

Chapter 2

Technology, Idealization, and Unconscious Dynamics in the Culture of Medicine

If I'd known I was going to live so long, I'd have taken better care of myself.

Leon Eldred

The miracles of modern medicine seem endless. Diseases that were once debilitating or life threatening can now be prevented or cured through antibiotics, surgical procedures, and advanced medical technology. The growing population of older adults can serve as a reminder of how much medicine has changed. For example, those over 70 remember a time when people commonly died of infectious diseases, as antibiotics have only been widely used since the 1940s. Not only are many illnesses now curable, but also the ability to prolong life has changed dramatically. Intubation, advanced resuscitation, and medications used to control blood pressure in intensive care units, which literally keep people alive, have not only saved lives but have also dramatically changed the way people live in the weeks and days before dying. Although some of these life-extending mechanisms do not actually improve quality of life (medical ethicists continually debate the acceptable use of life-extending measures), overall, medical advances combined with improved nutrition and enhanced quality of life have led to longer and healthier lives for many.¹ However, advances in medical science and technology raise a number of important and unique issues that will undoubtedly require increased attention, as our patients get older. Consider the following case example:

Betsy is a 97-year-old woman living in an independent apartment within a long-term care facility. She was referred for psychological treatment because she mentioned to her physician that she was considering killing herself and wondered if her physician could provide her with information about how to go to Oregon to receive assisted suicide. Betsy was in good health with normal to above average cognitive abilities. When we met, she told me that she was “stunned” to still be alive. Although she was aware of longevity in her family,

¹ Better medical care unfortunately has not meant better access to medical care, especially for the over 40 million Americans without medical insurance. I am also not addressing the fact some marginalized populations (e.g., Latino/Hispanic, African-American, Native American) receive inadequate medical care. An in-depth discussion of these issues is beyond the scope of this volume, but will be addressed less directly in subsequent chapters.

she commented that, in her generation, it was never expected that one would live well into their 90s. When asked if she was able to take any pleasure in her good health she replied: "I look around and see what is ahead of me, and I don't want to be disabled. What if I have a stroke or something, then what? If I kill myself, I am quitting while I am ahead."

Betsy's situation is illustrative of one kind of suffering in older adults. Living a longer life carries with it a number of complications and risks for the development of new conflicts, as well as the re-emergence of psychological issues that are related to emotional functioning and attachment. Although Betsy's story has many more facets to it, including a deep fear of dependency, her situation raises a number of familiar issues that affect those who live into their 80s, 90s, and those who live to be 100 or more. The first is the genuine shock of living so long. At the time of Betsy's birth in 1911, the average life expectancy for both men and women was 51.49 years (National Center for Health Statistics, 1999). Today's average life expectancy is 77.8 years (National Center for Health Statistics, 2007). As we saw in Chapter 1, it is now more common for people to live well into their 80s, with an increased likelihood of living longer. As suggested earlier, people in this generation have often had the experience of losing loved ones to common disease. Second, although it might be easy for those of us who are younger to speculate that people such as Betsy should be happy to be alive and in good health, it is not uncommon for patients to express a feeling of cruel irony associated with such a long life: Some people who are healthy and cognitively intact well into old age are fully aware of the potential ills that could happen to them, as they have seen countless friends and family succumb to dementias, cardiovascular diseases, and other ailments. Many of my older adult patients have talked about wishing they would die quickly, to avoid the fate of people they know who have strokes or dementias, as they have seen these others live on in a state of limbo, hovering between life and death. One only has to visit any skilled nursing facility where there are a number of incapacitated adults who are solely dependent on others' care to appreciate and understand this fear. However, the greatest apprehension expressed by many of my own patients is that they will remain cognitively intact in the face of severe physical impairment. They worry intensely about being aware of their own impairment, while powerless to do anything about it. Their peers who are demented and confused suffer a great deal, but their suffering can be muted by episodic confusion.² Those with mild cognitive impairment, or even normal age-related changes, can be especially worried about losing even more of their cognitive and physical abilities. This is a realistic fear. The longer people live, the more likely they are to develop medical illness. The ability of medical technology to prolong life, as well as the ever-increasing aging population, creates a number of issues that are new to many of us as mental health clinicians.

² I am risking overstating the case by suggesting that people who experience confusion associated with dementias do not suffer psychologically. This is not true; those with dementia do suffer, are aware of their confusion, and can benefit from psychotherapeutic interventions to help address this suffering. I have found however, that patients who do not experience confusion and are aware of their physical and cognitive impairment can be more vulnerable to fear of disability as they often experience constant reminders of far worse scenarios.

