

Countertransference in Two Settings: A Case Report

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INTRODUCTION

Yet despite the need for establishment of rapport and positive transference the physician only too frequently, even in the best institutions, openly displays a cynical, unrealistic and hostile attitude towards the addict; he is indifferent to the latter's genuine complaints, assumes in advance that he is a liar and maintains that it is a waste of effort and money to attempt a cure. (Ausubel, 1958; quoted in Imhof, 1993, p. 494)

Until recently, I did not find the views expressed in the above quotation at all curious or troubling. Psychiatry residents in inner city hospitals are very familiar with drug-abusing patients. They often come into the Crisis Center at inconvenient times either high or in withdrawal, reporting various psychiatric symptoms, demanding hospitalization. After a lot of time spent checking facts and trying to find the patient a bed at a detoxification center, we often learn that the patient has lied about various things, e.g. that he just left another detoxification center against medical advice that same day, or that he has lost his place of residence. This pattern of behavior leads to frustration and demoralization. As a result, we as psychiatry residents often view drug-abusing patients with skepticism or scorn, and see our evaluations of them as battles.

Under those circumstances, who wouldn't be cynical and hostile? I have thought to myself, "Of course I hate that drug abusing patient, anyone would." However, I had an experience during my addiction psychiatry rotation that has led me to examine this attitude toward these patients. I had the opportunity to evaluate the same patient twice, first in the Emergency Room (ER) and later in an outpatient methadone treatment center, with strikingly different results in each setting. In the ER, my interview was cut short when the patient refused to answer my questions. I felt hateful towards her, and I suspect she felt the same way towards me. In contrast, in the methadone clinic, I had a more extensive interview, developed a good rapport with the patient, and felt much more empathy towards her. The latter experience

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was far more satisfying for both the patient and me, but it was also somewhat unsettling, since it marked a shift in my view on substance-abusing patients. For the first time, I saw a drug-abusing patient as a unique, complex individual with a life history, which could help explain her current addiction and psychosocial problems. Suddenly, my antagonistic stance toward these patients was called into question. I could no longer simply approach all drug abusers as manipulative liars who could justifiably be dismissed. After meeting this patient (L.H.) for the second time, I found myself wondering how my two experiences could be so different. Why did I see her as a "manipulative liar" in the E.R., but was able to hear her "genuine complaints" in the methadone clinic? After all she was the same patient and I was the same physician.

In this paper I will first present these two different psychiatric evaluations and I will discuss my countertransference reactions to the patient in each setting. For the purpose of this paper, countertransference is defined as per Kaufman (1992) as "the therapist's total emotional reaction to the patient including the entire range of conscious, preconscious and unconscious attitudes, beliefs, and feelings, and the therapists verbal and nonverbal behavioral manifestations" (p. 185). Then I will turn to the literature on countertransference in treating substance-abusing patients to attempt to explain these two very different experiences. I will suggest that in many ways this patient and I were not the same people in these two interviews. We were greatly affected by our expectations of the interviews, which were quite different in these two settings, and by our transference and countertransference respectively. Finally, I will use my experiences with L.H. to explore the consequences of a dismissive attitude toward these patients, including foreshortened interviews, missing important psychopathology, and interactions that are less rewarding for both patient and physician.

CASE PRESENTATION

L.H. is a 35-year-old white woman with no past psychiatric history who has a seven-year history of using as many as ten bags of heroin intravenously per day. She also smokes crack and cigarettes daily. I first met L.H. when she was hospitalized for pneumonia. I was working in the Jefferson Crisis Center and was called to evaluate her and to make recommendations about treating her severe withdrawal from heroin.

It was a busy day in the hospital. In fact L.H. was one of about 15 patients who had been admitted to the medical service but had been held for more than 24 hours in an E.R. bed until a floor-bed opened up. I too was busy. There were several patients in the Crisis Center when I received a STAT consult to see L.H. The team had already started her on methadone, but she was still complaining of withdrawal symptoms. I found myself immediately irritated by this consult. I was busy and knew that opiate withdrawal is not usually a medical emergency. Attempting to set my annoyance aside, I went to see L.H., planning to gather information quickly and call the medical resident with my recommendations.

