

The Drive to Relate: How Modern Psychoanalysis can Join with Modern Medicine to Improve the Doctor-Patient Relationship

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Abstract

Advanced medical science and technology have made extraordinary contributions to health and longevity, but have simultaneously precipitated a psychological crisis for many recipients of medical care. Medical patients often express disappointment in the care they receive; they may feel dehumanized and that their doctor does not know or care about them. In addition, the medical literature is replete with discussions of the difficult problem of patients' lack of adherence to medical regimen. While the power of modern medicine to heal and save lives has never been greater, patients are not always satisfied with the doctor-patient relationship or cooperative with the care that is offered to them. Relational and Interpersonal psychoanalysts believe that there exists an innate need to emotionally attach to caregivers, and that this need is even more fundamental than Freud's concept of the need to gratify basic drives. Modern psychoanalysis emphasizes the importance to mental health of attention to the subjective and relational dimensions of life. Psychoanalytic research has demonstrated that being emotionally attended to, treated as subject, not merely an object, for example, has calming and healing properties. The present paper describes contemporary psychoanalytic concepts that can be utilized to better understand and address the medical patient's experience and behavior within the context of modern medicine. Drawing on theory and research, recommendations are made for improving the psychological dimension of modern medicine through attention to the subjective experience of both medical patients and clinicians.

Keywords: Relational psychoanalysis; Secure base; Mentalization; Attachment security; Holdingenvironment; Intersubjectivity; Counter transference

Introduction

Modern medicine has made extraordinary contributions to health and longevity. People live longer and healthier lives and derive great benefit from the vast improvements in medical science and technology. But this advance in medical care has precipitated a psychological crisis for many of its recipients. Along with gratitude for a life saved or health restored, patients often express disappointment in the care they receive--they feel dehumanized and may complain that their doctor does not know, or does not care, about them. Unexpectedly, at a time when the power of modern medicine to heal and save lives has never been greater, patients are dissatisfied and disappointed with the doctor-patient relationship.

Illness, especially a serious one, brings with it fear and a sense of vulnerability and isolation for the patient [1,2]. As such times, people need more from their doctor than an accurate diagnosis. They need to feel their doctor knows who they are and is thinking about them. This assures them that their doctor is trying his or her best to solve their problem and to come up with the best treatment possible. But the psychological need to be thought about goes even deeper. Especially at these moments, the patient experiences a fundamental need to feel acknowledged, understood and held in mind.

In an earlier era, the physician would have visited the patient at home and known him in the context of his family, for whom he also would have cared. For the modern patient, scans by machines and consultations with multiple specialists often substitute for the old-fashioned comprehensive physical examination, a ritual in which the patient has psychological as well as physical contact with the physician. Verghese [3] laments the diminishing of this direct contact with the patient and warns that the practice of modern medicine is creating the "iPatient," a phantom composite of scan and test results that substitute for the human being. The person of the doctor has become disengaged

from the person of the patient. Modern patients now are struggling to retain their subjectivity and sense of wholeness in the age of biomedical science, technology and subspecialization. Through technology, the human body is seen with penetrating clarity, but the human being is left hidden in the shadows. The field of medicine is making enormous strides in its quest to master the body; but it is losing its grip on the patient as a whole person and as a being in relation to others.

The fields of psychosomatic medicine, medical psychology, health psychology and consultation-liaison psychiatry have for many years studied ways to improve the quality of life for people with medical illnesses. And oncology is a subspecialty that has been particularly active in attempting to address the psychological dimension of serious medical illness. Gilewski from the American Society of Clinical Oncology, for example, recently stated two key concepts consistent with the present paper: 1. emphasis on science and technology often overshadows the humanistic aspects of medicine and 2. The doctor-patient relationship is of one of mutual influence and consists of reciprocal interactions [4]. All of these efforts to enhance the psychological and social dimensions of care within the biopsychosocial model have been fruitful, but they have lacked a theoretical framework with which to organize their thinking. Modern psychoanalytic theory has the breadth, depth and scope of interest to provide a highly useful and practical way to understand the psychological dimension of modern medicine as it is currently practiced.

