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Doctor-patient relationship

Physicians' Emotional Reactions to Patients: Recognizing and Managing Countertransference

Alicia A. Marshall, Ph.D., and Robert C. Smith, M.D.

Department of Communication, Cornell University, Ithaca, New York, Department of Medicine, Michigan State University, East Lansing, Michigan

Traditionally, physicians have been socialized to repress emotional responses to patients in an effort to maintain clinical objectivity. In this article we call into question that assumption, maintaining that rather than being hindrances such natural responses can be facilitators to the development of stronger physician-patient relationships. We focus on the concept of countertransference, defined here broadly as incompletely recognized emotional reactions a physician has toward a patient or his/her circumstances. In this article we differentiate between internally-focused and externally-focused countertransference. Internally-focused countertransference refers to unrecognized reactions that reflect the unique psychological state of the physician, whereas externally-focused countertransference focuses on the reactions that primarily derive from the behaviors or other characteristics of the specific patient or circumstances. We conclude by presenting a 3-step strategy for recognizing and managing countertransference responses to patients.

INTRODUCTION

Across all walks of life individuals meet, interact, and react in some way to one another. These reactions may range from instantly liking to being quite annoyed or frustrated. Encounters between physicians and patients are no different. Often we feel angry when a patient does not follow our directions, feel protective of the elderly patient that reminds us of a parent, or feel sad when a favorite patient moves away or dies.

Unfortunately, the biomedical model leads physicians to believe that human reactions should be suppressed to maintain "clinical objectivity." To date, it has been assumed by many that it is best to ignore personal reactions that patients may stir in us. However, psychologists, psychiatrists, and other mental health professionals have relied on such personal reactions for years as critical diagnostic and therapeutic tools as well as means to develop and monitor their relationships with their patients (1).

This paper shifts the focus from viewing these natural reactions as hindrances to patient care to seeing them as potential facilitators. To do so, it first examines the role of countertransference, defined broadly as incompletely recognized emotional reactions a physician has toward a patient or his/her circumstances (2). Next, it reviews reactions physicians often have to particular types of patients and, finally, provides strategies for managing these reactions.

DEFINITIONS AND EMPIRICAL FINDINGS ON COUNTERTRANSFERENCE

Countertransference, as originally defined by Freud, refers to an unconscious reaction of a therapist to a patient's transference (3). Over the years, some have proposed a more expanded meaning, encompassing the total emotional reaction of the analyst or physician to the patient and his/her circumstances (4). This definition incorporates all thoughts, feelings, and actions evoked in the physician and is not restricted to the patient's transference. Although some responses are conscious, most are unconscious and therefore incompletely recognized by the physician. This broader definition of countertransference allows for a more complete understanding of physicians' myriad reactions to patients and thus is adopted in this paper.

To clarify the role of countertransference, Smith (2, 5) differentiates between countertransference feelings and the resulting countertransference behaviors. Countertransference feelings refer to "any feeling, thought, or attitude in the [interviewer] . . . about which the [interviewer] was not fully aware" (2). Feeling warmly about an elderly patient or frustrated about a controlling patient are examples of countertransference feelings.

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Countertransference behaviors are "any potentially harmful behaviors observed during the interview . . . that were not due to lack of proficiency with basic interviewing techniques and about which the interviewer was not fully aware" (2). Such behaviors are actually observed in the interviewer and occur as a result of the countertransference feeling. For example, a physician with a countertransference feeling of fear of death might exhibit the countertransference behavior of avoiding discussion of death with a cancer patient. In combination, countertransference feelings and countertransference behaviors make up what we broadly refer to as countertransference or as physicians' unrecognized responses to patients.

Smith conducted two investigations, first with medical students (2) and then with medical residents and fellows (5) to better understand the potential effects of countertransference on physician-patient interactions. Smith relied on direct observation of trainees during a 30–45 minute patient interview to record countertransference behaviors. After these interviews, Smith openendedly discussed the interviewers' reactions to their patients to record unique countertransference feelings and to explicate countertransference behaviors.

