Moreno (Back) in the Doctors' Surgery

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Key words
concretisation, creativity, doctor, doubling, health, mirroring, Moreno, patient, psychodramatic methods, relationship, role, social system, spontaneity, tele, warm up

I am a creative being. As a child I was artistic. I was always making things; baskets, weaving, jewellery, drawings, paintings and furniture. Since deciding not to be a professional artist and to continue being a doctor, I have been on a quest to bring creative life to my medical work. In more recent years, psychodrama has been a companion in this quest.

Medicine provides a great deal to me; a meaningful occupation, a work place where I belong, income and intellectual stimulation. Medicine provides the social role of a general practitioner, in which I can express one of my main psychodramatic roles as a healer.

Each day when I arrive at work, I anticipate interactions that will be full of life. I want my patients to warm up to themselves when they are with me and to leave feeling more alive in themselves, however that may be. For myself, I want to feel the life force in me that comes from being present, open and vulnerable with others. In short, I want Morenian encounters in the consulting room.

It has taken me decades to embrace my identity as a medical doctor; psychodrama has assisted me in this journey. Now the medical doctor and the psychodramatist can stand side by side. No longer is it either medicine or creativity; the two walk easily together. With its philosophical underpinnings of spontaneity and creativity and its focus on relationship, psychodrama sits easily in my consulting room. It serves the dual purpose of improving rapport between my patient and myself at the same time as bringing life to both of us.

In small ways, I continually use psychodramatic methods with the patients I see. I take opportunities to double, mirror and reverse roles with them. I concretise and maximise, and sometimes I progress to using more involved psychodramatic processes. As medicine and psychodrama weave themselves together, I find that I may elicit a patient's history with doubling as well as a checklist of questions and the formulation of a management

plan is relational as well as being instructive. In fact, training in psychodrama has changed every facet of the way I relate *to my patient*.

We are in an era of medicine where patients expect their doctor to be more than an expert and a technician; they also want them to be a friend and a confidante. People come to the medical practice where I work because they have heard that not only are we competent clinicians, but we also provide an understanding and accepting atmosphere. They may seek me out because they have heard I am a good listener, or that I care. In this day and age, when you can get any technical answer from Google, such simple human services are highly valued.

A relationship-centred approach to medicine places a high value on empathy and engagement and sees them as an essential part of the therapeutic process. This was reflected in my medical training. When I was a medical student in the 1980s, we did role-playing in palliative care training, where we played doctors interviewing people with terminal illnesses and then we changed roles to play the patient. Later, in my general practice training, we were invited to be part of a Balint group; these groups provide a discussion forum for trainee GPs to focus on the doctor-patient relationships. I enjoyed and learnt a lot from those experiences and they laid the foundation for my later interest in psychodrama. With its focus on the relationship, I have found psychodrama to be a valuable companion in my profession at this time.

The duration of the warm-up of the patient to a medical consultation varies greatly. Sometimes a visit to the doctor is the culmination of years of wondering, analysing and procrastinating by a patient and, on the other hand, sometimes it is an emergency. The patient usually comes with a complaint; a symptom, which they present in order to find out the diagnosis and management. They have an expectation about the usual course of the consultation, which involves a history and possibly an examination and investigations, followed by a management plan and this affects their warm-up. The patient will also warm up to the doctor and their relationship with the doctor in a variety of ways. However, patients are not expecting concretisations and role play.

When a medical clinician prepares to see a patient, they usually go through their past medical history and investigations. They may get ready to perform a history, examination, various investigations and develop a management plan. Also, the clinician is increasingly expected to consider their relationship with the patient and the greater system around the patient, such as their family or their work. This leads to a familiar warm-up for the general practitioner.

Planning to use psychodrama in the consulting room takes the warm-up in a different direction than that produced by these pre-planned usual activities. There are several critical moments in a consultation as the action

moves away from medicine and towards psychodrama. At these times the psychodramatist practitioner needs to tune in with the patient and engage in psychodramatic actions that keep both of them warming up. The doctor benefits from being flexible and easy, and choosing carefully the patient whom they decide to do this with. Not all patients respond well to doubling and mirroring, and many will reject concretisation, enactments and other psychodramatic approaches. The use of a particular psychodramatic method is preferably determined by the presentation of the patient. For example, people who have received inadequate mirroring and doubling for an aspect of their functioning may benefit from these methods, and people involved in a complex social system may gain value from concretisation of that system.

Here is an example of how awareness of tele may guide a consultation. Moreno (1972, p. 84) wrote "tele is the simplest unit of feeling transmitted from one individual to another." Tele is something that happens between people without their conscious control and results in different degrees of attraction or repulsion, acceptance or rejection, closeness or distance, positive or negative feelings. Moreno considered that tele operates almost instantaneously between group members at their first meeting (Moreno 1972, p. XX). This shows how my experience of tele between my patient and myself led me to change my warm-up.