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Received August 07, 2013; **Accepted** September 18, 2013; **Published** September 24, 2013

Citation: O'Reilly-Landry M (2013) The Drive to Relate: How Modern Psychoanalysis can Join with Modern Medicine to Improve the Doctor-Patient Relationship. J Psychol Psychother 3: 126. doi: [10.4172/2161-0487.1000126](https://doi.org/10.4172/2161-0487.1000126)

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The present paper proposes that modern psychoanalytic theory, with its multi-dimensional view of subjectivity and human relationships, provides a unified and useful conceptual framework for understanding the psychosocial aspects of modern medicine. This paper discusses ways in which particular psychoanalytic ideas can elucidate the medical patient's experience, illness behavior and interactions with the modern medical system. From the vantage point of this in-depth, humanistic perspective on the highly technological field of modern medicine, ways to improve the quality of medical care are suggested.

The Psychological Trauma of Modern Medicine

Being the recipient of medical care involves confronting issues of life and death, as well as threats to bodily integrity and psychological wholeness. Modern medicine saves lives, but may result in living a compromised existence, frequently with continued dependence on and interaction with, the medical profession. The achievements of traditional medicine are invariably accomplished by bodily impingement and invasion, at times gentle and pleasant, as with medication that relieves painful symptoms, at other times aggressive, as when a surgeon excises a tumor. The practices of modern medicine disrupt personal physical boundaries to an even more dramatic degree. Machines can peer inside the body without entering, while others physically penetrate the body in order to explore or manipulate what is there. Doctors move organs and other essential parts from one body to another through transfusions and organ transplantations. In the case of surrogate mothers, a woman can use her whole body to carry, grow and give birth to an infant that is the genetic offspring of people she may never have met. Technology also enables modern medicine to make use of non-human replacements for human organs and other body parts, thus blurring the boundary, not only between self and other, but between the human and the inanimate.

New kinds of relationships are fostered between a physically incomplete human being and an external replacement device. O'Reilly-Landry [5] has elsewhere written about the emotional complexities of being physically and psychologically connected to a life-sustaining device such as a dialysis machine, including the internal fantasies that can be stimulated in the mind of the patient in such anxiety-laden, potentially traumatic situations. Although not part of the physical human body, replacement organs and devices certainly become incorporated into the mind of the person who is medically ill. Through symbolization, a mechanical device can come to represent, sometimes unconsciously, aspects of the inner psychological self. The following case of Mr. Q demonstrates how medical objects can take on emotional significance at an unconscious level.

Mr. Q.

Following a diagnosis of laryngeal cancer, Mr Q underwent surgery to remove his larynx. Now rendered unable to create speech sounds, Mr Q was presented with an electro-larynx, a hand-held, battery-operated device that substitute for a larynx by transforming air vibrations into mechanical-sounding speech. Initially resistant to using the device. Finally accepting that this was the only way he could communicate effectively with others, he overcame his initial inhibitions about using it in public. It soon became his constant companion. Years later, Mr. Q consulted a psychologist to help him deal with his feelings about his failing health. At one point, he was dissatisfied with an aspect of the medical treatment he was getting, but kept this to himself, as he was a very polite man who wanted to be respectful of his doctors. He was afraid his doctor would be upset if he complained.

