Physicians' Role in Managing Emotionally Distressed Patients Already in Psychotherapy

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Much has been written on how physicians should manage patients in emotional distress, including recommendations for making successful referrals to mental health providers. Little has been written, however, on the management of distressed patients who are already in psychotherapy. This article, drawing on three cases, a review of the literature, and systems theory, presents recommendations for managing these patients.

Physicians are encouraged to assess these patients for risk of suicide or homicide, substance abuse, and indications for psychotropic medication. They are advised to seek a patient's permission to speak to his or her therapist when the patient may be in immediate danger, when psychotropic medications, hospitalization, or psychiatric consultation is considered, and when the patient fails to respond to ongoing treatment. For patients whose therapists are not psychiatrists, psychiatric consultation is recommended when there are questions about psychotropic medications, when psychiatric and substance abuse disorders coexist, and when hospitalization is considered. Therapists skilled in applying systems theory should be consulted when the patient, psychotherapist, and physician agree that the patient is not making sufficient progress. In most cases, however, physicians should reassure patients about distressing symptoms, avoid expressing opinions about the therapist and psychosocial issues, and encourage patients to renew or to expand their commitment to their psychotherapy. **J Fam Pract 1990; 31:381-388.**

Nonpsychiatric physicians in ambulatory settings often see patients presenting with emotional distress.[1,2] Sometimes the distress is obvious, but often it is masked by physical symptoms.[3] Authors have advocated that primary care physicians be skilled in establishing rapport with such patients, eliciting their concerns, evaluating them for psychiatric illness, and performing initial management.[4,5] If the complexity of a patient's psychosocial problems exceeds a physician's expertise, the physician is advised to refer the patient to an appropriate mental health professional in a manner facilitating the patient's acceptance of the referral.[5,6]

Little has been written on how physicians should treat emotionally distressed patients who are already engaged in psychotherapy. Several questions arise from these situations: Should these patients simply be referred back to their psychotherapists? Should the psychotherapy be regarded as a failure and the patient advised to seek alternative care? Should the physician provide counseling in parallel with the psychotherapy? Should the physician prescribe psychotropic medication when it seems indicated? Should the physician contact the psychotherapist?

How the physician answers these questions can have a great impact on the patient's mental health. Doherty and Baird[7] have called the physician-patient-family relationship a therapeutic triangle in which one party can have a profound effect on the relationship between the other two parties. A patient already in psychotherapy presenting to a physician in emotional distress generates a similar triangle of patient, therapist, and physician. Physicians, therefore, by their actions and suggestions, can have a profound effect on the patient-therapist relationship.

This article will present and discuss three cases in which patients already engaged in psychotherapy came to

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see their physicians in a state of emotional crisis. Recommendations for managing these patients will then be developed.

ILLUSTRATIVE CASES

Case 1

Anne is a 23-year-old college student who presented to her physician after experiencing over a 2-week period many 5- to 10- minute episodes of shortness of breath, trembling, and severe anxiety. Although she felt these episodes were similar to asthma attacks she had in the past, she was unable to attribute them to the usual precipitants, and they did not abate after several days of increased adherence to a regimen of oral theophylline and inhaled albuterol. She also noted a gnawing pain in her stomach, which improved with food intake.

Two months before her visit, following a traumatic breakup with her boyfriend, Anne had begun to see a psychotherapist. She had missed her last two weekly therapy sessions because she was no longer able to afford them. Recent stressors included a heavy courseload, financial difficulties, the death of a grandmother who helped raise her, and a deteriorating relationship with her alcoholic father.

Her medical history was positive for asthma, sinusitis, and current use of oral contraceptives. She denied recent alcohol and drug use. She cried when describing recent urges to use alcohol for relief.

Findings on physical examination were significant only for obesity. She was an alert and well-oriented woman with a labile, tearful affect. She was preoccupied with guilt over losing emotional control and fear that she might throw breakable objects in her apartment. She suffered from insomnia, a variable appetite, poor concentration, and a loss of libido. There were no delusions or hallucinations. She described her mood as fluctuating between neutrality and sadness. She reported no suicidal or homicidal ideation.

