



Understanding unconscious interpersonal defensive responses in a chronic pain practice to improve interactions.

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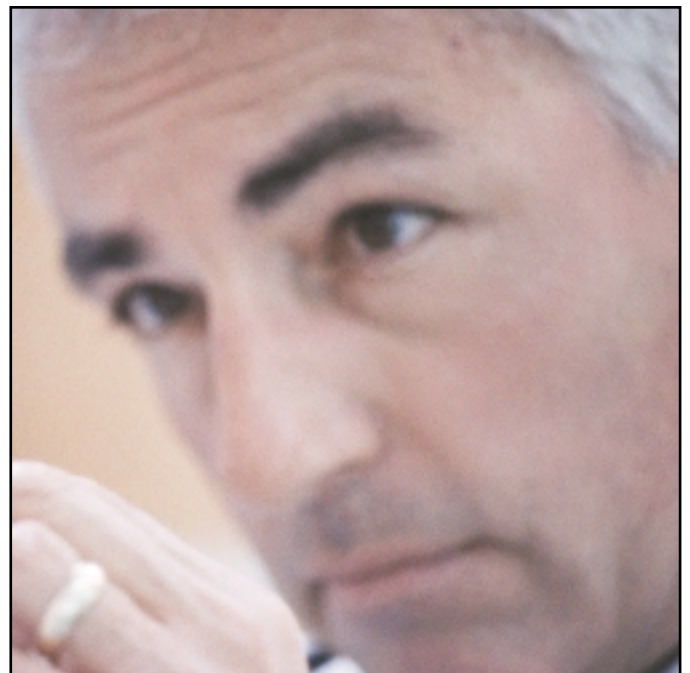
Have you ever noticed that some people bring out the worst in you? Have you ever found yourself being defensive, reactive, tense, authoritative, controlling, upset, confused, lost, or felt incompetent or vulnerable? Have you experienced blocks to effective treatment that seem to be “connected to something” but hard to figure out? Many articles have focused on patient psycho-pathology and issues while forgetting issues that the provider brings to the professional interaction. Perhaps something in the “psychological unspoken, unconscious, interaction” is blocking the provider’s ability to be himself/herself and effectively communicate/interact with patients.^{1,2}

Provider Issues

Providers, from all professions, have a basic desire to be helpful and provide assistance to others. There is a desire to provide patients with high quality care that is based on years of study in their field. There is a desire to integrate into patient care the most recent advances and new techniques. After years of study, and provider-delayed gratification required to complete professional education, there is a hope that patients will be grateful, open, accepting and unquestioning about services offered. If the provider has specialized in a specific area of chronic pain treatment, there is a belief that their training should be one of the major factors that will be of help to suffering patients.

Reality, however, is complicated by the demand of daily practice to see more and more patients; the expectations of insurers for a quick and complete cure; the concerns of employers who are focused on the bottom line; the demands for documentation, paperwork, forms, etc.; the impact of legal, along with attorney involvement in a case; and issues of financial constraints and reimbursement issues — all of which limit what can be done for patients. Time pressure leaves the provider feeling constantly under the gun to accomplish more, see more patients,

PROVIDER-PATIENT Interactions



and do the required paperwork within a limited period of each day's time.³

Patient Issues

Most people hope that they will remain healthy most of their lives. They expect that they will be exempt from physical problems and difficulties. Most hope that they will not have to be involved with the health care field. They have little desire to have their days revolve around doctor appointments. Instead they hope to focus on their daily lives, jobs, family, and other private things of life that are governed by their own private logic.

When patients are faced with complex health care issues, such as chronic pain, they find themselves confronting their own mortality and limitations. However, there is a belief that contacting the right provider will solve all their problems and they can then return to their usual lives without any hardship. They also expect that the practitioner they consult will know what to do or will refer them to the appropriate specialist to fix their problem.

As a result, they turn to providers as one would turn to an omniscient being. They expect that the provider will take the time to exclusively focus on them and their problem. They also expect the provider to allow them to talk at length about all the issues involved in their problem expect that the provider is interested in everything that the patient has to say. According to business marketing, as well as psychological advisors, clients only want to feel that they matter and that the interlocutor personally cares about them.³ There is a fear that with their disability and limitations that they will become invisible and no one will notice them again. They feel they are melting away from interactions in society where they previously had a role but now feel that "nobody knows their name."

