

# Can the Professional be Personal?

Managing relationships with ill and dying people.

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Monday 23<sup>rd</sup> August 2004

Traditionally, helping professionals – especially those in the medical and nursing fields - have been trained to be dispassionate or detached, and have been expected to not be affected by the emotional pain that patients might experience. Additionally, there has also been a belief that the emotional pain from their *own* lives that health professionals might bring to their work should either be non-existent or kept out of their professional lives. It has, I think, also been believed that the impact on the professional of working with emotional pain should be eliminated (or at least it is often disregarded).

The reality of working with people who are very distressed or who are in great emotional pain because of illness or impending death is that such pain not only can but *does* affect us. And further, because (like our patients) *we* are human and feel emotional pain too, we not only bring our own past painful experiences with us into our work, but our own past painful experiences can be stirred up by our patients' pain.

On this basis, *I am questioning the assumption that health professionals should be detached; that they should exclude their own feelings from their work; and that they should not be emotionally affected by their work.* However, I am also asserting that we should **not** simply give free reign to our own emotions. To do that would inhibit our patients' freedom to

express *their* pain; it would burden patients with our problems; and it would handicap our capacity to work effectively. What I mean, instead, is that we need to *experience, attend to, harness and utilise* what we feel and experience in order to work effectively in emotionally painful environments. In other words, we need to *manage* our relationships with patients. There are a number of aspects to this that I plan to explore with you this morning. Firstly, how do we recognise and *protect* ourselves against the impact of emotional pain in a way that is *useful*? Secondly, how might we mobilise our capacity to understand and to draw on our own feelings and experiences to *enhance* the care, health and quality of life of patients?

The last aspect focuses firstly on how we can pay attention to our *intuition* and to our *thoughts and feelings* to help us to understand better our patients' experiences and to intervene more beneficially. It also focuses on a new way of thinking about the role of the health professional. In this regard I will later explore with you what I describe as the "executive" and the "caring" dimensions of the health professional's role.

However, let me begin by talking about the ways we recognise and usefully protect or defend ourselves against the pain of caring for ill people, but also the destructive and unhelpful ways we can defend ourselves.

### **WHAT DO WE MEAN BY DEFENCES?**

For over a century the notion of psychological defences or "defence mechanisms" has been part of our common understanding of emotional functioning. Indeed so common has it been that the phrase "defence mechanism" has become part of colloquial usage – often inaccurately.

Probably at the core of this is the idea that the mind has ways of protecting itself against pain. But the common usage does not go nearly far enough because it only addresses the aspects of which we are *aware or conscious*. Defence mechanisms usually fall into the realm of *unconscious* rather than *conscious processes*. We do not make conscious **choices** to use a particular defence mechanism in the way we might choose to defend ourselves with this or that weapon against an invader.

A deeper understanding of the concept of psychological defences sees them as *unconscious* mental mechanisms that are mobilised to prevent unbearable, disturbing, unwelcome or painful anxieties, experiences, thoughts and phantasies from **entering consciousness**. I am using the term "anxieties" in a general sense, to refer to some of the more fundamental sources of human pain – like our own death, and the loss or threatened loss of those we love. We don't necessarily consciously experience defence mechanisms at work – but we may be aware of their consequences.

As we gain deeper insights into our mental functioning we can begin to recognise when a particular defence has kicked in and whether it is a help or a hindrance.

### **DEFENCE OR DEFENSIVENESS?**

Defences are frequently regarded as the opposite of coping. This is an unfortunately superficial view. It is like suggesting that the mobilisation **of** the body's immune system to fight infection is only a pathological response! We all employ defence mechanisms – we *must* in order to protect ourselves against unbearable pain. However, here a distinction

must be made between defence and defensiveness. Defence is about *protection* while defensiveness is about suspicion, guilt, self-interest etc. The key question is not *whether* psychological defences are used, but *how* they are employed – in the service of defence or defensiveness. When professionals in this field are defensive, they impact negatively on patients. However *healthy* defences can enable us to manage better our responses to the emotional impact of this work – or put differently, to mobilise the “personal” in the service of the “professional”, especially when we can recognise and attend to them.

