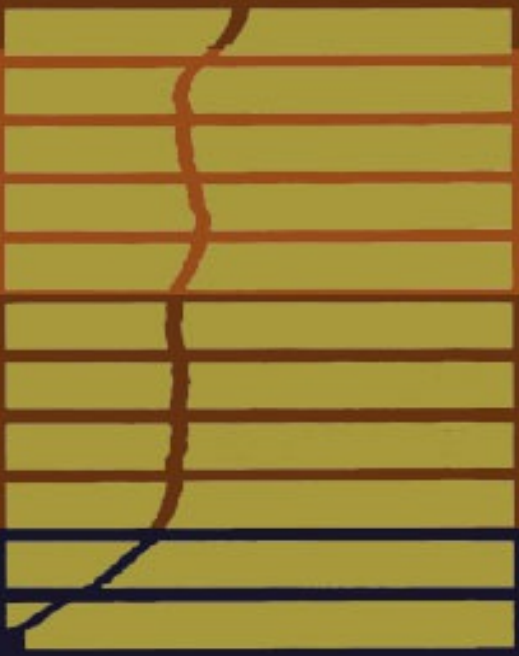
Therapy with Men in Health-Care Settings



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The stereotype of the male in our society calls for acceptance of injury and illness with courage and stoicism. To the extent that male patients expect to preserve this image, the healthcare setting imposes severe threat. Cries of pain, tears of frustration, and honest expressions of fear are frequently seen as unacceptable. Male patients may employ alternative behaviors to secure the attention and care that might have been elicited by more direct expressions of feelings. A prominent alternative to direct need and feeling expression is an exaggeration of physical symptoms and an escalation of medical complaints. The male patient often views the presentation of needs in terms of an "objective" external reality as more acceptable (Eisenberg, Falconer, & Sutkin, 1981).

In fact, the health-care setting poses many threats to the accustomed roles of men. In accepting admission to a hospital, patients may feel stripped of control, robbed of status, and forced into a dependent role. The illness that precipitated admission, along with culturally inculcated attitudes toward hospitalization, are apt to leave patients feeling fearful, anxious, and depressed. Male patients may employ a variety of coping strategies to deal with the abrupt emotional challenges and role changes of illness. Some of these strategies are adaptive and assist them in feeling more secure and more in charge of the situation, while other strategies exacerbate the situational stresses of male patienthood, and may threaten health or even life (Eisenberg et al., 1981).

The majority of patients eventually adjust to the demands of the healthcare setting and accept their physical condition as they come to understand the situation. However, in those instances in which maladaptive coping strategies persist, threatening the recovery of the patient, referral to mental health services may be indicated. Many hospitals offer a specialized group of mental health professionals who are specifically trained to meet the particular needs of the hospital setting (Olbrisch & Sechrest, 1979). For example, health psychologists must develop a rudimentary understanding of medical conditions as well as the contextual demands of the health-care setting. These areas of expertise supplement traditional psychological training to facilitate more accurate assessments and more effective

interventions with medical patients than would be possible when such relevant factors are not well understood.

It is essential that a male medical patient referred to a mental health professional be evaluated in the context of his physical condition as well as his environment, that is, the hospital. A full appreciation of the interactions of both of these factors promotes the development of most appropriate treatment plans. Although long-term psychotherapy may occasionally be indicated, most often the interventions required of health psychologists are brief, and at times may not even involve direct contact with the patient (Tefft & Simeonsson, 1979).

This chapter will describe health behaviors commonly encountered in male patients and the demands and pressures imposed on patients by the medical environment. Subsequently, methods male patients employ to cope with iatrogenic (caused by medical treatment) psychosocial maladies, the implications of mental health referral, and counseling/therapy approaches will be discussed. The chapter focuses on male medical patients who may come to the attention of mental health services due to their maladaptive coping strategies; little attention will be given to those patients who promptly and successfully cope with stress, illness, and hospitalization.