All of this is complicated by the constant broadcasting of health information on TV and radio discussing the latest medical advancement which will solve the most difficult of medical problems. Added to this mix are independent medical examinations where the patient feels that the examiner is more of an agent of the insurer, and from which they receive little information about their condition or what they can do to obtain help.

When quick solutions are not found, patients are frequently upset, confused,

depressed, angry — all of which result in a sense of exhaustion and hopelessness. Some patients feel that providers have been authoritative, directive, unsympathetic, and have not answered their questions. They feel their fears and feelings are not valued or understood. When seeing a new provider, they frequently expect the same rejection they perceived in previous providers resulting in an initial tension-filled interaction.^{4,6}

Patients may present as scattered, reactive, panic-stricken, voluble, dramatic, vulnerable, and overwhelmed. They may

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have had "a bad day" and feel the need to take it out on the world. When one feels vulnerable, it is typical to strike out at others. At the same time, they also want to feel nurtured and valued as special human beings.³

Chronic Pain Mythology

All of these interactions, and expectations, are further complicated by the unstated myths that surround issues of chronic pain. These include perceptions that chronic pain only happens to those who have psychological problems, early childhood abuse, chemical abuse, or those who are psychologically weak and vulnerable. There is also a belief that the majority of chronic pain patients are wanting to get out of work and live off disability bene-

fits. Conversely, when patients balk at what a practitioner says or offers, this only confirms more of what some practitioners have come to believe about the resistant pain patient. This is further reinforced by the fact that a few patients do tend to appear to complicate the lives of providers by their perceived lack of motivation to improve or expend effort to help themselves. Though this does not happen with the majority of chronic pain patients, the complexity of the syndrome — along with the fact that one's views are always based on the few negative experiences encountered — there is a tendency to generalize this view to all patients.^{2,5,7,8}

Unconscious Interactions

The author remembers once reading a book on marital counseling with a chapter on mate selection which was titled "One's Unconscious Speaking to the Unconscious of the Other." It went on to describe how one picks others to interact with that meet some type of unconscious need or pattern to which one reacts instinctively without thinking. This is one reason why most tend to gravitate toward the same types of relationships regardless of the logic involved in the situation. In fact, most interactions and choices in life are based on one's own private logic, i.e., something that makes sense to our inner needs and perceptions about the world and others.

This typically happens also in regard to professional relationships. Each person brings to bear on an interaction issues, needs, fears, frustrations, based on past interactions in the present, and more importantly, from the past. The situation is further complicated because one is not aware of this happening consciously. So the very act of two people interacting results in a dual-dynamic which is acted out unconsciously by both individuals. The negative reactions may be sparked by a number of factors including issues of the gender of the patient and provider, the voice tone of each, the posture, who the other person reminds us of from our past, along with our needs, wants and desires, fears, suspicions, and disappointments. Even though practitioners are frequently aware of issues that the patient brings to bear in the professional interaction, they themselves seldom stop to think of how their own similar unconscious issues may be changing the quality of the interaction. As much as practitioners may

want to deny it, they are constantly impacted by interactions throughout the day and certain stimuli may cause their unconscious to react in unexpected and unknown ways.

Transference

Since Sigmund Freud first conceptualized approaches to therapy, psychologists have known that all professional, as well as interpersonal, relationships involve the concept of transference. This is seen as the patient transferring patterns of interactions and expectations — in an unconscious manner — into the present real relationship. Frequently this is conceptualized as the patient reacting to the professional as though he/she is a parental figure. Depending on the quality of that relationship, the patient can react to the present interaction in a positive or negative manner. There should be, on the part of the professional, an awareness that transference is a normal part of the therapy process which needs to be understood and dealt with if the patient is to make a therapeutic improvement. While it does not always have to be acknowledged and analyzed as part of the treatment process, it does need to be understood along with knowing how to manage the transference so that neither party gets caught up in past issues and interactions. It is the curative effects of a corrective emotional relationship experience — in the present situation — which is therapeutic and essential to a positive outcome.

