Clio's Psyche

Understanding the "Why" of Culture,
Current Events, History, and Society

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The Psychology of Health Care
and Reform

Psychohistorical Explorations
of
Barack Obama

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Anxiety, Denial, Fantasy, Fear, and Hysteria Regarding Health Care Reform

Paul H. Elovitz—The Psychohistory Forum

Americans have had the fantasy—and many still do—that we have the best health care in the world. We certainly have the most expensive health care system, since nearly a sixth of our gross national product is devoted to it.[1] Yet about 46.3 million people are uninsured,[2] approximately 45,000 Americans die every year for lack of proper medical care,[3] and 900,000 go bankrupt yearly as a consequence of medical bills,[4] despite most having some medical insurance. While many separate aspects of our hodgepodge system are world class, by the standards of infant mortality rates, longevity, ease of use, recovery rates, healthy life expectancy after age 60, and cost, U.S. health care lags well behind those of the other highly developed rich nations. In this essay I will discuss the fantasies, fears, hysteria, and denial serving as a barrier to effective health care reform, and provide some psychohistorical insights regarding health care.

American Antipathy to Benefiting from the Examples of Foreign Health Systems

Although there are about 200 countries in the world, Americans often act as if other societies barely exist. American fantasies do require that there be some "bad countries" (Hitler's Germany in WWII, Stalin's Russia in the Cold War, Saddam Hussein's Iraq, etc.) that need to be fought in the name of freedom and liberty; and some deserving "good countries" (France, Britain, and Stalin's Russia in WWII; Iraq in the mind of our 43rd President, etc.) to be saved from the external or internal "bad guys." In many cases it is sufficient to simply give money to help the starving children of Africa (African countries are not differentiated by

most Americans) and elsewhere. The rest of the world is a blur beyond being a vacation spot, a place to find inexpensive goods and cheap labor, or a source of loans to America to maintain our deficit spending.

Through the early stages of the health care reform debate, Obama's call for transforming our system from the most expensive in the world—rated 37th in terms of delivering life extension and wellness—has been crucified as a foreign anti-American socialist takeover which would destroy the last vestiges of our freedom while we wait endlessly for the ineffectual doctoring of bureaucratic medical staff.[5] What is most striking is that American narcissism has allowed the opponents of reform to cloak the realities of health care in the rich developed countries in the ideology of *laissez faire* freedom versus totalitarian dictatorship. This essay is based upon a large variety of sources, with some specific information coming from *The Healing of America: A Global Quest for Better, Cheaper and Fairer Healthcare* (2009) by the former *Washington Post* journalist T.R. Reid, who excellently summarizes health care in America and around the world, although its approach is not at all psychological.

Throughout my life I have never trusted the ideology of either the right or the left. When it comes to health care this profound distrust is borne out by the facts. When I lived for two years under a socialist government, I was provided good health care despite the single provider and no consumer choice system. During my involuntary service in the Army at home and abroad this socialist system was established and paid for by the United States taxpayer. This is far from a rarity in America, where recipients of government health care include approximately 44 million elderly and disabled individuals currently on Medicare,[6] about 42 million American children and poor families on Medicaid, and substantial, but much smaller, numbers of prisoners, Native Americans, and veterans.[7] However, I have never been one of them since af-

ter two years I wanted nothing more to do with the military.

A Health Care Debate Dominated by Fantasy Rather Than Reality

It has been utterly mind-boggling and at times mind-numbing to spend innumerable hours in August watching town meetings on the C-SPAN cable network in which large numbers of often gray-haired individuals denounce the attempts to achieve health reform by Obama and the Democrats as either the first or the final step to a socialist totalitarian form of government. Even at a town hall meeting held in a senior citizens' facility where virtually everyone was on Medicare—a generally efficient low cost per patient government-run health care system—the participants were not very amenable to reform for fear of socialism or a loss of their own benefits. The Democratic and Republican Congress people seeking feedback and support from their constituents often found it difficult and even impossible to proceed because of staged disruptions including large signs of Barack Obama with a Hitler-like moustache.

A basic principal of psychohistory and psychoanalysis is to explore the emotional basis of fantasies, holding them up to the light of reality. Both personal and political fantasies can be incredibly persistent. For example, several years into the Iraq conflict an overwhelming majority of Americans continued to believe that Saddam Hussein was responsible for the 9/11 attacks in the United States.

Fantasies about government involvement in health care abound and typically involve little connection to reality. Below I will examine some of these that were prevalent at the August town hall meetings and throughout the discussion of possible reforms.

Some of the Problems with the Current American System of Health Care

Most health insurance comes through employer-initiated programs. It is common for insurance companies to win their insurance bids by keeping the employee cost to a minimum through cutting corners, which makes some sense from *their* economic standpoint because employees are likely to change jobs and therefore insurance companies about every six years. In providing insurance to individuals and small employers, "cherry picking" is common-place. Only the healthy without existing medical conditions are signed up for the insurance—pregnancy counts as an existing condition from many of these insurers—and the insuree is either dropped or rates are skyrocketed up to a prohibitive level when significant claims are made. In short, when insurance coverage is needed the most is when it is most likely to be denied.

Insurance companies are also notorious for using delaying tactics rather than making payments directly. Delay of payment tactics can certainly work. For example, recently my wife almost paid a $425 bill from the beginning of this year because the confusing paperwork going back and forth between the provider and the insurance company made it appear that the coverage was denied, which was not the case. Insurance companies can certainly wear you down. This is a far cry from France, Italy, and Taiwan where the payments are made within the week. In Taiwan if the check is not mailed out within the week, the insured doesn't need to pay for next month's insurance as a penalty. There are numerous horror stories regarding the consequences of American insurance companies delaying or denying insurance, some of which end with the needless death of the insured.

My Personal Experience With Health Care

As a college professor I have much better than average health insurance. Unfortunately, over time my employer and insurers have effectively worked to lessen the benefits and increased my out-of-pocket costs. For decades my good

health care coverage was appreciated as a compensation for relatively low salary for someone of my education, dedication to high standards, and achievements. In 1997, I was required to contribute a specific amount for the health insurance, beyond the usual yearly deductible and co-pays. (At the time I discovered had I signed up for a pension plan one year earlier, I would have been "grandfathered" into the traditional high quality, total consumer choice, no cost to me, Blue Cross Blue Shield, major medical plan!) Nevertheless, I was left with a better than average policy, for which I paid a moderate amount at first. Every year the cost of having this medical insurance plan increased, encouraging me to transfer to a Health Maintenance Organization (HMO). Early this year the choice of paying extra was taken away as I was forced into a plan which would cover only 70% rather than 80% of allowed customary charges—which are usually more than the going rate in the costly area where I live—unless I go to the doctors and laboratory affiliated with the plan. In these cases I would simply have a $15 co-pay. A definite advantage to their plan is that it covers preventative medicine such as yearly exams (but only at the hands of a doctor affiliated with the plan) and flu shots (again with designated doctors), which had always been an-out-of-pocket item.

Our dilemma became: do we stay with our family doctor who knows every nook and cranny of our bodies and pay more, or go to some doctor with whom we have no history and for whom I have no recommendation except that of my cost-cutting insurance company? The tightness of my stomach and rise in my blood pressure following even considering this possibility has several sources. First and foremost, I feel that my rights are being infringed upon and that I am being treated like a commodity shifted around for the benefit of the multi-billion dollar insurance industry. Profane thoughts start occupying my consciousness as I consider if I should stay with our fine internist, who was a colleague be-

fore she opted for medical school and private practice, or be forced to change doctors to save money.

The lower costs to me of a Blue Cross Blue Shield-sponsored physician might be a pleasant surprise. As much as I personally respect and like my doctor, I can see some potential advantages beyond saving money: my physician's memory is not as sharp as it once was and my paper file is so thick that it can be very time consuming to check something. If the new insurance-endorsed doctor has everything online the process can be very quick. I think of French doctors, who are without paper files, inserting the patient's identity card that brings up their entire medical record. Also, perhaps these doctors will have the latest training that my friend has not had. (Although she is no Luddite, my physician refuses to have a computer in her office on the grounds it will distract from her direct contact with her patients.) However, will they look into my wife's room at the hospital at 6:00 AM on a Sunday morning even though her admission and treatment were at the hands of another physician, like her? Positive experience, loyalty, not wanting to be pushed around by my insurance company, and a preference for keeping as much control as possible for my own medical care, convince me to pay more to stay with my trusted physician.

Fantasies About Health Care Feeding Popular Anxieties

Reviewing my own medical options helps me to understand more about the anxieties expressed by Americans regarding health care. As every psychoanalyst and politician knows, change is difficult. It is extremely dangerous for politicians since public anxiety can be mobilized to defeat change, as it was in 1993-1994 when Clinton's health care program was blocked. Debunking myths is not easy especially when there are so many industries, peoples, and groups with their own vested economic, ideological, and psychological interest. Below, I will examine many of the myths,

holding them up to the light of day. The primary myth is that if the government is involved in health care, it would take America down the road to socialism. (All the governments of the developed world have government health care and only some are socialist. Germany, which has government-mandated health care since the 19th century has a conservative government, not a socialist one.)

- Governmental involvement is by its very nature inefficient, and private insurance therefore is always more cost efficient than public insurance. (The reality is that government-run systems in other rich countries have much lower administrative costs than the private sectors of the U.S. health care industry.)
- Other rich countries all have socialized medicine. (Actually, most national health care systems which Americans think of as socialized are not socialized at all since high levels of care are provided by private doctors, private hospitals, and private insurance plans with lots of choices.)
- Americans would hate and have no choices in a government-run single payer health system. (In fact millions of Americans seem to like government-run systems since when they turn 65 they overwhelmingly switch to Medicare. In contrast, in Switzerland and Germany people keep their same private insurers regardless of their age.)
- People under socialized medicine come to the U.S.A. for treatment because their system is so inferior. (Although Canada and Britain withhold some services, their populations strongly support these programs. Canadians think as many foreigners come to their country for free medical care as people in the U.S. believe Canadians go to the U.S. for health care. Both numbers are exaggerated.)
- Countries with universal health care have far more withholding of service and longer patient waiting times than

does the U.S. (In fact there is more withholding of services in the U.S. than in the other developed countries. While countries like Britain and Canada limit the number of specialists so there are problems with waiting times, in Denmark, France, Germany, Sweden, etc., there are shorter waiting times than in the U.S.A. In Japan, patients are inclined to not even bother making appointments because the waiting times are so short.

- Under Obama "Death Commissions" would be established to determine who lives and who dies. (A pure fabrication meant to put the fear of death into those seeking reform.)
- Illegal aliens would be covered under the Obama health plan. (The House bills explicitly prohibit this.)
- Foreign systems all have bloated, costly bureaucracies. (The reality is that their systems are usually much less bureaucratic than that of the U.S., which is why a country like Japan, spending half of what the U.S.A. does on health care, has such markedly better results.)
- The systems in foreign countries are too un-American to work here. This follows from the notion of American exceptionalism—the U.S. is different and implicitly better than the rest of the world. (Although America has a different history than much of the world, the way the idea of American exceptionalism is used often reflects a not so unique xenophobia. Experts from Harvard, Princeton, and other U.S. institutions have designed by some of the best health care-systems around the world. The main obstacles to reform in America have been a lack of political will combined with the Washington system of gridlock.)

Most of the myths about health care being bandied about this year are based upon fear of growing government involvement in society. The ideological fantasies exclude

examining the present reality and the issue of what different proposals mean to real-life people—to say nothing of our federal, individual, state, and corporate budgets. Currently, the cost of a General Motors car includes $1,525 worth of health care expenses, while their foreign competitors directly pay nothing for the health care of their workers, giving them an unfair advantage. Conservative Republicans clearly lost the 2008 election, just as they lost the 1992 election, but they are determined to block an expansion of the social welfare aspect of government. During the massively deficit spending supported presidency of the second Bush, some conservative ideologues began to say that even Republicans could not be trusted with the national treasury, so that perhaps it is best if the government spends so much that it must cut out social programs. Throughout the year they have been organizing "tea parties," representing the culmination of the strategy of curing big spending in national government. The "tea" in the "parties" refers to taking radical steps against taxation, as they recall our founders did with the direct action of the Boston Tea Party of 1773. (In fact a group of libertarians started the Boston Tea Party in 2006!) Thousands of conservatives and libertarians showed up for a Washington, DC, anti-health care-reform, anti-spending rally organized on September 12th with former Republican Congressman Dick Armey as the most prominent speaker.

Prolonging the Process of Dying Versus Quality of Life in End of Life Care

American belief in technology and the impulse to deny the inevitability of death has led to fantasies of being able to postpone death indefinitely. But taking a long time to die is no way to live for most human beings. End of life decisions are not easy, but in our culture a number of factors combine to provide useless, inhumane, and expensive procedures postponing death, while creating a terrible life for the dying and their families. As Dr. Matthew Hayes puts it, the

patient "often must experience the indignity of suffering the cascading failures of systems and organs; each in their turn, aggressively treated by another tube, through another orifice, natural or newly created" (personal communication, 9/28/09).

A number of factors combine to create this nightmarish situation. Doctors so often perceive the impending death of their patients as a personal failure, assuaging their guilty feelings and those of the families who are often in shock by taking some action, however useless. The hospitals benefit financially because the bill for this extension of dying is picked up by Medicare, the insurance companies, the patients, their estates, or their families. As I will illustrate with the example of John Caulfield, palliative medical care is much more humane than pursuing the model of preserving life at all costs in the hospital.

About one third of all Medicare funds go to end of life services, mostly for the last few days or months of life. For John Caulfield, a member of the Psychohistory Forum's Advisory Board, Hospice was a life saving system, perhaps extending his life for two years. In his 82nd year he felt that hospitalizations for his heart condition were "killing," rather than helping him. The impersonality of the system overwhelmed him. On Hospice he stayed in the comfort of his home, except for rare emergencies, enjoying its peaceful quiet without medical intrusions. There he felt useful as he walked the dog, straightened the house, prepared dinner for his working wife, and enjoyed a social life with his family, while having the care of an empathetic doctor, nurse, and hospice worker—all of whom came to his home. Dealing with his health problems at home left him feeling that he had some control of his life and usefulness to his loved ones. When those who had not witnessed his struggles for health expected his death to be imminent upon his going on Hospice, those close to him recognized the life-extending quali-

ties of the system for John. After two years, he, along with his family and friends, knew he was ready to relinquish life when his body was just too worn out. Of course, a person who felt certain that going on Hospice meant death for them rather than relief from aggressive medicine, would likely die much more quickly.

Some Psychological Reflections and Defense Mechanisms

It is distressing that there is virtually no public discussion of the psychological aspects of health care in the current debate. We cannot separate our bodies from our minds or our minds from our bodies. Both are incredibly complex and interconnected. The marvels of modern society and medicine come at a high price, a price that is not simply financial. Health care brings dependency issues to the fore. Health care patients, without regard to age and title, are stripped down to their bare skin like newborns and are dependent on others. They often feel stripped of their dignity and considerable money as well. Others take control of our bodies, perhaps leaving us feeling much as we did as small children: helpless—unable to care for our own needs—dependent, and afraid. Patients are called by first names by individuals often a fraction of their age. In the face of feeling infantilized, is it surprising that many avoid preventative or needed care?

How do people defend themselves against the uncertainties of health and the impersonality of the health care system? Some mechanisms of defense coming to mind are denial ("I never get sick."), suppression (I know I must have cancer but I don't want to think or do anything about it."), intellectualization ("Of course I could get sick and that lump I have may be cancerous, but I would rather talk about health care policy than go back to the doctor."), projection ("Yes, I love money, but doctors just want people to get medical checkups because they are all greedy, even those working in

clinics."), undoing ("I was dumb not to go to a doctor for 20 years, now I go every month even though all my docs, who don't know about each other, say I only need come once a year."), and regression ("Yesterday, the doc called and said I definitely have a fast growing cancer requiring an operation tomorrow morning, instead I am going to go to a Caribbean Island for a month and just sleep on the beach like I did as a kid.").

Back in the early 1980s Henry Lawton and I organized a Saturday workshop on transference to institutions with papers by psychoanalysts who were also a lawyer, nun, and priest. The transference to hospitals and medical institutions is quite emotion-laden and powerful. Hospitals often evoke the feelings of the "good mother" who can heal and save you and sometimes the "bad mother" who can maim and kill you. My wife and some 1,800 other individuals volunteer at a local hospital precisely because they have a positive transference to it. Throughout most of history, transference feelings to hospitals were much more negative than they are today because these institutions were places where people were likely to die from high infection rates and shock prior to the use of anesthetics, antibiotics, antiseptics, and other life-saving advances of modern medicine.

In America the transference to insurance companies is much more negative than to doctors, nurses, and medical technicians precisely because the mostly profit-making insurance companies set themselves up as gatekeepers to health care. Thus they can become the evil "other." Despite their customer service representatives often having to finish each telephone conversion, politely asking if they may help you with anything else and then thanking you for using their services; gatekeepers are an obstacle. Last year, for reasons unknown to us, an insurance representative in communicating with the doctor's office, attributed to us false and inflammatory statements about the surgeon who had performed a pro-

cedure and was likely to perform another one. My speculation is that this individual was taking out her frustrations with her job, at having to say things by rote, and with whatever other issues she had, by enjoying the power of schadenfreude—the pleasure at the displeasure of others.

There is no question that our current health system often transfers power from the doctor, hospital, and patient to the insurer. This leaves the average person at the mercy of a typically low paid, medically uneducated employee of an anonymous insurance company. A friend who worked as an emergency room physician would find that insurers would attempt to block or delay vital treatment needed under exigent circumstances. So, when he and his colleagues should have been focused only on the medical needs of their patients, he would be on the telephone with the insurance company representative, demanding to know the individual's name, identification number, medical training, and the supervisor's name and identification number prior to slamming down the telephone and awaiting a call back from a supervisor who did not want to be sued. My friend is unusual in that he is virtually impossible to intimidate, is unfazed by confrontation, and prides himself on fighting for the rights of his patients.

If the U.S. insurance system were an individual it is tempting to see it as neurotic at best and psychotic at worst. A system set up to raise the maximum anxiety as it serves the narcissistic needs of companies staffed by people who may secretly be getting sadistic pleasure from their clients before ending their telephone calls with thanks for having called them and "Is there anything else we can do for you today?" It is a totally ulcerating process to get through the barriers established by the insurance companies starting with working past the machines answering your calls, and then repeating the same information when you actually get to speak to a representative. It is a system with about 25% administrative

costs compared to 5% in France, and even less in Japan and Taiwan.

During the health care debate, the only psychological reference that I recall was on September 23, 2009 during the Senate Budget Committee hearings in which Republican Senator Jim Bunting of Kentucky used the wrong word and, with a sneer, referred to it as "a Fraudian Slip."

The Goals of Health Reform Versus the Reality of Washington Politics

It would be good if the U.S. could reform its health care system to make it more economical, efficient, patient/provider centered, and empathetic while improving its overall performance to provide the longer life expectancies, low infant mortality rates, and other health achievements of the systems in France, Japan, and most other developed countries. This certainly will not happen in the near future, if at all; indeed the Washington system of gridlock makes even the moderate goals of the Obama administration problematic.

There is a sharp contrast between what is needed for effective 2009 health care reform and the needs of the political process. Given the incredible complexity of the current system several years of analysis and debate would be optimal. However, the reality of politics is that if health care reform is not passed within the next six months, then it is virtually certain that there will be no reform under this administration. While denying it, the Republican leadership is hoping for a repeat of the 1993-94 Clinton health care failure, resulting in a Republican takeover of the House and Senate in the 1994 election. In contrast to the Clintons' aborted efforts, Obama's strategy has been to bring the major drug makers, insurance companies, and other substantial health care interests, as well as the Democratic congressional committee leaders, into the process of planning reform. Their presence increases the chances of a bill being passed while lessening the likelihood of profound changes being made.

