The Stone Boy and the Crazy Lady: The Understanding and Regulation of Affect in Clinical Teaching

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Most clinicians and teachers in the field of family medicine are aware of the pragmatic and philosophical difficulties involved in teaching how to understand and manage affect in residents. Detailed, hermeneutic analysis of efforts in this area can help us understand how attention to affect can be cultivated in a teaching context. The supervision of two residents dealing with an affectively intense clinical situation is described.

> The physician owes the patient a sensitive understanding, a responsiveness that goes beyond presenting symptoms to include the phenomenological plight of the patient.
>
> —S. B. Sarason (18)

Ironically, in this age of technological and specialized medical care, personal interaction with patients is acknowledged, if only by its absence (16), as increasingly important. As Sarason (18) pointed out, the question we normally ask as medical educators is, "What do we want a resident to know and to be able to do in a technical sense?" What we may need to be asking is, "What kind of *person* do we want the resident to be, and how do we help the resident become such a person?" Because it is easier, less ambiguous, and less baffling, we often ignore the human, personal context of the resident, to the potential detriment of them, patients, and ourselves.

The understanding and management of the affect of physicians in the clinical relationship are clearly ways of nurturing this patient-centered (11) responsiveness. It is through the physician's appropriate expression of emotion that the patient experiences a sense of understanding and regard. But the place of emotion in the doctor-patient encounter is problematic at best. On the one hand, laments regarding the paucity of caring and compassion in physicians are regularly voiced (1). On the other hand, it is recognized that

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unconscious and unrecognized emotions toward patients can surface in the form of negative countertransference (22).

In informal discussions with residents, it appears that there is a persuasive conventional wisdom regarding the role of affect in the clinical relationship. Some residents cling to the more traditional model that the physician should be dispassionate, objective, and detached. A recycling of this objective stance is the increasing popularity of the image of the physician as scientist and the accompanying belief that the physician should function in a reductionistic, technological fashion with patients (6). Most residents state that physicians should "feel good" toward or "like" their patients.

In none of these interpretations is there much room for the physician's emotions. Good feelings are expected to be the altruistic and automatic by-product of contact with patients. Negative emotions receive even shorter shrift. Residents deny such feelings; label them transitory and irrelevant, the result of "stress"; or feel guilty and blame themselves for the presence of these feelings.

How can we teach residents to acknowledge and then to address the debt of "sensitive understanding" to which Sarason referred? How can we, in the words of another medical observer, teach a resident to "take on some of the patient's sufferings and concerns" (13)? How can we help residents accept that illness is both an objective and a subjective experience not only for the patient but for them as well (10)? How can we help a resident understand some of the personal fears and anxieties that shadow his or her professional behavior (21)? Exhortations are notably ineffectual. And reducing the complex realm of affect to technique-oriented skill training—"interviewing skills," for example (2)—although an approach of some utility, runs the risk of superficiality.

Teaching that focuses on residents' emotions is not only possible but desirable. To be successful, it must incorporate several perspectives: (1) resolution of faculty members' ambivalence toward the appropriateness of such teaching, (2) the faculty's readiness to enter into intimate I-Thou relationships with residents, (3) the faculty's willingness to work with the vulnerabilities and pain of the resident's life, (4) consideration of the impact of the resident's family of origin or current family systems to the manifest affect, and (5) promotion and encouragement of understanding and reflection in the resident.

THE ROLE OF FACULTY

Residents and faculty alike pose the legitimate question of whether dealing with the emotions of residents (even if they are stimulated by a specific patient) is really part of the educational process. If a resident does not know how to perform a colposcopy, it is clearly the attending physician's responsibility to demonstrate this procedure. If a resident asks only closed-ended questions during an interview, it is still reasonably the responsibility of the attending physician to instruct the resident in this psychosocial skill. But if the resident is

emotionally devastated by the patient, in what sense is it the attending physician's responsibility to reveal, to probe, to comfort, and to understand the resident's emotions?

Because gaps between theory and practice remain wide (15), we often find that regardless of our tendency to espouse values of openness, emotional authenticity, and rapport toward residents, these are not often translated into the clinical teaching encounter. Often the intangible, the ambiguous, and the uncertain dimensions of the physician-patient encounter in teaching are ignored (19), although they may hold equal if not greater importance for both the patient and the physician. Too often, the isomorphic hall-of-mirrors phenomenon (17), in which the resident's process with patients is reflected in the resident's subsequent encounters with the attending physician, suffers from a distortion in the glass. Although attending faculty members blithely instruct residents not to ignore the patient's feelings, we ignore the resident's emotions so we can get on with the "real business" of solving the patient's problem.

