L to R: R. Zehr, D. Duerden, D. Bernier and A. Abbass review videotapes of a psychotherapy session.

The case for specialty-specific core curriculum on emotions and health

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Emotion-linked disorders are common and costly, but diagnosable and treatable. These disorders can lead to excessive medical service use, poor outcomes and disability. When physicians have emotion-linked disorders, medical error can occur. With the advent of new diagnostic techniques and brief psychotherapies, medical educators are now able to teach residents how to better understand, diagnose and manage the emotional components of medical care.

The burden of mismanaged emotions on healthcare

Diverse research has established that people experiencing problems managing emotions, such as anger and subsequent guilt about that anger, can develop adverse health consequences and symptoms (see Table 1). Patients who have this problem tend to neglect their own health or directly damage themselves through substance abuse, poor diet, treatment non-compliance and self-injurious behaviours.

Table 1: Emotion-linked complaints and disorders

Specialty	Examples of emotion-linked complaints and disorders
All specialties	smoking, substance abuse, obesity, non-compliance
Cardiology	hypertension, chest pain, palpitations
Dermatology	psoriasis, dermatitis, urticaria, itch
Endocrinology	fatigue, obesity, thyroid dysfunction
Gastroenterology	irritable bowel syndrome, dyspepsia, abdominal pain
Internal Medicine	weakness, fatigue, syncope, pain
Neurology	conversion, headache, dizziness, pseudoseizure
Obstetrics and Gynecology	pelvic pain, sexual dysfunction
Ophthalmology	visual blurring, tunnel vision, transient blindness
Otolaryngology	dizziness, globus pallidus
Respirology	shortness of breath, choking spells, chest pain
Rheumatology	fibromyalgia, fatigue, chronic pain
Surgery	abdominal pain, back pain, neck pain
Urology	urethral syndrome, erectile dysfunction

Thus, patients with these problems are high users of medications and emergency, hospital and physician services. Because they do not take optimal care of themselves, they often end up in conflict with physicians prescribing care. Such conflict manifests in an increased rate of complaints and lawsuits from this group of patients, creating a challenging situation for the physician to manage.

These patients tend to frequent specialty clinics (and occupy positions on wait lists), looking for physical help for an emotion-linked set of problems. Specialists are often pressed or feel forced to investigate further despite the lack of suspicious history or physical findings. According to the study "Common symptoms in ambulatory care: incidence, evaluation, therapy and outcome" by K. Kroenke and A.D. Mangelsdorff, published in *The American Journal of Medicine* in 1989, 84 per cent of 567 common internal medicine complaints—such as chest pain, dizziness or weakness—yielded no new diagnosis and cost a great deal to investigate. A recent British study found that one quarter of all new specialty referrals studied resulted in no diagnosis. This included almost one fifth of surgical referrals and over one third of some medical specialty referrals.

To compound this healthcare burden, recent surveys show that many physicians and residents in specialty medicine themselves manifest problems managing emotions, often in the form of burnout. T.D. Shanafelt et al. found burnout was a significant factor in self-reported medical error in one study of residents published in the *Annals of Internal Medicine* in 2002. Thus, residents may have difficulty identifying emotional processes in patients they treat. Conflict, frustration, lack of treatment response, poor compliance and patient complaints can render practice unrewarding and even unbearable.

Diagnosing and managing emotional problems

The good news from recent research is that emotion-linked disorders can be directly diagnosed and, in most cases, treated. Videotaped research from the past 40 years by H. Davanloo at McGill University, author of "Unlocking the Unconscious," has helped clinicians learn to diagnose emotional pathways in a given patient. Focusing on emotionally charged situations allows physicians to actively see the patient's visceral, physiological response. This allows a direct view of the functioning of this system and its links to any active somatic complaints or behavioural problems.

