

Transference and Countertransference in Medically Ill Patients*

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Abstract

Transference and countertransference feelings/reactions are a valuable source of information about a patient's inner world. A consultation liaison psychiatrist has to help the entire treatment team to understand the patient as well as treat the patient. Studies about transference and countertransference in medical settings are insufficient. An idealized transference often develops, usually at the beginning of the treatment, whereas negative transference occurs rarely. At other times a displaced transference, with anger, directed toward the medical team or one of its members may develop. Acute intense transference and countertransference feelings/reactions may be indicators of serious character pathology, such as Cluster B personality disorders. Patients with terminal illness are in need of perceiving the physician as an ideal and omnipotent figure; therefore, encouragement of a regressive relationship is recommended. There is always a risk of either avoidance or over involvement with the patient, especially in cases of catastrophic illness or injury. Not infrequently, interaction with the patient may evoke a traumatic experience in the therapist that has not been worked through sufficiently, and may hinder the therapist's ability to relate to his patient. Therapist countertransference feelings may be informative about the entire medical treatment process of the patient. Collaborative meetings with the medical team may help a therapists to understand their patients' inner worlds and to correct his/her dysfunctional attitudes, which in turn might positively affect treatment compliance and improve prognosis. Herein, the literature regarding transference and countertransference in medical patients is reviewed with case examples.

Key Words: Medical illness, transference, countertransference

INTRODUCTION

In the light of previous scientific studies, it has been suggested that healthy lifestyle training, training in stress-coping techniques, problem-solving groups, and psychosocial group approaches should be included in the treatment of patients who are diagnosed with serious physical illness, such as cancer (Favzy et al., 1995). However, these structured approaches may be insufficient in responding to the needs of some patients. There may be a need for more personal approaches to some individuals who experience difficulties in coping with being ill (Postone, 1998). Individual psychotherapy might be essential, especially if the individual has developed various psychological disorders, or if the illness has triggered certain past internal conflicts. The ability to recognize and manage feelings of transference and countertransference,

and the reactions towards these feelings will contribute to a better understanding of the patient and to the medical treatment the patient is receiving. The competency of the psychiatrist in understanding countertransference issues that may develop during the treatment process of medically ill patients will also contribute to the treatment of the physical illness and/or to the ability to understand and manage problems that may arise during the treatment or rehabilitation of the medical illness (Laatsch et al., 1993). Although transference and countertransference feelings/reactions are very important in understanding the inner world of the patient and in the management of the medical treatment, the number of studies on transference and countertransference feelings that arise during the psychotherapy of a seriously medically ill patient is insufficient (Goin, 2005). This article aimed to review the literature concerning transference

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and countertransference feelings that arise during the psychotherapy of seriously medically ill patients, and to present some case examples.

Case Examples

Case 1

The patient is a 33-year-old female diagnosed with breast cancer. Psychiatric consultation was requested due to her hostile and aggressive attitude towards the hospital staff. She complained of insufficient care by her doctor. Although her complaints were grounded in reality, as there were problems due to the heavy workload of the hospital staff, in her clinical interview it became clear that her feelings were related to her father neglecting her in childhood. After divorcing her mother, the father did not call the patient and interacted with her only when problems arose. A negative attitude was the patient's way of expressing her difficulties and requesting the care and affection she needed.

Case 2

A 43-year-old male patient was diagnosed with kidney failure requiring dialysis 15 days ago. After 3 catheter insertions failed he rejected the treatment, even though his cognitive abilities were intact and he was aware that if not treated he would die. The psychiatric interview with the patient revealed that he was the first child of a large family and that he had polio during his childhood, as he had not been vaccinated. Although he had 11 operations between the ages 2 and 6 years, he could not walk. His mother was heavily invested in helping him to walk again. She brought him to various non medical healers such as *hodjas* and did what ever had been advised. He remembered that his legs were seriously burned with hot water during one of the recommended treatments. His negative and life threatening behavior towards dialysis was related to his mother's excessive attempts to cure him (perhaps due to her own feelings of guilt), which in retrospect could be considered sadistic. His conflict with his mother was projected onto his nephrologist and a negative transference developed.