The current administration is unrealistically promising not to raise taxes or take away services while reforming the system. Some reasons for these misguided claims are that no major American health reform has paid for itself in the past, health use increases with availability, and the realities of the political "sausage making process" means that efficiencies will be lost as special interests receive benefits to gain their support or acquiescence. At this point of the congressional process, it appears that governmental power will be utilized to force most of the uninsured into private insurance plans. This would extend coverage, but not reduce costs, as a single payer alternate might.

The major fiscal problem with the hodgepodge of the U.S. health system is that the incentives are to spend more money for administration, doctors, end of life care, hospitals, insurance companies, and technology. These incentives keep driving up the cost of health care. Other developed countries have used either a single payer system or governmental regulation to hold down costs while achieving better medical results. Considerable progress can be made even without a complete overhaul of the U.S. health care system. It would help to avowedly accept universal access to health care as a human right rather than as something that is dependent upon one's financial well being, as is the case in other industrialized countries. A consequence of this approach would be an emphasis on less expensive prevention rather than on the more costly reparative care**.**

Conclusion

The incredible cost and inefficiency of the U.S. health care system has placed a great burden on our economy while leaving 45 million people without coverage despite some aspects of it being the best in the world. Since nearly a sixth of our gross national product is devoted to maintaining it at a time when our economy is in recession and facing increasingly intense competition from countries spending far less

with much better results.

The enormous anxiety about change and ambivalence regarding reform have been fed by conservative ideology, fear—at times bordering on hysteria, massive denial, special interest groups, and a xenophobic disinclination to learn from the rest of the world. The annual 20,000 preventable deaths as a result of a lack of comprehensive and fair health care system and hundreds of thousands of bankruptcies due to the costs of health care are among those without the sufficient political power to make their voices heard. Psychological studies of why health and its care are so anxiety-producing can help us understand and assuage some of the resistance to change.

At present progress is being made toward making the system more comprehensive and less unfair; however, there is little indication, despite the President's intentions, that run-away health care costs will be contained. We in America are all participant observers in the current struggle to change the system.

Paul H. Elovitz, PhD, *a psychohistorian trained as a historian and psychoanalyst, has taught at Temple, Rutgers, and Fairleigh Dickinson universities before becoming a founding faculty member at Ramapo College of New Jersey. He is director/convener of the Psychohistory Forum, a past president of the International Psychohistorical Association, editor of this journal, a presidential psychobiographer, and the author of over 200 publications. Dr. Elovitz may be contacted at pelovitz@aol.com.*

Endnotes

[1] Up to date health care statistics are difficult to obtain: T. R. Reid,, *The Healing of America: A Global Quest for Better, Cheaper and Fairer Healthcare,* NY: The Penguin Press, 2009, has compiled a lot of these. The World Health organization most recent statistics are 15.3% for 2006 <http://www.who.int/whosis/whostat/2009/en/index.html>. Members of Congress have referred to health costs as 17% of the GNP or one sixth of the economy. All agree that there is a very rapid increase in the % of the

GNP going to health.
[2] US Census, US Department of Commerce, "Income, Poverty And Health Insurance Coverage In The United States: 2008," *U.S. Census Bureau*, 10 Sept. 2009, <http://www.census.gov/Press-Release/www/releases/archives/income_wealth/014227.html>.
[3] Katherine Harmon, "Lack of insurance causes more than 44,000 U.S. deaths annually, study says," *Scientific American*, 27 Sept. 2009, <http://www.scientificamerican.com/blog/post.cfm?id=lack-of-insurance-causes-more-than-2009-09-17>.
[4] David U. Himmelstein, "Medical Bankruptcy in the United States, 2007:results of a National Study," *The American Journal of Medicine Vol. xx No. x, 2009. <http://www.pnhp.org/new_bankruptcy_study/Bankruptcy-2009.pdf>*.
[5] According to the World Health Organization (WHO) in the year 2000 the U.S. ranked 37th o f 191 countries in terms of health performance. See http://www.who.int/inf-pr-2000/en/pr2000-44.html U.S. The WHO decided to discontinue such ratings because of the complexity of the issues involved.
[6] Reid, *Healing of America,* p. 12.
[7] "Housing and Household Economic Statistics Division. Income, Poverty, and Health Insurance Coverage in the United States: 2008," *U.S. Census Bureau*, 22 Sept. 2009, <http://www.census.gov/prod/2009pubs/p60-236.pdf>. ❑

Sources of the Emotional Explosion in the Health Care Debate

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The extremely heated and emotional debate that erupted in the summer of 2009 over President Obama's attempts to formulate and pass major reforms in the U.S. health care system might seem more than a little surprising. It was probably inevitable that such far-reaching change would generate considerable controversy and even fear. However, the virulence of the emotions and the linkage of health care to such seemingly unrelated "hot button" issues such as gun control certainly does not represent "politics as usual." This

paper seeks to trace the roots of this explosion by examining public opinion about health care reform at the time of the 2008 presidential election. While the American public appeared supportive of universal health care, one of the central reforms, the differences in opinion among various groups of citizens held the potential for the sharp cleavages that exploded in the following year.

The data for our analysis comes from the 2008 American National Election Study (ANES) conducted by the Survey Research Center of the University of Michigan. One major advantage of using this data set is that the respondents are polled on a very wide array of political topics, which allows us to examine how attitudes about health care reform are related to many other important issues. In this paper, we examine the attitudes about universal health care of the 1,442 white Americans in the ANES sample.

Whites were fairly supportive of providing universal health care at the time of the 2008 elections. Exactly half (50%) approved of extending the system to provide universal care in contrast to the 37% who opposed this reform, with another 13% neutral. While this fell short of a strong majority, it did suggest that President Obama could have found a very significant core of support for the major reforms that he was contemplating. Alternatively though, if a significant segment of these supporters were susceptible to persuasion, the opposition to health care reform could have become quite daunting, as it did in fact.

One method to assess the potential for the health care debate becoming emotional and even nasty is to break support for universal health care down by a variety of demographic characteristics and political attitudes. If attitudes about health care are correlated with sharp cleavages in American politics, the potential for the debate about the issue becoming strongly politicized would be much greater than if views about universal health care formed a separate dimen-

sion. Our analysis found that partisanship was highly correlated with support for universal health care in 2008. There was a huge difference of 45 percentage points in support for health care reform (69% to 24%) between the supporters of Barack Obama and John McCain. Likewise, people who did not like Rush Limbaugh were much more supportive of universal health care than those who did by the strong margin of 52% to 29%. That this difference, 23 percentage points, was significantly less than the one for presidential vote, moreover, suggests a potential for Limbaugh to rally his supporters even more sharply against health care reform, which certainly seems to have happened in the spring and summer of 2009.

People's need for health insurance would also be expected to shape their support for health care reform. This indeed turns out to be the case. Those without current insurance were considerably more supportive of universal health care by the margin of 63% to 47%; and those with family incomes under $40,000 were much more supportive of universal care than the more affluent; 64% to 43%. Yet, the difference between Americans younger and older than 65 (51% to 40%) was not that pronounced, despite the fact that seniors have Medicare. In retrospect, this limited age difference created another potential for increased opposition to health care reform when seniors became receptive to Republican claims that the Democratic plans threatened their Medicare benefits.

We also related attitudes about health care reform to several issues tapping two central issue dimensions in American politics: the role of government in helping the disadvantaged and cultural values. Health care represents an important issue in the debate over whether government should take a proactive role in promoting the social welfare of American citizens. Consequently, it should not be surprising that there were strong correlations between indicators of desiring a proactive government and support for universal

health care. For example, support for universal health care varied greatly between those who wanted government to do more and those who advocated a smaller public sector (63% to 30%). Likewise, 68% of people who were not concerned about the size of the federal deficit wanted universal health care compared to only 45% of those who demanded deficit reduction. Significantly, public opinion shifted considerably in a conservative direction on both these attitudes about the role of government in response to strident Republican criticisms of President Obama's economic policies. Consequently, support for health care reform was almost certainly undercut by growing public perceptions that government was "doing too much." The relationship between cultural issues and support for health care reform is more problematic because, *a priori*, there would not appear to be any *logical* linkage between them. Yet, conservatives on abortion, immigration, guns, and gay marriage were less likely to favor universal health care than those who were liberal by approximately 10 to 20 percentage points: (40% to 61% for guns, 43% to 60% for gay marriage, 42% to 51% for abortion, and 42% to 55% for immigration. Taken together, these findings suggest a very significant potential for health care reform to become enmeshed in the culture war divisions that have become the most emotional divisions in contemporary American politics.

The roots of the intense and even vicious debate over health care reform in 2009, then, can be found in public opinion at the time of the 2008 elections well before the issue became highly salient. Superficially, the general public appeared to be at least mildly supportive of reform. Yet, it is also easy to discern the launching pad for the bitter battle that soon erupted. First, even as the issue lay quiescent, attitudes about health care were fairly strongly correlated with partisanship. Consequently, the eruption of a strident partisan battle over health care in the Spring of 2009 almost certainly activated latent partisan feelings. Second, the association

between attitudes about health care reform and polarizing cultural divisions (surprising as it may be) provided more tinder for an escalating and expanding conflict. Third, the growing conservatism of Americans about the general role of government in 2009 undoubtedly contributed to the growing polarization on health care. Finally, the sharp growth in the opposition of senior citizens probably reflected growing hostility on cultural issues (e.g., fear of political and social change) as much as self-interest over perceived threats to Medicare.

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Understanding the Irrationality of the American Health Care System

David Lotto—Psychohistory Forum Research Associate

Let me start with the personal story of how I came to be involved with the issue of health care policy and attempting to change it. I am a psychoanalyst and psychotherapist, and have been in full time private practice in Western Massachusetts since 1977. From the beginning, and continuing to the present, I have been a "provider" for any and all health insurance companies who "covered" the people who live in my area. Initially, my primary motive for doing this was to

generate income. However, even after my practice was secure and well-supplied with referrals, I continue to maintain my contracts with the insurance companies, mostly because I believe that my services should be available to the public at large and not just to those who can afford to pay psychotherapy fees out of pocket. Starting in the mid-1980's, and increasing in strength and presence since then, therapists and Americans have had the phenomenon of managed care paying all or a large part of the patients' fees, but at the cost of dealing with a variety of severe intrusions on the treatment.

Unlike many psychotherapists, who terminated their insurance contracts when managed care took over, I chose to stay a "provider" because I felt that not being able to work with large segments of the population was worse than making the accommodations necessary to treat patients within the restrictions imposed by managed care. However, I did become quite actively involved with several organizations of psychotherapists, psychologists, and "consumers" which were trying to undo, or at least ameliorate, some of the depredations brought on by managed care. A number of us tried diligently for years to attempt to work legislatively and legally, as well as to try to negotiate directly, with the insurance companies. All of these efforts were notably unsuccessful.

Some time around 2003, it became clear to me that the only way managed care could be reined in or eliminated was through a fundamental change in the way health care was paid for in this country. Since mental health was only a small part of the 2.4 trillion dollar health care industry and was well embedded within the larger medical reimbursement system (MSNBC 3/12/09 Report, see http://www.msnbc.msn.com/id/29641091/), major change would have to involve the entire health care financing system. The power of the insurance corporations would have to be challenged and reversed. They would have to be either eliminated or severely limited and regulated. The most direct method

would be to adopt a universal government-run single payer system. Consequently, I joined Physicians for a National Health Program (PNHP), as well as several other single payer groups, and have spent a good deal of time since 2003 trying to master some of the complexities of health care policy and finance in this country.

This is all by way of introduction to writing about a psychohistorical account of health care policy and the current reform process. Although the essence of a psychohistorical view is to understand the psychological motives and processes crucial to comprehending past and present group behavior, we must also consider the political, historical, and economic elements. If we want to say something about what is irrational about health care policy and the current reform debates, we need to know something of the rational side of the issue.

As a starting point, consider that the vast majority of people who thoughtfully and disinterestedly examine health care policy conclude that some form of what is known as a single-payer system is the option that makes the most sense. This statement applies only to those who are both knowledgeable in the area and do not have a significant financial stake in the health care status quo. It also does not apply to free market advocates who believe that the private for-profit sector *always* does things better than the government or a non-profit.

Virtually every country in the developed world, other than the United States, has some variant of a single payer system. This country spends far more per capita (more than twice as much compared to many others) than any other country in the world and with mediocre health care outcomes. The latest numbers have us ranked behind other developed countries in population health care outcomes, such as life expectancy and infant mortality.

There are many arguments for the superiority of a single-payer system. The two most powerful are that it eliminates two-thirds of the roughly 31% overhead (dollars not spent on actual health care services) generated by the administrative complexity of our current fragmented multi-payer private insurance company system, for an annual savings of around $400 billion; and because a single payer entity has enormous market power (David U. Himmelstein, **"**Costs of Health Care Administration in the United States and Canada," *New England Journal of Medicine.* Vol. 349:768-775 No. 8, August 21, 2003. See <http://content.nejm.org/cgi/content/full/349/8/768>). As the sole purchaser of health goods and services, it is in a position to force all of its suppliers, from pharmaceutical companies and medical device makers to medical service providers, to sell their goods and services at the lowest possible price. This generates large additional savings and builds in a very powerful cost control mechanism.

The health care industry has become a major political force in Washington, which helps to explain the rapid increase in costs. Their interest in profits is placed before those of the insured and the cost containment interests of the public, thus contributing to the economic irrationality of the system. The level of irrationality in the current debate on health care has reached a point best described as hysterical. There is also latent racism in the attack on "Obamacare".

There are many sources of this irrationality, but here I will focus on its basis in the belief system, ideology, and ultimately the group fantasy, which appears to have a powerful grip on the population of this country. I would characterize this fantastical belief system as American exceptionalist libertarianism. At its heart is the conviction that this nation and its people both value and embody "freedom," more than any other nation or people. This fantasy is clearly quite narcissistic. We Americans are special; we are the land of the free.

Professional historians have long discussed the thesis of "American Exceptionalism" to characterize a variety of beliefs and behaviors exhibited by this country going back to pre-revolutionary times. Although the core meaning of this libertarian credo is that individuals should be as free as possible to pursue whatever it is that makes them happy, it has been extended to apply to business ventures and corporations. They too must be allowed the unfettered pursuit of their goals—primarily to make money.

This freedom, for both individuals and corporations, to do what they want is contrasted to public or even more strongly to governmental structures, which are seen as restricting this freedom. In the health care debate, those influenced by this libertarian ideology eliminate a single payer system *a priori* because it is governmental or closely regulated by the government

This is precisely what has happened during the recent deliberations of Max Baucus' Senate Finance Committee during which some dozen "stakeholders" were literally invited to sit around the table to discuss the provisions of the reform bill. Included, among others, were representatives of hospitals, drug companies, physicians, health insurance plans, some labor unions, and the chamber of commerce. However, there was not a single-payer supporter amongst them. When some PNHP physicians showed up to speak at a public hearing of the Committee to advocate for a single payer system, protesting the exclusion of representatives of their position, the police were called to forcibly remove them from the hearing room and they were arrested.

The subtler, and in some ways more dangerous, element is the power and pervasiveness of the predominant group fantasy/belief system in this country. Even among people who are aware of the obvious superiority of single payer, many will not actively fight and advocate for it because they recognize and acknowledge, and perhaps share a

bit of it themselves, the hold that this fantasy has on the American people at this point in our country's history. These are the people, like President Barack Obama and the *New York Times* columnist Paul Krugman, who say things like "if we were starting from scratch" or "in the best of all possible worlds" we would have single payer, but then add that "politically" it is just not feasible. Perhaps it is a case of a self-fulfilling prophecy.

We have seen the most virulent and hateful aspect of this libertarian fantasy in the various right wing flights of political imagination loosed by Rush Limbaugh, Glenn Beck, and at the health care town meetings last summer. The right wing inspired fear mongering—"death panels," mandatory abortion, socialized medicine, drastic cuts in Medicare benefits, rationed care, etc.—is the most obvious form it takes. In general, the diatribes of the extreme right wing are an excellent source of psychohistorical data as they express, in a relatively uninhibited and uncensored fashion, fantasies that allow us a glimpse of the most primitive and raw fears and wishes that drive the group. With regard to health care, fears seem to be mostly about government intrusion with its imagined threat to one's freedom to choose one's medical care. A variant on this is the fear that we will have to pay more in taxes, and therefore there will be less freedom of choice on how to spend our money.

There is also an extreme reluctance to put health insurance companies out of business, which would happen under a single payer system, because this would curtail the freedom of business entities to pursue their sacred right to make a profit.

Right wing ideologues are still a statistical minority, but the American exceptionalist libertarian group fantasy has many mainstream adherents. Their affect and rhetoric may be more tightly modulated and there is a veneer of rational argument, but there is far more similarity than difference be-

tween right-wingers and centrists who share an allegiance to this position. The Democratic Leadership Council (DLC), a group whose mission statement emphasizes its belief in the virtues of free enterprise, free markets, and private business, may not be overtly anti-government, but they are very comfortable with the notion that private insurance companies can do a better job than a government single-payer system in providing quality health care at affordable prices.

Another issue of psychohistorical relevance is the question of why health care reform is such a lightning rod for this primary process (to use a psychoanalytical term for unfiltered emotion) outpouring from the right. There are doubtlessly many possible explanations for this as well as for what anxieties lie beneath all the virulence and irrationality. There is the heightened anxiety that can arise when death fears are activated, when the integrity of one's body is threatened by illness or injury, as well as fears of intrusion and penetration, dependency, and loss of control that are connected to receiving health care from others.

In my opinion, one of the factors that make health care financing policy such a target and magnet for paranoid projections is its extreme complexity and ambiguity. From a psychoanalytic point of view, the more ambiguous the stimulus material presented, the more room there is for people to respond to the stimulus by projecting their own fears and wishes onto the material. This is the basis of projective testing, as in the Rorschach.

A related aspect of the explanation for the right wing tirade against health care reform is that this complexity and ambiguity creates an opportunity for disinformation and misinformation to be spread by those with their own agendas. These agendas can be financial—as in the lobbying and publicity campaigns paid for by the various financial stakeholders in the current system, insurance, drug, and numerous other companies. Yet these agendas can also be ideological—as

when conservatives, libertarians, and privatization advocates use opposition to meaningful health care reform to promote their anti-government, pro-business agenda.

To psychohistorically understand conservative reactions to health care and the policy reform debate we need to look at the effects of an important current group fantasy, belief system, and ideology, which I am calling American exceptionalist libertarianism. It has led to a vehement attack on reform proposals that might challenge the hegemony of privatized health care by feeding fears that it would threaten freedom.

Although such a psychohistorical explanation has its appeal, I still do not know whether its influence outweighs that of old-fashioned, naked financial self-interest. For example, does Senator Max Baucus' antipathy toward single-payer have more to do with being a true believer in the magic of the marketplace or with the large campaign contributions he has received from the health care industry? Both economic and psychological approaches provide vital insights.

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Some Personal Psychological Dimensions of Health Care

Sander Breiner—Michigan State University

There are some well-known, well-established, and

well-communicated lifestyle behaviors directly impacting health, yet a significant number of individuals do not act on them, whether for conscious or unconscious reasons, resulting in major physical pathology. The clearest example is cleanliness. Washing one's hands is widely publicized as a major precaution to avoid illness. However, general cleanliness of the body, clothes, food, and the home in general are so obvious that they are not generally discussed as health measures in the health care debate. Yet, these simple measures, when not followed, are among the most significant factors in individual and group infections.

The part of the population (10% to 30%) failing to take proper lifestyle precautions also requests more medical care per capita than the rest of the population, even expecting it to be provided at little to no cost to them. In other words, these individuals expect others to care for them, rather than taking better care of themselves. They respond as if they are incapable of caring for themselves and want the support of the medical community and the general population through their government. This would be a normal response from small children to their parents.

