Cases that crash
Disclosures: Philip R. Muskin, MD

No relevant disclosures to this presentation with the exception of:
Faculty: Columbia University
Psychoanalytic Center
Countertransference is the emotional reaction of the therapist to the patient. There are generally two types of countertransference reactions: concordant and complementary.

In **concordant** countertransference, the therapist experiences and empathizes with the patient’s emotional position (e.g., therapist thinks: “Boy, my patient is right! His boss sounds like a terrible person!”).

In **complementary** countertransference, the therapist experiences and empathizes with the feelings of an important person from the patient’s life (e.g., therapist thinks: “My patient is infuriating—I certainly see why his boss gets so angry at him!”).
Patient factors

- Patient is in the field or the relative of a colleague
- Diagnosis is unclear
- Prognosis is unclear
- Patient has “special” status – celebrity, VIP, given an unusual time for sessions
- Patient or family has unique statues – fame, wealth, influence
- Patient is referred from a valued referral source (mentor, “important” colleague)
- Goals of treatment are not clear
- Patient is doing poorly
- Therapist for the case has changed frequently (and/or psychopharmacologist has changed frequently)
- Conflict within the family regarding the care
- Pathological family dynamics
- Untruths
Therapist factors

- Identification with the patient
- Similarities to significant others (alive or not)
- Neutralizing the patient’s “patientness”
  - Viewing the problems as minor
- Relationship to patient or family outside of the professional relationship
- Seeing oneself as a hero, rescuer, or “last hope” for the patient
- Seeing oneself as forced to treat the patient or as a victim
- Disagreements with patient and/or family regarding case management
- Disagreements with other therapists/physicians involved the the case regarding management
- Promises (real or fantasized) about benefits to the therapist of treating this case
- Elements in the physician’s life
  - recent or unresolved grief, feelings of inadequacy, experience of conflict regarding professional obligations
- Untruths
From an attachment perspective, the therapeutic relationship can be seen as the resultant of two opposing sets of forces.

The therapist attempts (within the limited framework of therapy) to provide a secure attachment experience:

- to identify and assuage attachment needs and to facilitate exploration

The patient approaches the relationship with prior expectations of sub-optimal care-giving, and, unconsciously assuming an unloving and/or untrustworthy care-giver, aims mainly for a measure of security.

The attachment viewpoint suggests that the therapeutic relationship is shaped both by the dynamic of its actuality and the distorting effects of transference.
- Care-seeker–care-giver emotional connectedness is the key feature of secure base.
- The restriction, exaggeration, or uncoupling of such connectedness is what leads to the three varieties of insecure attachment.
- In insecure attachments the attachment figure is present in the mind of the care-seeker as a sought target for attachment behaviors, but there is a discrepancy between what is desired and what is available.
Who is the patient? Who are you?

• Secure attachment and adaptive functioning are promoted by a caregiver who is emotionally available and appropriately responsive to the child’s attachment behavior, as well as capable of regulating both his or her positive and negative emotions.

• Securely attached people tend to agree with the following statements: "It is relatively easy for me to become emotionally close to others. I am comfortable depending on others and having others depend on me. I don't worry about being alone or having others not accept me."

• Secure attachment usually results from a history of warm and responsive interactions with relationship partners. Securely attached people tend to have positive views of themselves and their partners. They also tend to have positive views of their relationships. Securely attached people feel comfortable both with intimacy and with independence.
Insecure attachments
Preoccupied

- People who are anxious or preoccupied with attachment tend to agree with the following statements: "I want to be completely emotionally intimate with others, but I often find that others are reluctant to get as close as I would like. I am uncomfortable being without close relationships, but I sometimes worry that others don't value me as much as I value them."

- Seek high levels of intimacy, approval, and responsiveness from their partners. They sometimes value intimacy to such an extent that they become overly dependent on their partners—a condition colloquially termed clinginess.

- They often doubt their worth as a partner and blame themselves for their partners' lack of responsiveness.

- People who are anxious or preoccupied with attachment may exhibit high levels of emotional expressiveness, worry, and impulsiveness in their relationships.
People with a dismissive style of avoidant attachment tend to agree with these statements: "I am comfortable without close emotional relationships." "It is very important to me to feel independent and self-sufficient", and "I prefer not to depend on others or have others depend on me."

They desire a high level of independence. The desire for independence often appears as an attempt to avoid attachment altogether.

They view themselves as self-sufficient and invulnerable to feelings associated with being closely attached to others. They often deny needing close relationships. Some may even view close relationships as relatively unimportant.

They are defensive.

People with a dismissive–avoidant attachment style tend to suppress and hide their feelings, and they tend to deal with rejection by distancing themselves from the sources of rejection (i.e., their relationship partners).
Fearful-avoidant attachment

• People with losses or sexual abuse in childhood and adolescence often develop this type of attachment.
• They tend to agree with the following statements: "I am somewhat uncomfortable getting close to others. I want emotionally close relationships, but I find it difficult to trust others completely, or to depend on them. I sometimes worry that I will be hurt if I allow myself to become too close to others."
• They have mixed feelings about close relationships.
  – Desire emotionally close relationships
  – Feel uncomfortable with emotional closeness.
• These mixed feelings are combined with, sometimes unconscious, negative views about themselves and their partners. They commonly view themselves as unworthy of responsiveness from their partners, and they don't trust the intentions of their partners. Instead, they are much less comfortable initially expressing affection.
The core of all therapy is truth
If a patient is not truthful the case will **crash**

There are different types of truthfulness
Patients can “lie” to themselves
   Damaging to the treatment but not fatal
Patients can “lie” to the therapist
   **Fatal** to the treatment

Therapists can “lie” to themselves
Lying to a supervisor is **fatal** to the treatment