Case 3

A 46-year-old female patient was the only survivor among the many people who were trapped under rubble in the 1999 Istanbul earthquake for 9 hours. She had heard that others had died like insects by cracking. Despite this horrible experience, she did not have any negative feelings about the earthquake and she reported

that she was fine and had no complaint. Her daughter who was also with her under the rubble was experiencing desperation and felt helpless. The psychologist on the consultation team realized that she was becoming angry, couldn't control her anger, and became desensitized towards the survivors. It was impossible for her to help the earthquake survivors. The unconscious meaning of these feelings surfaced during her supervision; the earthquake had triggered the earthquake in her inner world. When the therapist was 8 years old, she emigrated from Bulgaria with her family under very difficult conditions after her father had left the family. Only many years after this traumatic event did she come to realize that he had experienced irreplaceable losses. The earthquake and the experiences of the mother and daughter triggered his inner earthquake related to immigration. Countertransference feelings became a barrier to the therapist's ability to help her patient.

Case 4

The patient was a 21-year-old female student who had undergone 3 operations in the previous 3 years due to a hip fracture caused by a traffic accident. There were various complications and she had difficulty walking. She was in pain and fed up with medical interventions and treatments. The patient's medical problems triggered her conflicts with her disabled sibling who had a natal hip fracture. During her childhood, the patient had to meet her parents' expectations, both of herself and of her sibling. Her father had high expectations and he wanted his daughter to participate in various intellectual activities. Until her health problems, in addition to a successful academic life, she was also involved in various activities, such as photography and publishing. Beginning with the initial session, the therapist responsible for the patient's treatment urged her to explore her inner conflicts quickly and return to her education as soon as possible, rather than to remain focused on the psychic pain, and anxiety and conflicts related to physical disability and symptoms. Here, the therapist made an unconscious identification with the patient's father which prevented him working through the psychic conflicts and various identifications with her sister and their relationship to presenting complaints.

Case 5

The patient was a 30-year-old, highly successful businessman diagnosed with stomach cancer 6 months before beginning therapy to discuss issues unrelated to his illness. He believed that he became ill due to poor

self-care, however he did not think that discussing these matters would be beneficial and he wanted to talk about other issues in therapy. His mother had given birth to a stillborn baby prior to his birth. His parents' relationship was problematic due to extramarital affairs of the father. He grew up listening to his mother blaming his father for the baby she had lost. He had fears of losing his parents during his childhood and experienced intense anxiety about his health. He was a very precious child who grew up overprotected. He had always felt himself to be the focus of a divine project. Cancer intimidated his self-perception and psychological unity, as well as intensified his conflicts about dependency and feelings of guilt. His unconscious fantasy was to be responsible and punished for his brother's death. He denied his feelings related to his cancer. Although the therapist believed that the meaning of the illness should be worked through, she respected her patient's wish thinking that he is protecting himself from anxiety. During the course of therapy, the patient changed the subject whenever medical issues arose; he even cancelled sessions that were close to medical appointments. As the therapy progressed, although the patient claimed that he did not ever think about the illness, the therapist started to seriously worry about an illness that might begin in her internal organs and spread uncontrollably. Unconsciously, the therapist developed a countertransference reaction concordant with the patient's inner world. The therapist's examination of her own feelings and her interpretations regarding his defenses helped the patient to understand his reactions and fantasies towards the illness.

Case 6

A 25-year-old female who developed tetraplegia following a traffic accident was at the end of a 20-month rehabilitation process. She started to display unusual behaviors during the last month of her treatment. She made her family lock her door and separate her room's balcony from the other balconies on which the hospital staff hung the sheets used for all patients. The service nurse could no longer enter her room to perform daily follow-up and she had to wait outside the door.

The nurse felt marginalized because she had worked very hard during the rehabilitation process and expected gratitude. On the other hand, after a very difficult period of the medical intervention, the patient was in need of regaining control of her body and life. These feelings of the nurse might be regarded as an example of countertransference. The problematic behaviors resolved after informing the service nurse about patient's inner world.

Understanding the patient and her reaction better, the nurse could manage to organize her visits together with her patient, giving the patient a sense of control.

