Counter-transference and related Ethical Issues in psychiatric practice

Essay

Submitted for partial fulfillment of requirements for Master Degree of Neurology and Psychiatry

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2012

INTRODUCTION

The doctor–patient relationship is the cornerstone of medical ethics. The quality of doctor-patient relationship is crucial to the practice of medicine and psychiatry. The capacity to develop an effective relationship requires a solid appreciation of the complexities of human behavior and a rigorous education in the techniques of talking and listening to people. To diagnose, manage, and treat an ill person, doctors and therapists must learn to listen. They need the skills of active listening, which means listening both to what they and the patient are saying and to the undercurrents of the unspoken feelings between them. An effective relationship is characterized by good rapport. Rapport is the spontaneous, conscious feeling of harmonious responsiveness that promotes the development of a constructive therapeutic alliance. It implies an understanding and trust between the doctor and the patient ***(Sadock&Sadock, 2009).***

The therapeutic relationship (therapeutic alliance) refers to the relationship between therapist and the patient. It is the means by which the therapist hopes to engage with, and affect change in a patient .The therapeutic relationship has been theorized to consist of three parts: the working alliance, transference/counter-transference and the real relationship ***(Gelso, 2008).***

Transference is a phenomenon in psychoanalysis characterized by unconscious redirection of feelings from one person to another. It was first defined by Sigmund Freud in 1910 as a result of the patient's influence on the physician's unconscious feelings. Sigmund Freud acknowledged its importance for psychoanalysis for better understanding of the patients' feelings. It was almost invariably in terms of a warning against any counter-transference lying in wait for the analyst. Every psychoanalyst must recognize this counter-transference in himself and master it ***(Peter, 1989).***

In such cases the patient represents for the analyst an object of the past on to whom past feelings and wishes are projected ***(Patrick, 1997).*** Jung warned against 'cases of counter-transference when the analyst really cannot let go of the patient. Both fall into the same dark hole of unconsciousness ***(Jung, 1976)***. Lacan acknowledged of the analyst's counter-transference if he is re-animated the game will proceed without anyone knowing who is leading **(*Lacan&Ecrits, 1997).*** In this sense, the term includes unconscious reactions to a patient that are determined by the psychoanalyst's own life history and unconscious content; it was later expanded to include unconscious hostile and/or erotic feelings toward a patient that interfere with objectivity and limit the therapist's effectiveness ***(Patrick,1990).***

Some positive views of counter-transference began to emerge, approaching a definition of counter-transference as the entire body of feelings that the therapist has toward the patient. Jung explored the importance of the therapist's reaction to the patient through the image of the wounded physician: 'it is his own hurt that gives the measure of his power to heal ***(Anthony, 1994).***

A new belief had come into being that 'counter-transference can be of such enormous clinical usefulness. The therapists have to distinguish between what their reactions to the patient are telling them about their psychology and what they are merely expressing about their own to be aware of the distinction between neurotic counter-transference (illusory counter-transference) and counter-transference proper. The main exception is that for most psychoanalysts counter-transference is not simply one form of resistance, it is *the* ultimate resistance of the analyst ***(Quinodoz, 2005).***

Counter-transference can be a therapeutic tool when examined by the treater to sort out who is doing what, and the meaning behind those interpersonal roles (The differentiation of the object'sinterpersonal world between self and other) ***(Gabbard,1999).***

Most counter-transference reactions are a blend of the two aspects: personal and diagnostic, which require careful disentanglement in their interaction; and the possibility that nowadays psychodynamic counselors use counter-transference much more than transference is another interesting shift ***(Jacobs, 2006).*** One explanation of the latter point might be that because 'in object relations therapy...the relationship is so central, "counter-transference" reactions are considered key in helping the therapist to understand the transference, something known as indivisible transference counter transference***(Gorstein, 2009).***