When I entered her E.R. "room," L.H. was lying on the stretcher watching T.V., looking anxious and miserable. After introducing myself, I told her that I could see that she was very uncomfortable. I let her know that I was busy and didn't have much time and that if she answered my questions, I would make sure she got more methadone. I turned off the T.V. and began my psychiatric evaluation, focusing mainly on addiction history. No more than five minutes into the interview L.H. told me that she felt sick and couldn't talk to me anymore and turned the T.V. back on. I reminded her that I was the key to her getting more methadone, and that it was illogical not to talk to me if she wanted to feel better. She said that she didn't care; she wanted to be left alone. I left the room, telling her I would be back later. My initial annoyance at this consult was amplified into hateful feelings toward L.H. I had gone out of my way to help her, yet she was entirely rejecting of my efforts. I grouped her in my mind with 'all of those manipulative drug-addicts who have no tolerance for discomfort.' In fact, I never went back to see L.H. I asked my attending to complete the evaluation while I attended to other business. In retrospect I see that I rejected her just as she rejected me.

The next interaction I had with L.H. was while doing my Addiction Psychiatry rotation at the Family Center, a methadone program for women with children. L.H. came in to the Family Center for an admission evaluation, having been referred by a social worker. We recognized each other immediately. I felt annoyed and anxious at seeing her and geared up for a repeat of our last antagonistic interaction. Much to my surprise, L.H. greeted me with a genuine apology and looked embarrassed to see me again. She explained how sick she had felt during our previous encounter. I felt my attitude toward her immediately undergo a shift. I felt myself become more empathetic and open, and listened with great interest as she gave me her history. She spoke fairly openly, stopping periodically to comment "You're so nice. I'm sorry I gave you such a hard time before."

There were elements of her history that began to explain her current difficulties. A theme of terrible shame and isolation emerged. She reported being sexually abused by her alcoholic father from age 15-17. He served time for those offenses. At age 17 she started drinking daily and would drink until she blacked out. Then she began using crack and heroin. When she entered the methadone program she was using ten bags of heroin per day and smoking crack almost daily. Strikingly, in 18 years of constant drug dependence she had never sought any treatment for her drug problems. She has no legal history, so she was never forced by the court to get into treatment. She is estranged from her family, including her two children who live in Florida. Her son lives with his paternal grandparents and her daughter lives with her ex-husband. She would like to have contact with her daughter but her ex-husband does not allow this because of her addiction. Her main 'support system' is a man with whom she lives, who buys her heroin and pays for her food and housing. She emphatically denied that he was her pimp or that she was selling drugs for him, though these seemed the plausible explanations for his generosity. She clearly felt ashamed of her current lifestyle and regretted the choices drugs had led her to make.

Yet, it was only after being hospitalized for pneumonia that she sought help to change this lifestyle.

I began to wonder if it was no accident that L.H. had lived this way for so long. Clearly she had a significant chemical addiction. But, perhaps she also unconsciously chose this life because she felt that she deserved to feel humiliated and shunned by her family. I wondered if she felt that she didn't deserve help because she felt in some way responsible for her sexual abuse by her father. Could her shame and anger have prevented her from accepting my help in the E.R.? Might I expect this shame to interfere with her treatment at the Family Center?

DISCUSSION

One way to explain the intense hatred that I felt towards L.H. in the E.R., and the contrasting empathy that I felt towards her in the methadone clinic is by understanding the concepts of 'splitting' and 'projective identification.' These are defense mechanisms used frequently by substance-abusing patients, many of who have borderline or narcissistic character structures. Splitting is characterized by Gabbard (1994) as

alternating expression of contradictory behaviors and attitudes, which the patient regards with lack of concern and bland denial; 2) selective lack of impulse control; 3) the compartmentalization of everyone into all good and all bad camps which is often referred to as idealization and devaluation; and 4) the coexistence of contradictory self-representations that alternate with one another. (p. 45)

Descriptively, this definition of splitting seems to fit. L.H. demonstrated alternating behaviors and attitudes toward me in these two different settings. She impulsively dismissed me from her room when she became too uncomfortable. She devalued me in the E.R., and idealized me in the methadone clinic. However, she did not regard this contradiction in her behavior with 'lack of concern and bland denial.' In fact, when I encountered L.H. for the second time in the methadone clinic, she seemed aware of her devaluation of me in the E.R. and quite upset and embarrassed by this. In this latter sense the concept of splitting does not entirely fit with L.H.'s behavior.

The concept of projective identification helps explain our interaction in the E.R. Imhof (1983) says that by using the defense of projective identification, patients unconsciously "induce the therapist to experience the intense range of negative and hateful emotions that exist within the patient" (p. 499). This has the utility of letting the therapist know exactly how the patient feels. In retrospect, it seems that in the E.R. L.H. provoked me to feel what she must have felt in the past as an abused child and currently as an addict, i.e., frustrated and powerless. In an attempt to escape these uncomfortable feelings, I rejected her. This points to another unconscious goal of projective identification in the substance-abusing patient, i.e. involving the therapist in sado-masochistic role-playing. Imhof (1983) says the drug-abusing patient

"abus[es] himself in a most vengeful and ultimately masochistic manner." (p. 499) L.H. "actively produced her own failure and defeat" (p. 499) in this situation. By dismissing me from her room, she increased the time it would take her to get properly dosed with methadone and consequently increased her own suffering. She unconsciously may have felt that she deserved to suffer and be rejected because of her shameful past and current situation. I behaved just as she expected.

