Chapter 9:

Doctors and Professors Behaving Badly

I was upset. I had just walked out of therapy group with a 57 year old woman who was clearly suffering from neurasthenia[1] and depression. She was very anxious and expressing self-loathing and judgmental statements that sounded like she had been fed "You statements" such as "you gotta do it yourself. You have to pull yourself up." These statements had only served to exacerbate the unhealed, underlying emotional wounds. She had been seeing a psychiatrist and a psychologist. What were they doing for this woman? Had they gotten the grown children together and talked about how they had communicated with their mom? Had they been very validating about her intrapsychic experience to build her sense of self and calm her fears about her financial future? It didn't seem likely. As a humanistic-psychodynamic mental health professional, I could see the need for this kind of family therapy. Why had the psychiatrist not called me to come in and do a consult to see what I could suggest before she began Electro Convulsive Therapy (ECT)? The answer I finally had to accept is that psychiatrists think of themselves as the "be all" and "end all" of psychological patient management. They have a very difficult time calming their egos to wonder if a highly educated, experienced mental health professional, a non-psychiatrist, might be able to make a suggestion or provide a style of therapy that might help. This was a crushing blow to me. How could I have gone to graduate school for 16 years, achieved two graduate degrees, 217 graduate hours, years of experience working in hospitals and agencies and yet find myself being treated as if I were some kind of professional neophyte who can't possibly know what a patient might need to improve? How can that be? The only answer I can conceive is that doctors are so impressed with themselves that they lose the humility (which creates *character*) to ask other professionals for help.

"Now, wait a minute, Dr. Wood. Aren't you giving in to the 30% rule? Aren't you sliding them down the scale toward incompetence or 'badness' to satisfy your need for moral retribution? Isn't it entirely possible that they are just too fearful to ask a non-M.D. for advice and assistance? Maybe you should be more sensitive to their feelings of insecurity." Sure, that is possible. So I'll talk more about that later.

[1]Neurasthenia is an old term that goes back to John Brown (1735-1788) which means "lacking in strength in the neurological system." It is a useful term that describes very well the way patients feels. Modern psychiatry has not replaced the word with an equally useful word yet.

The psychiatrist listened to my expression of grief and frustration and said, "Let's see how she does on this regimen and then we can see about a different kind of therapy." I wanted to be politically correct, so I said, "Okay." A few weeks later she had gone through ECT and was confused but slowly her positive affect returned. Had I been wrong? Is this really all she needed? Is ECT so effective that there is no need for a psychological/systemic intervention? The truth of the matter is this same woman had come for ECT before, gotten better, and gone home in a more functional mood. But it hadn't stuck. She had slowly drifted downward again and landed back in the hospital. Will this happen again in a few months? If it does, she will not be the first mental patient to come in for multiple rounds of ECT, get better, deteriorate, and repeat the process all over again. For some patients this regimen works well. For some older patients the insult to the memory is permanent and they don't regain their full functioning capacity again. But this is not always considered a disaster. When the patient forgets the past oftentimes she or he is also forgetting the abuse (or TRAUNCIL) and can maintain a better mood and everyone is "happier" for it.

What is not assessed in research is the comparison with using an "effective" form of psychotherapy

that could have eased her symptoms without ECT and could have helped her maintain her level of mental acuity. She may have been able to continue her part time work that meant so much to her. The last I heard she had moved to San Antonio to be closer to (or watched by) her family.

Doctors Giving the Patient Information About Their Illness and Symptoms

I was leading a group in the hospital where I worked. The group had done quite a bit of processing already so I went into a teaching mode. "The genetic predisposition is like a seed in the ground. The interactions with your parents are like water." Standing in front of the therapy group, I didn't like the analogy that had come to my mind in the moment. After all, water is good. I drew what looked like a tumor and then covered it with wavy lines. "The genetic tendency gets covered over like a seed in the ground. If there is no rain or water the seed never sprouts, it lies dormant. Only if there is abuse or mistreatment does it start to grow and psychological illness… (I paused as if I were looking for a word). "Blossoms!" the exuberant lady to my left interjected. "Yes, blossoms," I said, glad that she had followed my lead.