Children involved in their play activities ignore discomforts, injuries, external demands, and time constraints. When we see any of these qualities in an adult, we recognize the immature behavior that is typical of neurotic character disorders. Examples include not going to a dentist when there is an obvious dental symptom such as pain, or avoiding vaccinations. Self-destructive behaviors point to the hidden psychodynamics of this segment of society. Its members' unhealthy behaviors mostly involve a lack of cleanliness, obesity, distortions in the ordinary rhythm of life such as sleeping and eating, unprotected sex, substance abuse, and "accidents."

Weight plays a large factor in overall health. Being slightly underweight prolongs human life and reduces the

amount and severity of various diseases that accompany aging. On the other hand, being slightly overweight significantly increases the development of a variety of diseases. Moderate obesity (Body Mass Index 35) almost invariably produces pathology; for example, diabetes. Pathological obesity (BMI 40 plus) produces serious pathology and significantly shortens lifespan.

Alcohol consumption is another one of the lifestyle choices that can increase risk of disease. Drinking alcohol for its toxic effect is injurious to the various systems of the body. The younger the individual, particularly under 22 years of age, the more the injury to the central nervous system; the more frequent and intense the toxic levels of alcohol, the greater the injury to all systems of the body. Similarly, recreational drug-taking is detrimental to the various systems of the body. Injury stemming from accidents while under the influence of alcohol and drugs is common. Unprotected sex has also significantly increased the variety of physically injurious diseases, usually with permanent effects. In addition, unplanned pregnancies, especially among teenagers and those with impaired health, produce a variety of social and medical problems.

Rhythm and cleanliness are large factors in a person's healthy well-being. Normal and regular patterns of eating, sleeping, and exercise are important in preventing illness. Washing one's hands for at least 20 seconds before handling any food or utensil is a major preventative of disease transmission, as is washing them frequently during the day, particularly after touching obviously contaminated substances such as the anus, shoes, and saliva. There are simple and easy means of controlling diabetes, including maintaining proper care, particularly of the feet and toes.

There is another factor that needs to be considered: a tendency for people to "accidentally" hurt themselves and others. In examining all accidents, there is a very high inci-

dence of unwise or ill-considered behavior that led to the injuries. In a study I did in the early 1970s of the various causes of death nationally, I demonstrated statistically that the most significant factor in the cause of death in this country was conscious and unconscious psychological factors, comprising approximately 35% of all deaths. The obvious psychological elements in suicide and murder are only part of the picture.

Since any psychological symptom is a protective device and a compromise formation, its purpose is to protect against conscious and unconscious anxiety and even express a forbidden impulse. Removing the symptom without some psychological treatment or support creates a need for something to take its place to relieve the anxiety and gratify some unconscious need. For example, removing hysterical paralysis by hypnosis or a drug may precipitate a psychotic episode. The need to hurt oneself or have an illness can have many determinants. Some common ones are: the need for punishment to relieve unconscious guilt; the need for attention, for example, Munchausen syndrome; the need to punish others who have to care for them; and the need to maintain a martyred position. There are others as well, such as the unconscious need to hurt or depreciate women and children. All such inappropriate behavior is usually well rationalized.

Universal health care is laudable, yet without healthy behavior and lifestyle, as well as personal responsibility, it cannot succeed in producing a significantly healthier society or reduce the enormous unnecessary expenditure of society's resources. In addition, if people's behavior became healthier, the underlying anxiety of all the inappropriate behavior would remain. The removal of a symptom without providing some psychological support would likely be expressed in some other injurious activity to self and others. When people behave in an immature and emotionally unhealthy manner, the cost to society is enormous.

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Reflections of an Original Emergency Room Doctor

Matthew J. Hayes—Fellow of the American College of Emergency Physicians

In 1966, in a major medical school affiliated teaching hospital, I approached the end of my internship and eagerly scooped up emergency room (hereafter "ER") work shifts, both for the experience and the $15.00 (under the table) reimbursement I was paid by the "relieved" doctor vacating the shift. The shifts were 12 hours long and chaotic. Organized medicine's general pattern for dealing with unscheduled medical problems was simple: a room was designated and supplied to accommodate the medical staff, who would provide coverage on a rotating basis, i.e. every attending staff member, alphabetically chosen, would be in charge, either by physical presence or by telephone link, regardless of specialty. That was it. Nationwide, this model, with insignificant modifications, was entrenched. The attending doctor was seldom present.

When a patient showed up, whether a gunshot victim or a comatose patient found on the street, the charge nurse took vital signs and called the attending physician's answering service. In those days of fixed telephone lines and no beepers, that was a formidable task. If it were Saturday afternoon, he might be fishing at a nearby stream or attending a local ball game; if Wednesday, he might be on the golf links.

Presumably, his answering service knew how to contact him. Big presumption!

After chasing her doctor for a significant amount of time, the nurse was finally put through and might find out that the attending was a gynecologist, and not much help to the male patients. However, the gynecologist usually asked other doctors to handle his general surgery and to handle his neurology patients. Perhaps the nurse could track them down and ask them to consult for him. Again, the telephone charade would repeat itself, with new twists as the first physician had signed off and gone out of town and the other might not have privileges at your hospital.

In a teaching hospital, things were significantly better because there was always a crew of interns and residents who were physically present in the hospital 24-7, but perhaps not assigned to the ER as such, though they did go there and consult, if asked by the attending on whose service they were currently training.

My shift began on Saturday at noon and ended 24 hours later. That evening, several automobile accident victims and a knife attack victim showed up within 20 minutes. The ambulances unceremoniously screamed into our parking lot, unloaded their patients onto the waiting gurneys like sacks of potatoes, loudly announcing monosyllabic reasons for being there as, "car crash!" or "knife fight!" With screaming sirens and excessive speeds they left.

There was lots of blood smeared around the auto accident victims, from superficial wounds, it turned out, while the knife fighter was dry and quiet. Dr. H.W., chief surgical resident, came through the ER at this moment and, as was his custom, spent a moment to schmooze with the charge nurse.

She walked him over to the fighter, who, though still very quiet, was now very pale. Without breaking stride, casting a quick but fixed glance at this patient's neck, he bounded over to the cabinet, retrieved a scalpel, pair of gloves, and urinary catheter. In less time than it has taken me to type this, Dr. H.W. had made a stab wound in the patient's chest, releasing a whoosh of air, and rammed the urinary catheter inside the chest cavity. I was at his side by this time. He looked at me disgustedly, and snapped, "tie that catheter down to the skin with a suture, hook it up to suction bottles, start an I.V. (intravenous) with broad spectrum antibiotic coverage, place the patient on oxygen, put him on my service with Dr. L. and review proper triage and intervention." He then left. The charge nurse beamed. I was crushed, but very impressed and learned a lesson which stayed with me for my entire career.

This patient had a "Tension Pneumothorax," a life-threatening, quickly impending disaster, which could be diagnosed by a careful look and could be cured in less than a few minutes. It did not call attention to itself like the many bleeding scalp and facial wounds on the surrounding gurneys. I got through my shift all right; more importantly, so did all of my patients. There was one more dramatic case which highlighted the mismatch of medical resources and patient need.

On Sunday, shortly before I was to be relieved, a somewhat tipsy member of the yacht club was brought into the ER skewed by a flagpole, from anus through his umbilicus. The aluminum spear point, tassel and all, was protruding from his abdomen by about six inches. The patient was conscious and talkative. The ER attending for Sunday was a dermatologist! Chastened by the previous night, I instructed

the nurse to start polling the usual hangouts for an available general surgeon and started the I.V., oxygen, urinary catheter, and tracked down anesthesia coverage for the impending surgery. By the time the surgical team was assembled and ready to go, I had blood typed and cross-matched, necessary X-rays done, and anything else I could think of to speed the transit to the surgical suite. It seems my actions were atypical and unexpected but appreciated. This patient lived to sail his boat another day—although flagless, I might add.

This was not my first ER shift, but it dramatized the core problem more than the others. There was a complete disconnect between the presented medical problem and the resources available. It would soon become painfully apparent that the mismatch could be laid at the feet of the hallowed paradigm of medical teaching that had produced such valuable advances, namely, "longitudinal specialty study and research." In the history of medicine, the field of general surgery and medicine gave way to area and organ specialties, which further sub-specialized into ever smaller fields of interest. For example, the HEENT (head, eyes, ears, nose, and throat) yielded the head to neurosurgeons at first, and EENT yielded eyes to ophthalmologists, who would further yield the retina to retinal sub-specialists, and so forth. However, who was looking at the whole patient? More particularly, presumably, each of these specialists and sub-specialists had the knowledge to deal expertly with a crisis in his field. How to mobilize that disseminated knowledge timely enough to benefit the patient in the ER? The answer shocked organized medicine to its roots. The vertical knowledge based teaching needed a paradigm shift in thinking. Simply put, a horizontally based body of knowledge, i.e., the emergencies of each specialty, needed to be organized and taught to postgraduate

doctors.

At every level of patient care the resistance, emotional venom, and incredulity that were rampant during these formative years of emergency medicine was widespread. Though it would be easier to list those few that were supportive I will list some of the major opponents: The American Medical Association, most medical schools, the American Hospital Association, Blue Cross, Red Cross, ambulance services—it is a long list. They all had vested interests in the status quo, and fought the movement with power politics, press, and money. The burden borne by the early practitioners in our nation's ERs was crushing. Underpaid, overworked, unrecognized, and trivialized by their peers who asked, "When are you going to smarten up and get a 'real job?'" Looking back, I find it hard to imagine how so many of us survived it somewhat mentally and physically intact. Our patients, though, benefited and it was obvious that our presence and our personal efforts to self-educate in disparate fields such as anesthesiology, cardiology, trauma, pediatrics, medical emergencies, and others was signaling that we would persist, with or without help from above.

The current efficient, world-class system of dealing with medical emergencies owes its existence to a handful of physicians who stubbornly challenged the status quo. As I look back, it is difficult to imagine that we changed thinking, training, education, and medical decision making on a national level. The memory is a personal reward that I hold dear.

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Overcoming Defenses against Death and Taxes

Herbert Barry III—University of Pittsburgh

In 1789, Benjamin Franklin wrote, "In this world nothing can be said to be certain, except death and taxes." Both inevitable realities are emotionally unacceptable. People therefore erect defenses against them in the vast, irrational component of the mind that Freud labeled the *id*.

Three such defenses are: denial, dissociation, and despair. Denial includes repression from conscious awareness and a fantasy of personal invulnerability. People therefore oppose government expenditures, which necessitate collecting taxes from individuals and businesses, for health insurance. Some people refuse to buy the insurance. Dissociation blocks conscious consideration of the unacceptable reality. People avoid the topics of illness, death, and taxes. Despair induces passive refusal to support changes in health insurance or in taxes.

These psychic defenses, combined with the power of vested interests, have prevented reform of the U.S. health care and tax systems. Changes cannot remove the inevitability of illness, death, and taxes, but reforms can ameliorate their unattractive effects. Health insurance companies have the primary purpose of maximizing their own profits, there-

fore increasing user costs (their revenue) and avoiding payments for expenses. Governments are preferable to insurance companies as providers or regulators of health insurance because medical costs can be minimized by universal health insurance, with an emphasis on preventing illness and improving quality of living. Universal health insurance is an ethical requirement, rather than a profit opportunity, with the catastrophic medical costs for a minority of individuals shared by the rest of the population.

Taxes can be reduced for most individuals and corporations by shifting the burden of them to wealthy owners of natural resources. Currently, most taxes are on income, production, and sales. Taxing these productive activities inhibits desirable behavior by individuals and corporations.

Perceiving and accepting objective reality can help the *ego* and *superego* to overpower the *id*. Rational remedies for emotionally unacceptable realities can replace the defense mechanisms of denial, dissociation, and despair. Beneficial health insurance reforms, being urged by President Obama and the Democratic leaders of Congress such as Nancy Pelosi and Harry Reid, can abolish maladaptive policies. The shift of taxes to owners of valuable land and other natural from contributors of productive activities would generate more wealth for the national economy and more government revenues. The resulting lighter tax burden on most Americans would help to overcome the three defenses of denial, dissociation, and despair against reform of health insurance and against improvement of health care.

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The Debate Will Go On: Health Reform and the Political System

Hanna Turken—Private Practice of Psychoanalysis

The fear of change is as old as the beginning of history. In early development, the human psyche spends a great deal of energy in maintaining a workable strategy in the environment we are given (adaptive and pathological defenses). Once these strategies are the preferred mode of operating, usually in young adulthood, we become resistant in various degrees to new ideas and changes that require too much deviation from the familiar. Rather than readjust and change, it is better to stick to what we know even if it is not to our satisfaction. This was much the case for middle class America as the debate began in regard to health reform.

Change in health care reform involves not only the psychological, but also political forces that oppose these changes on the basis that it is not good for the economy and therefore for the individual. There was a time in the practice of psychoanalysis and psychotherapy in which both private physicians and the insurance companies made sufficient profit. With the deregulation of business practices and the introduction of managed care, a disparity grew. Physicians and consumers became a regulated instrument of the insurance company and their unsanctioned freedom to profit by raising premiums and increasing deductibles. It has become crystal clear that the system is not working for the average consumers nor for the providers of services. Yet the debate goes on. Government lobbyists are spending more money today than ever to further the profits on Wall Street and for the pharma-

ceutical and insurance companies by influencing government and creating panic at the expense of the average Joe and Jane.

Let me start with some examples. R. was referred to me one year ago. For him I have filled out insurance forms time and time again that have been rejected one after the other. It was not until last month that we finally learned that all the money due back to R. went to his deductible; a deductible that was computed not on the basis of my fee, but on the basis of the 50% covered. This means that in addition to the deductible, he has to pay the 50% co-pay.

M., a widow, decided to retire when Medicare became available to her. She has had a bout with cancer, asthma and presently has trouble metabolizing sugar. She made her calculations and felt she could manage. M. was doing fine for the first six months until she entered the "doughnut hole" (the coverage gap when payments ran out) so she had to assume the full cost of her medications. Since her resources have been depleted faster than expected, she is taking what she feels is her only option: selling her apartment, moving to a retirement community in Georgia away from her daughter, extended family and friends. She was not prepared for this disruption to her life.

For the past four years V. has been working in the international unit of one of the largest investment banks rescued by the bail-out. She was hired on a per diem basis with the as yet unfilled promise of a permanent position within a year. She has no medical insurance, no sick days, and no vacation. She has applied to other similar facilities but with no prospect of getting better terms.

According to the latest polls, a majority of Americans are now in favor of some serious health reform; yet what will come out of Washington is a watered-down version of real reform. The feeling among those who were from the begin-

ning pushing for substantive reform is that we lost the chance and that more than ever, political campaign contributions from lobbyists to our government representatives is what drives the opposition. It seems that the required regulations in the pharmaceutical and insurance areas will not be forthcoming to the detriment of the people who need it most: the sick, the elderly, and the working poor.

As it stands now, it is no longer the individual fears that oppose health reform, but political power bought by big industry. I have often heard the expression by those who feel secure in what they have: "If it ain't broken don't fix it." But for a substantial number of Americans, it is broken.

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The Paranoid Belief in a Suppressed Cure for Cancer

Nathan Carlin—University of Texas Medical School

Many Americans believe that physicians have discovered a cure for cancer but are withholding it because such a revelation would significantly reduce their income. A few years ago, an American Cancer Society phone survey of 957 Americans with no history of cancer found that 27% agreed

this was the case. Although most of us find the belief that a cure is being withheld to be unfounded, the decades-long unethical Tuskegee syphilis studies provide a basis to believe that on some occasions there is a reason to entertain what others might call paranoid thoughts. The purpose of this essay is to offer a psychoanalytic explanation of such paranoid thinking in American culture. Regrettably, for reasons of space, almost all of my notes and the bibliography have been eliminated, but are available upon request.

Early in his writings Freud makes the argument that paranoia results from the repression of distressing memories, which parallels his early understandings of hysteria and obsessional neurosis. The difference, Freud argues, is that paranoia makes use of projection, whereas hysteria utilizes conversion into somatic symptoms and obsessional neurosis uses displacement or substitution. Recent research on paranoia suggests that feelings of paranoia are quite common among non-clinical populations, perhaps even as common as feelings of anxiety and depression. In previous work, I made the point, following Freud's logic as well as by taking into account the recent research on paranoia, that paranoia "in everyday life"—that is, paranoia among non-clinical or so-called "normal" populations—results from the *suppression* (rather than the repression) of distressing *thoughts* (rather than memories). The mechanism of projection is still at work, but because paranoia in everyday life results from suppression rather than repression, it is much less severe but also much more common.

By "distressing thoughts," I mean the commonplace thoughts that simply pop into our heads—unwanted and uncontrollably—forcing their way into our consciousness but which we nevertheless promptly push out of our awareness. Distressing thoughts include, for example, the urge to stand up and yell at inappropriate times, such as in church or during a political speech; the idea that one could trip somebody

as they are walking by; and the temptation to steal something when no one is looking. Most of us immediately scold ourselves for these urges, thoughts, and temptations because they are inappropriate. I suggest that they are suppressed—that is, consciously pushed out of our awareness—into what Freud called the preconscious, and from there they are, sometimes, unconsciously projected and subsequently re-experienced as paranoia. In other words, our distressing thoughts, which are often destructive and aggressive, after they are suppressed and projected, return in a disguised (usually reversed) form as a kind of attack against the ego. The urge to yell in church might be converted into the fear that people in church are talking about me; the idea that you could trip someone as they are walking by might be converted into a fear that people are going to trip or otherwise hurt you; and the temptation to steal might be converted into a fear that thieves abound.

I suggest that the common fear that physicians are concealing the cure of cancer is an expression of cultural paranoia. It is, in other words, the return of a disguised wish, and indeed an aggressive and destructive one. But what is this wish? Interestingly, in the survey conducted by the American Cancer Society, noted above, those who did not complete high school were much more likely to believe that a cure is being withheld than college graduates. Income level also seemed to be significant. Those who made less than $30,000 a year were more likely to believe this than those who made more than $100,000 a year. These data are important clues to understanding the social psychological dynamics at work here. It seems likely that there is a relationship between education and income, but the precise nature of the relationship is difficult to ascertain, and there also seems to be a relationship between education and income, and health. In any case, according to this survey, most of the people who believe that doctors are concealing a cure for

cancer come from lower income levels and have minimal education. So, if I were to translate the fears of these persons into a hypothetical representative statement, I would put it this way: "I am afraid that the doctor is going to hurt me and take my money." I would put the disguised wish this way: "I want to hurt the doctor and take the doctor's money." The inappropriate wish, I suggest, is suppressed but then projected and disguised as it returns in the form of cultural paranoia.

But why cancer? Why, in other words, would a cultural expression of paranoia be related to cancer? Cancer is the second leading cause of deaths in this country (Center for Disease Control and Prevention, 2009), so it makes sense that a cultural expression of paranoia would be related to cancer. While heart disease is the leading cause of death, it would be harder to attribute a malevolent conspiracy to, say, the treatment of heart attacks, because they are often acute rather than chronic. Sometimes, for example, a person dies from a heart attack before they even make it to the hospital, so it would be hard to blame a physician or the medical profession for this. But in the cases of various kinds of cancer, the treatment is often prolonged, the progress is ambiguous, the results are mixed, and people often feel isolated and estranged (David Bakan, *Disease, Pain, and Sacrifice: Toward a Psychology of Suffering*, 1968, pp. 6-7)—the perfect storm, as it were, for suspicion. So when, for example, physicians do not respond clearly and definitively to their patient's queries about cancer—"How did I get this? Why did I get cancer now? What is the prognosis?"—patients may feel that something is being concealed from them. While patients might fear that medical information is being concealed from them in any number of scenarios, such as at the dentist, the case of cancer proves to be a special case because it is so prevalent and seems to be haphazard. These "perfect storm" conditions are so strong, the data suggests, that even the rich and the educated sometimes fall into a bit of paranoid thinking with regard to the

cure for cancer, though to a much lesser extent.

