

The Lay of the Land

Medicine, Paradigm Change and Psychodrama

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This theoretical article summarises my understanding of the paradigm change currently occurring in Western medicine. Its purpose is to assist understanding of the existing medical landscape and the place of psychodrama in the development of a new paradigm in which relationships and personal experience are more highly valued.

Approaching the Area

We all come across the health system, either directly or indirectly, in the course of our lives and work. Many of us have had challenging experiences with doctors who fail to relate to us and our experiences adequately. Doctors are well trained in listening to the problems of patients, thinking about them and relating to their medical knowledge in order to diagnose and treat diseases. While doing this, however, doctors often avoid tuning into their own experiences and this has had a negative impact on their relationships with patients and also on their own health. Doctors may seem remote and uninvolved, and sometimes receive bad press for their shortcomings in this area. They commonly attempt to live up to what they perceive to be public dissatisfaction by increasing their knowledge and technical ability. However, any lack of involvement might be better addressed by assisting doctors to become more self-aware and human in the clinical setting, and

by assisting patients to develop more realistic expectations of doctors. Let us explore the source of the relative lack of attention that has historically been given to doctors' personal experiences and relationships with patients.

The Western Map: The Biomedical Model

Western medicine is founded on the biomedical model, a scientific model that evolved to make sense of disease. It has been dominated by the positivist philosophy in which knowledge is only valued if validated by our five senses, or extensions of these such as microscopes and chemical tests (McWhinney, 1997). One reason the biomedical model developed in the West was the concession, five centuries ago, of the Christian church to permit dissection of the human body. The 'body' became the domain of scientists while the 'mind and soul' remained in the stewardship of the church. Thus mind-body dualism, emerging originally in Ancient Greece, was strengthened and increased the separation of the mental and spiritual from the somatic. This division came to dominate philosophical thought and medical practice, and is still prevalent today. Over time, the biomedical model has become *the* cultural perspective about disease and health, our own folk model in the Western world (Engel, 1977).

Points of Reference

The scientists of the period, such as Galileo, Newton and Descartes, were analytical. They saw phenomena resolving into causal chains or units. This led to the classical scientific view of the body as a machine, disease as a defect in the machine, and the doctor's job that of body mechanic. This reductionist and mechanistic approach assumed that chemistry and physics would ultimately explain biological phenomena (Engel, 1977). Problems of the whole could be related to problems of its parts. Thus medicine focused on finding defects in an organ system or physical process in order to tend to these and restore the body to health. Another underlying assumption of this reductionist view is that objects have an independent existence. Objects, including people and their bodies, are considered to be separate from the observer and able to be measured objectively, without bias. The philosophy of objectivism is associated with a search for general laws that govern behaviour (Cohen & Manion, 1989), and fits with a deterministic view in which human beings are seen as products of genetics, physiology and environment.

Thus in the biomedical model, diseases are categorised in the same way as natural phenomena (McWhinney, 1997). A disease, with its accompanying causal agents, is seen as an entity independent of the person suffering from it. The doctor aims to diagnose the disease and prescribe a specific remedy. The doctor is thus a detached, neutral observer whose effectiveness is dependent on knowledge and ability. This approach has been spectacularly successful at curing many diseases and has led to a focus on increasingly sophisticated technology and specialised experts. However, the biomedical approach to disease has largely ignored psychosocial and behavioural aspects of illness, nor taken account of other influential factors such as the gender, beliefs or psychological state of the doctor.

Doctors and health workers trained in biomedical methods tend to apply similar approaches to social phenomena. In psychiatry, there has been interest in understanding brain biochemistry and developing drug treatments. Psychologists tend to work with observable phenomena such as physiological states and behaviour. The positivistic social scientist is thus an observer of, not participant in, social reality. Subjective aspects are omitted. The *person* of the patient and the *person* of the doctor have been disregarded. The consequences for the culture of medicine, its learning methods, the health of doctors and patients and their relationships, have been significant.

Is the Map Adequate? Paradigm Change

Kuhn (1964) defines a paradigm as a set of shared assumptions that are passed on as beliefs from one generation to the next. These assumptions are usually unstated, yet deeply held, and become the received wisdom that underlies the fabric of society. In the scientific arena, a paradigm is a way of viewing the world that informs scientific theories and methodologies in a particular period of history. Paradigm change occurs when anomalies arise that become too numerous to ignore, casting doubt on the fit between the paradigm and reality (McWhinney, 1983). A paradigm change in medical practice began during the twentieth century and continues today. Despite its successes, the biomedical model cannot adequately explain many areas of human health and experience.

