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ETHICS CASE

How Should Clinicians Respond to Transference Reactions with Cancer Patients?

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Abstract

Patients with cancer can feel particularly vulnerable and need special attention and support, so clinicians' attention to transference reactions—theirs and their patients—is especially important. Mismanaged transference reactions can undermine the therapeutic alliance in the patient-clinician relationship and negatively influence treatment outcomes. In oncology settings, real and perceived needs of patients in serious distress can occasion modification of usual outpatient protocols, particularly when flexible scheduling or home or hospital visits are warranted. Here, we comment on a case in which transference reactions of a young woman with cancer prompt her to terminate treatment. We discuss the importance of clinicians' recognizing and managing transference and countertransference, maintaining boundaries, and responding with empathy and integrity to cancer patients' concerns.

Case

Amy is a 25-year-old woman who has recently been diagnosed with lymphoma, but her prognosis seems to be good. She has a history of drug use and abusive relationships. Amy's father abandoned her mother when she was a child, and Amy spent most of her adolescence caring for her mother, who was also addicted to drugs, before having an argument and moving away. She has weekly meetings with the cancer center's psychiatrist, Dr. T, to discuss her well-being and her adjustment to cancer and cancer treatment.

Over the course of treatment, Amy opens up to Dr. T and begins to confide in him. She admits that her last boyfriend recently cheated on her and that she has not told any of her friends about her illness because she is afraid that they might desert her. "Everybody always leaves me," she says on multiple occasions. "I've never been able to open up to someone without them running away."

Dr. T notices that Amy seems to put a lot of effort into her personal appearance when she comes to appointments, sometimes asking him what he thinks of a particular outfit.

She also asks him about his personal life despite his efforts to keep the conversation focused on her and wonders if she is his favorite patient. Dr. T remembers his psychodynamic training and worries that Amy is developing an eroticized transference, unconsciously transposing her past and ongoing feelings of abandonment onto him and experiencing them now as a fantasy that he might be the attachment figure she longs for and have similar feelings for her. He is uncertain whether he should comment on this or try to focus on the more immediate concerns of the cancer treatment.

Amy becomes agitated as her treatment progresses. She confesses that she is afraid of losing her relationship with Dr. T if she gets better and that she has grown deeply attached to him. She asks to see him outside the hospital. "You're the only one who understands me," Amy says. Dr. T explains that he must maintain professional boundaries and that it is his job to be understanding. At this point, Amy accuses him of only pretending to care about her. She leaves angrily and does not answer any of Dr. T's subsequent phone calls.

Amy does not come in for her subsequent oncology appointment. When the oncologist, Dr. Y, finally reaches her, she says that she doesn't need more treatment and that he cannot force her to come in. Dr. Y discusses this exchange with the rest of the care team, including Dr. T, who explains what happened during his last meeting with Amy. Dr. Y groans in frustration, "Say whatever you need to say to her to get her back here for treatment." What should Dr. T do?

Commentary

Cancer is a complex illness with biological, psychosocial, and spiritual aspects. While oncology treatments focus on biological aspects, it is important to address all aspects of the patient's treatment. The value of providing psychosocial support to patients with cancer is widely known [1]. The George Washington University's psycho-oncology clinic [2], for example, is a multidisciplinary clinic involving psychiatry and social work as well as psychotherapy, art therapy, nurse navigators, and chaplains when available. It offers five to eight sessions of (brief) psychotherapy conducted by third-year psychiatry residents under supervision, at no cost to the patient. Patients may be continued or referred for ongoing therapy if indicated.

A new cancer diagnosis is an adjustment under the best of circumstances, if not a potential source of an adjustment disorder. Elisabeth Kübler-Ross has described five "stages of grief" that provide words to express feelings that otherwise might be difficult to bear and process, such as denial or disbelief, anger or outrage, sadness or even depression, guilt, blame or self-blame, and acceptance or at least acknowledgement of loss [3]. Additionally, people diagnosed with cancer may be experiencing relationship conflicts, have suffered from early adverse experiences, or be facing stigma related to the illness that makes it difficult for them to receive support or to cope with the

additional challenges that cancer diagnosis and cancer treatment entail. Susan Sontag noted that when she became a cancer patient, "What particularly enraged me—and distracted me from my own terror and despair at my doctors' gloomy prognosis—was seeing how much the very reputation of this illness added to the suffering of those who have it" [4].

Dr. T thought he was providing support to a patient whose major concerns had to do with a new cancer diagnosis. However, over the course of the treatment it became clear that Amy's past abandonment issues were being played out in the present—in the relationship between her and Dr. T—and became the central issue of their work together. As we will show, understanding transference, its influence on the patient-clinician relationship, and its impact on treatment is key in addressing Amy's abandonment of treatment.

