Psychospiritual Elements of Illness: Beyond Biomedicine

By Clifford C. Kuhn

A comparison of the widely accepted twelve-step recovery program of Alcoholics Anonymous with the current clinical application of medicine's biomedical model reveals the roots of several limitations in the latter that restrict the practical consideration of psychospiritual issues in the doctor/patient interaction. One such limitation is the "attack and eliminate" motif embraced by western medicine and generally endorsed by our society. The shortcomings of this motif in leading to a full understanding of healing are illustrated by a metaphorical fable. Suggestions are offered for challenging the conceptual limitations imposed by our restrictive clinical strategies.

Modern medicine, for all its extraordinary accomplishments and capabilities, is beginning to encounter a glaring limitation. Despite attempts to share more education and mutual responsibility with patients, American physicians rarely find the time or the terminology for discussing the spiritual aspects of health and illness. This works a hardship on both the physician and the patient at many junctures, particularly in the instance of chronic, unremitting, or terminal illness.

A major contributor to this limitation is the relatively restricted model employed in this society as a template for our understanding and practice of health care. At the turn of the century the model was almost exclusively biological. During the first half of the twentieth century, through the influence of Freud and others, a psychobiological model emerged and gained acceptance. A further expansion was attempted in the 1970s when George Engel introduced his biopsychosocial model (Engel 1977), which is the broadest construct yet to be considered by the mainstream of western medicine.

These developments notwithstanding, the American physician remains for the most part trapped in a predominantly biological model that focuses primarily upon symptom remission and the acquisition of mastery over environmental threats to health. This model seeks to be sensitive to quality of life issues, but finds sparse capability to operationalize concepts in this subjective area, usually settling upon rigid "rules" for living designed to prevent certain symptoms from occurring. Discussion of values, priorities, and purpose for life is consigned to the spiritual realm, which is essentially beyond even Engel's enhancement.

In an attempt to remedy this situation, I introduced elsewhere the Bio-Psycho-Socio-Spiritual Model (Kuhn 1988). As the name implies, this was an attempt to include spiritual elements in the diagnosis and treatment of illness. Employing this model in my clinical work, I have found it helpful in drawing attention to the spiritual, but beyond the addition of some questions that would not otherwise be asked while taking a history, it has thus far not led to any fundamental innovations in treatment planning. That is to say that, whereas there exist identified intervention strategies in the biological, psychological, and social arenas, physicians are lacking in guidelines

for effective responses to spiritual needs.

We have had for some time in America a model that could provide enlightenment. This model addresses spirituality and healing in a practical sense and promulgates attitudes and strategies that have proved effective in that realm for over a half century. This model is the twelve-step recovery program introduced to our society in 1935 by the fellowship of Alcoholics Anonymous (*Alcoholics Anonymous* 1976). What could we learn by comparing this model with our current medical model?

Whereas the medical model focuses almost exclusively upon remission, the termination of undesirable symptoms, and the prevention of future symptoms, the twelve-step approach encourages not only the remission of symptoms, but prescribes a spiritual change as well.

Although sometimes it is construed erroneously as anti-medicine, there is nothing inherent in the twelve-step program that is incompatible with the medical model. The difference might best be described as one of *emphasis* and *perspective*. The twelve steps accept powerlessness to control illness as a starting point. In contrast, the medical model is based on the assertion that illness can and must be controlled.

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Step One is, "We admitted we were powerless over alcohol — that our lives had become unmanageable." The key here is the verb "admitted," which means to concede, grant, acknowledge, or confess. It alludes to a reaction beyond the mere recognition or description of existing conditions. It implies a more difficult, perhaps even reluctant, communication, usually occurring after concerted attempts to deny the truth of the matter.

It is conceding that I am overwhelmed, have lost control, and cannot handle the situation without help. In admitting powerlessness, I am revealing that circumstances have exceeded my personal resources, and I have lost my usual capacity to manage my life.

This coincides precisely with the first step in the medical model. The patient comes to the physician in an attitude of surrender and confession, ideally ready to do whatever is prescribed to remedy the situation. Because many individuals are reluctant to "go to the doctor," this can be a dramatic and difficult human interaction. Nonetheless, there is willingness to admit personal "powerlessness" and to surrender. So far, both models are practically identical.

The second step in AA is "Came to believe that a power greater than ourselves could restore us to sanity." Again, the verb is interesting — "came to believe." Since believing is an exercise that usually involves spirit, this introduces an awareness of a possible spiritual experience. Attention is directed to the need for a power "greater" than myself to restore me. The focus remains upon changing the symptom, but there is an unmistakable acknowledgment that the resources for remitting the symptom lie beyond human power.

