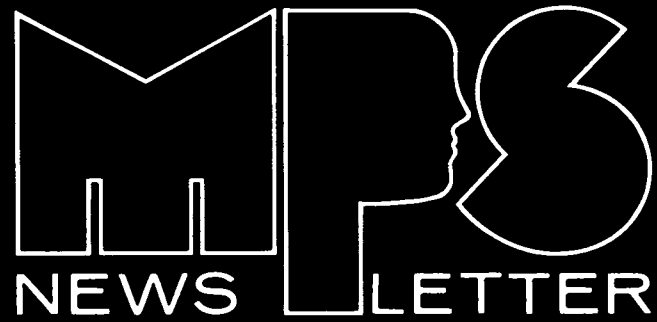


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**TREATING EMOTIONALLY DISTURBED PHYSICIANS:  
Part II**

By Reuven Bar-Levav, M.D.

## Reply to Dr. Bar-Levav's Jeremiad on Physician Suicide

Dr. Reuven Bar-Levav's ubiquitous pen has struck again! As one of those "chosen"<sup>1</sup> for attention, I feel like the man in Abraham Lincoln's famous story who had been tarred and feathered and was being ridden out of town on a rail. If it weren't for the honor, I'd just as soon walk!

What called down this lightning upon our heads? A careful reading of Dr. Bar-Levav's contribution suggests that the answer to this question falls into two parts, one concerning his reaction to the alleged content of our presentation (*The Suicidal Physician: "The Family's Therapeutic Role,"* Annual Scientific Meeting November 13, 1975), and one related to his observation that our remarks were delivered in an arrogant tone.

First, content. As embarrassing as it may be to an author, one must face the prospect that one has failed to communicate clearly (at least to Dr. Bar-Levav). The clinical example we gave ("The Doctor Who Worked Himself to Death") was intended to illustrate, as we stated, that: "It is uniquely difficult for a doctor to recognize and admit personal illness. Even the most astute clinician is prone to experience personal illness as a weakness, a narcissistic inquiry which triggers defensive psychic regression affecting the whole personality . . . allowing the doctor to deny a suicidal danger in himself that would be detected quickly in a patient. This denial often is supported by a *fantasy* that the doctor is a miraculous healer, immune to physical and emotional affliction. Often this *fantasy* of omnipotence is acted out, dramatized in the doctor's behavior and attitudes, especially in the doctor-patient relationship, *as the following case will illustrate*":

We went on to describe an emotionally disturbed doctor's abuse of his medical role and his wife's misguided attempts to conspire with a psychiatrist, who was a family friend, to arrange a surreptitious "quasi-therapy" for her husband. She persisted in this dangerous deception . . . "in spite of her own psychiatrist's urging her to see the danger in the limitations imposed upon her husband's psychiatrist-friend by these deceptions (and because) she could not bear to think of confronting her husband with the facts."

We thought that it was obvious to the audience that we gave this example to illustrate the *barriers* to effective treatment presented by a doctor's omnipotent fantasies, his family's unconscious compliance in these fantasies, and the fatal result that may overtake the therapy if such barriers are not removed.

1. For this use of "chosen," see Dr. Bar-Levav's editorial on the physician as the contemporary Jew in *Detroit Medical News* of April, 1976.

Further on in our presentation we took pains to emphasize the special danger that results when the therapist *shares* the doctor-patient's omnipotent fantasies: We warned that "When such countertransference phenomena in the psychiatrist coincide with a fantasy of omnipotence in the doctor-patient, tragedy will likely be the outcome."

It is not clear what it is about these words that made Dr. Bar-Levav believe that we intended to urge, as an example of good therapy, that the therapist conspire with the impaired doctor's narcissistic overestimation of his customary role as healer. We tried to do precisely the *opposite*.

In fact, we should welcome Dr. Bar-Levav's neat, clinical vignette describing his masterful treatment of an impaired physician. His case provides the positive, successful example of how one *ought* to treat that we omitted from our paper. We did so because we felt it redundant to lecture our colleagues on the rudiments of psychotherapy, but chose instead to highlight some important pitfalls not commonly discussed. However, Dr. Bar-Levav's general remarks on the therapy of physicians are so much in agreement with ours that, had we not made them first, we might now feel guilty of plagiarism.

Of course, when we said that ". . . we advocate the strict maintenance of collegial regard and consideration, an attitude which permits the doctor to sustain an already fragile self-respect and dignity," we did *not* mean that we recommend giving him *poor* medical advice or that we help him to *pretend* that he is not also a patient, as Dr. Bar-Levav seems to believe we did. The whole burden of our presentation was quite to the contrary.

