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The sociology of emotions in the psychiatric practice: how residents in psychiatry learn to dislike patients with borderline personality disorder

Abstract

According to the literature, the most disliked patient subgroup is the one diagnosed with borderline personality disorder (BPD). The current study aimed to explore how psychiatry residents' emotions toward patients with BPD are learned during biomedical training and how their emotional socialization within an inpatient psychiatric ward contributes to the formation of a professional, authoritative identity, while also strengthening ingroup members' bonds and reinforcing the asymmetric relationship in terms of power between psychiatrists and hospitalized patients. This article reports on the findings coming from a combination of ethnographic field research in a psychiatric ward of a general hospital and in-depth interviews with eight residents in psychiatry, regarding their emotions toward patients with BPD. The transcriptions of the interviews and the descriptions from field notes were analyzed by thematic analysis. One of the main themes revealed during the analysis of the data is called 'socialized emotions' and consisted of three subthemes: a) representational emotions, b) experienced emotions, and c) performed emotions. The three subthemes could correspond to three phases of the process of emotional socialization of the residents in psychiatry regarding patients with BPD: a) formation of emotionalized schemes, b) lived experiences, and c) clinical practices. The sociological understanding of how emotional aspects of the professional identity of the doctor are taught during the residencies is of particular interest. Both clinical and research implications are discussed.

Keywords: sociology of emotions, emotional socialization, residents in psychiatry, borderline personality disorder

Volume 6 Issue 5 - 2022

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Received: October 12, 2022 | **Published:** October 26, 2022

Introduction

Early works in medical sociology were interested in the social construction of emotions in the medical context, both in medical education and in clinical practice.[1-3] However, the sociologists' interest in the study of doctors' emotions waned until recently, as there seems to be a resurgence of sociological interest in the subject.[4,5]

Becker and his colleagues,[1] in the pioneer book titled *Boys in White*, described how medical school students learned to 'play their role' as doctors and how they collectively made meaning of their experiences, some of them related to emotional socialization. Specifically, among others, medical students learned to adopt cynical and depersonalizing attitudes toward certain patients. Likewise, Fox described the medical education as a training process for uncertainty[6] and detachment concern.[2] While training for uncertainty involves the medical student's own emotions, detached concern includes both the medical student's and the patient's emotions, as the medical student must strike a balance between the disconnection from emotions (especially when faced with the pain of the other) and the maintenance of a satisfactory level of concern for their patient. In addition, Hafferty[7,8] showed that medical students learned how to manage their emotions following specific 'unspoken rules' enacted by the medical culture. Namely, they learned to detach their negative emotions (fear, anxiety, and disgust) from their practice, as that is what was demanded from a doctor. As Smith and Kleinman note,[3(p56)] "We associate authority in this society with an unemotional persona, affective neutrality reinforces professionals' power" and medical students learn throughout their formal medical education that they should not talk about their emotions. The two scholars remarked, during their participant observation, that students made jokes or attributed blame to the patients, as mechanisms of emotion regulation (reducing the anxiety). It is about an emotional socialization leading to patients' dehumanization and objectification. We could not, however, omit the pioneer work of Hochschild on 'emotional labor',[9] a concept that encompasses how emotions are linked to workplace behaviors and expectations on employees. In the medical field, the terms 'surface acting' and 'deep acting' are used for the emotional behavior of doctors. Surface acting refers to the performed behavior of the doctor perceived by the patients as empathetic, while the doctor may not experience the same emotions, and deep acting refers to both the performance of these actions and the self-reflection on one's own emotional reactions.[10] As the prior studies were carried out in the mid-1990s, medical education has since undergone radical transformations, Underman and Hirshfield argued that sociologists must revise emotional socialization within medical education both in micro-, meso-, and macro-level.[5]

There is a medical specialty in which emotions are at the center of study and clinical work; we are referring to psychiatry. Psychiatry residents learn and practice to read the emotions of patients[11] and they are trained to help people regulate their emotions through therapeutic techniques. Yakeley et al[12(p99)] remark that "The student of psychiatry may not be so exposed to the visible devastations of bodily illness, but to less tangible, and hence perhaps paradoxically, more anxiety-provoking, psychic disturbances". How do residents in psychiatry undergo emotional socialization? How are their emotions toward their patients fabricated in the context of their biomedical training? Are they able to express their emotions and elaborate the blind spots of their counter-attitudes toward 'difficult' patients?

