The concepts of transference and countertransference in medical settings: a modern understanding

Luis Armando Centeno-Gándara[1]

[1]Hospital Universitario Dr Jose Eleuterio Gonzalez

February 9, 2020

Abstract

Transference and countertransference phenomena are present in every physician–patient interaction. The aim of this text is to present the concepts of transference and countertransference found in daily non-psychiatric clinical practice and some possible interventions addressing these phenomena that could improve the clinician´s work with his or her patients. To render understandable the concepts of transference and countertransference, first the basic psychological concepts from which they emerge will be presented. Modern medicine has been losing its humane aspects and the quality of the physician-patient relationship. Recognition of the phenomena of transference and countertransference could be used to face this dehumanization crisis.

KEYWORDS

Countertransference, Health Facility Environment, Physician-Patient Relations, Transference

1 | INTRODUCTION

The objective of this text is to present, for all health professionals who work in medical settings, the phenomena and concepts of transference and countertransference found in daily non-psychiatric clinical practice. It is also aimed at presenting some possible interventions addressing these psychodynamic phenomena that could facilitate the work of clinicians with their patients. With these objectives in mind, the phenomena and basic psychological concepts—whether psychodynamic or not—from which the concepts of transference and countertransference emerge will be presented first. For each concept presented, the definition and nature of the phenomenon, an example with non-psychiatric patients—all examples are hypothetical and not from real situations—and a possible intervention to manage this phenomena in cases where they complicate working with the patient, will be expressed. The phenomena are not discrete and tend to overlap, therefore, the reader should feel comfortable when discovering that the definitions are not mutually exclusive. Also, it is difficult to express definitions by genus and difference that are not very narrow or too broad,[1] thus, it is better to consider all definitions as an approximation to the real phenomenon that they attempt to define, and not to consider that the real phenomenon is what is defined.

To conclude this introduction, the author invites the reader interested in reviewing the history and empirical evidence on the existence of these phenomena to review Luborsky and Barret,[2]Yakeley,[3] and Ulberg and Dahl.[4]

2 | COGNITION, AFFECTIVITY AND BEHAVIOR

These phenomena are not classically psychodynamic but psychological in general, but they will help understand the psychodynamic phenomena proper. Therefore, they are presented first.

All psychological phenomena can be classified into two categories: mental and behavioral phenomena. Mental phenomena are subjective, they can only be known by those who experience them because they are confined

into the psych of each individual and are not found in the observable physical world. Behavioral phenomena can be recognized by another individual in addition to the person who carries them out because they are expressed in the observable physical world.[5] The thought "I'm reading this article" is a mental phenomenon, since only the individual who thinks it can know it exists. The act of moving the arms to turn the page in a book is a behavioral phenomenon because the person who turns the page as well as any other person who observes this with attention knows that this behavior, the movement of the arms, exists in the physical world. Also, mental phenomena can be classified into two subcategories, cognitive phenomena and phenomena related to affectivity. In this text, behavioral phenomena will not be subclassified, although they could be.

The term cognition can be defined as the group of mental phenomena that correspond to thought and perception[6]: "I'm hungry" is a thought, seeing a red colored glass in front of us is a perception.

It is not possible to define the term affectivity in a sufficiently exact manner. However, I will try to define it, for the purpose of this text, as the mental phenomenon that accompanies every human experience and defines it as agreeable or disagreeable.[5,7] Love, hate, and anxiety, for example, are affective phenomena.

Behavior is every body movement.[5] Walking, a frown, and speaking are all behaviors. Behavior, in contrast with cognition and affectivity, is an objective phenomenon.

3 | THE UNCONSCIOUS

It is impossible to exactly define the term consciousness.[7] The best way to define it that I have found, for the purpose of this presentation, is that it is every mental content that is within the subjective experience of a person at any given moment. By deduction, the unconscious is every mental content that is not found within the subjective experience of an individual at a given moment. For example, answer the following question: how old am I? now, the reader has a number in his mind, this mental content, which corresponds to the number of years lived, is now conscious but it was unconscious until a few seconds ago. Of course, there are unconscious mental contents that are easily brought to consciousness— called preconscious— such as our age, but there are other mental contents that are extremely difficult to bring to the conscious mind— called unconscious proper— such as the reasons why we love as we love or why we relate to others as we do.[8] To exemplify this, ask the passionate reader why he or she is frequently involved in an unsatisfactory—or satisfactory, for those who are fortunate—love relationship, and the answer would be, in contrast with our age, much more confusing. All cognitive, affective, and behavioral phenomena can be both conscious and unconscious.

