

A PIECE OF MY MIND

Herbert M. Adler, MD, PhD

Department of Family Medicine & Psychiatry, Jefferson Medical College, Philadelphia, Pennsylvania.

A Piece of My Mind—Actually

I finally gave Tom (not his real name) a piece of my mind, but it's not what you think. I didn't "dump on him," in the colloquial use of the phrase. Rather, I provided his mind with a part of my mind that I hoped would be therapeutic. For better or worse, this happens in every clinical encounter and should be recognized to be as intrinsic to clinical practice as gathering the history of the present illness—where it usually begins.

Background: During my psychiatry residency, I moonlighted by covering the practices of several primary care physicians. I now have a dual academic appointment in the departments of psychiatry and family medicine and teach primary care physicians how to conduct short-term psychotherapy. Tom's primary care physician had asked me to treat his pathological mourning for his cat, and Tom agreed to see me once a week in a room with a one-way mirror that would permit family medicine residents and students to view our interaction. By the eighth week, we both agreed that Tom had achieved a satisfactory outcome, and he continued to see his primary care physician for his usual medical problems.

As we sat facing each other during our first encounter, Tom's arms were folded defensively across his chest, his facial expression was forebodingly grim, his head was bowed, and he offered no eye contact. He was in deep mourning over the recent death of Rachel, his 16-year-old cat, and was eager to disgorge a tight-lipped recitation of Rachel's last days. In a minutely detailed monologue, Tom recounted Rachel's early symptoms of anorexia, her lassitude, efforts to feed her, their trip to the veterinary hospital, Rachel's downhill course, the call from the veterinarian who told him that Rachel had died, and his subsequent appointment with that veterinarian because he needed to know everything possible about Rachel's death.

I assumed Tom needed a compassionate response to his loss, but to my dismay, the more I learned about him—especially his chronic emotional indifference to his wife and children, the less empathic I became. A contributing factor to my unwelcome antipathy was the effort it took for me to stifle my counterproductive impulse to say, "Rachel is just a cat. Your family is starving for your affection." Tom would have rightly recoiled if I had diverted attention from his immediate pain over the loss of Rachel, to the chronic pain his family endured because the only things he got attached to were *things* that made no emotional demands, like the cars he worked on—and Rachel. Furthermore, had I presumed that Rachel was "just a cat," I would have been as misguided as a parent who expected a crying child to part with a tattered security blanket because it was "just a dirty blanket." I recognized that Rachel, who required little emotional reciprocity, had served as Tom's security blanket. With Rachel gone, Tom felt desolate.

How could I "rescue" him? I recalled meeting with a stutterer, who told me that he could speak fluently to his dog because his dog was effortlessly nonjudgmental. However, speaking fluently to his dog never enabled him to talk fluently with people. So, I concluded that even if I could be as agreeably tolerant of Tom's emotionally avoidant defensiveness, as was Rachel, I would not be helping Tom to move toward the interpersonal relationships he needed. Fortunately, I had a more relevant recollection—about a patient who was rescued from devastating despair by an offhanded response from her gynecologist. When she was 20 and single, her gynecologist diagnosed genital herpes during a pelvic examination. She felt like a pariah. "No one will ever want me," she remembers sobbing. "Can I ever have an honest sex life?" The gynecologist matter-of-factly replied, "I don't know why not." He then followed up with information about herpes, recommended a helpful book, and informed her of an Internet dating service for people with herpes. Ten years later, the patient triumphantly reenacted his casual hand gesture, shrug, and the bemused expression that accompanied the physician's words. That attitude, instantly conveyed by their interpersonal neurobiological attunement,¹ was no longer just his: it had become hers. She had immediately felt herself transformed from a disdained miscreant to a person with a manageable problem. She also recalled that what mainly repaired her self-image was incorporating her physician's response as her own. This deftly performed interpersonal clinical procedure, which entailed one phrase, a few expressive gestures, and medical information, revitalized her psychobiology.²

Could I do anything similar with the man slumped in a chair before me? My efforts began by recognizing in him a frightened child who had lost the safety of his security blanket and was resigned to the conclusion that no comfort could be found in personal relationships. Tom needed more than the passive comfort of a monologue with Rachel; he needed an empathic dialogue that connected him to another person.