We will attempt to answer these questions using as an example the diagnostic category of borderline personality disorder (BPD). In 1988, Lewis and Appleby[13] carried out an experimental vignette study, where they explored psychiatrists' emotional attitudes toward patients diagnosed with a personality disorder. In their article titled *Personality Disorder: The Patients Psychiatrist Dislike*, the researchers note psychiatrists formed pejorative, judgmental, and rejecting attitudes toward this patient group. Almost 30 years later, Chartonas et al[14] published an article titled *Personality disorder: still the patients psychiatrists dislike?*, based on the results of their study, where they used the Lewis and Appleby's questionnaire. The findings of their study confirm Lewis and Appleby's research findings; patients labeled as personality disordered are still the patients psychiatrists dislike.

According to the literature, the most disliked patient subgroup is the one diagnosed with BPD. Although patients with BPD are emerging as important and systematic users of mental health services, there is probably no other patient group in psychiatry that is more associated with stereotypes, prejudice, and stigma.[15] 'Non-compliant', 'difficult', 'conflicting', 'manipulative' are some of the negative evaluations these patients receive from the mental health professionals.[16–19] They tend to be seen more as 'bad', rather than 'ill',[20,21] and their behavior is portrayed as morally transgressive, leading to negative emotions on the part of mental health professionals. The most common negative emotions identified among mental health professionals are anxiety, anger, fear, and disgust.[22] Papathanasiou and Stylianidis[23] suggested disgust was associated with stronger negative attitudes from mental health professionals toward patients with BPD.

Below we will try to demonstrate how psychiatry residents' emotions toward patients with BPD are learned during the biomedical training and how their emotional socialization, including a broad range of social -verbal and embodied- practices and 'rituals' in the context of an inpatient psychiatric ward, contributes to the formation of the psychiatrist's professional identity of authority and constitutes an element of strengthening the bonds of ingroup members against outgroup members, reinforcing the asymmetric relationship in terms of power between the psychiatrists and the hospitalized patients.

Material and methods

In the context of the postdoctoral research project "Providing mental healthcare services to patients with borderline personality disorder/Creation of an Inclusion Model of Clinical Intervention (BPD-IMoCI)", a mixed methods research package was carried out. Specifically, ethnographic work in a psychiatric ward, in-depth interviews with clinicians and patients with BPD, focus groups with mental health nurses, and a survey with mental health professionals, were carried out. The study was approved by the Research Ethics Committee of the Panteion University.

The primary aim of this research was to uncover the emotional, relational, and contextual factors that influence the interactions between the clinicians and the patients with BPD. Regarding the interviews with the experts, 40 clinicians (20 psychiatrists and residents in psychiatry and 20 clinical psychologists) were interviewed. The interviews were based on an interview guide composed by the researchers for the purposes of this research. The guide explored the following aspects: a) perceptions, ideas, and beliefs, b) feelings and emotions, and c) lived experiences and therapeutic practices. In parallel, an ethnographic study (participatory observation) was carried out in the psychiatric ward of a General University Hospital in Attica region. For five (5) months (October 2017-February 2018) the first author participated in the daily activities of the psychiatric ward (medical visits, medical staff meetings, informal discussions between the staff in the hospital corridors or in the staff offices, etc.) and informally interviewed the medical and paramedical staff. The transcriptions from the interviews (formal and informal) and the descriptions from the field notes were analyzed by thematic analysis. To ensure validity of the analysis, the second author participated as external evaluator of the qualitative analysis process.

This article reports on the findings coming from a combination of ethnographic field research (field notes and informal conversations) in a psychiatric ward and in-depth interviews with eight (8) residents in psychiatry regarding their emotions toward patients with BPD. We will try to demonstrate that psychiatrists' emotions toward patients with BDP are not ephemeral and intrapersonal experiences which are limited to encounters with these patients, but they are produced during an interpersonal process within a specific context based on professional values and help the new clinicians make sense of their experiences in the ambiguous psychiatric reality. The quotes presented are selected on the basis of their representativeness or/and their relevance. Each quote is accompanied by a code (Resident in Psychiatry/RP + number) to distinguish the participant/informant.

Results

One of the main themes revealed during the analysis of the data is called 'socialized emotions', as it refers to the genesis and the use of emotions toward patients with BPD, in the context of the psychiatry residency training. The adjective 'socialized' demonstrates that the emotions are not inherent, but they are learned through the socialization process; they have social use and give people an identity and an orientation in the complex social world. By having an 'emotional template' toward specific situations, persons and things, people could feel less confused regarding the 'unfamiliar'.