This chapter will address aspects of an increased lifespan as well as medical technology in the current landscape of contemporary healthcare. In particular, I will address hypomania and idealization in the culture of medicine, how these dynamics are both fueled by and the consequence of technological advances, and how they affect both doctors and patients. Conversely, I will also discuss the related issue of the devaluing of medicine and medical practitioners. Changes in modern medicine, including the emergence of advanced medical technology, exacerbate expectations from patients and reactions to physicians. Given the changes in both life expectancy and medical technology, it is also easier to expect more from physicians and to devalue them and the medical system. Increased pressure is felt by all who are involved in the modern medical encounter. These dynamics as well as the idiosyncrasies inherent in the culture of Western medicine create conditions for both patients and physicians that eventually lead to disappointment, frustration, and a sense of helplessness. There are also increasingly unique challenges for mental health clinicians in talking to patients about the difficult feelings associated with a long life, feelings about their relationships with physicians, as well as their feelings associated with bodily failure. Indeed, many patients present as expecting definite and clear answers to complicated questions.

The Hypomanic Culture of Medicine

The fast-paced, energetic, aspects of medicine in this country can be characterized as being “hypomanic.” Although referring loosely to the familiar *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; *DSM-IV*; American Psychiatric Association, 1994) criteria of hypomania, my approach is more akin to the ideas of Melanie Klein and what she called “manic” defenses. Briefly, Klein described manic defenses as when idealization, feelings of being powerful, and hyperactivity are employed to ward off sadness, worries about aggression, and ambivalence (Klein, 1940). In other words, manic defenses are used to avoid difficult feelings. Although Klein construed manic defenses in a developmental context and felt that some people who have particular difficulties rely on these defenses extensively, here I am referring to the common and sometimes adaptive use of manic defenses, hence the use of the term *hypomanic*. Even minimal experience in the medical profession inevitably leads one to appreciate the consequences of a hypomanic culture. Particularly in hospitals, people talk fast, move fast, and think fast. Many people who work in healthcare are constantly engaged in goal-directed activity. Even in outpatient settings, patients remark that they spend only 5–15 minutes with their physician and commonly complain that doctors are rushed and pressed for time. This kind of pressure and a speed-driven culture has a rational component; when a patient is critically ill, physicians and medical staff need to move quickly in order to administer urgent care, which could be life saving. Additionally, many physicians, especially those who work in inpatient settings, are chronically sleep-deprived due to the demands inherent to call schedules, long work hours, and other personal and

professional responsibilities. In the outpatient setting, physicians are often tightly scheduled with the obligation to see a large number of patients in a limited amount of time.

Medicine has changed dramatically because modern physicians can offer a higher quality of treatment and care to patients than in the past. One hundred years ago, physicians had little to offer patients in the way of a cure, so instead they provided comforting words and a personal rapport. As medicine has advanced, the kinds of interpersonal connections within medicine have changed as well. Winnicott (1966) described the way he experienced changes as a result of a more modern medical practice:

It is a sad result of the advances in modern medicine that there is no personal clash between patient and doctor as whole persons; there is a visit to the doctor, a disease process found, treatment is given, and the disease is cured, but no one has met anyone, no one person has bumped into another person. (p. 183)

Many people experience lack of interpersonal connection in the present-day medical encounter. Medicine demands a great deal from its practitioners and a hypomanic style in the personalities of medical professionals can be viewed as a kind of acculturation to seemingly endless demands. On the other hand, the perpetually fast pace in medical facilities also reflects a tendency and desire to not engage with patients in an emotional way. The tendency to act vs. think was articulated in this way by Linsk (1993): “The dominant response to a presenting illness is to do something ‘don’t just stand there, do something’” (p. 174).

Doing something (i.e., acting in a concrete way to solve a problem) is the dominant response to medical issues in this country. One way that this is manifested in medicine is through the prescription of medications to alleviate or manage disease. Although medications are very important and in some cases life saving, it is also evident that behavioral interventions can diminish the impact of certain illnesses and can reduce the need for the use of medications, especially for conditions such as hypertension, Type II diabetes and high cholesterol, to name but a few. Interestingly, it seems that physicians in the U.S. are less likely than doctors in other parts of the world to spend time talking with patients about certain nonpharmacological aspects of medical care. For example, research suggests that American and British physicians diagnose illness in the same fashion, but American doctors are more likely to prescribe medications, and less likely to suggest lifestyle and behavior changes (McKinlay et al., 2006). Additionally, a recent study suggests that discussions about lifestyle and behavioral change comprise about 10% of the encounter between patients and physicians (Ory, Peck, Browning, & Forjuoh, 2007), and another study found that patients are insufficiently counseled or provided with educational information about diet, exercise, and smoking cessation (Heaton & Frede, 2006).