But I didn't feel able to provide the empathic connection that Tom needed. As I struggled to overcome my emotional detachment, I came to realize that my unwanted but unavoidable feeling of being disconnected while listening attentively to Tom opened the door to its solution. My feelings of detachment were distressing but authentic evidence of my attunement with Tom's inner experience. Emotions in an attuned relationship are more contagious than viruses, their vectors are words and gestures, and their effects are immediate because there is no incubation period. I had "caught" Tom's feeling of emotional detachment; I had unwillingly incorporated a piece of his mind. This informing recognition encouraged me to use our authentic connection to disarm Tom's defensiveness by earnestly disclosing, "I'm beginning to

Corresponding Author: Herbert M. Adler, MD, PhD (herbert.adler187@gmail.com).

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understand how hard it is to be you." His downcast eyes darted for an instant to meet mine, automatically checking the size of my pupils for empathic accuracy.³ Confirmed, he nodded gratefully, and his eyes welled up. So did mine, as we sat silently sharing a mutually affirming moment of being connected to the humanity in each other. This validated connection opened Tom to a safe, reciprocally attuning responsiveness with my mind. Together, we discovered long-buried land mines when I responded to some of his answers with an inviting "What else?" followed by a patient, expectant silence. Our dialogue cautiously converged toward an increasingly accurate empathic engagement that gradually transformed our conversation into a co-created interpersonal neurobiologic attunement⁴ that I used to provide Tom with a more functional way to think and feel about himself and his world—what I have condensed as "giving him a piece of my mind—actually."

Evidence suggests that this interpersonal neurobiologic treatment underlies both the ancient healing practice of "bearing witness" and the modern medical practice of empathically accompanying patients through their history of the present illness.⁵ Patients experience this as a feeling of being *understood* and a feeling of *safety* that induce trust, reduce stress, and activate the patient's self-reparative biologic processes, also referred to as positive placebo effects.

It is widely recognized that accurate empathy improves outcome through behavioral mediators such as diagnostic accuracy and adherence. This essay calls attention to the widely ignored interpersonal neurobiologic mediators of accurate empathy that make a direct biologic contribution to outcome.¹

If this seems like an unsupported assertion, consider the following:

- Interpersonal empathy is co-constructed by mutual responses that activate similar cortical and subcortical neural circuits between clinicians and patients.⁶

- *Accurate* empathy reflects and creates a synchronizing interpersonal neurobiologic attunement.⁷
- Functional magnetic resonance imaging has demonstrated that when verbal communication is *accurately* comprehended in speaker-listener dyads, it is correlated with an emergent neural coupling of spatiotemporal brain activity.⁸
- Patients in pain who are treated by an empathic physician experience less pain.⁹

The recognition that compassionate, empathic clinicians actually provide patients with a beneficial piece of their mind reflects recent advances in interpersonal neurobiology¹⁰ and supports labeling such a clinical encounter as a skilled interpersonal biologic treatment. But regardless of whether the clinical outcome of interpersonal neurobiology is positive or negative, it is an unavoidable component of daily practice. For better or worse, the clinical encounter compels us to give patients a piece of our mind because it brings us face-to-face with people who suffer (that is the etymology of "patient") and need our compassionate care. An unmet need will not be experienced as neutral, but as dismissive, or worse—a response that will diminish the effectiveness of treatment as well as the satisfaction clinicians derive from practice.

About a year after my last meeting with Tom, I heard from his primary care physician that Tom's wife had reported that he was emotionally more accessible to his family. When his physician asked Tom what he had gotten from our sessions, Tom said he was more comfortable with people, and he sometimes thinks, What would Adler say?

Tom's life is better because our empathic engagement permitted me to give him a piece of my mind that he is still using. And my life is better because of what Tom taught me about patient care.

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