IMPLICATIONS OF BEHAVIORAL HEALTH FOR PSYCHOLOGY

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A recent statistic released by the World Health Organization indicates that stress-related disorders (heart disease, stroke, respiratory disease, arthritis, etc.) are replacing infectious diseases as the major cause of death and crippling in Western Industrialized Societies. This statistic is supported by recent studies which show that minor tranquilizers like Librium and Valium, are the most widely prescribed drugs in general practice (Blackwell, 1975). In fact, surveys in the last twenty years have indicated that between 25 percent to 75 percent of the patients seated in a general practitioner's waiting room present with physical complaints, but on careful study have no physical findings.

The stressors that impinge on these patients seldom involve tissue damage or the threat of tissue damage. Frequently, they present in vague ambiguous forms that elicit cumulative physiological arousal and ambivalent feelings in these patients. For example, these (psychosocial) stressors may include an unhappy marriage, a problem child, a hypercritical boss, unrealistic performance standards, rejection, or loneliness. These problems cannot be remedied by primitive, 'fight or flight' or alternatively by modern drugs and surgery. Yet patients and physicians continue to trot out the same tired remedies, while the cost of health care continues to rise.

Several studies presented at recent Congressional hearings have shown that including outpatient psychological services in health systems reduces the incidence and length of hospitalization. The Kaiser Permanente Health Plan Study (Cummings, 1977) showed a sustained reduction in the use of medical services of 60 percent to 70 percent when psychological services were available to patients. A four-year study of people over 65 in Harris County, Texas, showed that access to psychological treatment reduced the mean length of hospital stay from 111 to 39 days, resulting in a savings of 1.1 million dollars.

The busy medical practitioner often does not have the training, the time, or the inclination to sit down and explore the psycho-social origins of his patients' organic complaints. He would rather treat 'legitimate disease.' But the patient insists that in spite of the negative physical findings, the physician do 'something' for him. The physician may be pressured into prescribing a psychotropic or analgesic medication, or perhaps ordering a new series of expensive and sometimes even dangerous tests, plus hospitalization. The results of these tests are again frequently negative, and merely serve to confirm the clinician's original impressions from history and physical examination. The patient is dissatisfied with these findings and because of his persisting physical symptoms, he loses confidence in the physician and may come to regard the physician as an 'incompetent quack.' The physician, in this atmosphere of failure, frustration, and hostility, may come to respond by regarding the patient as a 'type B.' After this unpleasant 'type B,' the patient will often move on to another medical practitioner, who in turn pressured into repeating another set of laboratory procedures and even escalating to exploratory surgery. As these frustrating and unpleasant transactions between physician and patient continue, the confidence of the patient in the health care system erodes. The cost of the health care system is inflated by these tests; valuable and scarce medical and hospital resources are tied up in cost ineffective interventions. Eventually, these patients end up being chronically managed with tranquilizers, analgesics, and/or barbiturates. Chronic use of these medications can include like tolerance, addiction, depression, and increased pain sensitivity. All of the above create further psycho-social problems. This appearance of 'treatment' postpones attention to the underlying psycho-social etiology or exacerbating factors. Hence, the underlying problems that the patient presents are seldom directly addressed by the busy physician. If the physician should find the 'guts' to suggest that the patient see a psychiatrist, the probability of resolution is not significantly improved. Because the patient does not believe that the problem is 'all in his head' or that he is 'crazy.' He is probably right on both counts. Part of the high probability that the psychiatrist would simply hospitalize him or prescribe the same medications the internist could order, there is also a high probability that the psychiatrist is 'busy' that he may have little time to spend with 'somatizers.' Psychiatrists know that time spent listening and talking is an investment-ineffective expenditure. To get a good return on one's investment of time and energy one has to see many patients briefly. Psychological interventions are time consuming.

Sometimes, if the patient persists in demanding a 'medical' solution he may find another physician willing to again intervene surgically, till eventually a small number of patients become poly-surgical addicts (Melzack, 1973). It is widely recognized today that there is excessive surgery done in this country for many chronic problems particularly those involving chronic pain.

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In urban industrial societies stress impacts human beings not so much in the form of physical trauma or disease but in a psycho-social form. Psychological stress is a complex concept (Appley & Trumbull, 1967; Lazarus, 1966; Rahe, 1966; 1975). The pressures of time, conflicting priorities, a problematic marriage, the rapid rate of change, a difficult child, occupational failure, educational failure, social and emotional disappointments are all forms of psycho-social stress that can place people in the short run, intermittently on 'red-alert' or in a state of chronic physiological and psychological mobilization. The patient may habituate to this hypervigilant state and eventually become unaware of its uncomfortable and abnormal character till structural damage has occurred. One of the major consequences of clinical biofeedback research is the discovery that many patients with stress related disorders have elevated baselines in specific physiological response systems or that they tend to show unusually long delays in returning to baseline after stressful stimulation. For example, the research on muscle contraction headache (Budzynski et al., 1970, 1973; Wickramasekera, 1972, 1973) has shown that about 70 percent of these patients will show elevated ECG levels from the head, neck, or upper back areas.

Within the area of behavioral science and clinical psychology, there have recently been a series of exciting developments in biofeedback, behavioral therapy, and the 'new hypnosis.' These developments have taken the form of promising diagnostic and treatment procedures for chronic stress related disorders. These diagnostic and intervention procedures are quite safe unlike the chemical and surgical ones, and have the advantage of appearing to be quite effective as indicated by short-term follow-up studies. The long-term follow-up studies of these procedures have still not been completed or reported. These new procedures have the additional advantage of being cost-effective and they appear to get these patients out of the expensive and overburdened health care system. But most importantly these developments have stimulated a large number of sophisticated and fine grained concurrent analyses of multiple response systems. These studies (Cohen et al., 1977; Taub, 1977) explore the complex interphase between physiological and psychological systems in normal people and patients with stress related disorders. In spite of some naiveté and exaggerations (Wickramasekera, 1976, 1977 a,b) which are typical of the adolescence of any new field, the long term consequence of these investigations appear to have great heuristic value.