One day, Mr. Q came to his psychotherapy appointment only to

realize he had left his electro-larynx at home. This came as a surprise to both Mr. Q and his psychologist, since Mr. Q never went anywhere without the device on which he so heavily relied for interacting with the world. Since talk therapy was not possible in the absence of his ability to speak, they both decided it did not make sense to meet, and Mr. Q went back home. For the next appointment, Mr. Q arrived with his electro-larynx. Since this was unusual behavior for him, it seemed possible that there was some unspoken, possibly unconscious reason for leaving it at home, and that perhaps this was not just a simple act of forgetting. The therapist recalled that the session prior to the forgetting had been a very emotional one for Mr. Q, as he had expressed a great deal of anguish and grief about what seemed to him at the time to be a very bleak situation. Wondering whether there might be a link between Mr. Q forgetting his electro-larynx and what had happened in the previous session, the therapist asked Mr. Q how he had felt about their earlier meeting just prior to the forgetting of his mechanical device. Just as he had difficulty criticizing his physician, so was it difficult for Mr. Q to acknowledge any critical feelings about the therapist. He did, however, admit to feeling disappointed that she had not been more supportive when he had clearly been in so much emotional pain. The psychologist recalled that in a much earlier session, Mr. Q had thanked her for providing him with the space to be able to feel and express his feelings without being intruded upon. Keeping this in mind, the psychologist had tried to create the same safe space for Mr. Q by giving him plenty of emotional room to express his feelings. She deliberately pulled back and remained fairly quiet while he expressed some deeply felt emotional pain. Unfortunately, this had not been what Mr. Q wanted at that particular moment. Together, Mr. Q and his therapist put together an understanding that Mr. Q's forgetting of his "voice box" was not accidental; it had been unconsciously motivated to prevent him from "speaking up" and expressing the criticism and anger he was attempting to avoid acknowledging. Mr. Q appeared to be defending against his anger by rendering himself incapable of expressing it verbally, thereby protecting the therapist from the potential psychological harm he imagined it would cause her. Attending to Mr. Q's emotional experience, particularly those aspects he felt were unacceptable, opened up a dialogue about the respectful, but ultimately self-defeating, way he had been relating to the therapist and to other doctors: he managed to preserve the relationship, but at expense to himself, since his failure to speak up directly with his medical doctors and with his psychologist prevented him from getting what he needed from each of them. This understanding was enabled by the conversation with Mr. Q regarding the way he psychologically made use of the device that represented to him the ability to put his feelings into words.

The Central Importance of Relationships to Treatment Outcome

Psychotherapy research has demonstrated reliably that the quality of the relationship between therapist and patient is a powerful factor in determining the outcome of the treatment [6]. This is not to say that the therapeutic relationship is the only thing that matters in determining psychotherapeutic outcomes. It does suggest, however, that the therapeutic value of a psychological treatment is diminished in the absence of a trusting and cooperative engagement with the therapist. Perhaps the same can be said of the relationship between medical doctor and patient: that the effectiveness of a medical treatment is greatest when the patient is positively engaged with the doctor and the medical system. The absence of such a positive emotional connection may contribute to a patient's lack of adherence to treatment recommendations [7] or failure to appear for followup care [8], common problems in the world of modern medicine.

Comfort and security are compelling factors in forming emotional attachments and in establishing psychological well-being. Studies of early maternal deprivation in monkeys famously demonstrated the importance of the early relationship between mother and baby to the subsequent social and emotional development of the monkey [9]. In one classic experiment, Harlow found that baby monkeys who had been separated from their mothers from birth preferred to spend time with a wire "mother" covered with soft terry cloth, rather than one that dispensed milk, and when distressed, ran to the terry cloth mother [10]. The wire mother who provided only milk can perhaps be seen as analogous to the doctor who tends only to the medical condition of the patient, ignoring the ever-important need for emotional and social contact. A better therapeutic relationship appears to be what medical patients are requesting when they complain that their doctor does not know them and does not spend enough time with them.

