The Physician-Patient Relationship

Three Psychodynamic Concepts That Can Be Applied to Primary Care

Paul E. Goldberg, MD

Psychodynamic concepts can be used to help understand and manage certain difficulties that arise within the physician-patient relationship. The concepts of transference, countertransference, and action (in the form of acting out and enactment) are discussed. A case description is included to show how these concepts apply to the day-to-day practice of primary care medicine.

Mrs B, an elderly diabetic with significant cardiopulmonary problems, was seen by her physician as a medical patient for several years, then briefly in psychotherapy, and then again as a medical patient. Mrs B’s interactions with the physician were marked by warm, grandmotherly inquiries about the physician’s children and by hostile accusations of missed diagnoses and indifference. The physician felt victimized when, on the way out the door after a long office visit, the patient began, in a lighthearted manner, to discuss thoughts of suicide. She frequently threatened to leave the practice, yet remained dependent on the physician. This became apparent when, on beginning psychotherapy, the patient refused to see another physician in the practice for medical visits, threatening to leave the practice unless the original physician continued to see her medically as well as in psychotherapy.

During both psychotherapy and medical visits, her legitimate concerns about isolation and the physical limitations of chronic illness became apparent. Widowed for many years, she wanted more contact with her children and grandchildren, but they lived far away and saw each other infrequently. However, these factors only partly accounted for her tendencies to become dependent on and fearful of abandonment by her physicians. The victim of an abusive childhood, she also had suffered through a long marriage to a distant and abusive husband. The patient’s anger at lifelong mistreatment by loved ones was transferred onto her physicians.

This patient presented with common behaviors arising from significant underlying psychopathology that impact on the physician-patient relationship and make management of medical problems more difficult. This article will examine these behaviors from a psychodynamic viewpoint by introducing the concepts of transference and countertransference—manifestations of unconscious mental activity of both physician and patient. Transference and countertransference lead to certain forms of action on the part of the physician and the patient that give rise to difficulties in the management of medical problems. The phenomenon of transference and countertransference is only one of many biopsychosocial factors that shape the physician-patient relationship. However, the ability to detect these unconscious forces in both self and patient may enable the physician to diagnose certain psychiatric disorders in the patient and to modify responses to certain difficult behaviors of the patient in a way that improves patient care.
TRANSFERENCE

The importance of transference in the primary care physician-patient relationship has been discussed by Zinn \( ^1 \) and others. \( ^2-7 \) Transference is the aspect of an interpersonal relationship in which a person's behavior toward another is influenced by relationships to important figures from childhood and infancy, usually parents and caretakers. One's feelings about the person from the past are transferred onto the person in the present. Accompanying these feelings is the expectation that the person in the present will behave in the same way as did the person from the past. It has been described by Greenson as what happens when one "misunderstands the present in terms of his past." \( ^8(p174) \)

Transference phenomena can occur in all human relationships. \( ^1 \) Transference has been broadly described as "an inherent human tendency to impose the organizing of prior perception of experience on the present and . . . as fundamental to shaping our psychic reality." \( ^9(p598) \)

Transference is a crucial component of interpersonal relationships and, therefore, of the physician-patient relationship.

Transference can be seen as a replaying of parental relationships in adult life. Parental relationships are, by nature, ambivalent because no parent can always be perfectly attuned to a child's needs. Conflicts about separation and sexual strivings toward the parent inevitably arise, and the child is left with both hostile and loving feelings for the parents. These feelings comprise the unconscious mental content that is transferred onto the physician. In psychodynamic thinking, transference has been divided into positive and negative aspects, which may be present simultaneously. Both aspects of transference may also be present in the primary care physician-patient relationship. Much can be gained by their recognition.

A patient's positive regard for the physician is not, of course, purely a function of transference feelings, but is determined by many factors rooted in the reality of the physician-patient relationship, including the patient's cultural background, the physician's communication skills, personal warmth, and other elements. Positive transference manifestations are, however, a significant part of the healing relationship and should be looked for and taken advantage of.

Zinn \( ^1 \) writes of the benefits to be gained by taking advantage of the positive aspects of transference. While many physicians intuitively and successfully use positive transference manifestations without necessarily being aware of them, negative, hostile transference manifestations in the patient may be more problematic. Their identification can help in managing difficult physician-patient interactions. Mrs B, described in this report, is an example of negative and hostile transference that causes significant difficulties in the physician-patient relationship.

