How the professional mentor works

Paradigms and our thinking as GPs – example: anxiety and panic

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Dr Peter Parkinson is a GP, a physician and a psycho-dramatist. He is responsible for establishing a 100-strong nationwide network of 'Professional Mentors' for GPs. This network, that can be accessed through 0800 MENTOR or www.mentor.co.nz, was described in the April 2001 issue of NZFP (NZFP 2001; 28[2]:34–35). It may seem bizarre that sitting together with another human being for an hour per fortnight can affect one's own well-being and improve perceived effectiveness of consultation so profoundly. In this and perhaps subsequent articles Peter will begin to unravel some of the intricacies that underly the magic of such human interaction.

Introduction

One hundred and fifty-three GPs, all of whom were attending to their own professional development and personal well-being using different processes, answered a fairly casual questionnaire. I designed this questionnaire to give those of us who were involved in developing the professional mentoring programme for GPs some idea about the effectiveness of these processes and to gain direction in planning for the future of professional mentoring. In other words, should we ditch it or continue it. The results were positive enough for us to continue.

Of particular interest, however, was the way that professional mentoring stood head and shoulders above other disciplines and processes, such as GPVTP, Peer groups, IPA groups, psychotherapeutic supervision etc. especially when it came to the four questions that related to patients. These were the four questions: Did the process you were using,

- increase work fulfillment?
- noticeably help patients?
- expand appreciation of health and disease?
- expand repertoire of interventions?

We reflected on the many ways that this may have come about. One thing was certain: the results did not come from a new drug, a novel surgical procedure or a souped up vaccine, for these have nothing to do with professional mentoring. We believe that it comes from the less tangible, less measurable factor: the increase in effectiveness of the inter-personal relationship between doctor and patient. Of the many, mentor-borne, factors that we believe could improve the outcome of the doctor/patient relationship, paradigm shift was high on our list.

What is a paradigm?

A paradigm is a way of perceiving something. It is a way of charting the ocean that one is in. If one consults a chart of the 'Approaches to Auckland' to enter the Port of Sydney one might end up on the rocks. Wrong paradigm!

The professional mentor is a person able to assist you to consider a variety of paradigms in order to give a better understanding and a greater sense of meaning to a clinical or human situation that is in front of you.

A paradigm is a theoretical explanation and as such it is not the truth. A paradigm adds depth to meaning, and, once it has done its job, will either be disbanded or else included in the next stage of development of the paradigm. Taking the map of Sydney Harbour simile further, having consulted the correct

chart and with the compass to have plotted a safe course into port, the novice captain finds his boat on the rocks! This novice captain needs to review his/her choice of paradigm. Tides eh?!

The paradigm that we, as doctors, use constantly is 'diagnose and cure', or, more simply, 'cops and robbers'. The disease is the robber of health and along come the cops (the doctors) with their guns (interventions) and hand cuffs (band aids) and kill, or at least imprison, the suspect until it gets a fair trial (investigation) and conviction (diagnosis). This paradigm comes horribly unstuck when the illness happens to be a feeling. Let's consider anxiety and panic.

Anxiety and panic

Simply calling a feeling an illness does not really solve anything. The robber of health and good feeling (anxiety and panic) multiplies, the potentially lethal drugs for killing the feeling proliferate and dependency on these drugs becomes a risk and a reality. It does keep the consultation brief and may reduce risk. But this is clearly incomplete, so let's try another paradigm:

'The feeling is big because the ability to respond is small.'

This is a paradigm that assumes that feeling and action work hand-in-hand. Let me give you an example that is simple enough to understand. Recently I was taking my rather large dog on a leash across a busy road, and I was a safe distance in front of an approaching Stagecoach bus. The feeling was big enough to prompt me into appropriate action, hence I kept walking at a steady pace. At the worst possible moment the dog spooked and attempted to backtrack, causing both of us to come to a dead (or potentially dead) halt in front of the oncoming bus. On losing the ability to act appropriately, my anxiousness escalated to panic. The dog found itself in my armpit as I snatched him bodily and ran with him to the other side of the road. Once on the pavement the panic vanished, I spoke to the dog in Anglo-Saxon, then I experienced the beauty that comes with the sea breeze and the view.

This paradigm, 'big feeling, secondary to small action', has lots of mileage. It means that the focus can be taken off ameliorating the feeling and focused on the patient's ability to respond.

The next paradigm shift is logical. *To what does the patient needs to respond?* Hence the paradigm expands now to include not only the relationship between feeling and action, but also the context. It may be quite simply achieved by asking the patient.