I usually look at the patient's name in the appointment book before they arrive and notice what I am feeling towards them and imagine what they are feeling towards me. I notice my warm-up and consider what theirs might be. Even before Terry arrived, I was becoming hurried, worried and irritated with him. He had a number of complicated chronic medical conditions that required careful monitoring and he could easily become unwell without diligent medical attention. Although he is not a personal friend he usually wants to chat. In contrast, I want to spend the precious minutes in the consulting room making sure that his medical conditions are adequately checked.

As I read Terry's notes before he came in and scanned through his numerous medical problems, I had an overall picture of his health. I was also worried about missing things. There was not much time and hence I wanted him to answer my medical questions quickly and clearly. Instead, Terry was chatty and wanted to talk about his life and hear about mine. He also had a couple of jobs for me on his shopping list, taking blood and giving him a prescription. Despite Terry's chattiness I proceeded with completing my tasks in a curt manner. This involved interrupting his attempts at engaging me in conversation about non-medical things. I got through my checklist of monitoring his conditions and completing chores. By the end of the interview, we had run out of time. Terry had dropped his chattiness and had little to say; his voice had become quiet and flat. I was feeling more impatient and irritated with him and I felt that I had failed to care about him as I should. I could feel a

hardness in my face and hear a monotone in my voice. I was glad to see him go.

Even before Terry arrived the tele that was operating from me to him was not helpful. As I prepared to see him, I warmed up to our previous meetings when I had been hurried and irritated. I also warmed up to a coping role from my original social and cultural atom; that of being a self-critic who compares himself to more caring people. I could feel my energy drop as this old role was enacted and I had a restricted ability to warm up to him anew in our consultation. At the end of the consultation, the hardness in my face and monotone in my voice indicated to me that my spontaneity had remained low.

This type of interaction demonstrates to me that there is very little chance of using psychodramatic methods with a patient when the tele is rejecting. Indeed, my training, experience and study in psychodrama leads me to conclude that strongly positive tele between the doctor and the patient is the most important factor in creating the opportunity for psychodramatic methods to be used. When the tele is mutually negative it is unlikely that the patient or the doctor will adequately warm up; there is too much fear and the spontaneity of both remains low.

At such times, I may consider several options that might permit a shifting of the warm-up; for example, with Terry it might be necessary to schedule longer appointments. Another approach that I sometimes use is to do a self-directed psychodrama in my consulting room in the few minutes before seeing a patient. In this psychodrama I enact the roles of the practitioner, the patient, the psychodrama director and the greater system around the patient. If I recognise worry or irritation in myself during this process, I can become more present, be gentle on myself, enter the world of the patient and shift my own warm-up. I then have more capacity to develop new responses and establish the foundation for positive tele.

At other times, when mutually positive tele leads to acceptance and ease, the warm-up increases. The doctor and patient are then more likely to enact roles that are required for the director and the protagonist, for example, to function as creative co-explorers in a psychodrama. It is the job of the psychodramatist doctor to develop positive tele towards their patient and from their patient towards them, so that such a shift may happen.

This is an example of a time when I assessed and acted upon my own initial warm-up to exhaustion during a consultation.

My energy usually dropped in my meetings with Paul. Things never seemed straightforward. The consultations usually ended up running overtime and I felt tired afterwards.

On this occasion Paul was distressed about a family crisis. Several things had happened and he was having a "meltdown"; he was feeling tearful, could not

concentrate properly and his sleep was disturbed. He was unable to perform his work and wanted a medical certificate.

He began to tell me about his family situation. As he did this, he started his usual pattern of looking away so that for most of the time he did not look at me. It took about half an hour to elicit the history as Paul explained various aspects of the situation. I got more and more tired taking in his story and I could feel my forehead creasing and my mouth tightening as the interview progressed. This was not the first time that Paul had presented to me with a crisis that required a medical certificate. Usually by this point in the interview I would feel so worn down that I would acquiesce without much resistance. However, on this occasion I had a different

response and rather than acquiescing I questioned Paul's response to these crises. I stated that making himself unwell with worry and anger so that he could not go to work would be one way of managing the situation and that he had other options. As I presented my response, I noticed that I sat up straighter in my chair, my voice became louder and my energy increased.

As I responded, he became quieter and started to listen more. Encouraged by this response, I reassured him that I believed in his commitment to work and I affirmed that his health was my main concern. I told him I would provide a certificate if needed.

By the time he left Paul was not talking so much. He had decreased the amount of looking away and was looking at me for most of the time. Also, he was sitting more still and upright in his chair.