Anne was informed by her physician that her episodes stemmed from her anxiety and depression, which was appropriate for her situation. She was assured that her symptoms were not physically dangerous and was advised to return in 1 week or to call before then if they did not begin to improve to her satisfaction. Anne was also advised to return to her therapist and to negotiate financial arrangements. If satisfactory arrangements could not be made, she was invited to return for a brief course of counseling with her physician, as that would be covered by her school's insurance plan. Blood was drawn for a theophylline level to rule out toxicity.

When notified of her subtherapeutic theophylline level by telephone 4 days later, Anne reported that she had returned to therapy, that her physical symptoms had abated, that her mood swings had decreased, and that she felt much better overall. Six months later, Anne had intentionally lost 12 pounds and suffered only from minor anxiety about obtaining employment after her upcoming graduation.

Case 2

Beth is a 25-year-old part-time student and secretary who presented emergently with concern over nausea and vomiting, abdominal cramping, constipation, headache, tightness in her throat, and excessive perspiration for the past 3 weeks. She had been seen at her first visit to the same practice 1 week prior to this visit by another physician who diagnosed anxiety and irritable bowel syndrome. A previous prescription for alprazolam, 1 mg daily as needed, was renewed, and she was given dicyclomine. These medications had not alleviated her symptoms, and she returned requesting stronger medication.

Beth admitted freely to a history of alcohol and marijuana use "to the point where it was a definite problem." Recently she had been using marijuana three times a week and denied all alcohol use. She had been seeing a psychotherapist for several months but had missed her last two appointments because of distressing physical symptoms. She admitted to avoiding important issues in therapy.

Her past history was significant for a rape with subsequent sexual difficulties. Her family history was positive for substance abuse and depression. She lived with her boyfriend who she stated was "as high-strung as I am."

Findings on physical examination, including a rectal examination, were unremarkable. Beth was an alert and well-oriented woman with an agitated, labile affect. She reported early morning awakening, diminished appetite without weight loss, difficulty concentrating at work, decreased libido, and little pleasure over the past 2 to 3 weeks. She denied suicidal and homicidal ideation. There was no evidence of a primary thought disorder or previous manic episodes.

The physician informed Beth of his assessment: that her physical health was excellent and that her emotional distress was causing her real and frightening physical symptoms. In reply to various questions she raised on the origins of her distress, the physician explained that it would best to query her psychotherapist, who knew her better. He elicited a promise from her to see her therapist as soon as possible and to discuss the issues she had been avoiding. He advised her that she will probably experience worse physical symptoms until then as she becomes more focused on these issues, and he reassured her that these symptoms would not be dangerous. He discussed the rationale for avoiding minor tranquilizers, including an

explanation of her risk for addiction. Beth was invited to follow up in 1 week with this physician or her initial physician, as she wished. The physician charted a plan to consider starting antidepressant medication if the patient did not show rapid improvement.

Beth saw her initial physician 5 days later. She had seen her therapist and spoke of a very difficult session in which she brought up several new issues. She was feeling calmer, and her sleep had improved. Over the next 4 months, Beth continued to see her initial physician for management of her irritable bowel syndrome and benefited from frequent reassurance about her symptoms. Her relationship with her boyfriend and her productivity at work improved markedly. She continued to see her therapist regularly.

Case 3

Carmella is a 32-year-old divorced mother of three children, aged 5, 8, and 9 years, who works as a unit clerk in a hospital. She was seen emergently at the urging of her supervisor after 4 weeks of poor sleep, difficulty concentrating, anhedonia, irritability, and uncontrollable crying spells.

Carmella's daily schedule consisted of work from 11 PM to 7 AM, getting her children off to school, 3 hours of sleep, caring for her children from noon until after dinner, and 3 more hours of sleep. Her mother helped with child care. She described her children as "basically good kids," though her middle child had been acting out in school lately. She felt for reasons she could not express that she was a bad parent. She had been divorced for 4 years and could not identify what had precipitated her recent decline.