I would like to close by emphasizing that I do not intend for this psychological commentary to replace other kinds of explanations with regard to the common fear that physicians are concealing the cure for cancer. To do so would open my argument up to the criticism that many Americans who have been marginalized and disenfranchised have good reason to fear persons in professional uniforms, and that by framing this issue as a psychological issue obscures the social conditions and material needs of the persons voicing this fear. Furthermore, paranoia is sometimes justified, and one ought not to pathologize marginalized persons when their fears are, in fact, justified. All of these criticisms are, to some extent, correct, and my point is to work with them, not against them. All this said, I still believe that this particular expression of cultural paranoia is maladaptive, especially if it leads persons to deny themselves medical treatment.

It is hard to say how we could address this cultural paranoia. One thing that could be done would be to improve our techniques for fighting cancer so that the grounds for such fears would no longer be sturdy. Another strategy would be to provide access to health care for all so as to address the underlying aggressive wish of this paranoia ("I want the doctor's money"). But this, in turn, might turn the tables of paranoia or explain another contemporary form of cultural paranoia: perhaps, in other words, the fear that the American health care system is going to be reformed can be understood as a form of anal eroticism that is also being expressed in terms of cultural paranoia.

The father of psychoanalysis may help us understand some of the deeper roots of paranoia. Sigmund Freud saw a connection between the anal stage of psychosexual development and later adult personality traits such as orderliness, which is why, in popular language, we refer to rigid persons

as "anal." He also saw a connection between feces and money, because feces are the infant's first creation and are, therefore, held to be valuable by the infant. Indeed, infants often finger and hold onto their own feces in, say, the bathtub and sometimes only reluctantly give them up. As adults, we are compensated with money for our creations and for our work, so there is a link between feces and money. I suggest that the anal erotic significance of resistance to health care reform, then, involves the wish "I want to hold onto my money," which, in paranoia, is converted into a fear "They are going to take my money." This might also explain, psychoanalytically, why, as noted above, the rich and the educated can fall into paranoid thinking with regard to the cure for cancer. The wish of the rich ("I want to *keep* my money") is different from the wish of the poor ("I want to *take* the doctor's money"), but both are anally significant and both, when converted into paranoia, are disguised by the paranoid idea that doctors are concealing the cure for cancer.

Perhaps it is true that people prefer speaking of sex rather than money and dollars rather than issues of class. In any case, if Freud is right that many of our psychological problems, individual and cultural, can only be overcome with the "talking cure," then we should do some more talking—openly and honestly—about money and class. Otherwise the paranoid fear of being "screwed" will be commonplace.

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Battling Cancer in America

and Germany

Angela Davies—Cancer Survivor

At the age of 54, when my 87-year-old mother was dying of cancer, a small lump was found in my breast during a regularly scheduled mammogram. The optimistic surgeon assured me that the lump would be successfully removed and all would be well. However, a week later the surgeon called, stating that the pathology report showed the cancer cells had spread into the surrounding tissue, requiring more surgery. That was the beginning of 12 years of chemotherapy, radiation, and additional surgeries to combat the metastasized cancer.

Although progress was made in treating the cancer, after four years it spread. My oncologist's office lost my medical folder. I was so upset and angry because five years of my life were in that folder. My confidence in my oncologist's staff had eroded so, after several months, I decided to move my treatment to Memorial Sloan Kettering Cancer Center in New York City. Even though my records are computerized there, I now ask for a copy of all my important tests and scans, keeping my own records and being my own advocate.

For so many reasons I am one of the lucky ones with cancer. To start with, I am alive. The week of 9/11/01 was when I found out that the cancer had spread, had metastasized, and I would need major surgery on my organs. I was frightened, but witnessing the horror of 9/11 gave me perspective. Although I had fourth stage cancer, at least I had a chance to live, unlike the young people who were killed that day. I have a loving husband and family that are quite supportive and an insurance company that has paid most of the cost. I am thankful for that, because it is enough to be dealing with a serious illness without worrying about how the

bills will be paid. My current treatments are alternate weeks of chemotherapy with scans every three months at a cost of as much as $28,000 a month.

While undergoing chemotherapy in the fall of 2008, a representative from Sloan Kettering spoke to me about the possibility of losing my insurance coverage. This was terrible news to hear, especially while having strong chemicals pumped into my body. I panicked. My oncologist expressed her concern, suggesting that I research coverage with other insurance companies because if we tried to pay costs out of pocket, it would bankrupt us, and if my insurance company changed, I might not be able to stay on the trial chemotherapy drug that has kept my cancer stable for two years. In addition, some insurers have a cap of one million dollars. We researched a number of alternatives and spent several stressful months waiting for negotiations between Sloan Kettering and the insurance company to be completed, and the contract signed. Fortunately we were saved, but I wonder if our future coverage will be threatened.

Our lives have changed drastically; each day is touched by this disease. People who mean well suggest that it is important to be positive and optimistic. Although I fear that a moment of concern or worry may shorten my life and burden the people around me, being continually positive is not realistic. There are days that I feel tired and grumpy. The chemotherapy has caused neuropathy in my hands and feet, so walking is uncomfortable and buttoning a blouse is a challenge. I got a new bike when I retired but I can't ride up our driveway because my legs just won't cooperate. There is no more tennis or taking long hikes, but I am alive! I have had to be hospitalized several times with infections—my enemies—but I receive chemotherapy and radiation as an outpatient. I once spent over 24 hours in an emergency room because I needed to be placed in isolation that was unavailable. There I was with a compromised immune system sur-

rounded by sick people: I had no privacy, was uncomfortable and terribly afraid of catching something contagious. I felt terrible.

My husband and I try to get through each day as if we are healthy—some days are better than others. We had a vacation planned when I found out that I would need more chemotherapy that would make my hair fall out. I thought that I was prepared for losing my hair, but when I showered one morning and my hair came out in clumps, I screamed and cried. My poor husband probably never imagined that he would be sleeping beside a bald woman, but there I was. Compared to dying, it's not such a big thing to lose your hair, but it was upsetting even when I lost it a second time. I did worry about being bald on our trip. I practiced tying scarves around my head, even bought several to match outfits I had planned on wearing, but there were times I wondered if we should just cancel the trip. A wig was out of the question. Our youngest son said, "Please Mom, don't wear a wig," and a friend with breast cancer who had lost her hair said that a wig was quite uncomfortable. Friends encouraged me even when I looked like a Chia Pet as my hair began to grow in, and my husband said it didn't matter to him if I had hair or not. He's made so many sacrifices because of my health problems; I just couldn't disappoint him by canceling the trip. The very first night of the cruise, I was so happy to see two other women on board who were also bald. We bonded and waved and smiled each time we saw each other. There were other women on board who came up to me and talked about their own battles with cancer. It made me feel so much better and thankful that we didn't cancel our vacation.

Illness within my family resulted in my learning a lot about Germany's health care, which contrasts strongly with the American system. In August, 2007 my brother Franco was diagnosed with non-Hodgkin's Lymphoma. He is an American citizen who has lived in Germany for over 30

years teaching voice at a conservatory after a career in opera. He was struggling with sore throats and hoarseness, so at the age of 58 he had his tonsils removed. Although the surgery went well and he was recovering, after a week he was called on a Sunday night asking him to return to the hospital the next morning and to bring someone with him. Monday morning at 8:00 AM he went to the hospital and was told that he had non-Hodgkin's Lymphoma and he needed to be examined to see how far along it was. I was so impressed that he did not have to make appointments for all of the tests. Everything was scheduled for him, done at that facility, and completed in one week so that by that Friday they had all of the information. He met with a team of doctors, received all of the results of his blood work and the Magnetic Resonance Imaging (MRI) and other scans. They informed him of finding Stage IV Lymphoma that was already in his bone marrow. The doctors told him he needed chemotherapy, radiation, and a stem cell transplant without which, he would be dead by Christmas. They suggested he go home for the weekend, think about what they had just told him, and return on the following Monday with his decision. He returned on that Monday, signed all of the consent forms, and started the first chemotherapy treatment the very next day! All of the tests and research were done in one week.

Since he knew that I was a patient at Sloan Kettering, considered one of the best cancer hospitals in America, he asked his doctor if he should return to the U.S. to be treated. His physician responded that there were doctors from Sloan Kettering there in Cologne studying the procedures being used at that facility. My oncologist confirmed that Franco could get excellent treatment in Germany, a country about five years ahead of the U.S. in treating certain kinds of cancer.

My brother received intense chemotherapy for nine months, alternating between outpatient procedures and stay-

ing at the hospital for three-week periods to monitor his vital signs after the more intensive chemotherapy. When he received the intensive four days of complete body radiation and stem cells, he was kept in isolation at the hospital for five weeks. Once he was back at home, his doctors made house calls if he ran a fever or was not able to get to the hospital. His eyes were damaged by the intense radiation and the clinic organized two cataract operations as soon as he was strong enough to be anesthetized. Both operations were a success and he sees perfectly without glasses. This was also completely covered by his insurance policy.

Franco received a stipend from his insurance each month because he had paid into the Artists' State Health Insurance for 30 years at a premium based on his income. Because he wasn't working, insurance premiums were waived for one year. All of his prescriptions were free and he did not have to pay for any doctor or hospital costs. Throughout his ordeal, a social worker and a psychiatrist assisted him with necessary support and counseling. To aid his recovery he can spend weeks at a spa free of charge. He focused on getting well, not on how much everything cost or if he was going to lose his job. People in America speak about socialized medicine as if it's the worst thing in the world, yet my brother's experience was incredibly efficient and thorough. It treated every part of his life with respect and compassion, without costing him anything.

In the year and a half since Franco's diagnosis he is cancer free, back to work, and feeling stronger everyday. Every three months he will receive scans and blood work to check for any recurrence. For the next three years he is considered handicapped and receives discounts on his income tax.

Life is a precious gift that I value. I am so thankful for each day I am vertical. My grandmother used to say,

"Courage, pray for courage." There are many days I hear her say those words and they keep me going when I am afraid of what's ahead. No one has any guarantees, but when I awaken during the night with my fears, I think of all the things I am thankful for. My blessings keep me going. I sometimes also think about all the families that are touched by serious illness and how they have been faced with bankruptcy and choices of buying a prescription or food. Americans are hard working and resilient and they deserve better. Health care for everyone can be solved and looking positively towards the future will carry us to that goal so we can focus on being well.

***Angela Davies** is a 66-year-old retired schoolteacher who, with her husband of 18 years, currently lives in Newton, New Jersey. They have a blended family of six children and ten grandchildren and at the moment are looking forward to the wedding of a daughter. The Davieses enjoy kayaking and traveling. This year they took a cruise to Antarctica, and may be contacted at AngeorgeD@aol.com.* ❑

Public Versus Private Health Care

Norman Simms—University of Waikato (NZ)

When I listen on satellite television to the acrimonious debates about reforms of American health care, it is difficult to recognize in either the *pro* (Democrat) or *contra* (Republican) positions anything resembling the experience my family has known over the past half century. My wife, our two children, and I have been living out of the United States since the mid-1960s, first in Canada, then in New Zealand, and for substantial periods of time in Israel and France. Each of these four nations has some form of public, state-run, government-supported, or national health system. Thus as an outsider who was once an insider, both sides seem to be more

engaged in what psychohistorians call group fantasies than rational discourse. Health care, in this sense, becomes, like disease itself, a projected waking group dream about the "body politic."

All four "socialist" systems of health care I have lived in have changed in the course of 50 years, not always for the better. There are three points that stand out which I wish to indicate before delving into why the American "town-meetings," television exposés, and grandiose speeches seem to go off the rails. Let me focus on the system we are most familiar with in the place where we have lived longest. This is not because New Zealand's system is the best in the world (which it isn't) or better than most (which it used to be) but simply because having lived in it for 40 years it is a living reality and not a rhetorical construct or a fantasy image.

Since 1970 in New Zealand, we have always chosen our own family doctors and when required, have been recommended to specialists. Where there are more than one, we have usually been able to make choices. No one appoints a doctor for us, and we consistently see the same doctor. On the whole, the notion here is that everyone's health depends on everyone else's, rather than something belonging within the envelope of the skin to an individual or within the walls of the house of one family.

The quality of care has been excellent or at least as good as we could expect when circumstances have not been optimum, such as when for political and economic reasons there have been staff shortages at the best of hospitals, and when individual doctors or nurses, and not the "system," have been deficient in provision of care. In our experience, the more these state medical plans have leaned toward the North American system, the more they have fallen down in provision of efficient and extensive care. The atomizing of health care creates the monstrous and chaotic paradigm of Hobbes' pre-state ("a war of all against all") society: not only

is disease the enemy who invades the private body, but each of one's neighbors is a rival whose health and well-being deprives the isolated ego of its strength and longevity.

When desired or necessary, the state insurance and care have been open to private supplementation. In New Zealand it is possible to opt for private doctors and nurses even inside the state hospitals, since for the most part it is the public institutions rather than smaller private hospitals run by insurance companies that have the most range and the most modern facilities available. The doctors we know see themselves as offering a service and sometimes when right-leaning governments have cut back on state subsidies, they have created their own lower rates or charged nothing for children under six, pensioners, and families on benefits.

Thus the arguments against a national health care system in the U.S. seem to rest on a series of assertions that sound bizarre outside of that particular and peculiar country. One, big governments are bad because bureaucracies are inefficient, top-heavy with administrators, and weighted down with paperwork. Two, private health, like private business in a free enterprise system, works best because competition improves quality, sharpens the need to please customers, and is attentive to individual needs. Three, taxes are a form of legalized robbery. Four, individuals always know best what to do for themselves and their families. Five, the only way to measure a doctor's worth is by the amount of money he or she can earn. Six, people who can't afford good health care don't deserve it because they are lazy, stupid, welfare-dependent or on illegal hallucinogenic drugs.

These arguments raise the question as to what is meant by *big government*? Outside the U.S.A., the terms *government* and *state* are not interchangeable, the first referring to the centralized mechanisms of power run by elected parties with the most seats in a parliament; the second referring to the organs of management and implementation of

government policies. My nearly 70 years of experience suggests that individual companies seek to maximize profits by cutting corners and by putting their own development above that of the general public, while civil servants and professionals working for public enterprises focus on their tasks in relation to patients and clients without concern for their own financial status. At worst it seems to me that any large systems, whether private or public, tend to bog down in paperwork so that the best thing to do is to opt for smaller, regionally-based hospitals and clinics rather than overly-centralized and impersonally-run facilities.

In the "good old days" of the 1970s and early 1980s, there were many advantages to the national health service that made it perhaps the best in the world. For one, each health board was composed of doctors, nurses, and elected members of the public. For another, rather than competing, each hospital cooperated with and complemented the others in matters such as sharing specialist services, taking overflow from crowded facilities, and so forth. Third, centralized purchasing of equipment, medicines, food, cleaners, etc. kept costs down as much as possible. Things changed here during the right wing revolution of the 1990s. Managerial models were imposed at the expense of service ethics and collegiality, to the point where for a while there were no longer hospitals, but instead Crown Health Enterprises, whose mission it was to make profits.

Today, in a modified version of the original system, many of the bad aspects of an attempt to privatize and nationalize health remain. While nowhere as horrendous as in America, these reminders still indicate the essential flaws in imposing the business model on a medical service: competition for care between individual doctors and hospitals leads to a focus on flashy instant treatments often inappropriate in terms of patient needs, while reduction in resources leads to delays, errors, and death. For example, in the past few

months a new medical lab testing service from Australia outbid the long-standing local group. Within weeks it proved inefficient and virtually impossible to coordinate. The overseas managers sought to maximize profits, made cuts to save resources and keep staff numbers down, and now, having failed to such an extent that the City Council has had to act, the old group has been asked back to try to salvage pathological testing in the nation's largest city. This is not a matter of socialism versus capitalism, but of greed and stupidity versus competence.

The question is whether competition or cooperation stimulates the best results and the most cost-efficient outcomes. Because it is motivated by profit, I do not believe that the business model provides the best structure for a health care system. Private enterprise allows for most business ventures to fail and for entrepreneurs to begin again; this is unacceptable in terms of the care and treatment of sick people. The outcomes that should be held steadily in view are cure of illness, mending of injuries, and care of those who require it. Outrageously high salaries and bonuses, especially for top administrators and bureaucrats, exploit the fears and pains of people who are sick and hurt. Since a considerable proportion of the hundreds of billions of dollars spent in the health care system goes to exorbitant salaries and excessive non-professional activities, one of the key factors that ought to be considered is encouraging, through scholarships and vigorous recruitment drives, larger numbers of men and women to train as doctors and nurses and to develop a wide range of intermediary preventative careers, general practitioners, social medicine experts, and other specialists. In this way, the closed-shop aspect of medicine will be given some fresh air and salaries would subside from the astronomical levels now achieved. The culture of litigation would also need to be addressed, so that physicians and hospital directors did not feel compelled to prepare for catastrophic costs

from malpractice suits and other claims.

Once we clear away this matter of definitions and of ideologies, something remains that is much deeper and profoundly shaped by group fantasies rather than by logical reasoning or historical experience. While it would be invidious to ascribe malicious intent to either side in the debate, I cannot help but hear in the cheers or jeers and see in the slogans and banners indications of psychohistorical forces. From the other side of the world, the current debate in America seems to miss the point. The imagery put forth by each side reflects different paradigms of care-giving, each side side-stepping the real issues and seeking to project on the other the neurotic fears about their own selfish dreams.

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Life's Final Moments in European Health Care

Peter Petschauer—Appalachian State University

Four people are involved in the description of my wife Joni's and my experiences with health care in Europe, the heartland of the supposed socialist or National Socialist expressions of health care. They are my father, Dr. Erich Petschauer; my mother, Hildegard Petschauer; my stepmother, Micky (Emmie Anders) Petschauer; and Agnes (Neas) Obwexer.

In each case, I am dealing with the last years of their lives and how they were treated in various parts of Germany

and Northern Italy. My father, my mother, and my stepmother lived in Southern Germany, Northern Germany, and Southern Germany respectively, and Neas, in the Dolomites of Italy.

All four were insured by their country's federal health care policies. My father and stepmother bought supplemental insurance to enjoy single-bed rooms and my stepmother purchased an additional policy that allowed her treatment access to the chief of the treating medical staff. All four had end-of-life policies that stated that no unusual steps be taken to shorten or prolong their final days.

My father contracted diabetes in his late 50s. The condition most likely emerged out of the stress of living through the unique conflicts he faced during World War II and the subsequent three years in 13 American prison camps. My stepmother made sure that he received the appropriate care at home, and then careful medical attention first from their private physician, and finally in the last days of his life in a hospital in Bavaria, where he died of diabetes-related complications.

In her 70s, my mother contracted senior dementia after a minor car accident in which a car slightly injured her left leg. After an initial recovery, she became seriously ill at her favorite spa and bought thousands of Deutschmarks worth of antiques. She was admitted to a restricted clinic and, after a year when part of her insurance had expired, transferred to a closed facility appropriate for her condition. My wife Joni and I were almost surprised by the thoughtful and empathetic treatment she received not only in the medical facilities but also by the persons from whom she had bought merchandise. All the owners of the stores where she had bought items, except the Turkish carpet men, took them back when my cousin and I explained the situation. I was most astonished that a national chain took back a DM 4,000 carpet, no questions asked.

The banker at the Deutsche Bank where my mother had been a cashier treated us with the sort of respect that can only be called empathetic. He, like the owners of the stores, spoke of a relative who had experienced problems similar to those of my mother. He did everything he could to smooth my mother's transition from retiree to incapacitated person. Even more astonishing to us, as my mother made the transition from the initial clinic to her final facility in Hanover, a judge, a staff nurse, and an independent nurse examined her and made the decision with us that my mother was not "street -worthy" and that she needed to be institutionalized. The facility where she lived for the remaining few years of her life was exceptional. The staff treated her with dignity, always calling her Frau Petschauer, and there was never an implication that she was there because the state paid for it after her own resources had been exhausted. She died one night in her sleep. Since my mother had made final arrangements long before her death, Joni, my cousin, and I had no difficulty honoring all of them.

