Ghosts in the Exam Room, Empathy, and Physician Well-Being

Sheldon Levy, PhD, MPH
Rebekah Schiefer, MSW, LCSW
John Muench, MD, MPH

The Ghosts

In a landmark article titled "Ghosts in the Nursery," psychoanalyst and social worker Selma Fraiberg wrote that unresolved issues from the conflicted pasts of some parents complicate their interactions with their own young children. As she stated, "In every nursery there are ghosts. They are the visitors from the unremembered past of parents, the uninvited guests at the christening."[1] Several years of research on adverse childhood experiences (ACEs) has shown that early experience with abuse and neglect, parental discord or mental illness, and other forms of family dysfunction can lead to physical and mental illness in adulthood.[2] In addition, recent research has shown significant associations between ACEs and fear of pain, pain itself, and pain facilitation.[3]

Adverse childhood experiences are known to be related to insecure attachment style in adulthood.[4,5] These "ghosts," both remembered and unremembered, often manifest themselves as anxious or avoidant adult attachment styles. This can affect not only health care utilization but also relationships with residents, fellows, and attending physicians, and can potentially hinder effective working relationships. For example, in a study of patients with chronic pain, preoccupied attachment style, a form of anxious attachment, was associated with greater than weekly pain-related visits at 12 months' follow-up, even after controlling for depression, catastrophizing, and pretreatment pain-related health care utilization.[6] And in a study of women with breast cancer, patients recalling abuse in childhood were far less likely to feel fully supported by their surgeon than those not recalling abuse. Additionally, the surgeons, unaware of the abuse history of these patients, reported greater difficulty with patients who recalled abuse than with nonabused patients.[7]

It should be remembered that trainees and physicians may have their own ghosts that they bring to encounters.[8] Trainees should learn how their own ACEs and relationship styles contribute to the physician-patient relationship, so they can meet the patients where they are and manage their own feelings. This will help them build a better working relationship with their patients.

DOI: http://dx.doi.org/10.4300/JGME-D-20-00195.1

The Exam Room

Residents and fellows may be unaware that some of their frustration with patients who lack resilience is due to the presence of such patient "ghosts." Learning about a patient's challenges with previous relationships, particularly those in their family of origin, can help physicians better understand the sources of problems in their relationship with patients and may help them to avoid replicating problematic dynamics from their patients' pasts. Trainees often fear "inflicted insight"—that asking about a person's past may trigger painful experiences that will cause them to decompensate.[9] Physicians may worry that if their patient does get upset, they won't know how to handle it. Yet, there is no evidence that this is the case. Most patients are comfortable being asked about ACEs and believe that their clinician is able to help with problems associated with ACEs.[10] Knowing the attachment style of patients along with their history of trauma may be useful for physicians and others in their treatment of patients and improvement of clinical outcomes.[11,12]

Deriving Well-Being From Patient Relationships

Knowledge of the patient's ACE history may also help trainees feel more engaged with and connected to their patients and less frustrated when interpersonal challenges arise in their care. Research on the social neuroscience basis of compassion suggests that empathy and compassion are modulated by the ability to engage in several interpersonal processes, including the ability to imagine another's perspective. They also require self-compassion and self-care.[13] Being compassionate and finding meaning in one's work contributes to self-care. One study exploring what physicians find meaningful showed that they most often value "moments of connection" resulting from

Downloaded from http://meridian.allenpress.com/jgme/article-pdf/12/5/529/2632901/jgme-d-20-00195_1.pdf by guest on 10 August 2024

BOX Knowledge and Skills for Physician-Patient Dynamics

Knowledge

1. The effect of the dynamics of a physician's family of origin on their interactions with patients and their families.
2. The effect of the dynamics of the patient's family of origin on their current relationships.
3. How the patient's current family as well as family of origin affect their adjustment to their illness.

Skills

1. Techniques to inquire about dynamics in patient's family of origin.
2. Techniques to inquire about dynamics of current family situation.
3. How to assess if family history and current relationships are affecting treatment.
4. How to assess if a physician's personal family history may be affecting their interactions with the patient and how to use this awareness to provide better treatment.

