Diagnosis Is Treatment

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The diagnostic process not only paves the way for treatment, but also functions as a type of treatment itself. Both behavioral and physical problems can respond to diagnosis properly used as a therapeutic tool. The role of diagnosis in dealing with psychological problems focuses on the ascription of meaning to psychological symptoms through proper diagnosis and effective sharing of that with the patient. The placebo effect is used as a model of how belief and understanding about physical symptoms (derived from the diagnosis) constitute treatment. Finally, it is shown that the meaning which the physician assigns to the disease affects recovery, and a "meaning model" of illness is derived and expanded.

A key responsibility of family practice is to oppose tendencies toward fragmentation in medicine, both of action and of thought. Family physicians have frequently called attention to the evils of fragmentation of action in health care, as when the organ systems are divided up among competing specialists with no one to care for the "whole person." Fragmentation of thought is harder to detect and can be just as destructive to good medical care.

The title of this paper, "Diagnosis is treatment," may appear at first sight to be a bald statement of an obvious self-contradiction, as with Orwell's "War is peace." In the authors' view, however, the apparent contradiction stems from the tradition of fragmentation in medical thinking, which divides diagnosis and treatment into two distinct activities which ought to remain distinct. Instead, the two processes can be combined and important advances in practice can result from a greater awareness of the therapeutic implications of diagnosis and the diagnostic process.

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The perpetuation of the rigid diagnostic-therapeutic dichotomy depends on another fragmentation in medical thought—the mental-physical dichotomy. According to this way of thinking, the diagnostic process is a mental undertaking, and thus cannot have any real effect on bodily states in the way that drugs or surgery can. This paper will question both the diagnosis-treatment and the mental-physical dichotomies, first by showing how "diagnosis is treatment" in behavior problems, and then with a similar demonstration for physical problems. Finally, a model will be proposed which seeks to explain why diagnosis is treatment and which also offers a synthesis of the mental and physical aspects of medical care, leading to some practical implications.

Diagnosis and Behavioral Problems

The therapeutic efficacy of diagnosis can be most clearly illustrated within the behavioral side of medical care. Unfortunately, however, both diagnosis and treatment are often neglected in the behavioral aspects of family practice. Some

0094-3509/80/030445-05$01.25

physicians, made anxious by the complexity of behavioral problems and psychiatric illness, tend to avoid the entire area. Others are put off by the often arcane style of traditional psychiatry and substitute a rough-and-ready, "just-a-friendly-chat" strategy of dealing with the behavioral problems presented by their patients. Even in this informal style a kind of diagnosis has been made, even if it is only that the problem is simple and remediable, and a kind of psychotherapeutic treatment is being employed, but the failure to label them as such prevents a true understanding and critical appraisal of the process.

The family physician needs a somewhat limited, not exhaustive, approach to behavioral diagnosis. This approach need not deal with the severe thought disorders that are most appropriately referred to psychiatric specialists, for example, but it should rest on a coherent and comprehensive theoretical base such as that provided by behavior modification or transactional analysis.

Consider two case examples.

Case 1

A 44-year-old lawyer presents with sharp chest pains. When they occur he anticipates death; when they don't he awaits them. No organic basis can be found, and the "attacks" follow no recognizable pattern. Family history is negative for heart disease. The patient describes a healthy family except for loss of his only brother (of five siblings) to cancer about ten months earlier. As this is discussed, the man becomes tearful, to his own surprise. It emerges slowly that he has not mourned his brother's death at all, but has been kept busy guiding the will through probate as executor until two weeks earlier when the process was terminated. As he talks about "finishing my brother's business" he weeps profusely and recognizes the delayed mourning. The first "attack" occurred the night he finished the probate process. Armed with this awareness, he is able to pair his feelings with his symptoms. He is encouraged to mourn actively, after which he finds that the chest pains do not recur.

Case 2

A 52-year-old man presents with hypertension of long standing and recent symptoms of ulcer activity. He is tense, successful, but chronically angry. The physician's initial questions about his family situation and possible sources of distress are actively rebuffed. The physician persists, until the patient tells him that he does not "believe in psychology." At that point the physician changes his focus and inquires about the patient's family of origin, particularly with respect to history of ulcer. The patient describes a stern, demanding, military father who would brook no dissent or backtalk from his only son. He remarks that "I got my lousy personality from him," the first hint of the patient's awareness that he may be difficult at times. He tells the physician he coped with his father by being good, suppressing his feelings, and trying to please. He recalls his mother as a kindly, giving woman who was the humanizing force in the family. However, she had become an invalid when the patient was nine years old and died when he was 13. Further discussion with the man, by now significantly less bellicose, leads to the discovery that his wife had gone back to work eight months earlier, and is enjoying her "new life." He speaks several times of "losing her" and "missing her." The physician asks if he had felt more tense or sad since she returned to work. The man considers the idea and says he could not say but would think about it. He returns two weeks later to say he had discussed the conversation with his wife, who had not realized how deserted he was feeling. He is feeling much closer to her and more relaxed. He also reports a decrease in gastric pain.

