EMOTIONS IN RESIDENCY: PROFESSIONAL ALEXITHYMIA

I. I'm going to start by reading a poem, written in the voice of a resident, by the distinguished physician-poet Rafael Campo

II. We might say that the resident depicted suffers from a kind of professional alexithymia….

- **a. As you know, alexithymia is a psychological disorder characterized by difficulty in experiencing, expressing, and describing emotional responses**
- **b. Individuals with alexithymia…**
  1. **demonstrate an externalized way of thinking that relies on facts and figures**
  2. **are often unaware of their feelings and the feelings of others and…**
  3. **are frequently described as cold and aloof**
- **c. Unfortunately, although of course medical training and healthcare institutions do not literally produce alexithymia, they can result in practitioners who are uncomfortable with and out of touch with emotion, who regard the acknowledgment or expression of emotion as somehow unprofessional**

III. Video – an example, admittedly a bit exaggerated, of how the medical training system works to stifle emotional responses

IV. Yet, as we are all very aware, despite the tendency of the culture of medicine to ignore the emotional responses of its trainees, the practice of medicine is full of emotions, positive and negative, in both patients and in physicians. WHAT ARE SOME EXAMPLES?

- **a. Positive emotions/attitudes – gratitude, happiness, pride, relief, empathy, compassion - - often ignore**
- **b. Negative emotions/attitudes - Anxiety, fear, vulnerability, guilt, sadness, dislike, impatience, frustration, anger, shame. Helplessness – don't even like to talk about them**

V. It is true that residents are afraid of not having any emotions toward patients BUT

- **a. they are more afraid of being overwhelmed by their feelings in response to patient care**

VI. Why residents fear negative emotions

- **a. Unprofessional**
- **b. Violate self image as good person**
- **c. Might lead to sub-optimal pt care**

VII. Why residents fear positive emotions

- **a. Will not be able to make good decisions about pts**
- **b. Will suffer because too attached to pt**
- **c. Compassion fatigue**

VIII. Physicians are not always good role models for learners in terms of dealing with emotions

a. **Physicians often deal with anxiety by distancing from their own emotions**
b. **They tend to ignore negative emotions (sadness, anger) they experience in response to patient care**
c. **Physicians are not very good judges of reading pts' emotions; or acknowledging pts' emotions**
d. **When they do acknowledge pt emotions, tend to offer only minimal empathy**
e. **They tend to rely on cognitive/behavioral strategies when interacting with patients (explaining, educating, recommending, prescribing rather than empathizing) OR**
f. **Engage in "blocking behaviors" that discourage further emotional disclosure (break eye contact, change topic**

IX. Do emotions matter in medicine?

a. **Emotions influence both drs and pts in areas such as**
1. **Decision-making, information-processing**
b. **Patient emotions influence clinical outcomes in diseases like diabetes, MI**

X. Benefits of clinical empathy

a. **Pts give doctors more illness specific information, ask more questions, share their concerns increases diagnostic accuracy)**
b. **Patients more participatory, more empowered in clinical encounter**
c. **Patient have better adherence to medical regimen and treatment plan**
d. **Patients more satisfied**
e. **Diabetic pts lower HgA1C, lower cholesterol, fewer metabolic episodes requiring hospitalization**
f. **Patients with common cold, fewer Sxs, shorter duration**
g. **Helps with recovery from depression**
h. **Also protective against physician burn-out**

XI. Although medicine is brimming over with all sorts of emotions,

a. **They are often perceived as complicated, unruly, unpredictable, confusing, and distressing**
b. **We do not do a very good job of preparing learners to deal with the emotions that arise in difficult, stressful, tense clinical situations**
c. **Residents often conclude that experiencing emotion is the problem; emotional detachment/suppression is the solution**

XII. There is, however, an alternative way of thinking about emotions

a. **Awareness of emotion: We could start actually paying attention and learning something about what we're feeling in clinical situations**
b. **Working with emotions: Once aware, we could learn to work with or modulate our emotions so that patient care (and physician well-being) do not suffer…**

c. Emotional connection: And finally, we could have as a goal trying to remain emotionally connected to, rather than detached from, patients

XIII. The Emotions Police?

a. Not the emotions police

b. Goal is *not* to…

1. "make" you feel certain emotions

2. or teach "correct" emotions (a patronizing, if not insulting attitude)

c. Goal *is*….

1. to facilitate learning identification, understanding, and exploration of feelings

2. to encourage you to think about what you are feeling, what your patients are feeling, and how you can work with all these feelings to best advance your patients' interests

XIV. Working with Difficult Emotions

a. Pay attention to problem emotions because…

1. Difficult emotions expressed reflexively usually make a bad situation worse

2. Hamper patient care

3. Inhibit teamwork

4. Make you stressed, guilty, ashamed

b. Sometimes expressing negative emotions has short-term benefits, but long-term reduces sense of safety and trust

c. We think of emotion as something that "just happens" to us; true there is an initial flurry that is just fight or flight

d. Responding vs. reacting

1. But if we become aware of our emotions, we have a choice about what to do with them

XV. Common mistakes in working with emotions

a. Strong negative emotions can be scary/shameful

b. Ignore/suppress the emotion/pretend it's not there

1. Emotions are unprofessional

c. Justify/rationalize the emotion

1. This patient is a jerk: I deserve to be annoyed

2. Feed the emotion (tell a story)

XVI. How can negative emotions help us?

a. Trying to attract our attention, trying to tell us something

b. What? (I need a break; I need to think about this situation differently; I need to channel my anger constructively)

XVII. Cultivating positive emotions

a. Compassion and caring should come from a brimming reservoir of joy and love, rather than scraping the bottom of our barrel

b. This means self-care – heart beats to itself first

XVIII. Strategies for cultivating positive emotions/attitudes

a. **Adopt the other's perspective**
b. **Remember the other is someone's mother, father, sister, brother**
c. **Change the story you tell about the other**
d. **Look for what you share in common with your patient**
e. **Respect difference**

XIX. Strategies for cultivating positive emotions/attitudes (cont)

a. **Broaden your perspective - When you look back from the perspective of tomorrow, what do you need to do to feel good about how you acted today?**
b. **Cue your core values - What would my role-model do in this situation?**
c. **Remember something that brings you joy**
d. **Keep a daily gratitude journal**
e. **Find something to appreciate in the situation**
f. **Contemplate something in nature**
g. **Do something nice for yourself/for someone else**

XX. Emotional equilibrium

a. **"The physician needs a clear head and a kind heart; his (sic) work is arduous and complex, requiring the exercise of the very highest faculties of the mind, while constantly appealing to the emotions and finer feelings."**
b. **The ability not to be emotionally overwhelmed by the suffering of others (steadiness); *and* the capacity to still be moved by that suffering (tenderness)**

XXI. Emotional Regulation

a. **Ability to modulate emotions, adapt them to the situation and patient's needs**
b. **Genuine, proportional concern for patients**
c. **Reinterpreting, reframing situation**
d. **Decentering from own anxiety back to patient experience**
e. **Mindful compassion – learning to be compassionately present in the face of patient suffering without being overwhelmed**

XXII. Finding an emotional center

a. **Pause:**
b. **Don't just do something – stand there**
c. **Take a breath**
d. **Say a prayer, quote a wisdom saying**
e. **Be curious, not furious**
f. **You are aware of emotions BUT not driven by emotions**
g. **Your emotions are within a larger context of doing good for the other (your patient) and for yourself**
h. **When you are centered, you can stay emotionally connected to your patient**