The situation with Micky was similar. After a fall that severely injured her right shoulder, she was unable to live independently, and her closest friend and I arranged for her to stay in a county facility for seniors a few minutes from her home. Unlike my mother, and because of the supplemental insurance she had bought, she enjoyed a single room with a fantastic view of the Alps. The staff once more was exceptional; she was always addressed as Frau Petschauer and everything was done to make her comfortable. Her doctor looked in on her every few days. When she developed a very aggressive cancer in her throat, he immediately admitted her to a nearby cancer facility, where again, our experience was nothing but positive. Her physician told Joni and me after two days of examinations that indeed she had cancer and that our options were to operate, once she had been strengthened sufficiently, or not to operate. Micky wanted

nothing to do with an operation and the doctor assured us, speaking in fluent English, that with or without an operation, her life expectancy would not change. However, her quality of life would deteriorate significantly. In accordance with her wish and his recommendation, we agreed against an operation. Micky died three weeks later in her sleep. Although she weakened considerably during the last few days, she remained totally alert until the evening before her death.

As with the others, an accident or fall was the cause of Neas' fairly rapid decline. She fell on the way from feeding the chickens, one of her most cherished daily activities. She had trod the path hundreds of times, but one afternoon in December she slipped and broke her left arm. In the hospital in nearby Brixen/Bressanone, she recovered quickly, except for a decline of her mental functions. She was in a pleasant room and treated well. While trying to wash her feet in a bidet one morning, she fell again and this time broke one of her hips. With that event, her decline accelerated, and when I saw her again in the family farmhouse in April of this year, the Neas of old had almost completely disappeared. She was nearly incoherent and bound to her bed. With Italian state support, her daughter was able to hire an in-home attendant during the week so that the daughter could continue to work. Itinerant nurses visited every other day to change bandages and adjust medications, and a doctor checked in regularly. Once more, death came in the night. In her early 80s, she died in her sleep in early July of this year.

The death of my father ended a conversation that had begun late in his life. We had spoken of literary works: a novel, plays, and his book about Gottschee in the former Yugoslavia where he was born as an out of Germany German-speaker (Volksdeutscher). Because of his rapidly progressing blindness, only the book was published. I have continued a very different type of conversation with "my father within" through the multitude of his documents dealing with his ex-

periences during World War II as an SS diplomat.

The three women had become my "mothers." Hildegard was my biological mother, but she was not quite up to that task; Neas became my adopted mother who embraced me beginning with World War II when I was three-years old all the way through to my 60s; and Micky, my father's second wife, who became my best friend.

Each one of the four had made arrangements for the end of life. Each had asked that no special steps be taken on her or his behalf, but in each case the state was not involved in these decisions. As those who remained, we were most grateful that these arrangements existed because the dying, and we as caregivers, could avoid excessive anguish, pain, and cost. The exceptional care these four were given allowed Joni and me to avoid dealing with details that would have detracted from remembering and honoring them.

Many Americans are afraid about how they will be treated in their final days, months, and years. It is a legitimate fear. Unless one happens to be middle or upper class, substandard care and facilities are often all that is available. The fear is justified because, being alone and distant from family members, many men and women will be neglected and abused. Sadly, the empathetic treatment that my father, mother, stepmother, and one of my childhood caregivers received in two European countries cannot be guaranteed if the state, insurance companies, nursing home corporations, and distant family members do not feel a moral obligation to provide good care. Even if family members feel an obligation, they are often so far removed physically that they cannot help the dying effectively. Consequently, unlike our four cases, the family members on the verge of losing a loved one must concentrate on fighting with the "system," or each other, and therefore cannot concentrate on dealing with the emotional needs and impending loss of a loved one as well as their subsequent grief. The mourning process is overshad-

owed in these distressful situations by issues that a more sensitive societal approach to the care of the dying would alleviate.

The majority of our friends in the United States have had similarly positive experiences with the last months and days of their loved ones. But Joni and I have also visited facilities where acquaintances and family members of acquaintances were literally being warehoused. The food was at best passable, the rooms were dirty, the staff was either inattentive or rude. Most of us have seen these situations.

Our experience with European end-of-life health care left us impressed with its high quality as we faced the medical problems, physical decline, and impending deaths of four loved ones. Most interestingly, my father and three "mothers" rarely worried about health care as such, leaving them free to concentrate on emotional, personal, and physical aspects of their last few months. What a gift some societies give all their members–not just the middle and upper class! Regrettably, during our national discussion of the health system, most of our fellow Americans are discouraged from looking for reform ideas in countries on the continent I left as a 17-year-old.

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Reflections on Health Care and its Reform

Paul H. Elovitz—Ramapo College

In response to our work on the subject, a Psychohistory Forum colleague challenged David Lotto and me to examine "the psychological roots of…[our] own beliefs" concerning health care reform, suggesting we were "unconsciously…cherry-pick[ing] arguments to fit with underlying ideological or psychological motivations."

I readily accepted his challenge. My position is clear-cut: The expensive human and economic costs of our current system are irrational for society as a whole, although it works well for the short-term benefit of significant segments of our population. The U.S. system creates enormous amounts of anxiety and uncertainty for many members of the middle and working classes. It is hard enough to be hurt, sick, or dying, without having to also navigate our crazy quilt system of health care that results in huge numbers of needless deaths, disabilities, and personal bankruptcies. Group justice is also an important element. In most cases it is the poor—black, Hispanic, and white—who are inadequately served by our system. For them there is not enough preventative health care and far too much reliance on using the extremely expensive, impersonal, and inappropriate emergency room as their primary health care agency.

The economic cost of the current system is utterly astounding given the poor showing of American health care regarding infant mortality rates, longevity, healthy life expectancy after age 60, recovery rates, and the psychological cost of dealing with bureaucracies that are often more obstructive than they are facilitative. It should be a national embarrass-

ment that Cuba, with a mostly failed economy and a per capita income of about $4,000, scores almost as well or even higher on health care results in some categories while devoting only half of what the U.S. does for the medical care of its citizenry (Reid, *Healing of America*, 2009, p. 149).

My motivation is not ideological, since I distrust all ideologies. I vote, for example, across party lines, as well as write in candidates when I find the choices offered to be unacceptable. I am repulsed by the human and economic waste of the American health care approach because it is hurting a U.S. economy already in comparative decline. On the basis of my own life experience, I know what it is like to worry about not having medical care due to a lack of money and insurance—I feel for the suffering of those who do not obtain proper care or who worry terribly about how they will pay the doctor, pharmacy, or hospital. My identification is with the frustration of millions dealing with big insurance companies. My dominant emotion regarding the U.S. medical care is anger. The failure of our national debate to look realistically to the experience of other developed countries adds to my frustration. It is important to keep in mind that I was trained as a psychoanalyst to use my countertransference feelings without becoming a captive of them. This fits in with the Eriksonian methodology of "disciplined subjectivity" that is so important to our work as participant observers in the great issues of our day. Thus I work hard to not let my anger, frustration, and hope for better health care cloud my judgment when I am examining arguments or deciding among competing statistics. This is not an easy process.

It is disappointing and enraging that health care in wealthy America should be so far behind the rest of the developed, and even some of the undeveloped, world. In 1912, the Progressive Party (Bull Moose) Platform called for health care for all Americans, yet almost a century later we have not made this a reality. On the basis of the five Congressional

committee bills that are now being reconciled prior to being voted upon, it does not appear that, even if successful, the final legislation being pushed by the 44th president will achieve universal care, though it should improve the health care situation. Despite a determined effort to contain costs, success seems unlikely in this regard, partly because of the legislative process, the complexity of the problem, and the health needs of an aging, increasingly obese, and physically unfit population.

Our colleague's charge of cherry-picking arguments and statistics, given the complexity of the health care system, is easy to assert, and there is insufficient space here to definitively refute it. However, the notably lower infant mortality rates and significantly lower health care costs in other developed countries, along with longer life expectancies and ease of use, does not represent cherry-picking. Higher U.S. breast cancer survival rates are admirable, but they do not negate these more basic indicators.

Two articles in this issue provide examples of some of the advantages of the German and Italian universal health care systems over that of the current one in the United States. They are provided in Angela Davies' moving article about her own health care in the U.S. system and that of her brother in Germany and reinforced by Peter Petschauer's four cases of end-of-life care of his loved ones in Germany and Italy. Davies, a woman who has been categorized as having fourth-stage cancer since 2001, astounds her friends, associates, and family with her uncomplaining courage and determination to survive the cancer that continues to ravage her body. Time and time again she comes back from appearing only steps away from death's door. It is a shame that she has to worry about issues of insurance coverage rather than have the empathetic ease of care her brother receives as an American long-term resident in Germany. The U.S. can and should do better.

Peter Petschauer brings up important points seen from the perspective of a compassionate human being, family member, and historian. He feels for those whose families cannot be with them physically or emotionally at the end of life because of distance, cost, and struggles with health care providers. However, healthcare, eldercare, and end-of-life care are not just a function of the financial resources devoted to them and the physical closeness of the family, as one might gather from a quick reading of Petschauer's conclusion. With typical humility, Peter ignores the role of his warm personality on the health care workers resulting in better care for his loved ones. Beyond that, I suspect that just the notion of the Petschauers' crossing the ocean repeatedly to be with those under their care helped inspire the staff to give the extra effort to those he visited. Their care contradicts his idea that it is the distance of their families that results in poorer end-of-life care. Also, no matter how good the quality of the health care system may be, for their own psychological reasons some people will fight with the system or each other. Anger can serve as an outlet for their enormous anxiety in confronting serious illness and death. Old intra-familial rivalries also surface at such times, especially because of the role reversals associated with the decline of parents. Consequently, healthcare workers sometimes have to ask the family to leave the bedside of the loved one.

The health issues of people closer to the beginning, rather than the end of life, also contribute to the health care conundrum. The obesity so common in a younger generation raised on super-sizing everything but exercise, has made for an epidemic of asthma and diabetes. The costs of these diseases are enormous in terms of medical personal, money, and suffering. Lifestyle changes are essential for the health of Americans, yet many self-destructively ignore them, and they are often overlooked in the current health care discussion, as pointed out by Sander Breiner. The importance of a healthy

lifestyle was brought home to me yesterday as I observed a 67-year-old seldom-seen neighbor full of vim and vigor. I commented to him that he looked so much better than he did a decade or so ago without mentioning that at that time I feared for his life because of his obesity, diabetes, and a heart condition. He proudly declared that a regiment of dieting, drugs, exercising, walking, and weight loss had led his doctor to declare he is now a recovered diabetic and does not have a heart condition. Further discussion revealed that his situation was more complicated. After making lifestyle changes a decade ago, a half dozen years ago he had relapsed to the point that his obesity and inactivity left him on the verge of a heart attack. He then had gastro/intestinal surgery resulting in a loss of over 100 pounds and a return to a healthy lifestyle.

Why is dieting so difficult for so many people? Psychotherapists know the reasons: Food represents our mother's love. We eat to live, but also to comfort ourselves, compensating for our disappointments and failures. Individuals who demonstrate great will power in stopping smoking or drug abuse often fail at dieting because it is not an either-or situation; one must ultimately eat. Many, like my neighbor, do a wonderful job of healthy eating only to relapse into dangerous habits. They then feel the need to compensate for their reduced self-esteem by eating even more. An exercise routine can be a great help because it restores self-confidence, breaking the cycle of overeating.

Lifestyle changes and athletics are excellent, although I must add a note of caution. A number of the athletic instructors/directors at my college have been easy to identify by their limping around campus as a result of overdoing their sports. Conversations with my students about their athletic activities often focuses on the medical problems that have followed from injuries, to say nothing of my observations of

once impressive muscles turned to flab on a large scale among many former athletes.

In viewing health care around the world, some common patterns that emerged are that there is so much anxiety about health and its care that providers and patients complain about it no matter how good the system may be. The latter is true even in France, which is often rated as having the best health care system in the world, and where there have been major reforms in 1996, 1997, 2000, and 2004. Laura Nicolas, a 25-year-old French scholar on a Fulbright teaching assistantship at Ramapo College, enlarged my knowledge of French health care, including some of its problems. Controls on the system were tightened up recently as a result of concerns about overuse. For example, an elderly woman using her medical insurance some 900 times in a single year! The health care system for students is slightly different than for the rest of the country. Competition between the two insurers was so intense that last year both were temporarily banned from a university.

Yulia Ivanova, a Ramapo exchange scholar from Russia, explained some of the ins and outs of the system in her country. Unlike most young professionals who spend little time thinking about health insurance, the costs of treating a broken leg led her to come to terms with the issue. The costs of medical care for her leg cost about a month's salary in Russia's somewhat haphazard health care system. She said her university provided a level of care for their employees, as do some other institutions in the country. The universal health care system of Russia, which advocates of Soviet communism used to brag about, was nothing to boast about, but it did provide minimal levels of health service which are now mostly lost. This is reflected by the life expectancy of Russian men dropping about eight years after the collapse of the Soviet system (http://www.accessmylibrary.com/coms2/summary_0286-390308_ITM). This decline was partly a

consequence of an extraordinary increase of alcoholism, continued high rates of smoking, and the personal demoralization in this period of societal dislocation, rather than simply a question of their collapsed health care system.

While I support a system of universal health care and think that the current reforms are a step in the right direction, I do not see them as a cure-all. Improving American health care through reform will not in itself make America a healthy country, although properly done it will save lives and money. The aging, fattening, and sedentary lifestyles of Americans will contribute to increases in our health expenditures. Baby Boomers (77 million were born between 1946-64) will soon be on Medicare, straining the system and greatly increasing health expenditures. Below are some of the questionable assumptions commonly found among those in favor of health care reform, followed by explanations as to why they are questionable.

- A onetime reform is all that is necessary, as asserted by President Obama in a speech promoting reform. (The reality is that given the incredible complication of the American system, many reforms will be necessary to maximize health benefits and control costs.)
- Health care reform will satisfy both doctors and the general public. (American economist Tsung-Mei-Cheng, has formulated the "Universal Laws of Health Care Systems." These are that people complain about all health care systems no matter how good, doctors and hospitals invariably insist—no matter how much money is provided to them—that they are not getting enough, and "the last reform always failed" [Reid, *Healing of American*, p. 27])
- Health reform can be achieved without raising taxes or reducing services, as planned and promised by President Obama. (A number of factors mitigate against this being

possible, three of which are Obama's limited control over the legislative process which involves placating conflicting interests, the aging of America resulting in more of our population being in the cohort requiring more care, and the enormous thirst of the American public for new and expensive treatments.)

- A governmental single payer insurance system available to all will inevitably drive out private health insurance companies, as David Lotto believes. (In Germany, France, Japan, and other countries, the health insurers, and the providers, are private. However, they are regulated carefully by the government and profit is not their primary motivation.)
- America will continue to be the world leader in the development of new life saving medicines and technologies even after reform, as is anticipated by our citizens. (Controlling drug and technology costs may lessen the economic incentives for these developments.)
- There is no need to deal with the legal issues faced by doctors. (Current legislation does nothing to lessen the cost of malpractice insurance for physicians and their subsequent inclination to practice expensive defensive medicine. Although this is not a major percentage of the costs, it is still a factor.)

It is important to remember that these questionable assumptions about health care by advocates are only a part of the picture. In communicating with colleagues in our psychohistorical community, they have provided me with many insights that did not take the form of articles in this issue. Below I will share a few thoughts of Marilyn Charles, Goeffrey Cocks, Tom Ferraro, and Nancy Unger.

Marilyn Charles, who wrote so movingly about trauma and its intergenerational transmission in our "Death and Dying" issue a year ago, brought up the question of the treat-

ment and de-institutionalization of people with chronic psychiatric problems. She argues that current policies are detrimental to a very troubled segment of our population. Her association with the psychoanalytically based Austin Riggs Center is significant. After the recent demise of the Menninger Clinic, it is important to be reminded of the yeoman service being done in this Western Massachusetts center, with its Erikson Research Institute bringing together top-notch clinicians, such as Marilyn, along with historians like John Demos, whose wife Virginia is a therapist at the center, and psychohistorians like Vamik Volkan. It is a thriving community based upon applied psychoanalysis.

Geoffrey Cocks of Albion College, the author of the well-received *Psychotherapy in the Third Reich: The Göring Institute* (1997) who is currently writing *Sick in the Night: Illness in Nazi Germany*, reminded me how much ideas about health care can be shaped by ideology. An extreme example is that shortly after coming to power, Hitler instructed doctors that "racial hygiene was to be the [first] task of the German physician." Although we Americans have no official medical belief system, how we treat "dis" "ease" is enormously influenced by our views of the world. One aspect of this is our love affair with expensive medical technology. Another is the ideological aversion to governmental involvement about which David Lotto writes.

Long Island psychoanalyst Tom Ferraro has some interesting ideas that I would label "diagnosing the health insurance industry." He presents fact after fact and argument after argument in furtherance of the thesis that the pathological pursuit of profits by the industry is detrimental to the health of America. After all, payments by insurance companies to reimburse patients who bought insurance for precisely this purpose are listed as "losses." In his view the insurance industry, even if Obama and the Democratic congressional leadership achieve their reforms, will continue to be an ob-

stacle to the health care of Americans. According to Ferraro, if it were an individual, its condition would be listed as a "psychopathic personality disorder." Although there are moments, especially when I think about the high overhead costs of our for-profit insurance companies, that I am sympathetic to Dr. Ferraro's approach, I also remember the competition among the German insurance companies who have adopted a model of competing for the benefit of the patient rather than for their own profit.

Historian Nancy Unger suggested that the paranoid belief in a suppressed cure for cancer, covered in this issue in Nathan Carlin's article, is a reflection of the enormous comfort some people can find in this thought: "Cancer which seems uncontrollable can in fact be controlled." Certainly we have made some progress in effectively treating some types of cancer, although the "War on Cancer," the popular name for the National Cancer Act signed by President Nixon in 1971, has yet to yield a victory. A most respected colleague, who prefers to remain anonymous, was so touched by Angela Davies' account of the treatment of her and her brother's cancer in Germany, that he fervently and indignantly asked the question, "Why not [universal health care] in America and why not now?" Many share this sentiment.

The fee for service payment system in medicine encourages greater medical intervention at enormous cost and often without bringing benefit to the patients. More is not necessarily better and it may even increase the chance of dangerous medical errors. Epidemiologists have established that about a third of all care—at a national cost of 600 billion or more dollars—does not result in better patient outcomes. Starting in the early 1970s, Dr. John E. (Jack) Wennberg of Dartmouth College discovered that there were enormous variations in the rates of medical procedures in communities near each other, based upon factors other than patient need. Considerable evidence has been compiled concerning back

surgery, hemorrhoid operations, hysterectomies, mastectomies, prostate operations, and tonsillectomies. The more doctors in an area, the greater the likelihood of surgery (Alix Spiegel, "The Telltale Wombs of Lewiston, Maine," National Public Radio, All Things Considered, October 8, 2009: see http://www.physicventures.com/news/telltale-wombs-lewiston-maine).

The research of Professor Wennberg and others who have followed his path of inquiry points to the iatrogenic (adverse) effects of medical care. Even aspirin, a great healer and lifesaver, kills many people every year. Fortunately, even in television advertisements, the negative consequences of prescription drugs must be referenced.

The need for so many people to somaticize rather than talk out their feelings adds to our national health care bill, as do those with Munchhausen's Syndrome. Illness, whether real, imagined, or feigned, can serve as an escape from disagreeable and tedious life/school/work situations. It may become a life pattern, as it did with Charles Darwin. An anxious relative, traumaticized by a childhood illness involving a lengthy separation from her mother, seeks reassurance that she is healthy by going to doctors without any significant medical issues three or four times every month. Rutgers Professor and Psychohistory Forum Research Associate Ted Goertzel is writing an article for an international journal on why people fail to protect themselves with vaccines and organize their diets around scientifically unproven beliefs regarding consuming special organic and other foods. Research I did in the early 1980s pointed to commonly held poison fantasies among residents of Northern New Jersey.