Unrecognized responses were observed in 13 out of 15 medical students (87%) and 16 out of 19 residents (84%) in a single patient interview. The most commonly experienced countertransference feelings were fear of harming the patient, fear of loss of control, fear of addressing unpleasant topics, general feelings of inadequacy, fear of death and cancer, and high identification with the patient. Sexual feelings, attitudes favoring biomedical data, fear of involvement, and intimidation were relatively uncommon feelings reported by the study participants. Common and potentially harmful countertransference behaviors included avoiding psychosocial issues, avoiding discussing death, taking excessive control over the interview and/or the patient, avoiding discussing difficult topics, and general passivity on the part of the physician.

Although not measured, it was proposed that these unrecognized responses can have counterproductive effects on the medical interview and the patient. For example, avoidance of psychosocial issues could result in missing invaluable information contributing to the patient's illness. Likewise, avoiding difficult topics can hinder the physician's ability to provide critical support or to broach critical issues such as suicidal tendencies.

Internally versus externally-focused countertransference

We propose that countertransference can be better understood if divided into two not always distinct categories: internally-focused and externally-focused countertransference. Internally-focused countertransference refers to unrecognized reactions that reflect the unique psychological state of the physician, rather than an overtly provocative patient situation. To be certain, the patient always has a role in eliciting such reactions, but here the focus is on the distinctive internal issues of the physician. Consider, for example, the physician who feels anxious confronting an older male patient for refusing to take prescribed medication. One explanation is that the patient reminds the physician of her father, and she feels anxious confronting this authority figure. Thus, the anxiety has less to do with the patient per se, and more to do with the physician's psyche and personal relationship with her father.

Internally-focused countertransference reactions have several defining features. First, they are idiosyncratic. We would not, for example, expect all physicians to respond to the above patient by feeling anxious. Second, internally-focused countertransference reactions tend to be quite intensely experienced. Third, they can produce behaviors that are unexpected and difficult for outside observers to understand. For example, most others would be surprised to see the above physician acting overly apologetic. Finally, we would expect to observe in this physician a similar reaction when interacting with numerous other older male patients.

There are, however, internally-focused countertransference reactions that many physicians have in common, such as the fear of death or the fear of losing control. Indeed, many experience anxiety when dealing with authority figures. Such reactions, though experienced by many physicians, are still internally-focused if they are primarily a manifestation of their own unique psychological make up.

Externally-focused countertransference refers to reactions that primarily derive from the behaviors or other characteristics of a particular patient rather than from the physician's unique psychological structure. That is, similar externally-focused countertransference reactions will be experienced by most physicians to the same patient. Thus, these countertransference reactions provide more insight about the patient than the physician. For example, most physicians respond similarly to a patient that is very demanding, argumentative, and generally difficult to manage by feeling frustrated and annoyed. Observers are not surprised to see most physicians reacting similarly. In addition, we would not expect such responses across all similar patients unless they also exhibited the provocative behaviors.

Internally-focused and externally-focused countertransference are, of course, on a continuum and often are evoked simultaneously. Consider again the older male patient described earlier who refuses medication. We might expect to see some level of frustration in any physician (*e.g.*, externally-focused countertransference). Nonetheless, the unconscious feeling of anxiety when addressing authority figures that leads the physician to being overly apologetic or pleasing goes well beyond this and is a clue to the particular physician's individual psychological issues.

Patient characteristics evoking externally-focused countertransference reactions

Researchers have devoted more attention to externally-focused rather than internally-focused countertransference to understand better what patient characteristics evoke the

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strongest reactions in physicians. Both Goodwin *et al* (6) and Harris *et al* (7) specify patient characteristics that regularly evoke both positive and negative physician responses. Goodwin *et al* asked physicians practicing in the same clinic to rank order 22 clinic patients from most liked to least liked. Harris *et al* took a slightly different approach, having 39 internal medicine residents rate a list of 64 patient characteristics on their willingness to treat such patients.