Health Behaviors of Men

A major facet of traditional male socialization is the avoidance of vulnerability, particularly emotional vulnerability. Thus the male patient who has been subjected to such socialization avoids asking that his emotional needs be met. Although unable to communicate his hurt, loneliness, fear, or desire to be held and nurtured, such a patient is no less likely to have such needs. Traditional men often feel more comfortable seeking medical attention than mental health services. Complaints of back pains, headaches, or chest pains may be viewed as legitimate avenues for obtaining attention. Moreover, for the man who strives to model John Wayne's endurance and responsibility, illness or injury may be the only "legitimate" escape from overwhelming burdens. At best, the use of medical complaints as indirect expressions of emotional needs is inefficient; at worst, subjective experiences of distress may be intensified by this approach. The lack of response by health-care professionals, who may come to label the individual as a hypochondriac or malingerer, or by family members, who may tire of caretaking roles

as they come to suspect that complaints are exaggerated, may contribute to his fears of neglect or abandonment (Eisenberg et al., 1981).

Those traditional men, however, who continue to "tough it out," unable to communicate their needs or their emotional pain, may suffer long-term consequences of a more serious nature. Continuous arousal of the body's stress responses often leads to irreversible physical damage and to the development of chronic illnesses, such as coronary artery disease, ulcerative colitis, and perhaps reduced resistance to cancer. Potentially reversible physical manifestations of constricted emotions and stress may also occur, such as reduced resistance to infection resulting in chronic "colds" or flu, allergies, asthma, and migraine headaches (Stone, Cohen, & Adler, 1980). Other men attempt to cope with the stresses of life in a manner consistent with the "strong, silent" image, resorting to the socially sanctioned anesthetic, alcohol. Chronic use/abuse of alcohol to manage stress multiplies the psychosocial stressors and may itself result in multiple health problems, for example, hypertension, gastritis, cardiac myopathy, cirrhosis, and dementia.

Demands and Pressures Imposed on the Male Patient by the Medical Setting

Preceding descriptions of the traditional male in this chapter, as well as in other chapters, suggest the probability that medical illness and hospitalization will produce extensive ramifications. The very nature of hospitals almost instantly imposes a "patient" role on admitted individuals. The process of becoming a patient requires that the person "voluntarily" surrender rights normally taken for granted by adults and most children. Perhaps the most efficient method for conveying this experience is a representative account of a patient's experience upon hospitalization.

Typically, disorders that are sufficiently serious to result in hospitalization are also sufficiently serious to provide some level of anxiety and depression. Thus it is with some level of emotional stress that the patient who is able to communicate is subjected to admission process. Throughout the admission and subsequent hospital experience, it is likely that he will be addressed by his first name but expected to pay appropriate "respect" to hospital personnel as demonstrated by formal address. As the patient answers the first of many sets of intrusive and personal questions, he will realize that a record is being prepared of every aspect of his life. This chart includes the intimate details of his financial, sexual, and

lifestyle status, and the contents of "his" chart appear to be available to everybody *except* him. He is then provided a wristband that usually displays his name, hospital number, date of birth, and the ward to which he is assigned.

Eventually, the patient will be transferred from the admitting section to the medical or surgical ward. The patient will be given a pair of pajamas (regardless of the time of day) into which he is expected to change. He will be given a room, usually with a roommate not of his choosing. He will be told when and what he may eat and drink. Depending on the patient's condition, he may be required to depend on nursing staff for attendance over bodily functions that he has controlled since he was toilet trained. In addition, he may be forced to permit a stranger to bathe him and change his clothes.

Typically, a patient is protected, during hospitalization, from the necessity of making a variety of "trivial" decisions, such as when to get up, when to go to bed, when to have visitors, and when to take food or medications. More significant decisions may be removed from patient control as well, since often the information needed to formulate decisions regarding his care is withheld. Although most of the hospital personnel appear to own the privilege of collecting information from the patient, the role of "patient" precludes inquiry of staff, even in issues concerning the status of the patient's health. Although many of the above procedures are necessary or expedient for hospital operation, they do tend to strip the patient of a sense of control, status, and independence.