Why American physicians may be less likely to discuss behavioral changes with patients is a complicated matter that involves the psychology of both patients and physicians, as well as systemic aspects of our medical system. However, it is likely that the high rates of noncompliance (not following the advice of one’s physician) play a role in the provision of medications in medical practice. Noncompliance, now often referred to as “nonadherence” in an attempt to sound less pejorative, is

a common phenomenon. Some estimates suggest that almost half of all medical patients in the U.S. do not adhere to medical advice regarding the prevention or treatment of disease (DiMatteo, 1994). One can imagine how difficult it must be to be a physician who spends most of their day advising patients on treatment and knowing that some patients will not follow medical and behavioral guidance. If a physician suspects that about half of their patients may not listen to their advice, perhaps the benefit of behavioral counseling may not seem to outweigh the time it takes to talk with patients about changes to their lifestyle and health behaviors. It may seem easier and more efficient to simply write a prescription. For example, in the case of high blood pressure, prescribing an antihypertensive medication takes less effort than providing behavioral counseling about exercise, weight loss, and reducing salt intake, which are all factors that can lower blood pressure. Research supports this idea. A recent study concluded that most Americans have decreased adherence to the dietary approaches to stop hypertension (DASH) diet, which has been found to reduce systolic blood pressure (Mellen, Gao, Vitolins, & Goff, 2008). However, it is unclear how many people receive counseling regarding the DASH diet. Another study reported that among physicians, counseling patients with hypertension regarding lifestyle habits was limited (Bell & Kravitz, 2008). Although one can appreciate the reluctance of physicians to counsel patients on behaviors that they suspect will not be followed through on, the practice of solely prescribing medication is one of many ways that physicians and patients alike become dissatisfied with the quality of medical care. And though it is true that many patients do not comply with lifestyle recommendations, the tacit message when physicians do not try to explain that patients can control some medical problems through behavioral changes is one of skepticism, doubt, and perhaps even cynicism. This creates a scenario in which patients may feel infantilized, devalued and that they cannot be trusted to take responsibility for their health.

For physicians, however, talking with patients takes a lot of time. Both medical research and popular literature frequently remark that doctors feel they are under increased pressure for demands on their time and that practicing medicine is not as gratifying as it used to be.³ However, the behavior of prescribing versus talking also reflects the hypomanic style that is present in contemporary healthcare. Moving quickly from one patient to another, solving one problem and moving on to the next, quickly coming up with a plan to treat an illness, and then attend to more severely ill patients is the current practice in modern medicine. Current medical practice in America often has the result of patients feeling objectified, that their problems do

³ There are a number of changes in medicine that have dramatically affected the culture of medical practice and eroded away the feelings of emotional and financial security physicians once considered integral to their profession. Although these changes are important to the present discussion, I have previously described how these changes affect physicians and result in increased pressure for both doctors and patients (Greenberg, 2007). I am also refraining from elaborating on how the medical financing system in this country (and the urgent need for healthcare reform) has added to the burden. These issues have been documented elsewhere in detail in the popular medical literature. For example, Cohn (2007) describes our current health care crisis through the eyes of patient experiences.

not warrant appropriate time and attention, and that their provider should simply fill their prescription and leave them be.

Although physician variables and the culture of medicine play a role in how patients feel about the medical encounter, it is also useful to consider ways in which patient variables affect interactions with physicians. Although our medical system is plagued by problems related to reduced access to quality care (especially for the disadvantaged), less time for interpersonally meaningful interactions with their doctors, the increasing intrusiveness from insurance companies that affects both physicians' decision making and the treatment patients receive, there are also issues that patients bring to the encounter. Many people get caught up in the hypomanic components of medicine for varied and complicated reasons. Again returning to the idea of medication prescribing, it is the case that a number of patients expect to be cured through pharmacological interventions and do not want to have to do the work of changing health behaviors. This is one way that medicine is idealized. The idea that one can simply take a pill to treat a problem can feel like an easy solution and that responsibility for one's health is in the hands of an all-powerful physician. However, for many medical conditions, even pills do not offer cures unless health behaviors are addressed. Expectations among patients complicate medical relationships further.

Patient Expectations in Medicine

The issues around prescribing medications serve as an apt metaphor for the ways in which individual psychology interacts with the culture of medicine. We all expect our doctors to make us feel better. Many people are accustomed to expecting a prescription when ill. Taking a pill can be a soothing and concrete experience, which can make us feel that we are actively doing something to help ourselves "get better." This is an understandable response and is akin to when a parent puts a band-aid on a young child to help their child feel better, even when it is not necessary. When a doctor counsels a patient to change their dietary habits, engage in an exercise routine, quit smoking, or make other behavioral or lifestyle changes, this requires much more effort than simply taking a pill. The issue of behavioral change in medicine is complex and historically has not been described in the psychodynamic literature. In fact, within traditional psychoanalysis, discussing issues and events "outside" the analytic setting was discouraged and thought to be merely a tactic to avoid important unconscious dynamics (e.g., Gray, 1973). Clearly, this is erroneous, for modern psychodynamic theory does not hold such a rigid stance about discussing "outside" concerns. Health behaviors such as smoking, drinking excessively, physical inactivity, and diet are important aspects of the psychodynamic encounter and factors that we should not only be informed about, but should consider actively discussing with our patients. An example of how I failed to address these issues early in my career and the consequences may serve to illustrate this point.