#### **COMMON PSYCHOLOGICAL DEFENCES.**

I want to briefly identify some basic primary common psychological defence so that we have a common understanding. Then I will look at how these defences might operate in professionals in this specific field, who after all are only using common human psychological defences themselves, just as their patients might. **Remember that these are primarily unconscious processes:**

**Splitting:** This is one of the primary defences we employ from very early in our lives. You will recognise – as I expand on it – its centrality in human functioning. Splitting is essentially the internal or mental separation of “good” feelings from “bad” feelings. By keeping them separate (or more accurately *by maintaining the psychological phantasy that they are separate*), we prevent our good feelings from being contaminated by the bad ones. We then might only feel the good feelings and not the bad ones.

**Projection:** projection and projective identification are used in close association with splitting. At its core, **projection** means getting rid of bad feelings by displacing them onto someone or something outside of us. **Projective identification** occurs when the person onto or into whom they are displaced becomes – in various ways - identified with the feeling or phantasy that is projected.

For example: A professional might feel helpless and therefore angry with a dying client. These feelings may be a combination of the projected feelings of anger and helplessness of the patient and the professional's own sense of impotence to save a dying patient. But to feel angry in such a situation may seem heartless. So instead, for example, the professional may project his or her feelings onto the management of his or her organisation who is then felt to be angry and heartless (and may actually become angry and heartless). The professional is then temporarily freed of his or her own difficult feelings. This is a good example of *defensiveness*. A healthy employment of the experience of being the recipient of projections of anger and helplessness would be to acknowledge and to recognise that this may be what the patient is experiencing, and the validation of these feelings in **the patient** would help him or her.

I would expect that the audience here today are people who *offer support* to or work in various professional capacities with those who are *experiencing* emotional pain. ***It is primarily against the fear of death or of disintegration, and the pain of loss – all of which can take diverse forms – which professionals must and do defend themselves.*** However loss and grief as major sources of emotional pain extend well beyond the most obvious forms to do with death and dying. We may also work with patients in diverse areas: people who are very ill or who may be dying; the

elderly; damaged or abused babies and children; damaged and injured people; and disabled people. Professionals *need* to defend themselves against the pain arising *from the work itself*. *Sometimes splitting oneself off does this.*

There are factors in the work itself and the closeness to others' intense experience of loss and grief that can and usually do re-ignite past losses that the professional has sustained. We tend more often to locate the pain **only** "there" in the patient where we can care for it, rather than **also** "here" where I must experience and deal with it in me. In fact the traditional view might be that if I am experiencing pain then I must not be coping with the demands of the job!

Another factor is that such work also stimulates potential **anxieties** in the professional. These too may be about the professional's own vulnerabilities ("What if I got breast cancer?" or "What if *my* child were dying?") These are frightening thoughts and feelings that the professional needs to defend against. If one were to remain in touch with these sorts of thoughts constantly, one might go mad.

When the professional becomes too strongly identified with the patient (the opposite of splitting off) such a loss of boundaries means that the professional's capacity to think and to have some space and distance in order to work is compromised. In over-identifying with the patient, the professional also becomes more vulnerable to the stimulation of past losses and of potential anxieties. They can also then *assume that they know what the patient is experiencing.*

Bearing in mind these risk factors: stimulation of past loss; activation of potential anxieties and over-identification we can examine the common psychological defences professionals use either to protect themselves (appropriately) or defensively.

### **SOME DEFENCES AGAINST THE FEAR OF DEATH & THE PAIN OF LOSS <sup>1</sup>**

#### **Avoidance (& avoidance of thinking)**

Avoidance may take a number of forms:

- not talking about death or referring to it euphemistically so as not to experience the pain it evokes personally;
- distancing oneself from the reality by addressing the issues in intellectualised terms (eg she is in the "protest" stage of grief); or
- by being over-concerned with statistics; or
- by dealing with the ill person or relatives by "telling and running".

Professionals can easily become absorbed in institutionalised cultures of work which promote the avoidance of thinking and feeling. But I will address this shortly.

#### **Task-centredness & aggressive intervention**

One version of this split is by professionals becoming over-involved with the *technical* aspects of their role:

- eg prayer rituals replace or help to avoid personal contact;

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<sup>1</sup> Obholzer A & Roberts V Z (eds) (1994) **The Unconscious at Work** Routledge, London

medical intervention replaces personal contact.