A psychologist had been treating Carmella for anxiety for the past 6 months. Until lately, the therapy had seemed to help, and Carmella had missed only a few sessions. She denied other personal or family history of psychiatric illness. She rarely drank alcohol and did not take medications or illicit drugs. She admitted occasional suicidal ideation, which she would never act on because of her children. She appeared tired and tearful and expressed hopelessness about her future.

The physician gained permission to talk to Carmella's therapist and was able to reach her in 30 minutes. He spoke with her by telephone in Carmella's presence. The therapist concurred with the physician's diagnosis of major depression and his plan to initiate tricyclic antidepressant therapy.

Carmella's sleep improved dramatically over the next 2 weeks. Her mood was very much improved in 1 month, and she felt that her life had become manageable again. Over the next few months, her therapist engaged her in family therapy with her children, and she developed greater consistency in disciplining them. With her physician's guidance, she was able to extinguish her youngest child's enuresis. One year after her initial presentation, Carmella continues in psychotherapy and expresses guarded pride about her parenting skills. Her medication is being tapered.

DISCUSSION

It is well known that many patients have physical symptoms that originate from emotional problems and that such patients tend to seek medical care more frequently than others.[8] In psychotherapy, as painful issues are uncovered and examined, patients are at risk for developing distressing emotional and physical symptoms and withdrawing from therapy.[9] Thus, it may be somewhat common for patients in this situation to seek medical attention. Physicians must manage these situations with great care to maximize patients' chances for short-term relief and long-term improvement.

In the cases summarized above, both Anne and Beth presented with symptoms of anxiety and depression. Both patients had psychotherapists whom they had recently stopped seeing. Both patients returned to their therapists and exhibited dramatic improvement. Carmella, on the other hand, was still active in therapy and presented with depression. Pharmacologic therapy seemed to ameliorate her acute symptoms, allowing her therapy to continue addressing long-term goals. If these patients' established psychotherapeutic relationships had not been discovered and utilized, treatment would have required much more physician time and effort, and positive outcomes would have been delayed at best.

On the basis of these cases, other clinical experiences, and a review of the literature, the following strategies are recommended for managing emotionally distressed patients already in psychotherapy:

1. The physician should determine whether any emotionally distressed patient is engaged, or has been recently engaged, in a psychotherapeutic relationship.
2. The physician should assess the patient for immediate danger—risk for suicide, homicide, or loss of impulse control—that might require hospitalization. Patients in psychotherapy are at risk for these dangers when their therapy uncovers previously denied, suppressed, or repressed internal or external conflicts. Much has been written about assessment of management of potentially dangerous patients.[10] It should be emphasized, however, that if a potentially dangerous patient is involved in psychotherapy, or if a patient may benefit from hospitalization, it is extremely important to contact the patient's

therapist, whose input and involvement may be integral in preventing a catastrophe.

3. If the patient is not an immediate threat to self or others, and if the physician feels that communication with the therapist is important, then the physician should seek the permission of the patient before initiating contact with the therapist. Such permission will be more forthcoming if the physician assures the patient that his or her intention is not to pry into sensitive aspects of the patient's life but only to access important, general information to optimize therapeutic decision-making. Seeking permission in this manner also shows that the physician respects the relationship between the patient and the therapist.

4. The physician should assess the patient for current or potential substance abuse. Among unselected American adults the prevalence of alcohol and other drug abuse is from 10% to 15%, and emotionally distressed patients are at higher risk.[11] Although it can be difficult to uncover evidence of substance abuse, when a physician demonstrates that his only objective is helping, and when he asks questions on substance use in a nonjudgmental fashion, he is more likely to elicit accurate information. If a patient who manifests both psychiatric and substance abuse problems is not responding to his current treatment, consultation with the therapist and referral to a psychiatrist or center with a "dual diagnosis" orientation are indicated.

5. The physician should assess whether psychotropic medications, especially antidepressants, might be helpful to the patient.[12] A decision to initiate medication should be made in consultation with the patient's psychotherapist. Even nonpsychiatrist psychotherapists often possess some knowledge of psychotropic medications, and they always have additional pertinent information and insight about the patient. If the physician feels uncomfortable assessing the potential value of psychotropic medications, or if the physician and therapist disagree on whether such medication is indicated, a psychiatric consultation may be helpful.

