

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 can seem limitless. Diseases that were once debilitating or life threatening can now be cured through antibiotics, surgical procedures, and a myriad of technological advances that allow doctors to detect maladies earlier. The growing population of older adults serves as a reminder of how much medicine has changed. For example, those over 75 remember a time when people commonly died of infectious diseases, as antibiotics have only been widely used since the 1940s. Elders describe knowing people who lost their lives to polio, as the vaccine was not introduced until the 1950s. 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, developments in medical science and technology raise a number of important and unique issues that will undoubtedly require increased thoughtfulness 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

¹ Although there have been substantial changes to healthcare coverage in this country, disparities in medical treatment persist. For example, some marginalized populations (e.g., Latino/Hispanic, African-American, Native American) receive inadequate medical care in comparison to white patients. An in-depth discussion of these issues is beyond the scope of this volume, but will be addressed less directly in subsequent chapters.

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, 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 reemergence 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 in the United States is 81 years for women and 76.2 years for men (National Center for Health Statistics, 2014) though many of us will live much longer. For example, it has been suggested that roughly 600,000 Americans will reach the age of 100 by 2050 (Volland, 2012). 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 (a comment echoed by Betsy’s children and grandchildren), 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, excruciating physical pain, 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 debilitating conditions, as they have seen these others live on in a state of limbo, hovering between life and death. They worry intensely about being aware of their own disability, while powerless to do anything about it. 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. In addition, the profound grief that impacts elders who have outlived so many old friends and family and even newer friends they have made is an added burden that can be too much to bear. Through this lens, life can become a constant state of preparing for the next personal loss. And many of us who are not “there” yet must contend with normal anxieties about how we will age and knowing that if we do become ill, we will be confronted with an ever complex, confusing, and, at times, frightening medical system—with or without the support of people we love. This is one of many ways relationships with physicians become more important. For many older adults, the trust and care of a doctor can provide a needed emotional connection.

This chapter will address aspects of an increased lifespan as well as the influence of medical technology in the current landscape of contemporary healthcare. In particular, I will speak to hypomania and idealization in the culture of medicine, how these dynamics are both fueled by and the consequence of advances in healthcare, and

how they affect both doctors and patients. I will also discuss the related issue of the devaluing of medical practitioners. Ideas of what modern medicine is capable of can be falsely seductive, setting up both patients and medical clinicians for extreme disappointment. The ways in which medicine has changed exacerbate expectations from patients and intensify reactions to physicians. It is easier to expect more from physicians, even if these prospects are not realistic, and then to devalue them when they don't deliver. All who are involved in the modern medical encounter feel increased pressure. 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 dissatisfaction, 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* (American Psychiatric Association, 2013) criteria of hypomania, my understanding of the increased activity among medical clinicians 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 excessively active defenses in a developmental context and felt that some people who have particular difficulties rely on a manic style, here I am referring to the common and sometimes adaptive use of manic defenses, hence the use of the term *hypomanic*. Even minimal experience with medical professionals inevitably leads one to appreciate the consequences of a hypomanic culture. Particularly in hospitals, people talk fast, move fast, and think fast. When I was teaching medical students, they lived by the dictum “Eat when you can, sleep when you can, use the bathroom when you can.” Such dramatic inconsideration of bodily needs sums up the frenzied culture of medicine quite well. 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 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. Even decades ago, Winnicott (1966/1996) described the way he experienced changes as a result of a more modern medical culture:

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 hypomaniac 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 this is manifested 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 United States 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, one 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). Further, an article in the *Chicago Tribune* (2013) reported:

Even as rates of obesity and Type 2 diabetes soar, researchers report that doctors are spending less time than ever talking to patients about nutrition because they lack time, training and optimism that patients can make lifestyle changes. Insurance is also more likely to cover procedures than behavioral counseling.