The theme 'socialized emotions' consisted of three subthemes:

a) representational emotions,

b) experienced emotions, and

c) performed emotions.

The three subthemes could correspond to three distinct phases of the process of emotional socialization of the residents in psychiatry regarding patients with BPD:

a) formation of emotionalized schemes,

b) lived experiences, and

c) clinical practices.

Representational emotions: the phase of the emotionalized schemes' formation

For residents in psychiatry, first contact with BPD is established through the classification systems of psychiatric disorders, the DSM-V and ICD-11, and generally, through psychiatric bibliography. Initially, residents in psychiatry learn about the disorder through the description of its symptomatology. During this phase, the schema of 'BPD' is created as a sum of clinical symptoms. 'BPD' is therefore understood as 'fluctuating self-image', 'impulsivity', 'emotional instability', 'chronic feelings of emptiness', etc. It becomes an intellectual, non-sentimental, process, as the psychiatric trainee gathers information about a subject (the nosological entity) to which they do not 'relate'. It could be considered an emotionless phase.

RP1: When you read about this disease in books, it doesn't move you. It's like the rest of them. Just another disorder of the psyche.

Citation: Papathanasiou C, Stylianidis S. The sociology of emotions in the psychiatric practice: how residents in psychiatry learn to dislike patients with borderline personality disorder. *Sociol Int J.* 2022;6(5):301–308. DOI: 10.15406/sij.2022.06.00303

Furthermore, the resident in psychiatry enriches their knowledge about the psychiatric disorder through the narratives of the older, more experienced, and the hierarchically senior psychiatrists who are perceived as mentors. Through these often-detailed narratives of experiences, the potential psychiatrist becomes acquainted with the patient diagnosed with BPD and their first emotions about them are born through a mediating relationship. At this stage, the personification of the nosological entity happens, during which the symptom becomes a personal trait, which in turn becomes a subject of criticism. This is how moral evaluations permeate BPD and how value-neutral BPD transforms into the 'evil', 'manipulative', 'vicious', 'immoral'[i] patient with BPD, as a protagonist in a story that usually includes details that bring forth feelings of 'contempt'. So, the emotionally neutral symptom concerning 'frantic efforts to avoid real or imagined abandonment', becomes a woman maintaining an affair with a married man, who makes sure they will be caught in the act by the man's wife, thus ensuring the end of the marriage and 'the wrecking of their home'. Or the symptom of 'fluctuating self-image', is understood through the story of a young male bodybuilder who decides to receive breast implants and solicits themselves as transgender, having sexual relations with a large number of unknown males.[ii] Undoubtedly, the moral evaluations that accompany the narrations about patients with BPD form the root causes of the negative emotions that affect the psychiatry residents' attitudes toward these patients.

RP2: I can't say the stories I heard did not affect me emotionally. I was affected and I was affected very negatively. I couldn't imagine what kind of person would do something like that (immoral).

During this phase however, one can find the element of curiosity, but also that of doubt. In their own narrations, the residents in psychiatry, make use of phrases like 'I heard', 'I was told', as they do not have the personal experience to give their own insights. This creates a fracture of doubt and the curiosity to determine themselves whether these aforementioned stories about patients with BPD will be substantiated by their own experience or disproven.

RP2: So, with a psychotic I know what to expect, but with borderline… it's… I don't know what to expect. That's when I think that anything is to be expected. As a feeling… I get… curious, ehm, the curiosity to learn. On the other hand, since I have no experience yet, that's when I want to see if everything they say is true.

Experienced emotions: the phase of the lived experiences

Since the resident psychiatrists learned the symptoms of BPD through psychiatric textbooks and heard stories of patients from experienced psychiatrists, they subsequently started gaining personal experience by interacting with these patients within a psychiatric setting. However, they entered the relationship not as 'tabula rasa', but having already formed certain representations and emotions (emotionalized schemes). Therefore, their experiences were perceived through a prism of emotions that had been created by the narratives of senior psychiatrists (bias prism). As one resident in psychiatry mentioned, *"I had created an image and feelings for these patients before I even met my first borderline patient"* (RP3).

Additionally, both the education and training they received and the context in which they were practicing psychiatry, did not provide the new psychiatrists with the skills and the appropriate means to be able to respond adequately to the individual needs of patients with a personality disorder, especially those with BPD. The constant negative experiences confirmed the narratives of the experienced psychiatrists and justified the negative emotions of the residents, but also strengthened the cohesion of the therapeutic group, which was faced with a common danger.

