

**When the Personal and Professional Collide:
The Unspoken Influence of Our Selves in End-of-Life Care**

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As helping professionals working in end-of-life care, we are deeply affected by loss in our personal as well as professional lives. In fact, many of us have chosen to work in end-of-life care as a result of our own experiences with dying, trauma and loss. Whether we are physicians, chaplains, nurses, social workers, psychologists, physical therapists or occupational therapists, we have certain values and ethics, socio-cultural influences, personal life histories and memories, preconceived notions and assumptions which we inescapably bring to our work (Katz & Johnson, 2006).

The “C” Word

In training, supervising and consulting to professionals involved in end of life care, I have been struck by the thirst for knowledge that professionals seek—not about statistics, evidence-based practice and the like, but about the subtle ways in which they can get “hooked” when providing care at the end of life. When I used the psychodynamic term for these personal-professional connections, I discovered an abundance of preconceived notions and biases about the “C” word (countertransference). Practitioners were concerned that countertransference implied a distant, impersonal, even sterile work style. They pictured caricatures of stereotypical Freudian psychoanalysts using academic and theoretical intellectualization in order to avoid being truly present and truly human. I found that I had to challenge these, often very seasoned, practitioners to look beyond the stereotype of the distant, *tabula rasa* analyst and understand that the “C” word is every bit as relevant to health care professionals working with patients and

families at the end of life as it is to psychoanalytic psychotherapists. I had to make the case that countertransference is a concept that actually beckons the helper to look at his or her humanness in the face of dying, death and bereavement, rather than avoiding it.

Historical Overview

It is true that the concept of countertransference was initially described by Freud as an unconscious process involving the arousal of the analyst's unresolved conflicts and problems (Freud, 1910). In Freud's classical definition, countertransference was regarded as an obstacle to treatment, a blind spot that the analyst had to overcome in order to work effectively (Freud, 1912). Over the years, however, the definition of countertransference has been extended to include the totality of feelings experienced by the therapist toward the patient—whether conscious or unconscious, whether prompted by the client's dynamics or by issues or events in the therapist's own life (Beitman, 1983; Kernberg, 1965; Langs, 1983). Countertransference is now regarded as a natural, appropriate, and inevitable emotional response (Gabbard, 1999; Maroda 2004; Racker, 1968), and “a crucial source of information about the patient.” (Gabbard, 1995, p.475). Working with countertransference is regarded as a positive and important therapeutic tool, “an indispensable instrument” (Gill, 1994, p.102) in our work. It is the basis for empathy and deeper understanding of both the patient's and clinician's own processes (Beitman, 1983; Heimann, 1950; Little, 1951; Wishnie, 2005).

Sandler, Christopher and Holder (1973), Dunkel and Hatfield (1986), Genevay and Katz (1990) and others have delineated the necessity of examining countertransference dynamics in interactions beyond strict psychoanalytic or

psychotherapeutic treatment. I, too, believe that countertransference is part and parcel of all helping relationships.

Countertransference in the Context of End-of-Life Care

In end-of-life care, professionals of all disciplines and levels of experience are subject to powerful reactions to their work. These responses are far more diverse than simply “compassion fatigue” or “vicarious traumatization.” Some of these responses originate in the helper, some “belong” to the patient (but are knowingly or unknowingly incorporated by the empathic helping professional), and some belong to that ‘alchemy,’ that ‘space’ that takes its own place in the poignant relationship between helper and patient. The context of death and dying brings these responses into an altogether unique realm of thought and practice. Countertransference responses can be complex and often enormously subtle in their manifestations. They inevitably affect every interaction, every theoretical discussion, every diagnostic work-up, and every treatment plan.

Whether we are psychologists in private offices struggling to sustain an empathic environment for those who suffer profound loss and deep trauma, whether we are physicians wrestling with those words that will dim the hope in our patient’s eyes, whether we are clergy or hospice social workers painstakingly striving to help patients make meaning at the end of life, whether we are administrators and teachers of clinical and residency programs working hard to prepare and support those in the trenches—*all* of us require an understanding of this subtle yet complex process that impacts our work every day.

For example, do you recognize any of the following scenarios?

The Midwest doctor who has sworn an oath to do everything possible to sustain life—how does he ‘help’ an elderly Chinese woman, whose family culture does not permit her to ‘know’ of her imminent death and the lack of further curative treatments?

The conservative Catholic social worker whose father committed suicide when she was twelve—how does she ‘help’ a family in its decision to stop all antibiotics and tube feedings for their 45-year-old father who is now brain dead?

The young psychiatrist who simply prescribes psychotropic medication for the elderly Jewish patient who can’t stop scrubbing his arms—how does he ‘help’ when he has missed the chart note explaining that this man survived the Holocaust by burying dead bodies in Auschwitz?

Understanding countertransference processes is invaluable in all therapeutic relationships, and working with patients and families at the end of life is no exception. One must simply overcome the stigma of the term, ‘countertransference.’ I prefer to use the term ‘countertransference’ as an ‘abbreviation’ for the totality of our responses to our work—emotional, cognitive and behavioral--whether prompted by our patients, by the dynamics incumbent to our helping relationships, or by our own inevitable life experiences.