At this point, the two models begin to part ways. In the medical model we have observed definite elements of surrender. The emphasis, however, is quite different. The response focuses immediately upon controlling the situation and,

more to the point, the message is that human resources are expected to be enough to provide the remedy. The medical model clashes with the second AA step in that it unabashedly suggests that we have the power to overcome the problem. Introduced at this early juncture is a battle motif. We identify the "enemy," diagnose, and attack. Although the two models still have much in common, their paths have begun to diverge.

Step Three of AA is, "Made a decision to turn our will and our lives over to the care of God, as we understood Him." At this point, the models have begun explicitly to communicate different messages. The twelve-step model assumes a definite spiritual focus and advocates a continuous daily practice of surrender and acceptance. The remaining nine steps include a moral inventory, repeated confession, and, finally, a spiritual awakening (*Alcoholics Anonymous* 1976, 59-60).

In contrast, from this point forward, the medical model focuses almost exclusively upon gaining control of the situation by "fighting" the identified disease entity. The emphasis is upon diagnosis and elimination of the problem. The measure of success will be the extent to which the symptoms are eliminated or controlled and "normal" life can be restored. When this is accomplished, the interaction will be considered complete, without ever referring to the issue of spiritual change.

Here we have revealed a very substantial difference between the two models. The twelve-step program emphasizes acceptance of powerlessness as its cornerstone, whereas the medical model strenuously resists it. In this respect, American medicine appears to be an accurate reflection of current societal attitudes.

There appears to be confusion in the minds of modern Americans about the meaning of the word "acceptance." We associate the term with the concepts of "approval" or "endorsement." In actuality, the first definition of acceptance in the dictionary is, "to take or receive with a consenting mind." To consent means "to agree, to acquiesce." Synonyms are to "accede, assent, comply, yield, allow, or permit." It is not suggested that to accept something is to condone, endorse, or even like it.

But somehow it seems "un-American" to accept things as they are. Perhaps this is because our nation was established by acts of rebellion and unwillingness to accept existing conditions. Whatever the reasons might be, we have made explicit and implicit promises to ourselves that we do not have to tolerate noxious circumstances. We reinforce the notion that, by ingenuity and persistence, we can change anything we do not like. For Americans, acceptance is "copping out." It is often considered a sign of weakness. We just don't have to do it. We need not accept our limitations. Consequently, we focus more upon our rights and entitlements, among which we consider the remission of symptoms when we get sick.

The medical model upholds this "patriotic" stance by implicitly and explicitly promising relief from any discomfort. This is a tall order and when medical treatment does not deliver on this promise, the disillusionment can be swift and rancorous. By contrast, critics of the twelve-step model, alluding to its emphasis on acceptance, often assert that it is "too soft" on its population, allowing individuals to elude responsibility for the symptoms of their condition.

We have already mentioned briefly another way in which the medical model reflects American society. In endorsing the motifs of battle — attacking, fighting, and eliminating — as worthy strategies for healing, the medical model is very "American." Perhaps these attitudes are rooted in the fundamental methodology of establishing our society, that of "taming the land," a euphemism for attacking and subduing its original inhabitants. Whatever the explanation, it would seem that our most common societal response to any perceived problem is to declare war on it (The War on Drugs, the War on Poverty, and so on).

The fundamental limitations of the "war" motif as a health-promoting model are illustrated by the following fable.

It's A Wonderful White

Once upon a time, there was a village in which the color white was valued above all things. The people in this community had discovered that contained in white was every color in the entire spectrum. Thus white represented for them the highest ideal of perfect integration, connectedness, and harmonious coexistence of all things. For this reason the color white was hallowed, revered, shared, enjoyed, celebrated, and, yes, even worshipped, throughout the land.

One day several citizens reported that they had been offended by the sight of the color shocking pink. Not only was it painful to the eyes, they contended, it also clashed horribly with every other color. Neither had it gone unnoticed that shocking pink, when worn by certain citizens of dubious reputation, led to disruptive behavior at community ice cream socials.

Thus a ground swell of support was organized to do away with the color shocking pink. Voices rose in opposition, suggesting that to eliminate this color might in some way compromise the integrity of white. After much deliberation, those offended by shocking pink prevailed and it was decided that this obnoxious color had to go. A vaccine was produced and in a very short time shocking pink was entirely eliminated from the village.

Having accomplished this, everyone was relieved to discover that the elimination of shocking pink made no perceptible difference in the color white. White was still white, and shocking pink was gone. Thus was born the germ of an idea that, on occasion, it might be possible to eliminate certain unwanted colors without affecting the wholeness or integrity of white. There were in fact a few who thought that eliminating shocking pink had actually improved the quality of white.

Before long, it was reported that the color chartreuse had caused great offense to many in the town and its banishment was proposed. As before, there was some debate, but, owing to the shocking pink precedent, the voices raised out of concern for the integrity of white were considerably fewer and easier to dismiss. Thus it came to pass that chartreuse was also eliminated. Once again it was duly noted that this had no perceptible effect upon the revered quality of white.