"being moved by their patients' humanity." While these physicians valued making a difference in someone's life, they described such opportunities not as "brilliant technical interventions," but rather as situations in which the physicians themselves were the "principal therapeutic agents."[14]

Clearly, the above processes are interdependent, and they are most likely to occur when physicians are able to see things from their patient's point of view. Sometimes this is difficult because patient perceptions can be driven by broad contextual issues, and some might even be unconscious, hidden from the patient themselves. Thus, developing empathy for complex patients requires the ability to hypothesize or imagine what might be happening with a patient and within a physician-patient relationship when there is insufficient evidence to draw clear causal connections.[15]

Moving Forward

In addition to resident self-awareness and cultivating empathy for the patient, the entire health care team must also be included in the work of understanding the patient's perspective and managing the dynamics that can contribute to burnout and a lack of empathy across the entire team. Multidisciplinary team meetings can also combat burnout by allowing protected time for residents to discuss difficult or challenging cases and by providing space for team members to offer support and exchange vital information.[16] These may offer the opportunity for role-modeling empathy and self-awareness as well. Another study examining the well-being of the health care team noted that team members' ability to authentically connect with patients was "crucial for generating emotional energy" when caring for a patient.[17] Reflective practice groups, including Balint[18] and narrative medicine groups,[19] encourage imagining clinician-patient relationships from the viewpoints of both patient and physician, and have been shown to increase practitioner job satisfaction.[20]

It is likely that some residents exhibit empathy more naturally than others. However, many learn empathic practice by observing the practice of a skilled mentor. We believe that demonstrating to residents a faculty's self-knowledge of issues in their own family of origin, their own "ghosts," as well as their effort to gain knowledge of their patient's family history, can simultaneously help residents facilitate greater empathy for their patients and enhance their own well-being. To do this requires faculty to share some personal history with the residents and give appropriate examples of how the dynamics of their family of origin relationships have affected their interactions with patients. The essential elements of the knowledge and skills that are useful in this process are presented in the BOX.

Perhaps one solution would be more purposeful exploration of patient backgrounds through ACEs and attachment surveys. Having some knowledge of the dynamics of the patient's family of origin can help residents and attending physicians better understand the patient's style of relating and how this may affect their interactions; this knowledge can help the entire team feel more adequate and less burned out in the care of their patients.[21] Clinicians bring their own personal histories to their encounters with patients, and the self-knowledge and awareness of their own pasts may contribute to more empathic responses to their patients, and hence their own self-care and well-being.[21] As one medical student reflecting on her own negative experiences with medical providers stated, "Pain wants authenticity."[22] Perhaps by reflecting on our own pain, we can be more authentic with others.

References

1. Fraiberg S, Adelson E, Shapiro V. Ghosts in the nursery. A psychoanalytic approach to the problems of impaired infant-mother relationships. *J Am Acad Child Psychiatry*. 1975;14(3):387–421. doi:10.1016/s0002-7138(09)61442-4.
2. Anda RF, Butchart A, Felitti VJ, Brown DW. Building a framework for global surveillance of the public health implications of adverse childhood experiences. *Am J Prev Med*. 2010;39(1):93–98. doi:10.1016/j.amepre.2010.03.015.
3. Sheinberg R, Burton E, Kearson A, Letzen J, Campbell CM. Child adversity linked to pain sensitivity in adults. *J Pain*. 2019;20(4 suppl):4–5.

Downloaded from http://meridian.allenpress.com/jgme/article-pdf/12/5/529/2632901/jgme-d-20-00195_1.pdf by guest on 10 August 2024