RP4: We do not provide psychotherapy here. I think they (the patients with BPD) are more in need of psychotherapy. But neither are we trained in any psychotherapeutic method during our residency. Here (in the psychiatric ward) we provide hospitalization and drug treatment. It seems that's not enough and that is why there are so many problems with these people when they are hospitalized.

RP3: I began to see in practice what I had heard of as stories for so long. That is when I understood why there is so much anger toward patients with BPD from the system. I have felt this anger as well.

RP5: I have and we have, the whole group, difficult patients, serious incidents have occurred. One cut themselves in the carotid during the interview, broke everything in the room and threw it all on the therapist's head. Such experiences, clearly, unite the members of the group, because only together as a group can such difficult incidents be faced.

But what would happen if clinical work with a patient with BPD was a positive experience? In the event that a resident in psychiatry would differentiate themselves and share a positive experience, the rest of the members of the therapeutic group would attempt to discredit the statement, by attributing the disagreement/difference to the patient's ability to cause splitting and creating conflict within the therapeutic group. In relation to this, a resident in psychiatry mentioned the following:

RP6: I recall a female patient with BPD, with whom I got along well. I managed to earn her trust and we started building a therapeutic relationship. I couldn't understand why my colleagues, especially the seniors, started a war against me. Until the professor took over my case, accusing me of causing a disturbance in the group and of not being ready to manage such patients yet. In fact, he characteristically told me that I fell into this girl's trap, who managed, through me, to divide the group.

The residents in psychiatry often felt the need to share their experiences and their emotions about these patients, with the more experienced psychiatrists. It was a way for them to reduce the anxiety that was created by their self-doubt, that they themselves did not do something right. Which consequently led to the erosion of a sense of professional competence and the development of a sense of personal failure. The following excerpts illustrate how the sharing of the experienced emotions constitutes a way of reassurance and self-restoration.

RP3: You wonder "What am I doing wrong?", you look for it "What do I have, what do I not have" and then you decide that you are gonna deal with it, as the others have. /…/ I grappled with it, that is, I was talking to a senior fellow who had taken the patient on in an advisory role. And I asked, "Am I doing something wrong?". And it bugged me and saddened me at the same time. It was something that affected me. I talked about it. And then I realized that, that's just how it is. It would be better if I didn't struggle with it. That this is just how it is and this is what I should expect.

However, sharing emotions, especially negative ones, was not something that was encouraged amongst psychiatrists. On the contrary, it was feared that by talking about their negative emotions, the residents in psychiatry risked being labeled as 'patients'.

RP6: A psychiatrist told me the other day, as I was talking to him about some (emotional) difficulties I have here, that it would be said

that I have psychological problems, that I am mentally ill, this and that… this was said by an academic psychiatrist!

The emotions of the residents in psychiatry were not only affecting the therapeutic relationship but were also influencing their judgment during the initial psychiatric assessment. Specifically, the emotions felt during the first encounter guided them regarding the diagnosis. In the following excerpt, we can clearly notice how the emotions of the psychiatrist in training turn into an element of bias, leading to a prejudiced diagnostic process, as it acts as a key criterion in the evaluation of the patient's personality.

RP7: Of pivotal importance. Meaning, that if the therapist or doctor feels bad, feels angry, feels some sort of discomfort, they have associated these feelings multiple times with the thought that this patient has something, they are characterological. They might be 'borderline', they associate these a lot.

R: So, their own feelings actually function as diagnostic criteria?

RP7: Yes, yes, yes.

Performed emotions: the phase of the clinical practices

Faced with the risk of emotional contagion (*"Somehow this person [with BPD] will transfer his impulsivity and anxiety to the other person [the mental health professional]."* RP2), the residents in psychiatry, who participated in this research, applied two basic coping strategies:

a) emotional distancing, and

b) dehumanization.

The first strategy was also used as a therapeutic intervention (demarcation of unbounded individuals), while the second strategy (the core of the asylum-culture) contributed to the strengthening of intragroup bonds (inside jokes as a common thread amongst the members of a group).

Furthermore, the residents in psychiatry 'conformed' to the way patients with BPD had been dealt with by the senior psychiatrists and those occupying a high position in the dominance hierarchy, in order to receive positive evaluations. Thus, they treated these patients with the two strategies that were described above, which they had witnessed being used as accepted practices within this setting.

RP2: You see (name of a professor) doing it, and (name of another professor) doing it as well. So, if they are doing it like that, it must mean it works. /… / As we are still young, we must follow our seniors, especially the professors. After all, they are the ones that evaluate whether we are up to the job or not.