The extreme development of the new view is what is known as "counter-transference self-disclosure": The analyst reveals to the patient what he is feeling, so as to highlight the difference between the analyst's experience and that of the patient. In one opinion, this implies an entirely different view of what communication between patient and analyst is all about ***(Quindoz, 2005).***

Before clinicians can establish an ongoing relationship with patients, they must address certain issues. For instance; they must openly discuss payment of fees from the beginning of relationship to minimize misunderstanding later. Patients need to be informed about doctors' policies for missed appointments and length of sessions.***(Sadock&Sadock, 2009).***

Psychiatrists should discuss the extent and limitation of confidentiality with patient, so those patients are clear about what can and cannot remain confidential. As much as physicians must legally and ethically respect patient's confidentiality, it may be broken in some specific situations. Other issues related to confidentiality include who has access to the patient's medical record, information required by insurance company, and the degree to which the patient's case will be used for teaching purposes. In all situations, the patient must give permission for the use of medical records ***(Sadock&Sadock, 2009).***

Rationale of the Work:

The doctor–patient relationship has been and remains a keystone of care: the medium in which data are gathered, diagnoses and plans are made, compliance accomplished, and healing, patient activation, and support are provided ***(Lipkin et al, 1995*****).** The therapeutic relation is affected and promoted by several factors. One of the important factors is counter-transference, which can take the form of negative feeling that are disruptive to the patient- doctor relationship, but it can also encompass disproportionately positive, idealizing or eroticizing reaction to the patient.

AIM OF THE WORK

The present thesis will be carried out with the following objectives:

1. To emphasize the role of counter-transference in the doctor patient relationship.
2. To review the relation of counter-transference to ethical issues in psychiatric practice.
3. To highlight the main ethical issues in doctor-patient relationship.

METHODOLOGY

In order to fulfill the aim of the work, a review of all available up-to-date literature on counter-transference and other Ethical Issues in doctor- patient relationship was done. The following databases were explored:

- Library of faculty of medicine; AinShamsUniversity.

- Library of faculty of medicine; CairoUniversity.

- Library of faculty of medicine; Al-AzharUniversity.

- Available psychiatric and psychology textbooks and journals on scientific web sites.

- A computerized search were done and the obtained results were categorized into different categories. These findings were discussed to give recommendations for further studies.

COUNTERTRANSFERENCE

During the past fifty years the concept of countertransference has become a topic of considerable interest. In order to understand the developments that have occurred in the history of the use of the term, it is helpful to consider first the evolution and disagreements that have occurred in the development of the concept of transference.

Transference

The term transference underpins, encapsulates both the theory and the practice of psychoanalysis and was first defined by Freud. He noticed that his patients unconsciously transferred ideas and affects onto the practitioner. He described this activity as a false connection. Laplanche and Pontalis provide the following succinct definition: 'In the transference, infantile prototypes re-emerge and are experienced with a strong sensation of immediacy' ***(Laplanche and Pontalis, 1973).***

Freud's transference:

Freud considered transference to be a transitory phenomena interfered with the therapeutic process and related more to the personality of the physician than to the patient psychopathology. His clinical observations had convinced him that these transferred psychic contents were the most significant

issue in the psychoanalytic process and the most important and useful clinical tool. This intense transference phenomenon could be discerned in other relationships outside the clinical setting where one person is in a position of authority over the other, such as between tutor and pupil. From a classical perspective everything is played out around the patient's unconscious infantile longings, love, hate and disappointments, usually related to parental figures yet re-experienced and transferred spontaneously by the patient onto the here-and-now relationship with the analyst ***(Freud, 1912).***

Transference and reality:

The problem of differentiating between transference and the patient's real perceptions towards the analyst is the subject of debate. Laplanche and Pontalis raise the question of the difficulty caused by such a loosely defined notion that leaves the analyst in the decisive position to make the judgment as to whether the patient's material is either transferential or based on a real perception of the analyst ***(*Schafer, *1983).*** Sandler emphasize the inevitably idiosyncratic influence of the analyst's personality on the expression of the patient's transference and further point out that the analyst is a real person and an active participant in the interaction ***(Sandler et al., 1973).***Lagache (1993) referred to the dilemma of authors who reject the idea

that everything occurs in the patient's communications is a consequence of transference ***(Lagache, 1993).***