So it was learned from these events that it was indeed possible to eliminate or banish an unwanted color with impunity, white being essentially unaffected by this action. Thereafter, whenever a color was identified as a candidate for elimination, the debate would focus upon the relative merits of the color itself, not upon the issue of compromising the quality of white.

And so the community thrived. Over the decades that followed, they became more efficient and effective in identifying and eliminating colors that were considered to be offensive for any reason.

After some time, those citizens possessing the most discerning visual acuity began to call attention to the fact that white no longer appeared to be white. "We've lost whiteness," they proclaimed. "It has become off-white!" These acutely observant persons were, for the most part, ignored. On the rare occasions when they persisted in their protests, the community, in keeping with the accepted policy for undesirable elements, "eliminated" them, and then went on about its business.

Over the years, more and more colors were banished. By the time it was decided to eliminate teal, simply because most people were sick of looking at it, the loss of uncompromised white had become obvious even to the least discerning eyes in the community. Reluctantly, everyone admitted that white had been lost.

A great debate ensued. What was to be done? Some suggested that the sensible thing was to accept that high-quality whiteness was impossible in this modern world and that it was unreasonable to seek it. Others advocated attempting to remember the most recent colors that had been eliminated, since they had done the most apparent damage. Perhaps if those colors could be restored, a relatively better white could be reestablished.

The debate raged on, but to no avail. It seemed that the quality of white had been irreparably compromised for all time. Curiously, no one in the village was able to recall the basic error in judgment that had been committed decades before, namely the assumption that white could remain whole and complete without all of its components.

The society in this fable has a familiar problem. It has lost something valuable and cannot figure out a way to regain it. As they address the problem, the citizens are entrapped by a limited attitude based on a false belief that originated from a misperception. In embracing strategies that endorsed the destruction of noxious colors, they had unwittingly consigned themselves to the ultimate loss of a highly valued community property, the color white. The time for recognizing this error was as it was happening, not after the fact.

I believe the story provides a metaphor of our current medical model. Most, if not all, of our treatments are refinements of the basic attack and eliminate strategy. We often find ourselves resorting to battle language when we advocate *resisting* infection, *beating* cancer, *fighting* depression, or *stamping out* heart disease. Our basic philosophy is that by eliminating that which is perceived as threatening to our health, we will be more healthy, more healed, more whole.

Have we not fallen into the same trap as the "keepers of the white," perpetuating the same myth — that wholeness is obtainable by attacking and eliminating? Has a battle motif ever led to healing? This question may have prompted the venerable Yiddish proverb, which teaches: "A bad peace is better than a good war." Perhaps it is time to acknowledge that the truer motif of healing is that of reconnecting, reintegrating, and becoming whole, just the opposite of attacking and separating.

This is not to disparage the biomedical approach, but rather to suggest that it does not go far enough. If I have an acute inflammation of my appendix, I want the best surgeon available to remove it. But I also would be well served to be reminded that there is nothing inherently healing about that surgical response. It is a welcome cure that remits a set of symptoms in a timely fashion, and by doing so extends to me the opportunity to heal.

My healing from the illness event calls for a deeper and broader perspective than the elimination of the offending organ. For example, it might require a contemplation of the roots of the antipathy between myself and the life form or organism that "invaded" my body. Did I make choices somewhere along the way that precluded the possibility for "peaceful" coexistence with this organism? Perhaps my full healing might require a change in my believing that I am essentially separate from the invading microorganism and that it is "foreign" to me, something to be destroyed and eliminated. Maybe if I had been more "at one" with other life forms the symptoms would not have occurred.

Looking for healing through our current medical model puts us in the position of the man who is looking for his car keys under the street lamp at night, not because he dropped them there, but because the light is better.

These germane considerations lead us into the realm of beliefs, values, purpose, and meaning — the realm of the spiritual. There is nothing in our current medical model to encourage or challenge us to think such thoughts and discuss them in the context of our clinical experiences. Admittedly, there is a great deal to reinforce the more limited perspective.

In the "war" motif, we are encouraged to think that by dodging a bullet, we have solved the problem of a sniper. But if we cannot heal our adversarial relationship with the sniper, are we not consigned to a lifetime of wariness and hypervigilance; a lifetime of dodging bullets? Who or what did the sniper represent? Why was he sniping at me? Are there more like him? How many more will we have to eliminate before I'm finally safe? Will we have enough resources or "ammunition" to eliminate them all?

The limitations are clear. Looking for healing

through our current medical model puts us in the position of the man who is looking for his car keys under the street lamp at night, not because he dropped them there, but because the light is better. We laugh at that joke because it describes an absurd situation. But we recognize that we are prone to practice that absurdity, probably because we are afraid of the dark.

The time has come for us to embrace, as a practical resource, a model that casts its light over a broader area, a model such as the twelve-step recovery paradigm. Until we do so, we will continue to exclude the meaningful examination of spiritual issues from the doctor/patient relationship.

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