As far as emotional responses are concerned, the primary negative emotions evoked by BPD patients, for the resident psychiatrists were fear, anxiety, anger, and disgust. The first two emotions could be said to focus on-self, while the other two on-patient. The expression of such aggressive emotions was encouraged in a variety of ways (e.g., with jokes). However, emotions such as fear and anxiety, which reflect the vulnerability of the residents in psychiatry, were not encouraged to be shared or communicated. During the participatory observation in the residents' office, feelings of anger that derived from the patients were often expressed by the trainees, but they never openly talked about the fear[iii] they felt when interacting with them, though it was indirectly captured in interviews as worry or/and insecurity[iv] (but not as fear).

RP2: I'm not afraid of them doing something to me, I'm worried that I may not be doing something right. As I haven't been trained yet, that's where I feel a little insecure.

The following dialogue between the researcher and a resident in psychiatry is rather revealing. The resident in psychiatry initially stated he didn't feel fear while interacting with BPD patients. Later however in the interview, he revealed that he had felt fear, but he had not shared this feeling with anybody, as it is not part of the culture of the clinic to discuss such matters. Even though, as has already been stated, the sharing of emotions was something the residents found particularly helpful.

RP1: As said (by other psychiatrists), sometimes it is as if we should feel threatened by this. Personally, I haven't felt threatened. On the contrary, I recall one (patient), who everyone said was probably borderline, we chatted and had a lot of one on ones…I didn't feel threatened, I actually felt… that because I'm enabling her to think more about herself, more than she should, that I… maybe I'm…

R: You're maybe what?

RP1: Maybe… maybe I will become the reason she does something bad… I had to think twice before asking questions and on how to phrase them.

R: And how did you deal with that?

RP1: My fear?

R: (small pause) Yes.

RP1: I can't say I expressed it. I kept it for me.

R: Did you discuss it with your colleagues and, mainly, your seniors?

RP1: No, no. With no-one…

R: Why?

RP1: We don't usually talk about these things in the ward.

Regarding emotional distancing, as one of the coping strategies, it was particularly facilitated by the framework of practice in biomedical psychiatry. Since hospitalization in the psychiatric ward of a general hospital is short-term and the patient's care is exclusively focused on treating symptoms through medication, psychiatrists did not come in close contact with the patients (as they would e.g., in community organizations where psychotherapeutic methods are applied) and therefore it was easy for them to treat the patient as just another case. Additionally, the biomedical model promoted the process of intellectualization, which focuses on the technical aspects of medical care, such as pharmacotherapy or other techniques,[v] and paves the way toward distancing oneself from the stress of patient care.

RP4: We find ourselves in the ward of a hospital, a psychiatric ward, where essentially, there is no intention of treating someone with a personality disorder. We usually hospitalize someone to treat depression, some anxiety disorder, meaning, some acute manifestation of a mental illness. So, usually, we encounter a personality disorder as a comorbidity. No case would be hospitalized because they have a personality disorder. This could occur after a suicide attempt of course, in which the attempt may not presuppose depression. In that way. So, the boundaries set, have to do with the ward's rules, which try to provide a framework for the hospitalization. A framework, that is, which acts as a reinforcing agent of pharmacotherapy, which is the main resource we have available of dealing with a patient.

Additionally, in a hospital environment in which a pure biomedical model is applied, that in turn sets a therapeutic goal of healing through medication, the poor response of these patients to pharmacological

treatment (treatment resistance), often led to the residents in psychiatry feeling frustrated and using emotional distancing as a coping strategy for said feeling. As a resident in psychiatry characteristically states:

RP7: Because one surely feels frustrated when they can't treat this patient, right? So, it could be an avoidance mechanism, keeping distance keeps the peace, I'm a biomedical psychiatrist and I know can't help you.

An extreme form of emotional distancing was the use of the pejorative term 'borderi' in communication between psychiatrists, both professionals and trainees. The term 'borderi' is an 'ingroup' term that was used derogatorily for BPD patients in the hallways, wards, and the psychiatrists' offices. It is in the neutral gender (which in Greek is used exclusively for objects and never for people) indicating the dehumanization of these patients, which contributed to the exoneration of the negative emotions (and attitudes) of the psychiatrists toward them. It also acts as a common code of communication between ingroup members (while not being understood by outgroup members), reinforcing their shared identity.

RP3: The term 'borderi'… (laughs) Alright, it will either be used as a joke between colleagues, or it will be used when the patient you have in front of you occasionally makes the therapists and doctors angry. And this anger creates the context in which stigmatizing answers could be given, expressing my anger in that way as well.

