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Treatment vs. Healing

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"*It is much more important to know what sort of patient has a disease than what sort of disease the patient has*." Sir William Osler, M.D.

The treatment of illness and disease has become a highly technical scientific endeavor. However, beyond the mechanics, biochemical substrate, and pharmacological interventions that make up modern medical treatment, the need to heal the *patient* has changed little since the time of Dr. Osler. Unfortunately, in the current high tech and statistically-based environments of "Evidence Based Medicine", "Managed Care", and the specialization of medical disciplines, the heart of understanding and healing *patients* has been all but lost, in favor of the focus upon the details of treatment techniques.

Sadly, this has occurred even within the field of psychiatry, where one might assume there would be the most respect for the *person* – but we seem to have slowly but surely moved from healing people to treating brains and neuroreceptors.

Beyond the specific changes which have occurred within psychiatric practice, this phenomena has significantly impacted how non-psychiatrists understand dealing with the emotional and psychological issues that at times accompany, complicate, and/or interfere with attempts to provide effective treatment for somatic, non-psychiatric maladies.

There is little dispute that there is a complex interface and interaction between somatic symptomatology, the physiological interventions of modern medicine, and the psychological substrates of the subject patient. In common language, especially within the non-psychiatric community, these interactions are often referred to as "stress-related problems". However, the situation is much more complicated, as “stress” is a generic and nonspecific term. It is not infrequent that in non-psychiatric medical records, the term “stress reaction” is used as a diagnosis – but this is no more meaningful in describing the actual nature or seriousness of the problems or pathology present, than it would be to use the diagnosis of a “heat reaction” for a patient with a burn injury. Yet way too often, it is simply assumed that if there is a “stress-related problem” arising, simply prescribing a psychotropic medication will suffice for addressing the difficulty – when in fact, in the long term, the addition of these agents at times only obscure, intensify and complicate the underlying psychopathology which is present, even as psychotropic medications may reduce some manifest neurovegetative symptomatology, and provide a modicum of acute relief.

The interactions between physiological, psychosocial and behavioral phenomena can take many forms. On the most basic level, if a patient is not cooperative and compliant with a physician's instructions, treatment can be compromised, sabotaged, and on occasions, inevitably futile. Of course, in order to be cooperative and compliant, a patient must understand and appreciate the importance of the instructions that he or she is being given. Even in cases which do not involve actual cognitive or developmental impairment, there are frequently times when psychological and emotional factors may interfere with the patient's understanding, acceptance and cooperation – but those issues can easily be overlooked by a practitioner who is not aware of the psychological dynamics of the individual person being treated, beyond the issue of their simply being cognitively intact enough to concretely understand what they are being told. Behavioral responses to pain, life-threatening illness, loss of physical integrity or identity, etc., are complex, and are difficult to predict and/or manage unless there is an understanding of the complexities of the psychology of the particular individual patient.

Additionally, there is the issue of the psychophysiological responses of the body to inner emotional experiences and affective states – responses which impact, for better or worse, physiologically based interventions. For example, very simply, a patient who is anxious and "uptight" will maintain a level of musculoskeletal tension which may prevent the physiological relaxation which is necessary for optimal responsiveness to various somatic interventions, symptomatic relief, and healing. On a much more complex level that is only partially understood, there are complicated interactions between the immune system, hormonal systems, autoimmune reactions, the nervous system, and even the dermatological system, which can be triggered by "stress", emotional malaise, anxiety or dysphoria – and which can impact the efficacy and effectiveness of physiologically based treatments, even if overt symptoms of clinical anxiety or depression are not present, or have been superficially contained through the use of psychotropic medications. Simply diagnosing such a situation as involving "fibromyalgia" oversimplifies the phenomena and obscures the need to understand and address the particular pathology is emerging and interfering with the healing process.

While understanding the underlying molecular and biochemical neurophysiological interactions which form the substrate of these interactions is beyond the scope of this discussion, it should be self-evident that recognizing the impact of the interaction between somatic, psychophysiological and psychological factors is important to any practitioner who seeks to achieve optimal results with a patient, and that this is especially germane to the practitioner of primary care medicine, and those addressing orthopedic/neurological injuries.