Physicians should be extremely cautious about recommending or prescribing minor tranquilizers such as benzodiazepines for patients in psychotherapy. Potential harmful effects of prescribing these medications include diminishing a patient's urgency to resolve difficult issues, injuring a patient's self-esteem by implying that he is unable to face these issues without a crutch, providing means for a suicide attempt, and potentiating a substance abuse problem. Declining to prescribe minor tranquilizers, however, may deprive an extremely anxious patient of symptomatic relief and the opportunity to consider difficult issues with greater stability of cognitive processes. Before treatment with a minor tranquilizer is initiated, the physician, therapist, and patient should concur on a management strategy, including a concrete plan for withdrawing the medication.

6. The physician should attempt to assess the patient's progress in psychotherapy. It is important to understand that this assessment differs substantially from assessing the expertise of the therapist. One must be especially cautious in formulating an evaluation of a therapist's skills through the eyes and ears of one of his patients. A major reason for the need for caution is transference, the process by which people displace feelings about one person, such as an abusive parent, to another, such as a psychotherapist.[13] Many therapists foster transference, since it allows them to demonstrate how the patient's erroneous perceptions and maladaptive behaviors in the therapeutic relationship may interfere with the patient's ability to form and maintain interpersonal relationships outside of the therapist's office. A patient's description of a therapist will often emanate more from the patient's intrapsychic processes and less from an objective assessment of the therapist's skills. A physician who responds to the patient's transference and allies with the patient against the therapist may provoke a patient to withdraw inadvisedly from therapy.

Similarly, a physician may be misled by relying on the patient's assessment of the results of ongoing therapy. A patient who feels more anxious or sad in therapy may be facing issues that must be faced before positive long-term advances can be made. Conversely, a patient who feels satisfied with his therapy may not be dealing with important, unresolved issues.

In assessing a patient's progress in psychotherapy, physicians should deemphasize *how* the patient is doing and focus on *what* the patient is doing, particularly whether the patient is participating fully. Does the patient keep appointments? Does the patient experience any emotions toward the therapy or the therapist? Is the patient honest with the therapist? Does the patient discuss potentially sensitive and painful issues? If the answer to any of these questions is no, then the patient should be encouraged to consider why and to discuss this further with the therapist. If the patient is considering whether to quit therapy, it is always best to advise the patient to discuss this consideration with the therapist. In such discussions, the therapist may be able to demonstrate to the patient that discomfort or difficulties with the therapy or with the therapist are symptoms of important problems amenable to further therapy. An exception to this recommendation would be an instance in which the therapist may be engaging in unethical behavior. In this case, potential risks and benefits of reporting the incident to the appropriate professional board or legal authorities should be discussed, and alternate arrangements for therapy should be considered.

7. The physician should avoid dispensing advice or insights on material psychosocial issues to patients engaged in psychotherapy or to patients who would benefit

by resuming therapy. Advice or insights contradicting the therapist's strategy may weaken or destroy the patient-therapist relationship. Patients facing uncomfortable issues may use even insignificant contradictions as excuses to stop psychotherapy.

8. The previous recommendation should not be misconstrued as advocacy for a laissez-faire stance toward psychosocial problems of patients in psychotherapy. The physician can be extremely helpful to such patients who are in emotional distress by listening, by demonstrating concern, and by providing support for the patient to continue therapy; it is helpful to express that such therapy is usually painful and difficult but ultimately rewarding. Follow-up is useful for ascertaining whether the patient has returned to psychotherapy and, if not, for discussing why the patient terminated therapy, considering therapeutic options, and formulating another plan.

9. The physician should endeavor to comfort the patient regarding physical symptoms. Often reassurance after a careful history and physical examination is sufficient, but performance of noninvasive tests and prescription of benign medications may also be necessary. Patients are often calmed by assurances of continued availability of the physician's services in the event of further distress.

