

# COUNTERTRA

Copyright © Dowden Health Media  
Personal Use Only

Recognizing a patient's personality type may help clinicians predict their countertransference when interacting with that patient

# Clinical guide to

# TRANSFERENCE

## Help medical colleagues deal with 'difficult' patients

### **Philip R. Muskin, MD**

Professor of clinical psychiatry  
Columbia University College  
of Physicians and Surgeons  
Chief, Consultation-liaison  
psychiatry  
Columbia University Medical Center  
Faculty, Columbia University  
Psychoanalytic Center for Training  
and Research  
New York, NY

### **Lucy A. Epstein, MD**

Postdoctoral clinical fellow  
in psychosomatic medicine  
Columbia University College  
of Physicians and Surgeons  
New York, NY

**T**wo strangers meet in the hospital cafeteria. Mrs. R, an elderly woman, asks Dr. W, a first-year medical resident, for help in getting a bottle of soda from the cooler. Afterward, Dr. W comments to a colleague with whom she is having lunch, "That woman reminds me of my grandmother."

What does that comment reflect about Dr. W? It is a statement about the doctor's transference. That is, she is aware of elements about Mrs. R that evoke internal responses appropriate to a prior important relationship.

What if Mrs. R was to subsequently faint, require admission to the hospital, and become Dr. W's patient? If Dr. W's comment indicates transference, would the same reaction to Mrs. R now be countertransference? Does that change if the doctor is unaware of emotions Mrs. R evokes? Is it still countertransference whether Dr. W is caring and compassionate, overly involved with Mrs. R, or—unaware of negative feelings associated with "grandmothers"—avoids the patient?

This article explores how complex internal experiences play out in the general medical setting and discusses how psychiatric consultants can help medical/surgical colleagues understand and manage difficult patient-physician relationships.

continued



## 2 sides of difficult patients

### Clinical Point

Countertransference and transference may be conscious, but they always have an unconscious component

### Box 1

## Roots of transference: From a child's experience of the world

Genetic factors play a role in personality formation. A child's personality, which emerges early in life, shapes interactions with people who are significant during childhood. Predispositions shape those experiences and influence what people internalize from those relationships.

In adults, many aspects of what we understand as transference—the experience someone has of a figure from the past—originate from the limitations with which children perceive and interpret their experiences. Transference is not truth about a significant past relationship; it is truth as the person experienced other people and now remembers or reacts to individuals who are reminiscent of those from the past.<sup>1</sup>

Not all psychotherapeutic treatments—

and thus not all therapists—use the concept of transference as a therapeutic component. Some therapists who employ transference in treatment will discuss how the patient interacts with the therapist only when the phenomenon interferes with therapy. Interpretation of transference is a therapeutic modality of psychoanalysis and psychodynamic psychotherapy. Discussion of how the patient interacts with the therapist is not the same as a transference interpretation. Because transference exists in all human relationships, transferential aspects in a relationship may have positive or negative effects on interactions outside the therapeutic environment. Whether acknowledged or ignored, transference—and thus countertransference—is present.

### The therapeutic dyad

Countertransference and transference are concepts embedded in psychodynamic thinking. They are part of how many people think about interpersonal relations, whether or not they use these terms. Countertransference and transference may be conscious, but they always have an unconscious component. Factors that influence what will be transference and countertransference in adult life have both:

- a biological component because part of personality is genetic
- a psychological component based upon experiences throughout life (Box 1).<sup>1</sup>

Transference is experiencing and/or relating to someone in the present as if that person was a significant individual from the past. The concept implies that all personal relationships contain elements of transference(s). That is, we all have the potential to displace or transfer to current situations infantile and internal conflicts that are out of place and thus not appropriate to the present person and/or situation.