The Role of Psychoanalysis in Treating Medically Ill Patients

Psychoanalysis is not merely a psychotherapeutic modality. It is also a theoretical perspective whose aim is to understand the psychological complexity of the human mind. With its attention to processes that occur outside of awareness and beneath the surface, a psychoanalytic perspective can be particularly helpful in addressing behavior that might otherwise be regarded as perplexing or enigmatic. Medical or health psychologists [11] and consultation-liaison psychiatrists are frequently called on to help when medical patients have difficulty adjusting to their illness or injury, or when they do not follow the prescribed medical regimen or engage in adequate self-care. Modern medicine poses a variety of problems for patients and medical caregivers that are relational in nature, and psychoanalytic ideas have for many years been applied to the treatment and management of the medically ill patient. Psychoanalytically-oriented psychiatrists have long played an important role in the management of the medical patient through their consultations in the setting of the general hospital [12,13]. Stein, for example, described unconscious phenomena as they occur within the scope of primary care specialties, emphasizing the importance to the medical clinician of paying attention to one's own subjective experience in the counter-transference [14]. Concepts derived from psychoanalytic theory, such as psychological defense mechanisms, transference and counter-transference, personality dynamics, and other clinical insights based on an understanding of the multiple layers of the mind, can enable mental health clinicians to understand what appears to medical clinicians to be merely irrational or impossible-to-manage behavior.

A Potential Role for Modern Psychoanalysis in the Practice of Modern Medicine

Psychoanalysis, at its origins, explored the multi-dimensional inner reality of the single individual. It addressed the types of inner experiences common to all: repression of thoughts and feelings we find unacceptable, internal conflict, and the tension between expression and inhibition of feelings and drives [15]. Freud knew that there are levels of experience that unconscious processes influence overt behavior, and that behavior and symptoms can have symbolic meaning that goes beneath the surface [16]. But for Freud and his earlier followers, psychoanalysis was a one-person psychology, concerned primarily with the psyche of the single individual. Transference, the feelings the patient has about the analyst that are rooted in past experiences with parents, was regarded as solely a manifestation of the patient's inner experience, having little to do with the reality of the analyst as a person

[17]. Counter-transference, the analyst's response to the patient's transference, was considered to be a nuisance best avoided [18].

As modern medicine withdraws from concern about emotion, subjective experience and relationships, modern psychoanalysis is tugging firmly in the opposite direction. It has been over a century since Freud developed his seminal constructs based on the idea that each human being struggles to tame our innate biological drives in order to be properly socialized [15]. In the latter part of the 20th and into the 21st centuries, psychoanalytic theory saw a shift from Freud's emphasis on an individual's defenses against sexual and aggressive drives, to an emphasis on relationships and emotional involvement with others. Relational and Interpersonal psychoanalysts emphasize that what is innate to human beings is a need to form relationships and that this need is even more fundamental than is internal conflict about the need to gratify basic drives [19].

During the second half of the twentieth century, psychoanalysis began to expand its scope and moved toward becoming a two-person psychology [20]. It began taking into account what goes on overtly and beneath the surface between two different people. The analyst became more than a mere blank screen upon which to project the contents of one's mind. A more contemporary view is that the therapist also has his or her own transference to the patient, and the analyst's counter-transference is considered a useful source of information about the patient and about the impact of the patient on others. Psychoanalysis has become a theory of intersubjectivity and mutual influence, [21,22] rendering it quite suitable for understanding the relational experience of the whole person embedded in the interpersonal process of the medical world, in addition to the psychological trauma wrought by the individual's experience of threats to body and life.

Useful Contemporary Psychoanalytic Concepts Secure Base

Psychoanalyst Bowlby [23-25] extended Harlow's ideas about early maternal-child relationship to human beings. He demonstrated the great importance to human psychological development of having a secure early attachment to the mother or to another consistently available care giving figure. He found that a child requires a "secure base," a relationship with another person who provides consistency, availability and relief from distress. From this secure base, the child feels free to explore the world, confident in the belief that he or she is not alone, even in the face of experiences of separateness. Gerretsen and Myers discuss the importance to the medical patient of the secure base, in terms of the perceived availability of the physician [26]. They analyze a case in which a terminally ill man with cancer goes from a state of anxiety to one of calm when the doctor assures the patient that he would be potentially available to him 24 hours a day during the weekend, so that the patient would not be alone with his pain. These authors suggest to doctors in similar crisis circumstances that they make explicit their availability in order to counter the patients' more standard assumption that their doctor, a significant attachment figure and source of soothing and comfort, is disconnected from them and their suffering.