This patient could be categorized into one of the groups of "hateful patients" whose behaviors Groves described as "related to profound dependency needs." \( ^2(p887) \) Groves noted the importance of physicians' ability to manage their own negative emotions that are engendered by these patients. Being aware of the transference origins of these patients' hostile behaviors will allow the physician to maintain a more distant, neutral position when confronted with these behaviors. The identification of transference-based behaviors in part revolves around the recognition of the sometimes subtle emotional states that patients manifest during the clinical encounter. One can learn to recognize the verbal and nonverbal clues of an anxious, angry, or seductive patient. A patient's unexpected or exaggerated emotional response to a given situation during the physician-patient encounter may signify the presence of transference phenomena. The recognition of this also involves a physician's awareness of his or her own countertransference response.

COUNTERTRANSFERENCE

That physicians might have negative emotional responses to Groves' "hateful patients" implies the existence of countertransference, which in its broadest definition is the physician's total emotional response to the patient. There has been much debate in psychoanalytic writings about the exact nature of countertransference. These differing views are reflected in discussions of countertransference in the general medical literature.

A narrow view that originated with Freud defines countertransference as limited to the physician's transference to the patient. \( ^10 \) The physician unconsciously anticipates certain behaviors in the patient based on behaviors of significant people from his or her own past. This generates the physician's transference response and may significantly influence behavior toward the patient. \( ^9 \) For example, a physician who was raised by an inaccessible, alcoholic parent may inappropriately feel threatened with abandonment by an alcoholic patient, thus generating hostility and influencing behavior toward the patient. This implies the presence of unresolved, neurotic conflicts in the physician. \( ^10 \) The physician "brings [his or her own] biases and emotional needs to the encounter, resulting in a dynamic interaction that ultimately shapes the outcome of the relationship." \( ^21(p203) \)

When the physician's own neurotic conflicts threaten to intrude on the physician-patient relationship, steps should be taken to avoid or at least minimize the contribution of countertransference. As has been
If transference and countertransference are indeed universal phenomena, one would expect that, in addition to hostile, frustrated countertransferences described thus far, virtually all patients whom a physician encounters would generate some type of countertransference.

Certain character traits in patients may evoke countertransference phenomena in physicians. For instance, annoyance and impatience with an overly detailed history given by a person with obsessional character traits may be related to the expected response of the average person to this type of behavior. This expected response is a form of objective countertransference. The physician’s annoyance may also be related to resonant of the patient’s behavior with the physician’s own personality structure, with obsessiveness being a well-recognized character trait among physicians. Awareness of countertransference may enable the physician to temper expression of annoyance with the patient. In addition, a patient’s obsessional preoccupation with trivial complaints may cause an obsessional physician to respond with a compulsive sense of responsibility to address in detail each of these complaints. This may give rise to frustration and guilt in the physician, who has only limited time to spend with the patient. The possibility that this mutual behavior may reflect transference and countertransference is discussed in more detail in the next section.

**ACTION: ACTING OUT AND ENACTMENT**

The term *action* in this context refers to a variety of behaviors, ranging from subtle changes in body language to spoken words to inappropriate, disruptive acts. This last type of behavior is referred to as *acting out*. When considered from a psychodynamic viewpoint, all these behaviors are seen as expressions of transference phenomena in overt behavior.

Acting out is commonly encountered in medical practice, especially in patients with personality disorders. Its occurrence causes much difficulty. It can take many forms, such as angry demands for tests, threats of lawsuits, and drug-seeking or seductive behavior. If a physician can understand this behavior (and the physician’s own emotional response to it) as manifestations of transference and countertransference, the physician may be able to temper his or her emotional response, remaining more objective and less “drawn in.” This will enable the physician to more easily set limits on this type of behavior by these patients. This approach can be especially useful in the consideration of boundary violations of the physician-patient relationship, such as physician-patient sexual contact. The transferences generated by patients with certain types of psychopathology make them especially vulnerable to victimization by physicians. Even in the absence of severe psychopathology in the patient, the psychological state induced by transference in the physician-patient relationship makes patients susceptible to these incidents. A physician’s countertransference should be considered when trying to understand boundary violations. Comments by Luber regarding a physician’s lyrical description of his erotic response to a patient include what amounts to a consideration of a narrow and a broad view of countertransference. Luber also notes that a physician’s emotional response might yield “useful data about the patient.”