My insecurity as a psychiatry resident in training made me vulnerable to acting out with L.H. this sado-masochistic game, in which I was the victimizer, she the victim. One reason I chose to be a psychiatrist is that I enjoy talking to patients and feel proud of my communication skills and ability to empathize with others. With her dismissal of me, I questioned these skills and my effectiveness as a physician. This made me angry and eager to get out of this situation as quickly as possible. Additionally, psychiatry residents may be particularly vulnerable to feeling overwhelmed by what Imhof (1983) describes as "the sheer mass of emotional problems" that substance-abusers bring to treatment which we feel "dwarf[s] our skills." (p. 495)

Although useful in explaining aspects of my interaction with L.H., the concepts of "splitting" and "projective identification" don't fully account for the differences in these two interactions. Why, for example, was she receptive to my assistance in the methadone clinic so that I was not induced to feel frustrated and powerless? To answer this question we must look at the setting of the E.R. as compared to the methadone clinic.

In the ER there is a lot of pressure toward efficiency. One must gather information and make clinical assessments quickly. The ER is noisy and not private and doesn't lend itself to revealing personal information. In contrast, in the methadone clinic, I had a private, quiet office and plenty of time to do my assessment. This relaxed both the patient and me and facilitated a more open discussion.

Another more subtle but important difference was the expectation that L.H. and I had of each of these two encounters. Gabbard (1994) describes the clinical interview: "When psychiatrist and patient meet for the first time, two strangers are coming into contact, each with a variety of expectations concerning the other. Establishing rapport and a shared understanding must always be the first agenda in a psychodynamic interview" (p. 66). "The dynamic psychiatrist approaches the interview with the understanding that the manner in which the history is taken may in and of itself be therapeutic" (p. 67).

In the ER setting, I was not doing a psychodynamic interview, but I did try to establish rapport and mutual understanding at the beginning of the interview. I let L.H. know that I could see that she was suffering and that I planned to be of help, but I was also pressed for time. My interview style, however, was aggressive since I was attempting to gather key facts from her history in order to determine methadone dosing. Gabbard (1994) suggests that such an aggressive style does not "create an atmosphere in which the patient feels free to talk." (p. 71) Though I *said* I appreciated her suffering, my somewhat gruff attitude may have led her to feel that I did not, and prematurely end our interview.

There are some patients who are able to tolerate this kind of information-gathering interview. These patients seem to understand the limitations of the ER setting and are able to provide needed information in spite of the less-than-ideal circumstances. Imhof (1983) gives us a way to understand why substance-abusing patients like L.H. may not be able to do this:

The individual with a serious, compulsive drug abuse symptom arrives for treatment in a relative state of psychological, social, biological, and/or economic decompensation . . . The drug abuser who presents for professional help is often terror stricken, anxiety ridden, depressed and demanding, and often attempting to communicate this helplessness and hopelessness in a pleading and pathetic manner. The clinical picture is one of relative ego regression and demonstrable states of fragmentation, depersonalization and most commonly a deep, immobilizing depression which is in itself a protective defense for a patient who can no longer utilize, exploit or manipulate the environment to gratify primitive oral needs. The drug dependent patient is concurrently dependent upon the external world for survival yet terrified of this dependency because of his basic mistrust and rage. (p. 498)

L.H. couldn't tolerate the E.R. interview because she was in such a regressed state. She was physically sick both from pneumonia and heroin withdrawal. Vulnerable and powerless, L.H. was unable to take care of her uncomfortable, anxious feelings in her usual way, by using heroin. Instead she was dependent on me to relieve her suffering and did not trust that I would meet her needs. Rather than let me know how much she needed my help which would make her feel more anxious and vulnerable, she rejected me, and via projective identification induced me to reject her.