In these cases the diagnosis *in itself* exercised a therapeutic effect for the patient inasmuch as it provided an understandable, acceptable explanation of his behavior. A formerly mysterious symptom was given meaning. By developing the "explanation" in an objective, non-accusatory fashion, the physician made the anxiety and the marital difficulty more understandable and acceptable. No longer on the defensive, the patient could allow himself more positive feelings toward himself and his relatives. If a symptom can be discussed in objective terms, and even drawn in a diagram, it may be seen as a manageable entity for which alternative solutions exist, instead of the shadowy specter it seemed before.

In addition to the diagnosis, the diagnostic *process*, which involves a human relationship between the physician and the patient, is also therapeutic, if the relationship is experienced by

the patient as caring and supportive. If the physician has involved the family unit in the diagnostic process, either in person or in the data he elicits and takes seriously, the family can be brought into the therapeutic support structure. By the time the symptom is brought to the physician's attention, the family has often developed sufficient motivation to undertake the task of reconstructing emotional ties and patterns of relating.

Thus in the behavioral aspects of family practice, a diagnostic intervention may constitute a form of treatment. It does not constitute complete treatment, nor does it render simple the subsequent therapeutic steps to which it leads. But it meets the basic criteria of treatment. To look at it as diagnosis alone is to underestimate the healing capacity of a satisfactory diagnostic process.

In the behavioral sphere, however, the problem, the diagnosis, and the treatment are all functions of language, symbols, and mental states, so it is easy to see how all three can have elements in common and can influence each other. In physical disease, on the other hand, according to the sharp mind-body dichotomy that affects much of medical thinking, the problem and the treatment are biologically objective, concrete states in the real world. Can these "organic" states be changed directly by a purely symbolic or intellectual function such as the diagnostic process?

Diagnosis and Physical Problems: The Placebo Effect

There are many examples in medicine of mental and symbolic functions influencing bodily health, such as biofeedback, hypnosis, and sudden death following strong emotion. One area, the "placebo effect," has been investigated extensively and provides relevant parallels with the role of diagnosis in behavioral problems.

Several pertinent features of the placebo effect are of interest:

1. It has long been known that many patients will demonstrate striking relief of physical symptoms when administered a substance or procedure known to be biochemically and physiologically inert. Between 30 and 40 percent of subjects show benefit from placebos.[1]

2. Placebo response may be as dramatic as the response to active drugs,[2] and the pattern of placebo response resembles the pharmacology of active drug responses.[3] Placebos can even produce side effects typical of active drugs.[4]

3. The placebo response is not restricted to relief of pain or anxiety; virtually all diseases and symptoms that have been investigated in double-blind studies show some response to placebo. The placebo causes changes in laboratory values and physical measurements as well as in subjective reports of symptoms. It even facilitates postoperative healing.[5] Thus a therapeutic trial of a placebo cannot aid in the "differential diagnosis" between "psychogenic" and "organic" symptoms, since in some circumstances, placebos may affect both.

4. A patient's response to a placebo is not determined primarily by age, sex, or intelligence. Studies designed to elicit a "placebo-reactor personality type" have yielded such conflicting results[6] that it is reasonable to assume that no such type exists. Those who respond to a placebo under some circumstances and fail to respond under others outnumber consistent reactors and consistent nonreactors combined.[1]

To understand the placebo effect, therefore, it is crucial to avoid a narrow focus on the sugar pill or other inert medication, and to look instead at the physician-patient relationship: "The physician is a vastly more important institution than the drug store."[7] Relevant features of this relationship include the patient's prior experiences with physicians and treatment, the patient's trust in the physician, the physician's faith in his own therapy, and the physician's ability to create a warm, sympathetic, and supportive climate.[4] The placebo effect is not restricted to the use of biochemically inert medication; there is a placebo-effect component to virtually every physician-patient encounter.[8] Even when patients are informed of the inert nature of the placebo, they may respond positively.[9]

How can the placebo component be used in routine patient care? Ideally, one should avoid sugar pills or vitamin B_{12} injections, which deceive the patient and which promote dependency on medication. Instead one should use the placebo component in ways that change the *meaning* of the illness experience for the patient, with positive therapeutic outcomes.

Egbert and associates have demonstrated how

the placebo can be used in a controlled study of postoperative pain.[10] Half their patients received a routine preoperative visit by the anesthetist, while the other half participated in a discussion of postoperative pain which included a realistic assessment of pain intensity and duration, coaching in relaxation and postural techniques to minimize pain, and the promise that a narcotic would be available if needed. Postoperatively, the experimental group required *half as much* narcotic as the control group, and were discharged an average of two days earlier. The investigators commented, "We believe that our discussions with the patients have changed the meaning of the postoperative situation. . . . By utilizing an active placebo action, we have been able to reduce their postoperative pain." They use the term "placebo action" to refer to the psychophysiological effects of their total healing intervention.

Other approaches to the placebo effect have stressed such emotional factors as sympathy and warmth, or positive expectations of the efficacy of therapy. By contrast, the specific focus of this paper is on the meaning that the patient places upon the illness experience. Diagnosis is a major mechanism by which the physician imparts a different meaning to the patient's plight than that which the patient imparts.