Transference

Freud (1895) suggested that in the psychoanalytic process, patients almost always are prone to develop some feelings and ideas towards the therapist that trouble them, and defined them as transferences that develop through a faulty connection. Later on, Freud defined the transference phenomena as new versions or copies of impulses and fantasies stimulated during the psychoanalytic process. According to Freud, transference in psychotherapy is the transference of libido through the mechanism of replacing the memory of the original object with the therapist, who becomes the new object of sexual desires. Sandler et al. (1995) defined this phenomenon as the patient's need for repetition. Although Freud (1916-7) originally viewed transference as a clinical phenomenon that hindered the analytic process, he later defined it as a therapeutic tool and highlighted the fact that transference is evident from the initial phases of the treatment and is very important to the psychoanalytic process. Subsequently, parallel to the developments in ego psychiatry, the meaning of transference was widened. Anna Freud (1936) discriminated the transference of defenses and the transference of libidinal impulses, while simultaneously she talked about action in transference in order to explain the transference of feelings and urges towards the therapist during the treatment process to real life by directing them to people the patient encounters in his/her social life. Other psychoanalysts further developed the concept of transference. Although it has been suggested that all behaviors that arise during adulthood are repetitions of the relationship-forming style acquired during the first years of life, and the only effective interpretations in the psychoanalytic process are transference interpretations, Sandler et al. (1995) opposed this view and proposed that relying only on transference issues would banish the therapist from other materials brought to therapy by the patient. Greenson (1965) defined transference as the repetition of feelings, ideas, impulses, fantasies, and defenses toward an inappropriate person that originally arose during early childhood within the relationships with significant others. This definition includes reactions towards others that have become habits. As the importance of object relationships in the inner world of the individual increased, the concept of transference began to be defined as a form of these inner relationships projected onto the outer world. As it is known, object re-

relationships in the inner world are projected to the outside world through the defense mechanism, projective identification; therefore, the analyst should be able to recognize and endure the patient's transferences, experience these in countertransference, and provide feedback to the patient via interpretations. In this regard, the concept of transference also includes unconscious efforts aimed at insight or directed toward the recurrence of early childhood experiences. Although it has been suggested that transference is unique to only psychoanalytic conditions and cannot be observed without the psychoanalytic process, this view is not currently accepted. Transference, as Freud (1912) also stated, may arise within other psychotherapeutic modalities and hinder the psychotherapeutic process. Points of view about the concept of transference and countertransference can be classified into 2 groups: modern and historical. According to the historical understanding, transference is the reenacting of early childhood relationships and the aim of interpretations is to help the patient in developing insight about how the early relationships affect the relationship with the analyst. This psychoanalytic relationship provides a model to the patient that can be adapted to other relationships. According to the modern understanding, in addition to reenacting a past relationship, transference is viewed as a new experience. Here, the aim of the interpretation is to make this new experience conscious for the patient (Cooper, 1987).

Transference is a phenomenon that arises in almost every relationship; it can arise in the first psychiatric interview and sometimes earlier than the first interview. Information about the doctor, sometimes information gathered on the Internet, and sometimes feelings that arise during the initial process of getting an appointment may be evaluated as transference. The patient-doctor relationship is always a combination of the real relationship and the transference. The real characteristics of the patient almost always add on to the transference feelings. Both responsiveness and unresponsiveness of the patient to the treatment can be explained within the concept of transference.

Transference in patients diagnosed with a physical illness

Patients who come to psychotherapy during the diagnosis and treatment of a physical disorder frequently complain that doctors do not show enough care, or less frequently, they may be unresponsive to the treatment. These situations may be handled as transference feelings (Cases 1 and 2). A real relationship with the therapist is very important for patients with a serious physical ill-

ness. The therapist acts as an auxiliary ego that adjusts the mood and self-esteem of the patient who is faced with a threat to his/her existence and whose abandonment fears have been triggered. Patients, especially the ones who experience a life-threatening situation, may enter into a psychological regression in which they need to experience unconditional trust. As a result, during the diagnostic phase and in the beginning stages of treatment, doctors are generally idealized. These positive transference issues generally have positive effects upon the treatment (Straker, 1998).

In some cases, transference feelings can split, and while the psychiatrist is idealized, anger feelings may be directed towards the medical treatment team. When this occurs, anger may be related to real disappointments related to the actual treatment, or may be related unconscious disappointment with the omnipotent object that was believed to protective at all times. In such situations, the aim is to help the patient in dealing with his/her anger and improve their relationship with the treatment team. The positive effects of an empathic relationship with the therapist and future transference feelings towards the treatment team, especially for terminal patients, should not be dismissed. In terminal cases, the therapist functions as a mother that helps the patient cope with the pain and management of physical care. The role of the therapist is very difficult and controversial in such situations; the therapist can begin to feel omnipotent, which may give rise to over involvement in the patients' life.