That this happens with such regularity may be explained by the fact that it is not only the emotional safety of the resident, but that of the faculty, which is in question. To be able to examine and reflect on a resident's emotions requires a fairly firm grasp on our own emotions. Simply put, as faculty, we need to be able to acknowledge and work with our own countertransference problems. It is easy to believe that we are inadequately prepared to deal with residents' psyches when our own may be something of a mystery to us. Thus, we stumble over our fears and vulnerabilities in attempting to help the resident access hers or his. Katz (9) warned that "what the physician fears in himself, he cannot allow the patient to express." This warning applies equally to faculty, resident, and patient.

WORKING WITH WOUNDEDNESS

Recently, much interest has been expressed in the professional literature in preventing burnout and stress among health-care professionals (12). However, although the prevention of burnout is a valid goal, it is probably impossible to live life without receiving some wounds. Because of the nature of the medical profession, with its omnipresent life-and-death focus, this may be particularly true for physicians. Thus, the real key to working with affect in the training of residents may not be attempts to prevent woundedness in our residents, but rather to help them recognize, acknowledge, and understand their own woundedness as a way of bringing them closer to the distress and suffering of their patients. The wounded healer uses his or her own wounds to help heal others (14). To function effectively in this capacity, one must understand that one's pain arises from the commonality of the human condition (20). To be true healers of patients in distress, residents must first start the process of emotional healing in themselves. When fear, defensiveness, or anger are brought to interactions with patients, the emotional result is a sense of distance and punitive judgment.

PROMOTING SELF-AWARENESS

Many residents (and most people in general) possess only a rudimentary knowledge of and acquaintance with themselves, their moral, emotional, spiritual, and even physical beings. Although Balint's (3) two-person psychology is only fleetingly referred to today, the timelessness of its goals is acknowledged by the continued existence of Balint groups, which stress the value of intuitive insight in clarifying the relationship between the physician, the patient, and the illness (5). Such groups imply that physicians are not immune from dysfunctional attitudes, feelings, and cognitions that if left unchecked, can significantly interfere with the effective care of patients. By contrast, it is also implied that awareness of problematic reactions to patients is a critical first step in learning responses that enhance the well-being of both the physician and patient. Without this awareness, theory, technique, and research findings that are pertinent to the care of patients may become significantly hampered in clinical application.

When residents are able to deal only with the mechanics and the technology of disease but avoid the significance of the illness to the patient, it may be because they are afraid of what this significance might be in their lives. To be present with the patient, one must be present with oneself; otherwise, one may withdraw either symbolically or literally.

Residents need to consider what they know about their feelings in professional situations—that is, how ready are they to identify internal feeling states? What are they able or willing to disclose about their feelings to patients (9), to peers, or to attending physicians? What do they reflectively understand about their feelings when they have a chance to review and evaluate them? Finally, residents need to explore the relationship of these feelings to the patient and to access to what extent those feelings either facilitate or impede the optimal care of patients.

FAMILY-SYSTEMS ISSUES

The relationship between the physician and the patient can mediate the uncovering of deep-seated, unconscious family-of-origin or nuclear-family issues. Often the resident's affect leads back to the resident's family situations because these are where most individuals have had their most profound emotional experiences (7). Frequently, the interaction of the physician and patient simply replicates the family-of-origin crisis, thus serving only as a repetition, not a correction.

As Howard Stein (23) poignantly observed, for these reasons the relationship between negative countertransference and family material is inextricable and intimate. Often what manifests as a countertransference response is an acting out of unresolved familial issues, which protects the clinician from overtly experiencing even deeper and more personal hurts. But when such concepts as countertransference and family-systems thinking remain neatly

boundaried outside the self of the resident, the dynamic relationship between the two of them is easy to miss.

TEACHING AND PSYCHOTHERAPY

If this process sounds uncomfortably like psychotherapy, it is because it resembles certain aspects of therapy. Like therapy, such a process of education is intimate, personal, transparent, open, and risky (8). However, it may more aptly be labeled a quasitherapeutic interaction. In this type of teaching, boundaries exist that do not exist in psychotherapy. For example, a teacher, in contrast to a therapist, does not have nearly the latitude to probe the resident's personal, subjective realities. The level of disclosure necessarily remains much narrower and shallower. Further, the goal of the interaction, although somewhat arbitrarily demarcated, remains the resident's professional growth rather than personal fulfillment.