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I asked my chemist friend this the other day, why he was extremely anxious. He said: 'I've been burgled twice in the last fortnight. Both times my life was threatened. I've been to the psychologist who specialises in post-traumatic stress disorder and he hasn't cured the extreme anxiousness that bugs me every day when I come to work.' I mentioned the above paradigm to him. Next time I dropped in to see him there was hardened glass, a concertina security door and bank counter wires separating him from the public part of the shop. He looked at me, pointed to his armourment and said: 'The panic's gone. Now I feel secure!'

If the patient says: 'I don't know what makes me anxious', then the paradigm runs out of steam. Time to invent a new one? Try adding this one to the paradigm sequence: *Something or someone hit one of the patient's triggers or 'buttons' and sparked off a conditioned response reminder of an old and very threatening moment.* You may thus ask the patient: 'Have you been reminded of a threatening moment?' You might get yes, and a chat about that could do wonders, or a visit to the psychologist mentioned above might also be very beneficial. It could also be valuable for the patient to know about this paradigm as a preferable alternative to the paradigm of being insane.

Again, alas, you might draw a blank and most of the time it's not to ask such a simple and straightforward question. Hence another paradigm could be considered, *that there are two separate memory systems.*

One is intellectual and contains the denial processes that keep untoward, unwanted and severely traumatic memories out of consciousness. The other memory system is that sparked off through action and emotional warm-up. In reality this one tends to access appropriate moments with alarming accuracy. It, too, has many safeguards, because many of our experiences are best kept well out of conscious memory. When the moment is right, and only when the moment is right, this pathway can lead to very significant treasures that lend exceptional insight into the most bizarre of happenings.

One lady who presented with panic attacks for no known reason chose to use the security of psycho-dramatic process and a personally selected group of support people in a facilitated group setting. In that setting of relative safety, she re-entered a panic experience. Once she was embedded in that feeling she closed her eyes and looked and listened. She saw pine trees and heard the sound of the wind passing through the branches. This was the scene where she was the victim of an early adolescent rape. Part of the safety and the purpose of entering this painful recall is because she knows that she will be able to resolve

the issue there and then. Once this had emerged she could see exactly where the panic that surged from unknown depths through her day-to-day activities had come from. She became furious with the perpetrator, something that she was unable to do at the time of the assault.

Thanks to the generosity, training and spontaneity of the actor who was taking the perpetrator's role, and to the safety of the psychodramatic process, she was able to deliver very clear consumer feedback to 'the perpetrator'. During the original assault the 'feeling was big, because the ability to respond was not just small, but absent'. In fact the feeling got so big that it went clean off the scale into denial. (That's another paradigm.) In this psychodrama she had been able to respond appropriately to the circumstance that caused the panic and feel empowerment instead. From there on in her life the conditioned response reminders (the triggers and buttons) recalling this scene were no longer panic ridden but contained the experience of power that occurred in the psychodrama.

For the GP is it useful to have an array of paradigms to consider? Without a paradigm range we are left with the paradigm of cure either by medication or referral. The paradigm range mentioned above adds the freedom of choosing personal empowerment as an option for your patient. Together with your patient you will be able to discuss the wider array of paradigms, and how referral to a psychotherapist or psycho-dramatist may work.

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Conclusion

In simply reviewing anxiety and panic as a patient's presenting concern we have considered the following paradigms:

- Cops and robbers
- The feeling is big because the ability to respond is small
- Feeling, action, thoughts and circumstance all work hand-in-hand
- The cause of the anxiety could be in the here and now
- Painful memories are kept well hidden
- Painful feelings of the past can affect the present by conditioned response recall
- Two separate recall of memory pathways; the intellectual and the emotional
- Discovering the origin of the anxiety might help by giving insight
- Completing the unfinished moment where one could not act earlier in life is a satisfying thing to do and cures flashbacks.

This wide array of paradigms, and the freedom to think up more on the spot, gives the patient a much better chance of having their presenting complaint comprehended in terms that makes sense to them and empowers them to take control of their own life.

Altering and choosing paradigms permits a wider range of options, from quick fix to deeper comprehension and permanent resolution. It is important for the clinician to remember that diagnosis is part of an alternative paradigm system, for what is the difference between 'being anxious', from 'being really anxious' and from having the diagnosis 'Anxiety Disorder NOS, DSM IV 300.00'.

Multi-paradigm approaches may take more time, however, as one client recently said to me, 'If you do not have the time to do the job properly, what makes you think that you will have the time to do it again?'