Teaching Interviewing Skills to Medical Students: The Issue of 'Countertransference'

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Abstract—The study reported here revealed a very high incidence of unrecognized feelings toward the patient ("countertransference") and potentially harmful associated behaviors in a group of medical students at the midpoint of their training. Fifteen students were studied individually by the author during a clinical interview each student conducted with a patient. Typically, unrecognized feelings were fear of harming the patient, fear of loss of control, performance anxiety, and fears unique to the individual student (such as fear of cancer in self). One or more of these feelings were present in 14 of the students. Interview behaviors that were potentially deleterious were present in 13 students; avoidance and/or overcontrol of the psychosocial aspects of the interview accounted for 11 of these instances, while two students exhibited behaviors unique to the student. Although these students all had demonstrated adequate interviewing skills previously, the unrecognized feelings were, in each of the 13 instances, related to impaired interview performance. These data suggest the need for interviewing instructors to teach medical students about the concept of countertransference in addition to interviewing techniques.

Many educators lament the nonhumanistic quality of modern medicine and advocate that physicians and educators redirect their attention to the doctor-patient relationship (1). Further, a systems-based approach to clinical medicine emphasizes that the doctor-patient relationship is a central feature in the science of clinical medicine (2). Nevertheless, while this relationship of the physician and his patient is frequently discussed, only a few teaching programs explicitly teach about it (3–5), especially the role the doctor plays in determining it (6). Yet, if this relationship is ever to be affected or changed, the doctor's role will have to be addressed specifically. It seems unlikely that it will be possible to produce much change in the patients since they are usually in distress and have relatively infrequent contact with medicine. To improve the doctor-patient relationship will probably require changing the doctor.

Why should the doctor's role be a concern for educators? First, some educators are interested in developing and enhancing the positive healing effect of the physician (7). Secondly, others are interested in reducing harmful effects of the physi-

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cian upon the patient (2). Correction of the latter problem is also a prerequisite for achieving the first goal.

The author in the study reported here was concerned with the possible adverse effects medical students may have upon their patients, as studied during patient encounters in a training interview. Psychiatric educators have long recognized the potentially harmful effects of physicians by teaching about "countertransference" (8), defined broadly as feelings about the patient that are incompletely recognized by the student or physician (9). Kernberg emphasized that these unrecognized feelings are quite justified and natural and do not signify that something is wrong with the doctor (9). Few educators of nonpsychiatrists have followed psychiatry's lead, even though Balint (10), Engel (2), Schildkrout (3), Johnson (4), Gorlin and Zucker (6), and others have warned of the importance of unrecognized feelings and attitudes in the nonpsychiatric dimensions of medicine. Perhaps one reason for medical education's slow entry into this difficult area is uncertainty about the magnitude of the problem. Although some educators think that unrecognized feelings are common in physicians (10, 11), there is little systematically obtained data on this subject. This paper contains a description of the author's systematic and open-ended assessment of countertransference and the behaviors it prompted in 15 medical students just beginning their clinical work. The results were based on observations of a single training interview by each student and showed a very high degree of countertransference which was associated with considerable adverse potential for the patient and impaired interviewing by the student. The ramifications of this finding for medical educators responsible for the interview are emphasized.

Methods

Of 21 medical students (in two separate groups) randomly assigned to the author for training at the University of Rochester School of Medicine and Dentistry in the various dimensions of psychosocial medicine in 1983, 17 were evaluated during a training interview for evidence of countertransference and the other four were excluded because they did not participate in an interview. Some of the students were ending their second year, while others were beginning their third year. They were taking required courses that involved learning about the clinical interview. The following objectives were made explicit at the beginning of their work with the author: (*a*) integration of the biopsychosocial dimensions of illness; (*b*) integration of open- and closed-ended interviewing styles; (*c*) development of specific interpersonal skills (empathy, sensitivity, respect, support, and serving the patient as an information resource); and (*d*) understanding oneself and how one's unrecognized feelings may affect the patient. Only the latter category is discussed by the author in the remainder of this paper. All students had received extensive instruction in psychosocial medicine during their first two years in school, including at least three supervised clinical interviews each.

Each student was observed during an interview in which he was instructed to obtain the history of the present illness, in its psychosocial as well as biological dimensions, in 30 minutes. While observing this interview, the author systematically noted and recorded the presence and type of "countertransference behavior," operationally defined as any potentially harmful behavior observed during the interview (such as disrespect or avoiding certain topics), that was not due to lack

of proficiency with basic interviewing technique. A 15-to-30 minute postinterview evaluation between the author and the student interviewer, with some of the other students (who also had observed the interview) listening as a learning experience, was always begun with an inquiry from the author about the feelings experienced by the interviewer. This was designed to elicit "countertransference," which was operationally defined as the presence of any feeling, thought, or attitude in the student that was not based upon the reality of the patient situation and about which the student was not fully aware. For five to 10 minutes, the author, using an open-ended technique, explored these feelings and also facilitated the reporting of feelings in areas where he had rated the presence of countertransference behaviors. The remainder of the time was devoted to developing other course objectives.