10. If the physician observes insufficient improvement despite continuing psychotherapy, he should verify this impression with the patient and the therapist. If all agree with this assessment, then a systems consultation,[14] usually performed by a family therapist, should be obtained. A systems therapist evaluates the patient in the context of relationships with persons likely to influence the patient's emotions and behaviors; these persons may include not only family members, but also friends, co-workers, educators, and health professionals.[15] The therapist devises strategies to discover and to neutralize destructive influences from covert alliances or conflicts and from others knowingly or unknowingly sabotaging therapy. Including all parties in therapy can help remove therapeutic roadblocks for the patient. An example would be a systems consultant's discovering that a distressed adolescent has been arbitrating his parents' escalating marital disputes; the consultant would meet with all three and arrange marital therapy in an attempt to relieve the adolescent's burden.

If either the patient or the therapist does not agree with the physician that the therapy has been unsuccessful, all three should set, by consensus, criteria for evaluating the therapy's success and a time frame for reevaluation. If these criteria are not met by the planned time, then a systems consultation should be obtained.

These recommendations describe minimum acceptable levels of communication between therapists and physicians. Many therapists and physicians work more collaboratively, communicate on shared cases regularly, and provide a more integrated approach for patient management. Such communication can be most beneficial if the patient is involved in negotiating ground rules for confidentiality and other management decisions.

CONCLUSIONS

Nonpsychiatrist physicians have an important role in managing emotionally distressed patients already in psychotherapy. In addition to assessing these patients for risk of suicide, homicide, loss of impulse control, substance abuse, and indications for psychotropic medications or hospitalization, physicians can determine whether patients have been participating fully in psychotherapy. In most cases, through reassurance that symptoms are not dangerous, physicians may comfort these patients and direct them back into therapy.

Communication with the psychotherapist is indicated when the patient may be dangerous, when substance abuse is discovered, when psychotropic medications or hospitalization may be appropriate, when outside psychiatric consultation is considered, and when the emotional distress does not respond to ongoing treatment.

Psychiatric consultation may be indicated when the physician and psychotherapist are unable to resolve questions about the need for psychotropic medication, when psychiatric and substance abuse disorders coexist, and when hospitalization is indicated.

Consultation with a therapist skilled in applying systems theory may be indicated when the patient is not making expected progress. When others discovered to be undermining therapy are included in the therapy, chances for success are improved.

Physicians must remain cognizant that they can undermine therapy by forming premature alliances with the distressed patient against the patient's psychotherapist. Chances for therapeutic success are optimized if physicians respect and work with their emotionally distressed patients' existing psychotherapeutic relationships. Unless the therapy fails to meet mutually established criteria for success, or unless the therapist may be engaging in unethical behavior, the physician should encourage the emotionally distressed patient already in psychotherapy to renew or to expand his or her commitment to therapy.

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Commentary

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The above paper[1] is a welcome addition to the family medicine literature and to a clinical conversation well beyond family medicine's borders. The broader context in which I would like to situate this commentary is the multiplicity of splits that often subtly sabotage some of the best intended biopsychosocial collaboration and that unconsciously contaminate the perceptions of role on the part of all participants. Among the splits that affect primary care physician–psychotherapist–patient relationships are mind-body, psychosocial-biomedical, soft-hard, care-cure, therapist (or counselor)–physician, hand-holding–real medicine, talk-procedure, psychiatrist–real doctor, mental-physical, good parent–bad parent, good child–bad child (as in compliance), and transference-countertransference.

What is more, patients might be in treatment not only with a psychotherapist, but also with a marital counselor, family (or couples) therapist, pastoral counselor, or psychiatric social worker in the biomedical (professional) health care system. Further, patients often seek out a wide range of lay or folk healers in the popular culture sector for treatment of what physicians (not necessarily the patient, however) might label as mental or emotional problems: eg, root workers, medicine men, shamans, *curanderos*, chiropractors, and pharmacists (the latter of whom occupy both professional and popular cultural realms). There are thus numerous potential rifts between patients' and physicians' perceptions or perspectives as to what is appropriate care, what is the nature of the problem, and with whom collaboration should or should not occur. It is crucial to know how physician, patient, therapist—and the wider social network such as family and co-workers—each views the nature of the problem(s) and its (their) treatment.

