

REVIEW ARTICLE

Countertransference in Dermatology

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The doctor–patient relationship in dermatology, as in all the fields of medicine, is not a neutral relationship, removed from affects. These affects take root in the sociocultural, professional, family and personal history of both persons in the relationship. They underpin the psychic reality of the patients, along with a variety of representations, preconceived ideas, and fantasies concerning dermatology, the dermatologists or the psychiatrists. Practitioners call these “countertransference feelings”, with reference to the psychoanalytical concept of “countertransference”. These feelings come forward in a more or less conscious way and are active during the follow-up of any patient: in fact they can facilitate or hinder such a follow-up. Our purpose in focusing on this issue is to sensitize the dermatologists to recognizing these countertransference feelings in themselves (and the attitudes generated by them), in order to allow the patients and doctors to build a dynamic, creative, trustful and effective relationship. Key words: doctor–patient relationship; countertransference; dermatology.

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From their first encounter, doctor and patient each bring along with them their family, professional and personal histories, as well as their personalities, character traits, reserves of narcissism and representations of health, beauty, youth, old age, love, life, disease, death and their preconceptions about the patient, medicine and doctors, medical vocation, etc.

The doctor–patient relationship that is subsequently established consists of mutual expectations and hopes. The patient expects relief and, if possible, recovery; the doctor expects gratitude from his patient and confirmation of his therapeutic powers. Such a relationship closely resembles that between teacher and pupil or parent and child, and it is thus likely to awaken memories of other important encounters, in both the doctors and patients, but also of former conflicts and disappointed expectations.

The doctor–patient relationship is a relationship marked by idealization and thus prone to disappoint-

ment. The patient is always hoping to meet the ideal doctor and the doctor, similarly, would like his patient to be an ideal patient (for example an always compliant patient).

The doctor–patient relationship is an unequal relationship, the starting point of which is the request addressed by a suffering subject to a subject who possesses a particular expertise. Expressing a request makes patients passive and dependent on the response of others and their suffering constitutes an *a priori* handicap. In fact, things are actually much more complex than this, because suffering also confers rights and allows the person who is a victim to exert an influence on his physician.

In the end the doctor–patient relationship is a paradoxical relationship, because although the object is the body, it generally passes through the medium of speech, and this can lead to incomprehension and much misunderstanding.

These universal characteristics of the doctor–patient relationship take on a particular hue in dermatology, because skin diseases are visible, sometimes even glaringly obvious, and any word proffered is likely to be short-circuited: the dermatologist very often diagnoses the lesions displayed by the patient at a single glance. Many skin diseases are chronic, harmful to quality of life and jeopardize patient compliance, thus carrying the risk of wearing down the doctor–patient relationship. Several disorders are also labelled “psychosomatic”, since psychological factors are believed to contribute to their occurrence or their evolution. Thus the dermatologists will very often be challenged by their patient in their scientific or personal convictions – whether they be rational or irrational – and their convictions and beliefs will be questioned. They will experience, consciously or unconsciously, different emotions caused by this challenge and by the resonances brought about by each encounter with each particular patient, according to the personal story of each one. Certain elements of reality, such as age, gender, physical appearance, but also intonation of voice and character traits, may trigger these resonances, but it is important to stress that these “resemblances” very often operate without the person experiencing them being aware of it. This phenomenon is known and referred to as “countertransference” (1). Freud defined countertransference as the result, within the framework of a psychoanalytical cure, of the influence of the patient on the unconscious feelings of the

doctor. The concept of countertransference thus indicates the doctor's emotional, conscious and unconscious movements, in reaction to those of his patient and according to the way he has experienced his own family, and his personal and professional history. The concept of "transference", on the other hand, refers to the patient and consists of the repetition, in adulthood, of modes of relating to others that were formed in infancy during early bonding. Each actor in the doctor-patient relationship thus projects figures from his childhood onto the other. However, within any doctor-patient relationship it is possible to speak of the "countertransference feelings of the doctor" by extrapolating the feelings that emerge in the psychoanalyst within a psychoanalytical cure (2). It should be remembered, in this regard, that psychoanalysis is, at the same time, a theory of mind, a therapeutic practice, a method of research, and a way of viewing cultural and social phenomena (3). The range of these feelings is very broad, from love to hatred, through sympathy, tenderness, sorrow, irritation or rejection. These feelings can follow on one from another or be combined in various ways, testifying to the wealth and complexity of any psychic life.

Some of these feelings, such as sympathy, the act of being moved by a patient, of feeling curiosity, interest, or even admiration for a patient, may be useful and can be put to service within the doctor-patient relationship. However they can also ensnare the doctor who experiences them without being in control of them, with the resultant risk of a "loss of distance" and of unwanted interference with a rigorous diagnostic and therapeutic approach. It is important not to confuse sympathy or being moved by a patient with empathic skills (4). The latter are a frame of mind which makes it possible for an individual to understand and recognize what the patient feels, without necessarily adhering to it entirely, i.e. retaining the critical faculties and the requisite freedom for shedding a different light on a situation. To express one's empathy towards a patient helps the latter to feel listened to and understood, but also supported and less lonely. This is all the more fundamental for good communication between patient and doctor when the relationship comprises different points of view and there is a conflicting component as a consequence, in which each is tempted to become entrenched in his own position for as long as each partner (or adversary) does not recognize the legitimacy of the other's experience.