Each student's interview was rated by the author in two specific and predefined ways*—(*a*) for countertransference behavior by designating which, if any, of the following categories applied: avoidance of certain topics (for example, death, disability, or loneliness), controlling the patient (inappropriately interrupting, changing subject, and directing interview), attempts to be pleasing (reassuring, making interview pleasant, overly social, and other unnecessary pleasing behaviors), detachment (aloof, disinterested, and avoiding relating to the patient), lack of respect and sensitivity (rude, brash, or self-serving behavior), seductiveness (only overt expressions), and miscellaneous (all other behaviors that were incongruous with the student's level of proficiency with a patient-centered approach); and (*b*) for evidence of countertransference by designating which, if any, of the following categories applied: fear of causing harm, fear of unpleasant topics, fear of loss of control, fear of affect, disdain, feeling intimidated, feeling inadequate, performance anxiety, biomedical orientation, identification with the patient, and feelings unique to the student.

* Definitions are available from the author.

Results

Of the 17 students, 11 were men and six were women. All were Caucasian, and their age range was 24 to 28 years. All had attended the University of Rochester for their entire preclinical training. Sixteen students had a science major in their premedical training, although two of these were combined with nonscience majors.

Exhibit 1 depicts all of the countertransference behaviors observed during the students' interviews with the patients and the countertransference assessments made by the author in the postinterview discussions with the students. Neither student B nor E had mastered the technique of open-ended interviewing, and, accordingly, neither countertransference designation could be satisfactorily determined. The 15 other interviewers demonstrated adequate interviewing skills in their patient interviews. However, 13 students showed some countertransference behaviors during the interview, while 14 in the postinterview discussion showed evidence of countertransference. In no instance was the student fully aware of either the behavior or the underlying feelings (countertransference), and, in most instances, they were almost completely unaware of them and surprised to learn of their presence and effect upon their behavior.

A very common pattern of countertransference behaviors was observed. Eleven students showed a behavior pattern of avoiding psychosocial issues and/

EXHIBIT 1

Summary of Countertransference Behaviors and Countertransference in 15 Third-Year Medical Students at the University of Rochester School of Medicine and Dentistry, 1983

Student	Countertransference Behavior*	Countertransference†
A	Avoidance of topic of death by changing subject in spite of frequent references to it by the patient	Afraid talk of death will harm patient and "stir him up"
B‡	Failure to perform open-ended interview and much controlling, closed-ended questioning (unable to determine whether countertransference related)	Uncertain about technique of open-ended interview (lack of adequate technique precluded an accurate designation of countertransference)
C	Excessive control of interview and occasional expression of opinions about how patient should live his life	Nervous about performing with a desire to make a good showing; feeling that he could convince patient how to mend his ways
D	Disinterest in a usually very interested student with a very superficial approach and avoidance of all affective material	Fearful of harming patient but even more fearful of incurring the ire of class for being as probing (and allegedly harmful) as he had in one postinterview discussion with another student's patient
E‡	Allowing patient to talk at will for the entire interview (unable to determine whether countertransference-related)	Student thought this was the way to do open-ended interview (lack of adequate technique precludes an accurate designation of countertransference)
F	Excessive control of interview leading to exclusion of affective material	Nervous about performing and to get into control assuaged anxiety
G	Anxious, flushed, and shifting about in chair without apparent adverse effect upon interview	Felt very nervous and had sense of confusion about what patient was saying and failure to perceive all that patient was saying
H	Excessive control of interview and avoidance of affective material	Nervous about performing and a desire to be in control; also very concerned such interviews are harmful to the patient
I	Completely avoided all closed-ended questions involving the gastrointestinal system, in a jaundiced patient of the student's same age who also had extreme weight loss and abdominal pain	Fearful the patient had cancer and didn't want to find out; also felt "panic and sadness" because of fear of cancer in self; a subsequent evaluation showed a small benign growth in the student's mouth, much to his relief
J	Changed topic abruptly from patient's concern about death to routine closed-ended questions about the social history	Patient and subject reminded the student of a relative who had died and with whom the student had been close; felt uncomfortable to even hear patient's complaints, much less death references
K	Repeatedly changed subject from patient's expressions of wish to go home	Very concerned about having a poor interview and wanted to cover everything
L	(None observed)	Nervous about performing and feeling of being out of control
M	Avoided patient's mention of death in family and feeling of desolation as well as patient's crying	Felt very "moved" with own emotions and fearful they would show; also felt embarrassment for being intrusive
N	Avoided patient's expression of depression by shifting to closed-ended questions	Fearful of allowing patient to express feelings because it could be harmful; also thought more important to "get the data" and deal with depression later
O	(None observed)	(Wished patient had been more of a challenge but no evidence of countertransference)
P	Aggressive and brash behavior with considerable impatience	Fear that patient would take control
Q	Very active avoidance of patient's frequent expressions of sadness and depression over severe loss of function	Fearful patient would be controlling; denial of affect in the patient

* Any potentially harmful behavior observed during the interview (such as disrespect or avoiding certain topics) that was not due to lack of proficiency with basic interviewing technique.