Many people who suffer ill health do not have diseases that fit conventional categories and diagnoses (Cassel, 1982). Only about a third of patients receive a specific diagnosis for their presenting problems in general practice. Much illness and suffering does not have a single cause discoverable through a reductionist approach. Illnesses are often multi-factorial and are affected by genetic, physical, psychological and social factors. For example, not everyone exposed to an infection will become unwell. The mind and body cannot be separated, as

demonstrated by the placebo effect (Anyon, 1998). A certain percentage of people who believe they are receiving a drug will improve more than expected, despite having no biomedical treatment. The burgeoning field of psycho-neuro-immunology demonstrates direct links between experiences of stress and immune function (Hassed, 2000). Studies show that social isolation and stressful life events worsen respiratory infections and increase risk of death after myocardial infarction (heart attack). Books such as *The General Theory of Love* (Lewis, Amini & Lannon, 2000), *Molecules of Emotion* (Pert, 1999) and *The Biology of Belief* (Lipton, 2005) explore the links between experience, mind and body. Brian Broom (2007) has focused on the links between physical illness and meaning, with mind-body psychotherapy proposed as one among many ways of facilitating effective healing. Mindfulness techniques derived from Eastern meditation practices are gaining popularity. Research increasingly provides evidence of their effectiveness in treating medical conditions (Hassed, 2000).

Yet We Still Use the Same Map

Despite these anomalies the biomedical model, with its attendant tendency to highlight physical factors as the cause of health problems, is endemic in Western society. Medical problems are still commonly seen as defects in the body or environment that require an external remedy such as drugs, surgery, dietary change or removal of chemicals and allergens. Most people expect and demand biomedical approaches to their ills. Even herbal medicine, homeopathic remedies and acupuncture can be seen as positivistic external treatments. It can be a challenge for holistically oriented 'mind-body' doctors to get patients to accept an alternative approach to their suffering. Furthermore, computer assisted analyses of positivistic data have enabled more accurate evidence-based medicine. Government funding agencies and insurers use this data to develop fact-based policies. As a society, we still navigate with the biomedical model.

A New Cartography?

However, new models are evolving. McWhinney (1983), a general practice theorist and teacher, proposed that the problems in medical orthodoxy constituted the state of crisis that occurs prior to new paradigm formation. He postulated a new paradigm in which more attention would be paid to illnesses that do not fall into disease categories. Medical practice would increasingly focus on the person and his or her environment and relationships, and would elevate the doctor-patient relationship to its rightful place at the centre of medicine. *"Sometimes the role of the physician will be to prescribe, but always it will be to mobilize, by every means possible, the patient's own healing powers. To do this, physicians will have to be much more than technologists. They will require advanced skills in communication and in understanding the deeper meanings that illness has for patients... The new paradigm should recognize illness ... as a learning experience - albeit a painful one - for body, mind and spirit"* (McWhinney, 1983:6). This new model will recognize the impact of many factors on the physical body, such as relationships, experiences, beliefs, meaning, story, scripts and life decisions.

Psychodrama's Compass

Psychodrama contributes an alternative philosophical orientation to biomedicine. Its originator, Jacob Levi Moreno, trained as a doctor at the end of the nineteenth century (Marineau, 1989). Despite training in an era that valued science and the biomedical model, he developed theories that were predominantly subjective and based on existential philosophy. The methods of the existentialist are qualitative with attention to the relativistic, particular and individual, whereas the objectivist searches for general laws that apply to all phenomena. For the existentialist, the problem of being takes precedence over that of knowing. Existence is understood in terms of each self-aware individual's experience of themselves in time and space. Knowledge can be derived from subjective experience that cannot be objectively

verified. This non-deterministic view of human nature is in line with post modern theory. Moreno viewed the individual as a creative being with free choice, rather than merely the result of genetics.

The central concepts of psychodrama are existential in nature. Spontaneity and creativity relate to free will, are non-conservable and valid only in the moment of their occurrence - the 'here and now'. But Moreno did not discard the objective and he continually attempted to integrate the empirical and the existential. His life long struggle is mirrored in the search for a new medical paradigm. How do we combine biomedicine with subjective relationship-based medicine? As Moreno (1959:225) puts it, "*The dilemma is how to tie ... personal experience into the rest of the cosmos*". Psychodrama theory and method emerged from his efforts to work with this dilemma.

Putting Subjective Phenomena on the Map

While psychodrama's philosophical basis is primarily subjectivist and existentialist, its methods and theory add objectivity. The psychodrama method enables the subjective world to be brought into the objective realm. This happens through the techniques that are used, such as concretisation, mirroring, doubling, role reversal, aside, soliloquy, interview for role and maximisation. These techniques enable the personal reality of the protagonist to be produced on the psychodrama stage. The drama created is accepted as the protagonist's subjective truth of that moment. Thus individual existential truth enters the objective world and the social domain.

Role theory and sociometry are the foundations of psychodrama. Compared to other concepts of self, ego and personality, Moreno suggested that role descriptions provided a more concrete approach to analysing and naming human functioning. Role descriptions concretise subjective phenomena. They are approximate and represent a person's functioning, just as a

map represents an area of land but is not the land. The three components of a role, thinking, feeling and acting, occur simultaneously. The subjective experiences of thinking and feeling go hand in hand with actions that are concrete and observable.

