a biochemical effect will result in some level of "cure", reversal, or amelioration of an acute process. However, along with a medication's desired biological effect exists, to varying degrees, it's unwarranted and undesirable "side effects". This balance between "positive" and "negative" effects can be difficult to maintain - especially for some of today's psychiatric medications (e.g. clozaril and the ever-present risk of agranulocytosis). At the very heart of this Biological Dimension is a focus on the underlying etiology behind the patient's current symptomatology; notice, I use the word "symptom" as a root and by design with full intent thereof. In an ever-present dichotomy with physician concerns, are the patient's own set of questions and anxieties. The patient is, after all, the one who is ingesting this "foreign" chemical and experiencing the impact firsthand. This is why physicians must explore the patient's concerns and preconceived notions regarding any proposed biological modality. This basic clarification

involving adequate and lucid information is, unfortunately, lacking in the majority of our "modern-day" doctor-patient relationships.

Therapy in the Personal Dimension focuses not on the etiology of a disease process but rather the patient's behavior, general health, understanding of illness, and psychological reactions to the overall stressors present. Treatment within this realm is directed at modifying the patient's feelings and general functional capacities to, hopefully, influence his/her own general well-being. No longer do we concentrate on the exact etiology of the underlying pathological process (i.e. the Biological Dimension) but instead turn to a different level in an attempt to help the patient "cope". This can be achieved, primarily, by offering "shelter" to the acute perception of illness. A functional 'physician-patient relationship' can thus serve as a powerful tool in the healing process. By working within this Personal Realm, the healing effect may be increased by a physician's interest, empathy, and competence. The majority of psychotherapy is thought to work within this dimension: to help facilitate a patient's self-understanding and self-awareness; to provide a mental construct in which to function and interact with others (as well as self). Insight-oriented therapy can help patients develop an explanatory perspective concerning their problems and "life situations". Supportive therapy can help the patient increase coping skills used to defend against everyday insults and attacks -

regardless of shape, form, or intent.

Given these, we must then consider the third dimension:

Environmental - the all-encompassing stage upon which we work and play. At times, our "stage" is for the sole actor or actress - no larger than the room necessary for one to function. At other times, the "stage" stretches out to a theoretical horizon - beckoning others to come and join in the bright lights and loud music. This transition of set, from singular to plural (from near to far), can be as delicate as the artist's brush or as slow as the meandering river. My point in utilizing these descriptive fragments is simple: our "environment" varies from moment to moment, yet how often does it truly change? Our environment is as large as our ego will allow it to be yet, simultaneously, as small as our mind's-eye will dare to perceive. Person-to-person contact, along with historical experience, affects the shape and color - the depth and size - of our "environmental understanding", and thus, our reaction to self and stranger-kind. Some individuals will require a great deal of rigid structure and support from their surroundings (e.g. a borderline personality) while others will need only temporary and fleeting glimpses of external reality (some would say, as an example of the latter, my own personality - but I would strongly disagree!).

With the above dimensions as a structural guide, we can now discuss short-term versus long-term treatment goals.

Short-term Treatment Goals:

1. To Stabilize an acute medical condition
2. To Relieve current symptoms and return to a "normal" level of functioning
3. To Achieve compliance with the medical regimen
4. To Increase self-esteem through an active process of discovery
5. To Ensure activity and "closeness" with family and/or friends (many want to "withdraw into themselves" as a normal defense reaction against the increasing anxiety associated with acute change or uncertainty)

Long-term Treatment Goals:

1. To Improve understanding of the current mental construct (with active use of adaptive response)

2. To Improve interpersonal relationships (both sexual and nonsexual)
3. To Recognize one's lifestyle and behavioral patterns
4. To Accept fulfillment of wishes and desires without direct harm or injury to oneself or others
5. To Return to a functional societal role (occupational/professional)
6. To Establish one's "own" personal identity
7. To Recognize the "triad's" natural importance and interdependence (self; stranger; friend)
8. To Understand past and present experiences (though this may uncover anger and grief)

