Visits You Dread, Visits That Delight: a psychoanalysis of primary care

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Disclosure Statement

Please note that I am paid speaker for Alaska Behavioral Health

I have no biomedical or ethical conflicts of interest

LEARNING OBJECTIVES

By the end of this presentation, you should be able to:

1. Review the literature on temperament and personality
2. Discuss how sociocultural forces, trauma, and genetics play a role in the way we all adapt to life
3. List 10 common psychological defense mechanisms
4. Describe a framework for analyzing practitioner-patient/family interactions go smoothly and those where dilemmas and impasse arise
5. Explore how to maintain hope and therapeutic optimism in times of difficulty

Where We're Going: the Human Brain

There are around 128 billion neurons in the human brain with approximately 500 trillion neuron-to-neuron connections. This intricate network that makes mental life possible needs nurturing, an intricate balance of safety, security, stimulation, and optimal amount of stress.

Trauma and unrelenting stresses in childhood and adolescence–particularly those that in the absence of consistent, secure attachments and relationships– disrupt neurobiology. Specifically they disrupt development of inhibitory centers, they impair learning and activate threat mechanisms that make emotion regulation more difficult; they may predispose an individual to have difficulty adapting to life.

Temperamental phenomenon, personality strengths and difficulties, and psychological defenses play out in pediatric encounters. Labeling these can help reduce frustration and offer practitioners the an opportunity to be conscientious

Temperament & Personality

Temperament & Personality

- Temperament: collection derived from Latin *temperamentum* ("correct mixture") may point Greco-Roman belief in balance of humors (sanguine, melancholic, choleric, phlegmatic). In general, these are qualities present at birth and considered biologically endowed, but/and mutable.
- Personality: In 1937, Allport defined this as "the dynamic organization within the individual of those psychosocial systems that determine (their) unique adjustment to (their) environment." What is broadly called someone's personality is made of different temperament types/qualities and characteristic qualities

Rothbart MK, Ahadi SA, Evans DE. Temperament and personality: origins and outcomes. *J Pers Soc Psychol*. 2000;78(1):122-135.

Dimensions of Temperament

TABLE 2.1.
Major Temperament Frameworks Since Chess and Thomas

Founder	Negative Emotionality/ Withdrawal	Extraversion/ Approach	Sociability	Activity	Regulatory Ability	Scales
Rothbart	Negative Affectivity	Extraversion/ Surgency			Effortful Control	Infant Behavior Questionnaire; Child Behavior Questionnaire; Early Adolescent Temperament Questionnaire
Cloninger	Harm Avoidance	Novelty Seeking	Reward Dependence		Persistence	Temperament and Character Inventory (and Junior version)
Gray	Behavioral Inhibiting System	Behavioral Activating System				
Buss and Plomin	Emotionality	Shyness (R)	Sociability	Activity		EAS Temperament Schedule
Kagan and Snidman	Behavioral Inhibition	Behavioral Disinihibition				Laboratory observation protocol

Rettew D. Child Temperament: New Thinking About the Boundary Between Traits and Illness. New York: Norton 2013.

Dimensions within the Temperament & Character Inventory (TCI)

Four Temperaments:

- Novelty Seeking (more selfish, impulsive)
- Harm Avoidance (quickness to fear)
- Reward Dependence (Hi Reward Dependence–needing a lot of social feedback / Lo RD = social detachment)
- Persistence (intentional self-control, executive function)

Three Characters (put in US Constitutional terms…)

- Self-directedness (Executive)
- Cooperativeness (Legislative)
- Self-Transcendence (Judicial)

Personality Health

Learning system	Evolutionary emergence	Prototypic TCI Profile	Genotypic network	General mechanism	Molecular process	Gene numbers
Associative conditioning	41 mya in primates (well developed in chimps & early humans)	Emotional-unreliable (sc-NH)	Emotional reactivity	Habitual response to extracellular stimuli	ERP and PI3K pathways respond to extra-cellular stimuli	249
Intentionality	1.8 mya in *Homo ergaster*	Organized-reliable (SCt-nhR)	Intentional self-control	Self-control of seeking food and other goals	Inositol/Ca^{2+} Second-messenger signaling within cells	438
Self-awareness	100 kya in *Homo sapiens*	Creative-reliable (SCT-nhR)	Creative Self-awareness	Integrated gene co-expression for health in changing contexts	Noncoding RNAs unique to sapiens coordinate groups of cells	574

How Stable is Personality Over Time?

The Big Five

1. Openness
2. Conscientiousness
3. Agreeableness
4. Extraversion
5. Emotional Stability v Neuroticism (tendency toward anxiety, fear, anger, frustration, envy, jealousy, guilt, sadness, and loneliness)

Images from Michael Apted's Up Film Series

Personality Stability Bleidorn W, Schwaba T, Zheng A, et al. Personality stability and change: A meta-analysis of longitudinal studies. *Psychol Bull*. 2022;148(7-8):588-619.

