

'Screen-time transference interference' in encounters with patients

Vladislav Afanasevich, MD



Dr. Afanasevich is a PGY-4 in Child & Adolescent Psychiatry, University of Nevada, Reno. He was a PGY-3 in Psychiatry, Saint Louis University, St. Louis, Missouri, when this article was written.

Disclosure

Dr. Afanasevich reports no financial relationships with any company whose products are mentioned in this article or with manufacturers of competing products.

I cannot recall the last time that I had a good look at the cashier who was scanning my grocery purchases. I could not tell you what color eyes he (or she?) had or how he styled his hair. This isn't for lack of an effort to recall, or a manifestation of poor memory or absentmindedness. Rather, I think that the situation reflects a larger cultural shift that has gained momentum since the beginning of the new century: that is, the effect of a preponderance of so-called *screen time* in our lives.

In that mundane scene in the grocery store, screen time encompasses the impersonal and mechanical act of swiping my debit card, entering my PIN, and impatiently waiting for the receipt to print. All the while, I stand awkwardly, eyes downcast and fixed on the display of the card reader, ignoring the human being directly across from me.

Obsession with screens

Our engagement with screen time has grown to pandemic proportions, and television is no longer the main culprit. According to a Nielsen global consumer report,¹ in 2010 in the United States, people spent an average of 5 hours a day in front of the "boob tube." Even if we take that statistic with a grain of salt, it still represents only the most visible tip of the media iceberg. Smartphones, laptop and desktop monitors, portable gaming consoles, electronic tablets, PIN pad displays, video billboards, and any number of other LED and

LCD screen surfaces have infiltrated the landscape.

Whereas most recent epidemiologic studies have addressed the deleterious effects of so-called *sit time* (sedentary activities with or without a screen) on physical health, I would like to address the deleterious effect of screen time on mental health and relational connectedness and the relevance of that screen time to psychiatric practice.

The 'techno-bubble of private space'

Almond,² in a humorous social commentary, "Connection Error," conducted an impromptu experiment in which he attempted to connect spontaneously with strangers, especially those who had a smartphone, in Boston. His narrative navigates the gamut of human interaction, from tedious and boorish to comedic and absurd, noting that, conspicuously, "smartphone users have created a techno-bubble of private space" in which they are physically present but emotionally unavailable.

A chance encounter with a young professional led Almond to this conclusion:



LET YOUR VOICE BE HEARD

CURRENT PSYCHIATRY invites psychiatry residents to share their views on professional or clinical topics for publication in Residents' Voices. E-mail residents@currentpsychiatry.com for author guidelines.



Discuss this article at www.facebook.com/CurrentPsychiatry

"...it's not technology that's caused the social atomization of our public spaces. In part, it's the frantic rush of capitalism, the way in which work transforms people into economic integers desperate both to prove their value and to experience a genuine sense of community, even if it's only virtual."²

It's precisely the intrusive alienation of the "techno-bubble" that blunders into the modern patient-physician interaction in my clinical psychiatric practice in a busy outpatient clinic at a university medical center. Specifically, the ever-glowing, ever-distracting computer monitor sitting between me and my patient, with its promise of digital information at my fingertips, serves more to distance me from my patient than to connect us in a meaningful, human way. Just as I can't recall the countenance of the grocery-store cashier, I miss the delicate, information-laden, minute-to-minute social interaction with the patient because it competes with the electronic intruder.

What's at risk when a computer screen is in the room?

Transference in the psychotherapeutic encounter is an established tenet of psychoanalytic theory. In "Basic theory of psychoanalysis,"³ Waelder defines transference as "not simply the attribution to new objects of characteristics of old ones but the attempt to re-establish and relive, with whatever object will permit it, an infantile situation much longed for because it was once either greatly enjoyed or greatly missed." This definition applies to the positive pole of transference phenomena—and it is this position that is desired in a successful patient-physician encounter.

A patient's warm and genial regard toward a provider secures trust, cooperation, and faith in the healing process. Establishment of positive trans-

ference toward the physician is essential to enhance the clinical encounter, regardless of what early object (caring mother, omnipotent father) is being projected onto the physician.

Attunement. Research into infant observation has revealed the critical role of caretaker responsiveness in the development of early infantile emotional regulation. Tronick et al⁴ demonstrated the importance of interactional reciprocity in the mother-child dyad.

In a series of experiments using the so-called still-face paradigm, Tronick et al⁴ saw that infants quickly fall into a state of despair and related negative affects when the mother assumes an unresponsive and detached still face. These episodes intentionally produce infant-mother emotional misattunement, which, although instantly damaging, can be successfully repaired through re-attunement by the mother. It is the primary caretaker's ability to reconnect and repair that is paramount to the infant's healthy psychological development.

This sentiment is echoed in Winnicott's concept of the "good-enough" mother (or parent), formulated years earlier, in which failures in infant-caretaker attunement are inevitable and to be expected—as long as repair outcompetes deficiency.⁵

Divided attention: Patient or screen? Or both?

What we can understand by applying the ideas of transference and optimal attunement to the clinical encounter is *how important uninterrupted face-to-face time with the patient is*. Indeed, nonverbal communication from the patient, expressed through body language and facial articulation, is particularly salient to the practice of psychiatry. Information technology—especially the electronic health record—now encroaches on the time-honored central dyad of the patient-physician interaction

Clinical Point

I miss the delicate, information-laden, minute-to-minute social interaction with the patient because it competes with the electronic intruder

Clinical Point

'Screen time interference' or clinical misattunement can have similar effects on patients as the still-face paradigm has on infants

by introducing a third entity into the traditional encounter.

Clinical misattunement, as understood through the still-face paradigm, increases in proportion to a provider's need to divide his (her) attention between the patient and the computer screen. And, as the degree of misattunement increases, positive transference is more difficult to establish and maintain. The quality of the clinical encounter then deteriorates, undermining the care of the patient and reducing physician satisfaction.

References

1. The Nielsen Company. How people watch: a global Nielsen consumer report. <http://www.nielsen.com/content/dam/corporate/mx/reports/2011/Lo-que-la-gente-ve.pdf>. Published August 2010. Accessed March 17, 2015.
2. Almond S. Connection error. *Spirit Magazine*. April 2014:76-86.
3. Waelder R. *Basic theory of psychoanalysis*. New York, NY: International Universities Press; 1960.
4. Tronick E, Als H, Adamson L, et al. The infant's response to entrapment between contradictory messages in face-to-face interaction. *J Am Acad Child Psychiatry*. 1978;17(1):1-13.
5. Winnicott DW. *The child, the family, and the outside world*. London, United Kingdom: Penguin Books; 1964.

Acknowledgment

Philip LeFevre, MD, Department of Neurology & Psychiatry, Saint Louis University, St. Louis, Missouri, provided inspiration and encouragement in the development of the manuscript.