The Meaning Model

As already noted, most studies of the placebo effect look either at characteristics of the placebo itself, or at psychological variables affecting the physician and the patient. Adler and Hammett,[11] however, have re-evaluated the placebo effect by examining the broad social and cultural context in which the physician-patient relationship occurs. Since many medical "cures," especially in cultures which use traditional instead of Western scientific healing practices, can be attributed to the placebo effect, Adler and Hammett sought to determine what different healing practices in widely divergent cultures have in common. They cite two common factors: all cultures provide, via a socially designated healing authority, an *explanatory system* that allows the patient to make sense of his suffering in terms consistent with his preexisting world view; and all cultures provide mechanisms to gather a *caring group* around the sick individual to provide assistance and emotional support.

Adler and Hammett conclude that these two elements, the explanatory system and the caring group,

> . . . are as essential to psychic functioning as nourishment is to physical functioning, are the basic factors composing what is subjectively experienced as a feeling of "meaning," are invariably used in all successful interpersonal therapies, and are the necessary and sufficient components of the placebo effect.

This view will be referred to as the "meaning model."[12] One additional element should be included; a more comprehensive meaning model would include attention to the patient's sense of *mastery* and *control* over symptoms. In the Egbert study,[10] for instance, the favorable influence on postoperative pain is only partially attributable to the fact that the pain was explained beforehand (Adler and Hammett's explanatory system), and that personal concern was expressed for the patient's welfare (Adler and Hammett's caring group); equally important was the fact that the patient was given concrete techniques for the control of pain that would change the pain from something that had to be endured stoically to something that could be manipulated and minimized. As Cassell[13] observes, the sense of mastery and control is a crucial factor in "the healer's art," especially in the care of chronic illness.

Thus, both the *process* and the *result* of diagnosis, as well as the other ways that the physician uses to impart meaning to the patient's illness experience, can be therapeutic in behavioral problems and in physical complaints. The meaning model suggests several reasons for this conclusion. First, the diagnosis is medicine's way of explaining symptoms. The extent to which the explanation will satisfy the patient will depend on the extent to which he shares the physician's presuppositions about what sorts of things cause and contribute to disease and healing. Secondly, the diagnosis is often a crucial factor in encouraging the expressions of caring and support from family and friends. Before the patient's changed behavior has been given the interpretive label of a diagnosis, others may be uncertain as to how to react to him or her; but once the physician as the authority figure has legitimized the behavior with a diagnosis, the patient has "a mantle for his distress that society will accept."[13] Thirdly, the ability to give something a name implies the ability to

gain control over it. This is true both in magical belief systems, where words and names have special powers in and of themselves, and in scientific belief systems, where the power to classify and label is seen as the forerunner of the power to understand and to manipulate.

The following case history illustrates an application of the meaning model.

Case 3

A 62-year-old white male presented with preoccupation with throbbing in the temples and persistence of hearing songs in his mind. His inability to deal with these sensations made him despair and led to alcohol abuse.

As a child he had been bothered by episodes of paroxysmal atrial tachycardia (PAT). His parents had been very nervous about these episodes and he lived for years in fear of sudden death. Then eventually, as he recalled, he realized that he had survived these attacks; he became less apprehensive, and learned to use Valsalva or carotid massage to terminate the attacks.

The patient's caring group made his fear of his PAT worse. However, once the explanatory system was altered and he saw the symptom as nonlife threatening, the frequency and severity of the symptom diminished. Acquiring a sense of control via Valsalva completed the process. Treatment of his current symptoms included encouraging him to develop similarly appropriate strategies to deal with them, using his PAT experience as a model.

The power of the diagnosis to affect patient outcomes positively, sometimes independent of other therapy, suggests that a rigid distinction between diagnostic and therapeutic interventions sets up a false dichotomy. The applicability of the meaning model to both behavioral and physical contexts shows that rigid distinctions between mental and physical health and disease are equally fallacious. The placebo effect is potentially as powerful as any active medicine or surgery, and is present as a component of virtually every healing encounter. The meaning model suggests that the placebo effect has a direct impact on the social and cultural dimensions of physical healing. It can no longer comfortably be said that words and thoughts are symbols which reflect but are powerless to alter the underlying physical reality. In medicine, the healing power of symbols is a basic reality.[14]

The thesis that "diagnosis is treatment" is important not for its philosophical intricacies but for its practical applications. It reminds the individual physician of the need to be more conscious of how his symbolic exchanges may help or hinder the patient's recovery. It suggests that an assessment of what meaning the patient applies to his illness experience ought to be a basic part of every medical work-up.[15] It points out possible research avenues to investigate systematically the influence of various symbolic features of the physician-patient encounter upon patient outcomes.

Acknowledgements

The authors wish to thank C. Knight Aldrich, MD, B. Lewis Barnett, Jr, MD, and Joy S. Spalding, PhD, for helpful comments in the preparation of this paper. This research was supported in part by a Fellowship from the Institute on Human Values in Medicine, financed by a National Endowment for the Humanities Grant #EH-10973-74-365.

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