Superimposed on the necessarily restrictive environment of most hospitals, certain kinds of interpersonal experiences between staff and patient have a potential for intensifying the patient's sense of lost power. Hospital staff consists of individuals each with a set of needs—personal and professional—that may come into conflict with those of patients. Common conflicts between staff and patients center on "compliance" or power issues. Occasionally, a staff member may feel that a patient is not sufficiently compliant and therefore is not under staff control. In some cases, this has occasioned a struggle literally "unto death." More vocal patients may also acquire the ominous label, "noncompliant," a label that may follow the patient long after the conflict has been resolved. Moreover, the conflict and the allegation of noncompliance often stem from unilateral decisions on the part of staff regarding their view of the patient's needs without benefit of the patient's input (Eisenberg et al., 1981).

A frequent source of staff/patient conflict arises when a staff member gives mixed or double messages. This may occur because the staff member is attempting to avoid some discomfort, but, regardless of the reasons, the patient is apt to feel powerless when the information he receives is found to be unreliable. Moreover, a patient may experience similar confusion and distrust when staff members disagree and provide the patient with discrepant information regarding his diagnosis and/or prognosis.

In fact, there are an endless number of personal and idiosyncratic issues over which conflicts may arise. Some staff feel that patients "should be grateful" for the care they are receiving. The expression of gratitude necessary to satisfy staff may very well leave the patient feeling even more dependent and out of control. Some staff may feel that a patient who is not depressed is denying, and may attempt to encourage the onset of depression; others may feel that a patient who directly expresses depressed feelings—particularly tearfully—is weak, dependent, and unmanly. In either case, the patient's right to his own feelings ends up being attacked.

A common and time-honored conflict between patients and their nurses is that of the lag time between patients' requests for PRN (as needed) medications and the fulfillment of those requests. Some patients request medications well in advance, partly to assure that their need will be met before it becomes too intense; others regard it as a matter of pride to display their stoicism and wait until the last possible moment to ask for assistance. In either case, those nurses who uniformly delay responding to patient requests amplify the frustration and powerlessness experienced by their patients.

This discussion of factors in the hospital environment that contribute to the subjective distress of patients is only cursory. The possibilities for experiences that leave a patient feeling helpless are infinite. For those male patients who characteristically respond to stressful and anxiety-provoking experiences with an intensified need to be in control, the hospital environment has the potential of creating iatrogenic psychosocial maladies.

Methods Male Patients Employ to Cope with Iatrogenic Psychosocial Maladies

Although a variety of psychosocial maladies are possible, anxiety is likely to underlie them all. For this reason, reducing anxiety and sense of threat is the major psychological task confronting all medical

patients. Most people attempt to master anxiety in ambiguous situations through assertion of control over the environment. The instrumental male is particularly prone to try and "do something" in an effort to restore his internal sense of control over the external environment. To this end, it becomes extremely important that he feel his actions will produce a response and that a sense of predictability can be achieved. Certainly, the majority of patients derive sufficient sense of control through direct expression of their needs and possess the capacity to tolerate relatively high levels of stress and ambiguity. However, as the mental health provider, one shouldn't expect to be called in to congratulate folks who adequately cope (Eisenberg, Sutkin, & Jansen, 1984).

The male patients most often referred for psychological services in medical settings are apt to employ an array of less adaptive mechanisms in their efforts to regain control (Wright, 1980). Several distinct types of male patients may be identified by the clusters of maladaptive behaviors that they exhibit. The most prevalent clusters to be referred to mental health professionals are those considered by the staff to be the "nasty patient," the "V.I.P." patient, the "poor me" patient, and the "tough-guy" patient.

