Transference Phenomena in Medical Practice: Being Whom the Patient Needs

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Transference is a process in which individuals displace patterns of behavior that originate through interaction with significant figures in childhood onto other persons in their current lives. It is a powerful determinant of patient behavior in medical encounters. Transference can affect the kind of physician-patient relationship a patient seeks and his or her response to interventions prescribed by physicians. The relationship is also strongly affected by the physician's own transference or countertransference. Rather than approach every patient in a uniform way, tailoring the approach to fit the relationship needs of the individual patient is advocated. Such tailoring would affect whether the physician is collaborative or prescriptive, how much personal information he or she shares, and how close or distant he or she is. Transference issues can also affect level of somatization and patient adherence to medical regimens. We discuss other problems with transference, such as the seductive patient and gift giving. By paying attention to the transference needs of patients, physicians can enhance the therapeutic alliance in which patients optimally participate in fulfilling their medical needs.

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In medical practice, physicians find that patients have varying hopes and expectations about the medical encounter. Some patients are quite business-like in their approach. They state their problems, get examined, and receive treatment with little more interaction than would be expected with an auto mechanic or travel agent. Other patients seem to want to take up residence in the physician's office. They make frequent visits, have many complaints, and harbor bottomless emotional needs. Most patients occupy a middle ground. They share more of their inner world with the physician than they would with a casual acquaintance, and they expect some degree of support and affirmation in return. Visiting a physician plays a very different role in the emotional life of each type of patient.

In addition to collecting objective clinical data, the purpose of the medical interview is to develop the physician-patient relationship (1). This relationship is shaped by the cultural and psychologic substrate of the patient and by the physician through his or her creation of the office milieu as well as by the physician's own psychologic history and manner in responding to patient needs. As it develops, the relationship takes on meaning for the patient. Although the meaning of illness has been well studied from the anthropologic perspective, the meaning of the physician-patient relationship for the patient has been less well evaluated (2, 3). Several models have been proposed for its analysis (4, 5). One model that seems to have special relevance to the study of the patient-physician encounter, because it is so important in all human interactions, is based on the psychologic concept of transference. From this perspective, I shall analyze several aspects of patient behavior and prescribe a way for medical practitioners to recognize and deal with these phenomena in a nonpsychiatric context.

Definition of Transference

Transference, first identified by Freud (6), is a process in which individuals displace patterns of behavior and emotional reactions that originated through interaction with significant figures in their childhood onto other persons in their current lives. This reaction represents a past (reflected in the present) that is neither the objectively verifiable past nor the remembered past; it is the psychically active past that powerfully motivates all human relationships, especially those that are emotionally charged (7). Transference phenomena are not inherently pathologic in themselves. They become pathologic if they condition behaviors and ways of interacting that inhibit satisfactory human relationships or the pursuit of social and material needs.

In parallel with the transferential relationship that a patient develops in the medical encounter, the physician (also a captive of his or her psychologic past) brings biases and emotional needs to the encounter, resulting in a dynamic interaction that ultimately shapes the outcome of the relationship. Although the precise definition is somewhat controversial, this process has been called countertransference (8). Other investigators and I have analyzed the physician's emotional response to the patient as a diagnostic tool revealing information about both the patient and the physician (9-11). I shall show that by moderating their countertransferential needs (that is, by being adaptable), physicians can best address transference phenomena in medical practice.

Psychiatrists deal with transference phenomena in ways that depend on the type of psychotherapy they use and the psychiatric theory to which they ascribe (12). In classical psychoanalysis, the patient develops a primitive transferential relationship with the analyst, sometimes referred to as the "transference neurosis," which is the source of basic insight into the patient's psychic structure (8). The transferential relationship, in which important early social experiences are recreated and revisited in the patient's actual relationship with the

therapist, is interpreted to the patient and, when "worked through" (13), may lead to development of more mature relationships in the outside world. For example, a man who had hostile, aggressive relationships with several women, including several psychotherapists, was understood by his analyst to have experienced important early relationships as an assault. In revenge, he sought to do the same to the women he encountered. Recognition of this problem was the first step in developing more satisfying relationships. In less intense forms of psychotherapy, transference phenomena are often left uninterpreted, unless they become a problem in the progress of therapy (14).