Countertransference is a dimensional concept, not an all-or-nothing experience. Some reactions to patients are based entirely upon their transference to us and have nothing to do with us (therapists) as people. Others derive mostly from psychodynamics within the therapist (Box 2, page 29). Coun-

tertransference has evolved to incorporate responses evoked by a combination of:

- the patient's transference
- the therapist's unique psychodynamics
- the real relationship in the therapeutic dyad.<sup>2</sup>

### Patients with medical illness

Psychiatrists think of countertransference as a psychological situation occurring in the office or on an inpatient psychiatric unit. We focus our attention on how we feel and what we think while working with patients. We talk about our reactions to patients in supervision, rounds, case conferences, and other situations where mental health professionals discuss patients.

Our medical/surgical colleagues' reactions to patients often correlate with certain patient presentations and may have little to do with the actual person who is the patient.<sup>4</sup> The medical setting provides an opportunity for countertransference to occur in the absence of apparent transference.

Somatic illness imposes on patients some degree of regression. This regression and attempts to cope with it are inherent to somatic illness and hospitalization. Several schemas<sup>5</sup> describe basic coping mechanisms common to most patients (Table, page 30).<sup>6,7</sup> Recognizing a patient's character style or personality



**Box 2****Reactions to other people: When are they countertransference?**

In the therapeutic setting, some reactions to the patient are experienced as unusually powerful, out of keeping with our self-image, or as consciously disturbing. Such reactions to a patient—while still countertransference—might result from projective identification. This type of countertransference is most commonly, but not exclusively, encountered in therapy of patients with borderline personality organization.<sup>3</sup>

We suggest that the term countertransference be restricted to therapeutic situations (any relationship in which one person has the role of treating

or helping the other person), including all patient-physician or patient-provider relationships. They have a transferential component because the physician occupies a role of authority/knowledge/power from which the patient seeks to benefit.

Outside of therapeutic situations, reactions to other people are our transferences to them, evoked by our internalized past relationships. We may have an emotional response to how someone behaves toward us (their transference), but that is a *counter-transference*, not countertransference.

type may help clinicians predict their countertransference when interacting with that patient. Uncooperative patients and those perceived as “difficult” are particularly likely to evoke negative countertransference.<sup>8</sup>

**CASE CONTINUED****No longer ‘grandmotherly’**

Mrs. R and Dr. W are now in a patient-physician relationship. Dr. W is no longer handing Mrs. R a bottle of soda but is inquiring about her life, use of alcohol and other drugs, intimate activities, etc. Mrs. R reacts with anger at the “personal questions.” In addition, Dr. W orders tests that are uncomfortable for Mrs. R, who refuses to cooperate with some procedures.

Dr. W’s memories of her grandmother (who was encouraging, supportive, and loving) color her experience of Mrs. R. She ignores nursing staff’s complaints about Mrs. R being demanding and difficult as the patient becomes aggressive and increasingly confused.

Unable to see the patient as she really is, Dr. W becomes angry and defends Mrs. R’s behavior. The nurses feel Dr. W is unrealistic and ignore her at the nursing station. Late on a Friday night, Mrs. R becomes paranoid, hallucinating that “demons” are in her room. She tries to elope from the hospital. Dr. W is off for the weekend, and the staff requests an emergency psychiatric consultation.

Mrs. R evokes a reaction from the nurses because of how she interacts with them. Dr. W’s response—based on her experience of her grandmother—has nothing to do with

the way Mrs. R relates interpersonally but reflects a reaction to the patient’s gender and age. Both reactions would be countertransference, using the modern definition.

If reactions to a patient such as Mrs. R are positive, no one seems to notice and the reactions might or might not influence her care. If the reactions are negative, they might influence her care and generate a request for a psychiatric consultation.

Countertransference might have a negative effect on patient care. For example, if a physician were to avoid Mrs. R because she is uncooperative, and if the nursing staff is intolerant of the patient’s confusion and agitation, she might be labeled as “demented” and be given medication without anyone exploring the etiology of her behavior.

Some patients cannot communicate because of neurologic disorders, intubation, language barriers, or because they are unconscious when admitted. Without information from the patient, medical staff may form ideas about the patient based on their unconscious fantasies. These fantasies may influence the patient’s care.<sup>9</sup> Psychiatric consultants are not immune to countertransference, but we come into situations with the opportunity to experience all participants from the outside.