I was also saying that childhood experiences work the same way. They, too, can lie dormant until a later time that stress and deprivation "waters them" and they spring to life. Therefore, their negative childhood experiences had created their current psychological condition. I drew a line and arrow from the hidden "tumor" to "symptoms." "Do you see?" They seemed to get it.

"Really?!" the patient exclaimed with a surprised look on her face. "I have never heard that before!" The patient, Elaine, a 45 year old, mother of three, was a former model and it showed. She was a beautiful woman who looked 35. She was showing all the facial aliveness of a Bipolar Disorder patient who'd just heard something extraordinary. I had just given information to the group which I had given to countless patients before. I had drawn a picture on the chalkboard and told them that their childhood development played a role in their bipolar and depressive disorders. I was pleased and yet disappointed at her response. "Do you mean that in all these years of getting treatment, your psychiatrists never told you about how your bipolar disorder developed?" I asked for confirmation. "No!" was her definite answer. I then said, "If I had a dollar for every time I've had this conversation, I'd be a millionaire." And it was almost true. Many times a year since I began leading groups in hospitals 15 years ago, I have been the first mental health professional to tell the patient that their illness was not just "a chemical imbalance" or "indigenous." I would be the first to explain that it was not independent of their childhood trauma or abuse. (see chapter six for more on TRAUNCIL).

"Bullshit!" one group patient at an outpatient unit bellowed at me with her Texas accent. She had never heard of such a ridiculous thing. She challenged me that it could be true. However, by the end of the week she was showing a great deal of mature interest in how childhood experiences can create or exacerbate one's mental or emotional illness. She had never been helped to understand this before that week. Doctors don't seem to have an interest in telling their patients about the "epigenetic" nature of their illness or the "diathesis-stress" model. Both of these models support the concept that there is a dormant potential for any illness that may or may not actualize into problematic behaviors. Only if the childhood stress factors (trauncil) are significant enough (frequency, duration, intensity), do they become actualized.

"I always tell my psychiatrist that my childhood was fine, that I was happy," Elaine said. Then she began to tell the truth about her childhood. "My mother, I think she was bipolar, was up and down. She and my father were great disciplinarians. If they came home and found me and my brothers chasing each other around, we would get it." "You mean they would spank you?" I asked. "Yes, they would use belts or switches or whatever. Sometimes my brothers would have fist fights with my father. My mother was never affectionate to us, no hugs, or 'I love you' or kisses or anything." "You mean when you arrived home you didn't get a kiss on the cheek?" I asked. "Oh, no, never. Only in recent years have I started to say, "I love you" at the end of a telephone conversation. My father now says, 'I love you' back but my

mother will only barely say it back sometimes. But I was scared for a long time to say it, I was afraid they might think I was sappy."

"My mother would change on a dime. 'Get in there and clean up that room!' she would yell at me viciously. But she was great when she felt good. We would go shopping at the mall and they would buy me all these wonderful clothes. But then they would take my brothers to Montgomery Ward and buy them clothes there. I confronted her one time. I said, 'Mother, it's not right that you take me to buy these nice clothes and then take Stan and Jerry to buy regular clothes.'" "How are your brothers doing today?" I asked.

"My older brother left home when he was sixteen and he never came back and my younger brother became an alcoholic and then committed suicide," she said with a matter-of-fact tone in her voice. "He was about 23 or 24. We don't even know where my brother is now." I said, "You don't even know where he is?" "No, we never see him. We don't even know if he is alive! We see him about every ten years."

She continued to explain herself, "But I thought my family was pretty good. We had a clean house. I would go to my friends and their mother would be sitting in a messy house and be smoking a cigarette. I thought I had it good compared to them." So when she told her psychiatrist that her childhood was good, he would believe her and prescribe a medication and never suggest or send her for therapy. This scenario is enacted a thousand times a day in cities all across the country, and I presume, around the world. The paragons of our mental health system, psychiatrists, don't seem to have a clue about what their jobs really are. It is not to treat the mentally ill. It is to assess the mental ill and seek out the very best of all the services available and make sure that they get all the help they can to be the best and most healthy person possible. I don't see psychiatrists putting a lot of energy into this mandate. Except one, and he knows who he is. Thank you, Dr. R.