THE TEACHING ENCOUNTER

Opportunities to teach residents about affect abound in the day-to-day course of faculty-resident exchanges. Such teaching requires the adoption of an inductive style of analysis, in which one does not work downward from the textbook abstractions and syntheses that give us such a secure sense of control, but upward from the careful analysis and interpretation of actual teaching cases. What follows is a detailed reconstruction and analysis of one such episode.

The following incident occurred during a two-day consultation that I performed with a family-practice residency located in another part of the state. The formal focus of the consultation was on stresses during residency, and one formal presentation on this topic had been delivered to a group of approximately 12 first- and second-year residents. This particular occasion was an optional follow-up to the previous discussions, an opportunity for residents to engage in more in-depth discussion. When I arrived, only two residents were in attendance, a female second-year resident and a male first-year resident.

After some conversation, I asked the residents whether they had any cases that were causing them difficulty or stress and that they would like to present. After some hesitation, Sharon stated that she would like more information about sexually abused children, the psychology of abuse, and resources to which such children could be referred. I mentally started to organize the didactic information that I had on this topic, preparing myself to give a mini-lecture on child abuse. Luckily, before I could proceed, the discussion took a different turn and quickly moved from the general to the specific.

Sharon related that she and Stephen, the other resident, were involved in the care of a badly bruised 2½-year-old girl on the pediatric unit. Both physical and sexual abuse were suspected. Ever since she had encountered a sexually abused 10-year-old girl during her first year of training, Sharon had become increasingly unable to deal emotionally with such patients.

Sharon stated that her feelings toward this little girl were so strong that she could not contemplate having her as a patient; for this reason, she had asked Stephen if he would manage the little girl instead. At this point, Stephen interjected, "So that's why you gave her to me. I kept thinking there was some complicated medical problem!"

"I was ashamed to tell you the real reason. I was afraid you would think, 'This is one crazy lady!'" Sharon responded.

At this point, Sharon started to cry. She was extremely embarrassed, partly because of her feelings and partly because of her display of emotion in front of another resident. Sharon continued to apologize for her affect, and Stephen continued, without much success, to reassure her. Finally, Stephen also started to look somewhat ashamed. Looking down at the table, he muttered, "It's better to feel something when you look at a kid like that. When I'm around these kids, it doesn't matter how cute they are, how much pain they're in, I don't feel a thing. It's like I was made of stone."

Paradoxically, this disclosure had the effect of calming Sharon down. Whereas well-intentioned efforts to console Sharon had proved ineffectual, the self-disclosure of the other resident's pain was comforting. We began to talk about what might lie behind the intensity of her feelings. At first, Sharon rationalized her outburst: fatigue, pressure, and her being a single parent with a small child. The conversation moved to Sharon's child. Yes, Sharon had thought how awful it would be if something like this ever happened to him. It emerged that she felt conflicted about being away from her son so often and for such long hours. Although he was well and responsibly cared for, whenever she heard this child patient moaning, her repressed feelings of guilt about her perceived "abandonment" of her child came to the fore.

The dialogue between the three of us continued. At this point I was feeling rather elated and excited because I thought we were starting to open important doors in Sharon's and Stephen's lives, ones that may have been closed, even locked, for some time. Simultaneously I felt anxious, as well as somewhat guarded, afraid that the discussion, which was supposed to be educational, not psychotherapeutic, would become too personal—that either Sharon or Stephen would reveal more of themselves than they really wanted to. Given my role as consultant, I did not want to intrude in too-intimate a fashion into the lives of individuals I might not see again. In the ensuing dialogue, I tried to steer a middle course.

Sharon felt guilty and inadequate about the intensity of her feelings about the abused child. Every time the little girl came to her mind, she felt agitated, grief stricken, and almost desperate. She mentioned that at night, she often could not stop thinking about the girl and that this lack of control frightened and alarmed her. She felt she was too involved with this case (although she was not officially the resident in charge, she frequently went by the child's bed to read her chart or simply to look at her). Sharon's strategies for dealing with her distress were to attempt to distance herself (e.g., by giving the patient to her partner and by distracting her attention) and to punish herself for being so emotional and silly.

She wondered repeatedly if she was crazy for feeling this way and castigated herself for being unprofessional and weak, a poor physician.

Stephen, although much more taciturn, gradually began to express some of his concerns. At first, he focused on his astonishment that Sharon could be swept away by feelings of such depth regarding a patient. After some time, however, he was able to disclose his sense of disappointment and failure that he remained so emotionally shut off from his patients. He described a doctor with whom he had worked as a medical student, who always hugged his pediatric patients and played with them: "I know this is what the kids wanted. I know that he got a lot out of it. But I just can't do it. It's not part of me." Stephen went on to describe himself as "frozen," medically competent (I learned later he sometimes performed in an outstanding manner) but unable to extend himself to his patients on an emotional level.