† Any feeling, thought, or attitude in the student that was not based upon the reality of the patient situation and about which the student was not fully aware.

‡ Students B and E were too deficient in interview technique to make a determination.

or excessive control of the patient (to the extent of suppressing the patient's reporting of psychosocial data); two showed no countertransference behavior (students L and O); and two showed behaviors more unique to the individual student (students G and P). More varied and multiple countertransference feelings, thoughts, and attitudes were found associated with all behaviors, although the following dominant themes were identifiable: performance anxiety, fear of harming the patient, a need to control the patient, and attitudes unique to the individual student. There was no evidence of countertransference in one student. A reductionistic attitude of sacrificing pertinent psychosocial information for biomedical data was expressed by only one student, and then it was not predominant.

Discussion

In this paper, the author presents data indicating that evidence of countertransference (incompletely recognized feelings about the patient) in a training interview is very common in medical students at the midpoint in their training. There were several common types of these naturally occurring feelings: fear of harming the patient, fear of losing personal control, and fear of a poor interview performance; in addition, there was another group of feelings characterized by natural fears of a more personal and idiosyncratic type. It also seems significant that a reductionistic attitude was encountered only once and that it was not the predominant attitude in that student. These data suggest that the students' own affective responses are more important determinants of interview performance than a supposedly ingrained biomedical bias. How did unrecognized feelings of the students affect the patients? They were associated, in most instances, with interview behaviors that avoided psychosocial data and/or exerted undue control over the patient to the extent of suppressing expression of pertinent psychosocial data. These student behaviors were not only counterproductive to the general goal of obtaining psychosocial information but also potentially dangerous to the patient. Consider, for instance, the vital information about suicidal intent that could be missed by avoiding discussion of death (students A, J, and M) and depression (students N and Q) or the effect of avoiding specific symptoms that are essential to understanding the patient (student I). More generally, the adverse effect upon the doctor-patient relationship of almost all of these behaviors is readily apparent.

This study was performed in a systematic and prospective way, rated predefined behaviors, and elicited the critical countertransference data in an open-ended fashion. Nonetheless, the possibility of the author's bias is a paramount concern. To control this in future work will require independent rating of both student-patient interactions and supervisor-student interactions, the latter for degree of open-endedness of the supervisor as well as for content. A further problem of the study is that only inferences can be made about adverse effects upon patients, since no direct assessments of the patients were made. The findings here, however, are quite consistent with others reporting the near universality of unrecognized feelings in physicians (10, 11) as well as with those of Stunkard, who found that addressing psychosocial issues frequently provoked student fears of harming the patient (12). Platt and McMath also found a strong need in students to control patients (11). Balint has also warned of the harmful effects on patients of unrecognized physician attitudes (10). From an educational standpoint, the concept that

unrecognized attitudes may interfere with learning or the use of skills has been lucidly described by Kubie (13).

The present data suggest a role for medical education. Physicians must learn about themselves and what impact they have on the patient. Underscoring this need is that not any of the students described here were significantly aware of either the unrecognized feelings or the behaviors they provoked. Specific methods for teaching about this have been described (8, 9, 14). These require experiential (10) approaches as opposed to the singular use of cognitively directed teaching (15). With experiential teaching, the student is helped by a supervisor to experience and become aware of his feelings, understand their effect upon the patient, and learn how to manage them. It was not possible with the present group of students to obtain follow-up data, but prior studies (3, 8) indicate that far more than one interaction is necessary to develop significant self-awareness. There is, however, ample evidence that it can be taught in both psychiatry (8) and primary care (3–5).

Avoidance and control behaviors were usually quite overt and appeared as insensitive overcontrol, as incongruities or unexpected shifts in the interview, and as unexpectedly poor interviews. In general, such interviews were highly suggestive of underlying countertransference. It was always essential, however, to be certain the student knew adequate interview technique. What was insufficient, upon observing a substandard interview, was to restrict supervisory attention only to the technique. Learning the techniques of interviewing is an essential beginning. Interview performance can be enhanced, however, by student understanding of heretofore unrecognized attitudes and feelings that unconsciously oppose the use of these techniques. The educator of today cannot be surprised to find that students, and practitioners as well, eschew the psychosocial aspects of the interview, not for lack of readily learned interview techniques but for lack of training in how to handle their own natural feelings.

Summary

The findings of the present study show that unrecognized feelings in students are common and readily apparent. They are important to medical education because of their potential adverseness to the patient and their interference with the learning and appropriate use of the clinical interview by the student. Teaching about countertransference poses a unique and difficult but achievable problem for educators since the feelings are usually unrecognized by students.

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