Empathy can allow the doctors to tolerate and accept the patient's doubts and fears, and their moments of despondency or rebellion, without interpreting them as a lack of confidence in them or as a criticism of their therapeutic suggestions (« But doctor, how is it possible that in the 21st century we still have to use creams to treat skin diseases?! » or « Isn't it very dangerous to apply corticosteroids to the skin? »). Empathy differs from sympathy. Contrarily to the positive effects of

empathy, an impulse of sympathy or the feeling of being a privileged confidant of the patient or being considered "someone who listens better than anybody else" or "the person who has finally understood", who has been able to give hope back to a patient who had lost it, all have some common characteristics jeopardizing the doctor-patient relationship. The risk is the establishment of a relationship of seduction between the patient and his doctor, with its potential consequences: the swing, for the patients, from satisfaction to disappointment and the feeling, for the doctors, of having been cheated, leading them to blame patients who may not necessarily have tried deliberately to put them in a difficult situation.

Another sentiment-trap that dermatologists may fall into, particularly in the case of patients presenting with cutaneous lesions that are resistant to treatment, is that of pity and need to make amends, which often accompanies it (5). While such a need frequently lies at the very root of a caring vocation, it inevitably reminds the person of old conflicts with attachment figures, to feelings of guilt for having been capable of wanting to hurt or to harm them and then on into an often dizzying spiral of endless devotion that goes well beyond what the situation reasonably requires, spurred above all by the necessity of easing one's own conscience.

On the other hand, other countertransference feelings like disgust, rejection, irritation, and even exasperation will more obviously hinder the doctor-patient relationship, inducing inadequate attitudes in the doctor which can lead to a mistaken appraisal of patient's psychiatric and somatic condition and ultimately to a severing of the therapeutic bond (6). Below is a clinical example.

Mr. C. is a rather self-effacing and quiet man, suffering from alopecia areata universalis. He is accompanied by his wife, who is a talkative woman, who speaks very readily and who takes it upon herself to answer the questions addressed to her husband by the dermatologist. Depending on the moment, but also on the more or less repressed ups and downs of his own life, the dermatologist may feel irritated by the attitude of the patient's wife and sorry for the patient's situation. Alternatively he may feel irritated by the behaviour of such an inhibited and passive patient. The dermatologist may thus wish, without giving the matter much thought, to continue the dialogue with the woman, excluding her husband and thus reproducing the couple's habitual relational style. He will almost certainly be tempted to do this by a sense of weariness or a lack of time and by his wish to finish the consultation more quickly. However it is equally possible that he brusquely interrupts the interfering woman and defends the husband whom he perceives as a defenseless individual that has surrendered to the authority of an overbearing wife.

These extreme attitudes risk both weakening the doctor-patient relationship and jeopardizing the therapeutic bond. The question is ultimately for the dermatologist not to be blinded by what appears obvious to him and to come to terms with the way this couple functions as a fused entity. Their way of being together is long established: the dermatologist is certainly not going to change them. On the other hand, despite the irritating spectacle of coupledom that Mr C. and his wife present, both of them are clearly suffering and both

have addressed their request for assistance to the dermatologist, even if they have done so in an awkward way. Let us not forget that for certain patients who have difficulties in identifying and expressing their feelings the partner who accompanies them can be a true “spokesperson” for what they cannot or dare not think or say.

Faced with Mr C. and his wife, the dermatologist conscious of his countertransference feelings will be able to avoid acting impulsively or impatiently and will play the part of a tightrope walker: he will listen to and welcome the remarks of the wife, without disqualifying them, and he will solicit the husband’s views wherever possible, at the same time turning to face him. Mr C. may perhaps come alone to his consultation one day and it will then be necessary for the dermatologist to welcome such change with benevolence and without triumphalism.

The countertransference of the dermatologist may also be required by the treatment plan itself, when this involves joint management by a dermatologist and a general practitioner or a dermatologist and a psychologist, psychiatrist, psychotherapist or psychoanalyst, or if the difficult decision has to be made whether to refer the patient to a mental health specialist and to present him with such a treatment plan. These are relatively common steps in various chronic dermatological diseases, regardless of whether a psychosomatic component is present.

The caring vocation of the dermatologists, which is frequently rooted in a desire for supreme power over illness and death, is likely to be defeated by contexts such as these and the dermatologists are likely to blame their patients for not showing sufficient willpower to recover or even for behaving in such a way as to defeat them personally. Feeling discouraged, dermatologists may seek to “get rid” of their patients. Conversely, they can second patients’ reluctance to consult a psychotherapist, or they can arrange for a hasty referral which they know is futile, and thus create patients who will remain devoted to them.

