

MEDICAL EDUCATION: PEER-REVIEWED ARTICLE

**What Should Health Professions Students Know About
Countertransference in Inpatient Psychiatric Environments?**

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Abstract

Inpatient psychiatric units are heavily regulated physical environments designed around the twin aims of treatment and containment. Less formally regulated but no less important are emotional norms and tones that also contribute significantly to psychiatric care environments. Inpatient psychiatric units are co-created by patients and clinicians, but clinicians have authority that patients do not. This means that clinicians' management of their own transference and reactions is clinically and ethically important. This article defines transference reactions and draws on case examples to canvass how positive and negative transference reactions can influence inpatient care of patients who are suicidal.

Transference, Countertransference, and the Therapeutic Environment

Inpatient psychiatric units are heavily regulated physical environments designed around the twin aims of treatment and containment. Less formally regulated but no less important is the emotional environment of the unit, a space co-created by patients and clinical staff. Clinicians bring more to the therapeutic encounter than their years of clinical training; for better and worse, treatment occurs in the context of their life experiences. Understanding and managing clinicians' emotional responses to patients, termed *countertransference reactions*, is an important part of creating an optimal therapeutic environment for everyone.

The twin concepts of countertransference (how clinicians feel about their patients) and transference (how patients feel about their clinicians) were born from psychodynamic theory, initially developed by Sigmund Freud.¹ Although countertransference was initially defined as the unconscious feelings that patients evoke in their psychiatrists, we will be using a more contemporary and inclusive definition that includes conscious as well as unconscious emotions and behaviors and patterns of thought.²

Although countertransference (and transference) reactions exist in all patient-clinician interactions, they are often particularly pronounced when clinicians treat suicidal patients in the inpatient psychiatric environment who are experiencing a moment of crisis: the psychiatrist fears a bad outcome and often the patient and care team lack a shared understanding of the underlying problem and corresponding solution. Stereotypic

adverse countertransference reactions to suicidal patients include anxiety, anger, and helplessness and are associated with worse patient outcomes.³

In this article, we explore common patterns of countertransference evoked by our work with suicidal patients on inpatient units, as well as techniques to mitigate their potential adverse effects on the patient care environment.

Common Countertransference Reactions

Anxiety and fear. Mr G presents to the inpatient unit with depression. He tells the psychiatrist, “This treatment is my last shot before I kill myself.” Discomfited, the psychiatrist spends several days before selecting a medication, then raises the dose far above the recommended maximum when the patient reports no effect. Later, the same psychiatrist contends that the patient has a personality disorder and should be treated with psychotherapy only. The unit psychologist counters that the patient requires medication management. The team social worker observes that the desperation of the patient has been adopted by the team and wonders aloud how it has negatively influenced his care.

Commentary. Faced with a daunting ultimatum, the team vacillates between being avoidant and overly aggressive. This reaction manifests as the psychiatrist giving in to an urge to abandon the patient or allowing feelings of fear to dictate deviating from the standard of care. A framework for the staff’s management of such a situation could involve (1) identifying the presence of significant countertransference dynamics, (2) naming the underlying emotion, (3) validating the response as a normal aspect of treatment, and (4) mindfully proceeding in treatment planning. In this vignette, the social worker has opened a space for a discussion of these issues to take place. The treatment team can acknowledge the patient’s frustration, build a therapeutic alliance upon a shared understanding of the problem, and **collaboratively explore options** for further treatment.

Anger and hatred. Recently fired from his prestigious job, Mr L is admitted to a psychiatric teaching unit and states that he has nothing left to live for. He refuses treatment options proposed by his team and insists that he meet with the chair of the department for daily individual therapy. When told that this is impossible, he avers that if he were at a more prestigious hospital “then maybe I would actually get some help.” The psychiatry resident angrily tells the patient: “Fine, you want to go to a different hospital? We can arrange that.” The resident later discusses the case with her attending physician and realizes that, while she felt personally humiliated by Mr L due to her own preexisting feelings of self-criticism, his behavior partly reflects his own insecurities. This observation allows her to feel some empathy in her future interactions with him. During their next meeting, the resident agrees with Mr L that he deserves the best possible care and outlines a treatment plan that she describes as “the gold standard.”

Commentary. Before any progress can be made in addressing countertransference reactions with patients, clinicians must start by **developing self-awareness**. Countertransference reactions occur due to a combination of patient and clinician factors; without an understanding of one’s self, one will have, at best, half the picture. The value of supervision aimed at identifying countertransference is underscored by the presence of “T groups” for psychiatric residents—the practice of encouraging trainees to obtain their own psychotherapy—and even developing “autognosis,” or “knowing one’s self,” rounds for medical and surgical trainees.^{4,5,6}