Likewise, case narrations starring patients with BPD were often presented in such a way that they resembled jokes, causing laughter for the residents in psychiatry, but awkwardness for someone outside the ingroup (e.g., the ethnographer). Humor and laughter constituted coping strategies, contributing to the strengthening of the group's cohesion, as members recognized the stressful nature of their work and contributed to a decrease in both intrapersonal distress and interpersonal (relational) distress (staff disputes).

RP4: By having a laugh. I think it's a way of defending the setting. If we could call it that. To cast away the difficulty and discharge some of the group's emotions.

Sometimes the jokes were directed at the patients themselves. In such cases, the jokes were offensive toward the patients and had a negative impact on the therapeutic interaction, leading most of the time to drop-outs. The quotation below illustrates how offensive humor could lead to a drop-out.

RP8: Concerning a woman with borderline, who had attempted suicide in front of her children /…/ when at some point she said to me, "I don't know if I want to live, die, etc.", I asked "What do you mean, do you want to die?" "Yes!", she answered "I don't want to live. I'm just wondering whether the suicide attempt won't be successful" and at that point, of course, I said to her "Oh, I can tell you the way!", I told her, "You will cut your veins, you will jump from the 5th floor and also take the pills to make the attempt successful!". That's when she said, "Are you mocking me?", I replied "No! I'm not mocking you. What you're telling me, this, that's what I'm reflecting". Of course, she left, but I do not know if she's alive right now.

Non-emotional identification with these patients made it harder to develop and express empathy. The unordinary way in which the patients expressed their emotions (e.g., with dramatisation) lead to the residents in psychiatry even questioning them.

RP3: Often when it comes to patients who have a personality disorder there is difficulty in cultivating this empathy. It is difficult. Maybe it's different, I should put it in another way. They do not manage to convince you that the pain they describe verbally and behaviorally is actually experienced. And why aren't they convincing? Because you don't feel it. Whereas in a depressed (patient), heavily depressed, the emotion flows outs (is expressed) a little differently.

The experience of negative emotions (anger and disgust) by psychiatrists and their inability to connect emotionally with these patients, could take the form of avoidant behaviors, but also punitive behaviors. Specifically, anger, under a therapeutic guise (e.g., by setting boundaries), was expressed through avoiding contact, strictness, but also the utterance of threats.

RP3: To see them last during the group visit, because there might be an unconscious tendency to postpone, to not come in contact with them until the examination, interview or discussion, to be more intense in your speech while talking to them. To be stricter in this particular relationship, compared to the rest of the patients. Or a tendency to respond more intensely or maybe strictly, in an effort to set boundaries on the therapist's or doctor's side. Sometimes something similar to a threat. If you do not cooperate or if you don't do 'this', you will be asked to leave, you'll be discharged. Something like that.

Discussion

The findings of this study, coming from a combination of ethnographic field research and in-depth interviews with residents in psychiatry within a psychiatric ward of a general hospital, describe the emotional socialization of residents in psychiatry during their training. Using the group of patients diagnosed with BPD as a means, psychiatry residents' emotions were explored. More specifically, through the analysis of the discourse of residents in psychiatry, we tried to conceptualize the emotional socialization process within the psychiatric practice.

Emotional socialization and psychiatry residency

A principal finding is that a main learning process of the training of the residents in psychiatry concerns emotions. The residents in psychiatry learn how to experience and how to express their emotions toward the patients. This emotional learning process takes place in three phases. In the first phase, the resident in psychiatry encounters the learning object, which is the diagnostic label 'BPD'. It is a stage where more cognitive processes take place rather than emotional ones. However, in this phase the genesis of emotions toward patients with BPD takes place through the narratives that have been shared with them by the experienced senior psychiatrists. At the same time, curiosity and doubt arise about all these narratives.

During the second phase, the residents encounter the patients. Their negative emotions -mediated by the professional narratives and filtered through a prism of bias- are in accordance with the emotions that senior psychiatrists had shared with them and are consolidated. At the same time, the residents in psychiatry express their need to share their emotions with the experienced colleagues, in order to obtain support to deal with the frustration and other emotional challenges that occurred during their encounter with patients with BPD. This kind of mutual sharing among the members of the group (new and old) strengthens their bonds and works protectively in terms of their professional identity.

