ABSTRACT. Recent research supports the hypothesis that more active engagement of the patient in occurring illnesses improves quality of life and probably even life expectancy.

In this study experience and theoretical knowledge from psychotherapy is transplanted to clinical practice in order to improve the physician's engagement in the patient-disease relationship. By defining severe and long-term illnesses as a psychotrauma, the transfer of the psychotherapeutical model leads to the creation of a new triangular relationship: patient-illness-doctor. Practical examples are used as illustrations for the conceptual differences between psychotherapy and clinical medicine. Options for dialogue show the difference between adaptation ("learning to live with") and adjustment (active coping strategies and controlling). The hypothesis is that a better dialogue will reduce illness-related stress, giving the patient better and more effective access to personal psychic and physical support systems.

Key words: clinical medicine, illness, immune system, psychotherapy, psychotrauma, stress

1. INTRODUCTION

One role of psychotherapy is to help patients understand current symptoms of any psychotrauma and to help patients formulate appropriate responses to a given trauma. This particular study emphasizes the similarity of psychotrauma experienced by patients after serious life events and both accident and disease. It explores the possibilities of teaching patients and physicians to understand this similarity and draw the consequences for their mutual communication. In addition, it discusses the positive mental and physical effects to be obtained if patients can integrate the psychotrauma of either accidents or disease into their lives, thus avoiding or reducing stress or pathological response to either event and improving their quality of life and longevity.

If accidents and diseases are both perceived as psychotraumas, patients' perceptions of these experiences are changed. This new perception encourages a more active relationship with the incidents and a shift in attitude concerning the physical disturbance.

For the most part, illness has been perceived as beyond human responsibility— to be passively accepted as inescapable fate. During the last 15
years, influenced by an increasing flow of research data and a growing
interest in prevention together with a more holistic approach in medicine
from lay people, nurses and medical professionals, we have learned how
an active relationship with afflictions can reduce or curtail them, or at
least reduce the consequences. This active relationship presupposes the
same flexibility in the perception of the trauma and the same dynamic
coping-strategy that psychotherapy has encouraged for over a hundred
years. Recent research by different disciplines provides significant indica-
tions that a dynamic relationship between patient and affliction can improve
quality of life and even increase life expectancy. Some of the dynamics of
the body-mind relationship, so long hidden in mysterious and abstract con-
ceptualizations, now seem to be visible in research connected with psycho-
immunology and neurology. One of the consequences of these findings is
that they indicate the necessity of shifts in the doctor-patient interaction.
The ultimate outcome of this shift, as is suggested in this study, is the
explicit development of an active therapeutic triangle: patient-affliction-
doctor. To achieve this improved position and to proceed with the prac-
tical details of recovery following trauma, the doctor/therapist must
establish the triangle doctor,-patient,-trauma, in equal or balanced geometric
positions.

I will introduce my study by using two brief dialogues: one derived
from psychotherapy and the other from medical practice, to demonstrate
some basic differences between the clinical and the psychotherapeutical
approaches. In the elaboration, I will provide suggestions on how to bring
the different approaches together. To emphasize and support the necessity
of this integration a brief presentation of relevant findings from recent
research will be included. In my conclusions I want to explain how recent
research and a shift in doctor-patient communication can be integrated
into the triangle model. Some more fragments from dialogues will be used
to illustrate the model and its intentions.

2. PRACTICAL EXAMPLES

2.1. A Dialogue in Psychotherapy

Client: "Last week at that party I felt quite good. I could talk with people,
just in the way I liked it. Until they asked me where I came from and who
I was. Such a moment is threatening, it creates anxiety, because telling them
who I am, immediately implies a change of their attitude and they start
treating me as the minister's wife. I never go shopping in my own village."