How can transference theory be relevant to the practice of medicine? Physicians are not trained in such depth in psychologic theory, lack the resources to acquire such knowledge about patients, and might even be put off by this kind of thinking. In addition, interpretation of transference is not part of most patient's expectations about the medical encounter. Although some patients may be gratified and feel supported by a physician's recognizing and naming their emotional state (15), most would be quite shocked to have their behavior interpreted as a transference reaction based on an early emotional experience. Some authors have written about medical practitioners making transference interpretations to their patients, usually in the context of the physician switching roles so that he or she is acting more as a psychotherapist (16-19).

Less interpretive ways of dealing with transference phenomena can also be psychologically therapeutic. Such therapeutic methods may result from physicians' responses to the types of relationship sought by their patients. Many of my patients seem to seek common interests with me other than their medical needs. For example, some patients discuss their vegetable gardens; others talk about neighborhood gossip. One patient likes to talk about his luck at gambling, whereas another likes to tell me about his family history. On the face of it, a patient's seeking this kind of a relationship and a physician's allowing it seems indulgent, frivolous, and a waste of time. Deutsch and colleagues (17) analyzed this tendency of patients to find common interests with their physicians as representing an infantile belief that they can only get good medical care when the physician has a special personal interest in them (17), thus casting a pathologic light on this behavior. In my experience, these interludes, when judiciously used in more healthy interactions, create a common bond between the patient and the physician, helping to fulfill an important psychologic need for both of them and to facilitate the other goals of the medical encounter.

Psychologic theory supports this view. Jaspers (cited in reference 12) wrote that doctors exist because there are persons without friends or love. Self-psychology theory postulates that transference reactions represent either the reactivation of a very positive relationship of early childhood or the substitution of a relationship for some unmet childhood need, such as a consistent, secure attachment to a maternal figure (20). In transference, adults seek out relationships that are self-approving (that confirm the success of their ambitions) or reassuring because of the two persons' essential alikeness (indicating that there are other persons similar to them). In psychotherapy, because the therapist is not placing transferential needs on the patient, the patient can mobilize his or her transference needs in a way that promotes growth through identification (21). At this stage, interpretation of the transference is not necessary to promote psychic healing. A similar situation exists with the relatively healthy patients noted above. Their reception of the physician's approval or treatment as an equal serves a similar healing function. I often seek a common, nonmedical interest with the distant or business-like patient as a means of stimulating attachment. The therapeutic alliance in medical practice (2), in which patients, optimally, participate in fulfilling their medical needs, is fostered by this bonding.

If being friendly or sociable with patients were all there were to managing transference in the medical setting, it would seem trivial or uninteresting. In patients with greater gaps in their social supports, however, being the person whom the patient needs is much more important than being merely friendly.

Case 1

Mrs. A., an elderly woman with variably controlled diabetes, is followed in an outpatient clinic. She was abandoned by her alcoholic husband shortly after the birth of her fourth child and was a single parent thereafter. She remains very involved with her family. At the outset of their relationship, Mrs. A.'s physician attempted to control her diabetes and manage her somatic complaints, including a mild painful neuropathy. As time passed, her somatic complaints diminished, and she became profoundly attached to her physician and other clinic personnel. She came early to socialize with the receptionists and regularly brought them homemade cookies. She talked about her doctor incessantly to her friends and fabricated stories about home visits that were never actually made. The receptionists, sensing her attachment, good-naturedly kidded her about her "boyfriend," and she rejected the physician's offer of a lift to her home because she was afraid "people would talk." She later adopted a more grandmotherly role: sending presents to his children, requesting their picture, and expressing her hurt when he neglected to send her a Christmas card. The physician fostered their relationship by acceding to some of her wishes, revealing some of the details of his personal life, and seeing her frequently and regularly.