Such fantasies and other forms of "magical thinking" further the deterioration of the current health care system. The evidence is overwhelming, America needs universal health care coverage. If the current legislation is passed, it will be an important step closer to achieving that goal. Com-

plex economic, political, and psychological forces render health care difficult to fix. A single piece of legislation will not solve the problem: Like life itself, a health system requires adjusting to changing needs and technologies. Universal health care is no panacea, and it will add to our deficit spending unless we are able to cap many of the expenditures associated with the fee for service system. Health care is about warding off our greatest fears—loss of autonomy, dependency, helplessness, illness, and ultimately death—all enormously anxiety producing. ❑

Psychohistory of Barack Obama

The Transformations of Barack Obama

Ken Fuchsman—University of Connecticut

If you read about a child whose parents had a shotgun wedding, whose mother and father separated before the child was a year old, each of whom later had a second divorce, and he hardly ever saw his father, you probably would not expect that such a youngster would be elected President. Barack Obama overcame these odds and is now our Commander in Chief.

Children from divorced, single-parent, and blended families are likely to have short-term and long-term behavioral problems. As a child, Barack Obama experienced all these family structures. Yet, he has emerged as a disciplined, often inspiring, figure. What transpired that enabled this often-troubled young man to be a model for others? I will discuss four factors in Obama's background, biography, and character that helped him transcend his family background.

The first factor to consider is class. Except for a few periods, Barack Obama, Jr. remained middle-class for much of his childhood. Without financial support from his father after the first year, and his mother often being a student, his maternal grandparents, with whom he lived for much of his childhood, regularly provided an economic base. Both of them worked full-time and sacrificed for their grandson. If poverty and ghetto living had been Obama's life, his prospects would have been much different. Instead, except for four years in Indonesia, he grew up in the relatively tolerant environment of multiracial Hawaii, and from the age of ten on, attended a school with middle-class and upper-class children.

The second factor to consider is education. Barack Obama is the first President both of whose parents earned graduate degrees. At the age of 19, his mother returned to college and eventually earned her doctorate in anthropology, while his father had a master's degree in economics from Harvard. When young Barry lived in Indonesia between the ages of six and ten, his mother would wake him up at 4:00 or 4:30 AM and teach him for three hours each morning before he went to school and she to work. Barry was sent back to Hawaii at the age of ten after being admitted to a prestigious private school, from which he eventually graduated. He began college at Occidental College in Los Angeles, but he transferred to an Ivy League school, Columbia, as a junior. Later, he earned a law degree at Harvard. His excellent formal and self-education allowed Obama to integrate the disparate parts of his disjointed background into a disciplined identity. He says: "the only reason Michelle and I are where we are today is because the country we love gave us the chance at an education" (Barack Obama, *The American Promise: Speeches 2007 + 2008,* 2008, p. 505).

The third factor is both genetic and cultural. Obama is outstanding intellectually. Those who knew Barack Obama

Sr. in Hawaii praise his intellect, showing what the son has inherited. The senior Obama, according to his Kenyan mother-in-law, "was extremely brilliant" (quoted in David Mendell, *Obama: From Promise to Power* [New York: Amistad, 2007], p. 29). Hawaiian Congressman Neil Abercrombie, who befriended Obama Sr. in college, describes his friend as having a "brilliant, brilliant mind" (quoted in Jon Meacham, "On His Own," *Newsweek*, September 1, 2008, http://www.newsweek.com/id/155173/output/print). According to David Mendell, Barry's self-deprecating mother told her son that he inherited his intellect from his father (Mendell, *Obama,* p. 34). She had brains herself, loved learning, and was admitted to the University of Chicago as an undergraduate. Both his parents, then, were endowed with intelligence, and their careers were connected to their academic opportunities and achievements.

The fourth factor is his temperament, which also involves both inheritance and experience. Even a casual observer, such as I, watching Obama at a campaign rally noticed how cocky he is. This extraordinary self-esteem has been noticed by many. In 2008, reporter Steve Kroft asked Obama where he got his confidence. The candidate replied: "My wife asks me that all the time. I think it's as a consequence of having grown up in a lot of different kinds of circumstances…My upbringing was unconventional. I had to—I was tested, I think, in a lot of different environments and… over time, I came to be confident about my capacity to connect with other people…you were asking earlier where I get my confidence from. I think if you ask a lot of children where do you get your confidence from, it's the love of your mother…She was one of the—one of the finest people that I've ever known. And a lot of what I do reflects the values she instilled in me" (http://transcripts.cnn.com/TRANSCRIPTS/0901/30/acd.01.html).

As a young adult, President Obama's father was not

lacking in self-confidence either, so maybe this trait also has a genetic base. Obama Sr.'s friend at the University of Hawaii, Neil Abercrombie, told David Maraniss that Obama Sr. was very opinionated and "never hesitated to tell you what he thought," and had no mercy with people who were not at his level (David Maraniss "Though Obama Had to Leave to Find Himself, It Is Hawaii That Made His Rise Possible," *Washington Post, 12/*22/2008, http://www. washingtonpost.com/wp-dyn/content/article/2008/08/22/AR2008082201679_pf.html).

Obama's self-esteem is a character trait, and so is another part of his temperament: his restlessness. A variation on this comes out in the very beginning of both his books. On the first page of his *first book,* describing himself at the age of 21, he wrote: "I was impatient in those days, busy with work and unrealized plans" (Barack Obama, *Dreams from My Father* [New York: Three Rivers Press, 1995], p. 3). Toward the end of this volume, the 33-year-old Obama stated he had "learned to be more patient these past few years" (Obama, *Dreams*, p. 439). In the opening paragraph of his second book, he characterized himself at the age of 35 as "generally impatient with life" (Barack Obama, *The Audacity of Hope* [New York: Three Rivers Press, 2006], p. 1). Evidence for a hereditary basis may be that Obama's mother and his maternal grandfather both were restless souls. His mother never stayed in one residence very long, and until moving to Hawaii in 1960, his grandfather Stanley Dunham took his family from one locale to another, including Kansas, California, Texas, and Washington. His opinionated father was not known for being a patient soul.

Obama would probably attribute his impatience with life to a few other factors: not living with a father, his mother's rootlessness, and his biracial heritage, leaving him between both white and black populations. What happens to a person can be less influential than how that individual inter-

nalizes and transforms events. Obama has written of the shock of finding his father was a bitter drunk rather than the heroic character he had been raised to imagine. Obama worried that his father's failures would haunt his own life. "I would find myself…feeling as if I was living out a preordained script, as if I were…a captive to his tragedy." The result was that "I now felt as if I had to make up for all his mistakes" (Obama, *Dreams*, p. 227). Obama's ambition and his being driven to succeed were, in part, a reaction to his father's wreck of a life. Obama admitted to Jon Meacham that to endure the rigors of running for President something's "got to be driving you, and in my case if you have somebody that is absent, maybe you feel like you've got something to prove…in my case, the stories I heard about my father painted him as larger than life, which also meant that I felt I had something to live up to…if the pattern sets in pretty early on where you're pushing your comfort level it probably has to do with those very early influences, and that can come from either the absence or the presence of a father who ends up motivating you in some way' (quoted in Jon Meacham, "On His Own, http://www.newsweek.com/id/155173/output/print).

He was also trying to make up for what he did not get from his beloved, demanding, and idealistic mother. The "sense of abandonment I'd felt as a boy" derived not only from his disappearing father, but from his mother who did not regularly provide him with a stable environment (Obama, *Dreams*, p. 430). What he did not get from his ambitious parents, he received, in part, from his maternal grandparents, and in part from himself. Obama's turning inward has a great deal to do with his self-development. He said: "At some level I had to raise myself…I had to learn to trust my own judgment; I had to learn to fight for what I wanted" (quoted in Meacham, "On His Own," http://www.newsweek.com/id/155173/output/print). Given his bi-

racial makeup as a teenager, Obama felt that no one in his world could understand his dilemmas. He admitted to feeling "utterly alone." He wrote that he "decided to keep my own counsel…to disguise my feverish mood" (Obama, *Dreams,* p. 91, 87). His lack of trust meant that he confided in himself; his friends at the time were not aware of his inner turmoil. Outwardly he was social and friendly, but retained an inner shell that only he penetrated.

This duality between sociability and introspection continued at college. His Columbia University roommate, Phil Boerner, who also knew him at Occidental, remembers Barack as "very generous." The two of them would "get pretty emotional about sports, food and injustice." They would also walk around the city and go to museums and bookstores. Boerner says of Barack that "everyone seemed to like him pretty well" (Phil Boerner, "Barack Obama '83, My Columbia College Roommate," *Columbia College Today,* Volume 36, Number 3, January/February 2009, p. 72).

Yet at Columbia he continued, even accentuated, his self-reliance. Obama described his time there as "my ascetic phase…I literally went to class, came home, read books, took long walks, wrote…during those two years, I had to look inward and gather myself" (quoted in Richard Wolffe, *Renegade: The Making of A President* [New York, Crown 2009], pp. 30-31). He told David Mendell, this was "the period when I grew as much as I have ever grown intellectually. But it was a very internal growth" (Mendell, *Obama*, p. 59). He came out of Columbia a self-disciplined man, knowing he did not want a life of money making but of assisting others, of service. The young Obama wanted to do for others what he had started to do for himself.

After graduation from Columbia, Obama began to move from self-reliance to a mixture of keeping his own counsel and connecting more to others. After an interlude in the private sector, the biracial Barack Obama, Jr. solidified

his African-American identity by finding employment as a community organizer in a decidedly black section of Chicago. As he embraced the ideal of a beloved community and worked toward change, he described himself in this period as having "wounds to heal, and could not heal myself" (Obama, *Dreams,* p, 138). Obama in Chicago became the paradoxical individual he still is today: highly confident and self-questioning; deeply engaged and yet detached; reflective and passionate; impatient with life but with a cool, steady demeanor; self-disciplined yet beginning to rely on others.

A crucial event occurred during his initial time in Chicago: he met his African half-sister, Auma, and learned the sad details of his father's adult life in Kenya. How a once-promising career collapsed after his arrogance led the nation's ruler to blackball the senior Obama, who subsequently became an alcoholic, dying in an automobile accident at the age of 46. The Kenyan's American son then wanted to avoid his father's tragic mistakes. After the shock of knowing about his father's dissolute life, the younger Obama's restless self-examination led him to feel something was missing. He lacked a certain kind of belief. Obama wrote: "I had faith in myself. But faith in one's self was never enough" (Obama, *Dreams*, p. 279). The black Christian church provided something for him that helped give him an emotional foundation; a wider faith, a bridge from self to community. It was another step in his evolving identity as an African-American. In embracing this black heritage, Obama also developed a deeper belief in community and transformation. The rhetoric of change that is so much a part of Obama's political rise and his own personal development came out of the black Christian church. The emptiness he had felt within himself was somewhat being healed by what he found in religion.

His personal and spiritual sojourn to Kenya also helped him recover the black side of his heritage. As he con-

fronted the past of his male paternal ancestors while at their Kenyan gravesites, Obama wished that his grandfather had told his father that "he could never escape himself, or re-create himself alone." It was an emotional, cathartic moment, a movement away from his distrustful self-reliance. "I sat between the two graves and wept. When my tears were finally spent, I felt a calmness wash over me. I felt the circle finally close." Obama found in Africa a connection with the pain of his paternal grandfather and father, and recognized that their "struggle" had become "my birthright" (Obama, *Dreams*, pp. 429-430). He was no longer utterly alone. In subsequent years, Obama's political message includes that we do not save ourselves alone but as a democratic community; salvation is not just individual, it is social. Social redemption engages him. Obama became immersed in political issues because the struggle for achievement, security, and excellence are inseparable, because individual and social renewal go hand in hand for him. Obama may not have relinquished the invisible shield distancing him from others, but he was leaning toward recognizing that interpersonal connection is vital.

The last, crucial step in Obama's transformation from emotional abandonment to belonging comes from his relationship with Michelle Robinson Obama. Here is a woman who combines the idealism of his mother and the realism of his maternal grandmother. He wrote that "she reminds me… a little of Toot," his grandmother's nickname. Obama credited "several improvements in my character…to my wife, Michelle" (Obama, *Dreams*, p. 439). She is both affirming and critical; she supports him and tries to ground him. Our current President retains the restless ambition of both his parents. Michelle allows him to go on his wanderings, but also demands place and support for her and their family. There has been tension between them over his commitment to his political career. Yet more than anything, she has removed

from him that sense of being an orphan. He can trust her; she may criticize him, but she will be beside him. Obama said: "My choosing to…marry a woman who is rooted in one place probably indicates a desire for stability that I was missing" (quoted in Amanda Ripley, "The Story of Barack Obama's Mother, *Time,* April 9, 2008, http://www.time.com/time/nation/article/0,8599,1729524,00.html).

It is here that the circle is completed, that the emotional wounds he endured as a child without a father and a mother who was not always available have mostly healed.

Struggle will remain his birthright, internal divisions will characterize his identity; he is both self-contained and interdependent. His personal struggle is entwined with the community of others who struggle. Obama brings the same determination, self-discipline, intellectual ability, vision, and practicality to confronting the social wounds as he does to his internal struggles, for to him the personal and the collective are bound together. He not only inspires, he organizes. His confidence and competency have enabled him to gain support from much of the American public. His remarkable personal, social, and political identity disguises his many contradictions. Still imperfect as his faith is, it has helped him to move from emotional isolation to becoming the persuasive preacher of collective hope. He has risen from feeling like an orphan to the nations' leader. His remarkable journey is still ongoing.

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A Psychohistorical Exchange on Barack Obama's Family Background

Ken Fuchsman—University of Connecticut
Paul H. Elovitz—Clio's Psyche

Introduction

Two psychological historians writing and presenting on the childhood and family dynamics of Barack Obama came to some different conclusions. The situation was the Psychohistory Forum's Research Group on the Childhood, Personality, and Psychology of Presidents Panel of the International Psychohistorical Association at its meetings at Fordham University on June 10, 2009. Ken Fuchsman (**KAF**) presented "Barack Obama and the Cycle of American Liberalism" and Paul Elovitz (**PHE**) "Psychological and Political Reflections on Obama's Presidency." Their varied choice of words and differing conclusions were even more apparent when Professor Fuchsman submitted the valuable paper, "The Transformation of Barack Obama," to this journal. While appreciating each other's papers, we think certain differing decisions warrant further discussion continuing in print below.

The Dialogue

PHE: Why did you choose to begin your paper with "Barack Obama occasionally sounds like Sigmund Freud?"

KAF: I connected Freud and Obama to highlight the combination of paternal deference and rebellion that characterize the father of psychoanalysis, our current President, the cycle of American liberalism, and many modernist cultural-intellectual movements.

PHE: You focus on the question raised by Obama, as to why his grandparents allowed their teenage daughter to marry the older African student. In "A Comparative Psychohis-

tory of McCain and Obama," *Journal of Psychohistory* 36, #2 (Fall, 2008): 98-143, I wrote Ann "was already three months pregnant and probably would have married in any case." What I did not write, but what I always thought important, was that she might elope with her African lover and break off relations with her family, as her parents had at about the same ages. Ann was an only daughter and her loss would have been extremely painful to them. I doubt that as a young man this consideration was clear to Barack. What are your thoughts on this formulation?

KAF: In his 1995 book *Dreams from My Father,* Obama has his parents marrying in 1960 rather than 1961, which would likely make his August 4, 1961 birth date occur at least nine months after the wedding. Therefore, he does not appear to know that his mother was pregnant when she got married. The first time I am aware that he knows about his mother's condition is when he was interviewed by *Time* for an April 2008 article on his mother, when they told him his mother was married six months prior to his birth. While Obama asserted in his memoir that his maternal grandparents, Stanley and Madelyn Dunham, accepted the marriage of their daughter, there is conflicting testimony. In 2004, Mama Sarah, Barack Obama Sr.'s Kenyan stepmother, said that Stanley Dunham opposed the marriage and was trying to get Obama Sr. expelled from the University of Hawaii.

Their daughter did elope to get married, but returned to her family afterward. Since she left Hawaii for Seattle to go to college when her son was seven months old, there might well still have been tension between her and at least one of her parents. Who knows where this possible trouble between daughter and parents might have originated and what it was about, but it looks like the Dunhams did lose their daughter for a while. Why would she go to college far away when she could have returned to the University of Hawaii, which she attended in 1960, if she did not have difficul-

ties with her husband and parents? It is not clear if Ann Dunham's parents were more afraid of losing her or more upset about her marriage and pregnancy.

PHE: Previously, my sources had only indicated that Ann returned to Seattle on the way to and from visiting her husband in Cambridge when he left for Harvard. Ann was going back to where she had been a teenager and from where she had not been eager to leave in 1960 upon graduating high school. I am most impressed by how your detailed research resulted in bringing into focus new information on Barack Obama's childhood and family relationships. A notable example is that Obama's father had left him when he was only ten months old, not two years as the President wrote. In trying to determine why I did not focus on some of this previously, I have several thoughts. First is my over-reliance on, at least in retrospect, Obama's own words in *Dreams From My Father* (1995), which I first read it in the spring in 2007, when his presidential prospects were quite poor and I did not anticipate the need to check out every fact as thoroughly as I would when he was the nominee.

In terms of my countertransference feelings for my subjects, I clearly identified with Barack and his grandparents in forming a picture of his childhood. Although I searched out a large number of sources elsewhere, I had already published when David Maraniss' valuable article, "How Obama Had to Leave to Find Himself, It is Hawaii That Made His Rise Possible," was published in the *Washington Post* (August 22, 2008). Also, as a historian, I tended to accept out-of-wedlock first-births as quite commonplace.

KAF: One of the biggest reasons for the differences between your work and mine is the evidence we had. What shaped my focus was reading about what Obama's mother did. Ann Dunham Obama went to Seattle while her husband was still an undergraduate at the University of Hawaii. She was enrolled as a degree student at the University of Wash-

ington in the spring quarter of 1962, which went from March 26 to June 7. Barack Obama Sr. graduated in spring 1962, and left Hawaii on June 22, 1962. His mother went back to the University of Hawaii in the spring 1963 semester. I was writing at a later date than you, so I had access to the Maraniss article showing when Obama Sr. left Hawaii and you initially did not. The newspaper stories I read about Ann Obama appeared in the Seattle area. These various articles led me to check with the registrar at Hawaii to see when the President's father graduated, the same office at Harvard to confirm when this particular Kenyan began his graduate studies there, and the University of Washington to confirm the registration dates of the President's mother.

PHE: As a psychological historian working on Obama, would you give an example of the problems with sources, the issue of verification, and the fallacies of memory?

KAF: An easy example of all three of these areas of concern is how each family of origin responded when Ann Dunham and Barack Obama Sr. married. In his 1995 memoir, Obama quotes his own mother as saying that back in Kenya, Hussein Obama was seeking to get his son expelled from the University of Hawaii. Nine years later, Sarah, the stepmother to the President's father, tells a Nairobi paper that it was Stanley Dunham who opposed the marriage and was trying to get Obama kicked out of the University of Hawaii. Without additional reliable testimony, the psychohistorian should do little more than list both accounts to show there was opposition to the marriage. Now, Obama tells his biographer, David Mendell, that his mother said initially her parents were livid over the marriage. But this is not sufficient to resolve these different accounts.

PHE: Your careful historical research is greatly appreciated. Your tracking down that Ann went to the University of Washington while her husband was still in Hawaii is important. Of course, like all new evidence it raises additional

questions. What was happening in her relationship with her husband? Was she fulfilling her high school dream of college in Seattle before the family moved to Honolulu, where her father insisted she attend school locally? How did she pay for school? The only reference I have to her working is as an au pair in Chicago as a 16-year-old.

I find myself ambivalent regarding your statement that "Obama as an adult, in part, developed a counter-identity in relation to both his parents." All children identify with both their parents in some ways and reject them in others. Please list the ways in which Barack identifies and disidentifies with each parent and discuss how conscious you perceive the process.