The Dovetailing of the Personal and the Professional

Our real, often intense reactions to work in end-of-life care tell us that there is a personal-professional interface between our own life developmental tasks and our professional interactions (Katz & Genevay, 1987). Yet, how many of us take the time to reflect on the convergence of our personal lives and those of the patients with whom we

work? How many of us have been trained to stop, breathe, and reflect on the dynamics that may be affecting us in this profoundly privileged work? Can we be sure that we are making the ‘right’ decisions on behalf of our patients, if we have not examined the multiple facets which impact our thinking, feeling and behavior in this very personal work?

Personal work? No, this is professional work, one might argue. In fact, I propose that our professional work with the dying and the bereaved is *extremely* personal in nature, that we are profoundly influenced by our patients and their families as much as they are impacted and influenced by us, and that our emotional responses *do* impact the clinical moment—whether we want them to or not, whether we are aware or not, whether we can *admit* it or not.

And, therein lies the rub. Until recently, end-of-life theorists, clinicians, practitioners and teachers have devoted great effort to understanding and evaluating one member of the therapeutic relationship—the patient. With the advent of quantum physics, however, the definition of an entity, of an experience, and even of a unit has changed. Scientific explorations of objectivity and subjectivity have revealed fascinating new discoveries of what has long been understood as the ‘gestalt’—the whole that is greater than the sum of its parts. These findings demand that we face the fact that we, as ‘experts,’ cannot responsibly divorce ourselves from this whole—nor from the ‘alchemical reaction’ that occurs when two individuals engage together at what is, perhaps, the most vulnerable time in a human being’s existence, the end of life. Patients, their subjective experience of their own illnesses, their families, and their worlds—everything, in fact--is irrevocably changed with our entry into the helping relationship.

Taking responsibility to examine and explore how we influence the individual and the individual's processes and outcomes, how the patient influences us, as well as taking stock of our own professional actions, is long over-due in the literature on end-of-life care.

It is time that we scrutinize *ourselves*, in *our* part of the dyad. We must examine what we bring to the therapeutic relationship, and, conversely, the ways in which it impacts us. This often means taking great risks in inviting our colleagues, supervisors and supervisees into our therapeutic realms. If we are to truly work with our countertransference responses, we are inevitably putting ourselves in the position of disclosing uncomfortable, even embarrassing, moments, actions, and outcomes of our work. It may mean that we reveal interactions, diagnoses, treatment recommendations and the like, which, upon their later reflection, were not as 'objective' and 'helpful' as we would have liked to have believed. And, paradoxically, perhaps some of these same 'failures' may, in hindsight, have been *exactly* what was needed!

Admitting our professional foibles (influenced by our personal life histories and experiences), not only benefits the patient, it benefits us—and, perhaps, even our colleagues. When we can bear to examine dynamics such as how we both over-help and under-help patients and families; how personal feelings, cultural and religious biases, and prior life experiences can contribute to inappropriate diagnosis, referral and intervention; and why treatment is prolonged with some patients and terminated prematurely with others—our forthrightness can encourage other professionals working in end-of-life care to confront and examine their own denial, fear, helplessness and anger related to death and loss, as well as their need to control, cure and save, and 'do good.' In supervision

and in trainings it has been enormously helpful to invite professionals to examine their inherent assumptions about a 'good death,' about resilience, hope, and dignity at the end of life-- when, in fact, the meanings attributed to these words become so relative and so differently understood by the patients, families and communities with whom we work (Katz & Johnson, 2006).

The Courage To Be Honest

If we have the courage to identify and confront the totality of our responses in patient care at the end of life, we can use them to inform and enrich our work. If we do not, we may find ourselves entangled in potentially damaging situations. It is my hope that examination of these complex personal and professional interactions will be requisite training for each and every person working in end-of-life care. And for those of us already deeply immersed in it, examining countertransference in end-of-life care can serve as a guide to unraveling and understanding our own responses to this exquisitely nuanced and deeply personal work. In so doing, we grow both personally and professionally.

END NOTE:

Interested in fostering your own awareness of instances where your professional objectivity might not be as "objective" as you think? Curious about what types of patients and families may unconsciously "hook" you? Want practical tools to help un-tangle the influence of the personal on the professional? CE-Credit. Net offers continuing

education credits for *When Professionals Weep: Emotional and Countertransference Responses in End-of-Life Care*.

When Professionals Weep addresses such issues as how practitioners "overhelp" and "underhelp" some patients because of their personal biases, blind-spots and experiences; how the lens of our own subjectivity can contribute to inappropriate diagnosis, referral, and treatment; why service is prolonged with some and terminated too soon with others; and how denial, anger and grief, fears of suffering, deterioration and pain and personal needs for control, admiration and affection hinder our best "professional" endeavors.

When Professionals Weep postulates that awareness of countertransference responses holds enormous potential. If we can distinguish what belongs to us, what belongs to the patient and what these responses might indicate about our interactions, our patients benefit in that we come to more deeply "know" them without acting out our own issues. However, *we* also benefit: we become more insightful, more resilient and more fully committed individuals and professionals.

Attending to the dovetailing of the personal and the professional brings us to new levels of compassion and awareness—of our patients *and* of ourselves.

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