The doctor is frequently idealized in such situations. The patient is in need of regressing to an earlier period that did not involve contradictional feelings, and in which he/she felt unconditional love and security; therefore, the approach to a terminal-phase patient is based on Kohut's idealized and omnipotent object transference concepts. (Norton 1963, Straker 1998).

Counter-transference

Another unavoidable phenomenon in the patient-doctor relationship is countertransference

Similar to transference, in the beginning, countertransference was considered a phenomenon that hindered the treatment process, and was thus defined as an unwanted occurrence by Freud (1937); however, later on, it was accepted as a concept to help understand the inner world of the therapist and began to be used as a concept that reflects all feelings of the therapist.

Racker (1968) mentioned that if countertransference

is correctly evaluated and understood, it could have positive effects on the therapeutic relationship.

Today, the concept of countertransference includes all feelings and attitudes of the therapist towards the patient, in a similar manner as the transference concept. Development of countertransference feelings and recognition of these feelings by the therapist is accepted as a necessary and effective process for understanding the inner world of the patient in psychoanalytic therapy.

Countertransference and patients with physical illness

Sometimes patients evoke reactions that are similar to their own pasts in therapists or doctors. In this situation, unresolved past issues of the therapist or doctor are triggered and the patient's treatment may be delayed or become impossible (Lindy, JD and Lindy, DC, 2004). (Case-4)

Racker (1968) referred to countertransference as a reaction towards the patient based on the therapist's unconscious feelings. He related the concept of countertransference with projective identification and addressed concordant and complementary identifications. Similarly, the whole, or a part of the psychic apparatus of the patient leads to a formation of a complementary or concordant identification in the therapist, leading the therapist to identify with some part of the patient's conflict. This type of countertransference between the patient and the resident responsible of her psychotherapy (case5) is an example of complementary identification. In concordant identification, the therapist identifies with a patient's conflicts, hopes, aims, or attitudes. An example of this type of identification was presented in Case 6.

Countertransference feelings may lead to difficulties in psychiatric treatment of patients with serious physical illnesses. Illness can trigger omnipotence and rescue fantasies of the therapist. The therapist wants to do something for the patient. He struggles to find a balance between passivity and wish to make an intervention; not to cause more pain, and excess interventions intended with time pressure and rescue fantasies. It should be remembered that countertransference feelings can surface in various ways. The therapist who has or is faced with loss, control, and death issues during the therapy may express his/her countertransference feelings in various ways. For example, he/she can give unnecessary comfort to the patient in response to the expression of feelings, or may remain passive in the therapeutic process, focusing only on daily issues, or may become bored with the patient

and begin sessions late or finish them early, or refer the patient to another therapist. Hopelessness, depression, anxiety, and low self-esteem are other feelings that may be seen in the therapist. If the therapist does not pay attention to countertransference feelings or is unable to recognize them, protective mechanisms step in and the potential to help the patient disappears.

In order to be able to recognize countertransference reactions, some reactions and behaviors are of particular importance. For example, if a therapist who usually can establish positive relationships with patients is becoming bored with a particular patient, then countertransference reaction should be considered (Tansey and Burke, 1998).

Severe and fatal illnesses result in psychological regression and the appearance of primitive defense mechanisms in patients. This results in strong countertransference feelings in the therapist. Such reactions may have negative effects on a patient's treatment, especially in terms of the functionality of the treatment team.

Kernberg (1999) divided countertransference feelings into 2 groups: acute and chronic. This discrimination may be used in understanding and evaluating countertransference feelings while treating patients with physical illnesses. Chronic countertransference feelings include feelings of the therapist that develop during the psychotherapeutic process. In cases of acute and severe transference, serious transference reactions, severe personality disorders, such as borderline personality disorder should be considered.. As it is known, these patients tend to project their own psychopathologies to the outside world.

Today, countertransference is considered an inevitable interactive phenomenon that develops in relationships. The therapist's task is to bear this experience and search for ways of understanding it on a deeper level. The therapist should always remember that his/her own experiences are guides in understanding the patient's inner world.

In particular, in patients with severe physical illnesses that result in functional impairments, there is a huge burden on the treatment team. Patients may deny that they need a long and intense treatment in order to preserve their hopes, or may not cooperate. On the other hand, the treatment team may evaluate these patients as dissonant and provocative. These reactions provide information about the inner world of the patient; however, if the treatment team does not

receive the necessary support for understanding these reactions, the establishment of the therapist-patient relationship, which is critically important, may be difficult. When problems due to the patient's behaviors arise, it may sometimes be necessary to consider the countertransference feelings of the treatment team in psychiatric consultations (Case 6).