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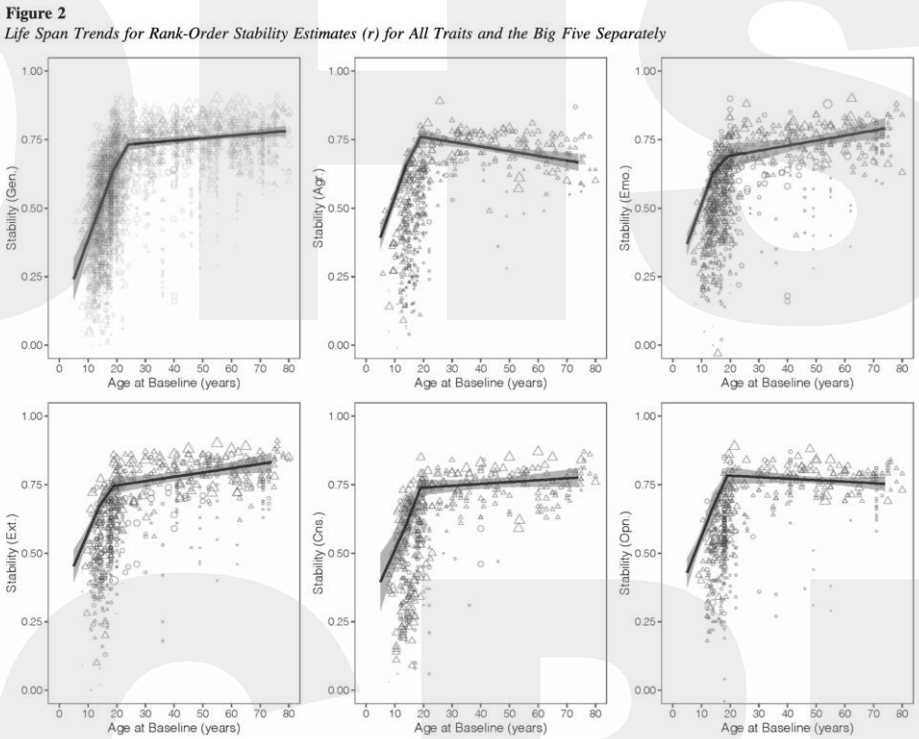
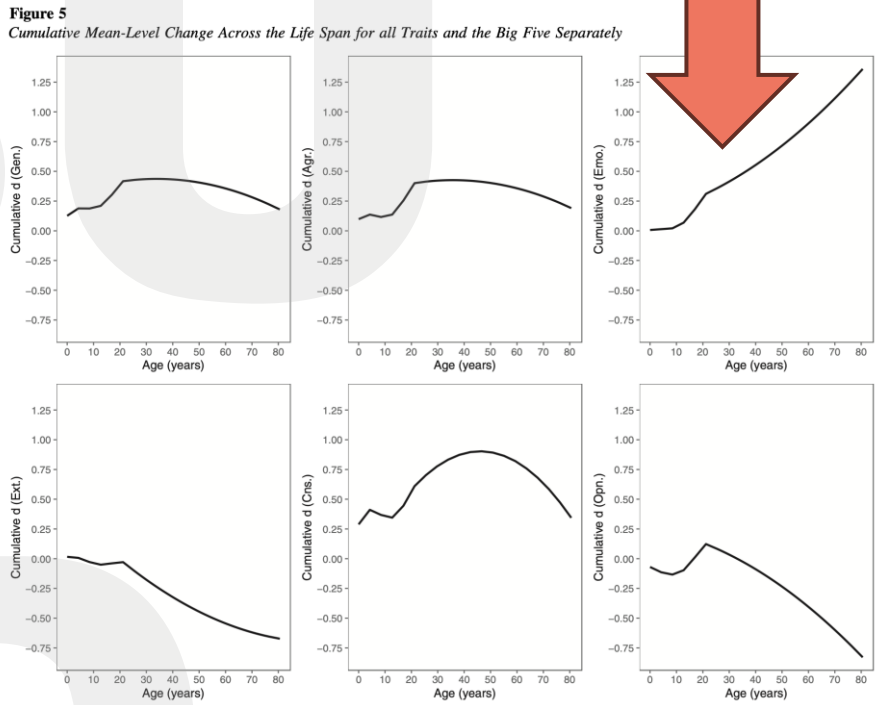


Rank Order Stability

The extent to which a person's level of a trait relative to others remains the same at a later time point

Emotional Stability



Mean Level Stability

The extent to which the absolute level of a trait changes over time

Personality Stability Bleidorn W, Schwaba T, Zheng A, et al. Personality stability and change: A meta-analysis of longitudinal studies. *Psychol Bull*. 2022;148(7-8):588-619.

What forces shape temperament into personality?

Socioeconomic Risk & Self-Control

Longitudinal study of 18,552 children in the UK, researchers found that the following risk factors were associated with reduced self-control by age 3

- Low parental education
- Lower income
- Lower "occupational class"
- Housing insecurity
- Younger parenthood

Some of these was mediated by mother's perceived economic stress

Children who, at 9mos were rated as demonstrating higher levels of negative mood were also less likely to display self-control by age 3