As a result of previous meetings with Paul, I approached him as a 'heart-sink' patient. The term 'heart-sink' patient is a term commonly used by doctors, particularly GPs, to describe the feeling of a sinking heart that they experience in response to that patient. I had felt exhaustion and exasperation in our previous meetings and I related to these past experiences as I prepared to see him. As a result, I warmed up to being a sunken-hearted practitioner with him. In the interview, after listening to him for a while I shifted from feeling interested to feeling exhausted and hence repeated the role response to him that I had had in our previous meetings.

On this occasion, I changed my response and decided to regain my energy. The reason that I warmed up to a new response was because I noticed my increased tiredness, the creasing of my forehead and the tightening of my mouth and I interpreted this as a drop in my spontaneity. An awareness of spontaneity or its lack is something that psychodrama training has given me. The training has focused my attention on building spontaneity in others and myself and has also given me an experience of what high and low spontaneity feels like. As I get to know people, I start to notice the characteristics of their warm-up and I utilise this to assess the level of their spontaneity. I also tune into these features in myself.

With Paul I used an assessment of my low spontaneity as a provocation

to warm myself up to a different response. I warmed up to presenting my honest feelings about his situation, despite this being challenging for him. I could feel the life in me increase as I proceeded to do this; I sat up straighter and spoke more directly and clearly. Functioning in this way with my patients was a developing progressive role for me. The terms 'developing' and 'progressive' refer to a system of role analysis which was first developed by Lynette Clayton (1982) and later refined by Max Clayton (1993). In response to my different warm-up, Paul's posture and demeanour suggested that his warm-up had shifted and his spontaneity had increased. This experience has shown me that it is sometimes useful to reveal my responses to my patients and that doing so may bring more life to the consultation. Since my interaction with Paul, I have continued to develop my ability to reveal myself in a way that builds the warm-up and spontaneity.

When I am confronted with a patient who is struggling with their sexual preference or gender identity, I consider the likelihood that they have had inadequate doubling and mirroring of this aspect of their functioning. Here is an example of mirroring and doubling of such a patient.

Georgina was a 21-year-old male to female transgender and this was her first consultation with me. She had only come out as transgender a month ago and had been referred to see me for a discussion about starting hormones.

At the start of the interview, she continually shifted around in her seat and maintained little eye contact with me. I invited her to tell her coming out story. She told me that, despite being biologically male, she had felt she was a girl right from when she was very young. She described the difficulties and emotional trauma of going through puberty and eventually coming out to her family as transgender a few weeks previously. Her family was accepting and supportive, which was a great relief to her. As she described her coming out process she spoke clearly, the tone of her voice was even, she held eye contact intermittently and was a bit stiller in her chair. I listened and nodded and made encouraging noises ("uum", "aha") whilst she did so.

I proceeded to say, "You are anxious sitting here with me, it's a big deal coming to talk to me about all this, it's all so new and things are moving fast." Georgina nodded and smiled a little in response. I said, "Despite all this, you are quite easy with me and I feel easy here with you." Georgina smiled again, breathed out and sank a bit more in her chair.

I continued to mirror and double Georgina and by the end of our consultations she was smiling, talking more and held eye contact for longer than at the beginning. She thanked me for seeing her and said that she planned to see me again.

At the start of the interview Georgina's lack of eye contact and restlessness indicated that she was anxious and perhaps worried about being misunderstood or judged. When I, initially, used active listening to encourage

her to tell her story, her voice became clear and she was stiller in her chair, which indicated an increase in her spontaneity. Then, after being doubled and mirrored for several minutes she sank, relaxing into her chair, smiled more and held eye contact for longer. This indicated that the mirroring and doubling had been accepted and that her warm-up had further increased. Also, I self-disclosed my response to her by letting her know that I felt easy with her and this further built her spontaneity. Her functioning shifted from anxious self-revelation, to relaxed collaboration with me.

Initially I listened to her story and invited her to keep going by using active listening techniques, such as nodding and making encouraging noises. Then, knowing that she had probably received little accurate doubling and mirroring as transgender, I considered that if I could do this well, I might be able to assist her with her development and confidence. This led me to move from active listening to mirroring and doubling. I did this for several minutes by making statements and changing my posture. As my mirroring and doubling was accepted and her warm-up increased, my own increased stillness in the chair and softness in my eyes indicated to me that my spontaneity had also increased. As a result of the mirroring and doubling I shifted my role from being an engaged active listener to being an easy and open confidante.

Concretisation is a fundamental psychodrama technique. "Concretisation gives size and form to concepts, feelings and situations. Internal experiences are given symbolic form by choosing an object to represent a feeling, relationship or situation and placing it on the stage, or drawing it on paper" (Phiskie, 2008)

I may invite the patient to use toys, stones and other objects to concretise a system from their life such as their workplace or family. I keep all these objects on a set of shelves in the corner of my office. If I have not asked the patient to concretise a system previously, I will usually introduce the process by creating something with the toys myself. I use the examination couch as the stage and place objects upon it. I might then go on to ask them to add to my creation or correct it. With patients that have used concretisation previously, I invite them to create something on a blank examination couch. Here is an example of this.