For instance, is there agreement on what biopsychosocial means, and on the division of labor (roles) that implements it? From 13 years of experience as a family medicine teacher (and even earlier, teaching family medicine residents rotating through a community mental health center service), and from a reading of *Family Medicine: The Maturing of a Discipline*,[2] I am aware that among many family physicians there is a split between the biopsychosocial model as ideology and actual practice. The biopsychosocial model often vies with even more powerful beliefs in culturally shared technological, mechanical, and depersonalized models of care.[3,4] Ideally, family physicians committed to the biopsychosocial model are well suited to establishing collaborative relationships with mental health practitioners. Both personal and institutional constraints, however, often prevent this ideal from being realized. Practice style preference, procedure orientations, income-generation priorities, lifestyle

choices, and the pressure of lineal time (eg, patient volume and flow) all conspire to make collaboration with therapists difficult as a high priority.

Brown and Mengel's three cases nicely illustrate how, under enormous anxiety and ensuing regression, patients often increasingly somatize their suffering and seek biomedical treatment, even if they are concurrently in psychotherapy. Under such circumstances, their idiom of distress becomes somatic, the site of experienced difficulty being "my body" rather than emotions or inner conflicts. The physician's difficult task is to reconcile the often competing demands of (1) honoring the patient's perception and experience of symptoms, (2) assessing and treating the patient, and (3) helping the patient to become more integrated, in part by reducing the very compartmentalization the patient is creating in seeking care from the physician rather than from the therapist at this moment. I hasten to add that this compartmentalization can be acted out by the patient only because the splits are institutionalized in the health care system.

Any discussion of physician-therapist collaboration and unconscious issues would be incomplete if it did not address the hidden triangular partner of third-party payers (insurance companies, government, employers) and the even more recent alphabet soup of industrialized medicine (DRG, HMO, PPO, PRO).[5,6] Bureaucratization, cost-containment policies, profit priorities, and stringent limitations on mental health care are part of the pernicious medical-economic atmosphere in which physician and therapist work. Preferring high-technology, procedural, short-term biomedical interventions, the cultural climate widens and deepens the many splits I have identified. Comprehensiveness and continuity of care, the importance of the ear in listening as well as the eye in seeing, tend to be downplayed as poor cousin "soft" science and are poorly reimbursed. (For a discussion of mental health treatment issues in the age of cost containment, see *Behavior Today*, a biweekly newsletter, for excellent coverage.) Fragmentation, overemphasis on the body as entity rather than as lived experience, and a discounting of the importance of unconscious issues, of the rhythm of relationships, and of time in healing are culture-wide symptoms that rend the physician-patient-therapist relationship fabric.

Even if roadblocks to collaboration could be eliminated, other issues arise. Should clinical notes or dictation be reciprocally shared among practitioners and kept in the medical-mental health chart? If this issue is at least in part one of confidentiality, do (or may) other values ever supersede it? What about the inclusion of sensitive psychosocial or biological information (eg, stigmatized illnesses such as AIDS, depression, alcoholism, even hypertension) and diagnoses in clinical charts, especially in rural or small town practices, where anonymity is less available to protect the patient's privacy in the community settings?[7]

A patient's transference and a physician's or therapist's countertransference are usually seen as strictly dyadic issues. From a larger systems view, however, these manifestations can also be symptoms of mind-body, mental health–biomedical, etc, splits *among* health care and mental health professionals themselves, and in turn, of role specialization and fragmentation. Not only can the patient emotionally bifurcate physicians into good and bad parental figures and roles, but physicians, too, can inadvertently do likewise (or, in complementary fashion, see the other professional or patient as child). At a more regressed level, patients and physicians can perceive one another not as whole persons (eg, father, mother, grandparent, sibling, projected self), but as parts or aspects of persons, as fragments of selves, eg, as one's bad conscience, as one's forbidden sexual or aggressive impulses, as one's disavowed shamefulness, as one's dissociated dependency or depression, etc. In our highly bureaucratized health and mental care systems, transference and countertransference inherent in dyadic and triadic (triangular) relationships will tend to be amplified by the fragmentation and compartmentalization of professional roles.

