The persistence of magic and religion in contemporary medicine and psychotherapy (final)

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The persistence of magic and religion in contemporary medicine and psychotherapy

Abstract

An examination of the ostensibly secular, modern and scientific fields of medicine and psychotherapy reveals the persistence of religious, primitive and magical thinking. Practitioners appear to meet the public demand for magical enactments at least half-way. In doing so, they may persist with practices despite evidence of its ineffectiveness, or with disregard for the question of its effectiveness altogether, or with imperviousness to the discouragingly weak therapeutic effects reported in scientific papers. Examples are drawn from coronary surgery, contemporary psychoanalysis and group analysis. The situation for group analysis is of special interest.

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Introduction

This paper examines a tension operating within the helping professions. The tension is between wishful thinking, fantasy and magic on one hand, and an orientation towards external reality on the other.

While there is no reason to suppose that the helping professions would be somehow free of a tension arguably present in *all* individuals and groups, the dominance of magical thinking may be especially difficult for us to perceive in our own professional cultures. I am thinking here of the oft-quoted insight attributed to Marshall McLuhan, among others, that fish know nothing about water; immersion in a culture has incremental, detrimental effects on the sharpness of our critical faculties when it comes to the medium in which we are suspended. Thereafter, should critical faculties become engaged in perceiving and thinking about these problems, it might be expected that group anxieties will kick in. It can hardly be otherwise when unexamined group beliefs at the core of our identification with a profession - upon which our livelihood and social prestige is secured – are brought to scrutiny. The whole process of this inquiry may be perceived to be a most unwelcome strike against our self-interest.

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I provide examples of the tension between magical-thinking and reality-based thinking in a range of helping professions – coronary surgery, contemporary psychoanalysis and group analysis - to illustrate the general phenomenon. Early in this survey I provide a brief outline of social pluralism, the conceptual basis upon which my arguments stand. The paper concludes with some comments on what I perceive to be the antagonism between the current professional culture of group analysis and scientific advancement in this field.

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1. An illustration from coronary surgery

I quote a passage on coronary stenting from the 2016 book by Ian Harris, called *Surgery, the Ultimate Placebo*. Ian Harris is professor of orthopaedic surgery at the University of NSW.

> *The idea behind "revascularising" coronary arteries is very appealing: 'My blood vessels were blocked and the doctor unblocked them'. Like so many things addressed in this book, this sounds good and seems hard to argue with, unless you look at it scientifically and ask the right questions.*

He discusses the debate between proponents of coronary artery bypass and proponents of stenting, and then goes on to say -

> *The arguments about what treatment is best and how it works distract us from asking the most important question: "Am I less likely to die if I have this procedure, compared to if I don't?"*

> *So what is the evidence? For 'stable' heart disease (not an acute heart attack), the largest and best known study comparing stenting to not doing a stent showed no advantage to stenting in any of the outcomes measured: mortality, heart attack or hospitalisation. And the most recent review of this topic came to the same conclusion.*

> *Even for 'acute coronary syndrome' (like a heart attack), a review of the randomised trials shows that there is no significant advantage in overall survival over five years for patients having routine invasive angiography/stenting.*

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There are differences in many other things, but not the big one – the chance of dying.

Recently, the American College of Cardiology put stenting on its list of the top five tests and procedures whose necessity should be questioned. So even they agree that you should question your doctor if he or she wants you to have your arteries unblocked – it is not as simple as it sounds.

Why does the procedure persist? One study detailed why cardiologists choose to stent patients, even when they know there is no clinical benefit. The reasons were: just in case, medicolegal, theoretical benefit, to relieve anxiety, avoid regrets, etc. This shows up the desire to intervene when we are in doubt… (p.155 – 158).

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2. Social Pluralism

Before providing further examples and illustrations I want to make explicit my intended focus and my standpoint. While the examples may seem to draw attention to the behaviour of individuals, or interactions between doctor patient dyads, they have been selected for illustrative purposes only - my intended focus is on the *group processes* that underlie these behaviours and interactions.

I emphasise group processes as most clinicians and theoreticians specialising in individual treatment – and it must be said, many with an interest in groups, organizations and societies - assume an *atomistic* and *voluntarist* positon on human affairs.