Attachment Security and Anxiety

By far, the most extensive body of psychoanalytic research on medical patients and illness behavior is in the area of **attachment security**, a term first used by psychoanalyst Ainsworth and colleagues to describe young children's reactions to brief separation from their mothers [27]. Clinical researchers have found that the degree of security or anxiety that patients experience in their close, intimate relationships

determines a great deal of what goes on in the medical setting. Medical patients with a high level of **attachment anxiety** are less likely to adhere to medical regimen [7] or present for follow up care [8]. Attachment security is at times able to predict medical outcome, including the glucose levels in diabetic patients [28-30] and physical illness such as auto Hunter and Maunder have looked at the impact of attachment security and style on how patients interact with medical clinicians and the medical system [31]. It would undoubtedly be helpful to medical clinicians to be able to recognize the attachment styles of their patients and the type of feelings and responses these typically engender on the part of the health clinician [32].

Mentalization

The attachment relationship gives rise developmentally to the capacity to recognize and reflect on internal states of mind [33]. Such reflective functioning, or **mentalization**, is the ability to conceive of the self and other as subjective beings. It is the ability to be psychologically-minded - to understand internal psychological experiences such as thoughts, feelings, motivations, desires and conflicts. Mentalization is an imaginative ability that involves the capacity to hold in mind, the mind of another. Mentalization-based therapies are effective treatments for a number of psychological disorders [34-36]. The tendency to mentalize and consider the subjective state of the patient (and clinician) is easily lost when the focus is on failing bodies and efforts to sustain life, and yet nowhere is attention to subjective experience more important for psychological well-being than in the context of modern medicine. Kraemer et al. [37] have described the difficulty in the stressful, action-oriented neo-natal intensive care unit, of maintaining the reflective functioning required addressing the great emotional needs of parents and staff as they deal with the anxiety and grief endemic to this setting. Malberg and Fonagy [38] have written about their experiences applying a Mentalization-based group intervention to help adolescent patients with end-stage renal disease cope with the great emotional disruption of having a serious, life-threatening illness and being dependent on chronic dialysis for survival.

Patient and Medical Clinician as Subjective Beings

The approach suggested in this paper is to conceive of both patient and clinician in subjective terms. To focus on the patient's experience is quite consistent with Miller and Rollnick's [39] Motivational Interviewing technique, an evidence-based approach to helping patients to change their behavior. In Motivational Interviewing, found to be effective with medical patients and those who misuse substances, the clinician focuses on the patient's subjective experience, which is often one of ambivalence about making the desired changes. While offering help and encouraging positive change, the clinician, rather than insisting on any particular behavior, accepts that it is ultimately up to the patient whether or not to follow the doctor's recommendations or engage in any behavioral change. In both Motivational Interviewing and Psychoanalysis, the patient's subjectivity is acknowledged and respected; the clinician helps the patient come to terms with mixed and conflicting feelings and to decide what he or she wants to do. Another approach that advocates eliciting the subjective view of the patient is Charon's Narrative Medicine, in which the physician goes beyond the usual review of systems, listens closely, and responds to a patient's personal story behind the illness. This is an intersubjective experience in which the physician seeks to "recognize, absorb, interpret and be moved by the stories of illness." [40]. Meza and Passerman [41] address the challenging issue of combining evidence-based with narrative medicine. Maunder and Hunter describe "an interpersonal

dance" between patient and medical caregiver, in which the patient's insecure attachment behavior elicits particular types of responses from others, and ultimately affects the type of medical care he or she receives [32]. Both Charon and Maunder and Hunter, place the patient into the context of an inter-subjective, two-person psychology espoused by modern relationally-oriented psychoanalysis.