**CASE CONTINUED****The psychiatric consultation**

During the interview, the psychiatrist asks Mrs. R if she takes any medications. She reports that she always takes “Centrum” at bed-

**Clinical Point**

**Uncooperative patients and those perceived as ‘difficult’ are particularly likely to evoke negative countertransference**



## 2 sides of difficult patients

### Clinical Point

When you discuss patient types with medical staff, present the information without using psychiatric jargon

### Table

## Patients' response to illness, with common countertransference by medical staff

Patient's coping mechanisms	Staff's countertransference
<b>Dependent personality</b>	
<ul style="list-style-type: none"> <li>• Unconsciously wishes for unlimited care</li> <li>• Depends on others to feel secure</li> <li>• May make excessive requests of staff</li> </ul>	<ul style="list-style-type: none"> <li>• Gratification at being able to take care of patient's needs</li> <li>• Resentment if patient's needs seem insatiable</li> </ul>
<b>Obsessional personality</b>	
<ul style="list-style-type: none"> <li>• Meticulous self-discipline</li> <li>• Illness represents loss of control</li> <li>• Will try to gain mastery over illness by focusing on details, information</li> </ul>	<ul style="list-style-type: none"> <li>• Relief at patient's willingness to actively participate</li> <li>• Power struggle is possible</li> </ul>
<b>Histrionic personality</b>	
<ul style="list-style-type: none"> <li>• Outgoing, colorful, lively</li> <li>• Attractiveness and sexuality important</li> <li>• Needs to feel the center of attention</li> <li>• Illness represents defect, loss of physical beauty</li> </ul>	<ul style="list-style-type: none"> <li>• Warm initial engagement</li> <li>• Fear of crossing boundaries</li> <li>• Wonder about veracity of complaints</li> </ul>
<b>Masochistic personality</b>	
<ul style="list-style-type: none"> <li>• Satisfies unconscious needs by suffering</li> <li>• Needs to play victim role</li> </ul>	<ul style="list-style-type: none"> <li>• Frustration when reassurance does not help</li> <li>• May unconsciously play into patient's need for punishment</li> </ul>
<b>Paranoid personality</b>	
<ul style="list-style-type: none"> <li>• Pervasive doubt of others' motivations</li> <li>• Often questions motives for interventions</li> <li>• Illness represents threat to safety</li> </ul>	<ul style="list-style-type: none"> <li>• Wary of lack of alliance</li> <li>• Anger that patient questions treatment motives</li> <li>• Frustrated at inability to form a trusting relationship with patient</li> <li>• Unsettled by lack of connection</li> </ul>
<b>Narcissistic personality</b>	
<ul style="list-style-type: none"> <li>• Grandiose sense of self, which protects against shame, humiliation</li> <li>• May demand superior care, insult junior team members</li> </ul>	<ul style="list-style-type: none"> <li>• May feel flattered by ability to treat patient as VIP</li> <li>• May alternately feel devalued, wonder about competence</li> </ul>
<b>Source:</b> References 6,7	

time and demands to know why she is not getting her "vitamins." She is given oxazepam and falls asleep.

The psychiatrist recommends benzodiazepine detoxification, suspecting Mrs. R is taking prazepam at home from an old prescription (when the medication was a brand called "Centrax"). This suspicion is confirmed when Mrs. R's family brings in a large shopping bag of medications she has collected over decades, and Mrs. R identifies her nighttime "vitamin."

A full evaluation for delirium is completed over the next 2 days. Mrs. R's confusion and aggressive behavior respond to oxazepam.

Patients with particular character styles evoke predictable reactions from others,

including psychotherapists. Discussing these reactions has been a part of psychiatric training for decades. A subset of patients has been described as "hateful," as they routinely evoke extremely negative responses.<sup>10</sup> Whether their primary disorder is psychiatric, medical, or some of both, these patients evoke strong countertransference reactions.

Psychiatrists may be comfortable discussing a "narcissistic patient, a dependent clinger with borderline features," but our medical colleagues might not share our comfort with psychiatric jargon.<sup>11</sup> It may be more useful to say to medical staff that the patient "thinks of himself as very important, cannot accept his need to be taken care of, and tends to see things in black and white."

