Expert Commentary

In the blink of an eye: Instant countertransference and its application in modern healthcare

“You have brains in your head. You have feet in your shoes. You can steer yourself any direction you choose. You’re on your own. And you know what you know. And you are the one who’ll decide where to go…”

— Dr. Seuss, Oh, The Places You’ll Go!

Walking to work every morning, one would wish that Dr. Seuss’ quote were true. As physicians, we are often endowed with vast knowledge, made to survive rigorous training, and entrusted with the immense responsibility of treating people. Yet, there are aspects of patient–doctor interactions that can stymie even the most experienced physician. Difficult patients do not follow rules, nor come with scripted presentations: no manual can prepare us fully for patients who reject help, tug on our heartstrings, revive our deepest memories, or elicit fear, pity or shock, and disbelief. As healthcare evolves and becomes increasingly fast-paced, and even disjointed in some regards, some basics of clinical care remain unchanged: a clinical encounter is, and will always be, an interaction between two human beings even when it is transitory or occurs in the “blink of an eye.” As such, emotions will be present, and need to be acknowledged and managed, so we can offer our patients, the best care possible.

Sigmund Freud first articulated the concept of countertransference at the turn of the last century. Put simply, over the course of interactions with patients, we develop feelings and these feelings affect how we resolve and process the patient’s problem at hand. Via supervision and self-monitoring, computed tomography (CT) can be identified and harnessed for an improved emotional and medical experience.

The language to describe emotional engagement in nonpsychiatric clinical, particularly in emergent and primary care arenas (i.e., emergency medicine, acute care, trauma surgery, etc.) is sorely lacking. Researchers have attempted to explain, manage, or codify such feelings often constructing models, cultural competency to bias, prejudice and the nebulous field of health-care disparities, the common factor remains human emotions, and specifically the emotions that we, providers, feel toward our patients. These emotions drive health care in ways that are not well understood. Moreover, they are dealt with differently across medical specialties, thus leading to a lack of unified approach to optimal care.

CT is not typically used as one of those approaches, as it is not well adapted to the pace of modern medicine (simply because of the traditional view of CT developing over time, being addressed over time and belonging mostly in the realm of long therapy). Despite those shortcomings, CT is often anecdotally cited as a reason for certain occurrences in health care, especially in patient groups such as individuals with mental health issues, addiction, high service utilization, nonadherence to medical treatment, severe illnesses, or impending mortality. The use of CT offers several advantages: contrary to bias, which is essentially negative, CT can be positive or negative and is much more nuanced, having different categories [Figure 1].

So how can we use CT in modern healthcare?

The main advantage if using CT is that it offers a lot more choices than bias concepts. It can be positive, negative, or otherwise. Based on studies conducted by our group and currently in preparation for publication, CT has toward patients affects the diagnosis of depression and decision making in various types of nonpsychiatric clinical encounters (chest pain, shortness of breath assessment, etc.). Our studies effectively extrapolate on literature related to bias and showing that gender, race, and socioeconomic status affect health-care decisions, and we expand to show that positive CT, not just negative ones, can affect care via assessment of symptom severity or choice of tests ordered. However, as mentioned above, CT is not suited for the fast pace of modern emergency care. So we would like to introduce the concept of instant countertransference (iCT), an instant, spontaneous set of feelings that form toward patients, even in the shortest of clinical interactions.
Characteristics of iCT:

Anyone who has ever spent time in an emergency department knows that patients get classified as difficult or not before they even get evaluated. Unspoken rules and expectations are set and communicated very subtly through the system. The concept of iCT summarizes salient aspects of these feelings and interactions. iCT is thus characterized by the following:

- It is instantaneous and often unconscious
- It is based on each individual’s set of preconceived notions and prior experiences, whether negative or positive
- iCT can be positive or negative
- iCT shapes the conduct of the interview, how physicians reach conclusions about a patient’s diagnosis, and how they may determine need or impairment
- iCT often forms around patients with certain themes, presentations, or complaints. Thus, it may be involved in patterns, or clusters, of certain physician–patient interactions
- iCT is different than traditional, classically defined Freudian CT in its scope, and will likely require different management aspects, an area yet unexplored.

In summary, iCT may be a very useful clinical and educational tool to help clinicians and trainees identify what they feel toward patients, and learn to manage it while providing humane, compassionate care. Future areas of work will include addressing iCT in real-life situations, and examining the impact of iCT on adherence to treatment algorithms. Finally, exploring how more intense negative iCT links to rising rates of burnout is a very promising area of work, we look forward to address in the near future.

iCT is compared to traditional countertransference and bias on Table 1.

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**Figure 1: Different types of countertransference based on Betan et al. Am J Psych 2005;162:890-898**

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| Countertransference | iCT | Bias |
|---------------------|-----|------|
| Develops over time and repeated encounters with patient | Develops in a blink | Ingrained, preexisting |
| Can be positive, negative, or more complex [Figure 1] | Positive, negative, or more complex [Figure 1] | Negative |
| Can be addressed through supervision (group or individual) | Responds well to teaching and supervision | Harder for clinician to identify and to address implicit in most cases |
| Related to patient’s personality pathology and behavior patterns | Hybrid: relates to a patient’s behaviors as well as inherent characteristics | Related to a patient’s inherent characteristics, not necessarily related to behaviors |
| Can be used by clinicians to make diagnostic and therapeutic use of their own responses to the patient | Like countertransference can be used by clinicians to make diagnostic and therapeutic use of their own responses to the patient | Bias may influence clinical decisions, may contribute to health disparities |

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