Zerbo, Cohen, et al. describe a model for consultation-liaison psychiatrists to utilize in the general hospital setting when encountering patients with personality disorders [42]. Though intended for mental health specialists, much can be learned that can be utilized by the non-mental health clinician. Individuals with personality problems present particularly difficult challenges for medical staff in that they may be dissatisfied with their care or caregivers and can be generally difficult to get along with; they prove particularly vexing, however, in their capacity to arouse uncomfortable feelings in those around them. Based on Transference-Focused Psychotherapy (TFP), an evidence-based, manualized psychodynamic treatment for people with personality disorders [43], Zerbo et al. [42] model makes use of those very unpleasant feelings that these patients induce in the clinician. This model understands these counter-transference experiences as reflections of the feelings the patient disowns because they are too painful for him or her to tolerate. In general, terms, the intervention centers on the clinician mentalizing the uncooperative patient; the clinician recognizes, empathizes with, puts into words, and reflects back, the patient's own emotions and subjective experience. Knowledge of TFP and of the psychological dynamics common to people with different personality styles helps the consulting mental health clinician to use transference and counter transference to better understand and empathize with the patient's underlying, unarticulated distress. A common result is that the patient feels acknowledged and understood, and frequently becomes a bit calmer and more cooperative. Although this form of treatment was designed for use in long-term outpatient psychotherapy, the model and framework were found to be applicable to the acute medical setting, even when no prior relationship existed between doctor and patient. In a similar vein, psychiatric hospitalist Skomorowski describes varieties of antisocial behavior and personalities as they present in the general hospital setting, and the need to understand their differing dynamics and subjective experiences in the context of the many stresses of being a hospitalized medical patient [44].

Lev-Ran et al. [45] present a case in which a prescribing psychiatrist, by attending to his own emotional reactions to a belligerent and non-adherent patient, and taking responsibility for his contribution to the negative interaction, was able to form the beginnings of a working alliance with the patient. This clinician avoided a power struggle of the type that frequently ensues with uncooperative patients, by attending to the patient's subjective experience, rather than the aggressive, non-compliant behavior itself: "I am hearing what you're saying about the medication and the treatment you're frustrated, you want to feel better, and you don't feel that this treatment is helping you yet...You thought that taking the medications would make a difference and were hoping it would happen immediately, and now that it hasn't happened that way you're not sure you are going to continue taking them. Have I got that right?"

Clearly, physicians, nurses and other medical professionals also feel the stresses brought about by negative interpersonal interactions that occur in the course of their work. The medical relationship is an intersubjective one, in which there is mutual influence of two people's psyches on one another. Of course, the doctor is there to meet the needs of the patient, but the physician or the nurse is no less a person

or a participant in the medical encounter than is the patient [46]. Medical clinicians can feel great joy when they are successful and their ministrations result in recovery, but they may despair when they fail, even when it is not their fault. And being human, they may make errors that sometimes lead to a bad outcome for a patient. As human beings, they utilize psychological defense mechanisms to cope with anxiety, frustration and hopelessness, the sense of loss when a patient dies or does poorly, or a sense of disappointment in themselves. They may also fear the anger and grief of their patients or patient's next-of-kin. Nissen-Lie et al. [47] found that the private personal life of the therapist affects the therapeutic relationship, and other medical clinicians should be open to the possibility that they may unconsciously communicate aspects of themselves to their patients as well. As the following example demonstrates, one's role as physician, nurse or other medical provider may also be influenced by one's personal life and history:

Dr. C.