MEDICAL TREATMENT

Medical treatment for acute life-threatening conditions should begin with immediate hospitalization: this removes the underlying triggers and, if structured properly, establishes emotional quiescence. A safe, secure environment with clear limits, personal expectations, appropriate biological regimens, and trained personnel can allow individual stabilization. Once admitted, regardless of will, the proper and various forms of somatic treatment must be instituted and rigorously followed; there can be no substitute for academic integrity in the diagnosing of illness - especially, mental illness. Once accurately diagnosed, the possibility of "dimensional-intervention" exists.

In cases of acute mental disturbance, one clear example of the above principle is the use of lithium carbonate. Although lithium's precise mechanism of action of lithium has never been determined (though there are studies that show an inhibition of Norepinephrine-sensitive Adenylate Cyclase), it's clinical use in this country spans across the last 25 years with unremitting evidence of relative safety and biological efficacy. The onset of action usually takes between 5 - 7 days with a target plasma level (for the treatment of an acute manic break, for example, between 0.9 - 1.4 meq/L - although individual patients may do well below this range). Elimination half-life is approximately 12 hours (in our exemplified patient). Lithium is rapidly absorbed with peak blood levels occurring 2 hours after ingestion. It is almost-entirely excreted through the kidney - but is present in all body fluids. Lithium blood levels need to be monitored somewhat closer (but not as closely in most patients as it

was first believed) to prevent elevated concentrations and possible toxic effects. Some patients, particularly the elderly, can experience signs of Lithium Toxicity (nausea, shaking, ataxia - to name but a few) at normally-therapeutic levels. It is critical that patients on lithium therapy maintain an adequate salt and fluid intake to avoid potential concentration of effect. The common side-effects are described as "minor" and approximately 50% of patients will experience thirst or polyuria; 40% tremor, 20% diarrhea, and 10% edema. These side-effects tend to decrease in severity over time. However, between 5 - 15% of patients on long-term therapy may develop hypothyroidism (which is why thyroid studies should be obtained as baseline before beginning lithium; annually monitoring thyroid function to detect a clinically-silent or early state of hypothyroidism is important as well). If hypothyroidism does develop, it can usually be managed with thyroid replacement; thyroid dysfunction usually reverses once the lithium is stopped. Contraindications and precautions for use include sodium or volume-depleted patients, renal or cardiac disease (increased risk of toxicity), DM, ulcerative colitis, and psoriasis (these medical conditions may all worsen in the presence of systemic lithium). The long-term complications of lithium are real and present. The medical literature shows clear evidence that for a "first-time break", once stabilized and "back to normal", long-term therapy is not required. In this case, a trial should be conducted: the Lithium can be stopped immediately without effects (there is no characteristic withdrawal from sharp discontinuation so tapering does not have to be performed) and the patient should be closely monitored for hypomanic or manic behaviors. If the individual cycles again into mania, then the lithium should be reinstated and the chart clearly documented with the clinical evidence, now, of requiring long-term treatment. If the patient does not immediately cycle into another episode, he/she may be left alone - without further lithium coverage; however, they must be regularly followed for return of their manic symptoms. It is not medically wise to continue a medication on a "First-time Manic" without a documented trial of time when the patient was not covered by the medicine; to do so, is to place the patient at increased risk of future complications without clear evidence that this risk is "necessary".