For the patient who is unable to express his fear and who may feel that he is going to be neglected and overlooked, intimidation may be viewed as the only path to security. Although irritability may be present as a function of illness and depression, the patient who wishes to establish some control may use his testiness to communicate to staff that he is aware of what is happening and will not "take it lying down." This fellow experiences the need to be vigilant, distrusting staff to respond adequately to his needs unless voiced frequently and loudly. All complaints tend to be tendered at the same volume and tone. Furthermore, his low expectations of caretaking lead him to make excessive demands on staff, in part to exert control and in part to conduct tests that staff would respond if they are *really* needed. In actuality, however, this tendency toward being demanding is likely to produce a response in staff quite opposite to that desired by the patient; staff become less responsive or even antagonistic. An unfortunate dynamic is likely to develop in which patient and staff behave as though they are antagonists rather than colleagues working toward the same goals. The patient becomes determined (to secure attention through escalating the behaviors that have led him to this point, and staff become increasingly resistant and seek to "break him" of his bad habits, often resorting to passive-aggressive maneuvers. A full-scale power struggle may develop in which the patient becomes increasingly angry and aggressive.

The more dependent the angry patient actually is on staff, the more he may resort to demands in order to determine his power (Eisenberg et al., 1981). For example, a patient who was newly spinal cord injured felt completely helpless and made unreasonable demands of staff to learn what tasks others could be intimidated into performing for him. Spinal cord injured patients (or any of a number of types of patients who have sustained a massive disability) are faced with the task of constructing new identities in much the same way that adolescents must establish an identity. They rely heavily on the feedback of those with whom they interact to establish a new self-image. When such patients use anger and demandingness as their approaches to having their needs met, staff may understandably react unfavorably. The patient, however, may lack the insight to recognize that the staff is reacting to his inadequate social skills (a correctable problem), rather than to him as a disabled person.

The "V.I.P." patient also feels out of control in the hospital environment, but marshals a different set of behaviors to secure some sense of control. Instead of attempting to overpower staff with aggression, this individual tries to intimidate staff by conveying to them how important, that is, personally powerful, he is. Essentially, he is saying, "Don't you know who I am? Surely you don't plan to treat me like just another patient. I'm entitled to special attention and consideration!" Therefore, the V.I.P. patient employing this strategy for control may tell anyone who will listen who he is, and will also tend to increase the frequency of this behavior as he feels more frightened and out of control. In some cases—perhaps where the patient does not feel that he is sufficiently important—significant exaggerations and falsifications of credentials may occur. In these cases, staff may find themselves feeling annoyed at the patient, but may be unable to identify the source of their annoyance.

This patient may parade a variety of credentials. One face is that of the professional, successful businessman, or celebrity, but there are many other ways of "displaying credentials" as well. Sometimes boasting of special knowledge or of the patient's relationship to a health-care professional are offered as proof that "you can't fool me. I know more than the average patient."

Financial status, personal contacts, spheres of influence, and personal attractiveness may all be deployed to assert a patient's merit of special service and attention. In Veterans Administration Hospitals, some unique kinds of credentials may be tendered. The patient may boast of, or even exaggerate, his military experiences, his rank, or his service-related health problems. Frequently, the patient who

engaged most glaringly in this activity is the patient who feels uncomfortable accepting what he may consider "charity" from medical staff.

Patient efforts to make staff aware of "V.I.P." status are not always so direct. The patient who interacts collegially with the health-care team by calling members by first names, the patient who takes charge of other patients, and the patient who is seductive in his interactions with staff may all be seeking to communicate that they are slightly more worthy and important than the other patients.

The "tough-guy" patient shares some characteristics with the "V.I.P."; in fact, some patients may show both faces in efforts to feel secure. The "tough-guy" need not resort to external cards of identity, however, to assert his "specialness." He displays such stoicism that he appears to require no help whatsoever. He is the joker of the unit and appears invulnerable to anxiety. This is the guy who waits six hours before requesting his four-hour-acting pain medication. The difference between this patient and the man who truly is in no distress is that this patient is denying his own needs in the interest of gaining recognition and consideration. He hopes to achieve the admiration and respect of staff for his stoicism and courage, hoping that staff will rush to his aid in the event of an emergency.

Acting quite different from the two characters just described, but with the same agenda of gaining control, is the "poor me" patient. This individual acts as though staff can't hear him if his complaints are accurate and realistic; therefore, he exaggerates his symptoms and intensifies his sick role in an effort to *convince* everyone in earshot of his need for attention and care. The "poor me" patient usually appears depressed, anxious, or both, and is often withdrawn. Pronounced grimaces are likely in response to inquiries about the patient's condition, and exaggerated difficulty in movement is likely to be displayed. Such patients may come to be regarded by staff as hypochondriacal; as a result, staff may attend to them less than other patients, causing the patient to escalate complaints and symptoms and setting off a vicious circle of dissatisfaction on both sides.