Another is by aggressive intervention. Eg:

radical surgery or heavy medical regimes are employed and help the physician feel omnipotent and split off the personal engagement with pain, into other professionals.

### **Chronic niceness**

This may involve excessive concern with making death a "nice" experience, and denying the negative aspects of caring for the dying. Professionals may wish to be the perfect carer making impending death or loss palatable, but in so doing creating excessive stress for themselves and not allowing the patient to feel angry or in a mess.

### **Survivor guilt & the need for gratitude:**

Professionals may find themselves feeling guilty for their own good health and fortune or even guiltily triumphant about their own survival. These are painful feelings in the face of someone else's tragedy. However, tolerating these contradictory feelings helps ultimately to manage them.

### **NEED FOR SUPPORT & CONTAINMENT**

Professionals need their own sources of nurturance to help manage painful feelings that arise from this work. Often shame prevents them from sharing their ambivalent feelings with supportive colleagues, leading to splitting and denial. But being *understood* may be the first major step to managing painful feelings – just as it is for patients.

At the heart of the matter, the most **unhelpful** defences are those which *maintain excessive* splitting between thinking and feeling, and which lead to:

feeling detached, omnipotent, ashamed of not being good enough, excessively diligent or perfectionistic, leading to burn-out; or becoming excessively matter-of-fact;

Professionals can become institutionalised in their delivery of care, working in ways that try to eliminate or minimise thinking and feeling.

A degree of denial and avoidance may temporarily ease the pain but ultimately psychological defences that rely heavily on splitting are very stressful and impoverishing. There is no easy answer to managing this individually, but ultimately it is in the recognition, understanding and acceptance of ambivalent feelings that make relief possible: so one may be able to resent the pain of the dying or grieving person while simultaneously empathising closely with their distress.

I want to mention briefly that groups or organisations also establish collective psychological defences against the pain evoked by the work in which they are engaged.

### **ORGANISATIONAL DEFENCES AGAINST PAIN**

Studies of organisations that deal with people in emotional pain have demonstrated ways in which their culture and organisation establish collective defences against pain. One of the most well known studies is that of the nursing system in a hospital by Isobel Menzies-Lyth. She demonstrated how the organisation of nursing services in the hospital *prevented* nurses from developing close relationships with patients. In so doing they rarely had to deal with emotional pain. However the destructive element was that they also experienced very low morale, poor job satisfaction and high staff turnover. By *avoiding* the pain of the work and of the nurse-patient relationship the staff were also denied experiences of emotional *repair* which are necessary in such painful environments. Other studies have described organisations such as hospices, schools for disabled children, nursing homes, wards for at-risk babies, AIDS organisations, psychiatric hospitals etc. All deal with loss, grief and associated emotional pain. It is in the collective ways of working, relating to each other, and thinking together, and the structure of tasks that organisational psychological defences are apparent. These often, like in Menzies-Lyth's study, artificially split the professional from the personal.

### **THE NATURE OF ORGANISATIONAL PAIN/ANXIETY**

All organisations exist to perform a particular key task - such as nursing the dying. The *very nature of this task* is a source of the pain that professionals have to face: nurses and doctors deal with pain, illness and dying; mental health professionals deal with madness and disintegration and so on. You

can determine from this that people working in many human services are constantly exposed to and have to manage, suffering of this kind.

Frequently the *task* in which people are engaged also influences the type of collective defences that develop.

The examples I have given of ordinary individual and organisational psychological defences against the emotional pain of working with illness and death have some common features. They can be helpful and they can be destructive. **In effect they do so by impairing thinking and eliminating pain from feeling.** Ultimately, the actions that ensue from destructive defences unexpectedly cause more problems than they solve. At the core of many of these defences is the splitting off of thought from feeling, and vice versa, as well as from effective action.

