

Individual risk factors for physician boundary violations: the role of attachment style, childhood trauma and maladaptive beliefs



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ABSTRACT

Objective: The assessment and remediation of boundary-challenged health care professionals is enhanced through examination of individual risk factors. We assessed three such factors – attachment style, childhood trauma and maladaptive beliefs – in 100 attendees (mostly physicians) of a continuing medical education (CME) professional boundaries course. We propose a theoretical model that draws a causal arc from childhood maltreatment through insecure attachment and maladaptive beliefs to elevated risk for boundary violations.

Methods: We administered the Experiences in Close Relationships Questionnaire Revised (ECR-R), Childhood Trauma Questionnaire (CTQ) and Young Schema Questionnaire (YSQ) to 100 health care professionals attending a CME course on professional boundaries. Experts rated participant autobiographies to determine attachment style and early adversities. Correlations and relationships between self-ratings and expert ratings and among different risk factors were examined.

Results: One fifth of participants reported moderate to severe childhood abuse; sixty percent reported moderate to severe emotional neglect. Despite this, average attachment anxiety and attachment avoidance were low, and more than half of participants were rated “secure” by experts. Childhood maltreatment was correlated with attachment anxiety and avoidance and predicted expert-rated insecure attachment and maladaptive beliefs.

Conclusions: Our findings support a potential link between childhood adversity and boundary difficulties, partly mediated by insecure attachment and early maladaptive beliefs. Furthermore, these results suggest that boundary education programs and professional wellness programs may be enhanced with a focus on sequelae of childhood maltreatment, attachment and common maladaptive thinking patterns.

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1. Introduction

“It is when the physician from a barren childhood becomes overly burdened by the demands of his dependent patients that trouble arises.”

[– George E Vaillant [1]]

The practice of medicine is inherently relational [2]. Effective medical relationships have unique boundaries, however, demanding a skillful balance of empathic intimacy and mindful objectivity [3]. When the challenging task of regulating these boundaries goes awry and boundary violations occur, health care providers are often referred to specialized assessment and remediation programs [4–10]. To assist

boundary-challenged health care providers (professionals who have been disciplined because of boundary violations), improve the quality of remedial boundary programs and inform preventive education and provider wellness, it is important to understand risk factors for boundary violations. As the majority of the current sample had a medical degree (i.e., M.D. and D.O.), our discussion below focuses on the literature in physicians.

For heuristic purposes, risk factors for boundary violations can be classified as distal or proximal, with proximal risks subdivided into structural and individual factors (Fig. 1). Structural factors – largely outside of the control of individual physicians – include institution-specific factors (e.g., a local culture of leniency or punishment regarding boundary violations) as well as issues in the wider medical and social world: (1) a medical culture that esteems self-reliance and minimization of personal needs [11], (2) expectation that physicians police themselves, (3) a legalistic climate [8,12] and (4) the rise of social media and related technologies [13]. Proximal, individual factors include more time-limited, remediable and situation-specific aspects (e.g., lack of

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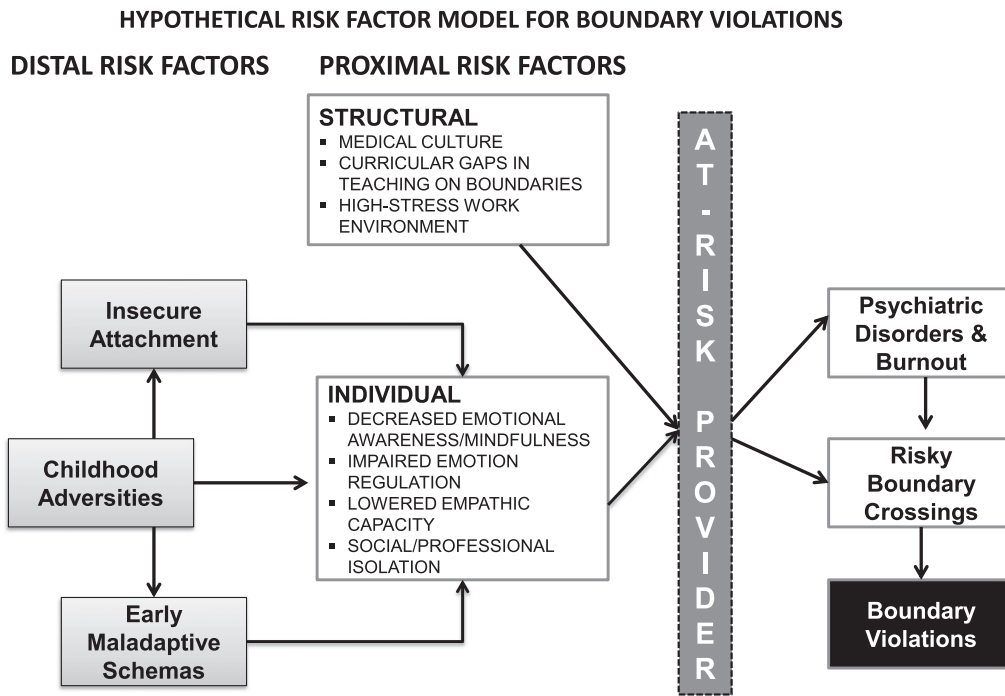