All patients may from time to time behave in one of the ways cited above as maladaptive. Ultimately, the difference between adaptive coping and maladaptive coping in hospitalized patients is, not unlike in other contexts, determined by whether or not the patient is getting his needs met in the most efficient way. Moreover, the patient who is coping adequately with the situation is likely to have an array of

responses from which he can flexibly draw when he determines that an approach is not working.

The Male Role and Mental Health Referral in Medical Settings

No attempt will be made here to supply an exhaustive list of issues for which medical patients are referred to health psychologists. There are presently a number of excellent texts devoted to this task (Gatchel & Baum, 1983; Stone et al., 1980). Rather, the objective of this chapter is to discuss specifically male issues as they appear in the health-care setting.

Occasionally, male patients in medical treatment will request help for mental health problems, such as depression or anxiety, or they will request assistance in adjusting to illness or a terminal diagnosis. These patients are generally similar to nonmedical patients seeking mental health treatment in that they are aware of the kinds of services available and recognize their need for treatment. However, such patients are relatively rare. Most commonly, male patients in the hospital for physical problems are not aware of the possibility of psychological services, *nor* do they recognize the need for such assistance. They are referred, often without their knowledge, by their primary physician at the request of staff or family members. Referrals may stem from concern for the patient, but also from complaints about the patient (Degood, 1979).

Staff and family *concerns* about male patients are reflected in consultation requests that ask the mental health professional to assist the patient in adjusting to a disability; in dealing with denial, depression, or anxiety; in coping with chronic pain or stress; in dealing with substance abuse; or in addressing family problems.

Staff/ family *complaints* result in referrals for evaluation for hypochondriasis, psychophysiologic disorder, or questionable functional overlay in patients' physical ailments. Other consults usually provoked by staff/family distress include noncompliance with medical regimen, anger or abusiveness, or substance abuse as referral problems.

Often the real issue impelling referral is the necessity for adjustment, that is, the necessity for the patient to undergo a shift in his role. As discussed earlier, the patient may be involved in role changes on several levels simultaneously. A description of the course of a dialysis patient may serve as an illustration

of some of the changes imposed on patients and some of the referral questions that might be asked of the mental health professional.

The kidney patient who has come to the hospital for examination and diagnosis is subjected to all of the demands of the hospital system described earlier, and may employ his most familiar coping style to contend with the stresses. If anger and noncompliance were selected, a consult might be directed to a health psychologist requesting help in securing the cooperation of the patient. Although the referral issue for staff may have been noncompliance, there is a strong possibility that the issue with which the patient will be dealing is a sense of powerlessness and a need to restore his control (Eisenberg et al., 1984).

Simultaneously, the dialysis patient must deal with changes in his life and in his role that extend far beyond the hospital and the temporary role changes imposed by hospitalization. The patient who had been employed often must deal with immediate retirement and loss of the breadwinner role. As noted in other chapters, this change alone may demand massive modifications in role expectations. In addition, the dialysis patient very likely has reduced physical strength and stamina, and may be unable to perform the heavier chores previously assigned to him in the family. Further, cognitive changes may have resulted from the accumulation of toxins (uremia) prior to dialysis, which threaten his ability to control household finances and his sense of intellectual competence.

Under these circumstances, it is not surprising that many patients experience an identity crisis, and search—almost frantically—for means by which they may regain control and wield some power. Anger, hostility, and even physical abuse may be directed at family members or hospital staff to demonstrate that he is still a person to be reckoned with. Again, the consult received by mental health professionals may fail to reflect the patient's concerns. The patient may exhibit very little direct concern over his physical health, especially if great energy is perceived as required to secure control. An absence of apparent patient concern regarding dialysis might lead staff to conclude that he is denying his medical condition, and requests might be submitted for assistance in helping the patient through denial. On the other hand, when the patient has discovered that his efforts to recover control have been only partially successful, and when he begins to experience the impact of his disability on his life, evidence of depression may appear. Ironically, staff members who were only shortly before concerned with denial, may quickly route

a consult to the psychology department for treatment of depression, especially if the male patient is expressing his distress with tears or other "non-masculine" emotionality.