DISCUSSION

There are very few studies on countertransference feelings towards severely physically ill patients. Perry and Markowitz (1986) worked with AIDS patients and stressed the fact that these patients regress and adopt roles based on symptom-free periods prior to their illnesses. The authors have suggested that focusing on the physical symptoms in the early phase of the psychiatric treatment is beneficial and that AIDS patients should not be forced into group treatment, as they may feel coerced. Psychiatrists working with these patients were reported to have unreasonable fears of contamination. These observations and experiences of Perry and Markowitz are valuable when considering the treatment of patients diagnosed with other serious physical illnesses.

Gunther (1994) observed the countertransference feelings of the treatment team working with patients who had severe physical traumas and proposed that these feelings are related to the basic characteristics of catastrophic lesions. Such injuries involve a threat to individuals' life and certain bodily changes or return to normal life becomes impossible. In such cases, patients generally do not have a chance to prepare themselves for the experience and serious medical and psychiatric interventions are required.

Countertransference feelings can be related to the loss of functionality and the rehabilitation process. Gunther (2005) categorizes the sources of countertransference feelings towards physically ill patients into 2 groups: universal and personal. Universal sources are related to the demands of the patient, which are the result of psychological regression, aggression directed towards the doctor, powerful feelings of dissatisfaction with the treatment team, damage to professional self-esteem, and narcissistic injury. Personal sources are related to the unconscious/conscious developmental experiences of the treatment team related to dependency, aggression, sexuality, self-esteem, and autonomy. As can be seen from the case examples, transference and countertransference feelings are diagnostic tools that help

in understanding the patient's inner world. Psychoanalytic theory presents a model of these concepts that is helpful in understanding the feelings of the patient and the treatment team, and therefore, increases the quality of the service we can provide to our patients.

In addition to their usefulness in the resolution of acute reactions, these concepts also are helpful in long-term treatment and in the rehabilitation process. Tansey and Burke (1989) suggested that countertransference feelings are sources of information about the patient, treatment team, and the treatment process. In their article on the rehabilitation process of a patient following multiple amputations, they observed that the medical treatment team working with the patient was overly involved with the patient in the beginning, as was the patient's therapist; however, they felt burdened with the patient's increasing emotional needs, demands, and problems related with the prostheses. In the beginning, the therapist felt a powerful attraction towards the patient, and perceived him as compatible with and willing to regain his functionality; but with time, he realized that these demands were unrealistic.

The therapist understood the extent of pressure this patient caused for him only when he was discharged from the hospital. Therefore, he realized how ineffective he had been as a therapist. Ineffective therapist and unsatisfied patient relationship projects patients relationship with his wife and his way of relating to others prior to his illness. Countertransference feelings of the therapist and the treatment team may overlap. Based on this fact, Tansey and Burke (1989) suggest that countertransference feelings may be used for evaluating the medical treatment and might be useful in understanding and helping the pathological behaviors of patients with a chronic illness. As a reaction to the negative feelings towards the patient in the treatment team, hostility (giving advice to the patient, creating feelings of guilt, talking about the patient as if he/she were not there, and ignoring the patient). The treatment team should be offered support for understanding and controlling their own anxiety, hatred, and guilt feelings.

In such cases, countertransference feelings that arise during the individual therapy of the patient might be helpful in understanding the problems of the entire treatment process. The therapist responsible for individual psychotherapy of the patient may review, in a team meeting, the reactions towards the patient in the light of his own feelings. In this manner, the treatment team can gain a better understanding of the patient

and thus become more functional as a treatment team (Laatsch L. et al., 1993).

CONCLUSION

Generally, doctors treating patients with serious medical illnesses are very busy and have inadequate information about the psychological processes. Psychiatrists have to evaluate these patients in crowded environments and generally have a limited time. Despite all these negative circumstances, the hospital psychiatrist sometimes has to help the team members understand their negative reactions towards the patient. Explaining the dynamics of the problematic behaviors of the patient to the team may be very helpful and help them regain the sense of control they have lost.

Transference and countertransference feelings and reactions are important information resources related to both the patient's inner world and the medical treatment process. Today, transference and countertransference concepts are accepted as effective phenomenon in the treatment process, which arise in the patient-doctor relationship. These concepts developed by psychoanalysts might be helpful in understanding breakdowns in the medical treatment process and the psychological problems of medically ill patients.

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