Amazingly, the woman sitting right next to her gave a similar story. Mary Kay was a 51 year old patient with bipolar disorder, with 2 sons, who lived alone. She had suffered so much from symptoms that she had been eligible for SSI disability. She received about $550 dollars a month which barely paid for rent, bills, and groceries. She enjoyed going out to the bars when she was a young mother and she continued to wish she could go out to a bar and meet someone. She had been seeing psychiatrists for years now. The previous day I had asked, "Have you ever worked on your issues in therapy?" With a sly grin and a glance at her group mates she chortled, "I ain't interested." But today was a different story. She told how her mother had developed a heart problem and had gone to bed. Her father had told her "Don't misbehave or your mother might die." If this bit of "unloving" parenting were not enough she began to run the household, first out of helpfulness, then out of fear for her mother's life. Even when her mother improved, Mary Kay would "keep her in bed" out of fear she would relapse. This threat of her mother's impending death kept Mary Kay on edge for almost 20 years before her mother's continued good health convinced her she'd been duped. Even as we spoke her mother was alive and traveling the country with her father. She had never explored the mental-disability-creating aspects of this inappropriate parenting ruse.

"I have never told my psychiatrist this," she said. "Will you tell him?" I asked. "I don't think so." "Then can I tell him? I'd like to (tell him) if I see him," I urged. "Sure," she said glibly. After a few hours, I entered the nurse's station. "Oh, Cedric, can I talk to you?" the charge nurse asked with enthusiasm. "I am so glad I caught you. Mary Kay said she had told you about some childhood experience. I asked her if she'd tell the psychiatrist and she said she didn't feel like getting into it again. Can you tell me what she said?" I was impressed with the nurse's interest, this was rare. She listened empathically to the story and said she was going to encourage the patient to tell her doctor. I agreed that would be good. Then the nurse said, "She said she has never had any of her psychiatrists do therapy with her."

These doctors should be ashamed of this state of affairs. You would think that psychiatrists, those mental health professionals at the top of the fee schedule, would be knowledgeable about the need and effectiveness of psychotherapy. But they are not. There may be a few of the most emotionally intelligent

that are caring but I have never had a higher order discussion of the psychology of the human mind with a single one. Most (60%?) psychiatrists are behaving badly in this way and it's a tragedy and a travesty of unprofessional behavior. Bravo, go to the other 40% who do therapy themselves or refer out on a regular basis. Will the American Psychiatric Association take on this research mandate?

I received a call yesterday. It was from a man in his 30's, "Jim." He was asking me if I was the kind of doctor who would monitor his amino acids. He was looking for a new doctor since he was not satisfied with his old doctor. His wife was about to divorce him and he didn't think there was any hope. Through a series of questions I learned that he had been seeing his psychiatrist for five years. Had his doctor recommended that he seek out a therapist to work on his depression and his conflictual relationship with his wife (who was also seeing the doctor for Bipolar Disorder)? "No," he said. Why was I not surprised? "Can I ask your doctor's name?" "Dr. Heid." I recognized the name. I had called on Dr. Heid several times but he'd never called me or referred anyone to me. One day I had stopped by and he opened the door and he allowed me to introduce myself. He allowed about 15 seconds. It was Friday at 4:50 and he was locking up shop. He could have taken an interest in my education, my approach, and my epistemology, but he didn't. This very same doctor who had seen my brochure had continued seeing this ailing man who was in desperate need of marital and personal counseling without referring him. Without mentioning my or any therapist's name as a way to solve some of the aggravations in his life, he had continued seeing him every month or two over and over again. Incredible. A blatant show of unprofessional egocentricism.

I resolved to go to the UT Southwestern School to discover what ethical behavior is being taught to doctors, if any. Fill in what you find out here.