Sociometry is the branch of psychodrama concerned with the measurement of human relationships. Based on subjective truth, it aims to objectively determine the basic structure of human societies as a means of treating the ills of society (Fox, 1987). Its techniques enable the nature of relationships in a group to be brought into awareness. Moreno (1959) believed that sociometric theory created a bridge between phenomenologists, existentialists and empirical scientists. He valued objectivity and the scientific method. This is demonstrated in the exhaustive data collection and analysis that he undertook during sociometric testing (Moreno, 1934).

Are We in the Same Country?

The relationship between psychodrama and the biomedical paradigm can be understood in terms of the areas in which their respective theories and methods are applied. The major schools of religion and philosophy are remarkably consistent in their teachings about 'levels of being' (McWhinney, 1997). A simplified hierarchy has three levels, physical, mental (psychosocial) and transcendental (spiritual). Engel's (1980) biopsychosocial model of medicine relates to these levels. He describes nature as organised hierarchically into cells, tissues, organs, person, family, community, culture and society. He notes that scientific culture focuses on the lower levels of this hierarchy, and holds this reductionist perspective responsible for the common view that doctors are interested in diseases more than people. He also suggests that as doctors function at the interpersonal level, they need to become more skilful in the psychosocial realm. Furthermore, McWhinney (1997:73) stresses the importance of developing self-awareness in medical training, arguing that "*we can understand others only to the extent that we*

know ourselves". When the level of the knower is not consistent with the level of the object of knowledge, the knower has an impoverished view of reality. These theorists stress the importance of enlarging doctors' visual fields to bring the interpersonal and social landscape into greater focus.

Moreno's main interest was in the interpersonal and social levels of existence. Hence in psychodrama there is a focus on systems with interconnecting elements. An individual is never viewed in isolation but always as part of a larger system. Intrapsychic role systems develop from social experiences. Moreno (1934) believed that the smallest unit of society was not an individual, but an individual and all their significant relationships in a particular social context. Using a scientific metaphor, he called this unit 'the social atom'. The interconnected social atoms form the complex pattern that constitutes society. Psychodrama is primarily a group method that specialises in relationships within or between people.

Working the Land

As discussed earlier, it is becoming clearer that social and psychological occurrences affect us on a physical level. Hence medicine expands further into interpersonal territory and psychodrama is well placed to assist. Limited forms of psychodrama are already used in medical training. These include the use of actors for simulated patient consultations, role-plays and two chair work. Unfortunately, badly run role-plays have been a part of many doctors' educational experiences. Trainers must be adequate to the task in terms of group warm up, group facilitation, and sociometric activities, to ensure worthwhile experiences.

There are many practical ways in which psychodrama can be further fruitfully employed. Doctors trained in an objective paradigm such as biomedicine are usually easily able to relate to its theory and methods. Psychodrama is an ideal method for training medical students and doctors in communication skills and

therapeutic relationships. Psychodrama adds a new dimension to the role-plays and simulated patient exercises currently used. Teachers can reflect and plan through enacting educational sessions. In peer groups and supervision groups, clinical scenarios can be brought to life and explored in action. As well, experiential psychodrama sessions are useful for therapy and the personal development of doctors. Medical and multi-disciplinary meetings, with their underlying paradigmatic assumptions reflected in the set up of rooms, leadership styles and the way interaction is facilitated, could benefit from a psychodramatic approach. Sociometric techniques are useful for organising students and doctors into groups. My thesis *Psychodrama for Doctors* (2005) expands on these applications and provides examples. It also examines the effects of the current paradigm on medical learning culture, the role development of doctors and the health consequences. At an individual level, I predict that as more people make their own personal paradigm shifts, a groundswell of change will occur. Participation in psychodrama events will increase spontaneity, creativity and self-awareness.

A New Map and Compass

We are moving from a mechanical, objectivist paradigm to a more holistic worldview where human values encompass biomedicine. Any new paradigm must take the old into account. Biomedicine has taken us far and will continue to do so. Yet its limitations and discoveries are leading us to develop a new map, with perhaps a new compass, different grid references and new poles. As far as we know, the land remains essentially the same - it is how we understand it, recognise its features and navigate through it that is changing with the current paradigm shift. Our ancestors had to alter their mind set when they learnt that the world was not flat, and again when microbes were discovered and when Darwin challenged the creationist view of the world. We are faced with an equally dramatic challenge when we consider interpersonal and emotional factors to be just as relevant as biomedical factors in physical illness.

A new paradigm has not formed until its way of viewing the world is assumed by the majority of the population, and its unwritten rules guide the science and politics of the era. So, like McWhinney (1997), I think we are still in the state of crisis that occurs prior to the formation of a new paradigm. Perhaps psychodrama is leading the way.

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