The underlying psychodynamics of this patient's choice of husband and of her needs in the physician-patient relationship are unknown. Most importantly, the physician accepted the role that this patient's transference needs placed him in, because he viewed it as psychologically therapeutic for the patient. Nunberg (cited in reference 22) wrote that the patient, in the psychiatric setting, is drafted into treatment by misguided transferential fantasies of who the physician will be for him or her. This expectation is disappointed when the psychiatrist drives the patient back to reality with interpretation of the patient's behavior. In medical practice, physicians need not disappoint patients like Mrs. A., because such patients' transference needs are

well modulated and do not discomfort the physician or themselves. Further, the intervention is in their best interest. Through her relationship with the physician, Mrs. A. has a "corrective emotional experience"; she is exposed, under more favorable circumstances, to emotional experiences that she either could not handle or that were not available to her in the past (23). Objectively indicating such a benefit, Mrs. A. has had fewer undiagnosable somatic complaints. The social support provided by the physician and the clinic setting may diminish her organic morbidity as well (24).

Just as psychiatrists can treat only a limited number of borderline or difficult patients, medical practitioners must decide what their resources are for meeting the demands of patients such as Mrs. A. It was relatively easy for Mrs. A.'s physician to have this kind of relationship with her, because she was not excessive in her demands and, in fact, was quite nurturing in return. She was a good match for her physician who maintains a very homey atmosphere in his office. Other patients have deeper, even unquenchable, needs that elicit avoidance reactions from their physicians (10). Avoidance reactions are also common among physicians treating patients who are generally found unattractive, such as obese or alcoholic patients or those with personality disorders. Physicians vary in their tolerance for these types of patients according to their previous experiences and prejudices. Physicians can become aware of countertransferential reactions through careful self-monitoring of emotional reactions to patients and through peer consultation about difficult cases (9). Finding a common interest with dependent or demanding patients is an additional technique for modulating their needs. It is at least less stressful for the physician to discuss common interests than to hear many undiagnosable somatic complaints. Seeking common interests also humanizes unattractive patients. For example, my relationship with a terse, sullen, alcoholic man became enlivened and more tolerable when I asked him to tell me about his experiences in the Korean War.

Stimuli to Transference

Transference plays an important role in the medical encounter because of the very nature of the physician-patient relationship. The patient arrives feeling poorly and places himself or herself at the mercy of the physician, the authority figure who is seen as holding the power to help, both physically and psychologically (25). The relationship is asymmetric; the patient usually needs the physician more than the physician needs the patient. The exchange of information is also asymmetric. Patients reveal more about themselves than do physicians, thus giving free rein to the activation of fantasies and subconscious drives (21). Patients generally have fewer limits on emotional expression in the clinical encounter than in their daily lives, because it is less likely that the physician will retaliate or withdraw (25). Ideally, the physician does not impose his or her own countertransference needs on the patient although, in the absence of psychotherapy, this is by no means assured (9). Finally, an aspect of transference that is unique to the medical encounter is that physicians poke and prod various and taboo parts of the human anatomy. Physical examination can elicit fairly primitive responses from the patient (26). Deutsch and colleagues (17) reported the case of a woman who became very regressed as a result of repetitive sigmoidoscopies by an overly zealous physician. All of these factors tend to stimulate the transference and, thus, the compulsion to repeat experiences of psychic importance either to master an experience that was previously frustrating or to re-experience an infantile drive that was pleasurably gratified (25).

Structural Concepts

Because the medical encounter is such a potent stimulus to transference reactions, these phenomena must be factored into the conceptualization of the patient's role in medical care. Szasz and Hollander (27) proposed a three-part theory that is based on the degree of control of each participant. The theory includes the activity-passivity model in which the patient receives care without responding (for example, the comatose patient); the guidance-cooperative model in which the patient actively cooperates with the physician but does not propose new ideas or disagree with the physician; and the mutual participation model in which the patient actively participates (sometimes even dominates) in formulating the problem and choosing the treatment. In the mutual participation model, negotiation is the process by which mutual agreement is reached (28-30). Mutual participation appears to be a desirable form of interaction as it is based on a democratic ideal. However, as Szasz and Hollander (27) understood, transference needs may be a more powerful determinant of the appropriate model for a given patient.

Case 2

Mrs. B. is a 39-year-old woman with a history of back pain that has prevented her from working as a housekeeper to supplement her welfare check. She has a history of hypertension, headaches, alcoholism, and obesity. Despite several medical and nonsurgical interventions, her back pain never improved. She was constantly overwhelmed by the burden of her illness and of trying to provide for her family. She often came to the physician in great distress saying, "Doctor, you've got to do something for me." Her physician replied, "No, Mrs. B. We need to work on this together." She was referred for chymo-papain injections which did not relieve her pain (31).