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 over-reliance of medication prescribing 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 United States 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 many patients will not follow medical and behavioral guidance. If a physician suspects that about half of their patients may not listen to their suggestions, 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, especially if doctors don't get paid for counseling. 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. One 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. Bell and Kravitz (2008) reported that among physicians, counseling patients with hypertension regarding lifestyle habits was limited.

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 behavioral recommendations, the tacit message when physicians do not try to explain that patients can control some medical problems through lifestyle changes is one of skepticism, doubt, and perhaps even cynicism. This creates a scenario in which patients may feel infantilized or devalued with the premise they cannot be trusted to take responsibility for their health.

For physicians, 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. However, the behavior of prescribing vs. talking also reflects the hypomaniac 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 attending more severely ill patients are the current practice in modern medicine. Current medical practice in America often has the result of patients feeling objectified, that their problems do 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 the meaning of nonadherence and how patients get caught up in the hypomanic components of medicine. 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. Conscious and unconscious 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 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 as well as our doctors are 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 involves a more explicit expectation. If the wish of the patient is that an omnipotent physician/healer/parent can make bad things in the body "just go away," everyone in medicine is set up to fail.

But as mental health clinicians, we can fail too, by assuming that we can analyze these fantasies without having to talk about health behaviors. The issue of behavioral change in medicine historically has not been described in the psychodynamic literature. In fact, within mainstream 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. Yet it can be difficult to address health behaviors in the context of a psychoanalytic treatment. For example, when I supervise psychiatry residents, who are trained medical doctors, those that get interested in psychodynamic therapy can forget to think about the body. I remember one talented resident trying to interpret unconscious motivations in a patient on a high dose of prednisone, a medication infamous for having the side effect of mania or psychosis. The resident forgot to look at the medication list when considering what might be contributing to his patient's sudden behavioral change.

It's hard to hold on to both mental and physical concerns, especially when we are trying to learn the complex craft of psychoanalytic therapy. I made a related mistake early in my career when I neglected troubling health issues in the patient described below:

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 proved even more challenging. 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 of 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. Instead, through modern-day transference interpretations, I tried to discuss his difficulties in feeling responsible for his health and the wish that his doctors could simply remove his bodily pain. These comments 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. Also, he told me that he consumed at least three non-diet sodas a day and he hadn't realized that all of the sugar he was consuming had put him at risk.

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 I thought his health had become relatively stable and the focus of therapy was his ongoing 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 mainstream 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 7, for people who have trouble accessing their minds, as Robert did, transference interpretations (even about others than the therapist) are not particularly useful, especially in the absence of expressed 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 reach him in a meaningful way.

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 I not addressing his weight was in effect a 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 from 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 recalcitrant in response to any medical advice. 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 any other kind of rehabilitation, such as physical therapy. 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 cared for, and 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 some medical patients 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. Mainstream psychoanalytic approaches have focused on addressing transference, yet with patients such as Robert, we need to incorporate additional psychodynamic approaches 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 modern 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 active 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 nonadherence 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 physician’s 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 and sometimes can have iatrogenic consequences. 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 and painful and require an active effort on the part of patients.

Modern medicine has increased the capacity to extend life; however, many patients expect that 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 to bleak and low sodium offerings (which is often suggested for people who have kidney disease and the kind of heart disease she had), 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, I 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. Joan’s physician then said, “We saved her life; what more 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 that she had previously preferred. In the context of her traumatic background, Joan felt that her kidney failure and heart disease were an unceremonious end to a life in which she had survived 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 compromised. 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 living with reduced physical abilities, Joan’s limitations allowed her the unwanted space of remembering 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 is a key factor 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 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, on-going limitations 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 constraints in medicine and in 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 every day 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 fear 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 discussing 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 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. Allocating culpability 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 advances, 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 desire that our physicians functioned as sympathetic healers. For many, when this does not happen, 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, 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 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 conduction 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. (I will discuss transference in much more detail in Chapter 7; therefore, this is an admittedly cursory introduction.) Freud (1893–1895) initially described transference 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 when he described it as a “displacement of psychical intensities” (p. 307). The idea 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 invasive 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. Denise 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 thought the disconnection 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 thought 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 objectivity 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 emotionally separated to some extent in order to successfully carry out their work, create a scenario in which doctors need to ward off emotions. 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 regarding the emotional distance employed by physicians 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 separation 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. On the other hand, Denise was anxious enough that she could benefit from a more nuanced understanding of her reaction to her physician. 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.