Robert was a 49-year-old man who came to see me for chronic pain and depression related to a number of failed back surgeries. He was difficult to engage in treatment and found the “space” afforded to him in a 50-minute session to be difficult. He wasn’t sure what to discuss and attempts to engage him in talking about his current family or relational life were strained and awkward; talking about his early family life was even more problematic. Despite this, he remained in therapy for many years and eventually achieved a measure of control over his pain, though he remained on disability leave due to the extent to his injuries. I noticed that over the course of about a year, Robert gained about 15 pounds. Although I was aware of this weight gain and made vague references about exercising (as this was part of his regimen for managing his pain), I never addressed the issue of his weight directly, and I never asked about his diet. Although through modern-day transference interpretations, I tried to discuss his difficulties in feeling responsible for his health, these interpretations were not meaningful to Robert. For example, I tried to address his sense of “waiting” for a cure and his feeling that others should be responsible for his health. Robert reported one day that he was urinating excessively and was planning to see his physician. Following that visit, Robert told me that his blood sugar was extremely elevated and that he was diagnosed with Type II diabetes. He told me that his physician informed him he was consuming too much sugar; for example, he drank three cups of coffee a day with five teaspoons of sugar in each cup.

Although it is likely that had I been more proactive in addressing Robert’s health behaviors the outcome would have been no different (as he later demonstrated that he did not want to proactively address his health), I use this example to illustrate the difficulties of addressing health behaviors in treatments that may have more of a psychodynamic influence. Since his health had become relatively “stable,” and the focus of therapy was on his on-going depression, I was unclear about whether or not I should make his weight an issue of treatment. As I had begun a more psychodynamic treatment with him I had been loosely following the “rule” of free association, the idea that what gets discussed in therapy is what the patient brings forth, what is on the patient’s mind, rather than that of the therapist. This idea, which is rooted in traditional psychoanalytic theory, is meant to allow space for transference to develop. Although the concept of transference will be described further at the end of this chapter as well as Chapter 5, for more concretely oriented patients such as Robert transference interpretations are not particularly useful, especially in the absence of patient-reported anxiety. Robert was not aware of anxiety. His focus tended to be more external. And although he dutifully came to therapy, Robert frequently “reported” to me the events of the previous week and there was little room for me to intervene.

My passivity in Robert’s situation did not allow confrontation for what turned out to be an emerging health problem and overall difficulties in taking care of his body. Though my “miss” regarding his weight was a way that I could understand more about how Robert avoided thinking about his health. It seems likely that my not addressing his weight was in effect in collusion with his own defensive system. Robert struggled with a deep denial of his own responsibility for his health. He felt angry and cheated by the surgeons who performed his back surgeries and that these procedures did not result in more symptomatic relief. It is often anecdotally noted that some people who seek out multiple back surgeries are looking for cures that may not exist. Millions of people suffer with back pain and not all of them ask for surgical treatment. The fact that Robert had several back surgeries does not prove

that he did not want to take responsibility for his own health. However, it added credibility to the hypothesis that Robert wanted an external cure to relieve his back pain. Throughout his treatment he struggled to take care of himself in a number of ways. Over the next several years, Robert had other health problems that were not addressed and he was very noncompliant with many forms of treatment. He seemed to be caught in an unending cycle of seeking out physicians for medical problems and then refusing to cooperate with treatment, feeling that the treatment options were not suitable for him because he was not well understood by his medical clinicians, whether or not treatment involved major behavioral changes. This was one reason his pain had persisted; less intrusive options than surgery were offered to him, but he refused, expressing that he did not want to feel any pain or discomfort from the procedure. Over time, it became clear that Robert wanted to be taken care of and that he wanted the responsibility for his health to be a problem that others would address. He wanted to be taken care of, but his anger about this desire was externally oriented in his medical and mental health caretakers, who were never able to help him to his satisfaction with his pain and suffering. Robert idealized the potential for help within modern medicine, but when he did not get the cure he hoped for, he devalued this potential, which he ultimately used to justify his noncompliance.

Since medical patients often present with more concrete issues, which are reinforced by a materialist medical system, it can be hard for psychodynamic clinicians to know how to interpret physical and psychological suffering and the impact of this suffering on health behaviors. Traditional psychoanalytic approaches have focused on addressing transference, yet with patients such as Robert, we need to develop a new approach and integrating ideas related to health and health behaviors can be one way to participate in conversations about the body, with an aim toward understanding the workings of the mind. Perhaps in part due to the sometimes over aggressiveness in medicine, we feel the pull of not wanting to be overly assertive with our own agendas and wanting to focus on what the patient feels is important to discuss. For Robert and I, once we were able to discuss in more detail his thoughts about needing to take care of himself we were able to identify feelings of anger about having to be responsible for his health and his wish that others could do this for him. In terms of transference interpretations, the last case in this chapter should help with understanding when transference interpretations are useful, as the presence of anxiety is often a key for knowing how and when to interpret the muddy and complicated transference issues patients present.