Because of the extraordinary burdens of her daily existence, this patient essentially wanted to adopt, at least psychically, the role of the comatose patient and be passively taken care of in the medical setting. Her physician, on the other hand, tried to force her to actively participate and take more responsibility for her care. This clash may have led to increased complaints of back pain and caused her to be more rather than less passive. Perhaps, if her physician had initially adopted the guidance-cooperative approach, he could have created an environment in which she felt taken care of in a way that did not foster increased dependency and that

permitted more effective treatment of her depression while avoiding an unsuccessful, invasive surgical procedure. Over time, she could have been encouraged to be more active and responsible for her care.

Physicians should not assume that these issues apply only to neurotic, lonely, or uneducated patients. Franz Ingelfinger (32), the former editor of *The New England Journal of Medicine*, felt quite relieved to relinquish a difficult decision about management of his esophageal cancer to his physician. Kahana and Bibring (33) also argued for physicians to adapt their behavior to match patients' character types which are determined in part by transference needs. One of the tenets of negotiation is to reduce conflict by exploring mutual interests (2). Such adaptation of behavior and negotiation need not be done explicitly and verbally. One of the patient's interests is to maintain a psychologic homeostasis. The patient communicates this interest through words and actions without necessarily making a formal request. Physicians can best contribute to that by adapting personal style and choice of participatory model to match patient needs.

Pitfalls of Transference

Sometimes, transference needs cause the patient to overstep the bounds of what is appropriate or manageable in the clinical encounter. In such cases, transference issues transcend structural concepts of the physician-patient relationship and become problems in management. Problems with transference can affect several areas of patient behavior.

The Seductive Patient

Patients, communicating through their attire, posture, or choice of words, may be openly seductive of their physicians. If such behavior reflects the patient's style and mirrors the way that he or she relates to most other persons, the interchange may be enjoyed (34). If, on the other hand, the patient's behavior is discomforting to the physician (assuming that the problem is not with the physician) or represents a desire for a nonmedical relationship, it must be addressed.

Case 3

Mrs. C., a middle-aged woman with an unsatisfactory marriage, brought her own dressing gown for appointments. She expressed disappointment when her physician did not do an internal vaginal examination for a complaint that did not require it and became emotionally distraught when he asked her to stop wandering around the examination room area after she was seen. The physician was very discomforted by her repeatedly behaving this way. This discomfort overwhelmed the physician and prevented him from evaluating his own countertransference reaction. As a result, he could not be objective in understanding the patient's transference and was, therefore, unable to confront or interpret her behavior. Instead, he avoided the issue by asking the nurse-practitioner to manage Mrs. C.'s medical problems.

Lewis and Usdin (34) recommend that this sort of patient be confronted with a statement, such as "At times you make me feel that you are interested in more than my being your doctor" (34). Such confrontation may allow the patient to verbalize the needs that lead to the inappropriate behavior. However, as such a question is outside the expectations of most patients, it may not always have the desired effect. For example, a patient once asked me for a date. When I suggested that this was an unusual request, she replied, "Why? Do you come from the country or something?" indicating the provinciality of my sense of propriety and, by her demeanor, effectively foreclosing further discussion. The distance between patient and physician must at least be modulated. Making appointments less frequent may not work because it may just stimulate the patient to make more somatic complaints. Instead, the physician must communicate the appropriate distance by being scrupulous about his or her own behavior and by giving the message, either explicitly or symbolically, that he or she is available only as a physician (9). I often show seductive patients pictures of my children.

