Background: Transference and countertransference influence any human interaction, including the patient-clinician relationship. Transference is the unconscious redirection of a patient's feelings, attitudes, desires, often regarding a close personal relationship in their earlier life, onto the clinician (1). Counter-transference is the unconscious redirection of a clinician's feelings, attitudes, and desires about a close personal relationship onto the patient (1). This Fast Fact illustrates the impact of unrecognized transference and countertransference and offers strategies to mitigate their consequences.

Importance: Transference phenomena is common in clinical care. It is not inherently pathologic, nor does it reflect failure on the part of the clinician or patient. Yet, if unrecognized, it can potentially lead to harmful consequences for patients and clinicians. For example, transference phenomena can contribute to implicit biases toward certain ethnic or socio-economic groups (2,3); avoidance behaviors which may contribute to the inappropriate use of life-sustaining medical technologies via the failure to identify patient-centered goals; and mistrust of the health care system (4). Unlike psychiatrists, psychologists and social workers, most clinicians lack the training to recognize and understand this phenomenon (4). Hence, transference feelings go unrecognized by many clinicians and may contribute to professional loneliness, cynicism, burnout, and depression (4). This topic is particularly relevant for hospice and palliative care clinicians who often care for dying patients who may evoke intense, often unexamined emotions. The following cases illustrate how transference phenomena can impact palliative care encounters.

Case 1: A 54-year-old male with an opioid use disorder and lung cancer presents for opioid management of cancer-related chest pain which has stabilized since his tumors have regressed in response to cancer treatment. The clinician introduces titrating down his opioids, but the patient responds in anger. Transference: The patient feels stigmatized within the healthcare system (5). He interprets tapering of opioids as a sign the clinician no longer believes his pain reports (5), leading to feelings of helplessness and clinician abandonment. The patient is unconsciously reminded of prior experiences of abandonment within the healthcare system or from family members from whom he was hoping to obtain support. This impacts his willingness to discuss non-opioid analgesic approaches. Countertransference: The clinician is influenced by prior patients with substance use disorder who diverted or misused opioids and left the clinician feeling betrayed and helpless. This reactivates childhood experiences of feeling powerless within his family. To avoid these feelings, the clinician desires to taper the opioids quickly. He severely enforces the terms of the taper and spends less time with the patient, which compromises the clinician's pain assessment and care. Reflection: Both the patient and clinician act out transferred feelings of alienation and helplessness. A clinician unable to recognize these reactions likely will not engage in a constructive pain assessment and discussion of analgesic management.

Case 2: A 32-year-old female who is an internal medicine chief resident is seen in a palliative care clinic to discuss her goals of care regarding progressive glioblastoma. After two months of treatment, she now spends more time in bed, has a poor appetite, and is withdrawn from her family. Transference: As a young physician, she does not want to burden her colleagues nor be perceived as a “needy” patient (6). She minimizes her daily challenges (6) and does not share her feelings regarding her transition from a high-achieving physician to feeling like an “invalid”. Countertransference: The clinician feels that the patient has a high-level of health literacy and would be forthcoming with her concerns (6). The clinician does not want to offend and therefore avoids asking questions the patient will recognize as screening for depression or suicidal ideation. Reflection: Failure to recognize transference phenomena contributes to substandard care by missing opportunities to explore the patient's feelings of helplessness and to screen for depression.
Conclusions and next steps: Whenever a clinician experiences intense emotion during a clinical encounter, be it pleasant or unpleasant, this may signify the presence of transference and/or countertransference (6). A methodical approach to self-reflection, self-monitoring, and coping can help clinicians recognize these feelings more consciously and thereby prevent harmful consequences (4).

1. **Name the feeling:** Transference and countertransference are unconscious processes. Naming the associated feeling(s) enables conscious awareness and thereby more control over behaviors.

2. **Normalize the feeling:** Anger, guilt, helplessness, and betrayal, though distressing, are common in clinical care. Acknowledging and normalizing these feelings can prevent clinicians from over-catastrophizing unwanted emotions triggered during the clinical encounter.

3. **Name the behaviors triggered by the feeling:** After bringing their feelings to conscious awareness, clinicians should reflect on how that emotion impacted their behavior. Doing so could lead to more adaptive responses should the unwanted feelings reemerge. For example, if a clinician notices inner helplessness, he or she could utilize those feelings to screen the patient for emotional distress.

4. **Incorporate routine consultation with trusted colleagues.** Sharing an intense patient interaction with colleagues can decrease isolation and build social support (4). Interdisciplinary teams should create intentional venues where clinicians feel safe to discuss the lived experience of caring for seriously ill patients. Such forums should be distinct from Morbidity and Mortality rounds since they are not intended to act as quality-improvement-themed “fix-it” rounds (7,8). Rather, they should help clinicians safely examine the social, emotional, and personal aspects of care, ideally in the presence of a mental-health professional.

References:

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