Technology and Idealization

Considering his specific issues, one might surmise that the negative and hypomanic aspects of the medical system in this country would be a perfect complement for someone like Robert. For people who are focused on the body, hope for more concrete solutions, and expect to be frustrated and disappointed by others, the medical system can be a perfect fit. Modern medicine offers cures, and even in cases in

which treatments are not good enough, many patients (and physicians) never have a real discussion about the limits of medicine and where personal responsibility should override medical interventions. The illusion of unlimited capacity for cures is one component of a hypomanic medical system (e.g., physicians who have trouble admitting to patients the limits of medicine) and can be reflected in those patients who want a cure, but cannot really imagine how to navigate the difficult sacrifices and frustrations that involve the work toward better physical health. Hypomania is seductive; whether we employ hypomanic defenses ourselves or get drawn into a hypomanic system, we are putting ourselves at risk of avoiding our emotions and denying our limits and responsibilities.

Denial and related noncompliance are aspects of how a hypomanic medical culture can interact with patient dynamics, especially when patients have difficulties taking care of themselves. Some physicians may feel so frustrated with noncompliant patients that they themselves may rely more on relatively easy, concrete solutions such as prescribing medication as a way to treat a large number of patients who may not be able to change behaviors in order to manage common medical conditions. Of course, one would not expect that a physician would ignore a patient's high blood pressure when they cannot make behavioral changes; medication is needed in order to prevent more serious medical consequences. In addition to the development of sophisticated medications, other kinds of technological innovations have dramatically changed the landscape of the medical encounter. Although there are many legal, ethical, and psychological implications to the phenomenal advances in medical technology, an important psychodynamic issue is how technology has taken a role in the provision of patient care. To use the example of heart disease (the current leading cause of death in men and women in industrialized nations), in the past, a physician might have spent considerable time talking to a patient about their health behaviors. Today, highly sophisticated technological equipment has dramatically changed the field of cardiology, in that procedures are now rapidly employed for patients with acute cardiac events. For example, cardiac catheterization, in which a cardiologist places a catheter into the arteries that supply blood flow to the heart in order to identify significant narrowing of the arteries, now has a central place in the treatment of heart disease. Though some cardiologists still talk with patients about health behaviors, they now also engage in more physically aggressive treatments to deal with the symptoms of heart ailments. This puts cardiologists in a different position than in the past. For example a recent patient received a cardiac stent to prevent further narrowing of an artery. He reported that his cardiologist did not discuss needed dietary changes that will help prevent the worsening of his heart disease. Although this patient is compliant with his medications, he was unaware (until he and I discussed it) what kind of diet is optimal for someone with heart disease. As this example suggests, procedures such as cardiac catheterization may replace the priority of talking with patients who have heart disease about their health behaviors. In an ideal world, cardiologists and other physicians who deal with patients with heart disease and other serious illnesses might also be available to talk with patients not only about diet and health behaviors, but also about the emotional distress associated with their disease. Sadly though, with the advent of modern medical technologies,

extensive consultations with patients are less likely to occur. It is more common that the increasing role of technology makes physicians less able to act in a talking role. This is different than other times in the history of medicine when the doctor–patient relationship was primary.

Advances in technology have not only changed the role physicians play in the lives of patients, but have also changed the expectations of patients. Many people feel that medications and technology can treat most medical problems, and of course this is true. However, this too often leads to the assumption and desire that medical problems can be *easily* solved through medications and medical technology. This is not necessarily true. Cancer patients may be able to be cured, but they have to undergo painful surgeries and treatments such as chemotherapy and radiation, which have very unpleasant side effects. Patients can receive solid organ and bone marrow transplants, but the side effects of these procedures as well as the often drastic behavioral modifications some people have to make serve as a reminder that technology and medical treatments are still difficult, painful, and require an active effort on the part of patients.

Modern medicine has increased the capacity to extend life; however, many patients expect even when ill quality of life will not be sacrificed. Though it is true that many patients can have a long life despite severe illness, the following case demonstrates in more detail how patients feel regarding quality of life limitations:

Joan is a 78-year-old woman who was transported out of Germany in the early days of the Nazi occupation. Several of her family members perished in concentration camps. Though she had a good life in the United States, she developed severe kidney and heart disease in her early 70s. She had a number of “close calls” and almost died several times in intensive care units. Many advanced life-saving methods were used to keep her alive. Though living, Joan had a number of physical limitations that included dietary restrictions, difficulties socializing with friends (as many days she could not get out of bed), and intense physical pain and discomfort. As a highly self-sufficient woman, being limited due to her disease was demoralizing: She hated dialysis treatments, she disliked having to limit her diet, and most of all she resented the physical effects of her disease, which included painful swelling in her hands and feet as well as frequent nausea. She needed a caretaker to help her get dressed as well as bathe and to use the bathroom. When I spoke with her physician about her case, and remarked that Joan felt burdened and depressed by her disabilities, her doctor told me about all of Joan’s close calls while hospitalized and suggested that Joan was expecting too much. He then said, “We saved her life, what does she want?” Joan’s feelings were much different, however. She wanted to feel better. She felt angry to be alive in such an impaired state and felt especially cheated that she could not enjoy the foods (particularly those that were high in sodium) that she had previously preferred. In the context of her traumatic background, Joan felt that her kidney failure and heart disease was an unceremonious end to a life in which she had survived seemingly far worse trauma.

