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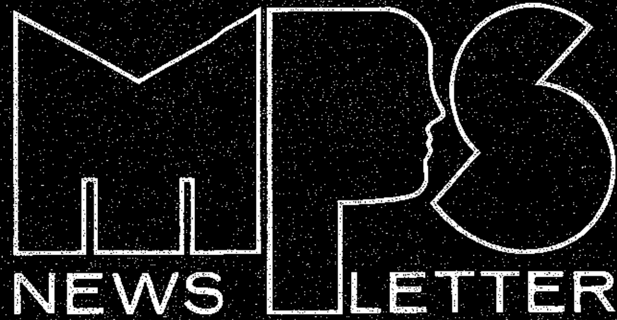

TREATING EMOTIONALLY DISTURBED PHYSICIANS

By Reuven Bar-Levav, M.D.

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The rate of suicide among psychiatrists is reportedly higher than that of physicians in any other specialty, and the rate of suicide of physicians is higher than that of the general population. These strange phenomena may be explained in the fact that many physicians enter medicine, as many psychiatrists enter psychiatry, unconsciously wishing to find answers to personal conflicts in a less threatening manner than undergoing personal psychotherapy. Such physicians bring into their professional lives unresolved emotional difficulties, and the popular myth that "shrinks are crazy" is perhaps not altogether slanderous. In addition, repeated exposure to emotionally disturbed patients sensitizes psychiatrists to feelings in general, and they are more likely to succumb to emotional pressure at moments of extreme stress.

A recent meeting of the Michigan Psychiatric Society devoted to "The Suicidal Physician" inadvertently focused attention on one additional cause for the high rate of suicide among physicians: They are likely to get only inferior therapy when they fall ill and become desperate. The presentation, representing the expertise of several senior psychiatrists, made it starkly clear that impaired or suicidal physicians, psychiatrists and other, are not likely to find proper therapy because their own fears prevent them from seeking help. More shockingly, their illness brings forth much anxiety in physicians charged with their treatment. Such anxiety, resulting from over-identification with an impaired or suicidal physician, is hopefully the reason for the basic flaws in clinical judgment.

Involvement with a sick or suicidal physician is a graphic reminder of the vulnerability of us all, including those touched by the magic powers of Medicine, and may cause physician-patients to receive unsatisfactory therapy when they need it most.

This writer recently had the need to struggle with the frightening aspects of being helpless, and therefore of having to ask for help from others. This task was most difficult because consulted physicians related in a collegial manner to allay their own anxiety in facing a person very much like themselves who had become ill, with debility and even death suddenly looming so closely by. Well-meaning and normally competent physicians tended to treat me, therefore, less thoroughly than they would have otherwise. Such seemingly kind treatment, during which I was generally addressed as "Doctor" was apparently designed to make *me* feel better, but in reality it probably was chosen to help those around me cope with their own impending panic. Indeed, I liked very much being called "Doctor," because it helped me overcome my fear of being a patient. But it delayed my placing myself in the hands of a competent physician, to my own detriment. I, with my understandable fears, almost joined my physicians with their similar but less justified fears in a pact of denial of the seriousness of my symptoms and the urgency of my need for good medical attention.

The same is even more true in the approach to the emotionally sick or suicidal physician. Yet firm recommendations were made at the MPS meeting that such physicians be treated in a "collegial" manner, and nobody questioned such recommendation. An episode was presented as an example of therapy in which the wife of a sick physician conspired with a psychiatrist to "treat" the husband without his knowledge or consent, continuing to do so over many months, thus providing a reality basis for his paranoid and unrealistic fears. It is not surprising that such treatment ended in tragedy. It is surprising and very troubling that such a case was used as an example of proper therapy, and that its validity was never questioned.

The recommendations of the team responsible for the presentation at the MPS meeting were couched in terms of certainty and in an all-knowing tone, as if they were unquestionably true. Psychiatric opinion often has such a self-congratulatory and authoritarian ring. It does not encourage scientific doubt nor further exploration of the truth. Questioning the validity of data and requiring proof of all findings are obviously basic tenets of the scientific method and have advanced the natural sciences. The relative absence of such an approach in psychiatry is probably a remnant of the early days of psychoanalysis, when beleaguered analysts assumed a posture of authoritarian defensiveness in order to survive in a hostile environment. Such an anachronism is perpetuated only because it serves the self interest of a small group of practitioners who proclaim themselves experts. It impedes the art and science of psychotherapy.

Opinions are frequently offered as statements of truth, as if handed down from on high. Since they are often identified as extensions of the person who offers them, questioning and doubting may seem to be personal attacks. Such a situation need not exist and should not be allowed to interfere with an objective and unhampered pursuit of better ways to treat our patients. It is indefensible and psychiatry can ill afford it.

My own clinical observations have repeatedly demonstrated that the most difficult and the most important single step in the treatment of impaired physi-

cians, including psychiatrists, consists of helping them overcome the reluctance and fear of admitting that they are really ill and need help. Contrary to the recommendations made by the MPS team, it is difficult but always imperative to not compromise with reality and, instead, to help sick physicians become patients, rather than cater to their understandable fear which is responsible for their wish to remain colleagues. A great deal of sensitivity, skill and firmness on the part of the therapist is required, as well as respect for the difficulties of the patient's struggle without yielding to them. Much courage on the part of the sick physician is also required for him to give up the omnipotence of being a helper for the relative impotence of one in need of help. But it can be achieved. When it is, the physician now patient often senses a great deal of relief. He or she finally realizes, consciously or unconsciously, that symptoms are not so terrifying to a physician that they need to be denied. By accepting the impaired physician with his illness as a sick individual, the first step toward recovery has been taken.