In essence, a differentiation must be drawn between medical "treatment", and "healing". When a patient is suffering from an illness or injury, obviously, more often than not, modern medicine offers a plethora of interventions which can hasten the patient's physiological recovery. Understanding the physiological disease process can be useful (if not essential) in devising specific mechanical and/or biochemical/pharmacological interventions to reduce or even resolve the pathological process present. Simplistically, surgical intervention can mechanically repair damaged organs, provide for improved

integrity of the physical body, support the musculoskeletal system, and excise diseased tissues; physical cleansing and the use of antibiotics can address infectious processes and related complications; pharmacological intervention can correct malfunctioning bodily systems. However, while any or all of these interventions may be absolutely necessary (if not at least strongly indicated) in the treatment of a disease process or injury – while the disease may be "treated", that is no guarantee that the patient will be "healed".

There is much involved in "healing" which the physician cannot directly control, even on a purely physiological basis. The actual process of the healing of a wound, the restitution of healthy tissue, and the regaining of functioning is essentially a *natural process* which no physician can completely control. The healing process can be interrupted or disrupted by a lack of appropriate medical care; and the healing process may be strongly supported, enhanced, and improved through provision of appropriate medical care – but the actual healing itself remains a natural, extremely complex, and still rather mysterious process.

However, beyond the objective somatic pathology present, in all but a few cases of illness, disease, or injury, there are also subjective aspects which come into play. Most commonly, the subjective aspect of disease is experienced as physical pain, and with treatment of the illness/injury, pain usually subsides – but that is not always the case. Subjective responses to illness, disease or injury are not limited to physical pain. A person may be "improving" or even "fully treated" or "cured" according to objective laboratory and clinical tests, but he or she still may not appreciate themselves as being in a normal state of health, i.e., they have not been "healed". Yet the technical aspects of modern medicine are largely focused upon treating objective symptoms of illness, disease and injury through "Evidence Based" modalities, with little or no focus upon promoting the patient to "heal" in the full sense of the term – which includes not only restoration of physiological integrity and health, but also a subjective sense of well-being.

Obviously, in emergency or life-threatening situations, the subjective experience of the patient (beyond adequately controlling pain, and obtaining what basic compliance is necessary) are of secondary importance to the physiological interventions which are indicated. However, once the emergent or life-threatening status has been resolved or is sufficiently reduced, if a physician does not understand the *patient* in whom the disease or injury has occurred, the treatments provided may be far less than optimally effective, may be significantly sabotaged, may be rendered essentially futile, or in the most severe cases, may even turn dangerously counterproductive.

The question then presents as to how the treating physician, whatever his or her specialty, can take into account an understanding of *the patient* in anticipating the possible problems that may occur in providing optimal treatment, thereby reducing the impact of potentially disruptive problems, while optimizing and maximizing the chances for therapeutic success – both in terms of a physiological resolution of pathology, and in regards to "healing the patient".

At the bottom line, after all appropriate treatment is rendered, the basis for the evaluation of the success of the medical intervention in the perception of the *person* who has been

treated rests in the *subjective* sense of relief from distress and a return to a subjective sense of well-being, personal integrity, and hopefulness.

It is in this area where a comprehensive understanding of psychopathology, as provided by a mental health practitioner, who has performed a complete and sophisticated psychiatric/psychological evaluation, can be most useful to the treating non-psychiatric practitioner – especially when communicated in a clear, jargon-free, understandable manner. This information must go beyond a simple recommendation for prescription of psychotropic medications, and must convey to the non-psychiatric practitioner a sense of the *person* whom he or she is treating; and recommendations for how to best approach the patient *as a person* who requires medical treatment. However, in providing only superficial support to our non-psychiatric colleagues, we are failing them, we are failing our patients, and we our failing ourselves as mental health professionals who seek to *heal people*, rather than simply treat disorders.