Fig. 1. Hypothetical risk factor model for boundary violations.

information about specific laws and guidelines), as well as personality traits (e.g., decreased emotional awareness/mindfulness, impaired emotion regulation, lower empathic capacity) and states of social and professional isolation [14,15].

Oposited to these more proximal factors for boundary violations are distal risk factors, which include childhood maltreatment and family-of-origin issues [16], insecure attachment and individual psychological processes [early maladaptive schemas (EMS); see below] [17]. Importantly, assessment of these distal factors abets an individualized approach to risk reduction. This individualized approach to boundary violations complements preventive and remedial measures targeting more proximal factors.

A relatively limited literature has used standardized instruments to identify distal risk factors in boundary-challenged physicians [7,9,16,18]. Overall, these studies find that, compared to controls, boundary-challenged physicians are more likely to have problematic personality traits [7,9,18] and dysfunctional families of origin [16]. Much of the literature on this important topic, however, is anecdotal and medicolegal in nature [19,20] and is focused on psychiatrists and psychotherapists [21,22] despite the fact that boundary challenges occur in every specialty [5,9].

Notwithstanding these limitations, the extant literature suggests that certain specific characteristics of physician's early environment and personality traits confer risk for boundary violations [7,9,16,18]. Based on these data and our experience with referred physicians, we identified three distal risk factors that can be assessed with brief, well-validated self-report scales: (1) childhood abuse and neglect; (2) attachment anxiety and avoidance; and (3) maladaptive beliefs (also known as "early maladaptive schemas" [23]). A theoretical model of how these distal risk factors contribute to boundary violations is depicted in Fig. 1.

Exposure to significant childhood adversities is the single most potent historical risk factor for a variety of important behavioral outcomes [24]. Notably, this factor remains understudied in physicians. Most reports examining early maltreatment in physicians have used vague definitions and non-standardized or abbreviated assessment tools that focus on either abuse (emotional, sexual or physical) or neglect [25–28], although these categories of maltreatment typically

co-occur [29]. We are not aware of any study of physicians utilizing a valid and reliable measure that addresses multiple categories of childhood trauma, such as the widely used Childhood Trauma Questionnaire (CTQ) [30]. The few available studies on this topic indicate that between 15% and 38% of physicians have been exposed to some form of childhood maltreatment [25–28].

Besides childhood maltreatment, a second distal risk factor in our model is the physician's "internal working model" of relationships: their attachment style [31,32]. In brief, a person's attachment style is rooted in recurrent interactions between children and their primary caregivers [31]. Once internalized as relational memory networks, these interactions form a blueprint for future adult relationships, including physician–patient interactions [32–34]. A person's attachment style is typically characterized as either secure or insecure, with the insecure category commonly subdivided into preoccupied, fearful or dismissing. Despite clear theoretical justification [33], we are not aware of any published studies examining the attachment style of practicing physicians. A qualified exception is a report by Ciechanowski et al. of 144 second-year medical students in which the proportions of student attachment styles approximated those found in the general population [35]: 56%, secure; 13%, preoccupied; 12%, fearful; 19%, dismissive [34]. Consistent with attachment's predictive utility, the securely attached group was more likely to prefer more relationship-oriented specialties (i.e., primary care) over specialties without a primary relational orientation (i.e., surgical subspecialties) [34].

Aside from its impact on attachment style, another way a person's early experience influences adult relational behavior is through the development of certain beliefs about the self, others and the world known as early maladaptive schema (EMS) [23]. EMS are automatic, frequently unconscious patterns of thinking and perceiving that can be measured with the Young Schema Questionnaire (YSQ). Important from a remedial standpoint is that belief systems are often amenable to change via evidence-based psychotherapeutic techniques derived from cognitive behavioral therapy [36]. We identified only one study of EMS in a diverse group of health care professionals in Britain's National Health Service [37]. This study found that physicians scored higher than nurses on the "Entitlement" EMS (i.e., beliefs about being special and superior, controlling others and having difficulty in reciprocal relationships)

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