Physicians use the fact that they themselves are healers and have collegial relationships with other physicians to resist the frightening prospects of non-being. To deal with the manifestations of this resistance as if they were aspects of reality is to participate in the distortion of reality, which is at the root of emotional illness and guarantees its continuation. Reality distortions for any reason bring about the ultimate failure of therapy, even if in the short run magic improvement occurs for other reasons.

A true therapeutic alliance requires that a psychiatrist have no direct relationships, secret or even open, with persons who are significant in the life of the patient without the latter's full knowledge and physical presence. Seeing a wife, for instance, without the patient's presence but with his consent, might well be a delaying interference. Such consent is often given out of unrecognized or denied fear and without real choice on the part of the patient. Such treatment relegates the patient to a position of incompetence, like that of a child. A physician who is impaired to such a degree probably ought to be hospitalized, with or without his consent, and in any event his license to practice medicine ought to be revoked for the duration of his incompetence.

Such seemingly cruel measures are dictated by reality and they are, in fact, the kindest and the most appropriate treatment in the long run. Such measures offer hope that such a grossly impaired physician may be restored to health and functioning, for he would no longer need to hide his illness and would be able to obtain proper medical care without shame or guilt. Harm would not be inflicted on unsuspecting patients, thus protecting the public, the reputation of the medical profession, and the doctor's license to practice medicine, once he has recovered. The most respectful way of treating such a physician, it regards him as a man rather than a superman whose efforts to deny and hide his illness from himself and others can be understood as desperate efforts to survive.

The fact that the very determination of disability presents such a complex problem is a sad commentary on the competence and the scientific objectivity of psychiatrists. Any three reasonably competent psychiatrists should have been able to come up with such determinations without difficulty. Yet, this obviously is not so. Unresolved personal problems and totally different frames of reference have made it virtually impossible for any three psychiatrists to agree on more than gross findings, producing chaos and confusion about the point at which a physician becomes too disabled to practice medicine. Pious self-congratulation is hardly in place. Urgent expansion of our knowledge is.

The points made above must not be regarded as merely philosophical ruminations. If valid, they have direct and immediate relevance to the treatment of sick or suicidal physicians, including psychiatrists. They may offer hope of lowering an unnecessarily high suicide rate among physicians, as the following clinical example may illustrate:

A psychiatrist in his 50's has been in therapy for approximately three years. This is his fourth therapeutic involvement, having previously undergone two courses of long-term psychoanalysis, lasting three to four years each, and one experience of shorter duration. His immature personality and life-long depression did not prevent him from functioning as a reasonably successful physician, for in the office setting he used his best judgment and experienced the most mature aspects of his being. After work, however, he was typically anxiety ridden and usually helped himself daily with regular consumption of alcohol. He was involved in several serious car accidents and in other bizarre, self-destructive behavior.

Although seeking therapy, he nevertheless requested the initial interview under the pretense of wishing to learn how to conduct therapy groups. It was difficult for him to admit that he was in serious trouble, although he did so verbally in the first session, but it was obvious from his fantasies that he had not now nor at any point in his previous therapies dared to really experience himself as sick. Even the provocative group setting was not sufficient to break through his physician-defense, and in individual sessions he spoke as a patient but usually felt as a fellow colleague. At one point he related an episode in which he treated an alcoholic and depressed woman patient. The fact that from time to time he somehow found occasion to relate such episodes from his practice was, in itself, usually a manifestation of this resistance. His judgment as a physician and as a psychiatrist seemed grossly impaired in this case, and when this was pointed out to him, he reacted by expressing some resentment, a small fraction of his great rage, and by typically skipping the next two sessions. A

very viable and unusually strong therapeutic alliance, developed over time with the aid of special techniques, kept the patient from bolting therapy altogether and allowed repeated intrusions into this and similar highly charged areas. He seemed, upon returning, to have totally forgotten the old issue, and when it was provocatively brought up the patient was no longer able to continue hiding his previously repressed rage, which he had assiduously kept in tight check throughout life. He accused his psychiatrist of being unfair and persecutory in grossly exaggerated and unrealistic terms. It turned out to be a major development in his therapy.

As the patient's rage eventually subsided, he was able to recognize the exaggerated nature of his reactions. His working-through of these distortions served as the opening via which he began a long-overdue review of memory distortions regarding his real father. The father he incorporated for over half of a century always seemed cruel, physically violent, insensitive and abusive. With this distorted memory as the main excuse, the patient repressed his rage, failed to fully mature as a man and often identified with the woman, who was perceived as the protector as long as he behaved like a good little boy. Only as he hesitatingly corrected these distortions did his life-long depression begin to lift, and only then did victory in his battle against alcoholism begin to seem possible. Therapy did not really begin to be effective until the patient could no longer fantasize himself a colleague and, instead, reluctantly experienced himself as a patient.

This very incomplete clinical capsule is offered to illustrate some of the pitfalls and promises involved in treating impaired physicians. The issues that complicate the problem involve not only psychotherapeutic philosophy and technique but also the self-image of psychiatry as a profession. The very lives of patients, not only physicians, depend on rational clarification of these knotty questions.

The discussion at the conclusion of the MPA meeting on "The Suicidal Physician" was, of necessity, too brief to be exhaustive. It may be continued now, and I invite other members of our Society to participate in it thoughtfully.