Dr. C grew up with a father who was very ill throughout much of her childhood. Seeing the way the doctors took care of her father made her want to become one herself. Throughout her medical training and as a practicing physician, she worked hard and developed a reputation as a very careful, thoughtful and skilled doctor, dedicated to the health and well-being of her patients. But this doctor had very poor relationships with many of her patients. Although they knew she cared about their medical condition and about getting them better, she behaved harshly toward them if she felt they were not taking good care of themselves or were not following her recommendations perfectly. Her patients often ended up feeling she thought they were unworthy of the high quality medical care she was providing for them. Some of her patients left her practice because of the bad feelings she caused for them, and many who stayed would lie to her about how they were doing because they didn't want to risk making her angry. Like everyone, this skilled, dedicated doctor had a personal psychological history that makes her behavior a bit more comprehensible.

Dr. C's early memories of her father were of a happy, active man who took her on great adventures. When she was eight years old, he was diagnosed with diabetes. The girl knew that her doctors told him that he needed to eat right and take medicine if he wanted to be healthy, and she tried as hard as she could to help him with that. Although he initially struggled hard and was good about following his diet and taking his regular injections of insulin, his condition did not improve. He was no longer as available to her when he was sickly and he eventually became quite withdrawn; he began to feel hopeless about his condition and was no longer so careful about his eating and medication adherence. She was always encouraging of her father to eat better and to take his medication, but he would become resistant and then angry with her, rebuffing her efforts to help him. This future doctor watched her father's health deteriorate despite her best efforts and eventually he died when she was 13 years old. Her admiration of his doctors inspired her to become a physician herself, and she imagined herself saving people from terrible illnesses. When her father died, she missed him terribly. But her experiences with her father were also traumatic for her in a way she never appreciated. From her childlike perspective, her father died because he refused to do what the doctors had told him to do. She loved her father tremendously and did not realize that she was also angry with him; in her unconscious mind, he was responsible for his own death, which had left her feeling alone and abandoned. Her experiences with her father led her to work hard as a doctor to keep people healthy, but her unacknowledged feelings of anger toward her father prevented her from empathizing with her patients who were suffering. Whenever a

patient reminded her of this aspect of her father, the doctor-patient relationship became an adversarial one and she forgot that they were both actually on the same side. It was not until she realized that her punitive behavior with her patients was her unconscious way of still trying to keep her father alive that she was able to return to a stance of empathy and compassion for her patients who were suffering.

While it is important for doctors to see the whole patient, they must also be able to see their whole selves. They must understand that they bring medical knowledge and technical skills to their work with patients, but they also bring their own subjectivity: the desire to heal, anxiety about failure to do so, reactions to loss, responses to patient's narratives, counter-transference reactions to difficult patients. They react as people, though their training may discourage them from giving voice to this. Psychoanalyst and general practitioner, Michael Balint, recognized that doctors become deeply affected by what goes on with their patients [48] With his wife, Enid, he developed what have come to be known as "Balint groups" [49], psychodynamically-oriented groups in which physicians have the opportunity to share their reactions to their most emotionally challenging cases. The groups provide an emotionally safe opportunity for reflection and an opportunity to process the difficult experiences doctors encounter in medical practice [50,51].

Holding Environment

Freud's ideas have been researched and refined [52,53], and extended to patient populations other than the neurotic, repressed adults treated by Freud. Winnicott was both a pediatrician and a psychoanalyst who was interested in the mother-child relationship. He contributed a key relational concept called the "holding environment" [54]. He observed that an appropriately responsive mother provides a secure and accepting, non-punitive physical and psychological space for the baby or young child to safely feel and express his or her feelings, anxieties and infantile passions. He used this model of the mother-baby relationship as analog to the therapist-patient relationship in psychotherapy and psychoanalysis. In accepting and being attentive to the patient's inner experience, the analyst "holds" the patient, creating a safe environment in which they can both get to know his or her true self. Likewise, the concept of the holding environment can be readily applied to the relationship between medical patient and medical clinician; the doctor, by attending non-judgmentally to the subjective experience and anxieties of the patient in the context of illness, can provide an environment of safety, soothing and psychological holding. The medical milieu can also be seen as providing a potential holding environment for staff as well as patients. Psychologists, through group interventions, "hold" the staff in some high stress settings such as Emergency Departments and Intensive Care Units to help them with their experiences of loss and vicarious trauma [55,56]. Even a well-run office with attentive staff can serve as a holding environment for anxious patients waiting to be seen.