Once medically and "socially" stable, plans can then be made to address the other dimensions of treatment. On an outpatient basis, formal Psychotherapy can be instituted. There are many types and forms of Psychotherapy; a quick summary list might include:

BEHAVIOR THERAPY RELAXATION TRAINING

- Systemic Desensitization (a slowly progressive technique used to reduce or control fear elicited by a specific stimuli)
- Flooding (the extinguishment of anxiety by placing the patient in continuous and, to some degree, overwhelming contact with the feared stimulus - thus helping them to learn that the stimulus does not, in reality, lead to imagined consequences)
- Behavior Modification (using the concept of reinforcement to shape behavior patterns)

The goal of behavior therapy is to Change the Behavior (with a simplified motto of, "change the behavior, and the feelings will follow"). Instead of examining underlying emotions or motivations and trying to understand the patient's thoughts and feelings, the therapist should concentrate on 'What The Patient Does' - believing that significant changes in behavior will lead to significant changes in thinking, attitude, and emotional reaction.

COGNITIVE THERAPY TYPICAL COGNITIVE DISTORTIONS INCLUDE:

- Arbitrary Inference (which is the drawing of an erroneous conclusion from an experience)
- Selective Abstraction (the taking of a detail out of context and using it to denigrate the entire experience)
- Overgeneralization (making general conclusions about overall experiences based on a single episode)
- Magnification / Minimization (which is the altering of significance of specific events in a way that is structured by negative interpretations)
- Personalization (interpreting events as reflecting on the patient when, in reality, they carry no relationship to him or her)
- Dichotomous Thinking (seeing things in an All-or-None way)

The basis of Cognitive Therapy involves an assumption that "cognitive structures" shape the way that people react and

adapt to situational changes in their lives; each person has her own specific set of "cognitive structures" which determines how they will react to a given stressor. A psychiatric syndrome (Anxiety) is believed to arise when these "structures" become overactive and predispose the patient to developing a negative response. The therapeutic techniques focus on teaching the patient new ways to change her pathological "constructs"; its goal is to help in restructuring negative cognitions which allows the patient to perceive reality in a less distorted manner and thus, react more-appropriately. In many cases, much could be gained from Cognitive Therapy. By first understanding a patient's approach to life stressors, we may be able to explain the source of an underlying "exaggerated Affect". This, in turn, may lead to different behavioral manifestations when faced with an "unresolvable" internal conflict.

INDIVIDUAL PSYCHOTHERAPY

Classical Psychoanalysis (this form of treatment requires a fundamentally healthy person who has sufficient adaptive resources to go through the intensive process of self-scrutiny. It's core component is the development of a transference neurosis by which unconscious drives and motivations are made conscious - via appropriate "interpretations" and self-awareness).

- In some cases, this form of therapy may be too extensive for an individual patient. Specific adaptations and "defense reactions" that have been employed in the past may not allow the patient to remain stable when the process of "self-discovery" begins.
- Psychodynamic Psychotherapy (concepts of psychoanalytic theory used in ways to understand not only her early relationships between parents and significant others but as well to focus on the "here and now". Patients are expected to explore their thoughts and feelings with an occasional interjection by the therapist to assist in understanding the underlying dynamics which shape the observed behavior. It is overall, a "less rigid" approach - compared to the Classical theory).
- Insight-oriented Psychotherapy (Focuses primarily on interpersonal relationships and, to a great degree, on the "here and now". Patients are encouraged to review and discuss relationships, attitudes toward themselves, and early life

experiences while the therapist maintains an involved and supportive attitude - occasionally offering interpretations to help the patient achieve insight. Instead of reliving, or re-experiencing earlier experiences, patients are encouraged to achieve more of an intellectual understanding about their behaviors and attitudes).

This, I believe, is an important step in almost any process of full recovery. In managing a singular case, Supportive Psychotherapy is a mandate and should be employed until "real - Trust and Faith" had been established in the Doctor-Patient Relationship. When the patient appears stable and ready for further advances into his/her own understanding, moving beyond this level (ultimately to the more-rigid and intense level of psychodynamic psychotherapy) is possible. Real progress and treatment is often possible; however, a patient's defenses can be strong and multiple in number. Patience and are of primary concern to avoid permanent psychic damage

- Relationship Psychotherapy (in this mode, the therapist assumes a much-more active role in becoming a loving and trustworthy surrogate parent who assists the patient in confronting unrecognized needs and unresolved drives. The focus is on achieving a "corrective emotional experience").
- Supportive Psychotherapy (this is mostly used to help patients "get through" difficult situations with the ultimate goal of helping them to "cope" with the self-described difficult experiences or periods of adjustment. The pt will describe what he or she sees as the problem and the therapist counters with either encouragement or specific advice).