Both studies reached similar conclusions. First and foremost, physicians clearly prefer working with patients who are doing well medically (6), have a controllable disease, or have cardiac disease (7). These positive reactions seem to reflect physicians' biomedical interests and expertise. They also found that physicians are most comfortable, and experience the most positive reactions, when the patients are easily managed. Patients who are compliant, and those that are well groomed and clean, also elicit positive responses from physicians. Not surprisingly, these findings suggest that physicians react more positively to patients who meet basic societal norms regarding personal hygiene, who follow doctors' orders, and who follow the classic biomedical definition of "patient."

Beyond simply listing provocative features, however, there have been some consistent constellations of patient characteristics that evoke negative responses. Taking the findings of numerous authors (8–12) into account, we identified the following six constellations that consistently evoke negative countertransference responses in physicians.

Challenging biomedical conditions. Just as the biomedical condition of the patient may strongly contribute to the physician feeling positively toward the patient, it also can contribute to negative reactions. Goodwin *et al* (6) and Klein *et al* (11) discovered that patients with severe organic diseases (*e.g.*, shock), who challenge the physician's diagnostic skills (*e.g.*, unexplained weight loss) or where no cure presently exists (*e.g.*, AIDS) are most likely to elicit negative responses in physicians. Gorlin and Zucker (9) suggest that such circumstances evoke countertransference feelings of inadequacy, a lower sense of self-esteem, frustration, or helplessness. These feelings might then result in avoiding the patient or family members, being reluctant to discuss the illness, delaying important information, or failing to request necessary consultation (9).

Somatizers. Somatizers are patients suffering from numerous symptoms or physical complaints with no organic disease basis (13). Each specialty has its particular type (*e.g.*, irritable bowel syndrome, fibrositis). These patients have frustrated physicians for a long time; they require more medical services (including diagnostic tests), make frequent appointments and phone calls, request more referrals, amplify their symptoms, and deny the role of stress in their illness (8, 10, 14). It is understandable that physicians might experience feelings of defeat, helplessness, exasperation, anger, or frustration. Because of these countertransference feelings, physicians often reject or avoid somatizers, make unnecessary referrals, order additional tests, or simply give up on them (9).

Challengers. These patients have a high need for control. They often challenge the physician's authority, expertise, or integrity and are generally viewed as demanding, time consuming, and undesirable (8, 10–12). Negative responses to challengers include feeling helpless, competitive, angry, defensive, threatened, and frustrated (9). Resulting behavioral reactions include engaging the patient in a power struggle, arguing over diagnosis or treatment options, or cutting the interaction short.

Clingers. At the other end of the psychological spectrum, clingers are completely dependent on the physician. Questioning nothing, they rely solely on the physician to make all decisions (8). As Groves explains, these patients have "a self perception of bottomless need and [a] perception of the physician as inexhaustible" (8), a view that often leaves the physician feeling "sucked dry." Although initially gratifying for many physicians who like to take charge, the neediness of these patients eventually evokes impatience, anger, and, possibly, guilt (9). Physicians typically react by distancing themselves, redefining the relationship from a warm and caring one to a cold and purely professional one, and even avoiding contact with the patient. Sadly, these reactions leave the patient feeling the very thing they feared most: abandoned.

Self destructives. One of the most difficult circumstances for physicians is encountering patients with self-destructive tendencies. These patients present histories of repeated failure, bad luck, disappointments, and suffering as well as opposing encouragement and resisting assistance. As Groves observes, these patients "glory in their own destruction" and have given up hope (8). Physicians usually feel sorry for them and experience a need to protect and take care of them. But this counterproductive reaction is typically rejected by such patients. Over time, physicians feel disapproval, anger, or even disgust (9). Potential countertransference behaviors initially include being helpful, assisting in planning coping strategies, and other concerned behaviors but later shift to rejecting the patient, neglecting the patient's physical needs, or exhibiting hostility toward the patient.