What Is Transference?

The relationship between patient and clinician is central to any type of therapy. Thus, both the patient's and the clinician's awareness and recognition of the feelings that they have about each other is vital to the treatment. In psychodynamic psychotherapy, patients' reactions to clinicians are often referred to as transference and clinicians' reactions to patients, as countertransference [5]. More specifically, transference can be understood as *repetition* of feelings, attitudes, and behaviors attached to early formative relationships in the context of a therapy relationship [6]. The clinician's unconsciously motivated response to a patient is known as countertransference [7]. Utilizing transference (and countertransference) in understanding patients, the ethical complexities of interacting with seriously ill patients [6], and promoting healing is at the heart of the psychotherapeutic process.

Although transference reactions can occur in any emotionally meaningful human relationship, the nature of the patient-clinician relationship can inherently evoke strong feelings. The power imbalance in this relationship between a patient in need and a clinician looked to for help can revive patients' memories of relationships with earliest caregivers and elicit powerful feelings of love, hate, longing, and dependency. This is especially important in the oncology setting, where illness and disability can threaten patients' autonomy, self-esteem, and self-control, leaving them feeling especially vulnerable. Such a situation can stir up powerful desires and fears from unresolved childhood conflicts that can then be directed toward the clinician [8]. Moreover, under the stress of illness patients can often regress, leading them to use less mature coping mechanisms such as denial of illness or nonadherence to treatment recommendations [6]. In the above case, Amy is the victim of neglect and abuse. Based on what she tells Dr. T, she fantasizes a savior—someone she can open up to, who cares about her, and who will not abandon her. Early in the therapy, she idealizes Dr. T as this savior. But

when he draws firmer boundaries, she feels betrayed and abandoned, re-enacting the roles of victim and abuser.

Types of Transference

Transference can manifest itself in therapy in many ways. Positive, negative, and sexualized transference are some common types of transference. When the patient views the clinician as a loving, caring, attentive, trusting figure, he or she may develop a *positive* transference in therapy. However, the patient can also experience the clinician as a distrustful, distant, adversarial figure, possibly leading him or her to develop *negative* transference [8]. *Sexualized* transference refers to transference in which the patient's fantasies contain elements that are primarily reverential, romantic, intimate, sensual, or sexual. It can be further differentiated into erotic and eroticized transference. *Erotic* transference is generally positive transference, which is egodystonic (i.e., recognized as unrealistic by the patient) and does not interfere with work in therapy. *Eroticized* transference, on the other hand, is a type of negative transference that involves a more intense, irrational preoccupation with erotic fantasies with the hope and expectation of reciprocation by the clinician [9]. Positive transference can facilitate a working alliance and willingness to come to sessions and talk about feelings, whereas negative transference can become resistance to treatment or simply put up barriers to treatment. In the above case, Amy initially develops a positive transference to Dr. T but later, as recognized correctly by Dr. T, develops an eroticized transference towards him.

Understanding Transference

A collaborative working relationship between patient and clinician is essential for transference to be explored in therapy. Some techniques that can help in establishing a strong therapeutic relationship include the clinician's taking a comprehensive developmental history, which facilitates understanding of the patient's early life experiences. It also enables patients to put forth a narrative of their life story and feel listened to with curiosity and interest [6]. In the case of Dr. T's patient, Amy, the history of "having an argument [with her mother] and moving away" might alert him to a pattern that might be repeated. Although her departure from therapy seemed an abrupt surprise, it was not a new behavior.

Most importantly, encouraging patients to talk freely about their emotional responses to the clinician allows them to bring up difficult feelings that they would not have done otherwise. It is important to maintain a nonjudgmental, open, and curious attitude to create a safe and trusting space for the patient [6]. Such an attitude allows patients to make connections between what they are feeling in the room with their clinician and their early life experiences, which enables development and growth [9].

Countertransference

In the same way that patients develop a variety of emotions toward the physician based on their past experiences, physicians bring their past to the room as well, and these memories—along with the patient's transference—may unconsciously influence their reactions to a patient [7]. While it is normal to have all kinds of feelings towards the patient, it is important to recognize and manage these emotional responses. Countertransference, when utilized correctly, can help the physician to understand how patients relate to others and experience the world around them. The key is to recognize, accept, and discuss these feelings, in supervision or consultation, if necessary [5]. For example, in the above case, while Dr. T was aware of Amy's desire for more contact, and even for extra-therapeutic contact, he may have been less attentive to his own reaction to her demands. He may have felt that Amy's cancer warranted extra attention and support from him and acted on these feelings, which might have added to Amy's emotional misunderstanding and frustration.