Interestingly enough, the two residents who had chosen haphazardly, it seemed, to attend this optional session complemented each other in startling ways. During this session, I tried to encourage and reinforce self-disclosure from both the residents, avoiding as much as possible any sense of judgment or condemnation. Rather, I worked on making the residents feel safe, getting them to trust each other sufficiently to allow the other to become the keeper of closely guarded secrets. We focused on how much each had to learn from the other; in a sense, each had what the other wanted. On the one hand, Sharon envied Stephen's control and competency, which represented for her the prototypical omnipotent physician. On the other hand, Stephen realized that without Sharon's compassion and caring, he was simply a caricature of a true physician—form without substance.

By the end of the session, I thought we had made some progress. We talked about experiences and reactions that meant something to these residents. We discussed some of their worst fears—some of their most intimately felt experiences of incompleteness and inadequacy. But I still did not feel as though I really understood why each resident was reacting in the way he or she described. I decided to use my remaining consulting time to talk to each resident privately to deepen my own and perhaps their understanding of their emotional responses. Both residents graciously agreed to a private half-hour meeting.

What had puzzled me about Sharon's reaction was not the reaction itself, which is a common and understandable response when confronting abuse in a helpless child, but the magnitude of the reaction. Sharon seemed literally paralyzed, overwhelmed by her emotions regarding this abused patient. Therefore, when we met alone, I asked whether she herself had ever been abused. At first Sharon denied it. After a moment, however, her expression changed.

"I was physically abused," she told me, "by my exhusband." She went on to say that her former husband had beaten her and that this behavior precipitated their divorce. After the divorce, Sharon continued to feel guilty that she had not set sufficient limits on his behavior and that it had taken her so long to leave the marriage. In effect, she blamed herself for having been victimized.

She recently had learned that her exhusband was planning to return to the same geographic area in which she lived. She was having to face reintegrating him at some level in her life, since they shared the parenting of their son. As the time drew nearer for him to return, Sharon grew increasingly anxious, afraid for her child and for herself.

Sharon responded to the abused little girl on pediatrics not only as a physician and a mother, but as a little girl herself, wounded and victimized by someone she had loved and trusted. This connection, which Sharon had not allowed herself to make before, made her realize that although her grief and fear were partly for her patient, they were also, in large part, for herself.

In our individual consultation, Stephen could not identify a nodal event that might have served to suppress his emotions toward his patients. He was clearly uncomfortable with a direct focus on this problem and kept reiterating, "That's just how I am."

Stephen had led a fairly unexamined life. He was suspicious of reflection and self-analysis. He claimed that he simply "did not feel things." As I listened, I remembered a story I had once read (4) about a boy who accidently kills his older brother. When he appears unrepentant and unmoved, he is roundly condemned by family and neighbors alike. Yet the boy's apparent callousness serves as a shield from the enormity of his act. It is only by degrees, and with support and compassion, that he is able to find his way back toward his feelings and an acceptance of the situation.

When Stephen was gently challenged about his lack of feeling, he conceded that although he experienced emotions, he did not know how to act on them or how to integrate them in his interactions with others. We talked about how uncertain emotional expression can be in our culture and how easy it is to move farther and farther from one's emotional states, especially if one is in a position of authority.

We also talked about Stephen's family of origin. Stephen was the only son and youngest sibling of an achieving family. He had an older sister who was a physician, as well as a physician father whom he both admired and feared. When he was still young, another sibling, a brother, had died in a drowning accident. He had never talked to his parents about this brother, although he had harbored some guilt and felt his parents similarly blamed themselves. Thus, he had learned early in his family that although emotions were risky and sometimes uncontainable, science provided a safe refuge. He wanted to be accepted by his father and he felt that the most certain way of doing so was to succeed in the arena of tangible, measurable accomplishments.

One thought in particular seemed to move Stephen. I wondered whether Stephen might not be able to achieve greater emotional intimacy with his pediatric patients by occasionally holding them on his lap and showing them a picture book for a few minutes. Stephen looked uncomfortable at this suggestion, and after a short silence said, "You know, I don't remember my father ever doing that with me."