We believe that it can hardly be claimed an enhancement of reality-appreciation to strip a physician of the title of doctor in the name of furthering his treatment. To pretend that he is *not* a doctor is to adopt a therapeutic *pose* that denies a significant part of the patient's identity. We must reject, therefore, Dr. Bar-Levav's recommendations on this point.

Perhaps it was not *what* we said, in fact, but *how* we said it (or even that *we* said it?) that explains the strangely contrary construction Dr. Bar-Levav placed upon our remarks. This takes us to the second part of our reply to Dr. Bar-Levav's criticism: his complaint that we delivered our remarks in an arrogant, pedantic tone. If this be true, or even if it only *seemed* so to Dr. Bar-Levav, this aspect of our presentation may have so jarred him that his attention to the content wavered. If we seemed arrogant to Dr. Bar-Levav and others, we regret it, for it was not our intention. If we inadvertently created the impression that any of us considers himself to be an expert in this difficult, professionally unrewarding and largely neglected field, then this was an unfortunate impression, quite contrary to the actual state of affairs. In painful fact, we are only groping toward an understanding of the impaired physician and have every reason to be hum-

ble about our achievements. (It is refreshing, by the way, to hear of Dr. Bar-Levav's successes in this line).

Speaking from out the cloud of his recent editorials, Dr. Bar-Levav has pronounced our remarks arrogant. To this charge we offer the same defense once given for a woman taken in adultery: Let him who is without sin cast the first stone.

Douglas Sargent, MD  
for co-authors, Drs. Thomas Petty, Viggo Jensen  
and Herbert Raskin

## Towards Clarity

Dr. Sargent and his co-authors have presented a carefully reasoned and fair clarification of their position. Leaving all personal barbs aside, the very fact that such a discussion takes place within a professional society that in the past has encouraged as much free dissent as any hierarchical church, is a most welcome and necessary change. Science and truth both flourish best under such conditions. The wide areas of agreement should not conceal a most crucial point of difference, a point that, in fact, appears to determine the very outcome of therapy. This rebuttal to a rebuttal aims at focusing attention on this all-important point.

Dr. Sargent writes, "We believe that it can hardly be claimed an enhancement of reality-appreciation to strip a physician of the title of doctor in the name of furthering his treatment. To pretend that he is *not* a doctor is to adopt a therapeutic *pose* that denies a significant part of the patient's identity." This clarification confirms the authors' previous statement that they "advocate the strict maintenance of collegial regard and consideration, an attitude which permits the doctor to sustain an already fragile self-respect and dignity."

It is surprising that Dr. Sargent and his co-workers, all sophisticated and knowledgeable of personality development, seem to completely forget that the most significant aspects of a person's identity are firmly established long before one is granted the title "doctor." Therapeutic interventions that are of real, rather than of apparent, value must, therefore, address themselves to the panic whose roots are in such an early developmental period. In this context, the title "doctor" is used simply as a manifestation of the resistance to this frightening, yet essential, task.

In the therapeutic setting, any sick individual is in reality a patient, whether he is professionally a plumber or a physician. In fact, the very opposite of what Drs. Sargent, Petty, Jensen and Raskin claim is correct. The following statement seems to be self evident: "To pretend that he *is* a doctor (when in fact he is a patient, yet wishes to deny this painful fact) is to adopt a therapeutic *pose*," a pose that guarantees the failure of therapy, for without a patient there can be no cure.

Current stress usually serves only as the precipitating cause of personality disorganization, for it is rarely powerful enough to cause such turmoil unless it ties in with affects and unresolved conflicts from the period of personality formation, very early in life. Reality manipulations, which include addressing the patient as "doctor" and otherwise stressing his adult roles and responsibilities can, at best, take off some of the pressure and return the patient to "functioning" at the pre-morbid level. It is unfortunate that the re-establishment of the pre-morbid state is all too often the actual, if not the declared, goal of psychotherapy, even though it allows only a most unstable and precarious existence. The opportunity to bring about even minimal personality change that might lessen the likelihood of frequent recurrences is missed. Even short-term psychotherapeutic interventions that address themselves to the underlying conflict often allow the defensive structure to be reconstituted at a less primitive and more stable level.