TITLE

Is it egopathic to be so cavalier about patients' life stories and unmet developmental needs? How can these psychiatrists go into the helping profession and know that they are only giving half the treatment required for the patient to get better? In this case these doctors are showing traits of the "psychopathic" egopath. They only care about their own pocketbook and are scheming to retain their patients and keep them to themselves. Sharing and caring is something they did not learn to do as children, evidently. Or can we blame the system? Is the true onus of responsibility on a system that allows doctors to carry on in this insular manner? What recourse do the patients or professionals, like myself, have? Is there any way to complain about this or enact supervision such that massive change would happen? I am still looking for them as I write this book.

How many psychiatrists are really caring about their patients enough to recommend therapy? I am sure the answer is a bell curve. There are a few, say 10%, that are of sterling character who really care about all aspects of the patient's life. The majority, however, hurriedly meet with their patients so they can move on to the next patient to garner the highest income possible. Then there are a few who are truly the flotsam of the field. They are the egopaths who really care very little about most of their patients and really don't have enough emotional intelligence to help them, except to give them medication. Their aggressiveness is passive so there are very few opportunities to see this mismanagement of patients.

A Disgruntled Patient: Carolyn

A client came in today. We'll say her name is Carolyn. She seemed sad. She said she'd been to see her doctor. "How did that go?" I asked. "Oh, okay. They're always switching nurse practitioners. I haven't seen Dr. B in a long time. The nurse practitioner was new. She just started asking me all these questions about my medication. They're never prepared. She hadn't read my chart." She mimicked how the nurse had asked her the questions. "You mean she didn't say, 'Hi, I am new and I'm so sorry to have to ask you these questions but I'd like to get to know you.'" "Oh, no," was Carolyn's response. "She only asked about side effects and if I wanted any refills. I told her I did."

We have made a lot of progress in the past few years in helping doctors understand that they are not

God or even little gods. We have also made some progress in helping their patients and coworkers not think of them as gods. How did it used to be? For centuries doctors felt that they were so intelligent and knowledgeable about the human body that they should be allowed to make all the decisions about a person's well being and treatment without question. Then the mistakes began to be publicized.

Over the years horror stories began to surface that reveal that doctors were human after all. They not only make mistakes, they also are subject to the same ego dynamics that the rest of us are subject to. There is one major difference between doctors (or anyone of maximum authority) and regular people: they have power over others and that power does have an effect on their character.

A classic example of doctor's egomaniacal sense of self was the hand-washing problem of the 1800's. Doctors had always gotten their hands bloody with one patient and then walked straight over to another to continue working. Doctors of that day had no idea of microbes and viruses. If you can't see it, it must not exist. But one wise doctor, Dr. Jim Smith, discovered or surmised that bacteria was spread by working with dirty, bloody hands from one patient to another. He admonished the medical community that washing the hands thoroughly would eliminate this danger. When the doctors heard of this concept they laughed and many of them refused to wash their hands. This refusal went on for thirty or forty years according to (Jim Smith Year). Why in the world wouldn't they at least try the technique to see what the outcome would be? I conjecture that their egos got in the way of their altruistic, caring selves. Many of them, I'm sure, got an ego rush from walking down the hospital corridor with blood all over their hands, arms, and lab coats. They knew everyone walking by would be saying, "There goes a doctor. He's been operating on someone. My, look how bloody he is. He must be an intelligent and important man." This bit of self empowerment, self-inflation, and self-aggrandizement cost thousands, possibly millions, of lives. Yes, they died because the egopathic doctor refused to wash his hands and then infected the next patient with bacteria that killed him or her.

Do you think that kind of egotistical attitude only existed in the 19th century? Think again. A few weeks ago I had to face a very depressed man who had been treated by two doctors; one a back pain specialist and one a psychiatrist. Despite years of anti-depressant medication, he had become so depressed that the two doctors decided to suggest something drastic: admit him to the hospital for med management and close observation. And yet, shockingly, between the two of them, they could not come up with the idea of trying psychotherapy. One hundred and fifty years and millions of successes (which includes modest improvements) with psychotherapy to relieve stress and depression, and these two doctors were so archaic and egopathic that they couldn't suggest to the patient that he try psychotherapy to help him deal with the multiple losses and disappointments in this life that were weighing on his mind. Amazing.