Hospital patients do not enter the medical environment as blank slates; rather, they are individuals with long-term patterns of adjustment that may be incompatible with the new demands imposed by disability. For example, prior to renal failure a kidney patient may have been able to tolerate poor marital adjustment largely by avoidance. That is, through work, child rearing, and outside recreation, the couple may have spent only limited time together, and may have avoided the necessity of resolving relationship problems. When such a patient is faced with the prospect of retirement, almost continual contact with his spouse, and significant dependency on her for assistance with a home dialysis program, the need for marital conflict to be dealt with through counseling may be literally a matter of life or death. Poor communication patterns, obstacles to dealing with a spouse or a health-care professional, may require alteration.

Obviously, most patients are able to accept the conditions of hospitalization and the necessary accommodations to physical disability or chronic illness through their own efforts and resources. The question, then, is when to refer medical patients to mental health professionals and when the patient should be given the opportunity to adapt independently. It is our bias that where the question exists, a referral for evaluation is in order; however, the realities of private sector health-care systems may make this recommendation impractical.

Probably the most important criterion for referring the medical patient for psychological intervention is the clear evidence that the patient's behavior or his emotional status is impeding his ability to benefit from treatment. Often the intensity of emotion expressed—whether anger, sadness, or anxiety—is considered the determinant of intervention need; however, the intensity of emotional expression may be much more a personal or cultural characteristic than a reflection of need. The effect on the patient's acceptance of appropriate medical treatment, his receptivity to learning more about his disorder, and his ability to make required lifestyle changes are examples of criteria for referral to health psychologists.

In some instances, the patient's psychological status may not only hamper treatment, it may also

directly exacerbate the health-care problem. For example, excessive anxiety that is poorly managed in the hypertensive or cardiac patient may have lethal results. In patients whose respiration is severely compromised by chronic obstructive pulmonary disease (COPD) or asthma, anxiety further restricts the transfer of air into the lungs, thereby increasing anxiety. Moreover, depression reduces respiratory capacities in such patients. Depression may also reduce the pain threshold in injured patients. It may also happen that a patient is in no apparent psychological distress, but that staff find him difficult and find themselves avoiding him for some reason. This patient, too, may have to modify his behavior in order to receive maximum benefit from hospitalization (Coombs & Vincent, 1971; DiMatteo & Taranta, 1979).

Medical patients who are identified *by others* for psychological referral are frequently in sharp contrast to patients who self-initiate their mental health treatment. Often, the problems noted by staff that prompt referral are not viewed as psychological problems by the patient. Rather, the patient may view the problem as being a physical complaint, a psychological problem of staff, or as not a problem at all. Further, since referral issues are often linked to the crisis of the hospitalization, many medical patients have never given thought to mental health treatment, and may have few or negative expectations of psychological treatment. It is not unusual to hear a patient ask if his physician thinks he is "crazy" since the doctor sent a "shrink" to see him. To many male patients, the consultation of a psychologist is a clear statement that *someone* believes them to be mentally weak and unable to cope independently. The notion of seeking assistance for lifestyle changes or adjustment to disability rarely occurs to medical patients.

Patients who have heretofore maintained privacy with respect to their personal lives—especially their sexual activities—may understandably consider intrusive those questions that the voluntary mental health consumer has come to expect. Mental health professionals who are naive to these considerations may find themselves facing a very resistant patient or being quickly ordered out of the room. Interpretations of patient resistance in this setting must be made very cautiously.