There is a range of psychopathology in physicians who engage in boundary violations that, when seen from a psychodynamic viewpoint, often necessitates consideration of countertransference.
As mentioned in the section on “Transference,” the presence of transference influences one person’s behavior toward another. This can take the form of behaviors intended to get the other (here the physician) to respond in a way that meets the transference expectations. Mrs B’s dependency needs are an example of this. As evidenced by the simultaneous presence of hateful, angry feelings toward the physician, an attempt at establishing a warm and friendly relationship with the physician was only in part influenced by a realistic expectation of the physician-patient relationship. Also present was the need to recreate an early experience of hating and fearing the one she looked to for love and support.

Action driven by transference wishes often involves more subtle, spoken interactions. Rather than being limited to use by persons with significant psychopathology, the use of speech in this manner is a universal part of human interaction. Its more subtle manifestations have been called enactment or, when emphasizing the fact that it involves reciprocal interaction between 2 people, mutual enactment. By being able to sense, on a moment-to-moment basis, the occurrence of mutual enactments, the physician can modify his or her response to the patient in a beneficial way.

An example of mutual enactment was described in the section on “Countertransference” where the obsessive patient, driven by the need to completely recount and consider each and every symptom, causes the obsessive physician to accede to this request to participate in a long, inappropriate discussion, resulting in too much time spent and the possibility of unnecessary testing and procedures as well as guilt and discomfort on the part of the physician. In this particular case, the physician’s participation is facilitated by personal underlying obsessional traits, including a perfectionist’s need to be complete. Were the physician able to detect the enactment as it was beginning to develop, in part by the ability to diagnose obsessional patterns of speech and in part by his or her awareness of his or her emerging guilty need to be a good physician by inexhaustibly considering all diagnostic possibilities, the physician would be able to set boundaries by limiting the discussion to appropriate consideration of the complaints within the context of the office visit. This would save time and limit physician stress.

Patients with significant underlying hostility and dependency needs may use these subtle forms of behavior in addition to the more easily recognized acting out.

Mrs B, characterized in this article, continued to manifest dependency needs and anger in interactions with the physician, saying, “You take such poor care of me. It shows you don’t want me as a patient. Why don’t you get rid of me?” The physician came to realize this behavior was a plea for a declaration of interest in and love for the patient and, simultaneously, an attempt to provoke the physician to force a referral to another practice, recreating the rejection suffered in her life. The physician chose not to respond to this behavior or to his own anger and frustration but, instead, remained silently attentive. In this instance, the physician was able to communicate nonverbally to the patient an assurance of not withdrawing from her in fear or anger, but rather acknowledging the right to be angry at frustrations in life. Furthermore, with awareness of being a transference object, the physician could tolerate bearing the brunt of the patient’s anger. Mrs B ultimately accepted the physician’s silence and, in fact, seemed amused by it. Escalation of the patient’s behavior into acting out was stopped. Silence may not always be an effective response to patients’ expression of anger and other emotional distress; however, it is a technique that some physicians can use effectively. While Mrs B continued to present multiple complaints to the physician as an attempt to satisfy dependency needs and maintained provocative behavior as an expression of anger, there was a mutual understanding between physician and patient. The patient was able to accept the time and care offered by the physician, who could now be supportive, addressing emotional concerns without becoming embroiled in these issues. The physician could, in addition, choose to address appropriate medical concerns without becoming mired in endless consideration of minor problems.

FINAL COMMENTS

A psychodynamic understanding of the physician-patient relationship can significantly enhance the physician’s ability to manage the types of patients characterized in this article. This has been described previously in discussions about transference and countertransference. One can also, as shown in this article, apply this understanding to the more subtle, day-to-day interactions with patients, defined here as enactment. The ability to detect transference and countertransference manifestations and acting out and enactment as they unfold during the clinical encounter is a skill that, like empathy, can be taught. These concepts may be more accessible during medical school and postgraduate training, and consideration should be given to their inclusion in these curricula.

Accepted for publication August 3, 2000.

This study was supported by a fellowship granted by the Philadelphia Psychoanalytic Institute, Philadelphia, Pa.
I thank Larry Blum, MD, for his invaluable help; L. Bernardo Menajovsky, MD, MS, Ilene V. Goldberg, JD, and Leo Madow, MD, for their editorial and creative assistance; and Catherine Marchok, MS, for library research guidance.

The case description in this article is based on patients encountered by the author, an internist, who also sees patients in psychotherapy. Details have been changed to protect patient confidentiality.


REFERENCES