KAF: Now we are talking about how different concepts we employed are another reason for the differences between us. I agree with you that children generally identify with and against their parents. What makes for a counter-identity, which in Obama's case is partial, is that the child is seeking to follow a different path than a parent; the parent is in some way a negative example. With his father, whatever unconscious motivation there might be, Obama is also quite conscious of these feelings. In *Dreams,* he writes of wanting to make up for his father's mistakes, and worries that he "was living out a preordained script, as if I were…captive to his tragedy." He wants to avoid being politically ostracized as his father was. In his second book, Obama writes that his own "particular malady" concerns trying to "either live up to his father's expectations or make up for his father's mistakes." Obama identifies positively with his father's ambition, education, and the heroic image of him created by his mother. With his white mother, his counter-identity is less conscious, and focuses on identifying himself as an African-American rather than as a biracial American. He tried to assure her that by doing so he was not rejecting her, but she did not buy it.

PHE: You focus on Obama barely having a father in his life and the negative consequences in terms of greater poverty, behavioral problems, fatherlessness, and the inclination to run away. Without rejecting the greater statistical likelihood of these negative consequences, it is worth emphasizing that parental loss is also associated with greater creativity, as our colleague Andrew Brink has demonstrated in *Creativity as Repair* and other books. Young Obama was loved, nurtured, and given direction in life, such as when his mother showed up to get him to challenge himself in college on the mainland. To what extent do you see Barack Obama's success as an attempt to compensate for his childhood losses?

KAF: Whatever creativity might result from parental loss, children of single-parent families have higher school dropout rates, more behavioral problems, and if they are female, are more likely to become pregnant out of wedlock. Obama himself discussed what parental loss meant for him as a person and what negative impacts it has for society. I do concur with you that Barry Obama was cherished, nurtured, supported, and challenged by his mother and maternal grandparents, but he does not present himself as a sheltered and nourished child. In *Dreams*, he wrote of feeling abandoned and at one place stated that he felt utterly alone given his particular biracial makeup. According to biographer David Mendel, he told a number of friends that he felt like an orphan. Yet at the same time, he was attending Honolulu's most prestigious private high school, and later was accepted to and graduated from Columbia University. His feeling emotionally bereft occurred in a setting of educational advantage.

Concerning his success being related to compensation for childhood losses, I would frame it differently. In his personal life, to make up for not having any parent who was always there for him, he sought to marry someone who would provide the secure emotional base he did not get. Publicly, besides wanting to avoid his father's pitfalls, he found his

identity in political reform rather than climbing the corporate ladder. For him, success cannot be achieved just individually; it is tied to the well being of others. Certainly, this notion of achievement by giving to the beloved community and being dependent on it, can be seen as a way of hoping to avoid further losses.

PHE: I am troubled by your inclination to ascribe some behavior as genetic that I perceive as learned. Let me give you several examples. One, you seem to credit Obama's intellect to "genetic[s] and culture." You suggest that "maybe there is a genetic base" for his self-confidence "as well." In the context of his self-confidence you use the word "cocky" and ascribe it to "inheritance and experience." Throughout my career, I have seen highly respected historians credit inheritance and genetics for what I, and most psychoanalysts, would interpret as learned behavior. In the case of Obama, he had a mother who nurtured and demanded intellectual excellence and set the boy's father up as the paradigm of intelligence, education, and self-confidence. In her absence, his grandparents supported these characteristics as he went to the finest school in Hawaii. In my opinion, there is no need to bring genetics into the picture, especially since you cannot provide any DNA or other empirical data for it. So why do you do it?

KAF: Whether or not most psychoanalysts emphasize learned behavior, Freud was a divided soul on the issue of inheritance versus experience. He clung to the notion of the phylogenetic inheritance derived from Lamarck, and stated a number of times that when experience conflicts with this biological force, experience is trumped by biology. While I have no adherence to Freud's outmoded notion of phylogeny, I do think that temperament, an evolving mixture of inheritance and experience, is necessary to help explain individual differences. I do not believe that it is accurate to state that I ascribe some behavior as genetic, as you say in your opening

sentence above. I state twice in my article for Clio's Psyche on Obama that I perceive a combination of genetics and experience. I see no reason to place them in opposition or regard them as easily separable.

I am very fond of Winnicott's famous statement about the maturational process and the facilitating environment. None of us is just a creature of our environment; decades ago Dennis Wrong warned against the over-socialized conception of humanity. It is not only what happens to us, but how we internalize things and what abilities we bring with us. Certainly, Obama had much to reinforce the value of education and achievement from his family and he went to fine schools, as you say, but he was also smart. His mental capacities had a strong biological base; if he was not well endowed mentally, he would have been less able to take advantage of his mother's values and his educational opportunities. Are you saying that intelligence has no basis in genetics?

PHE: No, I am not saying genetics has no influence on intelligence. What I am saying is that most, if not all, of what is ascribed to genetics usually turns out to be learned behavior. Careful observation and discussion of the subject usually stops when behavior is labeled genetic. To turn to another subject, in discussing Obama's restlessness, I am puzzled why you say, "Oddly enough, both Obama's mother and his maternal grandfather were restless souls." What is odd about a boy from a family so often on the move, whose mother moved him to another continent when he was a latency-aged child, then moved him home to Honolulu before going back herself to Asia and then Africa, being restless? To me it doesn't seem odd at all.

KAF: "Oddly enough" was a poor choice of words. I do see the President's impatience and restlessness as being connected to his mother's wanderlust, which may be derived from her father. As an adult, Stanley moved from place to place.

His own discontent may owe some of its origin to his being the one who discovered his mother after she killed herself, and was then almost immediately abandoned by his father.

PHE: Does your choice of the word "cocky" rather than "confident" or "extremely confident" in describing the President reflect your viewing him as arrogant, or feelings of envy you may have for him?

KAF: You make me laugh—am I possibly being diagnosed with Obama envy? It was after I saw Obama strut around the Hartford XL Center in February, 2008, and wondered how someone gets to see himself as the agent of massive political change, that I concluded he was cocky and also wanted to know more about him. I do not see him as arrogant. He may or may not be that, but I see him as paradoxical. He is very self-examining as well as having high self-esteem. He talks about his own maladies on a regular basis. He is not just one thing. I don't see myself as envious of Obama; I would not want to be in his shoes, or follow his path.

PHE: I am glad to make you laugh. However, with your choice of words like "strut around" and "cocky," I wonder if I should have asked if you dislike Obama. Do you?

KAF: These words are not value judgments at all, but observations. I actually admire Obama more than any President we have had since John Kennedy. Obama is deliberate, has far-reaching goals, is focused, and has a sense of humor. He also is more voluntarily honest and open about himself than any recent President (Clinton was more or less forced into discussing his private life). Obama's soul-searching period at Columbia University also appeals to me. In his speeches, Obama says that children without fathers are more likely to drop out of school, commit crime, end up in prison, and become teenage parents. None of these things happened to Obama. Instead he overcame the emotional pain of his childhood and forged an identity that enables him to be highly dis-

ciplined, committed, and concerned. How he has developed can well be a model for others with complicated childhoods.

PHE: Our sharpest initial difference was the role of Gramps (Stanley Armour Dunham) in Barack's life. You portrayed him much more negatively than I did. When I reread Obama's treatment of him in his two books, I realized that I had identified far more with Stan's positive elements, ignoring or downplaying the negative elements you and some authors such as Maraniss focus on. Clearly, I identified much more with his positive contributions to his grandson, including his being present for the fatherless boy and having great dreams for him. I suspect our differences are based partly on my being a grandfather and you not yet having that pleasure and worry. I also grew up in a family where the only grandfather I knew on a regular basis was generally denigrated—which seemed unfair and unjustified to me. What are your thoughts on our different approaches?

KAF: I think our differences here are more connected to what our aims were. My negative portrayal of Stanley is not my own evaluation of the man, but is in regard to whether Obama saw him as a positive role model for himself—I don't think he did. In his books, I think Obama underestimates the positive contribution his maternal grandfather made in his life and unfairly emphasizes Stanley's quick temper and petty rules. What I was looking at was who Obama saw as positive and negative male role models, given that he hardly ever saw his biological father.

PHE: It is good to know that we do not really differ on how Barack saw his grandfather. Turning to the President as a parent, when I see certain pictures of Barack Obama with his daughters, there is sometimes a look of uninhibited joy seldom seen in an adult in his 40s. What do you make of these pictures?

KAF: Belonging is something that has not come easily to

our President. It means a great deal to him to have a solid family of his own. This highly self-disciplined man has a strong playful side that comes out in his happiness with his children and the spiritedness of his interactions with Michelle. Also, I think he likes youngsters. I am thinking of the recent Presidential mid-day town hall, where a member of the audience said he had taken his daughter out of school to see Obama. The President then said he would write a note to her teacher excusing the absence, which he promptly did. The girl was delighted, as am I.

PHE: I think you are justified to write about Obama's feelings of being orphaned as part of what drove him to search for a community. Do you have further thoughts on the subject?

KAF: Before Obama could reach out as a community organizer, he had to find a way to trust others and to start finding a base in his own life. The future President went through this intense, ascetic soul-searching period as an undergraduate at Columbia. It is only with that foundation that he had the inner resilience to start reaching out to others. Another episode in his evolution was in Kenya when he felt connected to the struggles by his father and grandfather. This helped him extend his identity to his paternal forefathers, and led him to no longer feel utterly alone.

PHE: Looking at Obama from a broader perspective, what do you think of the following thought? America has had such a troubled relationship with African Americans, toward whom there is a mixture of guilt, fear, envy, and admiration, that they have chosen as president a "safe black," who was raised as a white, but who chose to be black, in his search for a satisfying personal identity.

KAF: Obama had to avoid coming across as too "black" in order to be elected President. I think that his temperament and outlook reflect more mainstream values than are some-

times associated with so-called militant blacks. In the campaign, Obama remained composed and steady while McCain at times did not. I believe that McCain lost whatever chance he had to be President over his inconsistent responses to the September economic crisis. At that turning point, it did not matter what Obama's racial makeup is, he seemed like a leader and President who then moved the electorate his way and largely nullified the issue of race in the campaign for many whites.

PHE: I would like to know your thoughts on the October 9th announcement of Obama being named as the 2009 winner of the Nobel Peace Prize for his work for nuclear nonproliferation, creating a "new climate" in international relations, and reaching out to the Muslim world. To me this award seems based on our president's promise and his being the first African-American to hold the office—to say nothing of his *not being* George W. Bush. It is like giving the best baseball player of the year award in May rather than waiting for the end of the season in October. I suspect that it will be a political liability. What are your thoughts?

KAF: I agree, this prize is based more on promise than performance, peaceful intentions more than solving difficult problems. Obama is the fourth American President to win this coveted award: Theodore Roosevelt won from negotiating a peace treaty, Wilson for the League of Nations, Carter for the mid-East accord and other efforts, and now Obama for supposedly altering the climate of world opinion and promoting diplomacy. Obama's rhetoric has a Wilsonian transformative quality. Where Wilson wanted to make the world safe for democracy, the Nobel announcement praises Obama's call for ridding the world of nuclear weapons. There is the same millennial tinge in the rhetoric of both Wilson and Obama. The twentieth century was not kind to those who expected our better nature to curtail our capacity for mass destruction. We can only hope that Obama's

soaring rhetoric can be matched by diplomatic skills and sensible decision making. It is way too early to tell. The tough challenges of Iran and Afghanistan still lie ahead, and the internal and external forces promoting conflict and destruction have not retired from the field.

PHE: It has been a pleasure to have this exchange with you because I have seen where it increases our knowledge of Obama and gets us to question some assumptions made in writing. Do you have any last words?

KAF: You and I have always been able to talk easily and honestly, and I am sure we will continue this conversation. I appreciate this opportunity and hope that others can benefit from our dialogue.

***Kenneth Fuchsman**'s biography may be found on page 301 and **Paul Elovitz**' on page 235.* ❑

Book Reviews

Abusing History

David R. Beisel—SUNY, RCC

Review of Margaret MacMillan, Dangerous Games: The Uses and Abuses of History (New York: Modern Library, 2009), ISBN 978-0-679-64358-6, Hardcover, $22.

I am proud to be a historian, and always have been, which is why reading Margaret MacMillan's new exploration of the nature of historical study is so distressing.

Past provost of Trinity College at the University of Toronto, MacMillan is currently warden of St. Anthony's College at Oxford University. Her book, *Paris 1919*, won numerous historical awards and was chosen as one of the ten best books of the year by the *New York Times*. Her new

book appears as part of the Modern Library's prestigious Chronicles Series. It received a good review in the *New York Times* and will probably receive good reviews elsewhere. Her words are bound to carry considerable weight.

In a number of ways, they deserve it. Soundly argued and well written, *Dangerous Games* is a good introduction to the kind of traditional questions thoughtful readers have been asking about history for years, though much of what MacMillan has to say is common sense. Few professional historians will find any surprises in it.

Of special interest are several statements concerning psychological matters, judgments that subtly and not-so-subtly reinforce the anti-psychological biases of mainstream history. Since they will likely pass general readers by unnoticed, they desperately need identifying as a number are shockingly uniformed, thoughtless, or downright wrong.

Although MacMillan begins with a few simple well-accepted observations, she invokes the authority of another specialty: "Memory, psychologists tell us, is a tricky business." Presenting a collegial face to an often ignored fellow discipline is of strategic importance (she later goes on the attack) as she notes what everyone knows: that memory is "selective" and "malleable;" that in remembering we often "make our own roles more attractive or important"; and that we "edit out…what no longer seems appropriate or right."

She makes an obligatory nod to French sociologist Maurice Halbwachs, who coined the term "collective memory" in the 1920s. (He meant by it "the things we think we know for certain about the past of our societies.") "Collective memory," she writes, "is more about the present than the past because it is integral to how a group sees itself." Who could disagree?

Yet MacMillan places these mundane observations around a glaring bit of mis-information, which begins inno-

cently enough. "In the 1990s," she writes, "there was much public concern and excitement about recovered memories. Authoritative figures published books and appeared in the media claiming that it was possible to completely repress memories of painful and traumatic events."

Now that the "panic has died down," she writes, "we are ruefully admitting *that there is no evidence at all that human beings repress painful memories*" [italics added]. "If anything," she writes, "the memories remain particularly vivid." She cites a University of Toronto study as proof, ignoring psychiatrist Bessel van der Kolk's findings, the work of the International Society for the Study of Traumatic Stress, the experiences of tens of thousands of therapists over the last hundred years, the millions who have successfully recovered repressed painful memories in their therapies, and the evidence of history itself.

What produced our current mistaken belief was, she writes, "The preoccupation of the Romantics with the supernatural and the imagination, as well as later work, most notably that of Sigmund Freud, into the subconscious, [which] predisposed us to believe that the mind can play extraordinary tricks on us." (What MacMillan is getting at here is unclear, since she has already noted that "psychologists tell us" the mind *does* play tricks, but in any case it is a good opportunity to do some Freud-bashing.)

She goes on to say that, "The director of the Yad Vashem memorial to the Holocaust in Israel once said sadly that *most of the oral histories that had been collected were unreliable*" [italics added]. The reason? "Holocaust survivors thought, for example, that they remembered witnessing well-known atrocities when in fact they were nowhere near the place where the event happened." There is a modicum of truth to these observations. No thinking person in the world doubts that memory is fallible. MacMillan is setting up a straw man, holding memory to an impossible standard of ac-

curate perfect recall every time out. This badly distorts the picture by more than implying that because some memories contain errors, *all* memories are suspect. She lets herself off the critical hook by quoting someone else—a major authority to boot. By not qualifying the half-truth, MacMillan gives potential ammunition to those Holocaust deniers who are on the prowl for statements by reputable historians they can turn to their advantage. It is an example of the kind of thoughtless misuse of history MacMillan herself cautions us against. When she speaks of the South African Truth and Reconciliation Commission's work, however, the question of faulty memory somehow disappears: 22,000 statements were collected over two years, an "extraordinary and moving experience which brought the evils of apartheid into the open."

Freud appears again as MacMillan resurrects the old saw about his ill-considered collaboration with Bullitt on the Woodrow Wilson project. She claims that, "Sigmund Freud did his own reputation no good when he teamed up with the American diplomat William Bullitt to write a biography of Woodrow Wilson. Freud never met Wilson and never read his intimate diaries, because Wilson did not keep them, yet he talked confidently of Wilson's obsession with his father and his feelings of failure."

So what? Examples of bad historical method are found everywhere, including the works of historians. The fact that Freud was not a historian, that his historical work was not always good history, and that many bad histories are also produced by historians does not negate the possibility that all may contain some psychological insight. I suspect MacMillan's Freud-Bullitt reference is an oblique way of discrediting psychologically-oriented history, using it as an unfair stand-in for the vast amount of sound, carefully documented psychological history that has been written over the past 40 years.

MacMillan rightly takes to task the "many vociferous

critics" who admit to not having read, or only partly read, the various studies they rail against (critical attacks on Frankland's official British history of RAF bombing during World War II are put to good use here), yet she fails to mention the thousands of historians who automatically reject psychological approaches without having once explored a single work of critical and carefully researched psychological history.

Her dismissive comments about repressed memory and Freud allow MacMillan to use the words *unconscious*, *trauma*, and *therapy* inconsistently and without according them their technical meanings. She asks, "How often have we seen revolutionaries committed to building new worlds, slip back unconsciously into the habits and ways of those they have replaced?" Or: "In Spain after Franco's death the Spanish came to "an unspoken agreement—the *'pacto del olvido'*—to forget the trauma of the civil war and the years of repression that followed." Or: "Examining the past can be a sort of therapy as when we uncover knowledge about our own societies that has been overlooked or repressed." Contradiction follows contradiction; at one moment there are no repressed memories, then, suddenly, there are.

MacMillan is too good a historian not to acknowledge the irrational, as when she speaks of "the unreasoning forces of ethnic nationalism." At times she seems on the verge of accepting a psychodynamic process. "Many of the old conflicts and tensions remained frozen into place just under the surface of the Cold War," she writes. "The end of that great struggle brought a thaw, and long-suppressed dreams and hatreds bubbled to the surface again." Citing as proof Iraq's invasion of Kuwait and the Serbo-Croatian-Bosnian hostilities of the 1990s she seems to be accepting the existence of repressed material. Yet once again, the Rational Model comes to prevail. To MacMillan, Kuwait and Bosnia were nothing more than part of a rational political phenomenon, unscrupulous politicians—Saddam Hussein and Slobodan

Milošević—fanning the flames of hitherto repressed ethnic hatreds.

Someone needs to ask how those "unreasoning" dreams and hatreds were "frozen" if they were not collectively repressed. She seems to have little understanding of historical trauma. MacMillan ignores the fact that repressed hatreds derive from *real* past traumas kept alive for decades, or even centuries, by intergenerational transmissions.

MacMillan writes that "History is about remembering the past, but it is also about choosing to forget." I want to emphasize the "choosing to forget" part since she presents it as if it is all about rational decisions. Since she has nominally dispensed with the notion of repression and repressed memory, she can be cavalier about the work of others. During the Cold War, she writes, "The threat of nuclear war, of course, was always present, and from time to time, during the Cuban missile crisis in 1962, it looked as if the last moment of the planet had come. But it did not, and in the end most of us simply forgot about the danger." The principle of simple forgetting as applied here will come as news to Robert Jay Lifton and all those who have spent a lifetime observing and writing about the psychological and political consequences of the world's massive collective repression of nuclear terror since 1945.

Much of what MacMillan has to say is sensible but often intertwined with thoughtless statements that run counter to the evidence, which will likely continue to feed the denials of the historical profession and no longer fit the 21st century. Explicitly and implicitly denying and devaluing fundamental psychological processes can also have the effect of turning people away from seeking out potentially healing therapy.

By way of conclusion, MacMillan gives good humanist counsel, writing, "If the study of history does nothing

more than teach us humility, skepticism, and awareness of ourselves, then it has done something useful." Moreover, "History demands that we treat evidence seriously, especially when that evidence contradicts assumptions we have already made." Good points all, if only historians could apply these principles to the psychological histories they still refuse to admit as a serious part of the historian's craft.