Joan felt that although she was alive, the life she led was not really “living,” and of course, these feelings are valid and understandable. Her life, compared with how she knew it before, had been extremely comprised. Not that long ago, Joan would have died from her illness. Medicine prolonged her life and the extension of Joan’s life is an example of a new generation of older patients. Not only is there shock and dismay for people like Joan in living with reduced physical abilities, Joan’s limitations allowed her the unwanted space of grieving the multiple losses in her life,

including family members who had died in the Holocaust, as well as other aspects of a painful and unjust life. However, her perception was that she was surviving these traumas quite well until her illness took over. For many trauma survivors, the use of hypomanic defenses such as distraction, continually moving and not thinking in an emotional way, are key factors in the prevention of severe depression, and will be further considered in the next chapter. However, in terms of the present discussion, for Joan, the advances in medical technology that had made it possible for her to physically survive, meant little. Though the comment from her physician sounds harsh, his point of view is understandable. He likely felt devalued in the face of Joan's complaints. Medical technology, which at times is capable of prolonging life, requires the presence and expertise of a physician. It is the interwoven relationship between medical professionals and technology that complicates expectations of doctors. The idea is that physicians should "cure," not simply prolong life in a compromised state. This dynamic was articulated by a doctor who reflects on his own as well as his father's career in medical practice: "My father's patients regarded him as a god. Now patients treat you as one and demand miracles. You know it all (or ought to) and you cannot let a patient die no matter what" (Bhargava, 2001).

This fascinating quote reveals many aspects of the dilemmas of both modern medicine and the idealization of both physicians and technology. Regarding the physician as a "god" suggests that in a time when technology was less central in the provision of medical services, patients could more easily have the *fantasy* that the physician is superhuman and can bestow omnipotent benevolence and cure all, as the character of the physician and the medical relationship was primary. It also reflects the problems that often occur when fantasies are enacted in reality. The ominous nature of the following sentence, "Now patients treat you as one and demand miracles" suggests how dangerous it is to really believe that one's physician is more than a caring human being well trained in their field of expertise. The contemporary overvaluation of technology suggests that the tools physicians have at their disposal give them god-like powers to miraculously cure their patients all the time. Finally, Bhargava's remark suggests what can happen to physicians in the face of expectations to always heal, no matter what. The idea that doctors "can't let anyone die" feeds the illusion among patients and physicians alike that patients can be kept alive under any circumstances with the aid of technology.

The wish that technology can "take care" of any medical problem is closely associated with the concept of denial. Many patients wish that their physicians were omnipotent healers who can cure the most serious of diseases. When physicians are perceived this way, it is less likely that patients will have space to think about their own mortality, or for some people, the even more uncomfortable thought that they could have taken better care of themselves. This belief is reinforced by the reality that doctors can now do more than ever before to help patients with severe diseases. It is easier to focus on doctors abilities or lack thereof, than to think about the idea of limitations in medicine and of the body. Complicating matters even more is that physicians are themselves vulnerable to the feeling of omniscience. Medical professionals often go into medicine with the conscious idea that their careers will involve the saving of lives as well as the promotion of good health. Although it is true that

with the help of medications and technology, physicians can help people live quality lives even with serious illness, diseases are still the cause of death and severe disabilities in many people. And while some illnesses are caused by health behaviors (such as when a heavy smoker contracts lung cancer) many ailments and injuries occur randomly. Genetic predisposition and unfortunate timing explain a number of negative outcomes. For example, hematological disorders such as leukemia strike children and adults of all ages and yet the cause is unknown. Random accidents are responsible for many trauma cases and can be due to unpredictable circumstances, such as when a person gets hit by a car in a crosswalk. These realities are difficult for many young adults who enter the field of medicine to integrate into their understanding of what it means to provide care to their patients. If one were to stop and take in the emotional aspects of the everyday traumas in healthcare, it could be difficult to bring oneself to practice medicine everyday with confidence and optimism. For physicians, feeling more powerful than they actually are (i.e., perceptions of omnipotence) may be one way to manage the intense feelings associated with the traumatic situations they see every day. On the other hand, avoidance of feelings can be brought to extremes, as when physicians and medical staff often go to great lengths to avoid painful emotions and the difficult aspects of vulnerability encountered in the medical setting. An unsettling dynamic I have personally observed in both medical and mental health professionals (especially mental health professionals who work with medical patients) is the tendency to blame patients for their illness. This emotionally defensive strategy puts the vulnerability in the “other” (the patient) and removes the emotion of fear from the medical clinician. While it is true that many poor health behaviors cause illness and that noncompliance is a common problem in medicine, assigning blame to a patient does little to ease the reality of the situation, for both patients and clinicians. Assigning blame to patients is one way to gain a sense of control regarding the uncertainty and randomness of many illnesses. So, while some patients may soothe themselves with ideas and fantasies that technology can “take care” of disease, physicians and other professionals who work with medical patients may adopt the perspective that if their patients had treated their bodies better in the first place, the disease may have been prevented. Unfortunately, neither stance is completely true nor serves to resolve the feelings about the realities and unfairness of illness and human suffering.