Displacement and transference:

Transference refers to the unconscious, automatic intrapsychic capacity to carry across ideas and images connected with an early significant figure into the relationship with the person of the analyst. Essentially, transference is a description and type of displacement, which functions as a defensive mechanism for the patient as a means to conceal and deny the true origin and source of a forbidden wish. Displacement is the process in which an image of one person is replaced by another, who then becomes synonymous with the first ***(Anchin and Kiesler, 1982).***

Transference resistance:

The defense of displacement manifests itself as resistance and refers to the resistances within the patient when he or she is antagonistic towards or refutes the analyst's interpretations. Such opposition is viewed as an indication of transference and denotes the patient's anxiety, which has been prompted by the analyst's interpretation, as the latter attempts to uncover the unconscious material that the patient struggles to keep repressed. It has also been noted that transference resistance

encompasses undisclosed conscious ideas that the patient has about the analyst ***(Sandler, 1973).***

Positive transference:

Freud had divided transference into two affective categories ***(Freud, 1912)***. Positive transference denotes the warm, loving, affectionate emotions the patient feels toward the analyst. Freud considered that these positive affects played a significant role in the treatment process and counted as a major contributing factor in the successful outcome of the work. He believed that the continuation of patients' tender, benign feelings predisposed them to accept the analyst's interpretations. Freud made a further distinction between affectionate and erotic transference. While the patient could consciously admit to having warm, benevolent feelings towards the analyst, erotic feelings tended to be subject to repression. At the same time he asserted, somewhat paradoxically, that any and all positive affects towards another person had at their base an erotic component, and yet a qualitative difference could be observed between the two. He further noted that although the erotic transference appeared at some point during the treatment, the positive aspect was apparent from the onset ***(Freud, 1912).***

Negative transference:

The patient's experience of hostile and aggressive feelings towards the analysts is manifestations of negative transference. The mobilizations of the patient's antagonistic feelings transferred onto the analyst are seen as a defensive strategy, as a means of avoiding the more disturbing erotic transference emotions. The ability to hold in mind conflicting impulses and emotions in relation to one person is known as ambivalence. Freud believed that the inability to acknowledge contradictory impulses of love and hate towards the same object lay at the heart of the problems that psychoanalysis attempts to address ***(Luborsky& Crits-Christoph, 1990).***

Transference and repetition:

The concept of repetition offers an explanation for the phenomenon of resistance. Freud coined the term 'repetition compulsion' to illustrate the dynamic nature of the unconscious. By definition repetitions are unconscious and will therefore continue to be enacted in the present. The Freudian notion of the compulsion to repeat offers supporting evidence for the theory of transference and the way in which the patient's past is reproduced in the analytic relationship ***(Anchin and Kiesler, 1982).***

Transference neurosis:

The compulsion to repeat is linked to the patient's neurosis in relation to the analyst. This reproduction of the patient's neurosis within the psychoanalytic setting is one of the fundamental aims of psychoanalytic treatment, as the patient is then considered to be amenable to interpretations and explanations that reveal their underlying infantile neurosis. Transference neurosis refers to patients' tendency to develop an intense transference relationship with their analyst, which is constituted out of their childhood conflicts and their current neurosis, replicated and re-enacted in the analysis ***(Beres&Arlow, 1974).***

Transference perspective of Melanie Klein:

Melanie Klein put forward a broader view than Freud's original definition of transference. Klein's transference revisions were based on her clinical observations from working with very young children. She considered that the appearance of transference phenomena in this patient group indicated the presence of matching anxieties in the children's lives. Furthermore, her observations led her to elaborate her conception of unconscious fantasy, as her attention was drawn to the conspicuous strength of these transference enactments. For Klein, transference was a ubiquitous phenomenon that