4 | MOTIVATION

Motivation is the psychological energy —physics defines energy as the ability to generate work,[9] in other words, the ability to generate movement—that causes an individual to present a behavior—remember that behavior, as has been presented, is every movement with a specific goal.[10,11] Motivations can be conscious and unconscious.

In general, from a psychodynamic point of view, there are four types of motivations: the search for pleasure through perception —libido—, aggressive impulses, the desire to attach to others, and narcissistic needs— namely, the desire to reach the maximum attainable development of an individual.[10] Each one of these motivations, of course, has their corresponding counterparts. In medical practice, these motivations can be easily detected: for example, the diabetic patient who does not take his drugs could be behaving motivated by a self-aggressive impulse, the somatizing patient who repeatedly goes to the emergency room to receive medical attention even though the doctors have tell him continuously that he has no physical disease could be behaving motivated by an impulse of dependence, etc.

The concept of motivation is relevant because it implies intentionality, namely, it implies that all mental phenomena are directed to an object that is not the mental phenomenon in itself[5]—in the interpersonal context, this object is individuals—, a property of the mind that is basic to explain the concepts that follow.

5 | SELF AND OBJECT REPRESENTATIONS

A representation is a cognitive phenomenon, a mental symbol that represents an object from the physical world.[10,12]Imagine a pencil in your mind: give it a length, color, and texture, this is a representation. Mental phenomena that correspond to self and object representations are of particular psychodynamic relevance. These representations can be conscious or unconscious.

A self representation is a mental representation that contains the positive and negative mental and body characteristics of the individual —virtues and defects, strengths and weaknesses, etc.—: our physical appearance; our needs and desires; our cognitive, affective, behavioral, and interpersonal traits —a trait is the relatively stable tendency over time that a person has to present certain psychological characteristics—[13]; and our ideal self —that which we want to become— and moral beliefs.[14] In order to consider healthy the representation that a person has of him or herself, positive characteristics must predominate over negative ones — colloquially to have good self-esteem—, both positive and negative characteristics must be as congruent with reality as possible —for example, I could have the firm belief that one day I will become president of Mexico and this clearly will not happen— and finally, the self representation must be relatively stable over time, so that if the characteristics assigned to it change, they should not do so suddenly but over the years. The self representations that an individual activates can be inferred through behavior or through the patient´s verbal communication. For example, imagine that you have just diagnosed one of your patients with breast cancer, and that when she answers to the question, what do you think and feel when receiving the diagnosis, she says: "I´m very afraid doctor. I never thought I could be in a situation like this, but there is nothing I can do, I have to face this disease and overcome it, I will do everything I can and I will not be defeated." Based on this response, it can be inferred that the self representation activated in the patient is that of a person surprised by the bad news, but brave and with a desire to fight against the disease, and not, in contrast, the self representation of someone who is defeated and hopeless.

An object representation corresponds to the mental phenomenon that represents an individual who is in the physical world, it is equivalent to the previously described self representation, but that assigns characteristics to a person who is not the subject whose mind contains this representation. Let us return to the previous case of the patient recently diagnosed with breast cancer and let us imagine that she now answer the question regarding what she thinks of the doctor who gave her the diagnosis: "I think that you´re just doing your job, doctor, and I thank you for informing me with the tactful way you did". Again, we can infer that the object representation that the patient activates in this situation is that of a person, the doctor, who is responsible, kind, and empathetic.

These concepts are basic for the introduction of the next psychodynamic phenomenon: internalized object relations.

6 | INTERNALIZED OBJECT RELATIONS

An internalized object relation is an affective-cognitive phenomenon that corresponds to a mental representation of an interpersonal relationship that is stored as a memory —the interpersonal relationship is in the physical world, the internalized object relation is in the mental world—. Internalized object relations are composed of a self representation interacting with an object representation and the affect associated with this kind of interaction[15]; internalized object relations are mainly unconscious. Internalized object relations are established during early development of individuals when we interact with our primary caregivers. Each one of the specific internalized object relations that have been stored in memory is called an object relation dyad.[16] A person contains a limited number of stored dyads and based on these dyads builds the knowledge of him or herself, of others, and later, of the world around him or her —remember that at the beginning of life, the world of the newborn includes only him or herself and his or her primary caregiver, as time goes by and hatching occurs, his or her world expands to include other things, such as secondary caregivers and inanimate objects.[17] Thus, a person´s knowledge of the physical world, not matter how elaborate, also has its origin within an interpersonal scenario.