Suggested Techniques: How to Talk with Patients about Manic Defenses

As psychoanalytic clinicians, our world is anything but hypomanic. We see people in the comfort of our offices, with a 50-minute hour as a unique cushion. Even when psychologists work in the hospital, we operate on a different timeline. We don’t spend 5 minutes with people, we try for 30 minutes (60 is a great gift), even though physical therapists or physicians or nurses competing for the attention of our patients may interrupt us. In our offices we try to provide a slower way of thinking and working through things. But some patients are so caught up in manic defenses whether in the hospital or out. And we have to consider how to compassionately slow down the process of hectic thought and communication. Consider this outpatient situation, of a woman seeing me for almost a year, in which I had some success in doing so:

An 80-year-old woman, whom I will call Connie, had an incredibly manic style. Ostensibly, she sought therapy because her husband had been institutionalized for dementia. Though one might expect that she could have been grieving the loss of her husband and partner of 60 years, she frequently described feeling angry at him

for not being “as smart” as he used to be. In fact, she seemed to be having a very fun life with friends, perhaps a relief at not having to be a primary caretaker. Yet, despite what seemed to be supreme coping, she continued to see me and I wondered what she really needed. Though she was superficially open to feedback from me, she frequently acted as if any comments I might make would have little impact. She regularly talked about considering stopping therapy because she was not sure she needed it. I tolerated her style of speaking and relating and offered practical advice when I could. Though at times I felt helpless and irritated, I waited for genuine moments of emotion to occur and then commented on them. The most poignant example of this occurred about 10 months after she started seeing me and is transcribed below. What followed is the last 5 minutes of a session. She had spent the majority of the session complaining about her husband and acknowledging (as we had discovered together) that it would be easier if he were to die:

- TMG: So, in some ways your problem is better in that you have the freedom you always wanted.
- Connie: Yes, I am having fun and I know some people think less of me that I don’t feel guilty.
- TMG: Well, every marriage is different. No one really knows what the inside of a marriage looks like.
- Connie: Yes, but we did have some good moments. (Pause.) I can’t really sit down and relax. I can’t read, even though I love reading. (Follows with worries she has dementia.)
- TMG: I can tell you for sure you have no symptoms of dementia.
- Connie: Thank you for saying that.
- TMG: Trust me, the only symptom you have is some difficulty with attention and even that is minor! Some middle-aged people have more problems with attention than you do. Although there might be a neurological extent of your problems with attention, which may be due to aging, I think it is more due to your anxiety.
- Connie: I am so used to keeping track of things, like I can remember every aspect of a conversation. And when I don’t have that, I worry I am losing my mind.
- TMG: But there is no data for that. As you get older, it might be harder to keep track of things as well as you used to. That is normal, but I think we need to keep track of that worry you have, because you might find it to be really rough if this ability to keep moving and keep track of things changes.
- Connie: When I am nervous I go into a closet, and I gather up a bunch of stuff I don’t need and then throw it out. I feel better then.
- TMG: That is great if that works for you for now. But it might not continue to be so easy, throwing out the trash, throwing out the feelings.
- Connie: Is that what that is? (Smiles. Pause.) It is so hard, holding onto the feelings. It’s not what I have ever done.
- TMG: I know, and it is fine if that has worked for you until now, but I think it is working less well these days.