Incommunicatives. Also difficult are patients with various characteristics that impede communication, including language or cultural barriers (9), low intellectual ability or lack of education (11), hallucinations (7), or inability to understand explanations or instructions (9). The most common countertransference reactions are feeling impatient, frustrated, and helpless. Accompanying behaviors include rejection, acting abruptly, and avoidance. In particular, such reactions hinder the physician in seeking assistance to overcome the communication barriers.

In sum, investigators have identified circumstances or patient characteristics that evoke both positive and negative reactions in physicians. What has yet to be fully articulated are strategies for addressing these reactions in a way that

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enhances quality of care. Certainly, most positive behaviors should be maintained, for example demonstrating concern, actively listening, and spending time explaining key issues. It is the negative or potentially harmful behaviors that are most important to recognize and to alter. Our final section presents three steps in this process of first recognizing and then managing potentially detrimental internally-focused and externally-focused countertransference.

RECOMMENDATIONS

Step 1: Develop awareness of all reactions

The first and most important step is to develop awareness of emotional and subsequent behavioral reactions to patients. This can be accomplished through a number of means. Certainly, reading about countertransference can assist in intellectually understanding emotional reactions. More critical, however, is the exploration of one's own unique responses to patients. One of the most powerful tools for such reflection is keeping a personal journal (15). Briefly record observations of interactions with patients, paying particular attention to any feelings experienced before, during, or after the interaction. Answering questions, such as "What do I feel before I go into the examining room to see this patient?" or "What do I feel immediately after the appointment?", is particularly useful in identifying responses to patients.

Participating in small group discussions, such as Balint groups with other physicians, can raise to consciousness feelings of, for example, frustration or sympathy for certain patients. Hearing the experiences of fellow colleagues also can validate emotional reactions primed by particular patients. Likewise, entering into psychotherapy affords physicians the opportunity to focus on their emotional responses to a wide array of stimuli that are often suppressed or ignored. Engaging in such structured conscious-raising activities sets the stage for heightened sensitivity to one's reactions to others.

Once countertransference feelings are recognized, it is crucial to examine how these feelings are affecting one's behavior toward the patient. A valuable tool here is an audiotape recorder. Tape recording sessions with patients allows one to listen for differences in interaction style across patients. For example, it is not uncommon to observe oneself spending more time with some patients than others or to be more responsive to some patients questions and more abrupt with others. Likewise, physicians often unconsciously shorten the interaction or avoid discussing particular topics with "difficult" patients. Listening closely to audiotaped interactions can highlight differences in bedside behavior that otherwise go unnoticed. Eliciting feedback from colleagues on such audiotapes can provide a more objective assessment of one's interaction style with patients. Similarly, eliciting feedback from patients concerning interaction style can provide a wealth of information.

Step 2: Differentiate internally-focused versus *externally-focused countertransference reactions*

Once aware of a reaction, it is important to determine its root; that is, determine whether or not the reaction primarily reflects one's own issues (internally-focused) or primarily reflects the reality of the patient (externally-focused). Once one or both origins of the reaction are identified, management decisions can be made that will enhance the physician-patient relationship. Internally-focused countertransference is typically counterproductive and should not be acted on directly during the interaction. Rather, it should be addressed through introspective psychological work with the goal of replacing dysfunctional behaviors with more productive ones, as well as gaining a better understanding of oneself. In contrast, externally-focused countertransference often can be of great diagnostic and therapeutic significance because it assists in identifying personality characteristics in patients. For example, once a patient's propensity to be challenging is recognized to be a feature of an obsessive-compulsive personality, then the importance of allowing the patient to have some say in decision-making (thus giving the patient more control and decreasing the unconscious need to be challenging) becomes apparent.

Continuing to record observations in one's journal is equally valuable in this step. Recording particularly charged situations can best lead to insights into the basis for the countertransference response. Specifically considering questions such as "Have I felt this way before with other patients?" or "Would anyone react in this way to the same patient?" can help you decide if the responses are internally or externally focused. Moreover, talking to colleagues informally or in Balint groups can reaffirm assumptions of externally-focused responses or suspicions of internally-focused ones.