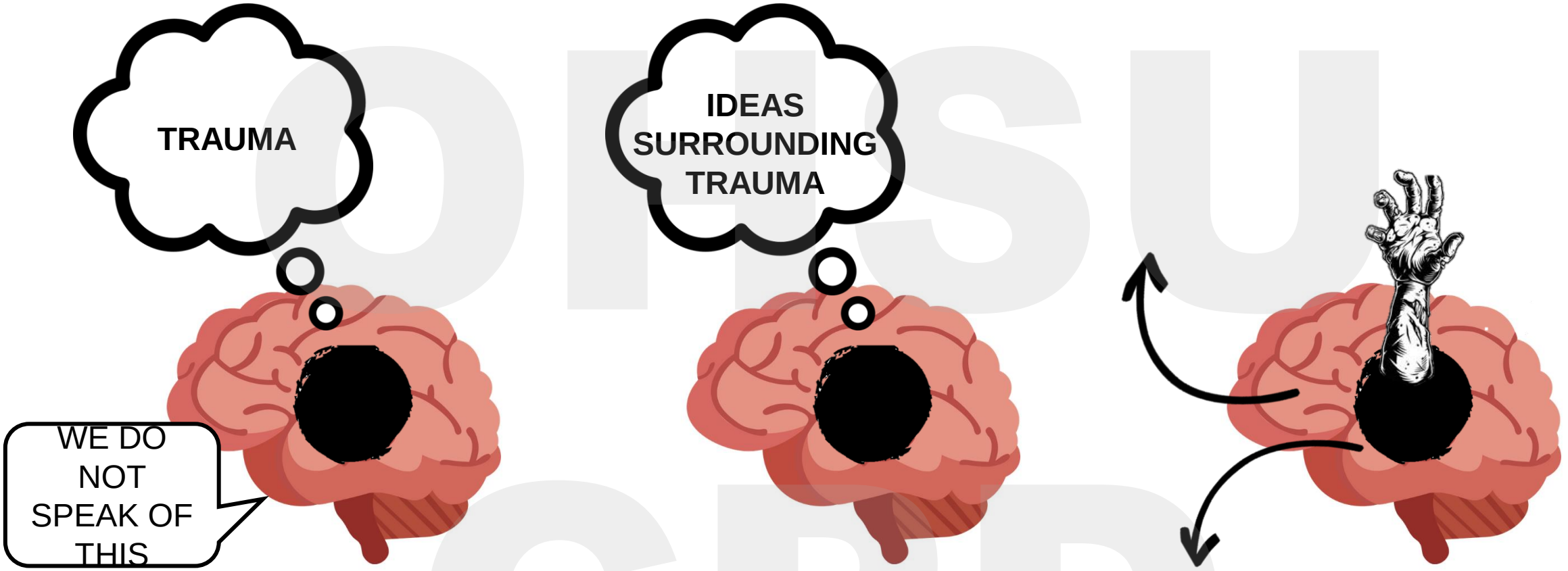
Ng-Knight T, Schoon I. Disentangling the Influence of Socioeconomic Risks on Children's Early Self-Control. *J Pers*. 2017;85(6):793-806.

Ghosts in the Nursery: parent stress + mentalizing

- Personality is flexible over time, with each component of our nervous system diminished or enhanced by nurturing.
- One of the most famous examples of this is captured by Fraiberg's "Ghosts in the Nursey" in which her team worked with at-risk mother's, families who had multiple generations of children involved the in the foster system. They found that "Mrs. Adelson" could stand and talk with the social for minutes without acknowledging the cry of her child or the underlying needs. The team speculated that "when this mother's own cries were heard, she will hear her child's cries."
- Subsequent studies have confirmed that parental reflective function (being able to imagine what is on the mind of a child) is related to child well-being and have suggested that infant, toddler, and middle-schooler emotional regulation can be impacted by first addressing parents' mentalizing needs.

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.

Camoirano A. Mentalizing Makes Parenting Work: A Review about Parental Reflective Functioning and Clinical Interventions to Improve It. *Front Psychol*. 2017;8:14.