The implications of referral for somatoform disorders warrant special note. It is an unusual patient with somatoform features who has not already inferred from a physician's comments that his complaints were viewed as hypochondriacal. The subtle distinctions between psychophysiological disorders, conversion reactions, and functional disorders are frequently unclear to health-care workers; therefore,

it is not surprising that patients are confused as well. The patient who believes that a "shrink" has dropped in to see him because a staff person does not take his pain or symptoms seriously will require preliminary education (and a great deal of tact) prior to any reasonable evaluation or intervention (Degood, 1979).

A man who is confined to the hospital bed with an acute illness and accompanying anxiety may come to view the warm, empathic mental health professional who visits him daily as a close friend. Having no previous expectations of a psychotherapy experience, the patient cannot be expected to understand the limited nature of this professional relationship. If he describes the time a therapist spends with him as "rap sessions," he is not necessarily trying to devalue the therapeutic experience. Likewise, the psychologically unsophisticated patient may not make a distinction between the therapist and other hospital visitors and may ask personal questions or offer compliments to the therapist. Therapeutic interpretations that might have been suitable in an outpatient mental hospital setting such as transference, dependency, weak ego boundaries, and so on are not directly applicable to the medical setting.

APPROACHES TO COUNSELING/PSYCHOTHERAPY WITH MALE MEDICAL PATIENTS

In view of the nature of men's socialization and the nature of the hospital environment, counseling conducted with male patients referred by staff clearly must be adapted somewhat from traditional approaches in more conventional settings. The importance of flexibility on the therapist's part cannot be overemphasized.

From the beginning, the medical patient calls for nontraditional psychotherapeutic approaches. The therapist comes to the patient, he or she stands, looking down at the bedfast patient who is clothed in hospital pajamas, and must be prepared to discuss what is for the patient the most relevant concern, his physical illness. However, conditions that allow the patient to feel comfortable in this contact with the mental health professional are quite diverse and require as much creativity as the therapist can muster. For example, one patient may need reassurance that the therapist is "not the usual kind of shrink" as he is informed, accurately, just what sort of activities are typical for this professional. Another patient may need to spend time telling the therapist just exactly why he would never have anything to do with a

psychologist before he may be ready to spend time talking about the referral problem. One articulate patient had to inform the therapist that he considered psychologists "barnacles on the ship of life" before he could begin to form a close and meaningful therapeutic relationship that continued for the remainder of his life. However, it should be noted that early contacts with this patient were conducted over card games. For another patient, the therapist's willingness to string the patient's guitar established the required rapport to begin psychological work. More typically, meetings over coffee in the dining room are used to replace traditional, but also more threatening, office visits.

These types of activities may be required in order to stay within the patient's "comfort range." Although what ensues in therapy is often quite typical and traditional, and despite significant psychotherapeutic gain, it remains important for the patient to be free to characterize the intervention in a manner that is comfortable for him. Therapists new to the hospital setting are sometimes offended when a series of intense therapy sessions are casually referred to by the patient as "our classes," but veteran health psychologists recognize that construing the activity in this way may be the critical factor enabling the patient to receive benefit.

Similar flexibility may be called for in selecting modalities of treatment for hospitalized males. In fact, health psychologists must be prepared to accept that some interventions are most appropriately directed at staff, either through direct consultation or through in-service training. In other cases, interventions may be achieved by educating and instructing staff in patient management techniques or behavioral programs so that *they* might intervene. Usually these approaches to treatment require assessment of the patient, but in some cases staff education may be conducted in team meetings without the specific evaluation of the patient (Gatchel & Baum, 1983).

Presumably, all major therapy orientations are represented by mental health personnel practicing in health-care settings, and it is likely that some patients benefit from each of these approaches. However, the nature of the referral often dictates, to some extent, the type of intervention. Because the availability of the patient may be time-limited, only short-term, crisis-oriented activities are possible. Since the patient may be seeing the therapist involuntarily and for purposes clearly not seen as self-actualizing, nondirective approaches may be futile. In other words, the patient and the referral problem may dictate the type of therapy employed. For example, the "Type A" patient, for whom a feeling of control is all

important, may be particularly averse to so nebulous an activity as therapy, despite obvious need for precisely that activity. Although the need to manage stress more adaptively may be as vital to this patient as medication or surgery, his intolerance of the ambiguity of "talking therapy" may preclude most types of intervention. In fact, the anger induced in some Type A patients by attempts at psychological intervention may be countertherapeutic and even dangerous. However, the same patient who objects to "senseless talking" may be intrigued by the technical aspects of biofeedback. Moreover, the technology provides, for this patient, pragmatic (and credible) evidence of stress, and of his capacity to modulate his body's response to that stress. Learning what is so visibly and audibly effective sometimes provides the patient with insight into the relationship between physical and psychological factors and allows him to progress subsequently via other therapeutic modalities (Gatchel & Baum, 1983).