Among other treatment methods, short-term dynamic psychotherapy effectively treats many patients with problems such as functional dyspepsia, irritable bowel syndrome, depression, anxiety, self-injury and personality disorders. Several studies have shown that this treatment results in cost savings in the healthcare system through reduced medication, disability insurance claims, physician visits and hospital use. Identifying and addressing emotional processes can unburden the patient, physician and healthcare system.

Developing the curriculum

A combination of didactic teaching, case-based small-group seminars, videotape training, bedside teaching and other adjunctive methods tailored to specialties is recommended to address the learning needs described above.

An effective curriculum for residents should include didactic seminars that provide a general overview of emotion physiology and the somatic and behavioural patterns of emotion. These sessions should review common patterns of somatization through videotape illustrations of diagnostic procedures, allowing residents to see the direct effects of somatization on a patient's body. Tapes showing the physical experience of emotions in contrast to somatization would help residents understand the complex emotions that frequently lead to somatic presentations.

Other seminars should review physician self-care, time management, professional boundaries, conflict management and general theory on medical error, with emphasis on affective and cognitive dispositions. The role of team splitting, black and white thinking, cognitive biases and a physician's own style of managing emotions should also be covered.

As a complement to didactic teaching, small group sessions would allow time for videotape case-based discussion, thus expanding on the material covered in didactic sessions. Cases can be tailored to the specific specialty group, highlighting common, challenging patient presentations. Through discussion of emotional processes and how to detect them in an assessment interview, residents can consider how they would manage a challenging patient situation. Such case-based discussions can review how a physician's emotional reactions may predispose to medical error with certain patients, such as the demanding or self-destructive patient. These sessions could be lead by the primary specialist, a physician-therapist or both.

As part of the curriculum, residents should videotape some of their consultations, review the tape, and present it to a supervisor and, when possible, peers. Videotape training has multiple benefits: developing self-awareness, learning emotion physiology and learning the somatic and behavioural concomitants of emotions. Supportive input from colleagues and supervisors during tape review creates a positive first experience of peer consultation. This is an invaluable educational experience that can normalize the seeking of peer input throughout a specialist's career.

At-the-bedside, case-based teaching by specialist supervisors allows experienced clinicians to teach residents how to use this information practically.

Additional learning resources should also be made available for residents. These include a videotape library illustrating different somatizing patterns during diagnostic interviews and the physiological changes during treatment. These resources should include literature on research and theory in the area of emotions and health, and physician self-awareness and self-care. In addition, residents should be offered collaborative research opportunities and elective experiences with physicians specializing in the diagnosis and management of somatizing and personality disordered patients.

Experience suggests that this curriculum may be covered in approximately 30 hours: eight hours of didactic seminars, four two-hour small group training sessions and eight videotaped interviews conducted by the resident. In total, this amount of teaching is small compared to the proportion of time the specialist will take diagnosing emotional factors in new patients, managing challenging patients, taking care of him or herself and teaching others.

While the objective of this type of training is not therapy for the resident, many trainees learn a great deal about themselves through this education process. They often develop a better understanding of why they entered such a demanding but rewarding field, as well as more empathy for patients, colleagues and themselves.

Changing Culture

Although most supervisors would agree these educational objectives have merit, they may not themselves have had such training experience. This implies an educational need for faculty to become versed in emotion-linked disorders, so that this new information can be incorporated into practice and then transmitted to residents. With a cultural shift in a department incorporating these issues, this education will be natural and ongoing in the continuing education of faculty.

The demands of current specialty practice and the burden of emotion-linked problems have brought about a need to train residents to understand and manage the emotional aspects of professional practice. The main objective is to develop a self-aware specialist who can understand and diagnose emotion factors relevant to his or her specialty. This education, combined with a self-aware culture and the presence of respected mentors, provides a fertile ground for this important development to take place.

For additional information on emotion-linked disorders or establishing a curriculum on emotions and health, visit **http://psychiatry.medicine.dal.ca/centreforemotions/** *or e-mail Allan.Abbass@cdha.nshealth.ca.*