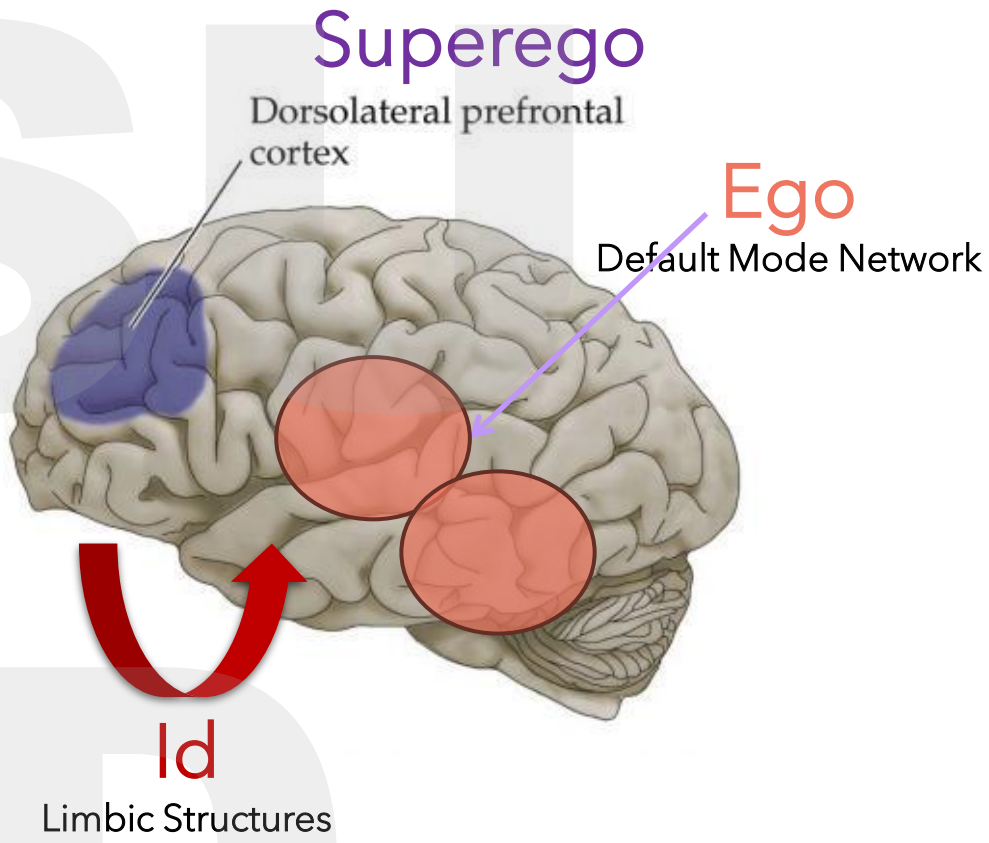


1st Generation **2nd Generation** **3rd Generation**

Yassa M. Nicolas Abraham and Maria Torok—the inner crypt. Scandinavian Psychoanalytic Review. 2002;25(2):82-91.

Common Mechanisms of Defense

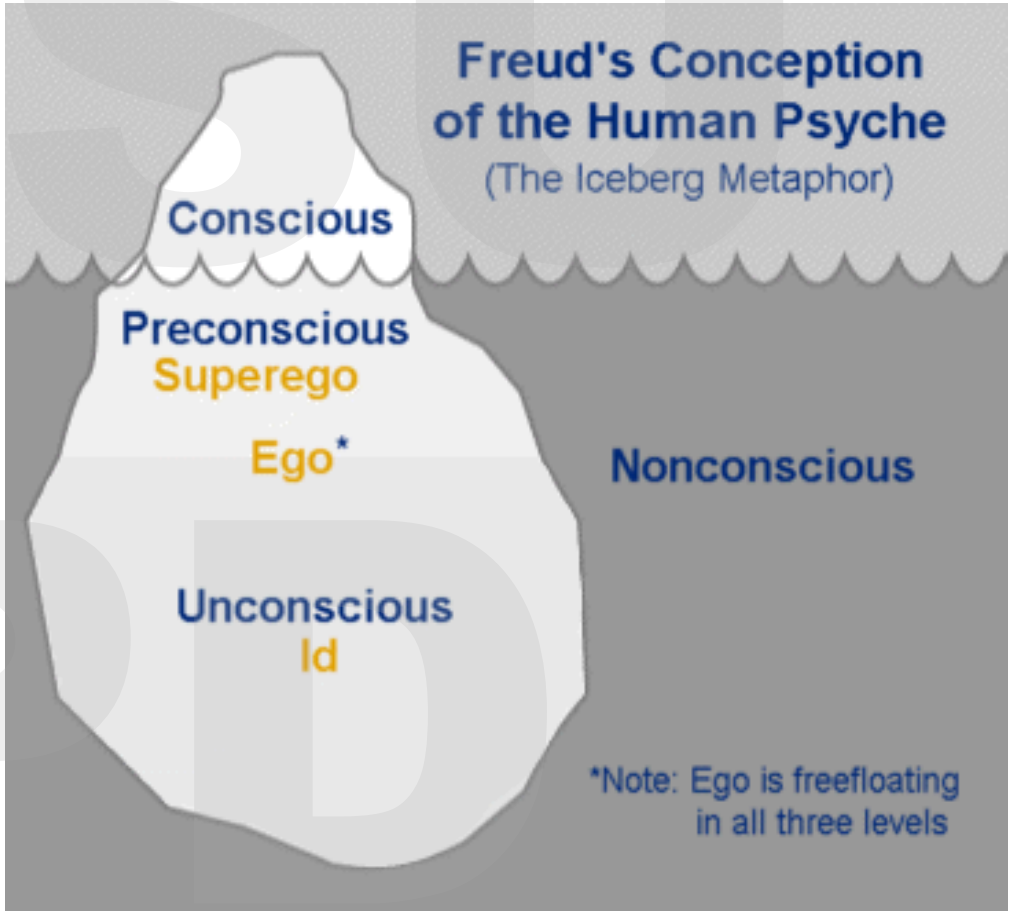
- Placeholding Metaphors
- “All our provisional ideas in psychology will presumably some day be based on an organic substructure”
- -Freud, *On Narcissism* 14th edition. London: Vintage; 1914.



Carhart-Harris RL, Mayberg HS, Malizia AL, Nutt D. Mourning and melancholia revisited: correspondences between principles of Freudian metapsychology and empirical findings in neuropsychiatry. Annals of General Psychiatry. 2008 Dec 1;7(1):9.

Freud's Topological Model

Repression can be seen as all of the defenses the mind employs to keep Unconscious material from bubbling to the surface.
repression can also be seen as an individual defense, a forgetting of something for defensive purposes.