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3 *Social atomism*, or individualism, is the view that there really are no social forces or
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6 determinants other than the individual person. In this view, what might appear to be social or
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8 group forces, or movements, are accounted for by the motivations or wishes of the
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10 individuals that make up that group.
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15 *Voluntarism* is the view that social and group situations are the outcomes of the voluntary
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17 wishes and strivings of the individuals that make up the society or group. The operation of a
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19 "free" will is assumed.
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24 I will not take the space now to spell out the logical problems with the "free" will position
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26 (Luiker, 2018) but simply sketch out these positions on this table.
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31 (INSERT TABLE 1)
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36 The column to the left represents magical and religious thought and the column to the right
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38 represents scientific thinking. Put in another way, the left column represents voluntaristic or
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40 "free" will positions, and the right column represents the determinist positions. Put in yet
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42 another way, the column on the left represents thinking dominated by internal wishes, what
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45 Freud called the primary process, in the service of the pleasure principle, and the column on
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47 the right represents thinking directed towards external reality, what Freud called the
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49 secondary process, in the service of the reality principle (footnote 1).
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54 The top row represents the individualist, or atomistic, position and the bottom row represents
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56 the monist position. Monists, in contrast to individualists, hold to one large overarching
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58 explanatory force.
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The top right square - the determinist/individualist position - might be filled by an important contribution of Freud. Freud has stated that psychoanalysis represents the third great injury to the narcissism of man brought about by science (1917). In his view, this injury follows Copernicus's demonstration that the earth was not the centre around which all other celestial objects revolved, and Darwin's notion that man was not created by God in his own image but ascended from apes. Freud's revolutionary contribution was "psychic determinism". Not only was our mental life not fully known to us, it was not even under our own control, nor was it accidental or arbitrary, but determined by preceding internal or external events like everything else in the natural world.

The top left square - the "free" will/individualist position - might be filled by the pre-Freudian position of most clinicians, which I touched on earlier. There are very many examples of the "free" will/ individualist position that could be provided, as it is the implicit position of secular Western society. For example, a central underpinning in its criminal justice systems is the notion that an individual behaves according to his own will - at least one not suffering from mental illness (whatever that might mean!) Another example is the tragic illusion behind the American right to bear arms. The "free" will/individualist belief in the utility of an individual man with a gun in the protection of his loved ones persists despite overwhelming evidence that the introduction of a gun into a home increases risk to the life of its occupants (Siegel et al, 2014; Siegel and Rothman, 2016).

I think a good candidate for the bottom right square - the determinist/monist position - would be Marx's concept of "economic determinism". Unlike Freud - who focused on the instinctual life of the individual, and attempted to explain social arrangements on this basis -

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Marx focused on economic relationships between *classes of people* as the fundamental explanation for all the possible social arrangements in which individuals find themselves (Marx, 1859).

The bottom left square - the “free” will/monist position – might be filled by the place of God in the events of the world. God behaves according to his own divine will, and individual humans merely play a part in his one divine plan for all of mankind. Any of the popular monotheisms could fill the bill.

A position which rejects an exclusive focus on individuals, on one hand, or one large overarching explanatory force, on the other, is pluralism. So if we wedge another row, in between the individualist and the monist rows, we add two more squares to the grid, the “free” will/pluralist and the determinist/pluralist positions.

One example of the “free” will/pluralist position might be the ancient Greek myths where human life takes place under the competing, complex interests of a society of *many* free-willed, capricious gods, but any of the polytheisms (e.g. ancient Roman, Nordic, Egyptian, Australian Aboriginal) could illustrate the “free” will/pluralist position.

Finally, we come to the winner of the beauty contest - the determinist/pluralist positon, or social pluralism - from which I speak today. Social pluralism is the view that social relations reflect complex, interacting, social and emotional forces and interests, some coalescing, some conflicting. In this view, individuals engage with various social interests – lead them, oppose them, be crushed by them, and so forth – while, at the same time, individuals are vehicles of social movements and emotions flowing *through* them. Each of these individual and social

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forces have complex causes located in the natural (not supernatural) world, thereby available to inquiry. The most thoroughgoing delineation of social pluralism I know of is found in Baker (1997), who locates the roots of social pluralism in the pre-Socratic Greek philosopher, Heraclitus.

From this position, the enactment of magical cuts to the heart by happy surgeons on happy recipients may involve not just a fraud perpetuated by a privileged class on the masses; not just the wishful thinking of caring professionals attempting to provide comfort to desperately ill patients and their desperate loved ones; not just the results of an inadequate medical education that relies on tradition and modelling of the elders rather than science and individual critical thinking; not just an ignorant populace; not just society's need to place their faith, when it comes to matters of life and death, in the hands of specially designated idealised members of the tribe who will "do their best" and thereafter allow God's will or plan to be revealed; not just the passivity of somatising patients who have not been encouraged to confront their own emotional pain and therefore see no option but to place their life in the hands of those who promise to remove their physical pain; but all this and more, interacting in complex ways, each element itself complex and inviting closer examination.

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3. An illustration from contemporary psychoanalysis

Having clarified my standpoint, I move now from surgery to an illustration of the tension between wishful thinking/fantasy/magic, and orientation towards external reality, in the field of psychotherapy. I will draw from Jurgen Reeder's book *Hate and Love in Psychoanalytical Institutions: the Dilemma of a Profession* (2004) which features prominently in the statement of the conference theme (footnote 2).