At all times, a person has a specific activated object relation dyad to relate with others or the world that surrounds them, even at this moment, for example, the reader has one active: Is it that of the demanding

reader —self representation— who is frustrated —affect—by the poor expressive quality of the author —object representation—, or is it that of the avid reader, satisfied with the text, who considers the author conspicuous?

This phenomenon will be essential for understanding transference and countertransference.

7 | TRANSFERENCE

Transference is the set of cognitions —thoughts and perceptions— and affects that the patient experiences about the practitioner.[18] The nature of the transference is determined by the token of activated object relation dyad in the patient's mind that represents the interpersonal relationship formed with the health care provider.[16] Every transference can be classified, based on the affect that it includes, in positive or negative.[19] Positive transferences include affects such as love, fondness, respect, gratitude, etc. Negative transferences include affects such as anger, hatred, distrust, disdain, contempt, envy, etc. Imagine a patient who has activated a dyad that contains a self representation of a sick person, who needs to be taken care of, in interaction with an object representation, the practitioner, who tries his or her best to heal him or her and therefore has a feeling of appreciation and gratitude; this is a classic example of a positive transference activated by a patient in interaction with their clinician. Now imagine a patient who activated a dyad that includes a self representation of an ill person that requires help, but in relation to a representation of the physician as cold and without interest in helping him or her, therefore, the affect it contains is frustration and anger; this would be an example of a very prevalent negative transference in everyday medical practice.

To diagnose the activated dyad in the transference, namely, self and object representation and the associated affect, it is necessary for the physician to pay attention to three sources of information: the patient´s verbal communication, non-verbal communication and the countertransference of the practitioner. Verbal communication includes the information that the patient transmits through speech; nonverbal communication includes the nature of speech —tone, intensity, speed and fluctuations in these parameters— and body language —facial expression, body posture and directed and non-goal-directed behavior—; and countertransference includes the affect that the clinician experiences when interacting with the patient.[16,20]

Each one of you must find the most effective personal way to diagnose an activated dyad using the aforementioned three sources of information. However, a simple and pragmatic method consists of diagnosing the patient's affect through nonverbal communication: Does the patient's facial expression correspond to what would be socially interpreted as an expression of positive or negative affects? is he or she laughing or frowning? is he or she very expressive or dour? what is the patient's posture? is he or she straight and firmly seated against the back of the chair or sprawled in his seat? does he or she play with their fingers showing anxiety or do they lie quietly on an object or a patient´s body part?, etc. Once the activated affect has been diagnosed, the diagnosis of self and object representations involved must be made; these representations can be inferred from the patient´s verbal communication, either directly, when the patient speaks about him or herself or about the health care provider with which he or she interacts, or indirectly when the patient does not talk about him or herself or the health care provider but of material that is not directly related to the physician-patient interaction.[21] In the section "Self and object representations", examples of the inference of self and object representations through direct verbal communication have been presented. To exemplify the diagnosis of an activated dyad in the transference when the patient uses "indirect" verbal communication, imagine a patient in follow-up for systemic arterial hypertension who presents in the clinic with high blood pressure, the practitioner asks routinely if he or she has taken their medication correctly, and the patient, rushing to answer, says yes, however, the clinician notices tension and discomfort in the patient´s voice and facial expression —use of nonverbal communication— and decides to point it out: "I noticed you felt uncomfortable when I asked if you had taken your medication, could it be that you have forgotten it sometimes and you are embarrassed to tell me?" so the patient answers yes —we have the affect: shame—, the physician then explores the motivation for not taking the medication and the patient answers: "this new drug that you prescribed was very expensive and I couldn´t afford it. I´m sorry, doctor " —indirect verbal communication—, from this comment it can be inferred that the activated self representation corresponds to the misbehaved patient associated with a negative affect, that is, shame, coupled with an object repre-

sentation that corresponds to the critical clinician —and perhaps inconsiderate for prescribing expensive drugs.