During the third phase, a kind of emotional labor takes place as the residents in psychiatry learn how to perform their emotions during the encounter with the patients with BPD. Applying emotional distance or even apathy through avoidant behaviors and dehumanization through offensive humor, the residents in psychiatry are trying to cope with

their negative emotions. These two coping strategies are supported by the context (focusing on treatment and not on recovery) and the nature of the biomedical work (focusing on the body/brain dysfunction as if it's mechanical and not applying a holistic approach). However, clinicians' emotions do not only serve the separation of the ingroup members from those of the outgroup, but they are used as criteria for the diagnosis of the BPD.

Influencing factors on the emotional socialization

We would like to focus on some factors revealed from the analysis that seem to influence the learning process of emotions toward patients with BPD by future psychiatrists: dominance hierarchy and conformity, emotional distancing, and aberrant humor.

According to the Neo-Weberian approach, regarding professional dominance, experienced psychiatrists exercise authority over their new colleagues. The power enjoyed by someone who has risen to the upper levels of the hierarchical pyramid is secured through 'compliance' (as a sign of respect and recognition, of prestige and authority) to the seniors, as new professionals -such as residents in psychiatry- depend on the seniors for their professional advancement.[24]

Thus, we saw that the residents in psychiatry did not differ emotionally from their senior colleagues toward patients with BPD. They adopted coping strategies that were used by those who occupied a high position in the dominance hierarchy of the psychiatric ward and were based on the suppression of emotions (denial, emotional distancing, detachment)[vi] and on the objectification of the subject. As many scholars note, although the official curriculum of the medical schools highlights the importance of empathy, the so-called 'hidden curriculum' conveys the emotional repression,[25] which could lead to the dehumanization and the objectification of patients.[26]

Both medical students and new doctors are constantly encouraged to keep their emotions secret. Denial is a common but primitive and dysfunctional defense mechanism which is often used by doctors and other health professionals, whereby strong emotions are presented as foreign to the self.[27] Thus, emotions that arise in health professionals from their contact with patients are suppressed and/or ignored. However, in the case of residents in psychiatry we saw that while emotions that showed weakness, such as fear and anxiety, were not expressed, both anger and disgust constituted unrepressed emotions. Anger was often expressed in punitive attitudes and behaviors, shattering the therapeutic relationship, and leading to withdrawal ruptures. The association between disgust and negative attitudes of mental health professionals toward patients with BPD was captured in another study.[23] Apathy has also been used as a way of coping with the frustrations of the nurses who care for these patients.[28]

Jokes are also a means of emotional distancing. In the study of Sayre[29(p681)] regarding medical humor used by the psychiatric unit staff, two major categories of joking emerged: whimsical and sarcastic humor. During the ethnographic research in the psychiatric ward, the sarcastic humor was observed and even in its most offensive form, that is gallows humor, defined as "joking of a grotesque, exaggerated, and extravagant nature, with a macabre 'eye on death'".[30] In this form of aberrant humor, "staff did not attempt to use sarcasm to mask their hostility to patients, but openly expressed their negative feelings",[29(p681)] as the resident in psychiatry who presented to her patient efficient ways of committing suicide. According to the literature, aberrant humor by psychiatric staff is used to deal with 'difficult populations'[31(p71)] and to cope with challenging behaviors, such as self-harm behaviors,[32] and behaviors that sabotage treatment, such as the inability to form a therapeutic alliance[33] and a lack of response to medication.[34] Patients with BPD present all the behavioral characteristics mentioned above. A typical example is the use of the pejorative label 'borderi' to describe the person who has been diagnosed with BPD, which demonstrates the dehumanization of these patients through their objectification.[35] Both the shared jokes and the pejorative term 'borderi' among the psychiatric team serve to separate psychiatrists (ingroup) from patients (outgroup) and to the strengthen the bonds between the ingroup members, as a joke with a coworker can build a sense of connection. However, this kind of humor reflects a degree of apathy. Those who share stories and those who are exposed to such stories and laugh at the often-tragic circumstances of patients (including self-injuries and suicide attempts), will be affected to some degree by the created atmosphere and develop a kind of immunity to human suffering.[36]

Clinical implications

Patients with BPD are in constant search of psychiatric care,[37] representing 36-67% of patients in psychiatric wards.[18] However, a significant number of studies have suggested that BPD is one of the most stigmatized psychiatric disorders among mental health professionals.[38–40] The current study recorded the negative emotional reactions of a professional group of residents in psychiatry toward patients with BPD as well. This study demonstrated that the negative reactions toward these patients were acquired through a social learning process. Initially, the emotions were formed by the narratives of the experienced staff and later were solidified by the negative experiences during biopsychiatric practices.