The enormous fear that patients often experience as literally and immediately life-threatening cannot be disarmed by addressing the adult ego, as we do when we call the patient "doctor." A patient may be willing to address himself to the basic fear of non-being, which originates at an early pre-verbal phase of development, but only when he senses that his physician is capable and willing to focus attention on such fear and work with it. It is necessary to overcome the understandable resistance to such a difficult task, and we cannot hope to succeed in it when we "strictly" maintain "collegial regard and consideration." Supportive psychotherapy is often misunderstood to mean encouragement of the adult patient. It really means lessening the fear of the infant within the adult, thus supporting the Ego in its struggle with the Id.

By stripping a physician of the title "doctor" we do not strip him of any real human dignity. We only remove the flimsy and irrelevant support that is obtainable from late-acquired professional titles. We lend him, instead, strength and assurance as we recognize the legitimacy of his fears. The patient gains real dignity as a person when he is acceptable even as a vulnerable, sick and non-collegial being.

These points of disagreement are not merely minor theoretical divergencies. They dictate what we actually do when we work with patients. While much theoretical agreement exists, what separates us is what actually determines the clinical approach and the clinical results. Both positions cannot be equally right. Since the very lives of many individuals depend on finding better therapeutic approaches, claims and counter-claims made by anyone should not be accepted until validated by direct and objective observations by others. I invite such observations and would welcome observers into my private practice. Those who claim that they see things differently can do no less.

Reuven Bar-Levav, MD

## Re-Rebuttal to Dr. Bar-Levav's Complaint

On behalf of my co-authors, I would like to comment on one aspect of Dr. Bar-Levav's most recent criticism of our paper on the treatment of the suicidal physician, that is, his rejection of our contention that one ought to treat the sick doctor with collegial regard and respect.

He complains that our attitude helps to reinforce the doctor's resistance against accepting the fact that he is ill, a resistance which he seems to believe is abolished when he gets the doctor to call himself a "patient." Further, he charges us with failing to appreciate that emotional disorders may have deep roots requiring radical measures to eradicate them.

I think that Dr. Bar-Levav confuses where the therapist must begin with where he hopes to end. It was Freud himself who advised proceeding from the surface, from the ego's side, in a therapeutic alliance with the patient's healthy ego, to reach deeper conflicts. To illustrate this concept he offered the metaphor of peeling the defenses away as one peels an onion. He pointed out (neophytes have learned to their sorrow the truth of this warning) that to do otherwise creates a chaotic situation from which the patient may have to flee in panic into deeper regression or even suicide.

As most psychotherapists are aware, to establish a therapeutic alliance with a disturbed person often requires supporting shaky defenses until the patient is capable of becoming an effective ally. One cannot, as if by magic, remove a defective ego, overhaul it, and then hand it back to the passive patient to be plugged in again. One must help the *patient* to do the work. It is only by working with the patient's residue of healthy ego functioning that he can be helped to rehabilitate the sick part. But I belabor the obvious!

All this is not to say that because one respects the patient as a human being, because one treats him with what Richard Sterba has called "medical tact," and *persuades* him to join in the task of therapy, that one denies his illness, his need for treatment or that the roots of his illness are deep within his personality.

However, no experienced therapist would begin the delicate work of therapy by abusing the patient with insults; and to strip a person of part of his identity is just such an insult. If one asks a person *who* he is, he usually replies with *what he does*. Thus to remove the title "doctor" or "teacher" or "plumber" and substitute the somewhat demeaning generality, "patient," may be experienced as disorganizing by vulnerable people. Why do it? We are *against* this technique.

Why, one wonders, does Dr. Bar-Levav place such reliance upon this simplistic maneuver, adopting the title of patient as a panacea for gaining access to deep conflicts?

Other means are available to the experienced therapist and their use must be no mystery to Dr. Bar-Levav. It seems contentious for him to assume that because we have not provided in our little talk a primer of psychotherapy, we do not understand the rudiments of our profession.

We share Dr. Bar-Levav's conviction that our differences are not merely of minor theoretical importance. Perhaps we ought to adopt a more strident tone in proclaiming them? Perhaps we ought to appear to be incensed at the thought of patients who might die if his views rather than ours prevail. But, reminding ourselves that our words are intended for our professional colleagues, and not for a hostile multitude, we reject the heroic mode. Rather, we will content ourselves with what we presented to our audience at the scientific meeting last November, when we reported our concern for the suicidal physician and our efforts to treat him. We hope that those who share our concern will want to read our article on the subject when it is published.

Douglas A. Sargent, MD