## Managing difficult patients

The characterizations that follow describe unconscious reactions to types of individuals who are routinely experienced as “difficult” patients. Some patients may exhibit a mixture of character styles (*Table*) and do not easily fall into 1 category. The concepts can be useful in clarifying the reactions that patients evoke in medical staff.

**‘Dependent’ patients.** Some patients demand continuous attention but are unaware of their insatiable neediness. Early in treatment, they may evoke positive countertransference because they are intensely grateful for attention. They can be enticing, unconsciously seductive, and gratifying to their doctors. Over time, they drain and exhaust their physicians, who resort to avoidance and wish to get rid of these patients.

**Recommendation.** Set limits to prevent the patient from feeling rejected or an actual rejection when he or she is transferred to another doctor’s care. Coach physicians to:

- ask patients to “Tell me what is most important for us to discuss today”
- be clear how long the visit will last.

Reassuring the patient that other issues will be addressed in the next visit prevents the physician from feeling overwhelmed by the patient consuming too much time.

**‘Entitled’ patients.** Another type of “difficult” patient projects an air of entitlement, which typically reflects an underlying insatiable neediness. They may use intimidation, guilt, and threats of punishment to get their doctors to provide the care they demand. These patients appear powerful (even though they may possess no special status), and they may be overtly devaluing of the physician while simultaneously demanding special attention.

The doctor resents the patient’s entitlement but develops an expectable countertransference fear that he or she will get in trouble if the demands are not met. Wishes to retaliate and “put the patient in his or her place” are common.

**Recommendation.** Saying, “It is understandable that you want the best care, and I plan to give you the best care,” makes it clear to the patient that the physician hears

the patient’s concerns. Advise the physician to request the patient’s “understanding and compassion” for other patients who also need the physician’s time and attention.

**‘Help-rejecting’ patients.** “Help-rejecting” patients demand care but show little faith in treatment and do not follow treatment plans. The harder the physician tries to help, the less likely the plan will succeed. For these patients, treatment success evokes a fear of abandonment; thus, treatment must fail to maintain the relationship.

Common countertransference reactions are initial anxiety that the treatment plan was not adequate, followed by anger and depression as the physician feels stuck with a patient for whom nothing works.

**Recommendation.** Setting realistic goals for treatment helps the physician guide the patient, who expects to be told not to return the moment he or she gets better. Telling the patient that medical care does not stop when a particular malady is treated speaks to the patient’s fear of being abandoned.

When the patient adheres only partially to the plan and a psychiatric consultant is called for an “uncooperative” patient, help the doctor understand how the patient sees the world. It is the patient’s psychological needs—not the physician’s failure—that control the outcome of the care.

**‘Self-destructive’ patients** may appear unaware of their dangerous actions. They evoke malice from their doctors, who feel the patients are purposely engaging in life-threatening behaviors. The patients’ unconscious dependence remains unknown as their denial of the consequences of their behavior frightens and angers those involved in their care. Some of these patients cannot be stopped before their actions cause them permanent harm or death.

**Recommendation.** You might remind the physician that we all are entitled to live our lives as we choose. To decompress intense feelings, advise the physician to share, without blaming the patient, what medical staff can realistically do. Saying “We’ll do the best we can” (rather than “Treatment is useless for someone like you”) permits the patient to receive the degree of care he or she can ac-

## Clinical Point

Help physicians see that it is the ‘help-rejecting’ patient’s psychological needs—not the physician’s failure—that control the outcome of care



## 2 sides of difficult patients

### Clinical Point

To decompress intense feelings, advise physicians to understand their limitations when treating self-destructive patients

cept without the physician feeling helpless. Understanding our limitations and obligations is part of using our countertransference to aid in patient care.

#### CASE CONTINUED

### Feeling better

When Dr. W returns on Monday, she angrily calls the psychiatrist to complain that her patient has been placed on a benzodiazepine and at the “implication” that Mrs. R was abusing medication. When they talk in person, the psychiatrist explains the situation to Dr. W and suggests they meet with Mrs. R together.