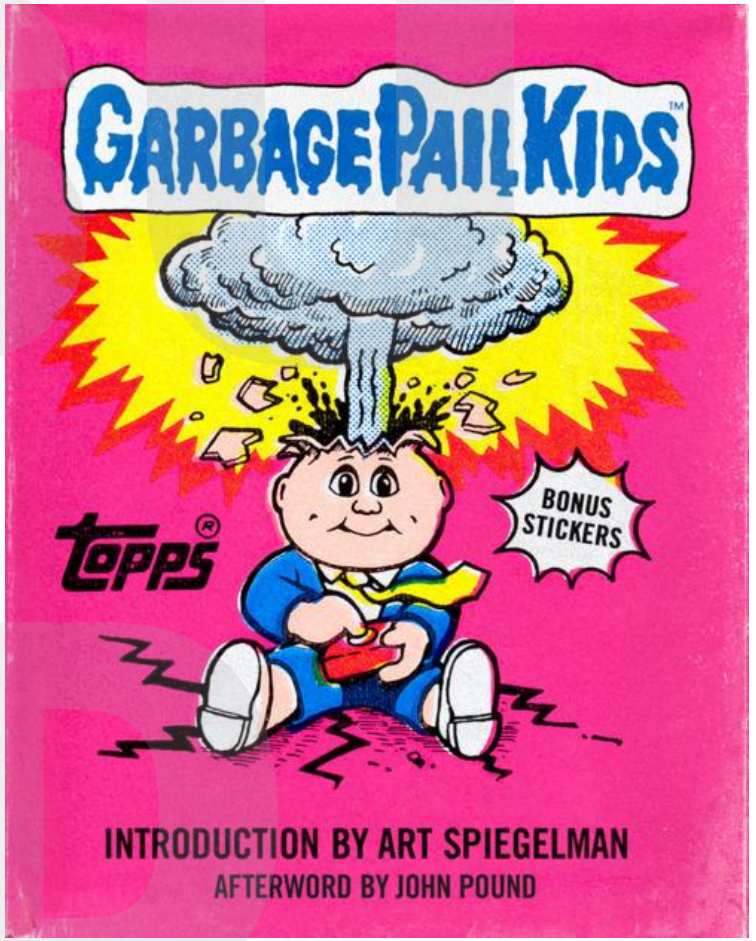
To Protect the Organism

"If the perception of reality entails unpleasure, that perception–that is, the truth–must be sacrificed."

-Freud, SE XXIII, p 237

"The reason why the repressed is so intolerable is that it threatens to overwhelm the ego's fragile manoeuvres in the real world through the urgency of its fantastic demands; this creates anxiety in the ego and makes repression necessary."

-Stephen Frosh, *Key Concepts in Psychoanalysis* New York: NYU Press. 2003. 21



Put simply, if something is going to blow your mind, you better block it out.

Ego Psychologists

Anna Freud (1895-1982), Heinz Hartmann (1894-1970), George Vailliant (1934-) fundamentally interested in the individual psychological and behavioral manuevers people employ in order to navigate untoward feelings.

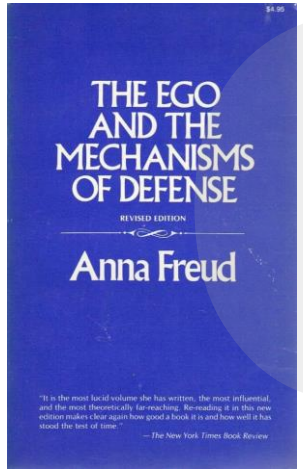


Table 1
Ego Defenses Defined in the DSM–III–R, Arranged in Order of Their Empirical Association With Global Assessments of Mental Health

Category	Defense
Psychotic defenses	Denial (of external reality)
	Distortion (of external reality)[a]
Immature defenses	Passive aggression
	Acting out
	Dissociation
	Projection
	Autistic fantasy
	Devaluation, idealization, splitting[b]
Neurotic (intermediate) defenses	Intellectualization, isolation
	Repression
	Reaction formation
	Displacement, somatization
	Undoing, rationalization
Mature defenses	Suppression
	Altruism[a]
	Humor[a]
	Sublimation[a]

Note. *DSM–III–R* = revised third edition of the *Diagnostic and Statistical Manual of Mental Disorders.*
[a] *Altruism, humor, sublimation,* and *distortion* are terms used in the text of this article but not in the *DSM–III–R.* [b] Devaluation and to a lesser degree splitting are included under my term *hypochondriasis,* a term not included in the *DSM–III–R* glossary.

Neurotic Symptoms in Practice

* If a drive, urge, idea, emotion breaks through there it is often expressed in a neurotic symptom. Repression then acts to make us assume that "well of course, that's just part of life." It causes one to be un-curious, un-questioningly going about one's routine

* Example: discomfort with one's psychotic symptoms + feeling the Other thinks you ought to start a certain medicine->drooling and EPS->anticholinergic->urinary retention->alpha blocker->…

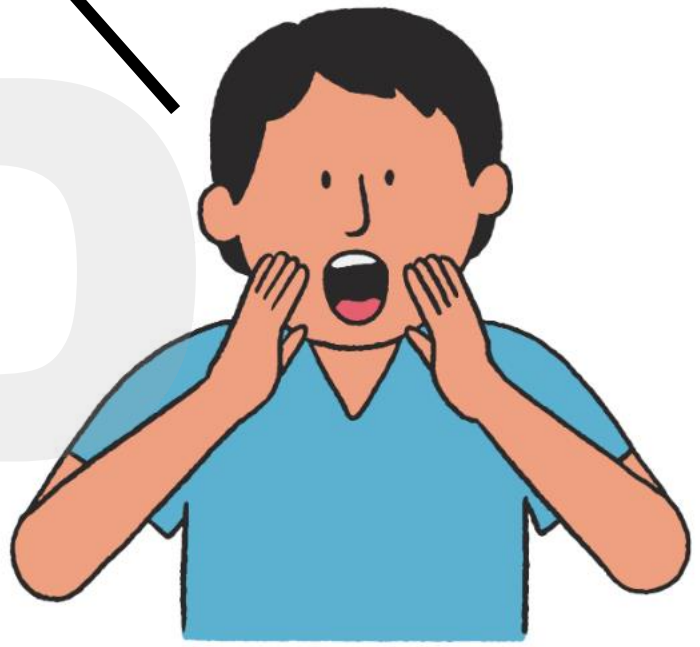
Thank goodness for the psychological-mindedness of Sesame Street

Foundational Defenses

Denial: Holding the absolute belief that something is true, despite overwhelming evidence to the contrary.

