The avoidant psychotherapy patient

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How would you handle this case?

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Mr. J, age 35, seeks treatment for panic attacks. He takes a benzodiazepine and attends psychotherapy but comes once a month, and keeps sessions superficial. How can he be helped?

CASE Unexplained panic

Mr. J, age 35, is a married, unemployed musician who presents for outpatient treatment for panic attacks. He experienced his first panic attack at his oldest son's baptism 12 years ago, but does not know why it occurred at that moment. He rarely has panic attacks now, but wants to continue medication management. He denies depressive symptoms, saying, "I'm the most optimistic person in the world." Mr. J tried several medications for his panic attacks before clonazepam, 2 mg/d, proved effective, but always has been vehemently opposed to antidepressants. Despite his insistence that he needs only medication management, Mr. J chooses to enroll in a resident-run psychotherapy clinic.

In sessions, Mr. J describes his father, who also has panic disorder, as a powerful figure who is physically and emotionally abusive, but also charismatic, charming, and "impossible not to love." However, Mr. J felt his father was impossible to live with, and moved out at age 18 to marry his high school sweetheart. They have 3 children, ages 12, 10, and 8. Mr. J worked for his father at his construction company, but was not able to satisfy him or live up to his standards so he quit because he was tired of being cut down and emasculated.

Mr. J's parents divorced 15 years ago after his mother had an affair with her husband's friend. His father learned of the affair and threatened his wife with a handgun. Although Mr. J and his mother were close before her affair, he has been unable to forgive or empathize with her, and rarely speaks to her. Mr. J's mother could not protect him from his father's abuse, and later compounded her failure by abandoning her husband and son through her sexual affair. Growing up with a father he did not respect or get comfort from and sharing a common fear and alliance with his mother likely made it difficult for Mr. J to navigate his Oedipal phase,[1] and made her abandonment even more painful.

When Mr. J was 6 years old, he was molested by one of his father's friends. His father stabbed the man in the shoulder when he found out about the molestation and received probation. Although Mr. J knows he was molested, he does not remember it and has repressed most of his childhood.

What could be the cause of Mr. J's panic attacks?

a) fear of becoming like his father
b) unresolved anger toward his father
c) unresolved anger toward his mother
d) none of the above

The authors' observations

I (JF) wanted to discuss with Mr. J why his first panic attack occurred during such a

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Table

Defenses against countertransference hate

Defense mechanism	Description
Repression	Remaining unconscious of feelings of hate; may manifest as difficulty paying attention to what the patient is saying or feeling bored or tired
Turning against oneself	Doubting one's capacity to help the patient; may feel inadequate, helpless, and hopeless. May lead to giving up on the patient because the therapist feels incompetent
Reaction formation	Turning hatred into the opposite emotion. The therapist may be too preoccupied with being helpful or overly concerned about the patient's welfare and comfort
Projection	Feeling that the patient hates the therapist, leading to feelings of dread and fear
Distortion of reality	Devaluing the patient and seeing the patient as a hopeless case or a dangerous person. The therapist may feel indifference, pity, or anger toward the patient

Source: Reference 7

symbolic occasion. His panic could be the result of a struggle between a murderous wish toward his father and paternal protective instinct toward his son. The baptism placed his son in a highly vulnerable position, which reminded Mr. J of his own vulnerability and impotent rage toward his father. Anxiety often results when an individual has 2 opposing wishes,[2] and a murderous wish often is involved when anxiety progresses to panic. Getting to the root of this with Mr. J could allow for further psychological growth.[3] His murderous wishes and fantasies are ego-dystonic, and panic could be a way of punishing himself for these thoughts. When Mr. J identified himself as his son during the baptism, he likely was flooded with thoughts that his defenses were no longer able to repress. Seeing his son submerged in the baptismal font brought back an aspect of his own life that he had completely split off from consciousness, and likely will take time to process. Considering the current therapeutic dynamic, I decided that it was not the best time to address this potential conflict; however, I could have chosen a manualized form of psychodynamic psychotherapy for panic disorder.[4] For a table that outlines the phases of psychodynamic psychotherapy for panic disorder, see this article at CurrentPsychiatry.com

Although Mr. J's initial willingness to discuss his past was encouraging, he refused to schedule more than 1 session every 4 weeks. He also began to keep the content of our sessions superficial, which caused me angst because he seemed to be withholding information and would not come more frequently. Although I was not proud of my feelings, I had to be honest with myself that I had started to dislike Mr. J.

How would you handle a patient you begin to dislike?

a) refer him to another therapist
b) consult with a colleague about how to handle the situation
c) continue therapy as usual
d) decrease the frequency of sessions

Countertransference reactions

Countertransference is a therapist's emotional reaction to a patient. Just as patients form reactions based on past relationships brought to present, therapists develop similar reactions.[5] Noting one's countertransference provides a window into how the patient's thoughts and actions evoke

Clinical Point

Noting one's countertransference provides a window on how the patient's thoughts and actions evoke feelings in others

See this article at

for a description of psychodynamic psychotherapy for panic disorder

feelings in others. It also can shed light on an aspect of the doctor-patient relationship that may have gone unnoticed.[2]

Countertransference hatred can occur when a therapist begins to dislike a patient. Typically, patients with borderline personality disorder, masochistic tendencies, or suicidality arouse strong countertransference reactions[6]; however, any patient can evoke these emotions. This type of hateful patient can precipitate antitherapeutic feelings such as aversion or malice that can be a major obstacle to treatment.[7] Aversion leads the therapist to withdraw from the patient, and malice can trigger cruel impulses.