This exchange illustrates an important way that I deal with most, if not all, patients who come to see me who tend to stay active to avoid feelings. I balance talking about concrete concerns with realistic observations and advice, while waiting for a moment to say something about a manic defense and the ways that this approach may have worked well in the past, but may work less well now. Additionally, I tend to match my speech with that of whom I'm seeing and so I tended with Connie in the beginning of her therapy to match her with quick thoughts and feedback. Further, since children and spouses of those with dementia often worry a great the potential of cognitive decline, I am not shy about providing reassurance to someone who has no symptoms of cognitive decline, again especially in the relatively early phase of therapy.

Although it might seem like I had missed an opportunity to comment on Connie's guilt—even when she brought it up—I intentionally did not do so. I felt that Connie was still too reliant on active coping mechanisms for her to really make use of talking about guilt. If she did respond to a comment about ideas that she could feel guilty, it would have likely been for my benefit and not hers. When she remarked that she thought she could lose her mind after I reassured her that she likely did not have dementia, however, I took that to reflect how intense her anxiety was when she was not employing manic defenses. Her comment about her anxiety ("losing her mind") was what I was waiting for. Though any thoughtful clinician could feel baited by so many of Connie's comments, I knew her well enough to know that seizing on them would likely shut her down. Instead, I waited (while still participating in what could sound like normal, reassuring conversation) to see if normalizing her experience and responding to her pragmatic worries would allow her to feel some anxiety. Anxiety that I suspected was present, but that could only be communicated if I allowed her space to think on her own and with the idea that I was not judging her. It was the case that Connie needed to be in control of even identifying her anxiety, something I had resigned myself to early on. In this situation, what I did worked. It does not always. But Connie had been with me for several months, and she seemed to feel safe enough to think about her contribution to her own symptoms.

If my patient comes in with a clearly manic way of operating, I try to manage such a stance in this way (and sometimes I can say this verbally): "Look, I totally get that you need to keep moving in order to keep yourself from being overwhelmed by what has happened to you. But by your being here, I think we both have the idea that you can't keep up the pace. Your pain, your situation, is a lot for you to have to try to manage. Are there ways we can get you to slow down? I know this might be scary. But what if you did slow down just a bit, and we can see how you handle that?" I did not have that luxury of saying that with Connie at first; she was too hyperactive, and there were too many crises related to her husband's dementia. And so I just waited for her to see herself, albeit with my gentle prodding, that her real reason for seeking therapy really had to do with anxieties about her own aging, as well as her feeling guilty about wishing her husband would die. At the time our interactions had taken place, we had gotten to an understanding that she was severely anxious, in part, because she wanted her husband to die, so she could have the freedom she had longed for. I had already accepted the fact that after 60 years of

marriage, she really had few feelings about her husband and what he was going through. And while I personally could not understand this, I had to adopt a neutral stance and accept that her feelings belong solely to her and are what should inform how I could be ultimately helpful.²

I try to encourage patients with a lot of manic defenses to “collect data” about what happens when they stop or even slow up a bit. How intense is the anxiety when they think of slowing down? Are there thoughts that come to mind when they feel like they need to rest? Once we can identify the manic defense and the panic that occurs when not being overly active, our patients and ourselves can slow down enough to think about what is really underneath the intense need to keep busy. After the session described above, Connie’s presentation changed dramatically. She was calmer and more reflective. She talked about her anxieties about her own aging and her potential to become ill. We even talked about her conflicts regarding spirituality and what would happen after she died. Eventually, we were able to reflect on her feelings about her husband’s dementia. Despite her feeling that he had not been as good to her as she would have hoped throughout the course of her marriage, she was able to express what seemed to be genuine empathy for him, as well as herself, regarding her conflicted feelings.

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, with 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 dialogue about the realities and limits of medicine difficult. In this scenario, both patients and physicians suffer from a loss of real human connection.

²It’s important to mention that it is very common for caretakers and family to have thoughts related to the idea that it might be better if a person with dementia passes away. Connie’s situation was more complicated.

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.

Relationships 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 just as 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 that can hold feelings of sadness, anger, loss, and disappointment. Especially without a wide emotional landscape, 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 that there are limits with technology, medicine, and our bodies.

