RESIDENT'S COLUMN

by Jeffrey Junig, M.D., Ph.D.

Reining in Compassionate Countertransference

As I sat down to Thanksgiving dinner, I kept thinking of the look of despair in her eyes. I was haunted by the last thing she had said to me the day before: that I could walk away and forget for the holiday, but that she couldn't. That, she reasoned, was why, in fairness, I should allow her to kill herself.

I had discussed and experienced countertransference during my short period as a psychiatry resident, particularly in relation to patients with borderline personality disorder. I was learning to be aware of my emotional reactions to patients; I was beginning to understand that my feelings could serve as indicators of some deeper meaning that my conscious mind was unable to grasp. But before now, I had been trying to make sense of occasional feelings of aloofness, anger or frustration. I had not yet felt such gut-wrenching, moral obligation to rescue a patient.

She was by far the most severely depressed patient that I had met since beginning my residency. Her pain had been unrelenting for over two years, despite treatment with multiple classes of agents and augmentation strategies. Her suicidality lived within her like a demon, waiting for the slightest opportunity to overcome the last remnants of her will to live. Since becoming involved in her care, I have found myself facing many questions, grist for the mill during residency experiential group. Does a person ever have the right to choose to die? And what motivates my actions to keep her alive? At what point are my actions self-serving, like those of a cancer surgeon who cannot accept defeat? My patient, a critical care nurse, answered all of my hopeful statements with more existential questions, all based in intelligent, plaintive nihilism.

But it was her eyes that mattered most. She had gazed directly into mine, her face tearful and contorted in pain. "Can't you see," she whispered, "that I'm too tired … that I just have … to … stop?" I stood with my arms at my sides, feeling a wall of professional boundaries threatening to form and at a loss for which side to stand on. Were she an animal, I would not have been able to walk away without doing something, including providing death's final relief. I felt limited by my role as a physician. The one natural impulse, to embrace and comfort her, was obviously off the table. And so, although I drove home from the hospital that night safe in the knowledge that I had done all I could as a physician, I wondered if I had failed as a human being.

I did not sleep well that night. My wife of 18 years knew instinctively where my mind was. She reminded me that I can't carry the weight of work with me all of the time. "How are you going to manage for the rest of your life?" she asked. I understood her point, but I also recognized that with this case, for now, forgetting seemed wrong in some way. I decided that the issue of letting go of work would have to wait until future experiential group meetings. My concerns that night were deeper, and centered on the nature of my feelings. I thought about my automatic reaction to her pain and my impulse to embrace and provide comfort. I worried that my thoughts were unique, and I was embarrassed and ashamed of them. Yet at the same time, I was haunted by the feeling that I had not done enough—that I had used the bounds of professionalism to avoid the messy work of truly helping a suffering person.

As I sat at Thanksgiving dinner, I thought of the despair in her eyes. As the warm glow of family connection entered my consciousness, I realized that her despair was seductive. In the business of life, we are often far away from the deep connection with others that perhaps most people secretly long for. In her desperation, her plea for salvation was raw, unfiltered and essentially human. I realized that the desire to respond was natural but dangerous in its primitiveness. I suddenly had empathy for practitioners who have made the mistake of giving out their personal phone numbers and who found themselves overwhelmed by boundary issues. I realized that I had much to learn. I acknowledged my respect for the field of psychiatry, in that I would be facing challenges unlike any other field of medicine.

Returning to the inpatient unit on Friday, I felt more confident about the position I had taken with regard to the wall of professionalism. I had learned something about the desire to remove the wall, and at the same time I recognized its importance. I also recognized, with gratitude, the privilege of being trusted with the despair of another. The experience of human connection provides the greatest rewards in all of medicine.

I decided to present my feelings to my attending as we staffed her case. I searched for the words to describe my feelings, predicting that I would be seen as immature, or unprofessional, for my reactions. "The way she stares with her eyes—so desperate …" I said. "I feel like … I wonder if …."

"You should give her a hug," he said. "I know what you mean. Let's talk about why you feel that way and what that tells us about our patient."

And while I had only just begun the long journey toward understanding and effectively using countertransference, I understood that my feelings were not shameful or superfluous. I was intrigued at the prospect of understanding how my own humanity contributed to, and potentially threatened, my therapeutic relationship with a patient. And I had new respect for one of the challenges ahead of me.

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