Looking for Love (and a Cure): Medical Relationships

Although faith in technology perpetuates the illusion that physicians are omnipotent healers and that with the help of modern medical equipment, many, if not all ills, can be cured, this dynamic is not solely due to the use of technology. From a psychodynamic perspective, we can easily understand how physicians could be subject to intense idealization and devaluation based on the ways that we understand human development and psychology. In other words, despite the influence of technology in contemporary healthcare, the relationship between doctors and patients remains

primary, and as such, is associated with the common dynamics one would expect in any relational encounter. When people are ill, they expect to be healed, the normal wish we all have as children. Good parents provide nurturing care for their children when they are sick and ease their discomfort. Likewise, it is understandable that we would all wish that our physicians serve a role as sympathetic healers. For many, though, when this does not happen in our adult lives, we can turn to our friends and families for this kind of support. In such cases in which a physician is not as comforting as we would like them to be, we can choose to not take it personally, and understand that although we wish for more from our physicians, that we may simply not get it. This is a disappointment most of us can bear, and we move on. For some patients, however, the disappointment is too much to take, and the feelings (often related to past disappointments) get re-experienced with their attending physician. Consider the example of Denise:

Denise was a woman in her 30s who required the implant of a defibrillator (a device placed in the wall of the chest to deliver an electrical shock for people who have life-threatening problems with the electrical conducting system of the heart). She was well liked by her cardiologist and was noted during her frequent hospitalizations to be a “good patient.” This outward behavior, however, was masking intense feelings of mistrust and hatred that Denise felt toward her cardiologist. When she entered therapy with me, Denise was troubled by intense anxiety, initially thought to be due to a problem with her defibrillator firing unexpectedly, which causes a great deal of anxiety for most patients. However, eventually it became clear that she felt intense anger toward her cardiologist, though the reasons for her feelings were unclear to both Denise and myself. Denise understood rationally that her cardiologist had helped her a great deal, yet found herself feeling extremely anxious before her follow-up appointments; eventually we related this to her angry feelings toward her cardiologist. She felt that her cardiologist did not care about her and admitted that she tried to “drag out” her questions to see if she could get her doctor to spend more time with her. She left her appointments feeling angry and empty, even though her health had improved dramatically.

Denise’s example, not uncommon among many patients who manage aggressive feelings though being overly “nice,” illustrates the common dynamic of transference as it often occurs in medical settings. Freud (1893–1895) initially described transference in as a “forbidden wish” (p. 303) and a “false connection” (p. 304) that others will meet needs that have not been met previously. Freud (1900) expanded the concept of transference in when he described it as a “displacement of psychical intensities” (p. 307). The idea then is that transference is in action when we impose our wishes and feelings toward some other person in our adult lives to the feelings related to those who were our primary caretakers when we were young. In my experience with medical patients, transference dynamics are at their height in those who are unaware of ambivalent or difficult feelings toward their parents. When I initially met Denise, she told me that her family situation had been good and that she enjoyed amiable relationships with both parents. Over the course of long-term therapy, however, I discovered that Denise did not feel so positive toward her mother and that she felt that her mother was intrusive and overbearing. Although Denise did not like the intrusive nature of her interactions with her mother, she found that in the absence of this dynamic, there was little her mother could offer her in terms of emotional intimacy. She was very conflicted about her relationship with her mother, as she

associated closeness with intrusiveness, but knew on some level that a caring, nurturing relationship between a mother and daughter had to involve more than intense, overbearing interactions. While this was eventually sorted out more in the context of her therapy, it became clear that part of her problem with her cardiologist was that her doctor was not engaged enough with her, and like many specialized physicians, was somewhat detached. Denise felt the detachment from her cardiologist meant that she did not care about her. However, her cardiologist was quite fond of Denise and spoke very highly of her. It became clear that Denise felt that interactions with pronounced boundaries indicated dislike or worse, the threat of a lack of love.