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I draw your attention to chapter 2, titled "Psychoanalysis as Praxis: A Personal View". This is the chapter where the clinical vignette appears. Reeder states that:

> *It is usually maintained that psychoanalysis is a method of treatment. That is indeed the way society and the general public judge it, and such is surely also the view of the future analysand as he or she concludes that now something must come about that will make life change for the better. On such a superordinate level psychoanalysis is not only an activity aiming at the removal of suffering and the liberation of creative forces – making people better equipped for envisaging and striving for a good life – but also a corrective measure to put right what for one reason or another has taken a deviant course.*
>
> *I am quite sure that most analysts would agree with such a description. But on a more intimate level, it would most probably not be these purposes that they call upon to explain why they choose to spend such a large part of their lives in the pursuit of an activity that really doesn't resemble anything else. More probably, they would say (or think): "I do it because there is really nothing else I'd rather spend my time doing".*
>
> *To those involved – analyst and analysand – analytic work is closest to what Aristotle calls a* praxis*, a self-fulfilling life activity. Once it is under way, analytic practice is its own incentive and its aims lie in the exercise itself" (p. 16)*

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Reeder's introduction of the concept of Aristotle's *praxis* as the closest to analytic work might be more helpful if this ancient Greek word was less ambiguous. Would it be too simplistic and cynical a reading of Reeder's passage to put it this way: the patient commences psychoanalysis seeking treatment - to make his life change for the better, to remove his suffering and liberate his creative forces, to put something right that has gone wrong in the course of his life – but what the psychoanalyst seeks is his *own* self-fulfilment through the activity of psychoanalysis itself? This does not sound like it is going to work out well.

Let me go back to the surgery example. If after being informed that the evidence from multiple well conducted studies agree that knee arthroscopies, cardiac stenting and back fusion are no more effective than inexpensive placebos, which is what Harris actually says, a surgeon replies that, on a more intimate level, he performs these procedures because "there is really nothing else I'd rather spend my time doing", what would we make of it?

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The clinical vignette itself (p.23) is a little over two pages. It tells us very little about the patient. No personal or clinical context relevant to understanding the patient is provided. It serves to illustrate an "intervention which was an experiment that turned out to be decisive for the rest of the session". Perhaps it *was* decisive for the rest of the session - there does appear to be a good deal of verbal engagement and alliance between the analyst and patient following the intervention. And there is a sense in this vignette of the dyad finding fulfilment in this engagement. This seems to take care of the analyst's intimate needs, but what problems are the patient experiencing? What are the difficulties in the way of the analyst and the patient solving these problems? What

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was the outcome of the analysis, and what role did this intervention, or the understanding from which this intervention arises, play in achieving this outcome?

In this chapter and those which follow, we learn much about the *author's* thoughts and experiences, but we learn nothing more about the patient and whether she achieved *her* goals, whatever they may have been.

4. An illustration from group analysis

My illustration is drawn from the conclusions of the 2009 *Systematic Review of the Efficacy and Clinical Effectiveness of Group Analysis and Analytic/Dynamic Group Psychotherapy* commissioned by the Institute of Group Analysis, London and The Group Analytic Society, from the Centre for Psychological Services Research at the University of Sheffield.

I quote from the part of the executive summary pertaining to the evidence from randomised controlled trials.

> *Five randomised controlled trials gave the following results:*
>
> • *Piper et al., 2001 found patients with complicated grief improved in both psychodynamic and supportive group treatment; there was no significant difference between therapy types.*

No more effective than a supportive group?

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• Blay et al., 2002 found brief psychodynamic group treatment gave clinically and statistically significantly greater benefit than usual clinical care for a mixed diagnosis group at the end of 8 weeks treatment, but at follow up (9-30 weeks post randomisation) there was no significant difference.

Any benefit disappeared 1 to 22 weeks after the group ended?

• Lanza et al., 2002 compared psychodynamic group therapy with group cognitive behaviour therapy for reducing aggression and violence in male veterans with a history of assault. With a small sample size (n=10) the degree of improvement was not statistically significant for either therapy and there was no significant difference in outcome between the psychodynamic group and the CBT control, although the rate of improvement was better in the psychodynamic group.

Neither treatment was effective?

• Tasca et al., 2006 found binge-eating patients gained similar benefit from [group] psychodynamic interpersonal therapy and group cognitive behaviour therapy, both being superior to no-treatment controls at the end of therapy: follow up data on the no-treatment control group were not available;

No better than CBT but better than no treatment at all? Given Blay et al (2002), above, we want to know if the treatment effect was sustained 1 to 22 weeks after the group ended, but we don't know because the no-treatment group was not followed up.