In sum, modern psychoanalysis has a great deal to offer to modern medicine. Delivery of care can be greatly enhanced by attending to the overlooked internal world of all who participate in the medical system. The relationship between physician and patient can be viewed usefully through an intersubjective lens, which sees the patient, not as passive recipient of care, but as a partner in a dyadic interaction in which each member has an impact on the other. The greater the clarity a clinician has regarding the subjective experience of the patient, the better the clinician will be able to empathize with and influence the patient toward healthful behavior. Finally, the entire medical system has the potential

to provide a complex holding environment, in which the anxious vulnerabilities brought about through confrontations with sickness and death might be contained and assuaged through careful attention to the subjective states of both the patients and clinicians.

Conclusion

When serious illness is involved, all participants in the medical relationship - patients and clinicians - confront anxiety and psychological trauma on a regular basis. Modern medicine saves lives, but as it does so, it can subject people to profoundly disruptive psychological experiences that can result in anxiety, depression, fear, grief, anger and other difficult emotional states. Traditional medicine treated the entire person within the context of a family and a familiar doctor-patient relationship, whereas modern medicine emphasizes individual body parts, technology, fast action and cost-effectiveness over interpersonal connection, subjective experience or reflection. There is now reduced personal contact between the person of the patient and the person of the doctor. Psychoanalysts have demonstrated that at times of stress, people seek proximity to attachment figures, those familiar providers of care who are a source of comfort. Individual patterns of attachment get played out in medical settings when a person encounters the stresses of illness. Traditional psychoanalytic concepts such as symbolization, unconscious communication, transference and counter-transference, as well as those from contemporary psychoanalytic theory, such as inter-subjectivity, mentalization, attachment security and holding environment, can be utilized to both understand and improve the psychological dimension of modern medicine.

The present paper proposes that a contemporary, relational psychoanalytic framework be utilized to organize thinking about the problems inherent to the practice of modern medicine. Psychoanalytic research shows that being emotionally attended to, psychologically recognized and understood - being treated as a subject, not merely an object - has calming and healing properties that can be helpful when people are contending with the anxieties and potential trauma of serious illness. The capacity to mentalize - to understand the psychological dimension of oneself and one's patients - can go a long way toward improving the relationship between doctor and patient and toward addressing the common complaint of patients that their doctor does not know them. The present paper proposes a conceptual reframing of the interpersonal interactions within the system of modern medicine. The following are offered as concrete ways in which psychoanalytic ideas can positively influence the practice of modern medicine. All of these involve attention to the subjectivity of the participants in the medical relationship.

1. Take steps to ensure that the doctor/doctor's office is experienced as consistent and available, i.e. establish a **secure base** for the patient.
2. Medical clinicians attend to the subjective experience of the illness and the medical treatments. i.e. engage in **mentalization**.
3. Medical clinicians attend to the subjective impact of the illness and treatments on family members.
4. Be aware of possible clinical manifestations of insecure **attachment style** or personality dynamics.
5. Integrate a **psychoanalytically/psychodynamically-informed** mental health clinician into the medical practice in order to provide consultation or direct intervention when problems arise.

6. Call on mental health clinicians for consultation.
7. Provide a **holding environment** in the form of patient-centered care in which specialists form an integrated team by communicating with one another and with the patient. This helps to reduce the patient's sense of fragmentation due to involvement of multiple specialists.
8. Provide a comfortable **holding environment** for patients who are waiting to be seen, e.g. short waiting time to see the doctor, attentive support staff.
9. Provide a **holding environment** for all medical clinicians, particularly those who deal closely with loss and trauma. This may involve psychologist-led groups.
10. Be attentive to one's own emotional reactions to patients and to what they might mean for the patient or for oneself [48].

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