This, as explained above, is often a "starting point" within the framework of medical dynamics. Without the proper environment, patients may never develop the trust and interactional relationship they may need to fully explore their own thoughts and emotions.

GROUP THERAPY

This form of psychotherapy provides patients with a social environment or even a surrogate peer group that will allow them to learn new and constructive ways to interact with others in a controlled and supportive environment. The therapeutic mechanisms which may arise from a properly-

run group session include:

- instilling of hope,
- development of socializing skills,
- imitative behavior,
- interpersonal learning,
- imparting of information,
- altruistic behaviors,
- diminished feelings of Isolation,
- development of a sense of "group cohesiveness".

MARITAL AND FAMILY THERAPY

Marital Therapy involves seeing a husband and wife (or an unmarried or homosexual couple) in order to help them stabilize and improve their relationship. The minimum component involves graded behavioral changes (via contractual agreements and other specified modifications). Often couples benefit from discussing their hopes and expectations of one another in the context of personal values, prior family experiences, changing social norms, and needs for both intimacy and independence.

Family Therapy tends to focus on the larger family unit - both parent(s) and child (children). Typically, the child is brought in initially for treatment of a specific problem - but, over time, it becomes clear that this problem exists in the overall context of the family structure and dynamics. Behavioral approaches are a mainstay of treatment and involve focusing on the "here and now" with use of Positive Reinforcement in place of Criticism.

CONCLUSION

As proposed, medical therapy can be structured in three general dimensions: the Biological; the Personal, and the Environmental. To have an impact on dis-ease and "illness", we (as clinicians, healthcare-workers, social scientists, etc.) must attempt to understand the individual patient's perspective prior to "jumping in" and casually instituting "treatment". Without such precautionary design, we risk inducing irreversible damage to an already-vulnerable system. I've always pictured the "mental construct" as a bridge of steel spanning across two cliffs - strong and precise

with accurate design specifications, powerful braces to provide internal support, and guide-wires of woven steel cable securely fastened to pillars of stone. Yet as sturdy as that bridge may be, as beautiful and functional as it may become, how will the structure stand when one of the cliffs collapses? The construct must be both strong and weak. It must be steadfast yet flexible. It must, at times, be allowed to break - and then, in a second's second (or a minute's minute) be rebuilt from years of life's reality and illusion-both.

Our environment is the source of external stimuli - which leads to cognition and thus, physiological affect (not effect, I would argue; the Effect is an individual's response - at whatever level, either conscious or unconscious, to imposed Affect). If we do not consider the implications of our surroundings (both positive and negative) on psychological state, then we should not expect to feel. We should not treat a blind man to the musical sweetness of an orchestra; we should not place a patient suffering from major depression in a brightly-lit, freshly-scented room because a closet will offer the same degree of healing. We should not offer a deaf man a glass of aged, red wine. Yes, these are exaggerations and ridiculous in both thought and description, yet in my opinion, a physician with a "negative outlook" or demeanor (one that offers little hope or insight - one that provides little change in autonomy or perspective) is more of a danger to the field of "medicine" than all of the automated logarithms and diagnostic flowcharts set forth by "managed care".

The human hand must be held. The human heart must be touched. We, as teachers, healthcare workers, researchers, scientists, philosophers, (or just "us" as mammalian creatures) must have the courage to reach out - in new and exciting ways - if we are to change the world around us. "Medicine" must be an active dynamic of both past and present-kind.

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References

r-0. Readers should turn to the definitive works of Leigh, Andreason, and Loren Eisely (just to name a few).

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