In general, positive transferences strengthen the therapeutic alliance and do not require any intervention.[22] In case of finding a negative transference in one of our patients, the practitioner should express in words the active transference to obtain confirmation from the patient that precisely, this hypothesis of the physician regarding the transference, corresponds to the patient's experience. Once the transference hypothesis has been confirmed by the patient, the health care provider could request subjective and objective proofs, in favor and against, that the patient has to support the veracity of his or her transference. With the information obtained through these interventions, the practitioner can now reduce the intensity of the negative transference by declaring the reality of the physician-patient interaction, the way the clinician experienced this interaction with the patient and recognize his or her potential contribution to the biased perception of the patient. Finally, in the event that the health care provider is aware that this transference has been activated in previous interactions with other physicians and that it has hindered the patient's treatment, the physician can point out this similarity with the objective that, in future occasions, the intensity of the same negative transference will be smaller.[23] Let us continue with the example of the hypertense patient mentioned before; the practitioner, after having diagnosed the activated dyad in the transference, verbally expresses it to the patient to obtain confirmation: "I get the impression that at this moment you feel as if you have misbehaved and you're embarrassed by this, and as if I were being harsh or critical of you for not taking your medication, is that so?", the patient answers affirmatively and then the health care provider asks for evidence for or against this perception, resulting in the patient being unable to provide any, finally, the clinician reduces the intensity of the negative transference by stating: "I understand that sometimes it is difficult for patients to properly take their medications. Don´t worry. We will try to think of a solution to make it easier for you to comply with the treatment, although it is true that I did not think about your being able to pay for this new medicine ", ending here the intervention to reduce the intensity of the negative transference.

8 | COUNTERTRANSFERENCE

Countertransference is the set of cognitions, affects, and behaviors that the physician experiences towards the patient.[24]Countertransference is a useful tool to infer the subjective experience of the patient and its recognition by the health care provider helps to better understand the affects and the self and object representations of the patient[25] and it decreases the risk of the practitioner deviating from the professional framework due to the strong countertransference reactions that some of the patients can induce. The nature of the countertransference is determined, mainly, and as long as the clinician's emotional state is stable and not very intense,[26] by the token of the activated object relation dyad in the patient's mind[23]; however, in some occasions, particularly when the clinician's affective state is intense, it can be determined by the activation of an object dyad of the physician's mind; namely, the origin of countertransference is primarily the patient, but, sometimes, it can originate in the health care provider.[19] The process through which countertransference originates is unconscious.

Every countertransference can be classified as concordant or complementary. When a concordant countertransference is experienced, the practitioner identifies with the self representation that the patient has activated, therefore, the clinician takes the patient's perspective, empathizes cognitively and affectively with the patient — he or she would think, for example: "If I were in the patient's situation, I would probably believe, feel, and act in a similar way" and his or her affects would become similar in quality to those of the patient, therefore, if the patient experiences sadness, the physician could also feel it.[27,28] When a complementary countertransference is experienced, the health care provider identifies with the object representation that the patient has activated, therefore, the practitioner's cognition, affects and behaviors would be similar to those that the patient perceives and expects from the clinician.[26] In addition, in the same way that transference is classified, it is useful to classify countertransference based on the affect it includes in positive and negative countertransference. Intense positive and negative countertransferences imply a risk that the physician will reassure inappropriately —such as affirming a patient that there is no problem because they have not taken their medication, when there actually is— or attack the patient, respectively.[27] In medical

settings, negative countertransferences can be particularly problematic and possibly carry a greater risk of legal problems.

To diagnose the qualities and the kind of countertransference that the health care provider experiences, he must take a pause and reflect: what do I think of this patient? what does this patient make me feel? and how am I behaving with this patient? Let us return to the example of the hypertense patient with poor adherence to drug treatment and suppose that during the interaction with the patient, and prior to the intervention of reduction of negative transference, the practitioner asks him or herself the previous questions and realizes that he thinks that the patient is irresponsible for not taking his medications, feels annoyed and critical of him or her, and raises a bit his voice in disgust —this last manifestation corresponds to behavior— therefore, the clinician concludes that his countertransference is complementary and that he or she is acting precisely the representation of the critical, and perhaps inconsiderate physician, that the patient has perceived —and probably unconsciously induced— in him or her.

Proper management of countertransference in medical settings, such that health care providers do not run the risk of acting in response to it, includes self-insight, anxiety management, empathy, and conceptualizing ability. Self-insight is the ability to know at any given moment what we feel, think, and how we behave; anxiety management is the ability to control anxiety associated with the countertransference so that it does not affects the practitioner's behavior; empathy is the ability to take the patient's perspective of a given situation; and conceptualizing ability is the ability to make use of the theory —for example, the theory presented herein— to understand the role of the patient in the physician-patient interaction.[29] As the reader will see, these three techniques overlap and interact with each other.