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• Lau et al., 2007 compared modified group analysis with systemic group therapy and found the latter somewhat more effective, although both groups showed a treatment response.

Both groups showed a treatment response? We really want to know more about this, but recall Harris's discussion of the effectiveness of bypass versus stenting - without a control group it's hard to know how much better off the patients were to participate in either treatment versus participating in neither. Also, in light of Blay et al 2002, we want to know if the treatment effect was sustained 1 to 22 weeks after the group ended. In the appendix of this Review it is stated under "length of follow-up": "not clear but questionnaires collected at end of therapy". We want to know that the claimed effects were more than the desire of patients to be kind to their hard working therapists when completing their questionnaire at their last meeting.

I return to the executive summary.

These results provide evidence for the efficacy and clinical effectiveness of group therapy approaches in a range of clinical problems, but not for specific benefits of any particular theoretical approach.

All group therapies are winners and all must get a prize? Do any *one* of these studies fill us with fire and enthusiasm for undertaking the prolonged and arduous training required to qualify as a group analyst? *This* is the best we can do?

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Perhaps it doesn't matter - because maybe there is really nothing else group analysts would rather spend their time doing? Professor Harris reminds us that bloodletting has a 3000 year history. What would we make of a surgeon who tells us, "Sure, maybe it doesn't work but I just love to bleed people"? Or argues that bloodletting involves a subtle, nuanced praxis that only surgeons and perhaps their most dedicated patients really understand?

Conclusions

This paper presented illustrations of the persistence of magical thinking in some fields of contemporary medicine and psychotherapy.

The example regarding coronary surgery is taken from a book by a professor of medicine and practicing orthopaedic surgeon, intended for the general public, arguing that surgeons and patients persist in surgical operations despite the evidence, available at least to medical practitioners, of its ineffectiveness. The example from a contemporary psychoanalyst illustrates his focus on how the psychoanalytic process meets his special interests and, I believe, his relative lack of interest in any benefits for his patient. In the field of group analysis, disdain for objectivity is evident in the seeming imperviousness of the professional culture to the discouragingly weak therapeutic effects reported in scientific papers.

A critic of medicine and psychotherapy may find in these illustrations reason to condemn either individual professionals or entire professional groups as perpetrating a fraud, but, as argued in section 2, I believe something more complex is taking place. This complexity goes beyond recognising that there is a demand for snake oil. In all three cases, the indifference to treatment outcome indicates, in my view, a turning away from external reality in both the

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professional practitioner and his patient. In this sense, the patient groups and the professional groups are engaged in an organised religious activity.

The situation for group analysis is of special interest.

First of all, there is no equivalent in group analysis, to my knowledge, of the research efforts to determine the effectiveness of treatments in medicine or individual dynamic psychotherapy (c.f. Abbass et al's 2007 & 2014 Cochrane reviews on the effectiveness of short-term psychodynamic psychotherapies for common mental disorders). On this basis, I think it is fair to suggest that the pervasiveness of magical thinking, and its corollary, indifference to scientific thinking and external reality, may be more pronounced in group analysis than in the other two fields.

Secondly, if this suggestion is accepted, we face the interesting situation that a group concerning itself with the growth of capacities for observing conscious and unconscious group processes appears immersed in a professional culture which is uncritical and unreflective of its own processes.

Thirdly, while a group culture of this type is antagonistic to scientific advancement, a critical examination of this culture may well lead to an understanding of important general impediments to studying group phenomena, and thereby strike a scientific advance.

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TABLE 1

	magic/religion	science
	"free" will	**determinist**
individualist	illusion behind American "right to bear arms"	Freud's psychic determinism
pluralist	polytheism	social pluralism
monist	monotheism	Marx's economic determinism

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Footnotes

1. For reason of space, I do not provide here an argument for my preference of a binary classification – magic/religion versus science, a supernatural versus a natural view of the world – over, say, the tertiary classification of Frazer – magic, religion and science – in *The Golden Bough* (1911 – 1915). For the same reason, I do not enter into a discussion of Freud's life-long project to understand how these two sides of humans – primary process and secondary process, the pleasure principle and the reality principle, emotion and thought – work together, required of any sophisticated account of human nature.

2. "The Conference theme reflects the evident burgeoning of all manner of antipathies and sympathies in the political/psychosocial domain. It also mirrors the title of Jurgen Reeder's book *Hate and Love in Psychoanalytical Institutions* (Other Press, NY, 2004) in which he explores the navigation between idealization (love) and denigration (hate) that may be seen to permeate most human experience in relationship (intimate and therapeutic), groups and organizations" (from AAGP Sydney Meeting 2017, Notes on the Theme, Structure, Content and Presenters).

For Peer Review