Maltsberger and Buie[7] identified 5 defenses therapists may use to combat countertransference hatred (***Table, page 45***). When treating Mr. J, I used several of these defenses, including projection and turning against the self to protect myself from this challenging patient. In turning against the self, I became doubtful and critical of my skills and increasingly submissive to Mr. J. Additionally, I projected this countertransference hatred onto Mr. J, focusing on the negative transference that he brought to our therapeutic encounters. On an unconscious level, I may have feared retribution from Mr. J.

I became so frustrated with Mr. J that I reduced the frequency of our sessions to once every 6 weeks, which I realized could be evidence of my feelings regarding Mr. J's minimization and avoidant style.

Clinical Point

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TREATMENT A breakthrough

Mr. J presents with obvious unease at the first visit after we had decreased the frequency of our sessions. At this point, Mr. J opens up to me. He says he has not been truthful with me, and has had worsening depression, anhedonia, and agoraphobia over the past year. He also reveals that he has homosexual fantasies that he cannot stop, which disturb him because he says he is heterosexual. He agrees to come once a week, and reluctantly admits that he desperately needs help.

Although Mr. J only takes clonazepam and citalopram, 20 mg/d, which I prescribed after he admitted to depression and anxiety, he has hyperlipidemia and a family history of heart disease. In addition to being a musician and working at his father's construction company, he has worked as a security guard, bounty hunter, and computer technician. His careers have been solitary in nature, and, with the exception of computer work, permitted an outlet for aggression. However, he recently started taking online college classes and wants to become a music teacher because he feels he has a lot to offer children as a result of his life experiences. His fantasy of being a teacher shows considerably less aggression, and could be a sign of psychological growth.

Mr. J is struggling financially and his home is on the verge of foreclosure. Early in treatment he told me that he stopped paying his mortgage, but demonstrated blind optimism that things would "work out." I asked if this was a wise decision, but he seemed confident and dismissive of my concerns. Although he now struggles with this situation, I consider this healthier than his constant pseudo-happy state, and a sign of psychological development.[8] Despite his financial stressors, he wants to pursue his dream of being a famous musician, and says he "could never work a 9-to-5 job in a cubicle."

The authors' observations

I do not think it's a coincidence that Mr. J stopped minimizing his symptoms when we decreased the frequency of his sessions. I had viewed our sessions as unproductive and blamed Mr. J for wasting both of our time with his resistance and minimization and had begun to dislike him. I felt impotent because he had been controlling each session with long, elaborate stories that had little relevance to his panic attacks, and I could not redirect him or get him to focus on pertinent issues. It was as if I was an audience for him, and provided nothing useful. However, I was interested in these superficial stories because Mr. J was

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charming and engaging. He likely reenacted his relationship with his father with me. Mr. J's superficial relationship with me caused me to dislike him, and, similar to his father, reject him. This rejection likely was damaging because I was unable to anticipate his needs, which would have been to increase—rather than decrease—the frequency of our sessions. Just like his father, I was not able to take care of him.

Mr. J is deeply conflicted about his father. He states that his father "is a monster who instills fear and intimidation into everyone around him, but he's charismatic, and I'll always love him." His view of his domineering father likely developed into a castration anxiety because he was afraid of competing for his mother's love, contributing to a muddled sexual identity. This was intensified when Mr. J was sexually abused; he may have been stimulated by the molestation, adding to his confusion. Although Mr. J has repressed the abuse and split off most of his childhood, he suffers from shame, guilt, and depression because of his ego-dystonic homosexual fantasies. Homosexuality is at odds with his self-image and contributes to his anxiety and panic attacks. He cannot adequately discharge this dangerous libidinal energy, and as he becomes more conscious of it, his anxiety intensifies.

OUTCOME Overcoming fear

As Mr. J sits crying in my office, he says he hasn't cried in front of another man in years. I wonder aloud what his father would think of this situation. His states that his father does not respect any type of weakness and probably would "knock his teeth in." Overcoming this fear of opening up will be a goal of Mr. J's treatment. His unbridled optimism borders on pathologic, and is a defense against reality.[8] Additionally, his reluctance to accept that he is suffering from depression, which he perceives as a weakness, will be a struggle throughout therapy. He likely will continue to minimize his symptoms when possible, making the true depths of his illness difficult to grasp.

Related Resources

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Drug Brand Names

Citalopram • Celexa
Clonazepam • Klonopin

Disclosure

The authors report no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

Clinical Point

Had I been more self-reflective, it's possible that I could have prevented substantial frustration, and understood Mr. J sooner

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Bottom Line

In any treatment relationship, clinicians may encounter patients who elicit feelings of countertransference hatred. Being aware of your defense mechanisms may mitigate frustration and improve patient outcomes.

Table 1

Psychodynamic psychotherapy for panic disorder

Phase	Comments
Treatment of acute panic	Therapy focuses on discovering the conscious and unconscious meaning of panic symptoms
Treatment of panic vulnerability	Core dynamic conflicts related to panic are understood and altered. Tasks include addressing the nature of the transference and working through them
Termination	The therapist directly addresses patients' difficulties with separation and independence as they emerge in treatment. After treatment, patients may be better able to manage separations, anger, and independence

Source: Adapted from reference 4