The division of labor between health and mental health professionals (and even among health care professionals, the surgical and internal medicine subspecialists being seen as more biomedically hard science than general internal medicine, family medicine, and pediatrics) often serves unconscious, protective functions for the referring or collaborating physician.[4] Patients whose internal and situational problems too closely resemble the physician's own—or threaten to reawaken them—will likely be fended off, and except for strictly biomedical problems, their mental health problems and progress will be seen as the domain of another professional and will be of little interest to the physician. In this situation, the primary care physician is using both the patient and the mental health professional as a bulwark against his or her own unresolved internal issues and feelings. Physician countertransference thus unwittingly adds to the fragmentation both of care and of the patient, even in the outward guise of collaboration.

Assessing and responding therapeutically to a patient's transference and to one's own (or a colleague's) countertransference can be at least as vexing as any biomedical diagnosis and management plan. Subjectivity is never of one piece. Physician, psychotherapist, and patient can confer differing meanings upon the prescription of medication and the medicine itself, just as they can project hidden meanings on the clinical relationship itself. The significance and potency of the medicine may be greatly and magically over- and underestimated. Disagreements

among practitioners over medication may inadvertently triangulate the patient.

Kernberg[8] described two types of practitioner countertransference, concordant and complementary, and deMause[9] similarly described two parenting styles, projective care and reversal. In the concordant countertransference, the therapist "identifies with the corresponding part of the patient's psychic apparatus, id for id, ego for ego, superego for superego. With complementary identification, the analyst [or physician, or therapist] identifies with the transference objects of the patient."[10] In concordant identification, the patient induces feelings and fantasies paralleling his or her own; in complementary identification, the patient causes the practitioner to embody an early parental or other emotionally significant figure. In concordant countertransference or projective care, the clinician embodies or becomes some aspect of the patient; in complementary countertransference or reversal, the physician or therapist embodies or becomes a benevolent or malevolent figure from the patient's past, or a condensation of persons from the past and present. Such out-of-awareness disembodiment and re-embodiment in another figure can likewise be done by the practitioner as well as by the patient.

Searles,[11] for example, writes of psychiatric patients' and hospital staff's fragmentation and externalization, offering insights into the complex intrapsychic texture of physician-therapist-patient-family-staff relationships.

> The externalization goes on because the patient cannot as yet face the anxiety-laden realization that he has *within him* ego elements which are sharply conflictual. Instead, he unconsciously fosters, in the staff, diverse and conflictual views of himself. Instead of his becoming aware of the war within himself he fosters—largely unconsciously—the staff's warring with one another about him....
>
> From the staff's point of view also, this group symbiosis, anxious though it is, meets neurotic needs. For those who are in a "Good Mother" position, or who personify "good" aspects of the patient's ego, there are the gratifications of feeling oneself to be a warmer, more loving, better human being than one's co-workers. For those in the "Bad Mother" position, who represent "bad" ego-aspects of the patient, there is the opportunity to ventilate pent-up resentments towards one's fellows, resentments which may long antedate the patient's arrival on the ward scene....
>
> Each member of the staff tends to relate himself particularly to a single one among the fragmented patient's various disparate personality components—tends to see it as though this represented the totality of the patient....

I quote Searles to underscore that the therapeutic triangle described by Doherty and Baird[12] is but one of many unconscious dramas people can play out in clinical relationships, and that such playing out is often mutual. The hidden play-within-the-play can be interrupted only if it can be recognized, eg, by physician or therapist tapping into one's own complementary emotional response to the patient as crucial clinical data.

It is thus insufficient to address collaborative and unconscious issues only in terms of primary care physician, therapist-psychiatrist, and patient. Who else is in the wings as well as on stage? Examples may include influential family members, clinic nurses and receptionists, business office personnel and other administrators, supervisors and co-workers, members and clergy of a religious congregation, the pharmacist (a key medical figure especially in small towns), the patient's barber or hairdresser, and so on. While it is unfeasible to assemble all of these in one gargantuan systems meeting, it is vital that physician and therapist know that these people exist, and to be able to contact them as the situation arises. From the therapeutic triangle to a universe populated by potentially therapeutic and countertherapeutic people, it is important to know the patient's (and physician's and therapist's) informal as well as formal personal network from whom advice is sought—people and institutions whose presence constrains and nurtures clinical work.

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