ANALYSIS AND INTERPRETATION

The Role of the Faculty

What were some of the strategies and directions I chose to pursue during this teaching opportunity? The appearance of only two residents at the teaching session suggested immediately that teaching could occur on a more intimate and personal level. I attempted to be sensitive to the residents' level of "presentness." When residents seem especially concerned and preoccupied, rather than proceeding mechanically to the "real" teaching that is scheduled to occur, it may be a signal to attend to their immediate emotional needs. In this case, the pivotal point in our interaction came when Sharon called herself "crazy" and began to cry. Her language and her affect were synchronous. Both were clear statements that the focus of teaching needed to be subjective and personal, not objective and general.

But pursuing such teaching opportunities can be frightening, indeed. As an educator, I sometimes like to think I have all the answers. But there is no textbook response to a resident's distress that is the result of negative countertransference issues (17). Thus, I feared "making a mistake," opening a Pandora's box of problems and perhaps revealing my vulnerabilities in the process. It was helpful to me to remember an adage I often impart to residents vis-à-vis their patients: talk less and listen more. My primary role with Sharon and Stephen was of a compassionate and concerned listener. My major responsibility was to allow the pain, guilt, and suffering of these two residents to unfold. The few interjections I made served to encourage a deeper level of self-disclosure when the resident seemed to wish to retreat from his or her own feelings, to normalize and validate the range of feelings the two residents shared, to avoid judgment and punishment in the transactions between the two residents, and to stimulate an atmosphere of mutual respect and support.

At several points during this critical 90 minutes, teaching could have taken a different direction. Because of the small turnout, the seminar could have been canceled. Despite the residents' obvious agitation regarding their young patient, I could have rigidly adhered to the formal curriculum. Once Sharon began to cry, the interaction between the two residents could have been terminated, and the focus shifted to "patching up" Sharon before the start of her afternoon clinic. The focus of teaching could have moved with excessive rapidity to problem-solving solutions for both residents, without allowing each to recognize and become familiar with those pieces of themselves they had invested so much energy in discounting. The focus of teaching could have been diverted to safer and less troublesome channels. In short, the content and focus of the teaching session could have served as a resistance or defense against powerful feelings in the residents. Instead, the teaching was directed to making such feelings *accessible* to the residents.

Impact on the Residents

A telephone follow-up two months later with Sharon and Stephen indicated that both felt they had benefited from this nontraditional teaching session. Sharon reported that her obsession with this particular patient had decreased and that she was sleeping better. She felt that in general, her response to abused patients was less phobic, although she still found their treatment to be emotionally demanding for her. Furthermore, she had decided to continue sorting out her personal issues from her professional practice by returning to counseling. Stephen also had made small but significant changes in his behavior. He reported that he now had more interest in behavioral science teaching and felt he was more willing to discuss his emotional reactions to patients with the faculty. From a faculty colleague, I learned that Stephen frequently patted his pediatric patients and played games with them (one nurse had even been overheard to remark that Stephen would make an excellent father because he was so fond of children!).

It is important to remember that the abused child was not a patient whose management was in crisis; this was not a morbidity and mortality report. As far as the medical system was concerned, the child was receiving adequate care. Of course, in the most literal sense, that obviously was accurate. However, at the same time, it is significant that this little girl evoked almost hysterical emotionality in one of her physicians and a kind of aloof coldness in the other.

It is interesting to note that before our discussion, neither resident had paid much attention to his or her emotional reactions to the patient. In the normal course of events, it is doubtful that these responses would have come up for discussion or examination. If not for the opportunity to reflect on an encounter with a patient from a psychosocial perspective, none of the issues, which were so compelling in the lives of these two young doctors, would have been addressed. Serendipitously, both residents were forced to incorporate aspects of themselves that initially frightened them and that they had previously succeeded in splitting off from their persona as "perfect" physicians (8), a process that had been accomplished at great cost to the residents, as was evidenced by Sharon's sleepless nights and obsessive thoughts and by Stephen's abysmally poor self-esteem, which bordered on self-contempt.

Focusing on residents' feelings relates to the development of authenticity and transparency among residents who are required to function as each other's colleagues for several years. What was painfully apparent at the start of the session was the dislike and suspicion that colored each resident's view of the other. Each felt negatively judged by the other and each envied what he or she saw in the other's performance as a doctor. Communication between them was poor because they feared rejection and contempt. One of the most important results of the teaching session was bridging the gap between these two physicians. Perhaps they gained the realization that neither crazy nor turned to stone, they were simply two people struggling, each in his or her own fashion,

with some of the real anguish of ministering to those in pain. It is vital that such issues at least be addressed as part of the medical education context because it is through such issues that we have a chance to explore what medicine is all about.

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