Harriet was a 20-year-old woman who had moved from Germany with her family several years ago and was having difficulty settling in Australia. She told me that she continued to live at home but was constantly angry and fighting with her parents and brother. I asked her to describe some of these events. She proceeded to sketchily describe one example of getting angry and then was quiet. I asked her what might have been the reason for her anger and she said she didn't know; she looked at the floor and then said nothing.

I invited her to choose toys and objects to represent herself, family members and

other significant people. I suggested that she place them on the examination couch at a distance from each other, which represented the closeness between each person. She proceeded to slowly and carefully place each object and adjust their positions. She placed figures to represent herself and her family in a small huddle in the centre of the couch. Then we stepped back and together took in what she had created; we both did this for about a minute standing beside each other in silence. I then commented on the closeness of the small huddle in the centre of the couch and the lack of other significant relationships in the concretisation. I asked her about her connections with people from Germany who were outside this core group. She picked an object to represent her closest friend whom she had not seen for several years. As she did this, her head dropped slightly and her eyes moistened. I said, "you feel sadness as you think about your friend" and she nodded in agreement and took two deep breaths. I suggested that we pause at that point.

At the beginning of our clinical interview, I enquired about her anger and fighting at home with her brother; Harriet's answers were short and revealed little about her situation. She was unable or perhaps unwilling to reveal the reason for her anger and there were long silences in the conversation. She was possibly confused and embarrassed about her behaviour at home. However, when she was invited to concretise her social system, her functioning changed; she became thoughtful and careful in its creation. Her demeanour indicated an increase in her spontaneity and creativity. She placed a small group in the centre of the examination couch to represent her father, mother and brother. When she chose an object to represent her closest friend, she enacted a new role involving the open expression of deep feelings, like those of a tender friend or lover. This was a progressive role that I had not seen her enact previously. If there had been more time we may have proceeded to a psychodrama with her friend. It is something I might suggest in the future, as I believe there could be more social atom repair needed in this area. Moreno, as described by Nolte (2014, p. 160), hypothesised that the social atom is a constantly changing social structure. The goal is to achieve a homeostasis where there is a balance of giving and receiving of emotions. This balance is disrupted when somebody dies or moves away or the roles change. There is then a reparative process as others take the place of the one who has left and roles are created, altered and expanded.

The tele with Harriet was strong, since I had experienced an easy rapport with her in previous counselling sessions: this laid the foundation for action methods to be used. I chose to use concretisation as I thought that asking questions had led to her being conflicted and reluctant to disclose. I suspect that she was used to being questioned by her parents, who were both professionals with enquiring minds and I imagine that she often felt interrogated by them. When we started working in action, I think that she saw me less as an interrogator and more as a co-explorer. My functioning

changed from seated enquiry to moving around and helping her create the concretisation on the couch. The concretisation helped me enter Harriet's world and warm up to her social system. When she enacted the role of tender lover, I doubled her by saying "you feel sadness as you think about your friend." She nodded and took some deep breaths and I took this to indicate that my doubling had been accepted and that the progressive role had been fully enacted. This indicated to me that it was a good time to pause the action.

I consider the use of concretisation when there is a complicated system with many personal, interpersonal and societal forces at play. In such a situation, it is often simple and clear to ask a person to concretise the elements of the system. This creates an observational view of the system and the person's functioning in it. Also, concretisation requires the patient to shift role to be more creative and often more playful. It feels quite easy to do this with a patient because there is no role play involved and people have sometimes heard of sand-play or similar therapies that involve concretisation.

As a medical practitioner, I have been able to incorporate the identity of a psychodramatist into my professional identity as a doctor. The integration of these identities affected my medical practice and the experience of my patients. It increased my ability to warm up to my patients and to my work as a doctor. My patients were, consequently, more able to warm up to themselves and their experiences in life.

Moreno, as quoted by J.D. Moreno, is famously reported to have said to Freud "Well, Dr Freud, I start where you leave off. You meet people in the artificial setting of your office. I meet them on the street and in their home, in their natural surroundings" (Moreno, 2014, p. 50). In taking psychodramatic methods back into the consulting room, I have had experiences of increased warm up, spontaneity and creativity. Also, I have had encounters with patients where I have entered into their world and they have entered into mine and we have both been changed as a result.

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Neil Simmons grew up and trained as a medical practitioner in England. He came to Australia for a working holiday in 1989 and decided to stay. Since living in the Antipodes he has pursued an interest in theatre and has been a playback theatre practitioner for several years. In more recent times he has become involved with psychodrama, in which he is now certificated. He works as a GP in a suburban practice which was set up to service the LGBTI+ community during the HIV crisis. He lives with his housemate, four chickens and three bush turkeys.