For example, in many situations an initial interview affords opportunity for the therapist to offer permission for a patient to feel frightened, depressed, and so on. The unfamiliar feelings and behaviors that he may have been experiencing—especially when they evoked surprised reactions in family and staff—may create additional distress for the patient who questions his "sanity" or "rights" to his feelings until he receives permission to accept them. Occasionally, once permission is received, the patient can easily deal with the situation on his own without further help, and may prefer to do so.

However, many patients, having been victim to the hospital system described above, are overwhelmed with anxiety and other unfamiliar feelings. They perceive themselves as being unheard. The opportunity to ventilate those feelings in the presence of an empathic and understanding listener may reduce their stress sufficiently to allow the patient to get on with his recovery (Eisenberg et al., 1981).

Education is the most effective intervention for the patient who either has not yet received sufficient information regarding his condition or has not been able to accept or understand clearly that information. Education is also an effective intervention for the patient who takes pride in his strength and capacity to "take care of everything" but who currently worries that he has lost that capacity, feeling powerless to cope with the situation he faces. An explanation of the psychological process occurring within him may relieve his fear of "losing his mind."

Failing to understand the role that they play in their illness, their slow rehabilitation, or in their negative interactions with others, some patients require confrontation that may be delivered most appropriately by a skilled therapist rather than by family members or medical staff. Such confrontations should be direct and also at a level that can be tolerated by the patient who is ill, angry, and threatened by "shrinks."

All of the previously cited strategies are effective therapeutic tools in any setting, but rarely do each of them have as much potential for creating real and durable change as they do in the crisis that is engendered by illness and hospitalization. However, all of these techniques may be insufficient for some patients. For example, the patient who has repeated episodes of Crohn's Disease (a severe and dangerous inflammation of the bowel) every time his in-laws come to visit will require repeated intervention of these and other behaviors in order to develop insight and the ability to modify his response. Further, there are some patients whose psychological issues are well entrenched and extremely destructive in the face of their current health status. While in some cases, less intrusive strategies may have provided such patients with superficial insight into their brain-body connection, more extensive therapy may be required for long-term change.

While a variety of intervention strategies is available to the mental health practitioner, another issue worthy of consideration is whether they are to be applied in the interest of the patient or in the interest of the agency. Agencies differ in the extent that mental health professionals are given autonomy to decide on treatment contracts with the patient. In many instances, the goals of the patient may be in direct conflict with the agency or the referring party. For example, patients who are seeking greater control over their restrictive and threatening environment may be referred by a staff member who sees them as aggressive and noncompliant. The chronic dialysis patient or terminal cancer patient who is opting to refuse treatment may be referred to the psychologist by staff who clearly desire to have the patient talked out of his wish. The patient who may be seeking compensation from the treating agency is in obvious conflict with agency financial needs. Also, the patient who feels (with some apparent justification) that he is not being treated compassionately by staff may create a conflict of interest for the therapist. It is important for mental health professionals to clarify for themselves and for patients the degree to which they are free to establish goals based solely on patient needs.

The health-care environment can be seen as having important interactions with the traditional coping styles of men. Further, the referral to mental health services may also impinge upon the attitudes of many male patients. Innovative strategies for psychological intervention may be required for this population. However, the effort is generally well rewarded in that individuals seen in this context frequently are motivated (once they are convinced of the efficacy of psychological intervention) to make rapid and highly significant changes. In addition, a population that ordinarily would never avail themselves of mental health services is afforded the opportunity to receive valuable assistance.

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