But let's return to the blood love. Why would intelligent men of science insist on staying bloody as they walked from one patient to the other? Erich Fromm, the eminent psychologist, wrote more on this use of blood as an aphrodisiac in his book The Anatomy of Human Destructiveness. Fromm makes the point that violent blood-letting over the centuries isn't always about destructiveness and cruelty. He says, "By shedding one's own blood or that of another, one is in touch with the life-force; this in itself can be an intoxicating experience" … (p. 169). This is one of the few mentions I have ever read that suggests that killing or simple blood-letting can be an experience that can be compared to a recreational drug or to an anti-depressant medication. The experience causes the serotonin to linger longer in the synapse between the neurons and the person feels better, stronger, calmer, saner. This is why doctors clung to their adrenaline-pumping bloody behavior; it caused them to operate on a higher plane. This is why the great Pericles of Greece decided, after creating the Golden Age, to sink the City State of Athens into a war with Sparta. He was getting bored and possibly depressed. The result was a devastation of everything whole and healthy in Athens and it led to Pericles' contraction of the plague and his own slow death. My God, was it really worth it just to feel the thrill of battle and the hope for a glorious victory? I would ask him.

I bring this up because it might be possible that doctors continue to behave badly because it is a rush and an anti-depressant high to be able to bully and overrun people with their power. They continue to use

their power to dismiss the little people so they can raise their sagging self-esteems and faltering sense of self.

Caretaking the victimizer

There are many scenarios in life in which the victimizer is coddled and protected. Once, when a group of doctors allowed egocentrism to takes its course, I was terminated from my job. I had not been told of a primary reason until after the termination. I wanted to have an "Adult-Adult" healing conversation with them to find out more about what had happened. The HR person said "No, you can't talk to the doctors; that would be inappropriate." There's an unbelievably strong drive in many poorly developed people to protect those they deem "powerful" or "respectable." It takes real strength of character to stand up to a person is power.

I am glad we have the word "inappropriate" in our language. It is a very useful word that can be helpfully applied to discern the best behavior. The word is used to connote an ethical basis for proper action between two or more persons. The interesting question is "how does one decide what is "ethical" and what is not. Or more appropriate, what is "more ethical" when two persons' ethics are in conflict. Where do ethics come from? The answer is simple. Ethical behaviors are created out of the matrix or nexus of the pain generated in interpersonal behavior. There is not a code of conduct existing that does not have its basis and purpose in minimizing human suffering.

So, was my wanting to talk to the doctors "inappropriate" because it would have caused human suffering? No, it was "inappropriate" because it would have been annoying to the doctors to have taken time out of their schedule to talk to me. They would have had to have activated their social intelligence to deal with my questions and remonstrations and they weren't interested in doing that. And, furthermore, having known them, I can tell you they were not good at these social skills. It did not matter to them that I was suffering from losing a very good job without being given the chance to learn about and improve my performance.

It is very clear in this situation that the assessment of "inappropriate" was very influenced by the power that doctors commanded. Hence, I had to suffer in silence with no pain-mitigating debriefing which would have meant so much to me.

The Doctor's Wife

Jane was a tall, handsome Hispanic woman. She was intelligent and well spoken. But as she told her story she began to cry. Her husband, Jack, was originally so warm and supportive. He was a medical intern who was on his way to success as a doctor. How could she *not* become interested and eventually fall in love? She was 36 when they met. At the age of 39 when they got married there was precious little time to get pregnant and have the children she had dreamed of for so long.

Jane felt she had found her man. She was willing to support him while he finished his residency. She knew the day would come when it would be her turn to make her dreams come true. She had already showed the world she was a first class corporate functionary. She had proven her mettle. Now she was ready to become a mother and satisfy her need to experience the softer side of life.

But getting pregnant wasn't easy. They had to try several techniques to increase fertility and still they did not succeed. And then the telltale signs began to appear. At first she didn't want to think the worst. She made excuses for his odd behavior. But after she found the pictures, it was just too obvious she would lose the dream of a happy marriage. Jack had been taking time off from work and spending a lot of time with another woman without telling Jane. When Jane found out she was livid and felt betrayed.