What action is needed to constructively mobilise the *personal* in the service of the *professional*? Essentially, it involves creating space, time and containment for reflection (ie. thinking) and emotion (ie. feeling), to be *engaged* with. The shoring up of splits like these means finding ways of *tolerating conflicting feelings* - love and hate, care and anger, grief and hope and so on - for the individual as well as for the organisation. Or, in other words, of bearing the unbearable. We want people working with emotional pain to protect themselves *constructively* in the face of this pain. **But the capacity to sustain concern and reparative support requires acknowledgment, affirmation as well as tolerating the co-existence of these unbearably conflicting feelings. The denial of such feelings is emotionally impoverishing to both the professional and the patient. It also creates emotionally sterile workplaces at best, and at worst, often institutionalises emotionally destructive or even toxic work cultures.**

This requires us firstly to be aware of and to pay close attention to our own feelings, thoughts, experiences and intuitions. When we can think about these, we can try to find appropriate ways to act on them.

One final comment on the role of intuition. Intuition has often been dismissed as unscientific, fanciful and “New Age-y”. However there is considerable understanding nowadays that intuition can arise from unconscious communication between people, in ways that are not yet fully understood. It is my firm conviction that intuitions should be attended to and it is my experience that when they are, they are a rich source of **emotional communication** that can provide a basis for seeking out more information and data. While intuition should be respected, other confirming information should also be sought. A brief example comes from work I once did with a suicidal patient and illustrates both the use of intuition as well as the opportunities afforded by attending to the feelings evoked in us when working in emotionally intense relationships.

A woman I once worked with told me over a few sessions in a very dramatic and manipulative way that she intended to kill herself. Naturally I was very worried by this, but instead found myself **feeling very angry** with her with thoughts which made me feel ashamed, like “Well go on – stop threatening and do it already!” Of course it would have been both dangerous and irresponsible (as well as unprofessional) to act on these thoughts and feelings. Unless I really thought about my feelings, I might easily have *become* angry with her, so strong were the feelings. Instead I was able to understand how angry *she* must be feeling and how ashamed she might be of her life failures. By attending to my own feelings of anger and shame I became able to help her talk about HER feelings of

anger and shame that led to her wanting to die; the result was considerable relief for her, the diminution of her suicidal feelings and an opportunity for emotional growth.

During an acute suicidal period I received a blank message on my messagebank. I had the strong intuition that this was a message from my patient and a call for help. I am very careful about breaching boundaries – as you will have gathered – so I would not normally make an unsolicited call to a patient. However, so strong was the intuition that I felt I should. When I called her, she was in the process of gathering a large dose of pills. I was able to persuade her to desist. Had I not called, I suspect the outcome would have been very different.

A way of engaging with the boundary of the personal and the professional might be to consider two key dimensions of the **role** of health professionals.

I have observed and recognised that there are two complementary aspects to the role of “health professional”. I have called these aspects the “Caring function” and the “Executive function”. I define the Caring function as the “soft-edged” or sensitive function that provides deep empathically based responsive intervention. The Executive function is a form of conduct drawing on one’s professional authority that is intended to help one to remain on-task. I also think of it as a “boundary regulating function”. The “hard-edged” or tougher “Executive” function involves regulating or managing certain boundary conditions essential for good professional practice. *This can be employed in negotiating the boundary between the personal and the professional – the issue at the core of this talk.*

Usually we think of this executive function as something that “managers” do. In the kind of work you are doing, the caring function in the

**professional-patient relationship** operates in tandem with an executive function *to manage the boundaries of that relationship*. What I have found though, is that many health professionals hold this Executive function in low regard while placing very high value on the Caring function: what I have come to think of as a “Saviour Complex”. A serious consequence is that the “personal” then penetrates and might overwhelm the “professional”.

Managing “boundary conditions” is critically important to managing all aspects of the professional-patient relationship. It is the proper management of boundaries that enables the human and emotional dimensions of the professional-patient relationship to emerge and to be properly worked with. It allows real human emotions to be present and experienced without them becoming an obstruction to or intrusion on the patient, the professional or the professional-patient relationship.

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We have to manage the emotional boundaries of our relationships with our patients. An example would be one where we allow feelings of our own to intrude on or override those of a patient, rather than *having and thinking about* our feelings in a way that helps the patient. An example of this was a Hospice nurse who consulted me many years ago, feeling completely burnt out. She was excessively zealous in looking after her dying patients to the point of invading their emotional space and their family lives; bringing patients flowers, gifts etc. What emerged was that she was driven to making these dying patients feel “good” because of her guilt about her neglect of her own elderly parents before they died. In other words, instead of recognising the *pain she was in and managing it*, she tried excessively to manage her patients’ emotional pain.

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