Self-insight should be used whenever the clinician detects that his or her mood is more intense than what is normal for him or her. When this happens, the physician should take a pause and ask him or herself: what do I think of this patient? what does this patient make me feel? and how am I behaving with this patient? This is the most essential factor in managing countertransference.

The management of anxiety associated with countertransference includes the normalization of thoughts and feelings that the health care provider experiences towards the patient and to control breathing. To normalize the countertransference experience, it is useful to remember that it is normal, expected, and healthy to have feelings and thoughts directed at patients as people with their own personalities,[26] not only as people with diseases, regardless of whether these feelings and thoughts are pleasant or unpleasant; in addition, the practitioner should not take the patient's behavior as something against him or her as a person, but as behavior that is secondary to the functioning of the patient's mind and to his or her way of relating to others. Finally, the author has found useful in daily practice, especially in intense countertransference situations, to focus on controlling breathing to decrease its frequency. Adhering to these two techniques, the intensity of anxiety associated with countertransference should decrease considerably.

In the event that the clinician presents a complementary countertransference, that is, when he or she identifies with the object representation included in the dyad activated in the patient's mind, the physician must make a cognitive effort to develop empathy, to acquire their perspective. For this, it is useful to remember that the patient is also a human being with all the virtues and defects that the health care provider can have[30] and should ask him or herself: If I were in the patient's situation, how would I feel? what would I think? how would I behave? and how would I like to be treated by my doctor? When the practitioner presents a concordant countertransference, empathy will be implicit, and it will not be necessary to develop it; what he or she should be wary of is over-identification with the patient's self representation, since this may cause the clinician to give the patient just what he or she wants, not what he or she needs. To avoid this, the physician must make an effort to think that in the physician-patient relationship there must be a certain healthy emotional distance between the health care provider and the patient and that every patient precisely looks for that in a practitioner, a professional who will guide them to solve their health problems.

Conceptualizing ability corresponds to the use of psychodynamic theory to understand the countertransference reactions of clinicians towards their patients.[30] After transference and countertransference have been

diagnosed, the physician must ask him or herself: how does my countertransference relate to the activated object relation in the patient's mind that dominates the interaction between my patient and me? is it a complementary or concordant countertransference? Doing so will reduce the anxiety and confusion of the physician-patient interaction[31] and will allow the physician to carry out the appropriate technique for transference management.

At last, there will be occasions when the countertransference is so intense that it could not be handled properly, being a high risk that the health care provider will deviate from the professional framework. Because a good physician-patient relationship is necessary for any successful treatment and the risk of iatrogenesis due to deviation from the professional framework is high, an uncontrollable countertransference is a rational reason to refer a patient with a colleague. However, before doing this, the practitioner should try to repair the relationship, if this countertransference has its origin in objective characteristics of the patient, the clinician should discuss this with him and give him the opportunity to change. If this last intervention is not effective or if the cause of the countertransference is personal characteristics of the physician, the health care provider must apologize for his or her professional limitations, express that the patient deserves to receive better care than he or she could receive with him or her and, finally, offer a referral to another practitioner.[32]

9 | CONCLUSIONS

It has been stated that Medicine has been losing, gradually and due to multiple reasons, its human aspects and the quality of the physician-patient relationship. Unfortunately, the illness seems to be generalized.[33-35] However, recognition of transference and countertransference phenomena in medical practice and the implementation of the techniques described herein could, through their positive effect on the physician-patient relationship, improve the medical and psychological outcomes of patients with physical diseases[36] and, which is more, face the enormous crisis of dehumanization of modern medicine.[37]

REFERENCES

1. Copi IM, Cohen C. Definición. In: Copi IM, Cohen C.*Introducción a la Lógica [Introduction to Logic]* . González-Ruíz EA, trans-ed. México, DF: Limusa; 2010: 169-206.

2. Luborsky L, Barret MS. The history and empirical status of key psychoanalytic concepts. *Annu Rev Clin Psychol* . 2006; 2(1): 1-19. https://doi.org/10.1146/annurev.clinpsy.2.022305.095328

3. Yakeley J. Psychoanalysis in modern mental health practice.*Lancet Psychiatry* . 2018; 5(5): 443-450. https://doi.org/10.1016/S2215-0366(18)30052-X.