She decided to confront Jack one night. It was an ugly scene. Jack accused her of setting a trap and judging him unfairly. He seemed to have an answer for everything. But Jane stuck it out and took his keys so he wouldn't run off with her car. He became irate and frighteningly rageful. He drove off in a self-righteous huff and the marriage was never the same after that. In fact, it was over.

As Jane scanned her mind for information, she began to realize there were tell-tale signs. For

instance, his mother lived with his younger brother in a filthy, pet-piss drenched apartment. She couldn't believe he had come from such a low functioning family; he was such a class act. His mother, though, always depended on him in peculiar, dominating ways. As the months went by, this young doctor began asking Jane to do more and more tasks which seems to her to be very inconsiderate and egocentric. Always, she would figure "well, you can't expect perfection." But looking back it all seemed so clear. He had become more and more self-focused and less and less considerate of her needs and expectations.

Jack was an egopath. That was the explanation her therapist gave her. Although the label didn't take away the pain, at least she felt comforted that someone saw it from her point of view. She had been led down the primrose path by this man only in the end to find her dream of a family in shambles.

The Physiologist

Marianne was a beautiful athletic woman in her 30's. She had married a man 10 years her senior and had a son. But she didn't love him so they divorced. Then she met Jack. He was handsome, athletic, and an doctor. He had been a physical therapist for years before going back to medical school. They created a great relationship based on fun, love, and comfortable times together.

Debriefing

One of the cruelties of workplaces and home life is the absence of debriefing. If supervisors and parents could learn this one tool it would decrease human suffering by 90 per cent. The egopath does not like nor want to debrief what he or she does. It is abhorrent to the egopath to have to explain what they did, justify what they did, and listen empathically to the target person express their pain or needs.

The egopath is not wired for sympathy. They just don't care. They don't feel the need to care. They are focused on what will make them feel good. This is called "lack of empathy." Daniel Goleman explicates perfectly where lack of empathy comes from in Chapter 7 of Emotional Intelligence. It is entitled "The Roots of Empathy." When you add in to the mix the power that comes with position or prestige you get an egopathic slamfest waiting to happen. It is shocking in the first few years of the 3rd millennium, the 21th century, after so many years of human development, we still have so little power in our society to curtail egopathic cruelty. It is not known by the majority of supervisors and business owners that unexamined power almost always leads to human suffering. How many young people will become managers, and how many old managers will be promoted this year without a shred of training in the abuse of power and how to avoid it? Millions around the world.

Many people who reach a power job have experienced an empowered, successful life and, therefore, have very little natural ability to feel sympathetic. Morals and ethics have always had to be taught to the young and egocentric. And yet, year after year, in company after company the need to do interpersonal ethics training goes fulfilled.

When a sympathetic soul says, "Don't worry, keep in mind that this suffering will make you a better person," they are speaking the truth. One's personal suffering has the beneficial side effect of raising the person's capacity for "other-mindedness." Princess Diana comes to mind. Why did she spend so much time mixing and mingling with the world's poor and suffering as princess? Because she cared. Why did she care? Because she had done so much suffering herself. Not only as a young person but in the years just preceding her moving onto the world stage. Her marriage had been a devastating disaster and it hurt her deeply.

Students entering Medical school/graduate school.

"I have to go early," my friend told me during the break from the day-long seminar on emotional intelligence. When I asked why, she said, "I have to go fire a graduate student who is an intern at my practice." I was amazed. She asked in frustration, "Why can't the graduate school identify these people before they are sent out to internship sites?" I looked her in the eyes and said, "Because they don't know how." It is a shame that even in graduate schools in psychology and counseling, the professors don't know how or simply don't have the intestinal fortitude to confront those students who are Axis II in their

interpersonal style. They become professors who lack the character to make sound, rational decisions concerning the lives of their students. They even behave abusively toward their students, coworkers, and clients. And if that weren't enough, as of this writing, I am not aware of any movement to correct this ubiquitous state of affairs.

Medical students and graduate students must be assessed for their mental health and their personality adjustment. Several magazines have printed articles about doctors "behaving badly" in their relationships with spouses, colleagues, and even patients. Only one article has tackled the need to test medical students for emotional intelligence. The main characteristic of EQ, of course, is the ability to feel empathy for others.