Distortion: Grossly reshaping external reality to suit one's inner needs.

YOU KNOW THAT VACCINES CAUSE AUTISM AND THAT THIS IS THE WAY THE GOVERNMENT CONTROLS US, BUT YOU STILL WON'T SIGN THIS EXEMPTION FOR MY SON. WHAT KIND OF A DOCTOR ARE YOU! YOU'RE VIOLATING THE HIPPOCRATIC OATH.



Less Mature Defenses

Passive Aggression: Failure, procrastination, illness which affects other more than one's self and other means of "passively" sabotaging others

Acting Out: Giving into an impulse outside the direct relationship.

Dissociation: Temporarily "checking out," altering one's behavior and awareness to (unconsciously) flee untoward thoughts, feelings or experiences.

Projection: Attributing one's own feelings to another.

There is a family that visits your practice frequently with vague concerns, never uses your advice line, makes demands on your frontdesk staff (who complain to you about the way they are treated). You ALWAYS find yourself running late for these appointments.

Projection

You are going on vacation and inform your patient's parent that you will be away.

Parent: "So you want to get away from all of us annoying parents and our troubles?

Physician: "What leads you to believe that?

Parent: "Oh, I just know. I know how you people operate."

Less Mature Defenses

Devaluation: Thinking someone is contemptible when they are not, this in order to preserve one's sense of self as superior

Idealization: Projecting one's own desired positive qualities onto another person

Splitting: Dividing the world and people into villains and heroes, idealized and devalued people

"Love is an open door."
Sure. However, projection is often a problematic one when it comes to long-term stable relationships.

Neurotic Defenses

Intellectualization: Avoiding intimacy through a focus on external reality (not thoughts, feelings, inner experiences).

Isolation of Affect: Separating discussion of topics/events from the feelings the awaken.

Rationalization: Like intellectualization, emphasizing the logic behind one's actions.

Displacement: Shifting the focus of one's desire, hatred or others feelings onto another.

Repression: Involuntary holding out of conscious awareness, something that could be available to one's self.

Reaction Formation: Transforming an unacceptable impulse into it's opposite.

Bernard Berkman (Jeff Daniels) and his son, Frank (Owen Kline) in
The Squid & The Whale (2005)

Mature Defenses

Ascetism: Gratification through renunciation. For example, planning to live within one's means. This one has an implicitly moral quality.

Altruism: Constructive service to others to alleviate pain.

Anticipation: Carefully, thoughtfully planning for an upcoming problem and imagining how one can best manage a transition/dilemma.

Humor: Using comedy to alleviate discomfort, with an acknowledgement in the joking that this is helping manage one's painful affects or anxieties.

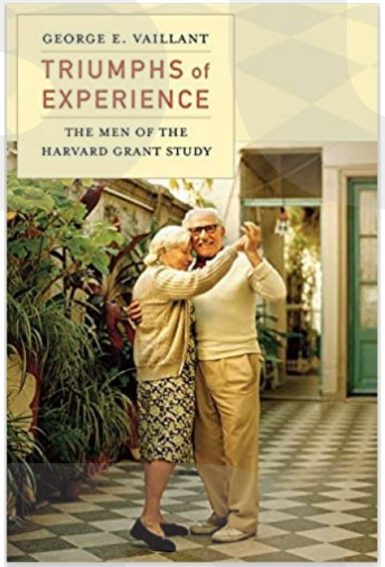
Sublimation: Channeling one's hurts or destructive impulses into something more constructive.

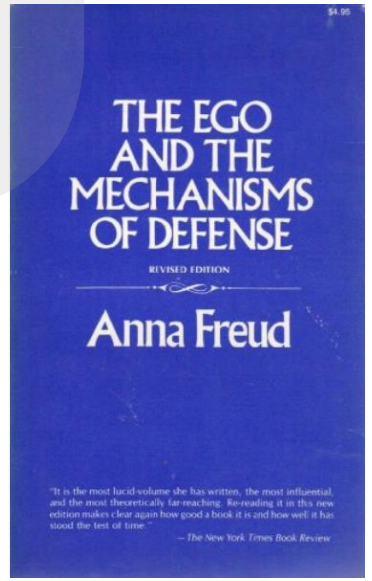
Suppression: Consciously setting aside a thought to later examine it. "Bookmarking" a feeling for later.

Psychological Defenses

For those interested in psychological defense, some good resources include:

- *101 Defenses: How the Mind Shields Itself* by Jerome Blackman. New York: Routledge, 2004.
- *The Ego and Its Mechanisms of Defense* (1936) by Anna Freud. New York: Routledge, 1992.
- *Triumphs of Experience* by George Vaillant. Cambridge, MA: Belknap, 2012.