It is becoming increasingly clear from a cost-effective viewpoint that after adequate medical evaluation most of these patients with chronic stress related disorders should be sent directly to the offices of the psychophysically oriented behavioral scientist rather than being 'dumped' on other physicians or recycled through the health care system. The most affluent or best insured of these patients are periodically referred to the ultimate 'dumps' which are the large private clinics and medical centers. At these centers, they continue to tie up scarce medical resources in cost-ineffective ways.

The treatment of chronic stress related symptoms like pain, anxiety, somatic preoccupations, insomnia, and depression; plus the stimulation of attitudes and habits that support physical health (reducing smoking, obesity, and drug dependence, developing a positive sex life and physical exercise program, etc.) is increasingly referred to as behavioral medicine or behavioral health (Wickramasekera and Rase, 1978). I predict that behavioral health will rapidly become a major growth area in the United States. Behavioral health can include at least three related components:

1. The primary prevention of stress related disorders.
2. The diagnosis and treatment of chronic stress related disorders plus reducing non-compliance with medical interventions.
3. A development of teaching and research activities in the field of stress related disorders. The complex interphase between psychological and biological variables is currently one of the most challenging and exciting areas of psychophysiology and its related disciplines.
The growing behavioral health movement will create a large number of new jobs for appropriately trained psychologists in clinical and experimental psychophysiology. It may also become an exciting and challenging new area of research and teaching for psychologists who prefer to work with more quantifiable dependent and/or independent variables. This research can most effectively be done in medical centers and schools where patients are available and multidisciplinary collaboration is easy. There is already a trend towards the increasing use of psychologists in medical schools, medical centers, and residency training programs (Matta, 1978).

These developments climax in September, 1978, in Toronto with the establishment of a division of health psychology in the American Psychological Association and the recent Yale conference on Behavioral Medicine (Schwart & Welch, 1977). The Yale conference and the division of health psychology are dominated by academically oriented psychologists. Unfortunately, academically oriented psychologists often have less than a complete grasp of the practical, financial, political, and legal realities that will be involved in the upcoming struggle with the medical establishment for the full and equal participation of psychologists in the diagnosis and management of chronic stress-related disorders.

It would be naive to believe that all physicians will respond favorably to being relieved of the responsibility of dealing with their 'crock.' The prospect of having plenty of free time to treat 'legitimate disease,' and other acute medical problems may please some physicians. But if 'crock' account for half of the patients in a general practitioner's waiting room, it is unlikely that all general physicians will react kindly to the prospect of losing half of their source of income. It begins to seem that so many physicians are so 'busy' because they are seeing patients who do not belong in their practice. After all the rhetoric is over, the bottom line in professional rivalries appears suspiciously like dollars and cents.

The upcoming struggle with the larger and more 'respectable' non-psychiatric branch of the medical establishment will, I suspect, begin with a struggle with neurology and eventually spread to other medical specialties. I predict that we will be poorly prepared as a profession for the struggle with non-psychiatric medicine. We were probably much better prepared for the previous struggle with psychiatry, the 'step-child' of medicine.

1. In the struggle with psychiatry, the credentials of psychologists as psychotherapy researchers and diagnosticians were well established.

2. In the area of psychophysiology, doctoral level psychologists frequently were at least academically as well-trained as psychiatrists.

But in the area of chronic stress-related disorders, most conventionally trained clinical psychologists will be incompletely prepared to recognize and treat these chronic symptoms unless they have had exposure to these conditions, or have had extensive continuing education courses in clinical psychophysiology and medicine-related fields.

If the above trends and predictions come to pass there may be several consequences for academic and professional psychology in Illinois and the United States.

1) There will be a need for continuing education for those clinical psychologists who would like to become involved in the behavioral health field, and who would be willing to make the effort to learn about basic clinical and laboratory procedures, psychophysiology, and the pathophysiology of these chronic stress-related disorders. It is important that the biological and medical aspects be taught by top-notch physicians and psychologists so that the behavioral scientist develops adequate ability to evaluate and recognize these conditions and seek further medical consultation when indicated. It is important that these continuing education courses measure acquired competence and not simply physical presence at the courses. Failure to diagnose or recognize certain signs in this area can in some instances have catastrophic consequences.

2) The prospect of this upcoming interdisciplinary development and struggle may have implications for revisions in the training of future professional psychologists and for promoting more research in the area of interphase between physiological and psychological variables.

3) The behavioral health movement will add new dimensions to the role of the psychologist. It is important that traditional clinical psychologists do not see the emergence of the behavioral health field as necessarily replacing the traditional preoccupation with mental health and the struggle with psychiatry. But rather as seeking to add to the existing roles of clinical psychologists, and broadening them to include a more meaningful interphase with the general health care establishment.
It is becoming increasingly clear that cost-effective intervention with the increasing incidence of chronic stress related disorders in urban industrialized societies requires the active collaboration of psychologists and physicians. Perhaps eventually, they will work as dual diagnostic-therapy teams sharing responsibility for the management of the patient, or perhaps as independent but equal practitioners. The health care system in a modern industrialized urban society can no longer financially afford the luxury of the mind-body dichotomy and the cost-ineffective consequences of simple minded dualism.

REFERENCES

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