One abuse MacMillan does not name is this continued failure of historians to accept the role of the irrational, of emotions and fantasies, and the power of repressed traumas and acknowledge them as causal agents in human behavior. Pretending or denying they do not exist, playing them down and rationalizing them away, as MacMillan does, keeps us from creating a more comprehensive history that is truly human.

***David R. Beisel, PhD**, has published numerous articles on American and European history. A second edition of his book, The Suicidal Embrace: Hitler, the Allies, and the Origins of the Second World War, with a "New Afterword by the Author" will be published this fall. He can be reached at dbeisel@sunyrockland.edu.* ❑

The Need for Roots

Matthew H. Bowker—Medaille College

Review of Mark Bracher, Radical Pedagogy: Identity, Generativity, and Social Transformation. Education, Psychoanalysis, and Social Transformation Series. New York: Palgrave Macmillan, 2009. 244 pages. ISBN: 1403975620 (Hardcover) at $80.00, ISBN: 0230621114 (Paperback) at $28.95.

Mark Bracher's *Radical Pedagogy* argues that the "most fundamental mission" of educators at all levels ought

to be "the construction, maintenance, and elaboration of students' identities" (p. 71). This pedagogy is indeed radical, not only because it represents a paradigmatic shift in educational theory and practice, but because its central construct, identity, is held to be the "prime mover" of human behavior (p. 3), the root of social justice and ethical responsibility, and the key determinant of successful learning.

In contrast to narrower conceptions of identity as subject position or group-membership, the book's first part theorizes identity comprehensively, across three loosely Lacanian registers (the affective, the imagistic, and the linguistic) and five identity structures elaborated by Robert Kegan (the impulsive, the imperial, the interpersonal, the systemic or institutional, and the trans-systemic or interindividual). This expansive understanding of identity grounds Bracher's claim that educators must recognize and develop students' identities on multiple registers. It also permits Bracher to explore how several types of identity failure and later, several traditional pedagogies, may contribute to repression, splitting, attribution errors, and misunderstandings of self and other.

Distinct from "cultural studies" approaches, Bracher's pedagogy is an explicitly psychoanalytic one, motivated by the analyst's "desire for absolute difference" (p. 131), in which the educator's goal is that students come to a greater recognition and integration of their internal otherness, the excluded aspects of their selves. This requires not only that teachers achieve a more sophisticated understanding of identity development and structuration, but that we confront the pitfalls of our own identity-maintaining practices. The book's second and third parts are devoted to facilitating this task. Bracher's sparing use of Lacanian formulae in his analysis of five traditional pedagogies effectively serves his purpose: to illustrate how the transference relationship underlying each pedagogy can jeopardize students' identity-development, in some cases by asking students to identify

with the teacher's knowledge or values, in other cases by affording encounters with otherness only at great historical or cultural remove.

After offering a method for self-analysis by teachers as well as a reflection on generativity as our most fundamental impulse and identity need in Part Three, the fourth and final part of the book focuses on changing harmful identity contents while supporting benign, prosocial ones through an empathetic, "sentimental education" (p. 173) à la Richard Rorty (not Flaubert). Bracher concludes by returning to his model of identity, arguing that students who have achieved integrated, interindividual identities will act responsibly within the complex ecology of "all humans (and everything else as well)" (p. 203), a pedagogical aim which seems utterly appropriate in a rapidly changing, increasingly interdependent, global era.

There is much to admire and little to criticize in *Radical Pedagogy*: It achieves its goals succinctly and convincingly. Nevertheless, the book compels us to ask important questions both practical and theoretical. On the practical side, it seems necessary to consider how educators can become aware of students' identity needs in a way that permits us to respond to them effectively. What kinds of interactions, assessments, or interventions might be called for? What role should individual, disciplinary, and institutional differences play in shaping suitable radical pedagogical practices? That is, should identity needs ever take a back seat to basic skill-development or other practically necessary learning? If the goal of the teacher is to assist each student develop her or his identity, then what (presumably radical) restructuring of teachers' contracts, duties, and institutional roles might be required to facilitate the necessary greater individual interaction between student and teacher?

Bracher's work also raises valuable theoretical questions which many readers will wish to pursue. It is difficult

to read the book without reflecting upon the presumption contained in it that teachers (of all subjects, at all levels) must be committed to social justice. While undoubtedly an admirable notion, educators must consider how this commitment (if indeed they share it) ought to be coordinated with the commitments of other faculty members, students, and educational institutions. Furthermore, it may be worthwhile to ask to what extent educating students to act in accordance with certain social and political ideals (even just ones) uses them, their energies, and their tuition payments to serve a vision of society's collective needs that may or may not be their own.

Even psychoanalytically-inclined readers may remark that the "discourse of the analyst," which strives for the "absolutely different" self-discovery of the analysand/student, accepts identity-bearing signifiers such as gentleness, reflexivity, empathy, and tolerance, while rejecting other signifiers such as hyper-masculinity, (p. 165), bellicosity, and impulsivity as products of repression, immaturity, or pathology. Of course, all pedagogies are value-laden, and these particular values are far from objectionable. Nevertheless, it is worth considering what place an identity-based pedagogy could give to a critique of the values embedded in identity-development, or, more broadly, in psychoanalytic theory and practice.

Finally, it is fair to ask whether new curricula designed according to identity-based criteria would permit students to experience the (arguable) greatness, human capacity, and ingenuity contained in classical or canonical works, such as those of say, Plato, Dante, and Shakespeare. While there are no indications that these or any other authors would be specifically excluded from a radical pedagogy, Bracher contends that "the most beneficial knowledge [about language and literature] is an understanding of how the various elements of language function to construct, deconstruct, and re-

structure both our individual and our collective identities" (p. 187). This claim that literature (or any other subject) is worth study primarily because it teaches us about the construction of our own identities may be uncomfortable for those who believe that significant achievements in all disciplines are worth knowing, rather, because they call us to embrace a humanity, an imagination, or even an identity that we had not previously known. It is a fascinating question whether such texts and such a (Harold) Bloomian vision of literary identity-enhancement could ultimately cohere with Bracher's approach. What is certain is that, by revealing identity's central role in both learning and social justice, Bracher's contribution adds to longstanding pedagogical debates like these a new, timely, and most welcome dimension.

***Matthew H. Bowker, PhD**, earned his doctoral degree in political philosophy at the University of Maryland, College Park and is Senior Lecturer in the Departments of Humanities and Interdisciplinary Studies at Medaille College in Buffalo, NY. His current research examines the moral and political implications of the literature, theatre, and philosophy of the absurd. He may be contacted at mhb34@medaille.edu.* ❑

Psychohistorical Insights on Remembering September 11th

Paul H. Elovitz—Psychohistory Forum

It will be a long time before we have the emotional and historical distance to best judge the political, psychological, and societal impact on America and world history of the September 11, 2001 attacks. However, being able to reflect after eight years does provide an inkling of how our society has changed as a consequence. At the Psychohistory Fo-

rum's September 12th meeting, "The Psychology of Remembering 9/11: The Uses and Abuses of Trauma," there was an extraordinary energy and intellectual involvement. This mood stemmed from more than the insightful and stimulating presentations by David Beisel and Danielle Knafo, as well as the comments of those in attendance. (As usual, papers were sent out prior to the meeting, including one by this author.) Three crucial stimulants were the location, the participants, and the continued, but more distant, societal focus on the subject.

From the 15th floor balcony of the conference room of the National Association for the Advancement of Psychoanalysis (NAAP) on Eight Avenue and West 14th Street, Margery Quackenbush, psychoanalyst and NAAP Director, had viewed the horror of the collapsing twin towers on that beautiful Tuesday morning eight years ago. In addition, several of the participants at our meeting had twice written about their therapeutic work to meliorate some of the trauma of those days. Psychoanalyst, artist, and author Robert Quackenbush worked with rescuers in the months after the 9/11 attacks and continues to worry that some who searched in the smoldering rubble for their "brother" rescuers may have succumbed to lung diseases or suffered serious effects of Post-traumatic Stress Disorder (PTSD).

In our discussion, Robert acknowledged he was in grief because the eighth anniversary of the events of 9/11 was the day before the September 12th meeting—recollections of the event were still prominent in his mind. This was evident to everyone when David Beisel told how a veteran from the Iraq War attended one of his courses and described in detail to the class the horrors he experienced in the war. Nevertheless at the end of the term he chose to reenlist. It was also evident when Ken Fuchsman talked about a recent reunion he had with some of the members of

his squad during the Vietnam War—how they were all still haunted by the memory of the death during their service. Quackenbush was so moved by these accounts that he had trouble speaking, becoming tearful when he gave his observations on what had been said. He wondered if the reason the Iraq War veteran's decision to reenlist was facilitated by being allowed in Beisel's class to speak his mind, unburdening himself. In thinking back on his own period in the military, as he listened to Professor Fuchsman, he felt certain that many men who served in the military during war time are haunted by memories from those times because their memories are connected to their youth and the innocence and feelings of entrapment that goes with being called into the service.

In the course of our discussion, psychotherapist Irene Javors vividly described the incredible psychic disruption of employees and the incapacity to work in a company whose office location gave a full view of the terror that day. She was called in to help because the employees had regressed to the state of feeling like terrorized children. Accordingly Irene, who was used to working one-on-one in her office rather than with groups, decided to work on providing a sense of security, as she would for children.

American society has gained a certain distance from that day of being the target of suicide bombers. Less psychic energy by society as a whole appears to be devoted to arguing about the nature of the memorial site. Society's focus at the moment is much more on economics, health care, and whether our new president, elected amidst so many messianic fantasies, will lead us in the direction of dystopia or utopia.

With typical humility, focusing on his students and using the Eriksonian method of disciplined subjectivity, Professor Beisel described his own denial on 9/11 when, during class that day, a student told him of a plane flying into the World Trade Center. He told his class it was almost certainly

a case of a plane accidentally flying into the building as one did to the Empire State Building in the fog of 1948. He only later, and reluctantly, accepted the horrible reality when his students brought news of the second plane crashing into the second tower, followed up by word of the attack on the Pentagon and rumors of a third plane about to hit New York City. David related his denial to the lethargy experienced by President Franklin Delano Roosevelt on December 7, 1941, as well as to Joseph Stalin's retreat into the Kremlin after the shock of the attack on the Soviet Union by the forces of his ally Adolf Hitler on June 22, 1941.

David Beisel, who has won many awards for his outstanding pedagogy, described how the day before our meeting he worked in his classes to get his students to probe the traumatic events of eight years before psychohistorically. He began by writing on the board the words "history," "memory," "remembering," forgetting," "ignoring," "memorials," "memorializing," "myth," "ritual," and "fantasy," and then encouraged the students to discuss those words in the context of 9/11.

Beisel has spent recent years focusing on the societal impact of group trauma and did an excellent job of putting the "Remembering 9/11" focal point in historical perspective. He suggested setting up a category of "Surprise Attack Trauma," bringing our attention to the surprise attacks of the Japanese in 1904 on the Russians in Port Arthur and in December of 1941 on Pearl Harbor, the Philippines, Singapore, and the Dutch East Indies. He reminded us of how traumas are utilized in American history by citing the slogans: "Remember Pearl Harbor!" "Remember the Maine!" and "Remember the Alamo!" (Should you not have gone through the American school system, or were daydreaming in history class at the time, the sinking of the American battleship U.S.S. *Maine* in Havana Harbor refers to the justification for touching off the war against Spain in 1898, while the Alamo

is a reference to the American citizens living under Mexico's rule, who died at the Alamo in the course of their 1836 rebellion against Mexico.) The blood of the beloved countrymen thus becomes the battle cry to justify wars of vengeance, retaliation, imperialism, and aggression.

World War II traumatized America to the extent where they felt the need to have a presidential commander-in-chief with military experience; consequently, all nine Cold War presidents were veterans. During the Cold War, the two great powers were reacting to being traumatized by the separate surprise attacks of 1941—Operation Barbarossa on June 22 and almost six months later, the attack on Pearl Harbor. The impact of these surprise attacks was so great that a few years after the demise of the Axis Powers in World War II, Russia and the United States devoted the next 40 years to defending against a similar catastrophe while making plans on how to win a thermonuclear war by beating the other side to the punch in a surprise attack. American school kids learned to "duck and cover" under their school desks in the hope that would save them nuclear destruction. While Beisel did not directly focus much on the paranoia of the Cold War period, it was certainly implicit.

In the course of our subsequent discussion, Professor Beisel pointed out that as much as the British consciously prepared for German bombing in World War II, the emotional shock was enormous when the Blitz actually began. In the end, members of the general population could not really prepare themselves emotionally. During the Blitz, there was also the phenomenon of many people, not only Prime Minister Winston Churchill, who, because of their utter fascination with the carnage and fires, risked their lives by insisting on going up to the roofs of houses as the bombs fell.

Professor and psychoanalyst Danielle Knafo's paper, "Learning from Israel, Open to Life," highlighted the psychological aspects of 9/11 and trauma. She pointed out that

the psychological literature demonstrates that not everyone who experiences a disruptive event, as she prefers to call it, comes away clearly traumatized. For example, only about 35% of those surviving Nazi concentration camps fit the clinical definition of Post-traumatic Stress Disorder. However, if they subsequently suffer set backs in life the symptoms may surface. Having just returned from Israel, she gave an example of an Israeli survivor who functioned very well until a variety of health problems and heart surgery led her to describe her psychic condition with the words, "Now, everyday I'm in Auschwitz!" Professor Knafo passed around a copy of her lengthy 2004-edited book, *Living with Terror, Working with Trauma: A Clinician's Handbook*, to which a variety of distinguished authors contributed their expertise.

Dr. Knafo distinguished between aggression and violence. She said that in aggression, one is aware of the identity of the aggressor and this awareness allows preparation to defend oneself practically and psychologically. In the case of violence, the threat is masked, hidden, and nonspecific. One is taken by surprise and thus feels trapped and unprotected. Most importantly, there is not a sense of having a choice of behavior to defend oneself. Terrorism, unlike combat situations, creates a violent world, a world in which the enemy can be anywhere and attack at any time.

She lauded my paper's emphasis on the mechanisms of defense ("A Psychohistorical Retrospective on September 11, 2001"), but wished I had more explicitly discussed the defenses of somatization (conversion reactions) and dissociation. She noted the ways in which trauma is stored in different centers of the brain and body. This led to general discussion of the current craze for body piercing and tattooing as ways of reacting to trauma and of getting control of the body. Knafo gave the example of the Israeli mother, locked in an intense struggle with her teenage daughter. She worried so much about her daughter being killed by terrorists

that she reversed her position on tattooing when she decided if her daughter was blown up by a bomb her body could at least be identified by the tattoos! Danielle Knafo also noted that Israelis and Palestinians have varying psychological capacities, and experience war and terror differently, with the Palestinians having a much higher rate of casualties. This author commented that the greater casualties are in part a result of having few resources to protect their population, as well as some of their politicians wanting to show their casualties to the world, to gain support as victims.

Rather than give a formal presentation, this author chose to let his lengthy article, "A Psychohistorical Retrospective on September 11, 2001," express his views. He limited his initial comments primarily to a discussion of how, on the previous day, the eighth anniversary of the attacks, his psychohistory class discussed the impact of those events on themselves. Each and every one of them remembered exactly where they were when they heard of the attacks, although at the time they were mostly ages nine to 13. Consequently they are rightly referred to as the "9/11 Generation." What the implications of this identification will be for their future support of war in the name of anti-terrorism, remains to be seen, although there is some evidence that they are more hawkish then their elders (Morley Winograd and Michael Hais, *Millennial Makeover: MySpace, YouTube and the Future of American Politics,* Rutgers University, 2008, p. 104).

The discussion became more defuse toward the end of the meeting, with interesting insights on American society, health care, trauma, and war. Irene Javors pointed out that people want magical change without disruption to their lives and that we have been living in the politics of fear. There was the discussion of the privatization of war, with the Halliburton Corporation doing the cooking, instead of having Army chefs. Ken Fuchsman, who ably chaired the meeting, focused on the enduring appeals of battle. He provided vivid

memories of being stationed in Da Nang during the Vietnam War, waiting for the shelling to get closer and closer. He also addressed how veterans feel when they return home from war to find that the public is oblivious to what they have been through. This author noted that in the current war in Afghanistan soldiers experience terror at the hands of an unseen enemy who blows them up with improvised explosive devices. Danielle spoke quite highly of the award-winning Israeli film, *Waltz with Bashir,* as one of the best war films of the year—"a great film."

Fuchsman argued that America has become a "Crazy Eddie Society," referring to the advertisements of the now defunct Crazy Eddie electronics retailer whose advertisements always ended with the words, "Crazy Eddie, his prices are IN-SA-A-A-A-A-ANE!" By that he meant society's wanting instant gratification without regard for consequences, as did Crazy Eddie Electronics before it went bankrupt, with its principal owner fleeing the country. The slogan that you can get everything you ever wanted at the guaranteed lowest prices ever, epitomizes a consumer culture sensibility of instant gratification at a bargain. Professor Fuchsman noted the breakdown of cooperation in American society, and the growth of what Richard Hofstadter referred to in his path breaking 1964 article as "The Paranoid Style in American Politics."

Although many of the subjects were disquieting, all the participants agreed that the meeting was quite valuable. The Psychohistory Forum wishes to express its appreciation to Margery Quackenbush for arranging for the space to hold our meeting in the conference room at the National Association for the Advancement of Psychoanalysis.

The author's biography may be found on page 235.❑

BULLETIN BOARD

CONFERENCES: The winter and spring meetings of the **Psychohistory Forum Work-In-Progress Saturday Seminars** are being scheduled. The September session on Remembering 9/11 with presenters **Danielle Knafo**, **David Beisel**, and **Paul Elovitz** was a success as was the November panel on the psychology of health care reform with presentations by Paul Elovitz, **David Lotto**, and **Denis O'Keefe**. There was a positive response to the Forum-sponsored panel of The Association for the Psychoanalysis of Culture and Society (**APCS**) Rutgers—New Brunswick meetings on October 9, 2009. **CALL FOR PAPERS**: Presentation proposals are welcome at both the 33rd Annual International Psychohistorical Association (**IPA**) meetings at Fordham Law School in Manhattan on June 9-11, 2010 and at the July 13-17, 2010 International Society of Political Psychology (**ISPP**) conference in San Francisco. **PUBLICATIONS:** Congratulations to **Barry M. Shapiro** on the publication of *Traumatic Politics: The Deputies and the King in the Early French Revolution by Penn State University Press* and to psychoanalyst **Stanley Teitelbaum** for *Athletes Who Indulge Their Dark Side: Sex, Drugs, and Cover-ups* (Praeger, 2009) Potomac Press will be publishing **Nancy Kobrin**'s *The Banality of Suicide Terrorism,* which includes some of her articles first published in Clio's Psyche: "Imitation of Judaism" (Vol. 9, no. 2, 2002) and "A Psychoanalytic Approach to bin Laden, Political Violence, and Islamic Suicidal Terrorism" (Vol. 8, no. 4, 2002). **NOTES ON MEMBERS:** Congratulations to **Glenn Jeansonne** and **Lauren Priegel** who married on September 5th. We welcome new members **Carol Lachman** and **Allan Mohl**, as well as **Molly Castelloe Fong**, who is returning after a long maternal sabbatical. **ERRATA:** In the September issue there were two errors. On page 143 of Ann Saltzman's article on the impact of 9/11, the total for 2003 is missing, it should read "115." On page 131 of her article on 9/11, Irene Javors, a Licensed Mental Health Counselor (LMHC), is erroneously listed as a CSW. **OUR THANKS:**

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Due January 10, 2010

Articles of 500-1500 words (and two long ones) are welcome, as are additional suggestions. Contact Co-Editors Peter Petschauer at petschauerpw@appstate.edu or Paul Elovitz at Pelovitz@aol.com

We Wish to Thank Our Prompt, Hardworking, Anonymous Referees and Diligent Editors

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