4. Ulberg R, Dahl HJ. Empirical support for the psychoanalytic concepts. Lancet Psychiatry. 2018; 5(7): 543-544. https://doi.org/10.1016/S2215-0366(18)30208-6.

5. Russell B. *Fundamentos de Filosofía [An Outline of Philosophy]* . Crespo y Crespo R, trans-ed. México, D. F.: Debolsillo; 2016.

6. Carter M, Shieh J. Glossary. In: Carter M, Shieh J. *Guide to Research Techniques in Neuroscience* . 2nd ed. San Diego, CA: Academic Press; 2015: 345-376.

7. Eguíluz I, Segarra R, eds. *Introducción a la Psicopatología: Una Visión Actualizada [Introduction to Psychopathology: An Updated Overview]* . 3th ed. Madrid: Editorial Médica Panamericana; 2013.

8. Gabbard GO. Basic principles of dynamic psychiatry. In: Gabbard GO.*Psychodynamic Psychiatry in Clinical Practice* . 5th ed. Arlington, VA: American Psychiatric Publishing; 2014: 3-32.

9. Silverthorn DE. Energía y metabolismo celular [Energy and cellular metabolism]. In: Silverthorn DE. *Fisiología Humana Un Enfoque Integrado [Human Physiology An Integrated Approach]* . 4th ed. Fernández-Castelo S, Gismondi MI, Klajn D, et al, trans-eds. Buenos Aires: Médica Panamericana; 2009: 89-127.

10. Auchincloss EL. *The Psychoanalytic Model of the Mind* . Arlington, VA: American Psychiatric Association Publishing; 2015.

11. Eagle MN. Theories of motivation. In: Gabbard GO, Litowitz BE, Williams P, eds. *Textbook of Psychoanalysis* . 2nd ed. Arlington, VA: American Psychiatric Publishing; 2012: 39-52.

12. Pitt D. Mental Representation. In: Zalta EN, ed. The Stanford Encyclopedia of Philosophy [database online]. Stanford, CA: Metaphysics Research Lab, Stanford University; 2018. https://plato.stanford.edu/archives/win2018/entries representation/. Updated December 11, 2012. Accessed March 17, 2019.

13. American Psychiatric Association. Alternative DSM-5 model for personality disorders. In: American Psychiatric Association.*Diagnostic and Statistical Manual of Mental Disorders* . 5th ed. Arlington, VA: American Psychiatric Association Publishing; 2013: 761-782.

14. Jacobson E. Narcissism, masochism, and the concepts of self and self representations. In: Jacobson E. *The Self and the Object World* . New York, NY: International Universities Press; 1964: 3-23.

15. Caligor E, Kernberg OF, Clarkin JF, Yeomans FE. Introduction: a model of treatment targeting self and interpersonal functioning. In: Caligor E, Kernberg OF, Clarkin JF, Yeomans FE. *Psychodynamic Therapy for Personality Pathology Treating Self and Interpersonal Functioning* . Washington, DC: American Psychiatric Association Publishing; 2018: 1-20.

16. Yeomans FR, Clarkin JF, Kernberg OF. *Transference-Focused Psychotherapy for Borderline Personality Disorder: A Clinical Guide* . Arlington, VA: American Psychiatric Publishing; 2015.

17. Gilmore KJ, Meersand P. Infancy: parenthood, the mother-infant relationship, and the mind of the infant. In: Gilmore KJ, Meersand P.*Normal Child and Adolescent Development: A Psychodynamic Primer* . Arlington, VA: American Psychiatric Publishing; 2014: 21-44.

18. Hersh RG, Caligor E, Yeomans FE. Transference-focused psychotherapy (tfp) and its applications: introduction to tfp and the roles of structural interview, goal setting, and contracting. In: Hersh RG, Caligor E, Yeomans FE. *Fundamentals of Transference-Focused Psychotherapy Applications in Psychiatric and Medical Settings* . Switzerland: Springer; 2016: 1-32. https://doi.org/10.1007/978-3-319-44091-0_1.

19. Cabaniss DL, Cherry S, Douglas CJ, Schwartz A. *Psychodynamic Psychotherapy: A Clinical Manual* . 2nd ed. Chichester, West Sussex: John Wiley & Sons; 2017.

20. Hall AJ, Horgan TG, Murphy NA. Nonverbal communication. *Annu Rev Psychol* . 2019; 70: 24.1-24.24. https://doi.org/10.1146/annurev-psych-010418-103145.