4. Murphy A, Steele M, Dube SR, Bate J, Bonuck K, Meissner P, et al. Adverse childhood experiences (ACEs) questionnaire and adult attachment interview (AAI): implications for parent child relationships. *Child Abuse Negl*. 2014;38(2):224–233. doi:10.1016/j.chiabu.2013.09.004.
5. Unger JAM, De Luca RV. The relationship between childhood physical abuse and adult attachment style. *J Fam Viol*. 2014;29(3):223–234. doi:10.1007/s10896-014-9588-3.
6. Ciechanowski P, Sullivan M, Jensen M, Romano J, Summers H. The relationship of attachment style to depression, catastrophizing and health care utilization in patients with chronic pain. *Pain*. 2003;104(3):627–637. doi:10.1016/s0304-3959(03)00120-9.
7. Clark L, Beesley H, Holcombe C, Salmon P. The influence of childhood abuse and adult attachment style on clinical relationships in breast cancer care. *Gen Hosp Psych*. 2011;33(6):579–586. doi:10.1016/j.genhosppsych.2011.07.007.
8. Mengel MB. Physician ineffectiveness due to family-of-origin issues. *Fam Syst Med*. 1987;5(2):176–190.
9. Levine RJ. *Ethics and Regulation of Clinical Research*. 2nd ed. New Haven, CT: Yale University Press; 1988.
10. Goldstein E, Athale N, Sciolla AF, Catz SL. Patient preferences for discussing childhood trauma in primary care. *Perm J*. 2017;21:16–055. doi:10.7812/TPPP/16-055.
11. Brenk-Franz K, Strauss B, Tiesler F, Fleischhauer C, Ciechanowski P, Schneider N, et al. The influence of adult attachment on patient self-management in primary care-the need for a personalized approach and patient-centered care. *PLoS ONE*. 2015;10(9):e0136723. doi:10.1371/journal.pone.0136723.
12. Tink W, Tink JC, Turin TC, Kelly M. Adverse childhood experiences: survey of resident practice, knowledge, and attitude. *Fam Med*. 2017;49(1):7–13.
13. Lown BA. A social neuroscience-informed model for teaching and practicing compassion in health care. *Med Educ*. 2016;50(3):332–342. doi:10.1111/medu.12926.
14. Horowitz CR, Suchman AL, Branch WT, Frankel RM. What do doctors find meaningful about their work? *Ann Intern Med*. 2003;138(9):772–776. doi:10.7326/003-4819-138-9-200305060-00028.
15. Schön DA. *The Reflective Practitioner: How Professionals Think in Action*. New York, NY: Basic Books; 1983.
16. Gorbenko K, Mendelev E, Keefer L. Can multidisciplinary team meetings reduce burnout? *J Eval Clin Pract*. 2020;26(3):863–865. doi:10.1111/jep.13234.
17. Cain CL, Taborda-Whitt C, Frazer M, Schellinger S, White KM, Kaasovic J, et al. A mixed methods study of emotional exhaustion: energizing and depleting work within an innovative healthcare team. *J Interprof Care*. 2017;31(6):714–724. doi:10.1080/13561820.2017.1356809.
18. Muench J. Balint work and the creation of medical knowledge. *Int J Psychiatry Med*. 2018;53(1–2):15–23. doi:10.1177/0091217417745288.
19. Greenhalgh T, Hurwitz B. Why study narrative? In: Greenhalgh T, Hurwitz B, eds. *Narrative Based Medicine*. London: BMJ Publishing Group; 1998.
20. Kjeldmand D, Holmstrom I. Balint groups as a means to increase job satisfaction and prevent burnout among general practitioners. *Ann Fam Med*. 2008;6(2):138–145. doi:10.1370/afm.813.
21. Schiefer R, Devlaeminck AV, Hofkamp H, Levy S, Sanchez D, Muench J. A family systems curriculum: back to the future? *Fam Med*. 2017;49(7):558–562.
22. Wild HB. There's no algorithm for empathy. *Health Affairs*. 2020;39(2):339–342. doi:10.1377/hlthaff.2019.00571.

All authors are with the Oregon Health & Science University. **Sheldon Levy, PhD, MPH,** is Adjunct Assistant Professor, Department of Family Medicine; **Rebekah Schiefer, MSW, LCSW,** is Assistant Professor and Director of Behavioral Health Education, Department of Family Medicine; and **John Muench, MD, MPH,** is Professor, Department of Family Medicine.

Corresponding author: Sheldon Levy, PhD, MPH, Oregon Health & Science University, Department of Family Medicine, 3181 SW Sam Jackson Park Road, Portland, OR 97239, 305.439.9247, fax 503.494.7659, levsh@ohsu.edu

Downloaded from http://meridian.allenpress.com/jgme/article-pdf/12/5/529/2632901/jgme-d-20-00195_1.pdf by guest on 10 August 2024