Both the policy makers and the psychiatrists must reflect on the efficacy of the provided services and the therapeutic protocols. The evidence indicates that the efficacy of pharmacotherapies for the treatment of BPD is limited.[41] On the other hand, we must reflect on the dropouts and the 'the revolving door syndrome', exploring not the personality traits of these patients as causes, but the role of clinicians' negative emotional reactions toward them. How is it possible for the therapy to work (independently, the therapeutic approach) if the therapists enter the meeting with such stereotypes, prejudices, defense mechanisms, and even punitive practices? We must break the vicious circle of maltreatment of these patients. It is important to pass from a healing point of view to a recovery model.[28] Only through a holistic recovery approach could we expect positive therapeutic experiences for both the patients and the psychiatric unit staff. Good practices and stories of recovery must be shared among the therapists, replacing the clinical failures and the 'horror stories' which accompany these patients within the mental health system. Senior and academic psychiatrists who act as mentors can play a key role in this. If negative narratives about BPD continue to dominate, patients with BPD will remain the patients that psychiatrists dislike the most.

Psychiatry residency training does not prepare future psychiatrists to deal with emotions in psychiatric practice, which can lead to emotional distancing and the adoption of avoidant behaviors toward patients with BPD. Emotions must be put at the core of the psychiatry residency programs. The psychiatric wards must be transformed to a safe place where people, both patients and staff, could express and reflect on their emotions. Through academic courses, seminars, workshops, and clinical supervision sessions the residents in psychiatry must work on their emotions, reflecting on their own emotional reactions and learning techniques and skills for empathy and emotion regulation.

Research implications

The current study is a qualitative one. Based on its findings an explanatory model of the emotional socialization of the residents in

psychiatry was designed. It is necessary for this model to be assessed in another context and regarding another patient group, to explore eventual similarities and differences. Also, quantitative methods could provide us with more data regarding the associations between emotional socialization and sociodemographic factors.

Although emotions play a primordial role in medicine (health behaviors, decision-making process, medication adherence, therapeutic alliance, recovery, etc.) and despite major shifts in both medical education and medical services provision, there is a lack of interest from the part of medical sociologists about emotions.[5] As Francis[42(p591)] states, "emotion is the connecting point between the biological and the social. As such, emotion is the touchstone for overcoming the rationalist dualism of Western thought, in which self and society are viewed as irreducibly separate and biology is unconnected to social structure". It is necessary for medical sociology to rediscover its critical role and to contribute to the development of a new mental health intervention paradigm that emphasizes the biopsychosocial model.

We could be moving toward a new branch of sociology, called the sociology of emotions in medicine, as a common area of research and intervention of the sociology of emotions and medical sociology, examining the role of emotions both as product of, and influential factor on, social interactions in the therapeutic relationship and medical practices (such as diagnosis and treatment). Medical education is a field of particular interest for sociological research, mainly regarding the medical students' and medical residents' emotional labor. More empirical work is needed to understand how emotional aspects of the professional identity of doctors are taught during their graduate studies until their residency. The differences between the hidden curricula of the diverse medical specializations are of particular interest.

Funding

This postdoctoral study was realized by means of a scholarship provided by the State Scholarships Foundation–IKY, funded by the Act for "Post doctoral researchers support" within the resources provided by the EP "Human Resources Development, Education and Lifelong Learning" with priority axes 6, 8, and 9. It is co-founded by the European Commission Fund and the Greek State.

Acknowledgments

The authors would like to thank Alex Herling for proofreading the manuscript.

Conflicts of interest

The authors declare that they have no direct or indirect conflicts.

Endnotes

i. The characterizations come from the participants themselves.

ii. The examples were given by the participants themselves.

iii. Fear of causing an 'accident' in the psychiatric ward, like e.g., a suicide and the resulting criminal repercussions for the attending psychiatric trainee.

iv. Concern involves a sense of caring for the patient and is therefore a trait of a 'good' therapist, unlike fear which indicates weakness.

v. In the psychiatric ward where participatory observation took place, innovative therapeutic techniques, such as phototherapy, were also utilized.

vi. According to Hochschild,[35] suppression of emotion is one of the two broad types of emotion work

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Citation: Papathanasiou C, Stylianidis S. The sociology of emotions in the psychiatric practice: how residents in psychiatry learn to dislike patients with borderline personality disorder. *Sociol Int J.* 2022;6(5):301–308. DOI: 10.15406/sij.2022.06.00303