Analyzing Interactions: Visits that Delight

What Makes for a Good Enough Visit?

Three components

1) Mutually Agreed Upon Goal
2) Grice's Maxims of Cooperative Communication are Maintained

- **Quantity** - one tries to be as informative as one possibly can, and gives as much information as is needed, and no more
- **Quality** - one tries to be truthful, and does not give information that is false or that is not supported by evidence
- **Relation/Coherence** - one tries to be relevant, and says things that are pertinent to the discussion
- **Manner** - when one tries to be as clear, as brief, and as orderly as one can in what one says, and where one avoids obscurity and ambiguity

3) Mutually Satisfying Outcome

Analyzing Interactions: Visits you dread

Winnicott's "Hate in the Countertransference"

The idea of "hate" in medicine in general and quite specifically in pediatrics is totally anathema to the way we think about ourselves…

Borrowing from Winnicott, hate might be completely disavowed because:

- Working with children, teens, adults, and families is our chosen field; we manage our feelings constructively through this service to others
- We are paid to do this work
- We discover new things and are pride ourselves in being life long learners
- We identify with our patients, their needs, wants desires, hurts
- If we ever express "hate" it is in quite sanitized forms, such as the natural–not our imposing, but "the system" "insurance dictates" "our schedule"

Winnicott DW. Hate in the counter-transference. *J Psychother Pract Res*. 1994;3(4):348-356.

Winnicott: "good enough" mothers love *and* can hate…for a moment

- "The baby is not her own (mental) conception
- "The baby is a danger to her in pregnancy and in birth"
- "He is ruthless, treats her as scum, an unpaid servant."
- "The baby at first must dominate, he must be protected from coincidences, life must unfold at the baby's rate and all this needs his mother's continuous and detailed study. For instance, she must not be anxious when holding him, etc.'
- "After an awful morning with him she goes out, and he smiles at a stranger who says: 'isn't he sweet!'"

Winnicott DW. Hate in the counter-transference. *J Psychother Pract Res*. 1994;3(4):348-356.

Our issues: things that fill us with dread

Personal Factors

- Personal Dissatisfaction
- Personal Biases
- Our unique history of having been a child
- Stress / Anxiety – things happening outside of our practice
- Sleeplessness
- Amotivation
- Personality

System Factors

- Documentation Burden
- Staff shortages
- Packed schedules (RVUs anyone?)
- Managing multiple, disparate concerns
- Training backgrounds that did not equip us for the present moment

With appreciation to Carrie Phillipi, MD, PhD -- OHSU Pediatrics

Case Example #1

The mother of an 11-year-old calls for an appointment to talk about her son's ADHD and are slotted for a 20min visit even though they've yet to establish care with your practice, but they shared with the frontdesk staff that this was an "urgent" and "straightforward" concern. Yet, when the patient and his parents arrive they discuss with the medical assistant (MA) myriad different concerns ("this thing on my son's scalp," "his recent stomach aches," "needing to get connected with a new therapist," "can you take a look at his recent paperwork," "his last psychiatrist said he needs bloodwork," "his dad needs some help with his parenting style," "is my son on the right meds?"). The MA comes to the workroom looking completely overwhelmed and describes the situation in desultory fashion.

You enter the room and are handed a large stack of papers, the identified patient is crawled up in a ball in the corner, the family dog is is in the room, two parents are there eager to talk with you, and the father sighs and says: "you probably won't be able to help, no one ever is. This is a waste of time."

You take a deep breath…

Case Example #1- Things You Might Do

- Check yourself
- Analyze the defense -- “you probably won’t be able to help, no one ever is.”
- Examine if there is an agreed upon goal
- Examine if there are communication barriers (Grice’s Maxims)
- Imagine there could be a mutually satisfying result

Case Example #1

- You take a breath, you introduce yourself to the parent and child at eye level, addressing them as equals
- You address the defense: "I will do my best to be helpful."
- You listen for 5-10 minutes, un-interrupted. Soon you realize that the patient's mother is exceedingly concerned and—keeping in mind that parent's are only able to mentalize their child when they themselves have been mentalized—you hold her mind in your mind. The story then unfolds that the mother is about to go for medical treatment and concerned that she is not a good mother, that she is abandoning her child, that he has medical concerns she has not addressed, and that she is worried about what will happen if her son has mental health difficulties while she is away. "Is there someone Don can call if he doesn't know what to do?"
- "So, what I'm hearing is…what we can do today is…does that sound all right?"

Case Example #2

The father of a 6-year-old girl with recurrent vomiting accompanies his daughter to an appointment. Despite an extensive medical work-up, including an upper endoscopy, the father pushes for more tests believing something other than lactose intolerance must be at the heart of his child's recurrent symptoms. Staff members who have interacted with this person have rolled their eyes and made comments like "lucky you, Mr. So and So is back." You enter this appointment with some degree of dread. Reading the MA note, you find that her vitals are normal, weight stable, and you can hear the child laughing and giggling as you approach the door.

Upon walking into the exam room, the patient's father says: "Good thing you're a good doctor, everyone else sucks. They don't listen and they just send us away… we need to have Sarah admitted today, because her vomiting is really bad."

