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Contagion

What made you want to leave?" I asked. "I just didn't think the doctors cared," he replied, referring to the orthopedic surgeons, although by all accounts they'd done an excellent job of fixing his hip.

The surgeons had frantically consulted us, ostensibly for depression, but probably because they thought he was a "difficult" patient: the evening before he'd threatened to leave the hospital against medical advice. Now, he seemed quite reasonable and willing to talk. His affect was depressed, as he slumped on the bed, talking with us in soft tones.

"I have been feeling sad for a while," he admitted, when suddenly, the door burst open, and a young lady stuck her head in.

"Hi!" she exclaimed. "How are you?" If she was aware that her behavior was in stark contrast to the prevalent mood in the room, she didn't show it. "I'm the speech pathologist," she said, and then with a bright smile and a wave, she added, "You guys talk, I'll come back later," and breezed out of the room.

There was a pause, and then the patient shook his head, "I won't be talking to her," he said.

"How come?"

He thought about it. "She's too—young," he replied.

"Too young?"

"Yeah, I guess—Look, I just don't want to talk with her, like I don't want to talk with those surgeons. You guys are different." We completed our assessment, and he thanked us for our time.

Later, I wondered why establishing a rapport with the patient had been relatively easy for us and so much more challenging for the surgeons and other staff. It occurred to me that "young" was the patient's way of expressing the obvious dissonance between his low mood and the speech pathologist's breezy attitude. He did not want to speak with her because her emotional state did not resonate with his own internal experience. Possibly, the surgeons had been similarly ebullient, as they usually are, and this grated on the patient.

It struck me that the resident and I had adopted the patient's emotional tone: his low voice, the slightly drooped posture, the restrained affect. And we had done this instinctively today, as we did all the time. Like most mental health professionals, indeed like most people who are socially attuned, we unconsciously calibrated our demeanor to achieve an emotional resonance with the person we were trying to connect with.

Empathy, I was reminded, is a complex process, a dance of intimacy in which physicians follow the patients' lead, even step into their shoes, in an effort to understand them. But I was also reminded that empathy has a dark side. After all, *empathy* is from the Greek "to suffer with." And suffer, we certainly did. It is no coincidence that psychiatrists have the highest rate, among all physicians, for substance abuse, divorce, and suicide.

That evening I reviewed the literature on *empathy* and *emotional resonance*. I perused the vast body of literature on the phenomenon of "emotional contagion," the tendency to display and experience other people's emotions. I had, for many years, made it a conscious habit not to worry about my patients' problems once I left the hospital. On a cogni-

tive level, their problems were not my problems. Their pain was not my pain. But in trying to understand my patients, in trying to empathize with their situation, even if only for the sake of diagnosis and effective treatment, I was taking some of their pain home with me. The tiredness I sometimes felt, that no doubt all psychiatrists feel, was not so much from physical exhaustion, as it was a side effect of empathy.

I read with fascination about “mirror neurons” first discovered in primates and in humans hypothesized to be located in the inferior frontal cortex. We are, the literature suggested, hard wired to mirror someone’s emotions—to feel happiness when we are around happiness, to feel sad when we are around sadness.

The surgeon deals with patients’ physical pain with a mixture of bravado and action, with medications and the edge of a knife. But a psychiatrist primarily deals with emotional pain. For a psychiatrist, then, pain is something to be explored, to be delved into, and ultimately, to be understood, perhaps even mirrored, before effective intervention is possible. It seems perverse that the more empathetic one is, the greater the risk of “contracting” a negative emotion.

The next morning I met Sandra, the psychiatry resident, at the doctors’ lounge. We discussed the cases we had seen and the new consults that had come in overnight. I sipped a cup of coffee, now acutely aware that as we sat at this table discussing depression, delirium, and suicide, in an earnest and somber manner, a group of family practice physicians joked and laughed as they discussed their patients.

I discussed the issue of emotional contagion with Sandra and asked her if she ever felt fatigued.

“You know,” she replied, “now that you mention it, I have been feeling tired, and we’ve not been that busy.” She gestured in the direction of the family practice group. “When I was doing FP for 6 months, we were actually far busier. Even though I was physically tired then, psychiatry is much more draining.”

There it was. Empathy and emotional contagion taking their toll.

But then I was reminded of a patient I had seen some months before, at my outpatient clinic. His depression had responded to venlafaxine, and he was in remission. But, even though he denied symptoms of depression, on that day, he seemed subdued.

“You are not smiling as much as you usually do,” I said to him.

“Well, you know that nurse of yours isn’t here any more. She usually put me in a good mood,” he said. “She laughs and jokes with me, so I’m usually smiling by the time you come into the room.” At that time, I actually felt a pang of disappointment. All the while, I’d thought it was

my treatment that had him smiling. Although, undoubtedly, the medicine had effected his remission, the smiles and the cheer that he displayed in my office were not because of a pill, but because of a nurse’s ability to transmit her emotional state to this patient.

Had Sandra and I, and perhaps other psychiatrists, forgotten that emotional contagion was a 2-way street? Why was it that we did not attempt to alleviate the patient’s mood by modeling a happier mood? Although, an overly lighthearted, carefree attitude like the speech pathologist’s would not be effective, surely there was a middle ground?

An effective leader judges the emotional temperature of a group, then first matches it himself, before attempting to change the collective mood. In much the same manner, maybe we should be emotional coaches, who first resonate with the patient’s mood and then gradually change that state by modeling happier behavior. Somehow, that seemed counter to all my notions of empathy—that it should be “natural,” that it should be genuine. Such a conscious calibration of empathy seemed disingenuous. But then, if it made the patient feel better, and kept us emotionally healthier, perhaps that indeed is the answer.

I thought of the psychiatry inpatient ward and the pervasive atmosphere of gloom that I’d always sensed there. As I thought of all the hospitals I had worked in over the years, I could not think of a single psychiatry ward in this country, or in England, or in India that was not similarly cheerless.

Every psychiatry ward runs the risk of becoming a self-perpetuating environment of despair. The ward in our hospital has no obvious imperfections. The wooden floors are burnished to a fine polish. The place is well lit. The nurses’ station, recently refurbished, is bright and has new furniture. But the place always has the unmistakable miasma of gloom, as if depression has seeped into its very walls.

A colleague of mine, during residency, had once told me that she handled the stresses of work by surrendering the problems to a higher power. The way she put it, “I wear a small cross, and then when I come home every night, I take the cross off and put it in a corner. It is a symbol of my problems, and every night, I put it away. It’s like a talisman that protects me.”

I used meditation, my colleague used prayer and a ritual, some used exercise, some used sublimation, and perhaps some of us resorted to repressing our feelings, or suppressing our empathy. But I wondered why we did not talk more about how we could prevent the transmission of negative emotions within our profession.

A few days later, as I left a patient’s room I saw a sign: “Wash your hands to prevent the spread of infection.”

I did as it said and went to see my next patient. ♦