When people are transformed into patients, they find themselves feeling increasingly dependent on parental figures for support and help. At these times, patients do tend to regress in functioning and often to previous levels of dysfunction. This may increase a sense of panic and dependency strivings that can be overwhelming to the patient and anyone with whom they come in contact — especially health care authority/parental figures. In fact, crisis theory suggests that in the midst of a crisis people tend to look sicker than they actually are. This enhances the transference relationship in both positive and negative ways requiring an increased professional awareness of the interaction.⁹

Counter-Transference

Professionals, themselves, also have subconscious reactions based on their own issues — both resolved or unresolved —

from the past. Practitioners therefor react to patients based on their own experiences, desires, beliefs, fears, dependency needs, vulnerabilities, etc. In so doing, they transfer emotions onto the patient that are unconscious and based on their own private logic system.

However, in professional interactions, it is critical for professionals to become aware of their own counter-transference tendencies which are, in turn, are unconscious reactions to the patient's own unconscious transference. Theodore Reik, Ph.D., a noted psychoanalyst who trained

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with Freud, talked of the importance of the provider having a “third ear” which is constantly scanning for messages and meanings in the patient’s communications, behaviors, withholding of information, and frustrations. He also talked of how one’s counter-transference could be useful for therapeutic diagnostic assistance and to help to guide proper responses.¹⁰

Understanding counter-transference requires a degree of personal awareness that develops over time. It involves observation and introspection to understand one’s own responses to patients. For example, counter-transference may include a tendency to be parental toward patients, authoritarian, dogmatic, impatient, critical, resentful of questions, en-

abling, too helpful, aroused, desirous, angry, resentful, or too rigid, to name a few. Instead of using any insight, or therapeutically helpful reaction, one may be tempted to misuse the information to instead label or find fault with the patient. Though there may be some truth in one’s impressions of — and reactions to — certain patients, unconscious counter-transference reactions may control the interaction.

Projective Identification Defenses

There is little discussion in the literature about how the other person’s psychological defense mechanisms can influence how we interact with them. Defense mechanisms are ways for the person to deal with the world in order to protect themselves psychologically, e.g., denial, rationalization, identification with others, etc. One particular defense mechanism that one rarely hears about is what is known as “Projective Identification.” This technique is used to blame others for what one is feeling or experiencing. In essence, the individual is saying that “I don’t have the problem — you do!” It is a way of justifying one’s particular view of the world using one’s own private logic.

Projective identification defense complicates an interaction causing the other person to react with the felt emotion that the individual is trying to evoke, or project, in some semi-conscious manner. For example, one person may feel angry and frustrated themselves, but through projective identification they can get the other person to react with those same feelings. Children are masters of this when they passively-resist attempts to involve them in meaningful interactions. Parents become upset and angry, frustrated and confused, while the child is feels “powerful” and relishes the whole experience. When one experiences emotions of the other person, one may act out those emotions in inappropriate ways. When this happens, one may get blamed by others — and oneself — for over-reacting. In reality, it is the behaviors and emotions of the other person that were projected onto oneself. As a result, one subconsciously identifies with the projected emotions in ways that are hard to explain. Many times, these reactions are tied to one’s own past fears and needs — making one feel even more intensely about the situation. These precipitated emotions can include, anger, explosive-

TABLE 1. Some common sense steps to improving provider-patient interactions.

1 Stop and ask “what is happening in the interaction?” Situations can be so filled with emotions (eg. resentment, irritability or anger) that one cannot be sure of “what just happened.” When the practitioner senses that he/she is reacting very strongly in an unexplained manner, it is time to stop and evaluate. By taking time to step back and consider the situation, one can start a process of more objectively observing interactions. One has to remember that feelings should not be the basis for action or reaction in a clinical setting. Nevertheless, the patient may re-double efforts to “project emotions” for an extended period of time when not getting the anticipated reaction from a practitioner. These emotions tell us something about what is happening in the interaction and what the patient is struggling with. Working to keep an emotional distance allows the practitioner to observe his/her own reactions and emotions not as action-oriented but as diagnostic, instead.