Step 3: Alter potentially harmful behaviors

The final step requires changing potentially harmful behaviors. It is important to first consciously acknowledge the emotion and its interfering behavior, thus recognizing one's "Achilles' heel." Repeatedly recognizing the reaction, and that it is a problem, sometimes results in significant change by itself. However, additional effort usually is required.

Externally-focused responses are more easily altered than internally-focused responses because they are less entrenched in our psyches. Repeatedly acknowledging these externally-focused reactions is particularly effective in eliminating them, especially when combined with the recognition that patients' often negative responses reflect their own personalities and are not to be taken personally.

For all patients who evoke potentially harmful externally-focused countertransference behaviors, three things should be remembered. First, meet the patient where s/he is initially. Accept the dependence or the need for control or attention. This should minimize the patient's need to further exhibit the characteristics that are stimulating the countertransference reactions. For example, giving the clingy pa-

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tient permission to call the clinic on a structured schedule (*e.g.*, only once a week) reassures the patient that s/he is not being abandoned, thereby decreasing the need for constant (*e.g.*, daily) contact. Likewise, acknowledging a patient's knowledge on treatment options should decrease the patient's unconscious need to assert his/her expertise. Second, resist the temptation to fight or change the patient's defense mechanism. Figure out how to harness it to help develop a trusting relationship with the patient. Acknowledging to a somatizer that s/he has a legitimate and chronic illness, such as irritable bowel syndrome, should not only calm the patient (through validating the symptoms) but also result in a more functional physician-patient relationship. Finally and above all else, establishing a strong relationship with these difficult patients is the best way to decrease potentially harmful countertransference reactions and accompanying behaviors. Exhibiting unconditional positive regard and empathy for these patients should result in a decrease in a patient's need to exhibit troublesome behaviors (*e.g.*, neediness or argumentativeness), thus decreasing the probability of experiencing countertransference responses.

Internally-focused reactions are more ingrained, less conscious, and more difficult to alter. Beyond repeated acknowledgement, working with a peer can be invaluable when attempting to alter negative behaviors. Rehearsing new, more desirable behaviors, first in one's mind and then with a co-worker, provides important insight into old patterns of behavior and reinforces new behaviors. For example, practice more functional behaviors while a colleague takes on the role of a particular patient evoking the negative responses. Recording insights gained or new behaviors discovered during these practice sessions in one's journal provides a running account of growth and development as an interviewer.

Interacting regularly with small groups of colleagues in structured sessions can also be useful for developing new behaviors. Colleagues can provide support, accurate feedback, and suggestions for more functional behaviors. During such small group interactions, individuals should discuss difficult encounters they have faced and observations they have had regarding particularly troublesome patients or circumstances. In describing these observations, other group members would then have the opportunity to provide feedback and to suggest potential new strategies for the individual to consider. The feedback should focus on specific dysfunctional behaviors to be altered rather than on the person. In addition, it should be descriptive rather than evaluative, contain a balance of both positive and negative observations, and provide a manageable number of new behaviors to adopt (15). Individuals should also feel comfortable discussing general day-to-day stressors and concerns. During such self-disclosures, individuals could not only receive advice but, more importantly, could receive support and general reinforcement from valued colleagues. These group interactions provide the added benefit of the opportunity to practice effective listening skills, and they provide social support.

SUMMARY

In sum, it should be recognized that all humans experience reactions to one another. These reactions should no longer be viewed as detriments but as valuable tools in providing quality health care to patients. In order to be useful, physicians must actively work to develop self-awareness of previously unrecognized responses. Once recognized, potentially harmful behaviors can be altered through the use of individualized work, as well as through interaction and rehearsal with peers.

Reprint requests and correspondence: Alicia A. Marshall, 322 Kennedy Hall, Cornell University, Ithaca, NY 14853.

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