As compared to the ER, the therapeutic framework was very different in the methadone clinic and L.H. and I had different expectations of our relationship. At our first encounter, L.H. had been forced to start using methadone because of her medical illness, not out of motivation to stop using heroin. In contrast, in the methadone clinic, she had decided on her own to try to get off of drugs and was proud of that decision. She explained simply, "I don't want to live this way anymore." She seemed to approach me with the motivation of someone who expected to be coming to the methadone clinic daily, to become involved in the therapeutic community there, including meeting with counselors, and going to groups. She also felt better physically. She had already been on methadone maintenance for several days prior to my official intake evaluation. For my part, in the setting of the methadone clinic, I expected to build a rapport with her in order to facilitate her connection to the clinic. We didn't have the same time limitation that we had in the ER. I didn't feel any pressure to cure her of her drug addiction immediately. In the E.R. if she had presented implausible information, I would have felt pressured to extract the truth from her. In contrast, in the methadone clinic, when she told me that the man with whom she lives is supporting her habit because "He's a nice guy," I didn't feel that

pressure. I knew that her counselors would have time to get to know her and recognized the probable lie as a reflection of the shame that L.H. must feel about her addiction and her lifestyle.

In addition to projective identification, i.e. the patient unconsciously inducing me to feel what she feels, my urge in the E.R. to get out of her room as quickly as possible, may reflect my personal biases against drug addicts, some of which are expressed in the introduction of this paper. I have thought of substance-abusers as lazy, self-indulgent junkies. If they were not so weak, they could just make up their mind to stop using drugs. As is always true, it is easier to cling to prejudice when one does not take the time to get to know a person as an individual. In this way, quick information-gathering E.R. interviews may facilitate prejudice and dismissal of patients.

CONCLUSION

In this paper I have offered several possible ways to understand why my two interactions with this patient were so different. A number of variables were important including 1) the patient's degree of regression which was influenced by her physical and emotional state, and affected her use of projective identification as a defense 2) the setting of the interview, including how rushed the physician feels and how private the location is. 3) the doctor's and patient's goals and expectations of the interview, i.e. is it for information gathering or to set the stage for a long-term therapeutic relationship. These three variables will, in turn, affect the extent to which the doctor's own biases about substance-abusing patients will come to the surface and negatively affect the quality of the interview.

One possible consequence of conducting an information-gathering interview in the E.R. is poor patient and doctor satisfaction. The patient does not feel listened to or understood, and the doctor feels tense as she goes to battle with the patient. I was drawn to psychiatry by the desire to relieve emotional pain, and by curiosity about human behavior. It was reassuring to me as a psychiatrist-in-training to see that drug-abusers are not simply "bad people" who deserve to be hated. As Imhof (1983) points out "such dislike is ego-dystonic, certainly not what 'good and loving' therapists should feel toward their patients." (p. 501) In the second interview, it was exciting to experience L.H. as a partner working with me to begin to change her life, rather than as an adversary. This interview was also more intellectually satisfying since it afforded me the chance to think about L.H.'s past experiences, how they might be affecting her currently, and how they might affect future treatment.

In spite of the increased doctor and patient satisfaction, it would be inappropriate and impractical to conduct, in the E.R., the kind of interview that I did in the methadone clinic. The task in the E.R. is to quickly assess patients and arrive at dispositions, not to attempt to understand the dynamics that have made patients who they are. Yet there are other serious consequences to brief E.R. interviews, including missing important psychopathology, and, according to Imhof (1995) "discharging the patient, often prematurely, and often at a point in treatment when treatment is most

needed." (p. 5) If one approaches a drug-abusing patient with a predetermined belief that she is a manipulative liar, it may be impossible to see real suicidality, homicidality or psychosis that require psychiatric stabilization. This is not to suggest that one simply takes drug-abusing patients at their word and admits all patients who threaten suicide, homicide or say that they are hearing voices. Like all stereotypes, there is a kernel of truth to the belief that substance-abusers should be viewed with skepticism. These patients are very skilled at manipulation in order to get what they need. The key is to recognize that various factors, both conscious and unconscious, affect our relationships with substance-abusing patients in settings like the E.R. If we are aware of the existence of these factors, we may be able to step back from our knee-jerk responses to these patients and more thoroughly evaluate them. It is important to have supervisors and colleagues with expertise in substance abuse to point out how our conscious biases and unconscious blind spots might be interfering with our effectiveness with these patients. Equally important, open discussions with peers can relieve some of the pressure of treating these difficult patients.

We may never forgive substance-abusing patients for inconveniently interrupting us in the middle of the night. But, if we can remember that there are complex factors that lead them to their current deteriorated state, we may forgive ourselves for not solving all their problems in one night. This may liberate us from the usual antagonistic interactions with these patients and allow us to set clear limits with them, gently handing back to them the responsibility for their addiction that they so often try to place on us. In this way, even in the E.R. setting we may help to truly set them on the road to recovery.

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