2 Objectively decide what to communicate to the patient. Work at communicating only clinically-useful dialogue rather than what an emotional patient may want the practitioner to feel and react to. The nature of the interaction can be changed from reacting to knowing how to act in a realistic and helpful manner. Responding differently is what becomes the therapeutic model that allows for healthy growth and change over time. The clinical communication should be done in a clear and succinct fashion followed by an immediate disengagement from the interaction before getting caught in extraneous emotions. There is nothing wrong with saying “no” as long as it can be done calmly and professionally — without resentment, irritability or anger.

3 Understand a patient’s defensive ‘Projective Identification’ and how to avoid it’s pitfalls. Understanding a patient’s psychological defense mechanism of ‘Projective Identification,’ the practitioner can start to make changes in how to personally respond. In recognizing this behavior, the practitioner can become empowered in new ways — thinking differently and reacting more realistically — so that provider-patient relationships will change over time. It takes away the blaming and focuses on what is happening in the interactions. It also imparts new powers to handle interactions better as long as one doesn’t let one’s own needs and psychologically-unresolved issues cloud perceptions and get in the way. However, it is important to note that identification of this behavior cannot always be successfully “interpreted” to the patient. Often the patient will strongly deny it and turn all the blame back on the practitioner.

4 Review one’s own myths and beliefs about chronic pain patients. Practitioners must look at their own myths and beliefs about chronic pain patients and examine how easy it is for human beings to blame others for situations. One has to look at how these views and beliefs are self-limiting and may cause the practitioner to react in a negative manner to patients. The practitioner must look at his/her own behaviors, including potential issues in communicating easily and making the patient comfortable in the interaction.

5 Understand one’s own fears of vulnerability and disability in life’s struggles. Practitioners must come to terms on how their own fears of vulnerability and disability get in the way. Professionals have spend years educating themselves, delaying gratification, putting off family, finances, and pushing themselves, working with little sleep, all at great odds, to overcome and keep moving forward. Having worked hard to overcome difficulties, it is easy to resent or be angry at those who do not possess the same drive and seem to have given up trying to overcome their disability.

6 Examine personal/professional insecurities and acknowledge that one won’t always have an answer. Practitioners must realize that situations often present themselves for which an answer is not readily discernable and these should not be a cause of personal or professional insecurity. Without this recognition, one may become embarrassed for not knowing, not having the answer, not having words to put thoughts into action, and find themselves becoming even more controlling, authoritarian, directive, and angry with patients who question or do not follow directions without comment.

7 Understand and avoid Counter-Transference Rage. Counter-transference rage describes a situation where the practitioner becomes angry and upset with patients, defensive, reactive, or demanding in response to a patient’s question or request. It is often better to answer the question or request even if inconvenient at the moment so that later, after thinking about it and how to phrase it, one can discuss it therapeutically separate from the needs and emotions of the present situation. It is often the case that when one reacts quickly — to what may turn out to be an unconscious interaction — one frequently “puts one’s foot in their mouth” and unnecessarily poisons a relationship.

8 Put oneself into the shoes of the patient. Practitioners will find it useful to recall instances where they themselves where in a dependent position having to deal with an authority figure having more control over their life than they did. Analyzing what they would have wanted the authority figure to do in such situations when they themselves were feeling out of control may help to find ways to move it out of a regressive parental-child type of interaction into one of an interaction among equals in some manner. It is important to find ways of insuring the competency of the patient so that in the future they will have had a positive corrective emotional experience which will allow them to ask and interact in more appropriate ways.

9 Listen to what the patient has to say. Often, patients are fearful that no one is listening to them. They have pent-up frustration over what has happened to them, how they perceive that they have been treated in the past, and the general lack of information they have received about their condition and what needs to be done. It is hard for many of them to accept that their lives have changed and they will need to make adjustments. Many times it is important to have a session where the patient is just able to vent and talk out their concerns so that they feel less misunderstood and less alone with their condition. During the patient's monologue the practitioner does not have to say anything except to actively listen and be actively supportive. Once the patient has vented frustration, it is useful to say something like: "I know that things are difficult and the entire situation is frustrating. You need to be able to talk all this out if you are going to figure out what to do next. I cannot help you with this but it might be helpful if you could talk to a pain management psychologist, or pain management psychotherapist, who can help you figure out the next steps for you. This does not mean that you are 'crazy.' It means that you need a specialist in pain management who can work with you to find ways of managing your pain over time. We have to focus on certain medical issues here so that we can assist you as best we can. We have certain things we can do here and some we can't. We understand how difficult this is, but....." This helps to limit and focus the patient once they have felt they have been heard. Further tips in talking to different types of patients are available in a previous article entitled "Taxonomy of Pain Behaviors."¹