Gift Giving

Gift giving can be seduction by nonsexual means. It is a common event in clinical practice and has been analyzed from the sociologic perspective (35). Before accepting a gift from a patient, its meaning to the patient and to the physician-patient relationship must be evaluated. For Mrs. A. (case 1), gift giving is part of relationship building and is important to her sense of what her role should be. Her gift giving, therefore, is accepted and supported. When gift giving is a means of manipulation, however, it is to be discouraged. Another patient, a man who is desperate for companionship, talks incessantly to anyone who listens, and complains to the receptionist staff when the physician spends only 20 minutes with him for a routine blood pressure check, is at the other end of the spectrum. For him, gift giving represents an attempted bribe to the physician to give him more time and energy, and it is discouraged. This patient's gift giving also has a hostile element; it induces the physician, who already feels burdened by the patient's dependency, to feel guilty about not accepting the patient's meager offerings. In general, how a physician feels in response to a gift is a good indicator of the gift's appropriateness. If a gift is inappropriate, the physician's goal is to give the message without turning away the patient. The physician can either interpret the gift giving behavior to the patient or (more likely) say that he or she has a policy of not accepting gifts.

Somatization

Amplification of bodily symptoms is one way that patients express their psychic and social difficulties. Gutheil (36) wrote that some patients feel so unentitled to ask for conversation time, they offer symptoms and accept medicine instead. Patients come to physicians with somatic complaints that reflect problems in other arenas. They can also develop somatic complaints when their relationship needs are not attended to in the office.

Case 1 Continued

Mrs. A. learned through clinic gossip that her physician was changing his place of residence, and he assured her that it would not affect his medical practice. Shortly after his move, Mrs. A. complained of severe leg pains. When asked how the pains began, she replied that she had been riding past the physician's new home and her son said, "You're going to lose your doctor. Anyone who needs a house that big is going to open a private office there, and he will no longer be in the clinic." The pain began that afternoon. It is remarkable that the patient could be so conscious of the cause of her problem without any amelioration of its effect. This example shows that transference issues are active throughout a relationship, not just at its inception. In this case, Mrs. A.'s symptoms subsided when the physician increased the frequency of her visits.

Persons with extreme forms of a somatization disorder are often subjected to many invasive and painful diagnostic procedures and surgeries by physicians who believe that they are acting in the best interests of the patient. For the somatizing patient, the relationship with the physician may be activating and recreating a negative childhood experience, such as an abusive parent. Physicians must temper their anxiety about missing obscure medical pathology with the need to avoid harming psychologically needy patients.

Compliance

It is well documented that relationship issues, especially patient satisfaction, are important in encouraging adherence to medical regimens (37). One factor affecting the physician-patient relationship is the appropriateness of the match between the physician's approach and the patient's psychic expectation. Therefore, for some patients, a collaborative approach is mandatory whereas, for others, a more authoritarian stance is effective. Transference issues can also have more subtle effects. One of my patients skips his appointments and, therefore, neglects his hypertension, because he imagines that I will berate him for failing to lose weight. Issues of distance are also relevant.

Case 4

Mrs. D. is an elderly diabetic with bilateral amputations and a history of more than 60 hospital admissions. Her new physician sought aggressively to manage her diabetes. He made frequent appointments and called her at home to adjust her insulin dose. For the first time, her glucose level was in an acceptable range. The physician decreased the frequency of visits, and Mrs. D.'s glucose level immediately went out of control. The patient complained, "You never call me anymore." By failing to recognize the importance he had in this patient's life, the physician undermined his efforts at better diabetic control.

Conclusion

Two themes emerge in the analysis of the role of transference in medical practice. First, physicians should modify their approaches to meet each patient's transference needs. These needs should affect the conceptual model chosen and the personality style adopted. The physician should not simply choose the model and style that he or she perceives the patient needs, but should allow his or her behavior to be shaped by the patient's requests and behaviors. Second, physicians should titrate the distance between themselves and patients so that patients neither overstep appropriate bounds nor feel abandoned. For example, sharing personal information with some patients can deepen the significance of the relationship whereas, with others, it can set a boundary by limiting patient fantasies. With still other patients, sharing personal information can stimulate inappropriate and undesirable fantasies.

Some psychotherapists feel that their role in therapy is to multiply the transferences (that is, to maximize the ways that a patient can interact socially) (Bridges N. Personal communication). In parallel, physicians must broaden their countertransferences so that they can be as adaptable as possible in dealing with patients. Paying attention to transference issues will help physicians to transcend the barriers to effective physician-patient relationships by allowing physicians to be whom the patient needs.

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