21. Joseph B. Transference: the total situation. *Int J Psychoanal* . 1985; 66(4): 447-454.

22. Caligor E, Kernberg OF, Clarkin JF. The Phases of Treament. In: Caligor E, Kernberg OF, Clarkin JF. *Handbook of Dynamic Psychotherapy for Higher Level Personality Pathology* . Arlington, VA: American Psychiatric Publishing; 2007: 203-230.

23. Kernberg OF. *Treatment of Severe Personality Disorders: Resolution of Aggression and Recovery of Eroticism* . Washington, DC: American Psychiatric Association Publishing; 2018.

24. Hofsess CD, Tracey JG. Countertransference a prototype: the development of a measure. *J Couns Psychol.* 2010; 57: 52-67. https://doi.org/10.1037/a0018111.

25. Clarkin JF, Yeomans F. Managing negative reactions to clients with borderline personality disorder in transference-focused psychotherapy. In: Wolf AW, Goldfried MR, Muran JC, eds. *Transforming Negative Reactions to Clients: From Frustration to Compassion* . Washington, DC: American Psychological Association; 2013: 175-188.

26. Bateman A, Brown D, Pedder J. Therapeutic relationships. In: Bateman A, Brown D, Pedder J. Introduction to Psychotherapy An Outline of Psychodynamic Principles and Practice. 3rd ed. London: Routledge; 2000: 51-61.

27. Bateman A, Holmes J. Transference and countertransference. In: Bateman A, Holmes J. *Introduction to Psychoanalysis Contemporary Theory and Practice* . London: Routledge; 1995: 95-117.

28. Mills J. Countertransference revisited. *Psychoanal Rev* . 2004; 91(4): 467-515. https://doi.org/10.1521/prev.91.4.467.48751.

29. Hayes JA, Gelso CJ, Hummel AM. Managing countertransference.*Psychotherapy* . 2011; 48(1): 88-97. https://doi.org/10.1037/a0022182.

30. Gelso CJ, Hayes JA. The management of countertransference. In: Gelso CJ, Hayes JA. *Countertransference and the Therapist's Inner Experience: Perils and Possibilities* . Mahwah, NJ: Lawrence Erlbaum Associates; 2007: 93-111.

31. Zerbo E, Cohen S, Bielska W, Caligor E. Transference-focused psychotherapy in the general psychiatry residency: a useful and applicable model for residents in acute clinical settings.*Psychodyn Psychiatry* . 2013; 41(1): 163-181. https://doi.org/10.1521/pdps.2013.41.1.163.

32. Gunderson JG, Links P. (2014). Getting started. In: Gunderson JG, Links P. *Handbook of Good Psychiatric Management for Borderline Personality Disorder* . Washington, DC: American Psychiatric Publishing; 2014: 27-36.

33. Hrh. (2012). Integrated health and post modern medicine. *J R Soc Med* . 2012; 105(12): 496-498. https://doi.org/10.1258/jrsm.2012.12k095.

34. Johna S, Rahman S. Humanity before science: narrative medicine, clinical practice, and medical education. *Perm J* . 2011; 15(4): 92-94. https://doi.org/10.7812/TPP/11-111.

35. Tucker JD, Nie J, Cheng Y, Zhu W, Kleinman A. Reviving medicine as the art of humanity in china. *Lancet* . 2014; 383: 1462-1463. https://doi.org/10.1016/S0140-6736(14)60715-7.

36. Kelley JM, Kraft-Todd G, Schapira L, Kossowsky J, Riess H. The influence of the patient-clinician relationship on healthcare outcomes: a systematic review and meta-analysis of randomized controlled trials. PLoS One. 2014; 9(4): e94207. https://doi.org/10.1371/journal.pone.0094207.

37. O'Reilly-Landry M. The drive to relate: how modern psychoanalysis can join with modern medicine to improve the doctor-patient relationship. *J Psychol Psychother* . 2013; 3(4). https://doi.org/10.4172/2161-0487.1000126.

ACKNOWLEDGMENT

I am in debt with Dr. Juan Pablo Garza-Varela and Dr. Adriana Morales-Martínez for their comments regarding parts of this manuscript.

CONFLICT OF INTEREST

The author declare that he has no conflict of interest.

ORCID

Luis Armando Centeno-Gándara

https://orcid.org/0000-0002-9105-077X