10 There are times that the patient may have valid points. There may be occasions that the patient may have valid points to make about treatment by the provider or staff although they may tend to expand on the issue in reactive or dramatic ways. It is important to listen, to let them know they are heard, and to apologize if it is necessary. "Giving in" many times is a way of winning through support. Patients tend to respect those who are willing to be open, honest, and to admit to issues rather than those who are defensive. This helps to reduce their anger and upset dramatically — if done early in the discussions. However, it is first important to allow the patient to vent and be heard.¹¹

11 Use a sense of humor to lighten interactions. Being able to relax and see the humor in day-to-day interactions helps one's perspective. Part of having a sense of humor is to be able to "laugh with the patient" rather than "at the patient." Because patients are usually anxious about being in a professional relationship, it helps to relax them if they can sense the humor in the provider's voice and tone. Knowing how to lighten up a situation can often loosen up the most tense person. Get help from those who do it successfully. Use them as a "humor mentor" to help learn how to be more relaxed with patients.

ness, resentment, confusion, dependency, the desire to take care of others, and so on.

Solutions

What is important is that providers have to first admit that dealing with patients in chronic pain is a difficult and, at times, exhausting process. In some ways, the profession is akin to what police officers have to deal with when they only see a certain side of the population. When faced with angry, defensive, resisting people on a daily basis, it is easy to come to believe that all of humanity is negative. In turn, like the police officer, it is easy to become bitter and resentful at the demands made upon providers. Even though a provider may know better and see many "good patients," becoming burned-out on a few difficult patients may color expectations of pain patient interactions. One then stops adapting, adjusting, or even trying new approaches, in favor of just reacting in order to "keep them at bay" with all of their demands and problems.

It is tempting to label patients as ungrateful, demanding, manipulating, con-

trolling, or malingering. Though there may be some truth in such descriptions, each of these labels could have both positive and negative ways of viewing behaviors. Much depends on whether or not the provider is open to examining his/her own reactions to patients. For example, talking down to patients only reinforces the patients' sense of feeling like children or victims. This may only increase the use of the aforementioned patient behaviors in an effort to force the situation and precludes the patients receiving help to understand the impact of their behaviors on the therapeutic interactions.¹ It is useful to remember what marketing consultants often stress to their clients: practitioners may believe they offer excellent client services, but instead their services are more focused on their own practice needs than on making the client feel valued, nurtured, listened to, and understood.³

Finally, some providers just have a poor bedside manner and don't care about it. This may have been shaped by a number of factors ranging from the providers personal style to the pressures of an every day practice. More recently,

it may have been shaped by the pressures of managed care with a business orientation to the bottom line while sacrificing a positive provider-patient relationship. The bottom line orientation has forced many providers into a natural defensive posture where they are required to manage costs and to block speciality care in order to improve the profit margin of the insurer. There is an emphasis on patients who misuse, or over-utilize, the system forcing a systemic tendency to find fault and label the patient as the cause of cost-over-runs. Lower reimbursements has forced providers to see more patients in less time in order to pay the overhead. At the same time, some providers believe that they know best and the patient needs to conform to their views if they want to get better. Others believe that any problems in patient interactions does not apply to them. They think that such discussions are directed at "those other providers" resulting in a lack of personal awareness or concern for what is happening in their own interactions. All of this blocks the development of realistic and long-term cost-effective services.^{12,13,14}

Conclusion

Interactions with patients are some of the more intense intimate interactions we face in life and as a result are filled with emotions that are bound to “spark” and impact us both positively and negatively. The goal of this discussion is to understand what it is that makes some interactions with patients, and providers, difficult. Knowing that all parties bring unconscious patterns to bear on provider-patient interactions allows providers to consciously review and improve their response style and interactions with patients. ■

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