Mrs. R is embarrassed when told about her behavior, identifies the pill, and admits taking prazepam for several weeks prior to hospitalization. She says she never understood how a vitamin could help her sleep so well. No longer delirious, Mrs. R is pleasant and asks many questions. She is surprised that “so young” a doctor was assigned to her case and asks if the chief of medicine could be brought in, as she is on the board of directors of another hospital. “No offense, dear,” she says to Dr. W; “I’m sure you did an excellent job, but usually only senior doctors take care of me.”

Later, Dr. W talks with the psychiatric consultant about her chance meeting with Mrs. R in the cafeteria and the discord with the nursing staff. She notes that she was doing an elective in another country when her grandmother died. She realizes that her feelings about her grandmother are superimposed on the patient, resulting in an inability to see the patient as she really is.

Dr. W accepts the psychiatrist’s suggestion to repair her relationship with the nurses with an apology. She now notes that Mrs. R is nothing like her grandmother and seems “pretty stuck up.” She is glad to be off the case and ac-

## Related Resources

• Gabbard GO, ed. Countertransference issues in psychiatric treatment. In: Oldham JM, Riba MB, eds. Review of psychiatry series. Washington, DC: American Psychiatric Publishing, Inc.; 1999.

• Blumenfeld M, Strain JJ, Grossman S. Psychodynamic approach. In: Blumenfeld M, Strain JJ, eds. Psychosomatic medicine. Philadelphia, PA: Lippincott, Williams and Wilkins; 2006:817-828.

#### Drug Brand Names

Oxazepam • Serax

Prazepam • Centrax

#### Disclosure

The authors report no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

cepts the psychiatrist’s idea that Mrs. R’s need to feel important should not make Dr. W feel bad about herself.

#### References

1. Gabbard GO. Basic principles of psychodynamic psychotherapy. In: Gabbard GO, ed. Psychodynamic psychiatry in clinical practice. Washington, DC: American Psychiatric Publishing, Inc.; 2005:1-30.
2. Harris A. Transference, countertransference, and the real relationship. In: Person ES, Cooper AM, Gabbard GO, eds. Textbook of psychoanalysis. Washington, DC: American Psychiatric Publishing, Inc.; 2005:201-216.
3. Goldstein WN. Clarification of projective identification. *Am J Psychiatry*. 1991;148:153-161.
4. Kuchariski A, Groves JE. The so-called “inappropriate” psychiatric consultation request on a medical or surgical ward. *Int J Psychiatry Med*. 1976;7(3):209-220.
5. Groves MA, Muskin PR. Psychological responses to illness. In: Levenson JL, ed. Textbook of psychosomatic medicine. Washington, DC: American Psychiatric Publishing, Inc.; 2005:67-90.
6. Kahana RJ, Bibring GL. Personality types in medical management. In: Zinberg N, ed. Psychiatry and medical practice in a general hospital. New York, NY: International Universities Press; 1964:108-123.
7. Geringer ES, Stern TA. Coping with medical illness: the impact of personality types. *Psychosomatics*. 1986;27:251-261.
8. Mozian SA, Muskin PR. The difficult patient. In: Barnhill JW, ed. The approach to the psychiatric patient. Washington, DC: American Psychiatric Publishing, Inc.; 2008:192-196.
9. Groves JE. Management of the borderline patient on a medical or surgical ward: the psychiatric consultant’s role. *Int J Psychiatry Med*. 1975;6:337-348.
10. Groves JE. Taking care of the hateful patient. *N Engl J Med*. 1978;298:883-887.
11. Pasnau RO. Ten Commandments of medical etiquette for psychiatrists. *Psychosomatics*. 1985;26(2):128-132.

## Bottom Line

Transference and countertransference responses in the care of patients with medical illness usually cause no difficulty, but understanding these conscious and unconscious interactions is useful when problems occur. Sometimes the intervention focuses on the patient and other times on medical staff. Psychiatric consultants can help colleagues understand who the patient is as a person, including how realistically difficult a patient might be.