One characteristic of an optimal therapeutic environment is the opportunity for all clinicians to seek supervision to help manage countertransference reactions. Such supervision is especially important when the countertransference reaction may be seen as “unprofessional.” Prior to the mid-20th century, medical literature did not explore the uncomfortable truth that clinicians sometimes hate their patients. Influential work by Groves,⁷ Maltzberger and Buie,⁸ and Winnicott,⁹ among others, acknowledged this reality, noting that some patients may evoke a dislike so intense that otherwise empathetic and professional physicians could potentially act out their hateful feelings through abandonment or even sadistic behavior. Supervision provides an opportunity to check these impulses in favor of more appropriate clinical care. As noted in the example of *the demanding patient* above, acknowledging that the patient deserves excellent care and channeling the patient’s entitlement into collaboration with rather than antagonism toward the team is one way that clinicians can work through adverse countertransference reactions.⁸

Helplessness and hopelessness. Ms N was psychiatrically hospitalized for 6 months following a suicide attempt. She was treated with intensive psychotherapy, multiple medication trials, and several courses of electroconvulsive therapy. Confident that the patient is much improved, the treatment team discharges her. Hours later, she presents with an overdose and is readmitted to the same inpatient treatment team. During rounds, the medical student on the team asks about options for treatment-resistant depression but is cut off by the senior psychiatrist who states: “Don’t waste your time. That’s not going to do anything for her.” The next time the patient is mentioned in rounds, her name is met with silence, and nobody suggests any changes in her treatment plan. Unlike other patients, she is not strongly encouraged to attend group therapy. The psychiatric trainee posits that both the team and the patient may have given up.

Commentary. Every clinician has seen a patient experience bad outcome after bad outcome and wondered if the patient is a “lost cause.” Although such a belief may in part be based in reality, it may also be an internalization of the patient’s same feeling of lack of hope. Here, while Ms N herself may not be consciously experiencing helplessness, her despair manifests in the actions of her team. When clinicians reflexively take on the fatalism projected by their patients, they risk actualizing the patient’s belief that they cannot be helped. As with advanced heart disease or metastatic cancer, psychiatrists also encounter severe illness that is treatment refractory. Such cases should galvanize reformulation, consideration of untried treatments, and seeking second opinions rather than embracing fatalism.

Notably, this situation also illustrates how countertransference can actually be leveraged for the patient’s benefit. Discussion of transference and countertransference in the inpatient setting has even been developed into a form of psychotherapy that can be used in the acute inpatient setting.¹⁰ The clinician’s inquiring as to whether the patient is feeling helpless and whether she feels that her team has given up on her may provide valuable diagnostic information, strengthen a tenuous rapport, and perhaps open a door to reestablishing a path forward for treatment.

“Positive” countertransference. Ms H recently immigrated to the United States as a refugee. She presents to the emergency department reporting symptoms of posttraumatic stress disorder. Although there is usually a time limit on phone calls, her

treatment team feels that the patient has already “been through so much” and allows her to skip group therapy to talk with her friends on the phone. The psychiatry resident finds himself staying late on the inpatient unit to meet with the patient a second and third time during the day and offers to treat her as an outpatient after discharge, even though this is not standard practice. However, as the patient improves and becomes more active, the resident feels a sense of protectiveness that prevents him from ever challenging Ms H or encouraging her to take a more proactive role in her treatment. During a community meeting, other patients on the unit demand to know why there is one set of rules for some patients and different rules for “the rest of us.” After meeting with his supervisor, the resident meets with the patient, acknowledges his mistake, and reestablishes boundaries with the patient.

Commentary. Not all countertransference evokes negative feelings that contribute to bad outcomes. However, as this vignette shows, positive countertransference reactions can also adversely affect patient care. Clinicians are most comfortable in a relationship dynamic in which they feel helpful, competent, and appreciated. When clinicians start making treatment decisions based on emotional responses, they risk being drawn into situations in which their care deviates from accepted best practice. Psychotherapists use the term *frame* to capture the context in which treatment occurs. Having a predictable and mutually accepted frame for patient and clinician means that both parties share an understanding of what to expect during treatment. Examples of the treatment frame include the frequency of meetings, limitations to confidentiality, and the responsibilities of both patient and clinician. Countertransference dynamics can pull the clinician toward violating the terms of the frame—for example, by the clinician’s spending more or less time with patients or bending rules due to “special circumstances.”

In this vignette, the treatment team, guided by an affinity for the patient, has found it hard to enforce unit rules or to encourage the patient to make the most of the therapeutic environment. In the process, the team has upset other patients, who rightly wonder why they are being treated differently. Whenever a deviation from the treatment frame occurs, clinicians (with the assistance of supervision) should clarify for themselves why the treatment frame has changed, and for whose benefit.

Conclusion

Designing an optimal therapeutic environment requires that all clinicians be aware of countertransference reactions, particularly when working with suicidal patients. By recognizing countertransference as a natural consequence of working with hospitalized suicidal patients (and not necessarily a harmful one, as countertransference can evoke sympathy or compassion), clinicians can reduce the distress that such interactions engender and ultimately improve patient care. Although this article focuses on the role of recognizing countertransference reactions in one’s self, clinicians may find that, with practice, they are also better able to identify countertransference reactions in their peers. With practice and guidance, all clinicians can improve their ability to manage complex and intense countertransference reactions even in the most acute settings, such as the inpatient psychiatric environment.

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