References

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.
- Bell, R. A., & Kravitz, R. L. (2008). Physician counseling for hypertension: What do doctors really do? *Patient Education and Counseling*, 72(1), 115–121. doi:10.1016/j.pec.2008.01.021.
- Bhargava, R. (2001). What happened. Rapid responses to survey: Why are doctors unhappy? *BMJ*. Retrieved March 14, 2008, from <http://www.bmj.com/cgi/eletters/322/7294/DC2#14377>.
- Core, E., & Pugh, K. (2001). A review. In P. Thomas, S. Davison, & C. Rance (Eds.), *Clinical counselling in medical settings* (pp. 5–23). East Sussex, England: Brunner-Routledge.
- Deardorff, J. (2013, March 26). Prescription for nutrition. *Chicago Tribune*. Retrieved November 1, 2014, from http://articles.chicagotribune.com/2013-03-26/health/ct-met-heart-nutrition-20130326_1_mediterranean-style-diet-heart-disease-diet-and-nutrition.
- DiMatteo, M. R. (1994). Enhancing patient adherence to medical recommendations. *Journal of the American Medical Association*, 271, 79–83.
- Freud, S. (1893–1895). The psychotherapy of hysteria. Studies on hysteria. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 2, pp. 253–305). London: Hogarth.
- Freud, S. (1900). The interpretation of dreams. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 4, pp. ix–627). London: Hogarth.
- Gray, P. (1973). Psychoanalytic technique and the ego capacity for intrapsychic activity. *Journal of the American Psychoanalytic Association*, 21, 474–494.
- Heaton, D. C., & Frede, S. M. (2006). Patients need for more counseling on diet, exercise, and smoking cessation: Results from the national medical care survey. *Journal of the American Pharmacists Association*, 46(3), 364–369.
- Klein, M. (1940). Mourning and its relation to manic-depressive states. *International Journal of Psychoanalysis*, 21, 125–153.
- Linsk, J. A. (1993). American medical culture and the health care crisis. *American Journal of Medical Quality*, 8(4), 174–180.
- McKinlay, J., Link, C., Arber, S., Marceau, L., O'Donnell, K., & Adams, A. (2006). How do doctors in different countries manage the same patient? Results of a factorial experiment. *Health Services Research*, 41(6), 2182–2200.
- Mellen, P. B., Gao, S. K., Vitolins, M. Z., & Goff, D. C., Jr. (2008). Deteriorating dietary habits among adults with hypertension: DASH dietary accordance, NHANES 1988–1994 and 1999–2004. *Archives of Internal Medicine*, 168(3), 308–314.
- National Center for Health Statistics. (1999). *U.S. decennial life tables for 1989–1991. Some trends and comparisons of United States life table data: 1900–1991* (Vol. 1, No. 3). Hyattsville, MD: Author.
- National Center for Health Statistics. (2014). *National vital statistic report, Health, United States: 2013: With special feature on prescription drugs*. Hyattsville, MD: Author.
- Ory, M. G., Peck, B. M., Browning, C., & Forjuoh, S. N. (2007). Lifestyle discussions during doctor–older patient interactions: The role of time in the medical encounter. *Medscape General Medicine*, 9(4), 48. Retrieved July 3, 2008, from http://www.medscape.com/viewarticle/565280_1.
- Volland, A. (2012). Do you have what it takes to live to 100? *U.S. News and World Report*. Retrieved November 30, 2014, from <http://health.usnews.com/health-news/articles/2012/05/11/do-you-have-what-it-takes-to-live-to-100>.
- Winnicott, D. W. (1996). On cardiac neurosis in children: 1966. In R. Shepherd, J. Johns, & H. T. Robinson (Eds.), *Thinking about children*. New York: Addison-Wesley.

Psychodynamic Perspectives on Aging and Illness

Greenberg, T.M.

2016, XV, 209 p. 57 illus., Hardcover

ISBN: 978-3-319-24287-3