Many dermatologists do not have the name of a psychiatrist to hand in their address book. The act of writing a letter to or calling a psychiatrist is difficult for them. It is also not unusual for them to share their patients’ negative vision of psychiatry and psychotherapies and to have many preconceived ideas about these fields; for example concerning the cost of psychotherapy, the length of psychoanalytical psychotherapy, or the inflexible silence of psychoanalysts. Dermatologists should know and be able to explain to their patients that there are different types of psychotherapies (cognitive and behavioural therapies, psychoanalytical psychodynamic psychotherapies, etc.), that a psychoanalytical psychotherapy can be settled on a basis of one session per week or less, in a face-to-face, seated arrangement and that generally psychotherapists are used to adapt their technique to the psychological, socioeconomic and clinical peculiarities of their patients (7). For some patients, and maybe this is the case for many patients presenting with somatic symptoms, the visual relationship

matters as much as the verbal relation and participates in the emergence of transference feelings; reciprocally, the gazing relationship and health care practitioner’s bodily responses to patients’ presentations are potential sources for countertransference feelings (8, 9).

On the other hand, certain dermatologists idealize psychiatry and psychotherapy and devalue their own psychological competences. They consider themselves as helpless and not sufficiently trained to recognize the moment when, if there are no manifest psychiatric symptoms, it is justifiable to broach with their patient the subject of their psychological suffering or to identify, for example, depression in a patient who has been suffering from psoriasis for a long time. The risk then is to allow a true “collusion of silence” between dermatologist and patient: the latter may not be aware of his depression or may be ashamed of it; the dermatologist may consider it “normal” to be discouraged when one suffers from psoriasis or he may be afraid to hurt his patient by speaking about depression, or else not be able to contain his patient’s sad feelings during the dermatological examination. To refer a patient suffering from a dermatological disease to a mental health specialist is a task not made easier, however, if the dermatologist believes that a particular psychotherapist has near magic therapeutic powers.

The dermatologist may also “believe in the psychosomatics” and be convinced of the psychogenesis, pure and simple, of a dermatological disease. When this happens, psychological linear causality is likely to replace somatic linear causality in the dermatologist’s beliefs, at the expense of all that constitutes the complexity and riches of any human being.

Another, and by no means lesser danger is when a dermatologist lacking in rigorous training in psychotherapeutic techniques embarks on a treatment and “confuses the roles”, or even embarks on interpretations of what he may have perceived of the unconscious conflicts from which his patient suffers, without clearly explaining the therapeutic treatment plan and without rigorously setting out a “framework” for his intervention.

Ultimately, one of the most fundamental contributions of psychoanalysis to the work of physicians, and thus also to that of dermatologists, is to have shown the importance of staying tuned not only to each one of their patients as they encounter them in their uniqueness and in their subjective trajectory, but also to themselves, to the feelings that patients induce in them and to the human, social and ethical values that will inevitably be called into question by each encounter. The encounter with a patient is undoubtedly an opportunity to get to know an individual beyond his disease, but it is also an opportunity to get to know oneself better and to re-examine one’s theoretical reference-points.

By trusting the capacity of their patients to astonish them and stimulate them into producing new psychopathological hypotheses, doctors will best pre-

serve the vitality of the doctor–patient relationship and the therapeutic approach itself as well as the psychosomatic approach.

Transference and countertransference are highly subjective and rather old concepts. They can nevertheless be quantitatively assessed and submitted to an experimental approach (10–12). For example it has been shown in a sample of patients suffering from personality disorders and admitted to a day treatment program that at the beginning of treatment, higher levels of symptom distress were related to less negative countertransference reactions (11). At the end of treatment, the correlation pattern changed, and higher levels of symptoms were related to lower levels of positive countertransference feelings, i.e. feelings of being important and confident, and higher levels of negative countertransference feelings, i.e. feelings of being bored, on guard, overwhelmed and inadequate.

There are many opportunities offered to physicians, and more specifically to dermatologists, for training in the psychological dimensions of the doctor–patient relationship in order to be aware of the importance of transference and countertransference phenomena within any clinical follow-up. This ranges from teaching medical psychology and the foundations of the psychosomatic approach, or teaching narrative medicine (13) within the curriculum of medical school, to the participation in scientific societies dealing with psychosomatic medicine, psychosomatic dermatology, or the relationship between dermatology and psychiatry (as for example, in France, the Société Francophone de Dermatologie Psychosomatique and, at a European level, the European Association of Psychosomatic Medicine or the European Society of Dermatology and Psychiatry). Another route is the participation, with other physicians or health professionals, in groups animated by a trainer who has a psychoanalytical reference, as proposed by Michael Balint (14–17). The purpose of such groups is to evoke and analyse together the most uncomfortable or destabilizing doctor–patient situations experienced by the participants. The impact of such a training on the empathic abilities of doctors has already been tested, with encouraging results (18).

To conclude, we would like to stress that countertransference phenomena are universal and important to take into account in every doctor–patient relationship, in dermatology as in any other medical practice, and not specifically in a psychotherapeutic setting. This area was still little invested by psychosomatic research, justifying in the future rigorous and inventive investigation methods, which can be promising for psychosomatic dermatology.

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