Case Example #2- Things You Might Do

- Check yourself
- Analyze the defense
    - "Good thing you're a good doctor, everyone else sucks."
    - "They don't listen and they just send us away."
    - "we need to have Sarah admitted today, because her vomiting is really bad."
- Examine if there is an agreed upon goal
- Examine if there are communication barriers (Grice's Maxims)
- Imagine there could be a mutually satisfying result

Case Example #2

There is a psychoanalytic technique of repeating the precise words that people use in hopes of eliciting from them their associations to their utterances. In this case, the pediatrician might repeat back the father's words and say: "can you tell me about the experience of having been just sent away?" Through the course of conversation that was long on listening, short on explanation on the part of the pediatrician, the practitioner learns three fundamental experiences of the father:

1. He is frequently unheard and unseen due to race and cultural differences from practitioners
2. He feels concerned that custody of his child is in jeopardy if he does not get to the bottom of his daughter's vomiting
3. His father died of sudden cardiac death, with multiple bouts of syncope ignored. He cannot sleep at night, fearing that his daughter's illness is being ignored

Signified - 

Signifier – "tree"

Case Example #3

"No one can help. I'm a lost cause. It's been this way my whole life."

A 31-year-old female college graduate who is presently un-employed comes to see you for chest and back pain. She notes feeling preoccupied with a feeling of heaviness, tightness, dull muscle pain at various points she notes are consistent with fibromyalgia. She reports a history of ADHD, OCD, and PCOS. She is working with a psychiatrist and is on a complex psychopharmacological regimen include lisdexamfetamine (Vyvanse), duloxetine (Cymbalta), lamotrigine (Lamictal), as well as oral contraceptives, spironolactone, and metformin and fexofenadine.

This is the patient's fourth visit to your primary care practice in the last two months, with previous visits for chest pain leading to a diagnosis of panic disorder (normal physical exam, onset and resolution c/w panic, EKG WNL, no fam hx of SCD) and breathing complaints c/w seasonal allergies and a deviated nasal septum.

Case Example #3- Things You Might Do

- Check yourself: Early in your history-gathering, are getting a feeling medical nihilism–that no matter what you say or do, what tests you
- Analyze the defense(s): "No one can help. I'm a lost cause. It's been this way my whole life."
- Examine if there is an agreed upon goal: there is a both/and…the stated goal (fibromyalgia) AND another desire–what is it?
- Examine if there are communication barriers (Grice's Maxims): the manifest content/question belies a latent request
- Imagine there could be a mutually satisfying result…what is it?

LEARNING OBJECTIVES REVISITED

So, we know that:

1. Temperamental traits are those that people are born with and undergo significant environmental shaping. The 20's are a time of utmost personality shift and generally people grow more emotionally mature as they age.
2. Trauma (ACEs), poverty, racism all impact the formation of intrapsychic and interpersonal functioning
3. Mechanisms of defense help us defend against unbearable thoughts, feelings, and experiences
4. Hating is okay. Acting out, losing empathy is not. Part of our job is holding onto dialectic tensions.
5. One way of framing a good enough visit is to maximize our emphasis on mutually agreed upon purpose, checking defenses and not indulging splits/absolutes, maximizing quality communication ala Grice's Maxims, and creating mutually satisfying outcomes

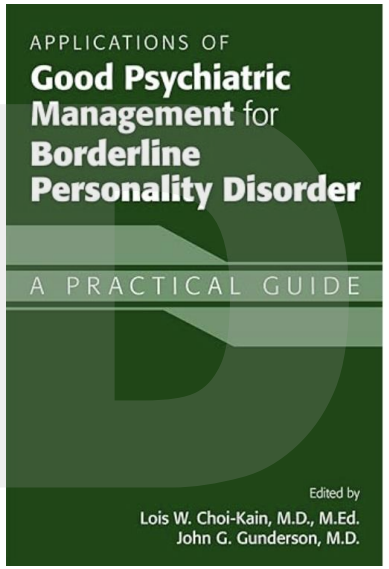
For More Reading on the Topic…

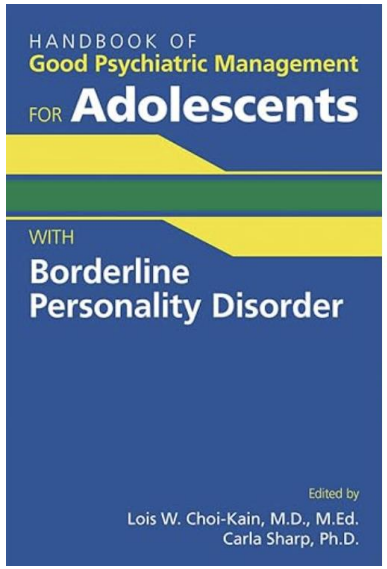
Larson J, Mitchell LE, Lynch S. Are pediatricians doing more family "therapy" than they realize? Changing families through single encounters. *Clin Pediatr (Phila)*. 2013;52(10):978-980.

Breuner CC, Moreno MA. Approaches to the difficult patient/parent encounter. *Pediatrics*. 2011;127(1):163-169.

Asnes AG, Shenoy A. The difficult pediatric encounter: insights and strategies for the pediatric practitioner. *Pediatr Rev*. 2008;29(6):e35-e41.

Chanen AM, Nicol K. Five failures and five challenges for prevention and early intervention for personality disorder. *Curr Opin Psychol*. 2021;37:134-138.





Thank You

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Special Thanks to David Rettew, whose book *Child Temperament: New Thinking About the Boundary Between Traits and Illness* was helpful in thinking about the stability of traits and personality over the lifespan.