Managing Negative Transference

When a patient expresses or harbors aggressive or sexual feelings towards the clinician, as in the above case of eroticized transference, it might not be easy for a clinician to maintain an open and accepting attitude. The challenge is to maintain therapeutic boundaries while empathically responding to the patient to prevent him or her from feeling rejected or abandoned, thereby risking premature termination. The clinician's first task is to identify the transference and *not* avoid its existence. Encouraging patients to talk comfortably about transference is often helpful, although this may not happen right away or may not be possible for all patients [9]. One way to do this is to explain to patients that a lot can be learned about them and their relationships with others by discussing their thoughts and feelings about the clinician. It is important for the patient to know that these feelings are not taboo and that the clinician is comfortable discussing and trying to understand them in order to prevent him or her from feeling embarrassed, rejected, or negatively judged [10]. For example, a clinician might say, "Thank you for sharing how you feel about me. Those feelings can often be very hard to talk about." Equally important, the therapist should clearly explain that there are boundaries of the psychotherapeutic relationship that must be respected for effective and safe treatment [9-11]. The clinician might say something like "*This* is the place where we can discuss feelings, so you can better cope with things that are going on elsewhere, such as your cancer treatment." While Dr. T identified the transference reaction, he was not able to help Amy explore the meaning or significance of this reaction.

In order to explore the patient's sexual fantasies, the clinician must first work through his or her own countertransference [11]. It is important to understand that the patient's sexual or romantic fantasies are not directly caused by personal attributes of the clinician but, as stated above, are closely tied to the setting and structure of therapy in which the patient's dependence on the clinician can arouse powerful feelings from past conflicts.

This realization prevents the clinician from feeling shame or guilt about the situation as well as from gaining narcissistic gratification associated with it [12]. If the clinician experiences sexual feelings toward the patient, he or she may become either overly involved with the patient or distance him- or herself from the patient, both of which are detrimental to effective and safe treatment. It is important to seek consultation if the clinician's own sexual feelings are compromising patient care [8].

The nature and strength of the therapeutic relationship is another variable in management of negative transference. Interpreting the transference or making any connections between early childhood experiences and transference without adequate therapeutic alliance can be premature and risk being misinterpreted or rejected by the patient [8]. Working with sexualized transference is challenging and may pose a threat to treatment if mismanaged. However, it is often a window into the internal world of patients—their unconscious conflicts, narcissistic wounds, and past trauma—and, when worked through, can be highly therapeutic [13].

Ethical Considerations in Psychotherapeutic Technique

Ethical traditions dating back at least to the Hippocratic Oath have recognized the importance of maintaining professional boundaries [14], and Freud specifically cautioned against ignoring erotic feelings in psychoanalytic treatment [15]. Dr. T may well have respected the principle to "do no harm," but he didn't seem to appreciate that even if a patient is not in psychodynamic therapy, it is important to attend to transference reactions that may interfere with the treatment— specifically, the psychotherapy, but even the cancer treatment. While there may be instances when it becomes important to alter protocol by scheduling a hospital or a home visit or a telephone or Skype session, one always needs to be mindful of what is going on with the patient, what is going on with one's own feelings, and what is going on in the relationship, and then decide what needs attention and when is it appropriate and necessary to comment on these feelings to further the patient's best interest and the goals of the therapy.

What could Dr. T have done differently and what could be done at this point to salvage the treatment—the psychotherapy and, more importantly, the oncological treatment? Retrospectively, it might have been useful had Dr. T explicitly reviewed the treatment goals at each stage of the treatment, identifying issues related to the cancer and cancer treatment that needed attention and how issues from the patient's past would be addressed. Also, when Dr. T recognized Amy's eroticized transference and was uncertain how to respond to it, seeking out supervision might have been helpful. Is there anything Dr. T can do to get Amy back into therapy, or is it too late? Since she is not responding to his telephone calls, it might be useful to draft a letter explaining that the treatment is important, that he is available to continue with her if she should choose or that she could work with someone else. Another member of the team might reach out to her if she doesn't respond.

In sum, this case is a cautionary tale of the importance of being vigilant of transference reactions, even when they may not appear to be the immediate focus of therapeutic concern. Transference may help foster a therapeutic alliance, but it needs to be addressed if it becomes a source of resistance. Moreover, it is important for the clinician to be aware of his or her own feelings in face of a cancer diagnosis and to realize that cancer may not be the only issue a patient is dealing with.

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