Though Denise's individual psychology explained a great deal of how we eventually understood her feelings about her cardiologist, and by discussing these feelings we were eventually able to get a better sense of her experience of her parents and how these experiences impacted her present day relationship with her cardiologist, it is understandable that many patients find physician detachment uncomfortable. Although it would be ideal for doctors to be emotionally available as most of us long for our doctors to be caring and sympathetic, it may be unrealistic to expect them to always be emotionally present. Though one hopes that physicians are able to be present "enough" to not blame patients for their illness and to treat them with kindness and respect, some detachment could be viewed as adaptive. As previously discussed, the many demands on physicians, including the large numbers of patients doctors must attend to (many with traumatic medical conditions), and the fact that some specialty and procedurally oriented physicians need to be detached to some extent in order to successfully carry out their work, creates a scenario in which doctors need some measure of detachment in order to bring the integrity and professionalism to the practice of medicine we expect from them every day. Especially for those physicians who regularly perform highly sophisticated procedures, such as surgery, a degree of detachment could actually be considered ideal. This perspective on detachment and the way it creates room for our work as mental health clinicians was well articulated by Core and Pugh (2001):

The nature of the need for medical and surgical intervention often requires the organization to operate in such a way that feelings are denied, and the use of the defenses of splitting and projection dominate. Counsellors in medical settings may, therefore, allow the health carers to continue to do their tasks that require this 'process of detachment' while providing the listening and response required by the patient. (p. 9)

These British authors take a very different stance on physician detachment. They provide a normalizing context for physician detachment and also point out that mental health professionals can serve in the role of helping patients deal with emotions, as our jobs do not require the kind of emotional detachment asked of physicians. In fact, being emotionally present is needed in order for us to do our jobs well. Core and Pugh seem to be speaking of the desire implicit in transference that physicians can "do it all." These authors remind us that in reality, we cannot ask physicians to be all things at once. This does not mean that our patients are not entitled to disappointment when they find shortcomings with the limits of emotional availability in medical care; rather, it means that being sympathetic to both patients and physicians might be an effective and humane way to approach the complicated dynamics

in medicine. Labeling transference feelings regarding physician attachment can be useful to some patients; on the other hand, it is important to validate the reality that many physicians are detached in their patient relationships. And as noted regarding Robert, transference interpretations are simply not useful for some patients. For example, Denise was anxious enough that she could benefit from a more nuanced understanding of her reaction to her physician. Her anxiety caused Denise to question the intensity of her reactions. However, it was also crucial that I validated Denise's feelings that her physician was not as emotionally available as she might have liked. This allowed Denise the space to consider whether her expectations of her cardiologist were realistic. Holding both realities in mind – the interpersonal problems that occur in medicine, and that unfulfilled wishes of patients may be linked to past disappointments – allows space for patients to understand more about their own feelings of loss and the realities of limitations that occur in the body and in the culture of medicine.

Conclusion

As people in the twenty-first century live longer than ever before, we are subject to increasing medical problems as well as the disappointment of failures related to reduced physical functioning. In this context, idealization and hypomania serve many purposes. They prevent devastating aspects of bodily decline, yet allow people to hold on to the hope that their healthcare needs will be met, as well as receiving “cures” from a powerful authority. The hypomanic culture of medicine is the perfect scenario for transference feelings to emerge, and the idealized wish that physicians can cure all and be sympathetic healers. Technology plays into idealization in that there is seductive hope for curable treatment when in actuality a cure may not exist. Physicians are vulnerable to the dynamics of being omnipotent healers, as they themselves experience vicarious trauma on a day-to-day basis with often little emotional resources of support, at least within the fast-paced and emotionally avoidant field of contemporary medicine. Without support and help in dealing with the traumas physicians face, grandiosity and omnipotence can take over and result in physicians feeling that they can offer more than they can, which makes the dialog about the realities and limits of medicine difficult. In this scenario, both patients and physicians suffer from a loss of real human connection.

The complicated dynamics inherent in human psychology suggest that idealization and devaluation are intrinsic and are to be expected to some extent in many encounters in which vulnerable and sick people seek out professional help for healing. As people age and experience more acute and chronic illnesses, we are faced with unprecedented numbers of patients for whom we need to be able to interpret and understand powerful emotional reactions.

The interrelationships in medicine are complex, and it is tempting to blame physicians for getting caught up in omnipotent ideas regarding their role as healers. Conversely, it is easy to blame patients for their own culpability in their illnesses.

Neither stance is completely true. The reality is that there is an uneasy tension between the problems of modern medicine and patient responsibility. The medical community is confronted with overwhelming expectations from patients to cure any health issue, from relatively benign conditions to serious diseases. Patients want to be cured and physicians want to heal. This scenario often works out well until a patient cannot be completely cured or attain full recovery. Then, a place is needed in the patient's psyche and emotional landscape for feelings of sadness, anger, loss, and disappointment; it is easy for these feelings to become attached to doctors and the limitations within the field of medicine. As mental health clinicians, we can offer help with the management and expression of these intense feelings, while easing the blow of reality for many patients that there are limits with technology, medicine, and our bodies.

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